PRACTICAL SKILLS LOGBOOK

FACULTY OF MEDICINE

GEORGE EMIL PALADE UNIVERSITY OF MEDICINE, PHARMACY, SCIENCE, AND TECHNOLOGY OF TÂRGU MUREȘ

ACADEMIC YEAR 2025 - 2026

YEAR OF STUDY: 3

Student's Name: _____

Matriculation Number: _____

E-mail Address: _____

Hospital Name: _____

Hospital Address: _____

Tutor's Name: _____

Dear students,

We present this practical skills logbook that describes the medical activities that are part of your clinical training and all the skills you should acquire during the sixth year of study in the medical field.

This logbook will help you identify and address any gaps in your theoretical and practical knowledge and prepare you for future professional responsibilities.

Completing this logbook allows you to track your personal learning progress, the degree of achievement of the proposed items as well as to obtain continuous feedback from the clinical training supervisor. If you have found that there are gaps in your knowledge, it is important to ask for further explanation and assistance during the mandatory on-call rota.

During the clinical training programme, the clinical training supervisor or designated teacher will answer all the questions and problems you may encounter during the training hours. They will be responsible for supervising your progress in acquiring the notions related to the clinical training.

Please fill in this logbook as required and have the signatures and seals of the doctors for the skills acquired, as this logbook will be collected, reviewed, and evaluated by us. You will be admitted to the graduation examination only after this logbook has been correctly and fully completed.

To continuously improve the teaching process, your constructive feedback is very important and, therefore, we recommend that you also complete the evaluation chapter at the end.

We wish you a pleasant clinical experience this academic year!

The teaching staff of the Faculty of Medicine
George Emil Palade University of Medicine, Pharmacy, Science, and Technology of Târgu Mureș

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A. GENERAL INFORMATION

Important information regarding organisation and procedures during clinical training can be found on the UMFST website and on the Blackboard platform:

www.umfst.ro

If you have any questions regarding the organisation of your clinical year, please contact the Dean's Office; they will be pleased to assist you.

Please respect the scheduled practical activities in the hospital and, if necessary, seek individual guidance from your tutors.

General objectives:

- Develop the ability to care for patients individually, under the supervision of medical teaching staff
- Foster a sense of responsibility towards patients and colleagues
- Develop practical skills in the context of relevant theoretical knowledge
- Development of communication, social and emotional skills
- Integrate relevant differential diagnoses into everyday medical practice
- Apply problem-solving medical approaches
- Establish a working diagnosis on clinical grounds

For the protection of your patients, you must have adequate immunity to mumps, measles, rubella, diphtheria, varicella (chickenpox), and pertussis (whooping cough). For your own protection, you should be vaccinated against Hepatitis B and, if possible, Hepatitis A.

In accordance with Art. 20 of Law 46/2003 (Patient Rights Law) it is strictly forbidden to photograph/film patients, medical documents and personal data within healthcare units without their consent, except in cases where images are necessary for diagnosis, treatment or to avoid suspicion of medical negligence.

B. CLINICAL TRAINING

1. Medical Semiology 1

Semester: 1
Number of course hours: 42 hours/semester
Number of clinical internship hours: 42 hours/semester
1.1 . Patient's medical history:

No.	Date	Patient's initials/ Observation sheet/ Record number	Signature and seal of the supervisor
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

1.2 Clinical examination of adult patients:

The clinical examination will include the following elements:

- General examination (position, body weight/nutritional status),
- Examination of the skin and subcutaneous tissue (pallor, skin discoloration, erythema, rash, purpura, jaundice, cyanosis, oedema, varicose veins),
- State of consciousness (sleep disorders, syncope, coma, convulsions),
- Neurological disorders (static and movement disorders, active motility, coordination, reflexes, sensory assessment, involuntary movements),
- Endocrine disorders (palpation of the thyroid gland, examination of the lymph nodes, palpation of the lymph nodes),
- Fever (types of fever) or hypothermia,
- Eye examination (changes in the eyeballs, changes in the eyelids, tearing disorders)
- Hair (excess, loss, discoloration),
- Nails (changes, implications),
- Oral cavity/pharynx disorders: changes in the gums, teeth, tongue, tonsils
- Clinical examination of the musculoskeletal system (normal and pathological joint mobility).

