## Peer Assessment Committee
## College of Physicians and Surgeons of New Brunswick

# Supplemental Information for Assessment

**Not all questions will apply to every physician. If you do not believe a specific question or series of questions is relevant, please indicate N/A (Not Applicable).**

Please Note: page 7 of the questionnaire (pertaining to office operation), may be completed by your Administrative Assistant or secretary if you choose. In that event, please ensure the name and signature of the person completing that page is clear

**SURNAME** **GIVEN NAMES:**

**PRIMARY PRACTICE ADDRESS:** ***(location in which you see the majority of your patients)***

***Hospital/Facility Name if applicable*** ***Street number*** ***Suite number***

***City*** ***Province*** ***Postal Code*** ***E-mail***

***Office telephone*** ***Home/cell*** ***Fax number***

***How many years have you practised in your current community?*** ___________

**Total years of post-graduate training (internship/residency): ________________**

**Hospital/Location(s) for Internship/Residency      Type of Training      Year**

**College of Family Physicians of Canada:      Certificant: Yes      No**

**Member:   Yes      No**

**Royal College of Physicians and Surgeons of Canada: Fellowship: Yes      No**

**Year:      Specialty:**

**Hospitals with which you are affiliated:      Admitting Privileges**

**Yes      No**

**Yes      No**

## 2. WHAT IS YOUR PRACTICE STRUCTURE?

**If you are in a group practice, please indicate the number of full and part-time personnel with whom you work on a regular basis (daily/weekly) in your office practice.**

| For Office Practice | # F/T | # P/T |
| --- | --- | --- |
| Physicians | | |
| Registered Nurses/RNA's | | |
| Nurse Practitioners | | |
| Administrative Staff | | |
| Other (please specify: | | |

**Please indicate your access to, or the availability of, the following: (please enter Yes or No)**

| | |
|---|---|
| basic laboratory services ( i.e. hemoglobin, urine, blood glucose analyses, etc) | |
| advanced lab services ( i.e. bone density, cardiac stress test, electromyography, etc) | |
| basic radiological services | |
| CT scans or MRI's | |
| specialists to which you can refer | |
| one or more long term care facilities in your community | |
| social service agencies to support your care of patients | |
| regular contact and interaction with peers | |

**Please describe your arrangements for the provision of patient care in your absence, i.e. cross-coverage, vacations, etc.**

**Are you a member of a call group? Yes No**

**How often are you on call?**

**Have you chosen to focus or restrict your practice? If yes, please specify:**

**Please estimate the number of patients on your roster: ______________________________**

**What percentage of these patients are referred by other physicians? ________ %**

**Do you foresee any significant changes in your practice in the next two years? ______**

**If yes, please specify**

**Please indicate at which location you see patients, the number of patients seen, and the number of hours spent in direct patient contact in a typical work week. Please do not provide a range, but indicate the upper limit of patients seen, and the number of hours you spend in direct patient contact.**

| **Facility - please circle the one which best describes your primary area of practice** | **# patients seen** | **# hrs direct patient contact** |
|---|---|---|
| **A. OFFICE PRACTICE** | | |
| **Private Office** | | |
| **Community Health Centre** | | |
| **Family Health Network** | | |
| **Walk-in Clinic, After Hours, Urgent Care** (non-static patient base, no appointments, episodic care | | |
| **Academic Family Practice Unit** | | |
| **Locum** | | |
| **B. HOSPITAL- Please indicate if this is an academic teaching hospital** | | |
| **Inpatients** | | |
| **Outpatients** | | |
| **Emergency** | | |
| **Surgical Assists** | | |
| **Day Surgery** | | |
| **Hospitalist** | | |
| **C. LONG TERM CARE FACILITY** (nursing home, etc) | | |
| **D. GOVERNMENT FACILITY** (armed forces, prison ) | | |
| **E. HOUSE CALL SERVICE** | | |
| **F. OTHER** (please specify) | | |

