



Pre-Visit Questionnaire – Emergency Care Physicians

Name: _____

Address of office to be visited: *Your Principal Site:*

Business Number:

Fax Number:

The purpose of this questionnaire is to familiarize the practice visitor with you and your practice, and to reduce the time necessary for on-site collection of information.

A. Medical Education

Year of graduation:

Post-graduate qualifications and certifications:

FRCPC: Yes No

CCFP EM : Yes No

ABEM: Yes No

EM: Yes No

Courses completed:

ACLS: Yes No

PALS : Yes No N/A

ATLS: Yes No

B. Continuing Medical Education

1. Please list conferences and presentations, and dates in the past 12 months:

2. Reference material consulted in the past 12 months:

In ER

Out of ER

(e.g., Up to Date, MEDLINE, etc)

(e.g., Cochrane, AMA CPGs, etc)

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C. **Research Activity in Last 3 Years**

D. **Teaching in The Last Year**

E. **Guideline Developments**

F. **Administrative Duties**

G. **Description Of Practice**

1. **Characteristics of the Emergency Department:**

Tertiary: Yes No

Rural: Yes No

Community: Yes No

Urgent Care Centre: Yes No

ED visits annually? Yes No

What percentage of patients are admitted from your emergency department annually?

Don't know

Total hours of physician *site coverage per day*:

Total number of *scheduled hours per shift*:

Total number of shifts you work clinically in an average month:

Is this a designated Trauma Centre? Yes No

If yes, level 1, 2 or 3?

Please select the type of facility that best describes your emergency department setting: Adults only?

Pediatrics only?

Mixed adults & Pediatrics

Does this institution have cardiac catheterization capabilities? Yes No

Does this institution function as a referral center for burns? Yes No

Does this institution have a labor and delivery ward? Yes No

2. **What are the challenges unique to your practice population?**

3. **Which of the following Emergency Department Procedures do you perform:**

Procedural sedation? Yes No

○ If yes, do you have an assistant? Yes No

○ Is an assistant available who is trained to recognize adequate ventilation? Yes No

○ What kind of monitoring equipment is used?

ECG? Yes No

O2 Saturation? Yes No

Blood pressure monitoring? Yes No

Electrical Cardioversion? Yes No

Fracture reductions? Yes No

Intubations? Yes No

Chest tube insertion? Yes No

Central line placements? Yes No

Extensor tendon repair? Yes No

Revision of finger amputations? Yes No

Lumbar puncture?? Yes No

Other? Yes No

If yes, please describe:

4. **Which of the following resources are available in your Emergency Department to support your practice?**

Internet? Yes No

Emergency Department Information System (computerized patient tracking)? Yes No

Portable Telephone/Communication Devices? Yes No

Overhead Paging System? Yes No

EMR (electronic charting and order entry)? Yes No

EHR (access to drug information, DI and Lab results generated elsewhere for this patient) Yes No

Electronic Decision Support (context specific reference material): Yes No

24 hour Lab Support? Yes No

Emergency Medicine Residents Yes No

Non-Emergency Medicine Residents Yes No

Can patients be admitted to active treatment beds from this ED? Yes No

If yes, is it a:

Tertiary Hospital: Yes

Community Hospital: Yes

Rural Hospital: Yes

If no, is this department part of:

An Urgent Care Centre: Yes No

Community Health Centre: Yes No

H. Unique Emergency Department Features

Do you meet to discuss emergency department protocols and policies? Yes No

Emergency Department electronic radiology viewing? Yes No

I. Practice Policies

1. What arrangements are made to prioritize patients for visits? _____

2. Are there policies to move infectious patients quickly out of the waiting room? Yes No

If so, are there isolation facilities available in the department? Yes No

3. Are all tests reviewed by the physician who requested each test? Yes No

Laboratory tests?

Comments: _____

Microbiology? Yes No

Comments: _____

Diagnostic Imaging? Yes No

Comments: _____

EKG? Yes No

Comments: _____

Specialty Tests? Yes No

Comments: _____

4. Are patients notified of all clinically meaningful abnormal results? Yes No

5. When sensitive examinations are performed (e.g. genitalia), is a third person present? Yes No

If no, please explain: _____

6. What is the procedure to ensure review of investigation results before they are filed in the patient’s record? _____

7. Do you have adequate back up in the event of major trauma, catastrophic event or other unusually high demand for service in the emergency ward? Yes No
- Physician backup? Yes No
- Comments: _____
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- Support staff? Yes No
- Comments: _____
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8. Do you have appropriate services to transport patients to other facilities when necessary? Yes No
- Comments: _____
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J. Please comment on important communication and/or relationship issues with other disciplines in your institution

K. Is there anything else you'd like to discuss regarding your Emergency Department practice?

The Practice Visit will be conducted by another Emergency Physician. The visit will take about four hours to complete. Please mark your preferred times for a Practice Visit (3 slots minimum):

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
am								Preferred a.m. times:
pm								Preferred p.m. times:
								12:00-16:00 <input type="checkbox"/>
								13:00-17:00 <input type="checkbox"/>

Please mail the Pre-Visit Questionnaire when complete to:

Dr. Nigel Flook
 c/o College of Physicians and Surgeons of Alberta
 2700 Telus Plaza South, 10020 – 100 Street NW
 Edmonton AB T5J 0N3
 or fax to (780) 428-2712