THE CONSORTIUM[1]

Overseas Registration Examination
Part 2

Diagnosis and Treatment Planning Guidance

[1] THE CONSORTIUM is made up from the following organisations:

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Introduction

A candidate is expected to be able to show competence, knowledge and familiarity in the different aspects of dentistry which are outlined in the Learning Outcomes in the GDC's document '*Preparing for Practice'* (*PfP*)[2]. The standards of conduct, performance and ethics required are described in the GDC's publication '*Standards for the Dental Team'*[3] .

PfP divides the Learning Outcomes for UK undergraduate curriculum into four Domains which reflect the full range of knowledge, skills, attitudes and behaviours that a dentist must demonstrate at a level appropriate for registration. These Domains which are integral to the ORE Part 2 are:

- The Clinical Domain
- The Professionalism Domain
- The Communication Domain
- The Management and Leadership Domain

The full range of knowledge, skills, attitudes and behaviours that are contained within these Domains of the *PfP* are examined within the four component examinations[4] of the ORE Part 2.

Diagnosis and Treatment Planning:

Information and Instructions

The ORE Diagnosis & Treatment Planning Exercise is a simulated clinical assessment of patient management and care. You will be assessed in 5 separate aspects

1. Oral History assessed by 2 examiners
2. Provisional diagnosis, special investigations, radiographic request and radiographic report assessed by 1 examiner
3. Contemporaneous notes assessed by 1 examiner
4. Written treatment plan assessed by 1 examiner
5. Oral treatment plan assessed by 2 examiners

Examiners will also be looking at your overall Professionalism during the examination and your Communication skills both verbal and non-verbal.

You will also be assessed on good clinical judgement and justification of the choice of treatment, the type of any restoration or prosthesis suggested, and any referral you wish to make. If you suggest a referral it is expected that you will make it clear why it is required.

Candidates are referred to the GDC's document '*Preparing for Practice**Error! Bookmark not defined.*** for the generic blueprint of the examination.

The examination will be completed during a 54 minute session. In order to help you with your time keeping you will be given a clock with the various sections of the exam marked on the clock face. (see appendix 1)

This clock is for guidance only. Your official examination time will be controlled by the helper with a stop watch. In the case of any malfunction of the clock, please understand it is your responsibility to monitor your own time use.

Please read the following notes carefully so that you are fully aware what is expected of you during this examination.

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[2] http://gdc-uk.org/aboutus/education/documents/preparing%20for%20practice%20(revised%202015).pdf
[3] http://gdc-uk.org/Dentalprofessionals/Standards/Documents/Standards%20for%20the%20Dental%20Team.pdf
[4] http://www.orepart2.org.uk/guidance/

You will be collected from the holding area by one of the helpers and taken to one of the four or five areas where the Diagnosis and Treatment Planning examination is taking place. Once you arrive in the clinic area and just before the examination commences you will be given an individual clock to help with your timing, and a folder with your candidate number.

Inside the folder you will find the following colour coded sheets:

1. Candidate information about patient	Colour White
2. Patient History Form	Colour Blue
3. Provisional diagnosis	Colour Orange
4. Radiographic Prescription	Colour Orange
5. Special investigations request	Colour Orange
6. Radiographic report	Colour Green
7. Treatment Plan	Colour Green

The colours relate to the clock face and should be completed during that phase of your examination

- The second sheet “Patient History Form” coloured blue should be completed during the first 10 minutes while you take the history.
- The third, fourth and fifth sheets coloured orange should all be completed during the 11 minutes following the departure of the examiners and the patient.
- The last two sheets coloured green should be completed during the 23 minutes you are allowed for examining the further artefacts and preparing your treatment plan and radiographic report.

When you are taken to your chair you will find an examiner and your patient.

1. History taking and contemporaneous note making – 10 minutes

You will meet your patient, who will be a role player who has been briefed on the clinical scenario and should in all respects be treated as the “patient”. You will not be able to examine the patient or their mouth.

You will have ten minutes to take the necessary history for this patient. During this time you will be expected to make contemporaneous notes, which will be marked.