No.	Date	Patient's initials/ Observation sheet / Record number	Signature and seal of the supervisor
1.			
2.			
3.			
4.			
5.			
6.			
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9.			
10.			

1.3. Completing the patient's medical record (observation chart):

No.	Date	Patient's initials/ Observation sheet / Record number	Signature and seal of the supervisor
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

1.4 . Semiology of the respiratory system:

Practical activities will include:

- Clinical examination of the respiratory system:
    - chest topography
    - inspection: general, chest, chest deformities
    - palpation: chest wall, chest sounds, respiratory movements
    - percussion: topographic percussion, comparative percussion
    - auscultation: vesicular murmur, superimposed breath
- Semiology of respiratory syndromes:
    - Obstructive disorders – acute bronchitis, chronic bronchitis, bronchiectasis, atelectasis, asthma.
    - Acute syndromes − acute pneumopathy, tumours, pulmonary fibrosis.
    - Emphysema.
    - Pleural syndromes − pleural effusions.
    - Mediastinal syndromes − respiratory failure
- Introduction to specific respiratory system investigations: thoracentesis, sputum culture, chest X-ray with normal/pathological findings, spirometry (observation).

No.	Date	Clinical activity		Signature and seal of the supervisor
		Activity	Patient's initials/ Observation sheet/ Record number	
1.		Complete clinical examination of the respiratory system		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.		Identification of the semiology of specific respiratory syndromes		
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.		Chest X-ray		
22.				
23.				
24.				
25.				
26.		Sputum culture (interpretation)		
27.				
28.				
29.		Thoracentesis (observation)		
30.				
31.		Spirometry (observation and interpretation)		
32.				
33.				

1.5 Optional learning experience *:

No.	Date	Description of optional clinical experience
1.		
2.		
3.		
4.		
5.		

*— Not a mandatory requirement

2. Medical Semiology 2

Semester: 2
Number of course hours: 42 hours/semester
Number of clinical internship hours: 42 hours/semester

2.1 Completing the patient's medical record (observation chart):

No.	Date	Patient's initials/ Observation sheet/ Record number	Signature and seal of the supervisor
1.			
2.			
3.			
4.			
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10.			

2.2 Semiology of the cardiovascular system:

Practical activities will include:

- History of cardiovascular disease
    - Clinical examination of the cardiovascular system
    - General examination
    - Inspection of the chest/precordial area
    - Palpation of the chest/precordial area: palpable superimposed heart sounds/their significance, palpable systolic/diastolic murmur
    - Precordial percussion
    - Heart auscultation
        - Main areas of heart auscultation
        - Normal heart sounds
        - Pathological changes in heart sounds: arrhythmias, superimposed heart sounds (systolic murmur, diastolic murmur, heart murmur/pericardial friction rub)
- Clinical examination of peripheral arteries (pulse palpation: location, characteristics, pathological changes, significance)
- Blood pressure measurement – hypertension, hypotension
- Clinical examination of veins

- Cardiovascular system investigations: Chest X-ray, ECG (interpretation), Echocardiography (observation)

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Complete clinical examination of the cardiovascular system**		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.		**Clinical examination of peripheral arteries**		
11.				
12.				
13.				
14.				
15.		**Clinical examination of veins**		
16.				
17.				
18.				
19.		**X-ray**		
20.				
21.				
22.				

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
26.		**ECG (Interpretation)**		
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				
35.				
36.		**Echocardiography (observation)**		
37.				
38.				
39.				
40.				
41.		**Blood pressure measurement**		
42.				
43.				
44.				
45.				
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47.				
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50.				

2.3 Semiology of the digestive system:

Practical activities will include:

- Collecting a history of digestive disorders (abdominal pain, changes in appetite, dysphagia, heartburn, nausea, vomiting, digestive bleeding, changes in stool)
- Clinical examination of the digestive system:
  - General examination and examination of the oral cavity/pharynx
  - Abdominal examination
    - inspection
    - palpation (technique): superficial and deep palpation: painful areas of the abdomen and their topography, palpation of the liver (hepatomegaly, significance), palpation of abdominal masses, ascites (significance), palpation of the spleen (technique, significance), palpation of hernial points
    - rectal swab
- Paracentesis (observation)
- Digestive system investigations: X-ray (barium swallow, significance), upper/lower digestive endoscopy (observation), abdominal ultrasound (observation)

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Complete clinical examination of the digestive system**		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
16.		**Paracentesis (observation)**		
17.				
18.				

