EVALUATION FORM

Program Title: _____

Date: _____

Expected Clinical Outcomes

1. Will information gained from this program result in enhancing optimal patient care? _____ Yes _____ No

2. If yes, please list change(s) you intend to make in your practice as a result of this program.

3. Please rate your confidence in implementing these changes.
   _____ High confidence _____ Moderate confidence _____ Low/No confidence _____ N/A

4. Please identify any barriers you perceive in implementing these changes (select all that apply)
   _____ Cost
   _____ Lack of time to assess/counsel patients
   _____ Lack of administrative support/resources
   _____ Insurance/reimbursement issues
   _____ Patient compliance issues
   _____ Lack of consensus of professional guidelines

5. How will you address these barriers to implement changes in knowledge and behavior?

Basic Program Evaluation

	5	**4**	**3**	**2**	**1**
6. The material was presented at an appropriate level.					
7. I have gained knowledge that will improve patient care.					
8. The program met my expectations in accomplishing the educational objectives.					
9. The program content was objective, balanced, and free from commercial bias or influence.					
10. Your overall rating of the quality of the education offered at this program.					

11. Additional Comments/Explanations:

12. How can this program be improved? (Please list both strengths and weaknesses.)

13. Based on your educational needs, please provide us with suggestions for future program topics and formats: