Ohio State University  
Robotic Urologic Surgery Mini-Fellowship 2013-2014  
Visiting Resident Program Questionnaire

Name: ___________________________________  PGY year: _________  Male or Female: __________

Training Program: _______________________________________________________________________

1. Do you have robotic surgery at the institution where you are training? (circle one)  Yes  No
2. How many robots at your institution? (circle one)   0  1  2  3  4  5
3. Do urologists in your training program use the robot? (circle one)  Yes  No
4. For how many years have urologists at your institution been performing robotic surgery? (circle one)  
   0-1  2-3  4-5  >5yrs
5. Approximately how many robotic cases are performed weekly in your program? ________ cases/week
6. How many urologists in your training program? __________ urologists
7. How many performing robotic surgery? __________ urologists
8. Which procedures are urologists in your program performing robotically? (circle all that apply)  
   Prostatectomy  Pyeloplasty  Nephrectomy  Partial Nephrectomy  
   Cystectomy  Adrenalectomy  Ureteral Surgery  Donor Nephrectomy  
   Pediatric Urology  Other
9. What is the greatest extent of resident participation in robotic surgery in your program? (circle one)  
   None  Observe only  Bedside assisting  Console surgeon  Entire cases at console
10. What PGY level of resident typically is allowed to operate from the robotic console in your training 
    program? (circle one)  
    None  PGY 1  PGY 2  PGY 3  PGY 4  PGY 5  PGY 6
11. Are residents in your program graduating with proficiency in robotic surgery? (circle one)  
    Yes  No
12. Do you have a curriculum for robotic surgery training for residents in your program? (circle one)
   Yes   No

13. Do residents in your program have access to a robot for dry lab training or a robotic simulator? (circle one)
   Yes   No

14. Do you plan to perform robotic procedures in your practice after you graduate? (circle one)
   Yes   No

15. Have you already identified where you will practice upon graduating? (circle one)
   Yes   No

16. If yes, is there already a robot at the hospital where you will be operating? (circle one)
   Yes   No

17. Please rate in order from 1 to 5 your preference for which months would be best for you to spend your week at Ohio State. If you have no preference, please indicate so at the bottom. (1=most preferred to 5=least preferred)
   _____ November
   _____ December
   _____ January
   _____ February
   _____ April
   _____ No preference

Please send completed questionnaire, CV, and letter of support from your resident chair or program director to Heidi Pieper at Heidi.Pieper@osumc.edu by October 15, 2013.

Please note that participants will be expected to have double occupancy at the hotel. Reservations will be made at the discretion of the meeting planners. You will be notified prior to the event whom you are expected to share a room with. Please inform us if you have special needs in order for us to ensure we can accommodate your request.

CONTACT INFORMATION
Heidi Pieper
Center for Minimally Invasive Surgery
558 Doan Hall
410 W. 10th Avenue
Columbus, OH 43210
(614) 293-9072  P
(614) 293-7852  F