NSPAR

Nova Scotia Physician Achievement Review

Pre-Visit Questionnaire

Name: ____

Address of office to be visited:

____

____

____

Business Phone Number: ___________________________

Fax Number: ___________________________

Email: ___________________________

The purpose of this questionnaire is to familiarize the practice visitor with you and your practice, and to reduce the time necessary for on-site collection of information. Please respond to all questions.

A. MEDICAL EDUCATION

Year of graduation: _______________

Post-graduate qualifications and certifications:

____
____
____

B. CONTINUING MEDICAL EDUCATION

Please list conferences and presentations, and dates in the past 12 months*:*
____
____
____

Please list paper and electronic reference material consulted in the past 12 months:

In Office	Out of Office
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________

C. DESCRIPTION OF PRACTICE

Number of office hours worked per week: ____________________

Average number of patients seen per hour in the office: ____________________

Hospital privileges: Yes ___ No ___

If yes:

What type (e.g. admitting, courtesy, acute care, long-term, on-call duty, etc.)
____
____

On average, how many hospital visits do you make per week? ___________ # visits/week

Do you perform OR assists? Yes ___ No ___

Describe the demographics of your practice population (i.e. male/female ratio, age ranges, special areas of interest etc.):

____
____
____
____

Do you provide antenatal care? Yes ___ No ___

Do you ever have medical students or residents in your office? Yes ___ No ___

Surgical procedures performed in the office:

____
____
____

Do you receive referrals from other physicians? Yes ___ No ___

If yes:

In what area(s) do you receive referrals?

____
____
____

D. OFFICE PERSONNEL:

How many physicians do you work with in your office? ______________________

Do you share your practice with another physician(s)? Yes ___ No ___

How many RNs / LPNs do you work with in your office? ______________________

How many administrators/others do you work with in your office? ______________________

Additional description (optional):

____
____
____

Do you discuss policies with office personnel? Yes ___ No ___

Does your staff have written job descriptions? Yes ___ No ___

Do you instruct office personnel on:

- communicating with patients? Yes __ No__
- measuring blood pressure? Yes __ No __ Not performed by staff __
- performing other clinical tasks? Yes __ No __ Not performed by staff __
- disposal of bio-medical waste? Yes __ No __ Not performed by staff __
- cleaning and sterilization? Yes __ No __ Not performed by staff __

If cleaning and sterilization is not performed by your staff, how is it handled?

____
____
____

E. PRACTICE POLICIES:

What is the average length of waiting time for patients in your waiting room? ________________
What arrangements do you have for:

(a) the after-hours care of your patients?

____
____
____

(b) vacation coverage?

____
____
____

Are all tests reviewed by the physician who requested each test? Yes ___ No ___

What is the procedure to ensure review of investigation results before they are filed in the patient's record?

____
____
____

Are patients notified of all abnormal results? Yes ___ No ___

What is your average time to complete:

(a) referral letters __________________________
(b) third party requests __________________________

When sensitive examinations are performed (e.g. genitalia), is a third person present?

Yes ___ No ___

If no, please explain:

____
____

Are patients' records stored electronically ("computerized")? Yes ___ No ___

F. Practice Visit Arrangements:

The practice visit is conducted by a physician in a practice similar to yours. The visitor will be in your office for about four hours. ***You will need to be available to the visitor for at least part of this time.*** The practice visitor will also need access to an appropriate area for chart reviews.

Please mark your preferred times for a practice visit (**Mark a minimum of 3 time slots**):

Is there any time during the next month that you are not available (eg. vacation, CME, etc.)? If so, please specify:

____

____

Preferred day of the week:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Preferred time of day:

08:00 – 12:00 hours	09:00 – 13:00 hours	12:00 – 16:00 hours	13:00 – 17:00 hours

Please mail the Pre-Visit Questionnaire when complete to:

Address Here

(902) ###-#### (telephone)
(902) ###-#### (alternate telephone)

Practice Visit Number:
Practice Visitor: ______________________
(print)

Practice Visitor: ________________________
(signature)
Date: ______________________