An examiner, who will remain mainly silent during this part, will observe you and complete a structured mark sheet. The examiner will make sure that the role player’s responses are accurate and may ask for clarification if they do not understand any of your responses.

The contemporaneous notes will not be collected until the end of the examination and then will be assessed by another examiner. You will therefore be able to keep these notes with you during the other stages of the examination.

Available at this chair will be (artefacts) the clinical results from the routine examination you would normally undertake. Examples of the results are:

- Study casts or photos of study casts to give you information such as
  - the occlusion
  - number and position of teeth
- Details of obvious pathology with unaided vision such as caries
- BPE
- Photographs to show you such things as
  - lip line
  - gingival colour

It is advised that you do not spend time looking at these until you have completed your history taking. This information will then help to inform you to complete the forms in the next section.

2. Complete provisional (possible) diagnosis, special investigations & radiographic prescription forms – 11 Minutes

At the end of the first 10 minutes the "patient" and examiners will leave the surgery and you will have 11 minutes to complete your contemporaneous notes, examine the artefacts and prepare the following:

Please Note it is your responsibility to check that all the artefacts are present. There is a list on the top of the artefacts stating what is present. (A cast is a single upper or lower so upper and lower will be 2 casts.) If you believe the artefacts do not agree with the list please contact the helper immediately and inform them of the issue.

a. Written provisional (possible) diagnosis.
b. Radiographic prescription including clear justification for this request. If no radiographs are required please indicate this on the request form.
c. Written list of any special investigations you would make if you were examining this patient.

The provisional (possible) diagnosis should be formulated from the complaint, history, and routine investigations (artefacts). It will guide you in prescribing any necessary special investigations. You should only request information you need to acquire for this patient during a clinical examination, including radiographs, etc. to allow treatment planning.

Examples of Special investigations other than radiographs (this is not an inclusive list)

- Vitality tests
- Full mouth periodontal charting
- Body temperature
- Condition of muscles of mastication
- Cracked tooth tests

At the end of this time a helper will collect the

a. Written provisional diagnosis. (sheet 3)
b. Radiographic prescription including the clear justification for this request (sheet 4).
c. Written list of special investigations you would make if you were examining this patient. (sheet 5)

and bring you a further folder with other artefacts giving the results of any special investigations and the necessary radiographs. Do not worry if they do not contain all the requests you made. There will be enough for you to make your treatment plan.

3. Written Treatment Plan – 23 minutes

You will now have all the necessary artefacts and information required to plan your treatment for your "patient". You will have twenty-three minutes to consider these artefacts and formulate a treatment plan and write down the treatment options and their advantages and disadvantages. You will also have to complete a written radiographic report for one radiograph, which will be clearly identified. You should use the real radiograph and not the one illustrated on the sheet.

Your treatment plan should also consider the potential risks of treatment, the long term stability, your patient's wishes and the suitability for your patient. If you consider it necessary to refer your patient you should give some justification and reasons for the referral, and be able to inform your patient of the possible outcomes of such a referral.

4. Presentation of Treatment Plan to the patient – 10 minutes

At the end of the treatment planning time your "patient" will return with the examiner. The examiner will ask you to present your treatment plan to your "patient". This treatment plan should be presented to the "patient" in lay terms explaining your essential findings in such a way that the "patient" has sufficient information to understand the advantages and disadvantages of the possible options that you consider are available, and to give valid consent for your proposed preferred option. (**In view of the difficulty of understanding costs of treatment in a foreign country you will not be expected to give indication of costs other than the relative difference of any treatment recommended e.g. implants high cost relative to denture).**

It is expected that the treatment plan will include not only active treatment but also any necessary care and prevention and the possible influence of any medical problems.

While you are explaining the advantages and disadvantages of any treatment you consider and finally giving your preferred choice, the patient or examiner may seek further clarification of your suggested treatment options.

This oral treatment plan will be assessed by the examiner.

At the completion of your treatment plan you must hand in all your written sheets of your contemporaneous notes and treatment plan for marking. If you do not hand these sheets in you will be unable to attain full marks.

You must not make copies of these sheets or remove any information from the examination area. Removing such information would be seen as infringing the regulations.

All examiners will mark independently and also asses your professionalism. You should refer to the GDC web site for further information on professionalism.

