PHYSICIAN PRACTICE ENHANCEMENT PROGRAM
College of Physicians and Surgeons of British Columbia
300–669 Howe Street
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Telephone: 604-733-7758
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GENERAL PRACTICE

PRE-VISIT QUESTIONNAIRE

The purpose of this questionnaire is to provide the Physician Practice Enhancement Program (PPEP) with the most current information about you and your practice. The information that you provide will be reviewed by program staff and assessors appointed to review your practice.

You may wish to consult with other staff members in your practice when completing this form; however, please note you are personally responsible for completion of this form and for the veracity of the information contained herein.

Please complete this questionnaire and return it to the College.

A. CONTACT INFORMATION

Name: _____ CPSID: _____

Email: _____ Date of birth: _____

Cell phone: _____

Name of primary practice: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone: _____ Fax: _____ Direct line: _____

Preferred method of contact: ☐ Email ☐ Office phone ☐ Cell phone

B. PROFESSIONAL INFORMATION

1. Please indicate from the options below all that apply to you:

   ☐ general/family practice – solo physician (a physician who works alone and not in partnership or association with another physician)

   ☐ general/family practice – multi-physician practice (a practice where two or more physicians practice at the same clinical office)

   ☐ general/family practice – locum physician (a locum tenens physician is a physician temporarily substituting for another)

   ☐ specialist (please specify): _____

   ☐ hospitalist

   ☐ surgical assist

   ☐ administration (describe): _____

   ☐ academic (describe): _____

   ☐ research (describe): _____

   ☐ other (e.g. outreach, telemedicine): _____

C. PROFESSIONAL DEVELOPMENT

2. Please attach a print out of your Official Transcript of CME Activities from the College of Family Physicians of Canada MAINPRO® Program for a **minimum of the last three years**.

   If there are ***additional*** CPD courses you have attended that are relevant to your scope of practice, you may list them here:

Course title	Date attended (YYYY-MM-DD)

3. Medical degree obtained from _____
   NAME OF UNIVERSITY YEAR

4. Post-graduate training:

Type of training/program/residency	Name of university	Year

D. PRACTICE INFORMATION

5. Describe your practice experience (type, community, number of years):

   _____

   _____

   _____

6. Briefly describe the scope of your current practice and your practice setting(s)—do you have a particular focus?

   _____

   _____

7. Are you practising outside your initial medical training? ☐ Yes ☐ No

   If yes, what additional training have you undertaken?

   _____

8. Is alternative or complementary medicine part of your practice? ☐ Yes ☐ No

   If yes, please describe.

   _____

9. How many patients do you see per week?

   a. in your office _____

   b. in hospital _____

   c. elsewhere _____ Please describe: _____

10. How many hours per week do you spend in direct patient contact? _____

The remaining section applies to ANY community-based care, including GP, locum, walk-in, and medical assessments (e.g. aviation or immigration physicals and travel medicine).

11. If you are engaged in a multi-physician practice (see definition in question 1), please list all multi-physician practice settings you work at and include the associated medical director, number of physicians, and the percentage of your work at the location. This includes walk-in clinics, primary care clinics, long-term care facilities, nursing homes and medical assessments.

Name of multi-physician practice	Name of medical director*	Number of physicians	Amount of work at this location (%)

*See https://www.cpsbc.ca/files/pdf/PSG-Walk-In-Urgent-Care-Multi-Physician-Clinics.pdf for the role of the medical director in walk-in, urgent care and multi-physician clinics.

12. At which location do you prefer to be assessed?
*Please select a **community-based** office from the list above or your primary address of practice (if **community based**) at which your assessment can take place.*

***Note:** For physicians who practice in multiple settings, your assessment should be at the location where your broadest (least focused) scope of practice takes place.*

☐ Primary address of practice (from page 1)

☐ Multi-physician practice listed above (provide practice name and address)

_____

13. At the **chosen practice setting for your assessment** (indicated in the previous question), which of the following services do you provide?
This helps the program determine an appropriate assessor, and which version of the multi-source feedback to use for your assessment. Questionnaires will vary depending on whether or not you have long-term patients.

- ☐ Family medicine (GP)
- ☐ Walk-in clinic
- ☐ Both GP and walk-in By appointment: _____ % Walk-in: _____ %
- ☐ Locum
- ☐ Other (please describe): _____

14. Do you practice obstetrics in this practice setting? ☐ Yes ☐ No

If yes, do you provide full service or antenatal care only?

☐ Full service ☐ Antenatal care only

15. How are your medical records organized? ☐ Paper ☐ Electronic ☐ Both

If electronic or both please indicate the program: _____

16. Do you have PharmaNet access at this practice setting? ☐ Yes ☐ No

If yes, do you use it when prescribing? ☐ Yes ☐ No ☐ Sometimes

17. How do your patients, lab staff, hospital, etc. contact you after hours?

- ☐ Phone ☐ Call group
- ☐ Direct pager ☐ Answering service
- ☐ Email ☐ Not contacted after hours
- ☐ Other (please specify): _____

E. NOTES/ADDITIONAL COMMENTS

18. Are there areas of your medical practice you would appreciate guidance in improving? Please describe.

_____

_____

_____

19. Is there any additional information (e.g. practice specifics) that would be helpful for the assessor to know in advance of the assessment?

_____

_____

_____

We encourage physicians to review their medical records to ensure that information on why a patient came in, what was found, and what action was taken, is easily discernable.

F. CERTIFICATION OF REGISTRANTS

I hereby certify that I have personally completed this form and that the information provided herein is true, complete and accurate. If, following the completion of this form, there is any change to the information provided in this form, I will inform the College immediately with full details of that change. I understand that it is professional misconduct to make a false or misleading report to the College of Physicians and Surgeons of British Columbia.

☐ I agree

Signature: _____ Date completed: _____

PLEASE RETURN THIS FORM BY:

Mail College of Physicians and Surgeons of BC
300–669 Howe Street
Vancouver BC V6C 0B4

Fax 604-733-3503

The information in this form is collected under the authority of section 26.1 of the Health Professions Act, RSBC 1996, c.183 (the Act) and sections 1-19 and 9-1 of the Bylaws under the Act. The information provided will be used for the conduct of a peer practice assessment. If you have any questions about the collection and use of this information, please contact the College at 300–669 Howe Street, Vancouver, BC, V6C 0B4 or by phone at 604-733-7758 extension 6121 or 1-800-461-3008 (toll free in BC).

G. FEEDBACK

Thank you for completing your pre-visit questionnaire for the Physician Practice Enhancement Program (PPEP). We rely on your feedback to help us improve. This section is for program development and evaluation purposes only, and will not be shared with your assessor. All responses will be collated to ensure anonymity.

Please indicate your level of agreement with the following:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
PD1. I am open to feedback regarding my practice and improvements that can be made.	◯	◯	◯	◯	◯
PD2. I anticipate that my upcoming PPEP assessment will be a worthwhile experience.	◯	◯	◯	◯	◯
PD3. I would like to make changes to improve my practice.	◯	◯	◯	◯	◯