INDEPENDENT HEALTH FACILITIES PROGRAM

Pre-Assessment Questionnaire

OPHTHALMIC ULTRASOUND

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.

Signature of Quality Advisor/Medical Director	Date
Signature of Owner/Operator	Date
Signature of Most Responsible Person	Date

NOTE: Some of the questions in this questionnaire are not applicable to solely-owned facilities. Please answer those questions that pertain to your practice situation.

THE FACILITY

Please include a copy of your facility's organizational chart

GENERAL			
Name of Facility			
Billing Number			
Mailing Address			
Telephone		Fax	
Hours of operation			

Name and mailing address of **owner/operator** of this facility, if different from above:			
Name(s) and billing number(s) of other facilities owned or operated by the licensee of this facility:			
What licensed procedures are you currently providing?			
Name of Manager/Technical Director of facility (if applicable):			
Telephone		Fax	
Email			

Is the facility wheelchair accessible?	Yes No
Where is your IHF License posted?	

Does your facility have separate areas for each of the following functions?			
Patient waiting area	Yes	No	N/A
Patient washrooms	Yes	No	N/A
Procedures rooms	Yes	No	N/A
Facility storage supply	Yes	No	N/A

Please provide photographs of your examination room and ultrasound equipment.

QUALITY ADVISOR

Please attach the following:

- **your curriculum vitae**
- **RCPSC summary and detailed listing of Continuing Professional Development activities**
- **written agreement between you and the owner/operator (if applicable)**

Surname (as given on CPSO register)			
Given name(s) (as given on CPSO register)			
CPSO #		Date of Birth dd/mm/yyyy	
Sex	M F		
University at which you obtained your Medical Degree			
Year obtained			
Royal College of Physicians and Surgeons of Canada Fellowship	Yes No		
Specialty			

CONTACT INFORMATION (if different from information on page 2)			
Facility Name and Billing #			
Facility Address:			
Email		Office Phone	
Direct Phone		Fax	
Other facilities for which you are Quality Advisor (please indicate facility name and billing #):			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	

Facilities for which you provide interpreting services but are not the quality advisor (if applicable).		
Facility name		
Facility name		
Facility name		
Do you have regular contact and interaction with peers?		Yes No *(pick one)*
Do you have regular contact and interaction with referring clinicians and specialists?		Yes No *(pick one)*
Do you have regular contact and interaction with the owner/operator/licensee?		Yes No *(pick one)*

INTERPRETING PHYSICIAN (OTHER THAN THE QUALITY ADVISOR)

Please attach the following:

- **your curriculum vitae**
- **RCPSC summary and detailed listing of Continuing Professional Development activities**

Surname (as given on CPSO register)			
Given name(s) (as given on CPSO register)			
CPSO #		Date of Birth dd/mm/yyyy	
Sex	M F		
University at which you obtained your Medical Degree			
Year obtained			
Royal College of Physicians and Surgeons of Canada Fellowship		Yes No	
Specialty			
CONTACT INFORMATION (if different from information on page 2)			
Facility Name and Billing #			
Facility Address:			
Email		Office Phone #	
Direct Phone #		Fax #	
Other facilities for which you are Quality Advisor (please indicate facility name and billing #):			
Facility name		Billing #	
Facility name		Billing #	

What services (e.g. interpreting, consultation) do you currently provide within the IHF?
How often do you visit the facility and how is this documented?

When was your last visit?		
Do you have regular contact and interaction with peers?		Yes No *(pick one)*
Do you have regular contact and interaction with the owner/operator/licensee?		Yes No *(pick one)*
How do you contribute to the process of continuous quality improvement?		

EQUIPMENT

List ALL the ultrasound equipment currently in use in this facility:

Type of equipment	Year manufactured	Equipment manufacturer	Serial number	Date acquired dd/mmm/yyyy	Modifications and upgrades	Calibration record available (please attach copy)

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Type of equipment	Year manufactured	Equipment manufacturer	Serial number	Date acquired dd/mmm/yyyy	Modifications and upgrades	Calibration record available (please attach copy)

QUALITY CONTROL

Please attach copies of the last preventative maintenance report.

Person responsible for conducting and documenting/conducting quality control activities	

POLICIES & PROCEDURES

Please provide a copy of your Ophthalmic Ultrasound manual.

Does your facility have a policies and procedures manual as described in the Clinical Practice Parameters and Facility Standards for Ophthalmic Ultrasound?	Yes	No
Is the manual site specific?	Yes	No
Where is the policies and procedures manual kept?		
Is a printed copy accessible to all staff?	Yes	No
How frequently is the policies and procedures manual reviewed by staff?		
Who reviews and updates the policies/procedures manual? (i.e. Quality Advisor, Technologists, Managers, etc.)		
Are all changes initialled and dated by staff?	Yes	No

PROVIDING QUALITY CARE

Who are the members of your Quality Advisory Committee? *(Please provide a list of names and their title)*		
How often does the Quality Advisory Committee meet?		
Are these meetings documented and minutes taken?	Yes	No
Does your Quality Management Program include all components listed in the CPPs & FS?		

OPHTHALMIC ULTRASOUND CHART REVIEW: A-scans and B-scans (if applicable)

Please complete the following chart and attach 5 A-scans and 5 B-scans (if applicable) and corresponding lens stickers.

	Patient ID#	Eye Operated	Pre-Operative Refraction	Desired Post-Operative Refraction	Ultrasound Lens Power Suggested for Desired Refraction	Implanted Lens	Post-Operative Refraction
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							