

Specialty: Family Practice

Drs. MSP Billing # _____

GP with community practice **Only doing locums** **Hospitalist** **Works only in clinic(s)**

First Name:	Name you go by (if different):	Last Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Office / Contact Information:

Location 1	Information We Have	Corrections if Needed	Location 2 (if applicable)
Clinic Name:			
Street Address:			
City:			
Postal Code:			
Office Phone #:			
Office Fax #:			
Practice Status:	<input type="checkbox"/> Public (MSP) <input type="checkbox"/> Private Pay		<input type="checkbox"/> Public (MSP) <input type="checkbox"/> Private Pay

Office Private Line (back line) for Physician Contact Only: _____

Office E-mail Address	
<input type="checkbox"/> Private (for physician office use only)	<input type="checkbox"/> Public (ok for patient use to contact your office)
Public Website (for patient use):	

Senior MOA Contact Information (For our follow up call only – will never be publicly displayed)

Name	Phone Number	Moa Contact E-mail Address

Status (Please check off all that apply)

<input type="checkbox"/> Accepting New patients for ongoing care <input type="checkbox"/> Only doing follow up on previous patients <input type="checkbox"/> Accepting limited new referrals (limited for number of patients accepted or by geographic location only) Please specify limitations: _____ <input type="checkbox"/> Accepting referrals from colleagues for specific services (*see list on page 2)	<input type="checkbox"/> Accepting referrals for new Nursing Home Patients (Please list which nursing homes:) _____ _____ <input type="checkbox"/> Accepting referrals only through a clinic: (Please list which clinic(s)) _____ _____
Other practice limitations (if any):	Practice opened at this location: <input type="checkbox"/> Prior to 2011 <input type="checkbox"/> 2011 <input type="checkbox"/> 2012 <input type="checkbox"/> 2013 <input type="checkbox"/> 2014 <input type="checkbox"/> 2015
Languages spoken in your practice:	Wheelchair Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter available: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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If you are accepting referrals from colleagues for specific services, please check all that apply:

<input type="checkbox"/> Acupuncture
<input type="checkbox"/> ADHD: Pediatric
<input type="checkbox"/> ADHD: Adult
<input type="checkbox"/> Alcohol issues
<input type="checkbox"/> Allergy testing
<input type="checkbox"/> Ankle
<input type="checkbox"/> Injection
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Autism
<input type="checkbox"/> Aviation medicine
<input type="checkbox"/> Birth control counseling
<input type="checkbox"/> Botox for chronic migraine
<input type="checkbox"/> Botox injections: cosmetic
<input type="checkbox"/> Botox neuromuscular
<input type="checkbox"/> Cancer chemotherapy
<input type="checkbox"/> Cast
<input type="checkbox"/> Application
<input type="checkbox"/> Removal
<input type="checkbox"/> Child and Youth Addiction Medicine
<input type="checkbox"/> Chronic fatigue syndrome
<input type="checkbox"/> Circumcision - Infant
<input type="checkbox"/> Cognitive behavioral therapy
<input type="checkbox"/> Cosmetic dermatology
<input type="checkbox"/> Cosmetic hair loss treatment
<input type="checkbox"/> Cryotherapy
<input type="checkbox"/> Depression
<input type="checkbox"/> Eating disorders: Adult
<input type="checkbox"/> Eating disorders: Child and youth
<input type="checkbox"/> Elbow
<input type="checkbox"/> Injection
<input type="checkbox"/> End of life counseling
<input type="checkbox"/> Endometrial sample
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> First trimester screening
<input type="checkbox"/> Flexible sigmoidoscopy
<input type="checkbox"/> Forensic
<input type="checkbox"/> Ganglion
<input type="checkbox"/> Gender identity issues
<input type="checkbox"/> General competency assessment
<input type="checkbox"/> Geriatrics
<input type="checkbox"/> Hand
<input type="checkbox"/> Injection
<input type="checkbox"/> Healthy newborn care
<input type="checkbox"/> Hip

