CCSMH Late Life Suicide Prevention Toolkit
EVALUATION for FACILITATORS

We really appreciate your feedback as a facilitator to make the toolkit as useful as possible.

Contact info (optional):
Name: _________________________________________________________
Title: __________________________________________________________________________
Organization: ___________________________________________________________________
Phone: ______________________________ E-mail: _____________________________

☑ I would like to speak with CCSMH staff about my presentation

1. In which province/territory do you live? __________________________________________________________________________

2. In which type of setting do you work? Please check all that apply:
   ☐ Hospital  ☐ University/College
   ☐ Long Term Care  ☐ Community
   ☐ Private Practice  ☐ Other (please specify): ______________________

3. How did you use the Late Life Suicide Prevention Toolkit?
   ☐ Workshop (length of time): _______________________
   ☐ Presentation (length of time): _______________________
   ☐ Other (please describe): __________________________

4. Who was your audience? (brief description of types of learners in the audience)
   __________________________________________________________________________

5. How many people attended your session (approximately)? ______________

6. Please rate the following aspects of the Toolkit:

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<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Content of the PowerPoint presentation</td>
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<tr>
<td>Content of the Facilitator’s Guide</td>
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<tr>
<td>Content of the DVD</td>
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<td>Quality of the learning materials presented? (i.e. DVD, PowerPoint, clinician pocket-card, national guidelines)</td>
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<td>How would you rate the Toolkit overall?</td>
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7. What elements of the Toolkit did you find most useful?
   __________________________________________________________________________

8. What elements of the Toolkit require improvement? Please explain.
   __________________________________________________________________________
9. Additional comments:

Thank you for taking the time to complete this survey.

Please return this form to the CCSMH at your earliest convenience (attn: Project Manager):

e-mail: shelsdingen@baycrest.org    *    fax: 416-785-2492
mail: Baycrest, 3560 Bathurst Street, Room 311, West Wing, Old Hospital, Toronto, ON M6A 2E1

For more information about the CCSMH,
please visit www.ccsmh.ca or call 416-785-2500 ext. 6331.