## 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)** | |
|---|---|---|---|
| **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** | |

| **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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