

Pharm.D - Year 6

Internship and Residency

Complete subject manual: 12 practicals and activities. Each chapter includes a student observation or work record.

Use the PDF bookmarks to navigate. The table gives each practical's content-page count; the combined manual has continuous page numbers.

Contents

No.	Practical / activity	Content pages
1	Internship Orientation and Rotation Plan	2
2	General Medicine - Six-month Rotation	2
3	Specialty Rotation 1 - Two-month Record	2
4	Specialty Rotation 2 - Two-month Record	2
5	Specialty Rotation 3 - Two-month Record	2
6	Comprehensive Pharmaceutical Care Case	2
7	Clinical Intervention and Outcome Log	2
8	Patient Communication and Care-transition Record	2
9	Medicine Distribution and Resource-use Review	2
10	Health Promotion and National Programme Activity	2
11	Interprofessional Teamwork and Professional Reflection	2
12	Internship Work Record and Final Assessment	2

Internship Orientation and Rotation Plan

Experiment 1 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the internship orientation and rotation plan internship activity.

Principle

The supplied syllabus defines a twelve-month rotational internship/residency: six months in General Medicine and two months each in three other specialty departments.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Confirm allocation

Enter the approved institution, preceptor and rotation dates.

2. Plan rotations

Record General Medicine and the three specialty departments actually assigned by the institution; do not assume a fixed specialty list.

3. Complete induction

Review access, confidentiality, medicine-use workflow, communication and emergency escalation.

4. Set learning goals

Agree the clinical pharmacy competencies and expected activities for each rotation.

5. Maintain the plan

Record approved schedule changes and completion review by the preceptor.

Observations and Record

Record item	Entry
Institution / preceptor	_____
Rotation allocation and dates	_____
Induction completed	_____
Learning goals	_____
Schedule changes / review	_____

Internship and Residency

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers

1. Why maintain a verified work record?

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Rotation Record

Rotation	Duration in supplied syllabus	Assigned department / dates
General Medicine	6 months	_____
Specialty rotation 1	2 months	_____
Specialty rotation 2	2 months	_____
Specialty rotation 3	2 months	_____

General Medicine - Six-month Rotation

Experiment 2 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the general medicine - six-month rotation internship activity.

Principle

General Medicine training develops integrated case assessment, medicine review, follow-up and communication in the allocated ward.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Prepare daily cases

Review new admissions, current problems, medicines and significant changes.

2. Provide clinical pharmacy input

Verify medicine history, identify medicine-related issues and communicate a reasoned plan within the approved role.

3. Follow patients

Track agreed response and safety endpoints, treatment changes and outcomes.

4. Support discharge

Reconcile the authorised list, counsel and communicate the follow-up needs.

Internship and Residency

5. Review progress

Meet the preceptor to assess work records, knowledge, skills and professional behaviour.

Observations and Record

Record item	Entry
Dates / allocated ward	_____
Cases and pharmacy services	_____
Interventions / outcomes	_____
Discharge work	_____
Preceptor progress review	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers

1. Why maintain a verified work record?

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Specialty Rotation 1 - Two-month Record

Experiment 3 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the specialty rotation 1 - two-month record internship activity.

Principle

A specialty rotation applies clinical pharmacy services to the actual assigned department, with objectives appropriate to its patients and medicine-use processes.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Name the department

Enter the institution-assigned specialty, preceptor and dates; this guide does not preselect a specialty.

2. Map needs

Identify common clinical problems, high-risk medicines and department-specific monitoring or protocols.

3. Agree objectives

Set case, medicine-review, counselling and communication goals with the preceptor.

4. Provide and follow services

Record actual cases, pharmacy assessments, team decisions and monitored outcomes.

5. Complete review

Summarise learning, unresolved competency needs and the authorised end-rotation evaluation.

Internship and Residency

Observations and Record

Record item	Entry
Assigned specialty / dates	_____
Clinical service objectives	_____
Cases / assessments	_____
Accepted actions / outcomes	_____
Preceptor evaluation	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers**1. Why maintain a verified work record?**

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Specialty Rotation 2 - Two-month Record

Experiment 4 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the specialty rotation 2 - two-month record internship activity.

Principle

A specialty rotation applies clinical pharmacy services to the actual assigned department, with objectives appropriate to its patients and medicine-use processes.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Name the department

Enter the institution-assigned specialty, preceptor and dates; this guide does not preselect a specialty.

2. Map needs

Identify common clinical problems, high-risk medicines and department-specific monitoring or protocols.

3. Agree objectives

Set case, medicine-review, counselling and communication goals with the preceptor.

4. Provide and follow services

Record actual cases, pharmacy assessments, team decisions and monitored outcomes.

5. Complete review

Summarise learning, unresolved competency needs and the authorised end-rotation evaluation.

