The College of Physicians and Surgeons of Ontario

INDEPENDENT HEALTH FACILITIES PROGRAM

Pre-Assessment Questionnaire

DIAGNOSTIC IMAGING / NUCLEAR MEDICINE
PHYSICIAN

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

QUALITY ADVISOR

Please ensure the following are attached:

- **your curriculum vitae**
- **your RCPSC SUMMARY AND DETAILED LIST of Continuing Professional Development activities**
- **a copy of your CPSO letter for Specialty recognition *(if applicable)***
- **the written agreement between the owner/operator and yourself**

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 in which you obtained your Medical Degree			
Year obtained			
Royal College of Physicians and Surgeons of Canada Fellowship	◯ Yes ◯ No		
Specialty	◯ Yes ◯ No		

CONTACT INFORMATION			
Facility Name and Billing #			
Facility Address:			
Email		Office Phone	
Direct Phone		Fax	
Other facilities for which you are Quality Advisor:			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	

Please provide a list of the facilities for which you provide interpreting services but are not the quality advisor (if applicable).	
Facility name	
Facility name	
Facility name	
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)*
Have you chosen to focus, subspecialize or restrict your practice?	◯ Yes ◯ No *(pick one)*
If yes, please specify	
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)*

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	
Ultrasound - Nuchal Translucency	
Ultrasound – Vascular	
Fluoroscopy	
Mammography	

Mammography intervention	
Bone Mineral Densitometry	
Computed Tomography	
Magnetic Resonance Imaging	
Nuclear Medicine	

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 (i.e. HARP testing) reviewed and signed off?	◯ Yes ◯ No *(pick one)*
Are all corrective actions documented and signed off?	◯ Yes ◯ No *(pick one)*
Are quality control activities reviewed annually?	◯ Yes ◯ No *(pick one)*

Storage of Imaging Studies	
Please indicate how you store your imaging examinations:	
Conventional Films/Thermal Images	◯ Yes ◯ No *(pick one)*
PACS	◯ Yes ◯ No *(pick one)*
Combination of the Above	◯ Yes ◯ No *(pick one)*

INTERPRETING PHYSICIAN

(This section must be completed by ALL affiliated physicians other than the Quality Advisor/if applicable)

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

CONTACT INFORMATION			
Facility Name and Billing #			
Facility Address			
Email		Office Phone	
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Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
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Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
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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)*	
Have you chosen to focus, subspecialize or restrict your practice?	◯ Yes	◯ No *(pick one)*	
If yes, please specify			
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)*	

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