Ovarian Cancer for the Health Care Provider Online Video Evaluation

Date of Activity Completed: _____

Please check the rating that best reflects how much you knew about each of the following areas before the course, and how much you know after this activity using the 5 point scale.

1) Not at all knowledgeable 2) A little knowledge 3) Neutral
4) Some knowledge 5) Extremely knowledgeable

Ovarian cancer incidence and prevalence
_____ Knowledge before activity _____ Knowledge after activity

Ovarian risk factor
_____ Knowledge before activity _____ Knowledge after activity

Ovarian cancer prevention
_____ Knowledge before activity _____ Knowledge after activity

Ovarian cancer symptoms/clinical features
_____ Knowledge before activity _____ Knowledge after activity

Ovarian cancer screening
_____ Knowledge before activity _____ Knowledge after activity

Referral to appropriate healthcare provider for ovarian cancer treatment
_____ Knowledge before activity _____ Knowledge after activity

Ovarian cancer survivorship issues
_____ Knowledge before activity _____ Knowledge after activity

Will this education improve the quality of patient care in your office?
□ Yes □ No

After completing this course, I will be more likely to recognize possible symptoms of ovarian cancer.
□ Yes □ No

Given the risk factors and symptoms for ovarian cancer, which strategies you would employ if you suspect ovarian cancer?

After completing this course, I will be more likely to refer patients to a gynecological oncologist.
□ Yes □ No

What topics or activities could we offer in the future to meet your CME needs? Please be as specific as possible.

How do you plan to apply the principles of the intervention process in your practice?

The content met objectives.
□ Yes □ No

The content was free of commercial bias.
□ Yes □ No

Information Required for CME Credit

***Note: Your CME credit will be processed and a transcript mailed to you approximately two weeks from the date of receipt.**

Full Name: _____

Medical Lic. #: _____ Prof. Classification: □ Physician □ Other_____

Address: _____

City, State, Zip: _____

County/Counties served: _____

Email: _____Specialty: _____

My race/ethnicity is:
□ American Indian or Alaska Native (I) □ Asian (A)
□ Black or African American (B) □ Hispanic or Latino (H)
□ Native Hawaiian or Pacific Islander (N) □ White (W) □Other (O)

Gender: □ Male □ Female

Please mail this form to:
Texas Medical Association
Attn: POEP
401 W. 15th St.,
Austin, TX 78701-1680

(or fax to (512) 370-1693, Attn: Laura Wells)