5. Advice on completing the written forms

5.1 Patient History Form

You should record in legible handwriting:

- **a.** the "patient's" demographic details
- **b.** the "patient's" main complaint and any other concerns they may have listing their symptoms and when they started and any modifying factors.
- **c.** a structured record of the medical (including any medications), social & past dental history
- **d.** any other relevant information such as dental care routines, diet and any other factors which influence dental health
- **e.** "Patient's" wishes

5.2 Provisional or possible Diagnosis Form

This form will be pre-populated with the patient's demographic data and requires you to enter what are the most likely reasons for the "patient's" complaint(s) from the evidence you

have received from your history taking and the artefacts supplied in relation to the examination. Where possible you should indicate the reasons for your conclusions.

5.3 Radiographic Prescription Form
This form will be pre-populated with the "patient's" demographic data but you should enter which radiographic film(s) you require clearly indicating when necessary the site and tooth. You should also indicate the justification for the request. If no radiographs are required write this clearly on the form. Remember it is unethical to prescribe more radiographs than are required to make a diagnosis.

5.4 Special Investigations Form
This form will be pre-populated with the "patient's" demographic data and you should enter any special investigations that you would wish to carry out. This should not be a list of all possible examinations and investigations but carefully considered and only those which are justified from the history.

5.5 Written Treatment Plan Form
This form of two sheets will be pre-populated with the "patient's" demographic data and you should enter the treatment and care options for the "patient". This should include any urgent, immediate and planned treatment as well as long term care plans together with your preferred treatment. You should then complete the other questions on the second sheet. You should also indicate any risks of the proposed treatment.

You will be expected to explain if you would treat the "patient" yourself or would refer them for all or part of the treatment explaining your reasons. You should also give the "patient" some information about the possible outcomes from such a referral.

5.6 Radiographic Report Form
This form will be pre-populated with the "patient's" demographic data **and a copy of the radiograph or section of radiograph on which you should report.** It will only be necessary to report on the one view shown on the report form. You should use the real radiograph to make the report and not the one illustrated on the sheet. Your report should be the standard expected by the GDC and should include which film view it is, details of the side, bone quality, bone level, teeth present, restorations or caries present, and any other relevant details. Finally you should comment on the quality, and any issues related to the film itself.

6. Marking

6.1 Candidates will be graded in each of the following areas by the Examiner(s):

1. Oral History
2. Provisional diagnosis, special investigations, radiographic request and Radiographic report
3. Contemporaneous notes
4. Written treatment plan
5. Oral treatment plan

6.2 Additionally candidates will be assessed on the Domains of Professionalism and Communication Skills and Management and Leadership where appropriate.

6.3 The grades awarded by each Examiner will use a four level grading system which describes the level of competence achieved by the candidate. These levels are:

- Exceeds Standard
- Meets Standard
- Below Standard
- Well Below Standard / Not Done

6.4 These grades are then converted to numerical values. The total points that are available for each area of assessment will vary, as does the points needed to pass that area of assessment.

6.5 The percentage marks from the five areas of assessment will be aggregated to provide an overall mark which will be used to determine whether a candidate has passed or failed.

7. Example candidate's forms

The examples of the colour coded documents which will be given to each candidate are shown at the end of this document (Appendix 2)

8. Sample Exercise and Mark Sheets

A sample exercise and the associated mark sheets are shown at the end of this document (Appendix 3)

PH v13.2 27/03/2017

Appendix 1: Clock Face

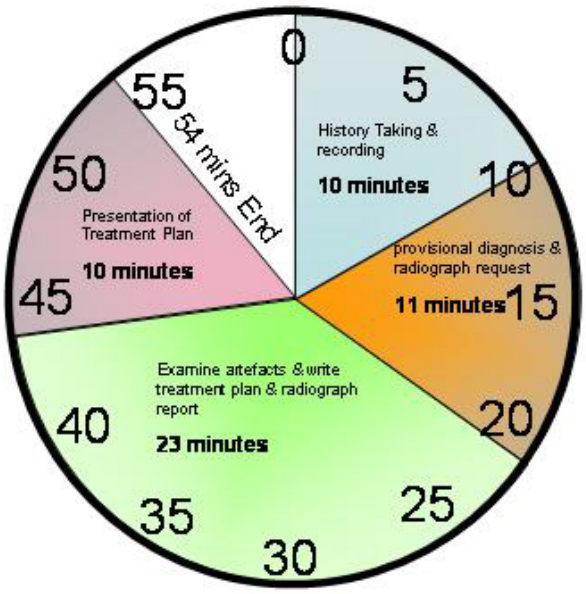


Illustration of the individual clock faces which will be handed to candidates.

