

# Peer Review of Medical Records

## PRACTICE QUESTIONNAIRE



Name of Practice: \_\_\_\_\_

Name of Director/Owner: \_\_\_\_\_

Completing this questionnaire will help the College to match your practice with an appropriate Peer Reviewer. The information will provide a “snapshot” of your current practice, staff, and practice type.

### 1. Current Employee Data

Actual initials are important for paper records for the reviewer to identify the person who made the entry in the record.

Staff	Initials	Role(s) i.e. associate, locum, manager, etc.	Status i.e. full time or part time
<b>Veterinarians</b>			
1.			
2.			
3.			
4.			
5.			
6.			
<b>Registered Veterinary Technicians (RVTs) or other Technicians</b>			
1.			
2.			
3.			
4.			
5.			
6.			
<b>Other Office Staff</b>			
1.			
2.			
3.			
<b>Total Number of Staff</b>			

### 2. Patient Data

Species Type or Animal Population	✓	Details/Comments	Approximate # or % of Practice
<b>Companion Animal</b>			
Dog			
Cat			
Small Mammal			
Bird			
Reptile			
Other			
<b>Food-Producing Animal</b>			
Beef			
Dairy			
Swine			
Small Ruminant			
Poultry			
<b>Equine</b>			
Pleasure			
Breeding			
Performance, Racing			
<b>Other</b>			
<b>Total Number of Patients</b>			

### 3. Veterinarians' Scope of Practice/Areas of Interest

Have veterinarians in your practice chosen to focus their practice?

Veterinarian	Specialty, Area of Interest or Practice Focus
1.	
2.	
3.	
4.	
5.	
6.	

### 4. Case Types and Conditions

Estimate the percentage of case types seen at your practice in a typical month:

Case Type	% of Case Load	Common Conditions Seen/Procedures Performed
Wellness		
Acute Medical		
Chronic Medical		
Elective Surgery		
Other Surgery		
Referral from another veterinarian		

### 5. Records System

**a. System Type:**

- Paper
- Electronic
- Combination of electronic and paper

Name of software package: \_\_\_\_\_

**b. If your system is electronic, how are corrections to the record managed and indicated?**

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**c. Other comments regarding your records system:**

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### 6. What are your learning objectives for this Peer Review of Medical Records?

1.
2.
3.

## 7. Conflict of Interest

The information you provide on this questionnaire will assist us in matching your practice to an appropriate Peer Reviewer. Matches are made on the basis of similarities in scopes of practice and the absence of any potential, apparent, or real conflict of interest. Below is a list of Peer Reviewers that may be matched to your practice. Using the checkbox beside each name, please indicate any Peer Reviewers with whom you may have a conflict of interest.

<b>Conflict of Interest</b> Indicate "Yes" if any potential, apparent, or real conflict of interest exists.		<b>Peer Reviewer</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Donna Chui
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Jacqueline Côté
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Claire Duder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Susan Kilborn
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Destiny Locking
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Pat Meyers
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Karen O'Keefe
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Suzi Peters
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Robyn Suderman
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Jenny Tye
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr. Lara Zahra

### Comments:

Please provide details regarding any Conflicts of Interest indicated above.

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Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_