# Case Discussion Form

|  |  |
| --- | --- |
| Presenting doctor name: | Meeting date: |
| ACRRM member number: | Venue: |
| Email: | Time (duration in hours): |
| Facilitating doctor name: | Facilitating doctor email: |

|  |
| --- |
| Case title: |
| Case description: |
| Learning needs: |
| Summary of reflection and discussion: |
| Future action plan (educational, professional development): |

Presenting doctor name: Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facilitating doctor name: Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_