Appendix 2. The colour coded documents given to candidates for completion during the DTP component of the examination

Candidate No **01-001**

Sheet 2 blue Patient's History Form -

Patient's Name DOB Date

…… …/…/…. … /…/…..

Address ……

……

……

……

Present Complaint
and History

Other Complaints
and History

Past Dental History

Medical History

Social History

Notes

Candidate No **01-001**

Sheet 2a blue Patient History Form Continuation

Patient's Name	DOB	Date
……	…/…/….	… /…/…..

Candidate No **001**

Sheet 3 Orange Provisional Diagnosis Form

Patient's Name DOB Date
…… …/…/…. … /…/…..
Address ……
……
……
……

	Provisional Diagnosis	Clinical symptoms/ presentation (ascertained during the history) that have led you to this provisional diagnosis
1		
2		
3		
4		
5		
6		
7		
8		

Candidate No **01- 001**

Sheet 4 Orange Radiographic Prescription Form

Patient's Name DOB Date
…… …/…/…. … /…/…..
Address ……
……
……
……

Radiographs required (state film view – if appropriate side & tooth)

	Radiograph	How does this request contribute to your making a diagnosis
1		
2		
3		
4		
5		

The numbers above are to help identify the separate radiographs required however it is not necessary to fill all boxes and you may feel none are required which you should state above along with your reasoning.

Candidate No **001**

Sheet 5 Orange Special Investigations Prescription Form

Patient's Name DOB Date
…… …/…/…. … /…/…..
Address ……
……
……
……

List any Special Investigations required

	Investigation	How does this request contribute to your making a diagnosis
1		
2		
3		
4		
5		
6		
7		
8		

The numbers above are to help identify the separate tests required however it is not necessary to fill all boxes and you may feel none are required which you should state above along with your reasoning.

Candidate No **01-001**

Sheet 6 Green Radiographic Report Form

Patient's Name DOB Date

…… …/…/…. … /…/…..

Address ……

……

……

……

Please report on……. shown in the box below. You will have the radiograph in your folder of artefacts

Picture of radiograph relevant to question

Radiograph

Side

Bone level

Teeth

Restorations

Caries

Other

Film Quality

Candidate No **001**

Sheet 7 Green Treatment Plan Form

Patient's Name DOB Date

…… …/…/…. … /…/…..

Address ……

……

……

……

Immediate/Emergency Treatment

Initial/Stabilisation Treatment

Preferred Definitive Treatment

Long Term & Maintenance Treatment

Candidate No **001**

Sheet 7 Green Treatment Plan Form Continued

Considering this patient, briefly describe what has led you into choosing this overall care plan and the benefits (likely success, cost, time, etc) to the patient.

Considering this patient are there any potential disadvantages of this treatment (complicated, high risk of failure, short life of restoration, etc) for the patient.

Would you provide all or part of the treatment for this patient yourself? If so which part or parts? (Give your reasons.)

If no (whether for all or for part) give your reasons

Would you refer the patient for all or part of the treatment ? If so which part or parts and to which Specialist/s? (Give your reasons.)

If no (whether for all or for part) give your reasons

Candidate No **01-001**

Sheet 7a Green Continuation of Treatment Plan Form

Sample Exercise: Diagnosis and Treatment Planning

Actor Scenario Information

Note: This information will be given to the actor playing the simulated patient. This information will not be presented to the candidate.

You have gone to your dentist for the following reason:

You are concerned over the wear of your front teeth, the lack of back teeth and the recent loss of the upper crown (cap) on the right lateral incisor (upper front tooth next to middle tooth). You complain that it is necessary to cut all your food into small pieces and you can only chew on the left side.

