

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS EVALUATION FORM BEFORE YOU LEAVE**

**The Late Effects of Polio: Clinical Practice Workshop**

**Date: ……. / ……. / ……. Name: ………………………………………………………………………………**

*(optional)*

**What type of profession or discipline best describes you?**

1. **I am a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (e.g. physiotherapist)
2. **I work in**

◻ Private Practice ◻ Private Hospital ◻ Student

◻ Non-profit / Community ◻ Public Hospital

**How did you find out about this Workshop?**

|  |  |
| --- | --- |
| ◻ My Workplace◻ Polio Australia’s ‘Polio Health’ Website◻ Professional Peak Body: ……………………….…… | ◻ Colleague◻ Other website: ……………………………………………◻ Patient / Client |
| ◻ Other …………………………………………………………………………………………………………………………………………… |

**Why did you select to attend this particular Workshop?**

◻ Interested in working with LEoP clients

◻ Currently work with LEoP clients

◻ CPD hours

◻ Free Workshop

◻ Other: ………………………………………………….…….

**What aspect/s of the Workshop did you find the most useful?**

|  |  |
| --- | --- |
| ◻ Pathophysiology of polio virus◻ Diagnosis of LEoP / PPS◻ Symptoms of LEoP / PPS◻ Assessment of LEoP / PPS | ◻ Allied Health Professional roles◻ Exercise Prescription for LEoP / PPS◻ Q&A with polio survivor◻ Other  |
| **I think the duration of the workshop was:** ◻ Too long ◻ Suitable ◻ Too short**What other information would you like to have been presented with (e.g. prior to participation, additional materials during the delivery of the workshop)?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Will you be taking follow-up action after hearing today’s information?** ◻ Yes ◻ No**If ‘Yes’, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Would you be willing to receive a phone call or survey for us to know the effect of this workshop on your clinical practice?** ◻ Yes ◻ No

 **PTO**

**Please use the scale to answer the questions. After participating in the LEoP Clinical Practice Workshop:**

|  |
| --- |
| **(1 = strongly disagree to 5 = strongly agree)** |
| I have a better understanding of the symptoms associated with the LEoP and/or Post-Polio Syndrome (PPS) |  | **1 2 3 4 5** |
| I am more confident in my ability to recognise the development of the LEoP and/or PPS |  | **1 2 3 4 5** |
| I am more aware of how activity for people with the LEoP and/or PPS differ from other neuromuscular conditions and/or general ageing |  | **1 2 3 4 5** |
| I am more aware of other clinical management options/interventions for people with the LEoP and/or PPS |  | **1 2 3 4 5** |
| The workshop was well organised |  | **1 2 3 4 5** |
| The presenter communicated the information clearly |  | **1 2 3 4 5** |
| The presenter had sufficient subject matter knowledge |  | **1 2 3 4 5** |
| The duration of the workshop was suitable |  | **1 2 3 4 5** |
| The information / knowledge provided met my expectations |  | **1 2 3 4 5** |
| I would recommend this workshop to other health professionals |  | **1 2 3 4 5** |

|  |  |
| --- | --- |
| **Would you like to register as a health professional who has some knowledge of and/or experience in working with polio survivors?** | ◻ Yes ◻ No |

All following information will be displayed publicly on the Polio Health website

Your Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of clinic/business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact: Ph: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the location wheelchair accessible? ◻ Yes ◻ No ◻ N/A

I do: ◻ Home Visits ◻ Appointments at clinic ◻ Both

**Additional Comments:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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