THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
EMAIL: QUALITY@CPSM.MB.CA

Quality Improvement Program
Physician Questionnaire

This questionnaire is designed to provide us with the most current information about you and your practice. The information enclosed is for program use only. PLEASE NOTE: Not all questions will apply to every physician. If, for instance, you do not have a university appointment, this section will not apply to you. If you believe that a specific question is not relevant to your practice, please indicate Not Applicable – N/A.

Name: _____

Practice Location/Address: _____Telephone: _____

E-Mail: _____ Fax No.: _____

Year of medical school graduation: _____

Year of completion of post-graduate training: _____

Field(s) of post-graduate training: _____

College of Family Physicians of Canada - Certificant: (Y/N) ____ Member: (Y/N) ____

A. OFFICE PRACTICE CHARACTERISTICS

1. Years of practice in present community: _____

   Total Years of Practice: _____

2. Type of practice: Solo ☐ Group <3 ☐ Group >3 ☐

   Do you share with other physicians in your practice?

   Staff (Y/N) ___
   Office Space (Y/N) ___
   Patient Records (Y/N) ___

3. How many patients do you have in your practice (approximate)? _____

4. What is the gender distribution of your practice? (M/F) _____

5. What is the age distribution of your practice? 0-19 ☐ 20-44 ☐ 45-64 ☐ 65-84 ☐ 85+ ☐

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6. Do you have a call schedule? No ☐ Yes ☐

If **yes**, describe briefly: _____

7. Complete the table with the **hours** worked in a typical week:

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Office							
Hospital							

8. How many patients would you typically see per day in your office? _____

9. In a typical week, please estimate the percentage of your patient visits that fall with in each of the following categories. Please do not provide a range, but indicate the upper limit of visits in each category. Please note that the total should equal 100 percent.

% Patient Visits	Category
0.00%	**New presentations/acute condition management:** New or known patients with new complaints or conditions requiring the formulation of a diagnosis in an office practice setting.
0.00%	**Management of patients with ongoing/chronic conditions:** Patients with chronic conditions requiring long-term monitoring with or without the presence of co-morbidities.
0.00%	**Health maintenance:** Patient visits for well care and preventative health maintenance (e.g. periodic health exams, screening, well child care etc.).
0.00%	**Psychosocial care:** Patients to whom you provide general counselling, psychotherapy sessions or referrals to various supportive social agencies in their community.
0.00%	**New consultations/pre-operative management:** new or known patients presenting prior to surgical/medical procedures for pre-operative examinations, testing, and treatments.
0.00%	**Operative patient management and procedures:** Providing patients with intra-operative or procedural treatments.
0.00%	**Post-operative management and follow up:** Patients to whom you provide post-operative or post-procedural care, which may include follow up of patients with conditions that could require long-term care.
0.00%	**Emergency medicine management:** Patients to whom you provide care in the emergency department.
0.00%	**Other:** (please specify)
0.00%	**Total (100%)**

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10. Does your clinic use an Electronic Medical Record? _____

    If **yes**, which EMR program do you use_____

    Are you able to access patient medical records remotely? (Y/N) _____

11. Do you have access to "E-Chart"? Yes☐ No☐ If **yes**, please describe how do you use it:
    _____
    _____

12. Do you provide telemedicine? If so, please describe.
    _____
    _____

13. In order to understand the nature of your practice, briefly describe the demographics of the patients in your practice, for example, socio-economic status of patients, special areas of interest in your practice.
    _____
    _____
    _____

14. Please list the five most common medical diagnoses which you see in your office:

    _____
    _____
    _____
    _____
    _____

15. Please list the three most common surgical procedures performed in your office:

    _____
    _____
    _____

16. Do you perform any laboratory work (including short list)? No☐ Yes☐

    If **yes**, list laboratory tests that you perform:

    _____
    (Attach the list on a separate sheet of paper, if preferred.)

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B. UNIVERSITY AFFILIATION

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

If **yes**, specify type of appointment: _____

If **yes**, describe your responsibilities, e.g. administrative, teaching, research:

_____

_____

Number of hours required for this appointment per week or month: _____

C. PRACTICE IN HOSPITAL, PERSONAL CARE HOME, HEALTH CARE FACILITY, OR OTHER LOCATION

1.

Name of Facility and Appointment Held	Major Clinical Activity	# of Hours/ Week

2. In the last typical full week worked:

a. How many patients did you attend in each facility?

Name of Facility	Inpatient	Outpatient

b. Total hours/week spent in: Rounds _____ Medical Staff meetings _____

Patient Care _____ Other _____ (Specify): _____

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D. **CONTINUING MEDICAL EDUCATION** (most recent calendar year)

_____ Hours of formal programs approved by the University CME Department or Professional Society

_____ Hours of informal programs (rounds, medical staff meetings, conferences or programs that are not approved, independent reading)

List conferences/meetings attended, journals read regularly AND/OR electronic or other resources commonly used:

_____
_____
_____
_____

Please attach a transcript of CME activities that you have completed over the last 2 years. This can be printed from the College of Family Physicians of Canada website.

E. **ADDITIONAL INFORMATION**

Please provide any additional comments that you think would help us to better understand the nature and scope of your practice. If you have held any leadership roles in the last 5 years, either related to your practice or related to your community, please list them here.

_____
_____
_____
_____

F. **REPORT**

The Quality Improvement report will be available on your portal. You will be provided a link by email when the report is ready.

Date Completed: _____ Signature: _____

Please return the completed questionnaire to: (submit via scan and email or by mail)

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