Tourette Syndrome Association Medical Program Evaluation
"Tourette Syndrome – Diagnosis and Management"
Speaker, University
Date
Location

Form Approved
OMB No. 0920-XXXX
Exp. Date XX/XX/20XX

Learning Objectives:

1. Cite the criteria used to diagnose Tourette Syndrome
2. Describe conditions co-occurring with TS
3. State theories about etiology
4. Describe the range of management strategies

1. Please indicate your PROFESSION & SPECIALTY:

Physician_____ PA_____ Nurse _____ NP_____ Ph.D._____ Psychologist_____
(specialty) (specialty) (specialty) (specialty) (specialty) (specialty)

Social Worker_____ Counselor _____ Occupational Therapist_____ Other_____
(specialty) (specialty) (specialty) (describe)

2. Do you have experience in managing patients with TS or tic disorders? Yes____ No____
If yes, how many? 1-5 ___ 6-10 ___ more than 10 ___

3. Please rate your knowledge about identification and management of TS before and after participating in this program

Knowledge BEFORE today's program			**Self-rating of your knowledge related to:**	**Knowledge AFTER today's program**		
None	Some	A lot		None	Some	A lot
1	2	3	Diagnosis/Recognition	1	2	3
1	2	3	Co-occurring Issues	1	2	3
1	2	3	Treatment Options	1	2	3
1	2	3	Patient/family Education	1	2	3

4. How much of this content was new to you? Almost all____ 75%____ 50%____ 25%____ Almost none____

Please rate each of the following statements

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**N/A**
5. My skills in diagnosing/recognizing TS will be improved as a result of this program	1	2	3	4	
6. My skills in managing patients who have TS will be improved as a result of this program	1	2	3	4	
7. I can state theories on etiology	1	2	3	4	
8. If given an opportunity, I can apply the knowledge gained as a result of this program	1	2	3	4	
9. I intend to use my knowledge to identify and diagnose patients with TS	1	2	3	4	
10. I intend to educate patients and families in my practice about TS	1	2	3	4	
11. The presenter communicated the content effectively	1	2	3	4	

Please describe any expected changes to your skills, strategy and/or practice:

Suggestions to improve this program:

and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D- 74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).