Q - 2

Practice Enhancement Program
St. Andrew's College
119 – 1121 College Drive
Saskatoon SK S7N 0W3

Phone(s): (639) 398-0545 or
(639) 397-0705

Email: admin@pepsask.ca
Website: http://www.pepsask.ca

Physician Pre-visit Questionnaire – Family Physician

Please complete and return this questionnaire within two (2) weeks.
Complete online, save to desktop and email to admin@pepsask.ca

A. Demographic Data

1. Surname: _____ Any Prior Surname: _____
2. Given Names: _____
3. Date of Birth: Day ____ Month ____ Year ____ 4. Female ☐ Male ☐ Other ☐
5. Office Address **(please include name of clinic)**
6. Telephone: Office _____ 7. Mobile _____
8. Email address: _____
   This is the email address that PEP will use for all communications moving forward. Please continue to check your inbox, as well as your junk mail.
9. Year of Graduation (medical school) _____
10. Medical Degree from University of _____
11. Location of University _____

---

12. Are you currently on **parental leave**? Yes ☐ No ☐
    Expected date of return (dd/mm/yyyy):
13. Are you currently on **medical leave**? Yes ☐ No ☐
    Expected date of return (dd/mm/yyyy):
14. I will be retiring from the practice of medicine in the **next 6 months**. (if yes, please comment below)
    Comment: _____

B. Educational Information & Practice History

Please specify type of postgraduate training - *e.g. Internship, Residency*

Name of Hospital	Location	Postgraduate Training	Years (yyyy – yyyy)
1.	1a.	1b.	1c.
2.	2a.	2b.	2c.
3.	3a.	3b.	3c.
4.	4a.	4b.	4c.
5.	5a.	5b.	5c.
6.	6a.	6b.	6c.

List the places you have practiced and the years you practiced there **(please include clinic name, community and/or hospital you practice at if applicable):**

	Name of Clinic and Community		Years (yyyy – yyyy)
7.		7a.	
8.		8a.	
9.		9a.	
10.		10a.	
11.		11a.	
12.		12a.	

C. Description of Practice

1. Are you a member of the College of Family Physicians of Canada? Yes ☐ No ☐

2. Do you have certification from the College of Family Physicians of Canada? Yes ☐ No ☐

   a. If yes, year Certificate obtained: ☐

3. Have you obtained a Certificate of Added Competence from the CFPC? Yes ☐ No ☐

   a. If yes, in what area? ☐ b. What year? ☐

4. Are you engaged in: Solo Practice (only physician in the practice/clinic) ☐
   Group Practice (within a group setting) ☐
   Other ☐

   Describe 'Other': ☐

5. Have you chosen to limit your practice to a specific area (e.g. sports medicine)?

   ☐

6. Briefly describe the nature of your practice.

   ☐

7. Briefly describe arrangements for patient care when you are ***not*** available for extended periods.
   e.g. holiday, CME, etc.

   ☐

8. Specifically describe arrangements for patient care after hours, on weekends and statutory holidays:

   Always available yourself ☐ Share call within your own practice group ☐

   Share call with physicians outside your practice group ☐ Unavailable after office hours ☐

   Formal Agreement with local ER ☐ Other ☐

   Describe 'Other': ☐

9. When one of your patients is admitted to hospital for a problem that would normally be managed by a family physician, is it your practice to: (Choose all that apply)

   a) Care for your patient yourself exclusively ☐
   b) Transfer care of your patient to a hospitalist or another colleague ☐
   c) Transfer care of your patient to a specialist ☐
   d) Other ☐

   Describe 'Other': ☐

D. Academic / Teaching Involvement

1. Do you have a faculty appointment? Yes ☐ No ☐

   a) If yes, in which department? ☐

2. Do medical students or residents attend your office for teaching purposes? Yes ☐ No ☐

If you do ***not*** have a faculty appointment but see students, residents or other professions (i.e. nurse practitioners, etc) for teaching purposes, please describe:

☐

E. Distribution of Work

Hours of Work:

1. In a typical workweek, state the number of hours spent:

   a) In direct patient care (not including call) ☐ hours
   (Includes in-office, hospital, homes for the aged, telephone consults, other)

   b) Outside of direct patient care (not including call) ☐ hours
   (includes clinic management, paperwork, other)

   c) On call ☐ hours
   If applicable, please describe: ☐

2. TOTAL HOURS (***not*** including on call) 0 **hours**

3. If relevant, how many hours do you spend each week:

   a) Working in a Walk-In Clinic/Extended Hours Clinic ☐ hours

   b) Name of 'Walk-In Clinic' (if applicable) ☐

   c) Assisting in the operating room ☐ hours

Patient Volumes:

4. In a typical workweek, state the number of patients you would expect to see:

   a) In your office (including telephone consults) ☐ patients
   b) Walk-In Clinic ***or*** Extended Hours Clinic ☐ patients

   c) Out of office:
   Hospital (in-patient) ☐ patients
   Scheduled out-patient visits ☐ patients
   Homes for the aged, extended care facilities ☐ patients
   Other ☐

5. TOTAL PATIENT VISITS per WEEK 0 **patients**

Other:

6. Do you perform other contractual or sessional work? Yes ☐ No ☐

   a) If yes, please describe:

7. What percentage of your patients are referred by other physicians? ☐

8. Do you perform surgical procedures in your office? Yes ☐ No ☐

F. Hospital Practice

1. Do you have Hospital Appointment/Privileges Yes ☐ No ☐

   a) In which area of the SHA? ☐

   b) In which hospitals? ☐

G. Continuing Medical Education

1. Please list your CME participation during the last two years.

H. Assessment Information

1. Are your records maintained on a computer database? Yes ☐ No ☐

2. If so, which EMR system is being used? Accuro ☐ Med Access ☐ Other ☐

   If Accuro, please specify if it is Web/Cloud based or locally hosted.

Date Completed: ☐ Completed by: ☐