

# TSA Physician Training Retreat 3 Month Follow-up

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

This survey is in reference to the Tourette Syndrome training retreat program you attended on XXX. The retreat was hosted through a partnership with the US Centers for Disease Control and Prevention. We would like to assess the impact of the program on your patient care and survey results will enable us to better focus our outreach efforts.

Public reporting burden of this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, 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).

## 1. Please indicate your profession.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Physician           | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Social Worker          |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Ph.D.              | <input type="checkbox"/> Counselor              |
| <input type="checkbox"/> Nurse               | <input type="checkbox"/> Psychologist       | <input type="checkbox"/> Occupational Therapist |

## 2. Looking back, how much knowledge have you gained from the training retreat about diagnosis and/or management of TS?

- None
- Some
- A lot

## 3. Check the following practice areas in which you feel that you have made changes in your patient care as a result of something you learned from the TS Training Retreat Program.

	Considering changes	Planning changes	Have made changes	Not yet applicable
Recognition and accurate diagnosis of TS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identification of co-occurring conditions in patients with TS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment planning for individuals with TS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education of the patient and family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 4. Since the TS Training Retreat Program, how many patients with tic disorders/Tourette syndrome have you evaluated?

- 0
- 1-5
- 6-10
- >10

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**5. Do you think that your skills in managing patients with TS have improved as a result of attending the program?**

Yes

No

Comment:

**6. Did the TS Training Retreat Program make you reconsider any patients for a possible TS diagnosis?**

Yes

No

N/A at this time

**7. As a result of the TS Training Retreat Program, do you feel that you have focused more on evaluating co-occurring conditions in patients with TS?**

Yes

No

N/A at this time

**8. Whether or not you have made a change, please rate the usefulness of the program to your current practice.**

Very useful

Useful

Somewhat useful

Not at all useful

**9. Please describe any other changes you may have made as a result of something you learned from the TS Training Retreat Program.**