The University of Texas at Arlington School of Nursing  
Masters of Science in Nursing Program  
Preceptor Evaluation of Psychotherapy by Nurse Practitioner Student

<table>
<thead>
<tr>
<th>Student Name:____________________</th>
<th>Site:___________________</th>
<th>Date:_______________</th>
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<tbody>
<tr>
<td>Course:____________</td>
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Please indicate type of therapy you are evaluating:  
Individual_____  Group_____  Family Therapy_____  

Please use the following scale to indicate the student’s performance during this clinical based on course and clinical objectives:  
NA = Not Applicable  
0 = Unsatisfactory Performance  
1 = Meets Expectations  
2 = Exceeds Expectations

**ASSESSMENT**

1. Obtains appropriate history/data base of strengths, motivation for change, and problem areas relevant for individual, group, or family therapy.  
   N/A 0 1 2

2. Obtains history/data base for individual, group, or family therapy in an organized, timely manner.  
   N/A 0 1 2

**DIAGNOSIS**

3. Formulates appropriate hypotheses/diagnoses of problems presented by individual, group, or family.  
   N/A 0 1 2

4. Provides rationale for hypotheses/diagnoses of problems based on biopsychosocial principles and appropriate theoretical models.  
   N/A 0 1 2

5. Interprets findings of screenings and other measurement instruments/tools correctly in formulating treatment plan.  
   N/A 0 1 2

**MANAGEMENT**

6. Counsels or coaches the individual, group or family using appropriate therapy models and age appropriate strategies for meeting treatment plan goals.  
   N/A 0 1 2

7. Provides safe practice based on legal and ethical principles of psychotherapy.  
   N/A 0 1 2

8. Evaluates effectiveness of treatment plan based on therapeutic outcomes.  
   N/A 0 1 2

   N/A 0 1 2

10. Designates follow up appointment as appropriate.  
    N/A 0 1 2

11. Makes appropriate referrals to other health care professionals and community resources.  
    N/A 0 1 2

12. Collaborate with individual, family, or group in decision making.  
    N/A 0 1 2

13. Works collaboratively with others  
    N/A 0 1 2

**PRESENTATION/DOCUMENTATION**

14. Oral presentation of individual, group, or family progress is succinct and accurate.  
    N/A 0 1 2
15. Written documentation of therapeutic session is succinct, complete, and accurate. N/A 0 1 2

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<th>ROLE</th>
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<tr>
<td>16. Seeks and accepts constructive criticism during debriefing/supervision.</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>17. Uses effective communication skills.</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>18. Develops therapeutic alliance with individual, group, or family using effective strategies.</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>19. Presents a professional demeanor appropriate for clinical setting (i.e., appearance, dress, behavior, and language).</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20. Advocates for rights of individuals and families with mental health needs.</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
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Did the student communicate learning needs and objectives to preceptor? Yes_________ No_________

COMMENTS:
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

STRENGTHS:
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

AREAS NEEDING IMPROVEMENT:
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

SUGGESTIONS:
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

Preceptor Signature:___________________ Telephone Number:___________________

Preceptor Name (Print):_____________________________________________________________________________

Would you like the student’s advisor to contact you to discuss this student? Yes_____ No_____ 

Thank you for taking the time to complete this Evaluation Form. Please return the completed form to:
UTA NP Program
Attention: ____________________________________ (Clinical Advisor)
P. O. Box 19407 / 411 S. Nedderman Drive
UTA School of Nursing
Arlington, TX 76019-0407
Office: (817) 272-2043
FAX: (817) 272-5006

Thank you for your service to the profession and to the UTA School of Nursing!