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THIS FORM IS TO BE SUBMITTED THROUGH THE CPSM PORTAL

Physician Questionnaire - Family Medicine

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.

DO NOT USE

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1. **Year of medical school graduation:** *(*Required)* ______
   Y Y Y Y
2. **Year of completion of post-graduate training:** *(*Required)* ______
   Y Y Y Y
3. **Field(s) of post-graduate training:** *(*Required)*

4. **College of Family Physicians of Canada:** *(*Required)*

	Yes	No
a. Certificant	○	○
b. Member	○	○

5. **Do you hold a Certificate of Added Competence?** *(*Required)*
   - ○ **a.** Yes
   - ○ **b.** No
6. **In which area is your Certificate of Added Competence?** *(*Required)*

______

Practice Characteristics

7. **Years of practice in present community:** *(*Required)* ____________________

8. **Total years of practice:** *(*Required)* ____________________

9. **Type of Practice:** *(*Required)*
   - ◯ **a.** Solo
   - ◯ **b.** Group <3
   - ◯ **c.** Group >3

10. **Do you share with other physicians in your practice?** *(*Required)*

	Yes	No
a. Staff	◯	◯
b. Office Space	◯	◯
c. Patient Records	◯	◯

11. **Do you provide team-based care? (Work in a multi-disciplinary setting where patient care is shared with other health care professionals.)** *(*Required)*
    - ◯ **a.** Yes
    - ◯ **b.** No

12. **How many patients do you have in your practice (approximate)?** *(*Required)* ____________________

13. **What is the gender distribution of your practice?** *(*Required)*

    ____

14. **What is the age distribution of your practice (percentage)?** *(*Required)*
    - % ____________ **a.** 0 - 19
    - % ____________ **b.** 20 - 44
    - % ____________ **c.** 45 - 64
    - % ____________ **d.** 65 - 84
    - % ____________ **e.** 85+
    - % ____________ **Total**

15. **Do you have a call schedule?** *(*Required)*
    - ◯ **a.** Yes
    - ◯ **b.** No

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16. Briefly describe your call schedule: (e.g. 1 in 4, 10 days/month, 3 weeks/year) *(*Required)*

____

18. How many patients would you typically see per day in your office? *(*Required)* ______________

19. In a typical week, please estimate the percentage of your patient visits that fall within 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. *(*Required)*

% ________ **a. 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.

% ________ **b. Management of patients with ongoing/chronic conditions:** Patients with chronic conditions requiring long-term monitoring with or without the presence of co-morbidities.

% ________ **c. Health maintenance:** Patient visits for well care and preventative health maintenance (e.g. periodic health exams, screening, well child care etc.).

% ________ **d. Psychosocial care:** Patients to whom you provide general counselling, psychotherapy sessions or referrals to various supportive social agencies in their community.

% ________ **e. New consultations/pre-operative management:** new or known patients presenting prior to surgical/medical procedures for pre-operative examinations, testing, and treatments.

% ________ **f. Operative patient management and procedures:** Providing patients with intra-operative or procedural treatments.

% ________ **g. 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.

% ________ **h. Emergency medicine management:** Patients to whom you provide care in the emergency department.

% ________ **i. Other**

% ________ **Total**

20. Please specify Other from the previous question. *(*Required)*

____

21. Does your clinic use an Electronic Medical Record (EMR)? *(*Required)*

- ◯ **a.** Yes
- ◯ **b.** No

22. Which EMR program do you use? *(*Required)*

____

23. Are you able to access patient medical records remotely? *(*Required)*

- ◯ **a.** Yes
- ◯ **b.** No

DO NOT USE

24. Do you have access to "E-Chart"? *(*Required)*

- ◯ **a.** Yes
- ◯ **b.** No

25. Please describe how you use it: *(*Required)*

26. Do you provide virtual medicine care? If so, please describe.

27. In order to understand the nature of your practice/work, briefly describe the demographics of the patients in your practice/work, for example, socio-economic status of patients, special areas of interest in your practice/work. *(*Required)*

28. Please list the five most common medical diagnoses which you see in your practice/work: *(*Required)*

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29. Please list the three most common surgical procedures performed in your practice/work: *(*Required)*

UNIVERSITY AFFILIATION

30. Do you have a faculty appointment: *(*Required)*

- ◯ **a.** Yes
- ◯ **b.** No

31. Specify type of appointment and describe your responsibilities, e.g. administrative, teaching, research: *(*Required)*

32. Number of hours required for this appointment per week or month: *(*Required)*

PRACTICE/WORK IN HOSPITAL, HEALTH CARE FACILITY, OR OTHER LOCATION

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35. In the last typical full week worked, total hours/week spent in: *(*Required)*

a. Rounds

b. Medical Staff meetings

c. Patient Care

d. Other

36. Specify Other from the previous question: *(*Required)*

CONTINUING MEDICAL EDUCATION (most recent calendar year)

37. *(*Required)*

a. Hours of formal programs approved by the University CME Department or Professional Society, including participating as an examiner for clinical exams.

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

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

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ADDITIONAL INFORMATION

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

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