CPSO

INDEPENDENT HEALTH FACILITIES

PHYSICIAN PRE-ASSESSMENT QUESTIONNAIRE

DIAGNOSTIC IMAGING / NUCLEAR MEDICINE

NOTE: This document must be prepared/completed by the most responsible person involved in the day-to-day activities within the facility

The information contained in this document is accurate to the best of my knowledge.

Quality Advisor	Date
Licensee	Date
Most Responsible Person	Date

QUALITY ADVISOR

Ministry of Health – Quality Advisor Acknowledgement Form (Please attach signed agreement)	Attachment included ☐
The written & signed agreement between the Licensee and yourself stating your responsibilities (job description) as the QA of the IHF.	Attachment included ☐

Surname (as given on CPSO register):		
Given name(s) (as given on CPSO register):		
CPSO #		
Year Speciality obtained:	dd/mm/yyyy	
Royal College of Physicians and Surgeons of Canada Fellowship:	Yes ○ No ○	
Speciality:	Yes ○ No ○	Please list:

CONTACT INFORMATION			
Facility Name and IHF Billing #			
Facility Address:			
Email:		**Office Phone:**	
Direct Phone:		**Fax:**	

What services (e.g. interpreting, consultation) do you currently provide within the IHF?

How often do you visit the facility? Is this documented?	

When was your last visit?	dd/mm/yyyy
Do you have regular contact and interaction with peers?	Yes ○ No ○
Have you chosen to focus, subspecialize or restrict your practice?	Yes ○ No ○
If yes, please specify	
Do you have regular contact and interaction with referring clinicians and specialists?	Yes ○ No ○
Do you have regular contact and interaction with the Licensee?	Yes ○ No ○

Where do you report?	Onsite ☐ Offsite ☐	**If offsite, where, (e.g. Home, Hospital)**	
If offsite, describe your interpreting workstation(s) setup. (# of monitors (colour vs BW), resolution (e.g. 3 MP/5MP).			

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility.

Examination Categories	**# of examinations read or procedures performed**
General Radiography	
Ultrasound - General	
Ultrasound – Obstetrical/Gynecology	
Ultrasound - Nuchal Translucency	
Ultrasound – Vascular	
Fluoroscopy	
Mammography	

Bone Mineral Densitometry	
Nuclear Medicine	
Nuclear Cardiology	

Describe your activities in relation to interaction with the facility staff:
How do you contribute to the process of continuous quality improvement?
How are you involved in updating and maintaining the quality control activities?
As Quality Advisor you are required to advise the Licensee on the quality aspects of the facility. Briefly explain how you accomplish this role:

Do these activities include the following?	
Are all quality control results reviewed and signed off (e.g. HARP testing)?	Yes ○ No ○
Are all corrective actions documented and signed off?	Yes ○ No ○
Are quality control activities reviewed bi-annually?	Yes ○ No ○

Storage of Imaging Studies	
Please indicate how you store your imaging examinations:	
Conventional Films/Thermal Images	Yes ○ No ○
PACS	Yes ○ No ○
Combination of the Above	Yes ○ No ○

Please identify other facilities for which you are Quality Advisor:			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	

Please identify other facilities for which you provide interpreting services but are NOT the Quality Advisor (if applicable).			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	

INTERPRETING PHYSICIANS

All Physicians providing interpretative services for the facility must submit Interpreting Physician form.			
NAME:	**CPSO#**	**Still providing Services**	**Form Submitted**
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐
		Yes☐ No☐	☐

INTERPRETING PHYSICIAN

(This section must be completed by ALL affiliated physicians *other than* the Quality Advisor). One physician can list information below. Each additional physician can enter info into the standalone "Physician Pre-Questionnaire – Additional Physicians".

Please ensure the following are attached:

- ***For Nuclear Medicine and Nuclear Cardiology*, please attach a copy of Scope Approval letter from the Quality Assurance Committee of the CPSO (if applicable).**

Surname (as given on CPSO register):			
Given name(s) (as given on CPSO register):			
CPSO #			
Year Speciality obtained:	dd/mm/yyyy		
Royal College of Physicians and Surgeons of Canada Fellowship:	Yes ○	No ○	
Speciality:	Yes ○	No ○	Please List:

CONTACT INFORMATION			
Facility Name and IHF Billing #			
Facility Address:			
Email:		**Office Phone:**	
Direct Phone:		**Fax:**	

What services (e.g. interpreting consultation) do you currently provide within the IHF?

Do you have regular contact and interaction with peers?	Yes ○ No ○
Have you chosen to focus, subspecialize or restrict your practice?	Yes ○ No ○
If yes, please specify	
Do you have regular contact and interaction with referring clinicians and specialists?	Yes ○ No ○
Do you have regular contact and interaction with the Licensee?	Yes ○ No ○

Where do you report?	Onsite ☐ Offsite ☐	**If offsite, where, (e.g. Home, Hospital)**	
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Ultrasound – Vascular	
Fluoroscopy	
Mammography	
Bone Mineral Densitometry	

Nuclear Medicine	
Nuclear Cardiology	

Please identify other facilities for which you provide interpreting services but are NOT the Quality Advisor (if applicable).			
Facility Name:		**Billing #**	
Facility Name:		**Billing #**	
Facility Name:		**Billing #**	

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