**Practice Descriptor Codes** (for use with question following)

| | ANESTHESIA | | OBSTETRICS AND GYNAECOLOGY | | SURGERY (CONTINUED) |
|---|---|---|---|---|---|
| 101 | Anesthesia | 501 | Gynaecologic Oncology | 810 | Ophthalmology |
| 102 | Chronic Pain Management without general/spinal anesthesia | 502 | Gynaecologic Reproductive Endocrinology & Fertility | 811 | Orthopaedic Surgery |
| | GENERAL/FAMILY PRACTICE | 503 | Gynaecologic Surgery and prenatal care | 812 | Otolaryngology |
| 201 | General/Family Practice with active/admitting hospital privileges | 504 | Office Gynaecology | 813 | Plastic Surgery |
| 202 | General/Family practice without hospital privileges | 505 | Obstetrical Practice limited to prenatal care | 814 | Surgical Practice without operative treatment |
| | MEDICINE | 506 | Obstetrics | 815 | Thoracic Surgery |
| 301 | Allergy | 507 | Urogynaecology | 816 | Urology |
| 302 | Cardiology | 508 | Sexual Counselling | 817 | Vascular surgery |
| 303 | Clinical Immunology | | PAEDIATRICS | 818 | Transplant Surgery |
| 304 | Clinical Pharmacology | 601 | Neonatology | 819 | Endoscopy |
| 305 | Critical Care Medicine | 602 | Paediatrics | | OTHER |
| 306 | Dermatology | 603 | Paediatric Cardiology | 901 | Acupuncture |
| 307 | Emergency Medicine | 604 | Paediatric Nephrology | 902 | Administrative Medicine |
| 308 | Endocrinology | 605 | Paediatric Neurology | 903 | Community Medicine (Public Health) |
| 309 | Gastroenterology | 606 | Paediatric Surgery | 904 | Palliative care |
| 310 | Genetics | 607 | Paediatric Allergy/Clinical Immunology | 905 | Psychotherapy |
| 311 | Geriatric Medicine/Nursing Homes | 608 | Paediatric Oncology | 906 | Sport Medicine |
| 312 | Haematology | 609 | Paediatric Orthopaedics | 907 | Clinical Fellow-without moonlighting |
| 313 | Infectious Diseases | 610 | Paediatric Gastroenterology | 908 | Clinical Fellow-with moonlighting |
| 314 | Internal Medicine | 611 | Paediatric Haematology | 910 | Child and Adolescent Psychiatry |
| 315 | Medical Oncology | 612 | Paediatric Haematology/Oncology | 911 | Substance Abuse |
| 316 | Nephrology | 613 | Paediatric Infectious Diseases | 912 | Aviation Medicine |
| 317 | Neurology | 614 | Paediatric Respiratory Medicine | 913 | Hyperbaric/Diving Medicine |
| 318 | Nuclear Medicine | | RADIOLOGY | 914 | Sleep Medicine |
| 319 | Occupational Medicine | 701 | Diagnostic Imaging | 915 | Complementary Medicine |
| 320 | Physical Medicine and Rehabilitation | 702 | Therapeutic Radiology/Radiation Oncology | 916 | Long Term Care |
| 321 | Psychiatry | 703 | MRI | 917 | Urgent Care/Walk in Clinics |
| 322 | Respiratory Medicine | 704 | CT (computed tomography) | 918 | EEG |
| 323 | Rheumatology | | SURGERY | 919 | EMG |
| | LABORATORY MEDICINE | 801 | Laser Surgery | 920 | Spirometry |
| 401 | Medical Biochemistry | 802 | Assistance at Surgery | 921 | House Calls |
| 402 | Medical Microbiology | 803 | Cardiovascular Surgery | 922 | Sclerotherapy |
| 403 | Pathology-Anatomic | 804 | Clinical Associates-Surgical | 923 | Hypnotherapy |
| 404 | Pathology-General | 805 | Colorectal Surgery | 924 | Teaching |
| 405 | Pathology-Haematological | 806 | Cosmetic Surgery | 925 | Research |
| 406 | Pathology-Neurological | 807 | General Surgery | 926 | Administration (in Medical schools, hospitals etc. |
| | | 808 | General Surgical Oncology | 927 | Other Professional Activities i.e. College Activities |
| | | 809 | Neurosurgery | | |

**<u>Clinical Activity:</u> using the descriptor codes on the previous page, please describe your clinical practice. The focus should be on <u>what you actually do</u>, rather than any certification(s) you hold. If you list more than one code, please estimate the percentage of time you spend in each area.**

| Code | 0 - 10% | 11 - 20% | 21 - 40% | 41 - 60% | 61 - 80% | 81 - 100% |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Other -please specify | | | | | | |

