PHYSICIAN PROFILE

This questionnaire is designed to provide the Peer Assessment Committee with the most current information about you and your practice.

Not all questions will apply to every physician. If you do not believe a specific question or series of questions is relevant to your practice, please indicate N/A (Not Applicable).

Please Note: page 5 of the questionnaire (pertaining to office operation), may be completed by your Administrative Assistant or Secretary if you so choose. In that event, please ensure the name of the person completing that page is clear.

SURNAME ______________________ GIVEN NAMES: ________________________________

DATE OF BIRTH _________________________ SEX : Male Female

MEDICAL DEGREE FROM UNIVERSITY OF: _______________________ YEAR: ________

Year internship/residency program completed: _________________________________

Total years of post-graduate training (internship/residency): _________________

Hospital/Location(s) for Internship/Residency Type of Training Year

College of Family Physicians of Canada: Certificant: Member:

Royal College of Physicians and Surgeons of Canada: Fellowship:
Year: ________________ Specialty: _ ___________________________

Hospitals with which you are affiliated: Admitting Privileges

______________________________________ Yes No

______________________________________ Yes No

PRIMARY PRACTICE ADDRESS: ***(location in which you see the majority of your patients)***

____

____

____

Email address*:*
(This may be the preferred communication method of the assessor)

Office telephone Home/Cell telephone Fax number

How many years have you practised in your current community?

SECONDARY PRACTICE OR MAILING ADDRESS (***if different from above)***

____

____

____

Office telephone Fax number

1. WHAT IS YOUR PRACTICE STATUS?

If you are not involved in active practice, and have given up your medical license, it is only necessary to provide the demographic information above and this section, # 1.

I am fully retired from all clinical practice (***do not treat or prescribe for patients)*****, and I am no longer licenced:**

No Yes Date of retirement: ______________________

I am on medical/maternity leave, and intend to return to practice:

No Yes Anticipated return date: _________________________

By placing a check mark in the box, you verify that the information provided on this questionnaire is correct, true and accurate.

2. WHAT IS YOUR PRACTICE STRUCTURE?

Are you in a group or solo practice? Group Solo
(Note: A group practice is one in which two or more physicians and medical support staff work together and share facilities and other resources.)

If you are in a group practice, please indicate the number of full and part-time personnel with whom you work on a regular basis (daily/weekly) in your office practice.

For Office Practice	# F/T	# P/T
Physicians		
Registered Nurses/RNA's		
Nurse Practitioners		
Administrative Staff		
Other (please specify:		

Do you share the following with other physicians in your office?

Staff Yes No
Office space Yes No
Patient records Yes No

Language of patient charts: English French Both

Which best describe your patient records?

Electronic medical/clinical/patient records: Software used: ____________________
Hand-written records: Yes No
Hospital records only: Yes No
Are your complete medical records located in your office? Yes No
If no, please indicate where and how you obtain your patients' complete records:

Do you consider your practice to be urban or rural in nature? Urban Rural

Please indicate your access to, or the availability of, the following: (please enter Y or N)

basic laboratory services (i.e. hemoglobin, urine, blood glucose analyses, etc)	
advanced lab services (i.e. bone density, cardiac stress test, electromyography, etc)	
basic radiological services	
CT scans or MRI's	
specialists to which you can refer	
one or more long term care facilities in your community	
social service agencies to support your care of patients	
regular contact and interaction with peers	

Please describe your arrangements for the provision of patient care in your absence, i.e. cross-coverage, vacations, etc.

Are you a member of a call group? Yes No

How often are you on call? ____

Have you chosen to focus or restrict your practice? If yes, please specify:

Please estimate the number of patients on your roster: _________________________________

What percentage of these patients are referred by other physicians? %

Do you foresee any significant changes in your practice in the next two years? Yes No

If yes, please specify:

This page may, if you choose, be completed by your Administrative Assistant or Secretary.

During what hours is the telephone in the office answered?

____

Where does your “after-hours” message direct patients in an emergency

____

What is the approximate wait time for patients to get an appointment? ____________________

What is the approximate time allocated for each appointment? ___________________________

Do you have space each day for emergency patient appointments? Yes No
If yes, how many appointments? _________________________________

Is the following emergency equipment available on site?

Oxygen: Y/N : Ambu-Bag: Y/N: Airway: Y/N: Adrenalin: Y/N:

If not, where? ____

How long would it take emergency personnel (911) to reach your office? ___________________

Please describe your refrigeration equipment and temperature monitoring procedures:

____

Please describe your sterilization equipment and procedures.

____

Where are prescription pads kept? ____

How do your store and/or dispose of controlled drugs, vaccines, and drug samples?

____

How do you dispose of sharps and/or other biomedical waste?

____

(If not the physician,)
This page completed by ___________________________ **Position:** __________________________

I verify that the information provided is correct, true and accurate.

Please indicate at which location you see patients, the number of patients seen, and the number of hours spent in direct patient contact in a typical work week. Please do not provide a range, but indicate the upper limit of patients seen, and the number of hours you spend in direct patient contact.