You have worn a lower denture for 3 years but it recently broke (during an examination with the retiring principal of the practice) and you are not wearing it at the present time. You have thrown the broken parts of this denture away. You are not keen to have another denture as you have been unable to eat with this previous denture because it rocked and caused a sensation of gagging. You do though wonder if it were made correctly and would consider an offer of a well made denture which did not rock.

You have an anxious and slightly retiring personality. You would not be insistent on any particular treatment plan but would want to know what is involved.

Medical History

High blood pressure

Medication	Atenolol	50mg daily
	Atorvastatin	10mg daily
	Bendroflumethiazide	25mg daily
	Omeprazole	20mg daily

You are otherwise fit with no allergies or other problems

Social History

Married

DOB 17/12/49

Non smoker

Alcohol 12 units per week

You drink several cans of cola every day and know on getting stressed on occasions that you grip your teeth. You do not know if you grind your teeth at night.

You brush your teeth twice a day and are aware sometimes after cleaning your teeth that there is a little bleeding from the lower front teeth.

Further Scenario Information for the Actor

This information should be used to answer questions only if asked:

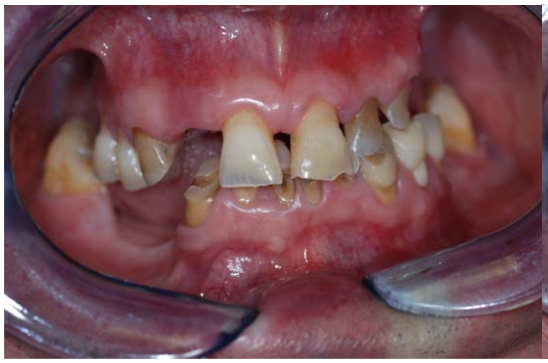
You have some concern about the appearance of your teeth as they are discoloured and unsightly but would not offer this information otherwise, as you would be embarrassed to mention concerns about your appearance.

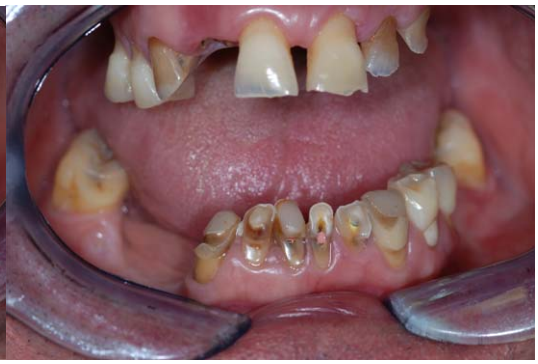
When you were examined previously by the retiring principal you noticed that you did not gag immediately when he placed the mirror head just on to your soft palate. However you did notice a slight gagging sensation was occasionally elicited when he placed the mirror deep under your tongue.

You notice that sometimes that your gum gets sore just behind your upper front teeth after eating hard food.

You had some root fillings done on the lower front teeth approximately 10 months ago.

This is how your teeth appear:

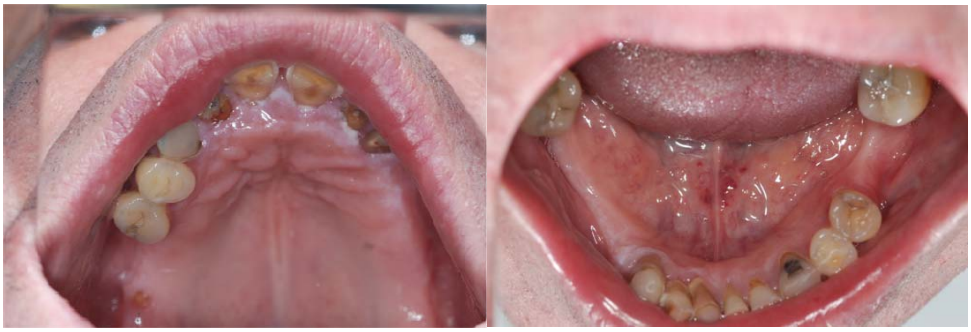




Artefacts Provided following Candidate's Request for Information

These artefacts will be present when you first meet the patient.

