



## Pre-Visit Questionnaire – Surgical Specialists

**Physician Name:**  
**Physician/Report #:**

**Address of office to be visited:**

**Business Telephone Number:** \_\_\_\_\_  
**Business Fax Number:** \_\_\_\_\_  
**Email:** \_\_\_\_\_

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.

**MEDICAL EDUCATION**

Year of graduation: \_\_\_\_\_

Post-graduate qualifications and certificates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROFESSIONAL DEVELOPMENT**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list journals, textbooks and electronic reference material consulted in the past 12 months.

In Office

Out of Office

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PEER REVIEW**

Have you had the opportunity to operate with colleagues?

Yes    No

Please explain:

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What changes have you made to your surgical techniques / approach as a result of observing or being observed?

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What feedback about your care of patients do you receive from hospital or regional activities (e.g. morbidity and mortality rounds, other rounds, OR statistics, chart audits, etc)?

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**DESCRIPTION OF PRACTICE**

Number of office hours worked per week:

Average number of patients seen per hour in office:

Type of hospital privileges (e.g. admitting, surgical, etc.):

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Where:

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Describe the characteristics of your practice population:

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Surgical procedures performed in the office:

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**OFFICE PERSONNEL**

How many physicians do you work with in the office? \_\_\_\_\_

How many RNs/LPNs do you work with in the office? \_\_\_\_\_

How many administrators/others do you work with in the office? \_\_\_\_\_

Additional description (optional):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you discuss policies with office personnel? Yes No

Do you instruct office personnel on:

- |  |     |    |                        |
|--|-----|----|------------------------|
| ▪ communicating with patients?           | Yes | No |                        |
| ▪ cleaning and sterilization?            | Yes | No | Not performed by staff |
| ▪ 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRACTICE POLICIES**

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

What arrangements do you have for the after-hours care of your patients?  
\_\_\_\_\_  
\_\_\_\_\_

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

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

If no, please explain:

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

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 a.m. times:</i> 08:00-12:00 <input type="checkbox"/> 09:00-13:00 <input type="checkbox"/>
pm								<i>Preferred p.m. times:</i> 12:00-16:00 <input type="checkbox"/> 13:00-17:00 <input type="checkbox"/>