Internship and Residency

Observations and Record

Record item	Entry
Assigned specialty / dates	_____
Clinical service objectives	_____
Cases / assessments	_____
Accepted actions / outcomes	_____
Preceptor evaluation	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers**1. Why maintain a verified work record?**

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Specialty Rotation 3 - Two-month Record

Experiment 5 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the specialty rotation 3 - two-month record internship activity.

Principle

A specialty rotation applies clinical pharmacy services to the actual assigned department, with objectives appropriate to its patients and medicine-use processes.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Name the department

Enter the institution-assigned specialty, preceptor and dates; this guide does not preselect a specialty.

2. Map needs

Identify common clinical problems, high-risk medicines and department-specific monitoring or protocols.

3. Agree objectives

Set case, medicine-review, counselling and communication goals with the preceptor.

4. Provide and follow services

Record actual cases, pharmacy assessments, team decisions and monitored outcomes.

5. Complete review

Summarise learning, unresolved competency needs and the authorised end-rotation evaluation.

Internship and Residency

Observations and Record

Record item	Entry
Assigned specialty / dates	_____
Clinical service objectives	_____
Cases / assessments	_____
Accepted actions / outcomes	_____
Preceptor evaluation	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers**1. Why maintain a verified work record?**

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Comprehensive Pharmaceutical Care Case

Experiment 6 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To document a full patient-centred pharmacy care assessment during internship.

Principle

Comprehensive care integrates the patient's goals, clinical findings, medicine history, treatment risks and follow-up.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm complete history and confirmed medicine list; clinical findings and care goals; current regimen and patient-specific risks. Note missing information explicitly.

3. Develop the pharmacy assessment

Prepare a coded SOAP record, medicine-indication table and prioritised problem list. Link each proposed action to a goal and monitoring endpoint. Discuss with the interprofessional team, implement only within the approved role and record the actual outcome.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Internship and Residency

Observations and Record

Record component	Student entry
Case / dates	_____
SOAP and medicine-indication list	_____
Problem / goal / action	_____
Team decision	_____
Follow-up and outcome	_____

Result

Assessment: _____. Proposed action: _____. Supervisor decision: _____. Follow-up outcome: _____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers**1. Why collect patient-specific information?**

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Clinical Intervention and Outcome Log

Experiment 7 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To record a specific pharmacy intervention and evaluate its outcome.

Principle

A clear intervention record identifies the issue, rationale, communication, decision and subsequent result.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm specific medicine-related problem; evidence and urgency; responsible clinical team. Note missing information explicitly.

3. Develop the pharmacy assessment

Use a problem-recommendation-response-outcome format. Record whether the team accepted, modified or declined the proposal and why, where known. Follow the agreed endpoint and distinguish implementation from a demonstrated clinical outcome.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Internship and Residency

Observations and Record

Record component	Student entry
Date / case / problem	_____
Proposed action / rationale	_____
Team response	_____
Implementation status	_____
Observed outcome / follow-up	_____

Result

Assessment: _____. Proposed action: _____. Supervisor decision: _____. Follow-up outcome: _____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Patient Communication and Care-transition Record

Experiment 8 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To communicate an accurate medicine plan during a care transition.

Principle

Continuity depends on a verified list, understandable patient instructions and an explicit handover of unresolved issues.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm sending and receiving medicine plans; intentional changes and discrepancies; patient understanding and follow-up. Note missing information explicitly.

3. Develop the pharmacy assessment

Reconcile the plan and confirm medicine access. Explain the authorised changes with teach-back or device return-demonstration. Send the required clinical handover through the approved route and document the next action owner and patient follow-up.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Internship and Residency

Observations and Record

Record component	Student entry
Case / transition	_____
Verified list / changes	_____
Counselling and understanding	_____
Handover / unresolved issue	_____
Follow-up owner	_____

Result

Assessment: _____. Proposed action: _____. Supervisor decision: _____. Follow-up outcome: _____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers**1. Why collect patient-specific information?**

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Medicine Distribution and Resource-use Review

Experiment 9 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the medicine distribution and resource-use review internship activity.

Principle

Clinical pharmacy services include coordination of safe and timely medicine supply and appropriate use of healthcare resources.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Map the workflow

Record order receipt, verification, dispensing, administration information and returns in the assigned ward.

2. Identify a risk

Review a supplied/allocated delay, discrepancy, expiry or shortage concern and its clinical relevance.

3. Propose a response

Discuss a feasible process correction or authorised alternative supply route with responsible personnel.

4. Evaluate

Record timing, resolution and any remaining patient-care issue.

5. Document learning

Link the observation to safety and resource stewardship without inventing cost savings.