1. Intra Oral photographs



2. Information seen from Simple Dental Examination

Oral Hygiene

Fair with small amounts of generalised plaque and a little calculus lingual to the lower incisors
Some bleeding on probing
BPE 2/2/-
2/2/2

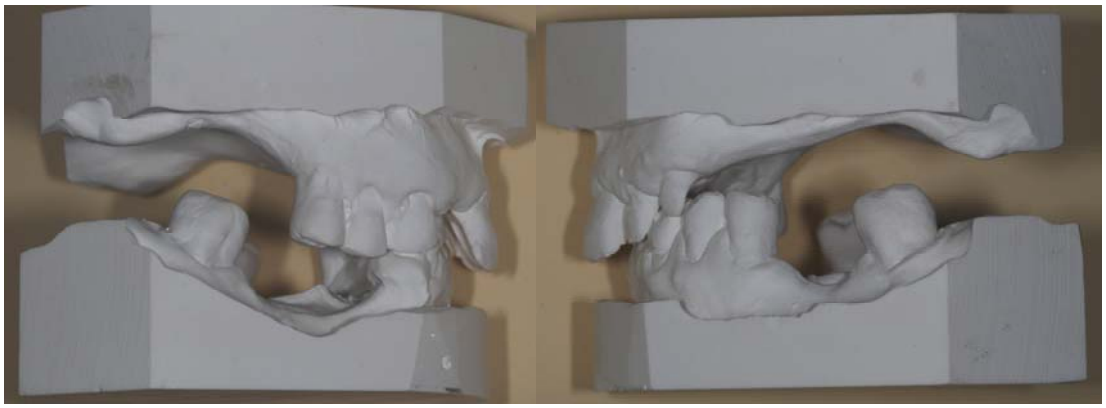
Periodontal status

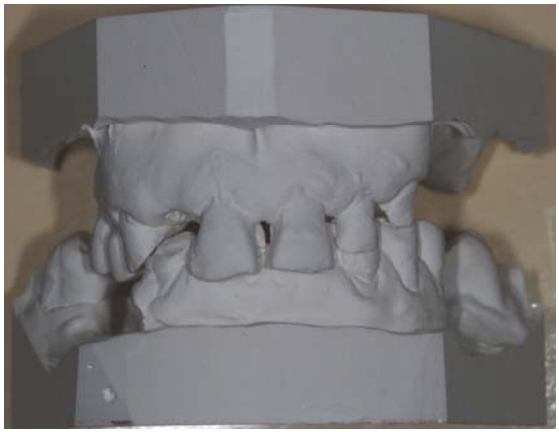
Generalised recession

Occlusion

Class 2 div 1 (Casts enclosed)
There is a slight loss of vertical height approximately 2 mm at the incisal edge with a similar increase of the freeway space.

3 Casts





Artefacts Provided following Candidate's Request for Special Investigations & Radiographs

Periodontal status
Generalised horizontal bone loss

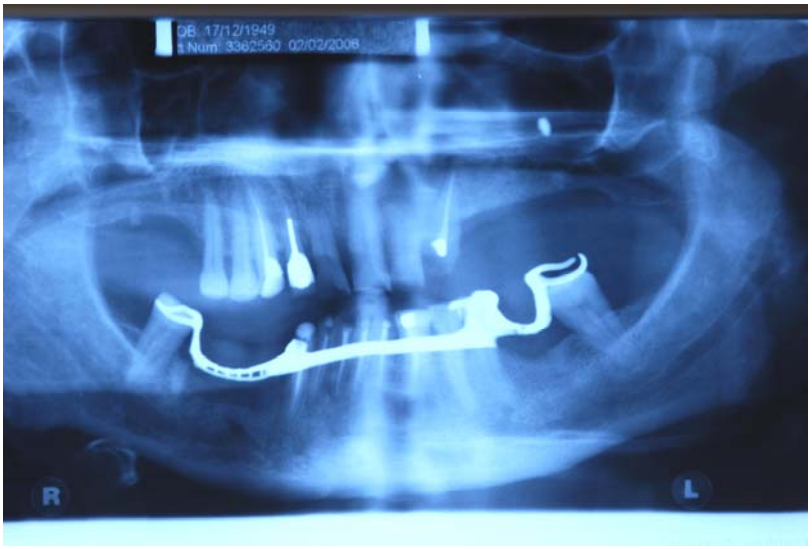
Caries
There is no active caries but some restorations are of poor shape.
The 12 the dentine is slightly soft

