



## Pre-Visit Questionnaire – Medical Specialists

**Name:**

**Physician/Report #**

Address of office to be visited:

Business Telephone Number:

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Business Fax Number:

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Email:

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

**1. MEDICAL EDUCATION**

(a) Year of graduation: \_\_\_\_\_ (b) Specialty certification(s) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2. DESCRIPTION OF PRACTICE**

(a) My practice is predominantly: Community-Based  or Hospital-Based  or 50:50

(b) My specialty discipline is: \_\_\_\_\_

(c) My sub-specialty / special practice interest(s) in this discipline is: \_\_\_\_\_

(d) Proportion of patient contact time: *In-patients:*  %

*Out-Patients* {  *Hospital Office:*  %  
 *Out-patient Clinic:*  %  
 *Community Office:*  %

**Total =**  %

(e) Proportion of patient contact time spent on procedures:  %

Please list procedures: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(f) Total number of scheduled medical practice hrs. worked/week:  hours / week

(g) Average number of additional on-call hours each week:  hours / week

**3. PATIENT INFORMATION**

(a) Average number of patients seen per hour in the *New patients:*  / per hour  
 clinic or office:

*Review Patients:*  / per hour

(b) What percentage of your practice patients are self-referred?  %

(c) Describe the roles of support personnel who assist in your office-based clinical activities :  
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**4. PROFESSIONAL DEVELOPMENT**

- (a) How many hours each week do you attend clinical case rounds or formal rounds with colleagues in your discipline:  hours / week
- (b) How many hours do you spend each week in clinical teaching:
- o *During your clinical practice (e.g. teaching clinics or rounds with residents or students):*  hours / week
  - o *Structured teaching outside your own practice:*  hours / week
- (c) List practice quality improvement projects that you have participated in during the last 12 months:

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- (d) Please list journals and electronic references you have accessed in the past 12 months.

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- (e) What medical textbooks have you purchased in the last 12 months?

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**5. OFFICE PERSONNEL:**

- (a) Do you have any administrative responsibilities in the site of your principal practice location? Yes  No
- (b) How many physicians share your office facilities?
- (c) Do you share practice records or charts with other physicians? Yes  No
- (d) Do residents or medical students dictate or write medical records for your practice? Yes  No

*If yes to either (c) or (d) above, what percentage of all the visit records are written by you?*  %

- (e) Do you instruct office personnel on:
- communicating with patients? Yes  No
  - measuring blood pressure, temp., etc.? Yes  No  Not performed by staff
  - performing other clinical tasks? Yes  No  Not performed by staff

If yes, please list:

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**6. MANAGING THE INTERFACE BETWEEN PRIMARY & SECONDARY CARE**

(a) Access

- What is the waiting period for typical consultations? \_\_\_\_\_
- How are referrals triaged?  
\_\_\_\_\_  
\_\_\_\_\_
- How are urgent referrals identified and handled?  
\_\_\_\_\_  
\_\_\_\_\_

(b) Preparatory Investigations

- How are the results of previously performed investigations gathered?  
\_\_\_\_\_  
\_\_\_\_\_

- Are case specific preparatory investigations requested? Yes  No

(c) Interim Management

- Are referring physicians given instructions for patient management while waiting for consultations? Yes  No
- Do you provide instructions about monitoring for adverse changes while patients wait for consultations? Yes  No

(d) Final Report

- How soon after a visit is a report typically sent to the referring physician? \_\_\_\_\_
- Are follow-up reports sent in response to subsequent test results? Yes  No

(e) Responsibility for Future Care

- Do you indicate who is responsible for on-going care and follow-up? Yes  No
- Do you identify who is responsible for follow-up of all abnormal results and what that follow-up should be? Yes  No
- Do you provide opportunities for shared care – patients to revisit or primary care physicians to contact you when appropriate? Yes  No
- Do you offer the referring physician instructions for on-going care? Yes  No
- Do you offer instructions for monitoring/managing adverse change? Yes  No

**7. PRACTICE MANAGEMENT**

- (a) What is the average length of waiting time for patients in your waiting room? \_\_\_\_\_

(b) What arrangements do you have for the after-hours or weekend care of your patients?

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(c) Are all tests reviewed by the physician who requested each test? Yes  No

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

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(e) Are patients notified of all abnormal results? Yes  No

(f) When sensitive examinations are performed (e.g. genitalia), is a third person present? Yes  No

If no, please explain:

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

(h) Please identify any healthcare system issues that pose as a barrier to the provision of optimum care to your patients.

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A Practice Visit is conducted by a physician in a practice similar to yours and a physician experienced as a practice visitor. The visitors will be in your office for about four hours. Please mark your preferred times for a Practice Visit (3 slots minimum):

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
am								<i>Preferred</i> 08:00-12:00 <input type="checkbox"/>
								<i>a.m. times:</i> 09:00-13:00 <input type="checkbox"/>
pm								<i>Preferred</i> 12:00-16:00 <input type="checkbox"/>
								<i>p.m. times:</i> 13:00-17:00 <input type="checkbox"/>

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

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**Please mail the Pre-Visit Questionnaire when complete to:**

[insert program advisors name and contact information]