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
19.		**Abdominal X-ray**		
20.				
21.		**Abdominal ultrasound (observation)**		
22.				
23.				
24.				
25.				
26.		**Upper/lower digestive endoscopy (observation)**		
27.				
28.				
29.				
30.				

2.4 Semiology of the urinary system:

Practical activities will include:

- History of urinary disorders (lower back pain, urinary incontinence, dysuria)
- Clinical examination of the urinary system:
  - oedema of renal aetiology
  - abdominal examination:
    - palpation of the kidneys
    - auscultation of the kidneys
- Urinary system investigations: urography, ultrasonography

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Complete clinical examination of the urinary system**		
2.				
3.				
4.				
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10.				

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
11.		**Urography (interpretation)**		
12.				
13.				
14.		**Renal ultrasonography (observation)**		
15.				
16.				
17.				
18.				

2.5. Optional learning experience *:

No.	Date	Description of optional clinical experience
1.		
2.		
3.		
4.		
5.		

*– Not a mandatory requirement

3. Surgical Semiology 1

Semester: 1
Number of course hours: 42 hours/semester
Number of clinical internship hours: 42 hours/semester

3.1 Organisation of surgical services

This practical activity will include: completing the surgical clinical observation chart, the record register, and the request for blood and blood products.

No.	Date	Practical activity			Signature and seal of the supervisor
		Type of activity	Type of activity	Patient's initials/ Observation sheet/ Record number	
1.			Completing the surgical observation chart		
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.			Completing the record register		
12.					
13.					
14.					
15.					
16.			Completing the blood request form		
17.					
18.					

3.2 Sterile surgical equipment. Sterile washing of the surgeon's hands, methods used

No.	Date	Practical activity	Signature and seal of the supervisor
1.		Practicing sterile hand washing for surgeons	
2.			
3.			
4.			
5.			
6.		Practicing putting on sterile surgical equipment	
7.			
8.			
9.			
10.			

3.3 Surgical instruments

No.	Date	Clinical activity	Signature and seal of the t supervisor
1.		Identification of surgical instruments	
2.			
3.			
4.			
5.			

3.4 Surgical suture, surgical knot

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Surgical suture (observation)		
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

3.5 Types of dressings, dressing techniques.

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Types of dressings, dressing techniques. Upper limb (performance)**		
2.				
3.				
4.				
5.				
6.		**Types of dressings, dressing techniques. Lower limb (performance)**		
7.				
8.				
9.				
10.				
11.		**Types of dressings, dressing techniques. Head and thorax (performance)**		
12.				
13.				
14.				
15.				

3.6 Injections and IV

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Injections** (subcutaneous and intradermal) **(administration)**		
2.				
3.				
4.				
5.				
6.		**Injections** (intramuscular) **(administration)**		
7.				
8.				
9.				
10.				
11.		**Injections** (intravenous) **(administration)**		
12.				
13.				
14.				
15.				
16.		**IV** (preparation of IV, IV kit) **(performance)**		
17.				
18.				
19.				
20.				

3.7 Minor surgery patient

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Minor surgery patient** (incision of a hot/cold abscess, evacuation of a seroma, nail excision, excision of a benign mass, excision of a foreign body) **(observation)**		
2.				
3.				
4.				
5.				

3.8 Cannulation of a vein and measurement of CVP

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Venipuncture, CVP measurement (observation)**		
2.				
3.				

3.9 Local anaesthesia

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Local anaesthesia (observation)**		
2.				
3.				

3.10 Haemostasis

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Haemostasis** (temporary haemostasis) **(performance)**		
2.				

3.				

3.11. Punctures (pleural, pericardial, Douglas pouch)

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Punctures** (pleural, pericardial, Douglas pouch) **(observation)**		
2.				
3.				