Mobility
No mobility of any teeth

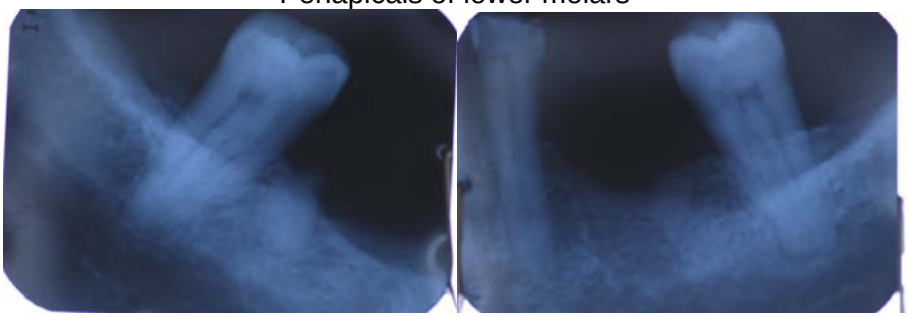
Gagging
No immediate response to placing the mirror head just on to the soft palate.
Occasionally there was a gagging sensation elicited by placing the mirror deep into the sub lingual sulcus.

Radiographs

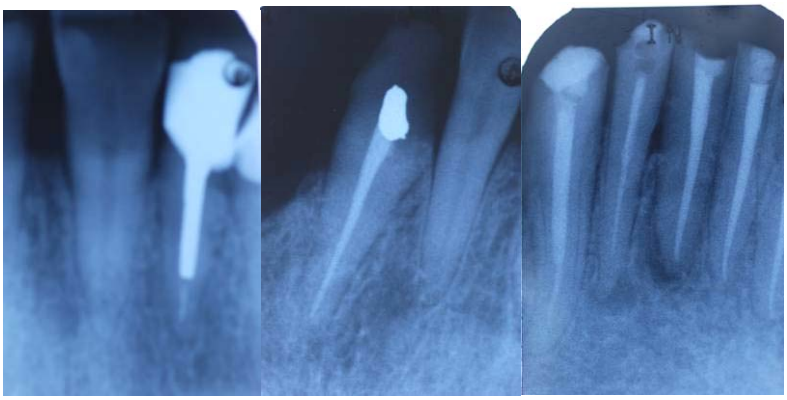
OPT



Periapicals of lower molars



Periapicals of incisors



Candidate Number:	01- 1
Date	
Examiner Name	
Examiner Number	

History Taking Stage MASTER SHEET

Exam Stage: History

Domain: Com- Gathering

Item		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
Primary Complaint					
Primary complaint meets standard: *Achieved a good understanding of the patient's major complaints*					
GRADE (Please tick)					
Secondary Complaints					
Secondary Complaints meets standard: *Achieved a good understanding of the patient's additional complaints (or confirmed no additional complaints)*					
GRADE (Please tick)					
Medical History					
Medical History meets standard: *Achieved a good understanding of the patient's general health and relevant specific conditions.*					
GRADE (Please tick)					
Social History					
Social History meets the standard: *Achieved a good understanding of the elements which affect the oral health or treatment*					
GRADE (Please tick)					
Past Dental History					
Past Dental History meets standard: *Achieved a good understanding of the main elements which influenced oral health prior to the current complaint*					
GRADE (Please tick)					
Communication					
Communication meets standard: *Makes themselves clearly understood and the patient at ease with good listening and body language*					
GRADE (Please tick)					
Global Assessment		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
GRADE (Please tick)					