Internship and Residency

Observations and Record

Record item	Entry
Workflow / issue	_____
Patient-care consequence	_____
Proposed response	_____
Owner / resolution	_____
Measured process outcome	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers**1. Why maintain a verified work record?**

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Health Promotion and National Programme Activity

Experiment 10 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the health promotion and national programme activity internship activity.

Principle

Internship objectives include health improvement, prevention, community communication and participation in relevant national health programmes.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Select the assigned activity

Record the current authorised programme/activity and intended population.

2. Prepare the message

Use approved current programme material and a simple understandable message.

3. Plan delivery

Agree venue, permissions, language, referral route and accessibility needs.

4. Participate

Document actual education, screening-support or other allocated role without claiming unperformed services.

Internship and Residency

5. Evaluate

Record reach and an appropriate feedback/process measure, with privacy protected.

Observations and Record

Record item	Entry
Programme / approved activity	_____
Audience and objective	_____
Student role	_____
Activity performed / reach	_____
Feedback / referral / review	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers

1. Why maintain a verified work record?

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Interprofessional Teamwork and Professional Reflection

Experiment 11 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the interprofessional teamwork and professional reflection internship activity.

Principle

Professional practice requires clear communication, responsibility, timely work and reflection on feedback.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Record a team situation

Choose an actual coded situation involving communication or shared decision-making.

2. Describe the contribution

State the pharmacy role, concern raised and how the team responded.

3. Assess behaviour

Reflect on punctuality, preparation, confidentiality, respect and accountability.

4. Use feedback

Record preceptor feedback and a specific improvement action.

Internship and Residency

5. Review improvement

At a later review, state what changed and what still needs development.

Observations and Record

Record item	Entry
Situation / date	_____
Pharmacy contribution	_____
Team communication	_____
Feedback / reflection	_____
Improvement and later review	_____

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers

1. Why maintain a verified work record?

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Internship Work Record and Final Assessment

Experiment 12 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To complete and document the internship work record and final assessment internship activity.

Principle

The supplied syllabus requires a preceptor-verified work record and assessment of knowledge, clinical pharmacy skills, responsibility, teamwork and initiative. Certification belongs to the authorised institution.

Requirements

- Institution-approved rotation plan and clinical service procedures.
- Allocated patient/ward records accessed with permission, activity log and preceptor.

Procedure

1. Compile the portfolio

Index actual rotations, case work, interventions, counselling, service activities and progress reviews.

2. Review completeness

Check dates, supervisor verification and unresolved competency requirements.

3. Complete self-reflection

Summarise strengths and development needs without entering a supervisor score.

4. Preceptor assessment

Present the required work record for the authorised assessment during and at the end of training.

5. Certification

Record the genuine institutional completion decision and certificate status only after issue.

Observations and Record

Record item	Entry
Portfolio index / dates	_____
Preceptor verification	_____
Assessment status	_____
Improvement requirements	_____
Institutional certificate status	_____

Internship and Residency

Result

Activity / date: _____. Work completed: _____. Preceptor feedback: _____. Follow-up: _____.

Precautions

- Enter only work actually performed; leave supervisor verification and certification fields for the authorised person.
- Use coded cases and protect patient privacy.
- Escalate urgent clinical issues through the treating team and follow the institution-approved responsibilities.

Viva Questions and Answers**1. Why maintain a verified work record?**

It documents the activity, competency and feedback required for assessment.

2. What supports a clinical recommendation?

Current patient findings, suitable medicine information and a clear rationale within the approved clinical role.

Preceptor Assessment Form

The supplied syllabus uses a 0–5 score for each domain. A score below 3 in any domain represents unsatisfactory completion in that document. The authorised preceptor/institution enters the assessment and applies any current institutional requirements.

Domain	Score 0–5	Preceptor comment
Case-management knowledge	_____	_____
Clinical pharmacy skills	_____	_____
Responsibility / punctuality / case work	_____	_____
Teamwork and professional behaviour	_____	_____
Initiative / discussion / research aptitude	_____	_____

Preceptor name: _____ Signature: _____ Date: _____

Continue Learning with FirstHope

Complete Notes on the FirstHope App

Complete subject and semesters are available on FirstHope app only.

- Get complete subject and semester notes in the FirstHope app.
- Available for B.Pharm, D.Pharm, M.Pharm and Pharm.D students.

[Click here to get the FirstHope app](#)

Join the FirstHope Telegram Channel

Join FirstHope Notes and keep up with channel updates.

[Click here to join Telegram](#)

Instagram

@firsthope.official

[Click here to follow Instagram](#)

YouTube Channel

FirstHope-Pharmacy / Live streams

[Click here to watch the YouTube channel](#)

WhatsApp Channel

Follow FirstHope on WhatsApp.

[Click here to join the WhatsApp channel](#)

FirstHope Website

firsthopenotes.com

[Click here to visit the website](#)