Facility - please circle the one which best describes your primary area of practice	# patients seen	# hrs direct patient contact
A. OFFICE PRACTICE		
Private Office		
Community Health Centre		
Family Health Network		
Walk-in Clinic, After Hours, Urgent Care (non-static patient base, no appointments, episodic care		
Academic Family Practice Unit		
Locum		
B. HOSPITAL- Please indicate if this is an academic teaching hospital		
Inpatients		
Outpatients		
Emergency		
Surgical Assists		
Day Surgery		
Hospitalist		
C. LONG TERM CARE FACILITY (nursing home, etc)		
D. GOVERNMENT FACILITY (armed forces, prison)		
E. HOUSE CALL SERVICE		
F. OTHER (please specify)		

Practice Descriptor Codes (for use with question following)

	ANESTHESIA		OBSTETRICS AND GYNAECOLOGY		SURGERY (CONTINUED)
101	Anesthesia	501	Gynaecologic Oncology	810	Ophthalmology
102	Chronic Pain Management without general/spinal anesthesia	502	Gynaecologic Reproductive Endocrinology & Fertility	811	Orthopaedic Surgery
	GENERAL/FAMILY PRACTICE	503	Gynaecologic Surgery and prenatal care	812	Otolaryngology
201	General/Family Practice with active/admitting hospital privileges	504	Office Gynaecology	813	Plastic Surgery
202	General/Family practice without hospital privileges	505	Obstetrical Practice limited to prenatal care	814	Surgical Practice without operative treatment
	MEDICINE	506	Obstetrics	815	Thoracic Surgery
301	Allergy	507	Urogynaecology	816	Urology
302	Cardiology	508	Sexual Counselling	817	Vascular surgery
303	Clinical Immunology		PAEDIATRICS	818	Transplant Surgery
304	Clinical Pharmacology	601	Neonatology	819	Endoscopy
305	Critical Care Medicine	602	Paediatrics		OTHER
306	Dermatology	603	Paediatric Cardiology	901	Acupuncture
307	Emergency Medicine	604	Paediatric Nephrology	902	Administrative Medicine
308	Endocrinology	605	Paediatric Neurology	903	Community Medicine (Public Health)
309	Gastroenterology	606	Paediatric Surgery	904	Palliative care
310	Genetics	607	Paediatric Allergy/Clinical Immunology	905	Psychotherapy
311	Geriatric Medicine/Nursing Homes	608	Paediatric Oncology	906	Sport Medicine
312	Haematology	609	Paediatric Orthopaedics	907	Clinical Fellow-without moonlighting
313	Infectious Diseases	610	Paediatric Gastroenterology	908	Clinical Fellow-with moonlighting
314	Internal Medicine	611	Paediatric Haematology	910	Child and Adolescent Psychiatry
315	Medical Oncology	612	Paediatric Haematology/Oncology	911	Substance Abuse
316	Nephrology	613	Paediatric Infectious Diseases	912	Aviation Medicine
317	Neurology	614	Paediatric Respiratory Medicine	913	Hyperbaric/Diving Medicine
318	Nuclear Medicine		RADIOLOGY	914	Sleep Medicine
319	Occupational Medicine	701	Diagnostic Imaging	915	Complementary Medicine
320	Physical Medicine and Rehabilitation	702	Therapeutic Radiology/Radiation Oncology	916	Long Term Care
321	Psychiatry	703	MRI	917	Urgent Care/Walk in Clinics
322	Respiratory Medicine	704	CT (computed tomography)	918	EEG
323	Rheumatology		SURGERY	919	EMG
	LABORATORY MEDICINE	801	Laser Surgery	920	Spirometry
401	Medical Biochemistry	802	Assistance at Surgery	921	House Calls
402	Medical Microbiology	803	Cardiovascular Surgery	922	Sclerotherapy
403	Pathology-Anatomic	804	Clinical Associates-Surgical	923	Hypnotherapy
404	Pathology-General	805	Colorectal Surgery	924	Teaching
405	Pathology-Haematological	806	Cosmetic Surgery	925	Research
406	Pathology-Neurological	807	General Surgery	926	Administration (in Medical schools, hospitals etc.
		808	General Surgical Oncology	927	Other Professional Activities i.e. College Activities
		809	Neurosurgery		

<u>Clinical Activity:</u> using the descriptor codes on the previous page, please describe your clinical practice. The focus should be on <u>what you actually do</u>, rather than any certification(s) you hold. If you list more than one code, please estimate the percentage of time you spend in each area.

Code	0 - 10%	11 - 20%	21 - 40%	41 - 60%	61 - 80%	81 - 100%
Other						

Please list the most common conditions/diseases/procedures that you see/do in your practice:

3. <u>WHAT IS YOUR COMMITMENT TO CONTINUING MEDICAL EDUCATION?</u>

Regardless of your certification or membership status with the CFPC or the RCPSC, do you voluntarily fulfil their professional development requirement? Y/N: Unsure:

Below, please provide information about the type of professional development activities you participated in over <u>the last 12 months</u>, and estimate how many <u>hours</u> you spent on formal CME.

	<10	11-20	21-30	31-40	41-50	>50
RCPSC/CCFP accredited courses, conferences, workshops						
Internet-based CME Activities (on-line journals, guideline						
Practice-based small group learning sessions						
Self-directed learning programs						
Hospital committees						
Hospital educational rounds						
Other courses, conferences & workshops						
Other: please describe						

Finally, we would like you to take a few minutes to reflect on your practice over the past twelve months, considering your areas of strength and areas which could be deficient. Please tell us what you hope to get out of this assessment, and state one specific question and/or learning objective for the review. (Your objective may be in a clinical area, relationships with patients, new CME you would like to explore, etc.)

Thank you for your participation in peer review.

I see my area(s) of strength as:

I believe that I may have certain deficiencies in

I would like to have more clinical knowledge

Following this peer assessment, I would like to

In the coming year, I hope to do CME in these specific areas

In five years, I would like my practice to be

My Electronic Signature* **Date: ____**

***By placing a check mark in the "My Signature", you verify that the information provided on this questionnaire is correct, true and accurate.**

Please describe yourself: i.e. your family, community involvement, special interest or hobbies, etc.