**Please list the most common conditions/diseases/procedures that you see/do in your practice:**

**This page may, if you choose, be completed by your Administrative Assistant or Secretary.**

**During what hours is the telephone in the office answered?**

**Where does your “after-hours” message direct patients in an emergency?**

**What is the approximate wait time for patients to get an appointment?**

**What is the approximate time allocated for each appointment?** ______________________

**Do you have space each day for emergency patient appointments? Yes No**

**If yes, how many appointments?** ____________________________________________________

**Is the following emergency equipment available on site?**

**Oxygen: Y/N : Ambu-Bag: Y/N: Airway: Y/N: Adrenalin: Y/N:**

**If not, where?** ______________________________________________________________________

**How long would it take emergency personnel (911) to reach your office?**

**Please describe your refrigeration equipment and temperature monitoring procedures:**

**Please describe your sterilization equipment and procedures.**

**Where are prescription pads kept?**

**How do your store and/or dispose of controlled drugs, vaccines, and drug samples?**

**How do you dispose of sharps and/or other biomedical waste?**

**(If not the physician,)**
**This page completed by** ___________________________ **Position:** _____________________

**Finally, we would like you to take a few minutes to reflect on your practice over the past twelve months, considering your areas of strength and areas which could be deficient. Please tell us what you hope to get out of this assessment, and state one specific question and/or learning objective for the review. (Your objective may be in a clinical area, relationships with patients, new CME you would like to explore, etc.)**

**Thank you for your participation in peer review.**

**I see my area(s) of strength as:**

**I believe that I may have certain deficiencies in:**

**I would like to have more clinical knowledge about:**

**Following this peer assessment, I would like to:**

**In the coming year, I hope to do CME in these specific areas:**

**In five years, I would like my practice to be:**

**STAFFING**

Please indicate the number of full-time and part-time personnel that you work with on a regular basis (daily/weekly) within your practice. For part-time laboratory physicians, please estimate the fraction of full-time work (e.g., 0.5 or half-time). For technologists, assistants, administrative staff, an estimate of total full-time equivalents is sufficient.

| | # FT | #PT |
|---|---|---|
| Staff | | |
| Laboratory Physicians | | |
| Technologists | | |
| Assistants | | |
| Administrative Staff | | |
| Other please specify__________________ | | |

Hours of Operation: ___________________________________________

Number of Tests _____________________________________________________

Variety of Tests (e.g., bacteriology, biochemistry, haematology, blood bank, etc.; may be reported as DBS units) available:

**EQUIPMENT**

1. Microscope
   a. Make/Model/Year:
   b. Does the range of objectives suit the practice? Yes No
   c. **IF NOT**, what are the deficiencies?
   d. Does it function properly? Yes No
   e. Is it adjustable for Kohler illumination? Yes No
   f. Is it cleaned, adjusted and maintained at least annually by a microscope technician? Yes No
2. Miscellaneous
   a. Is there a bone saw and a containment system for surgical pathology specimens? Yes No
   b. Is there an adequately ventilated and lighted surgical gross dissection bench? Yes No
   c. Is the cryostat in reliably functional order and regularly maintained? Yes No
   d. Is the dictation system for Gross, Frozen Section Gross and Microscopic descriptions reliable and convenient? Yes No

3. Level of Automation
   a. Which procedures are manual?

      ______________________________________________

   b. Which procedures use automatic staining?

      ______________________________________________

   c. Which procedures use an immunostainer?

      ______________________________________________

**PROCESSING**

Please indicate the average processing times (i.e., the time between receipt of the specimen in the laboratory and availability of slides to the pathologists) of the following:

| Case | Average Processing Time |
| --- | --- |
| Tissue | |
| Cytology | |
| Haematology | |
| Bone Marrow | |
| Special stain requests, including immunostains | |
| Gross descriptions typing time | |
| Microscopic and final report typing time | |
| Retrieval of stored reports, slides and blocks, when required for current case reporting | |

**STAIN AVAILABILITY**

Please provide a list of stains used

| Stain | Stain | Stain |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

My Electronic Signature* Date:

*By placing a check mark in the “My Signature”, you verify that the information provided on this questionnaire is correct, true and accurate.