<input type="checkbox"/> Injection
<input type="checkbox"/> Hospital consultations in geriatrics
<input type="checkbox"/> Hospital consultations in palliative care
<input type="checkbox"/> HRT counseling
<input type="checkbox"/> Hyperhidrosis botox treatment
<input type="checkbox"/> Hypnotherapy
<input type="checkbox"/> I & D abscess
<input type="checkbox"/> IUD insertion
<input type="checkbox"/> Joint aspiration
<input type="checkbox"/> Knee
<input type="checkbox"/> Injection
<input type="checkbox"/> Viscosupplementation
<input type="checkbox"/> Breastfeeding support/Lactation consultation
<input type="checkbox"/> Leg ulcers
<input type="checkbox"/> Menopause
<input type="checkbox"/> Methadone treatment
<input type="checkbox"/> Mindfulness
<input type="checkbox"/> Miscarriage: D & C
<input type="checkbox"/> Miscarriage: medical management
<input type="checkbox"/> Obesity
<input type="checkbox"/> Pain management
<input type="checkbox"/> Palliative care
<input type="checkbox"/> Pap smear by female physician for cultural reasons
<input type="checkbox"/> Post traumatic stress disorder
<input type="checkbox"/> Preconception counseling
<input type="checkbox"/> Pregnancy termination
<input type="checkbox"/> Primary care obstetrics
<input type="checkbox"/> Refugee health
<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Sexual medicine
<input type="checkbox"/> Shoulder
<input type="checkbox"/> Injection
<input type="checkbox"/> Sigmoidoscopy
<input type="checkbox"/> Skin biopsy
<input type="checkbox"/> Smoking cessation
<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Surgical excisions
<input type="checkbox"/> Travel medicine
<input type="checkbox"/> Trigger point injections
<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Vein sclerotherapy
<input type="checkbox"/> Wedge excision nail
<input type="checkbox"/> Wrist
<input type="checkbox"/> Injection

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I am MOST interested in...

I do NOT see or do...

Relevant required investigations/information for ALL referrals...

Referral Details (If applicable):

1. How does your office accept a request for routine referrals?	<input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Other _____
2. Does your office have a referral form?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Blank form attached <input type="checkbox"/> E-mailed to:
3. On average, how long does it take your office to notify the GP office that an appointment has been booked for their patient?	<input type="checkbox"/> Book by phone when office calls for appointment <input type="checkbox"/> Book within one week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 1-2 months <input type="checkbox"/> 2-4 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> 12-18 months <input type="checkbox"/> 18-24 months <input type="checkbox"/> 2-2.5 years <input type="checkbox"/> 2.5-3 years <input type="checkbox"/> > 3 years
4. On average, what is your office's non-urgent wait time from request for a non-urgent consultation to the appointment itself?	<input type="checkbox"/> Within one week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 1-2 months <input type="checkbox"/> 2-4 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> 12-18 months <input type="checkbox"/> 18-24 months <input type="checkbox"/> 2-2.5 years <input type="checkbox"/> 2.5-3 years <input type="checkbox"/> > 3 years
5. How does your office respond to a referral request?	<input type="checkbox"/> To referring office by: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Directly to the patient <input type="checkbox"/> Other _____
6. After you receive our referral information, will your office accept a direct call from a patient to book their own appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Urgent consultations are accepted for:	
8. Optimal method of referral for urgent appointments:	<input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Other _____
9. Additional information that will facilitate urgent referral requests:	

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Cancellation Policy/ Patient Instructions:

Please indicate your cancellation policy: (e.g. cancellation notice required, fees charged, etc.)

Please indicate any pre-appointment instructions you wish your patients to be aware of: (e.g. bring list of current medications, call to confirm one week prior to appointment, etc.)

Hospital Privileges:

Please check the hospitals where you have privileges if applicable:

<input type="checkbox"/> Royal Columbian Hospital <input type="checkbox"/> Burnaby General Hospital <input type="checkbox"/> Eagle Ridge Hospital	<input type="checkbox"/> Ridge Meadows Hospital <input type="checkbox"/> Surrey Memorial Hospital <input type="checkbox"/> Langley Memorial Hospital	<input type="checkbox"/> Vancouver General Hospital <input type="checkbox"/> St. Paul's Hospital <input type="checkbox"/> Other _____
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Sub-Specialty Clinics You Participate In (if applicable):

Please list clinics where you practice:

Clinic name:	
Status:	<input type="checkbox"/> Public (MSP) <input type="checkbox"/> Private Pay
Street Address:	
City:	
Office Phone #:	
Office Fax #:	

Clinic name:	
Status:	<input type="checkbox"/> Public (MSP) <input type="checkbox"/> Private Pay
Street Address:	
City:	
Office Phone #:	
Office Fax #:	

What days and times are your phone lines open?

Days	From:	To:	Lunch:	Notes:
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Thank you for completing this form!
Please return completed form to:
Cathy Minler, Pathways Administrator
Ridge Meadows Division of Family Practice
Fax No : 604-457-1300
E-Mail : cminler@divisionsbc.ca
Questions ? Call 604-457-1385