3.12. Wound suppuration (Celsus marks, wound dehiscence):

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Wound suppuration (Celsus signs, wound dehiscence)**		
2.				
3.				

3.13. Monitoring surgical drains (amount of secretions, appearance, permeability)

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Assessment of drainage tube permeability, appearance, and amount of secretions**		
2.				
3.				
4.				

3.14. Optional learning experience *:

No.	Date	Description of optional clinical experience
1.		
2.		
3.		
4.		
5.		

*— Not a mandatory requirement

4. Surgical Semiology 2

Semester: 2
Number of course hours: 42 hours/semester
Number of clinical internship hours: 42 hours/semester

4.1 Osteoarticular trauma. Temporary immobilisation techniques (fractures, dislocations, sprains). Temporary immobilisation technique at the accident scene.

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Temporary immobilisation of osteoarticular trauma** (fractures, sprains) **Performing**		
2.				
3.				
4.				
5.				

4.2 Surgical drainage. Drainage of superficial fluid.

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Drainage of superficial fluid (Observation)**		
2.				
3.				

4.3 Tracheostomy

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		**Tracheostomy technique (Observation)**		
2.				

4.4 Bladder catheterisation

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Bladder catheterisation (Observation)		
2.				
3.				
4.				
5.				

4.5 Enemas

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Enemas (Observation)		
2.				

4.6 Gastric intubation and lavage

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Gastric intubation and lavage (Observation)		
2.				

4.1 Minimal pleurostomy. Passive and active pleural drainage. Intercostal nerve infiltration.

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Minimal pleurostomy (Observation)		
2.				
3.				

4.2 Surgical examination of the abdomen. Paracentesis

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Surgical examination of the abdomen		
2.				
3.				
4.		Paracentesis Observation		
5.				

4.3 Breast examination

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Breast examination Performance		
2.				
3.				
4.				

4.4 Rectal examination

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Rectal examination (Observation)		
2.				
3.				
4.				
5.				

4.5 Examination of the throat, limbs, clinical tests for varicose veins

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Examination of the throat		
2.				
3.				
4.		Clinical tests for varicose veins		
5.				
6.				

4.1 Examination of superficial tumours and ulcers and complete description of semiological characteristics

No.	Date	Clinical activity		Signature and seal of the supervisor
		Type of activity	Patient's initials/ Observation sheet/ Record number	
1.		Examination with complete description of tumours		
2.				
3.				
4.				
5.				
6.		Examination with complete description of superficial ulcers		
7.				
8.				
9.				
10.				

4.2 Optional learning experience *:

No.	Date	Description of optional clinical experience
1.		
2.		
3.		
4.		
5.		

* — Not a mandatory requirement.

C. On-call duties

During an academic year, students must complete a minimum of 8 calls of 6 hours each (according to the teaching regulations in force) in accordance with the clinical placements for each module.

No.	Date	Time range	Clinic	Signature and seal of the on-call doctor
1				
2				
3				
4				
5				
6				
7				
8				

Practical activity on-call (minimum 1 case/call)

Clinical case (1)	
First name, last name /OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis *	
Therapeutic plan *	
Prognosis *	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (2)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (3)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (4)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (5)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (6)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (7)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

Clinical case (8)	
First name, last name / OC No:	
Background and symptoms • **Major symptoms** • **Personal physiological and pathological history** • **Hereditary and collateral history** • **Medication** • **Behaviour and social aspects**	
Physical examination (relevant to the current condition)	
Laboratory results	
Imaging	
Primary diagnosis	
Differential diagnosis*	
Therapeutic plan*	
Prognosis*	

* - optional

Optional learning experiences *:

No.	Date	Skills acquired while on duty
1.		
2.		
3.		
4.		
5.		

* - not a mandatory requirement for the practical exam.

** - examples of skills: patient monitoring, injections, dressings, wound care and suturing, etc.

D. STUDENT FEEDBACK

Please answer the following questions, cut out the page, and place it in the questionnaire box!

- Describe the most interesting experiences during clinical training:

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.....
.....
.....
.....
.....

- Describe the most difficult experiences during clinical training:

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.....

- List at least 3 aspects that should be improved in the future:

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