Comments

Candidate Number:	01- 1
Date	
Examiner Name	
Examiner Number	

Provisional Diagnosis, Radiograph Request & Report MASTER SHEET

Exam Stage: History

Domain: Com- Imparting

Item		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
Provisional Diagnosis					
Provisional Diagnosis meets standard: ***Identified majority of most likely oral conditions or problems***					
GRADE (Please tick)					
Justification of provisional diagnosis					
Primary Complaint meets standard: ***Provides sufficient and plausible reasons for provisional diagnosis***					
GRADE (Please tick)					
Special Investigations					
Special Investigations meets standard: ***Recognises whether further investigations are required to confirm diagnosis***					
GRADE (Please tick)					
Prescription for radiograph(s)					
Prescription for radiograph(s) meets standard: ***Prescribes appropriate views and minimally required for diagnosis***					
GRADE (Please tick)					
Radiograph Report					
Radiograph Report meets standard: ***Correctly identifies film view, teeth and whether useable and identifies the majority of any pathology***					
GRADE (Please tick)					
Global Assessment		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					

Comments

Candidate Number:	01- 1
Date	
Examiner Name	
Examiner Number	

Oral Treatment Plan Stage MASTER SHEET

Exam Stage	Domain	Item		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
Treatment	Clinical	**Patient preparation and preventative care**					
		Patient preparation and preventative care meets standard: ***Identifies initial treatment needed to allow treatment to start and the care to maintain dentition***					
		GRADE (Please tick)					
		Clinical treatment					
		Clinical treatment meets standard: ***Prescibes appropriate treatment to meet the patient's request and needs***					
		GRADE (Please tick)					
		Advantages & disadvantages of the treatment options					
		Advantages & disadvantages of the treatment options meets standard: ***Explains advantages / disadvantages and the relative risks to allow informed consent***					
		GRADE (Please tick)					
		Referral					
		Referral meets standard: ***Gives sufficent information to expalin need, benefit and possible outcomes of referral***					
		GRADE (Please tick)					
		Medical history link					
		Medical history link meets standard: ***Considers the medical history and effect on treatment and necessary steps***					
		GRADE (Please tick)					
		Communication					
		Communication meets standard: ***Provides adequate understandable information in logical sequence***					
		GRADE (Please tick)					

		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
Global Assessment					
GRADE (Please tick)					

Comments

Candidate Number:	01- 1
Date	
Examiner Name	
Examiner Number	

History Contemporaneous Notes MASTER SHEET

Exam Stage: History

Domain: Com- Gathering

Item		Well below standard / not done	Just below standard	Meets standard	Exceeds standard
Primary Complaint					
Primary complaint meets standard: ***Achieved a good understanding of the patient's major complaints***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Secondary Complaints					
Secondary complaints meets ***standard: Achieved a good understanding of the patient's additional complaints (or confirmed no additional complaints)***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Medical History					
Medical History meets standard: ***Achieved a good understanding of the patient's general health and relevant specific conditions.***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Social History					
Social History meets the standard: ***Achieved a good understanding of the elements which affect the oral health or treatment***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Past Dental History					
Past Dental History meets standard: ***Achieved a good understanding of the main elements which influenced oral health prior to the current complaint***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Communication					
Communication meets standard: ***Notes sufficient information to provide a readable and understandable record to defend***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Global Assessment		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					

Comments

Candidate Number:	01- 1
Date	
Examiner Name	
Examiner Number	

Written Treatment Plan Stage MASTER SHEET

Exam Stage: Treatment

Domain: Clinical

Item					
Patient preparation and preventative care					
Patient preparation and preventative care meets standard: ***Identifies initial treatment needed to allow treatment to start and the care to maintain dentition***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Clinical treatment					
Clinical treatment meets standard: ***Prescibes appropriate treatment to meet the patient's request and needs***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Advantages & disadvantages of the treatment options					
Advantages & disadvantages of the treatment options meets standard: ***Explains advantages / disadvantages and the relative risks to allow informed consent***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Referral					
Referral meets standard: ***Gives sufficent information to expalin need, benefit and possible outcomes of referral***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Medical history link					
Medical history link meets standard: ***Considers the medical history and effect on treatment and necessary steps***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					
Communication					
Communication meets standard: ***Provides adequate understandable information in logical sequence***		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					

Global Assessment		**Well below standard / not done**	**Just below standard**	**Meets standard**	**Exceeds standard**
GRADE (Please tick)					

Comments