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
Veterinarians			
1.			
2.			
3.			
4.			
5.			
6.			
Registered Veterinary Technicians (RVTs) or other Technicians			
1.			
2.			
3.			
4.			
5.			
6.			
Other Office Staff			
1.			
2.			
3.			
Total Number of Staff			

2. Patient Data

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

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 — Name of software package: ___________________________________

☐ Combination of electronic and paper

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.

Conflict of Interest Indicate "Yes" if any potential, apparent, or real conflict of interest exists.		**Peer Reviewer**
☐ Yes	☐ No	Dr. Donna Chui
☐ Yes	☐ No	Dr. Jacqueline Côté
☐ Yes	☐ No	Dr. Caitlin Crain
☐ Yes	☐ No	Dr. Marianna Ferrant
☐ Yes	☐ No	Dr. Susan Kilborn
☐ Yes	☐ No	Dr. Destiny Locking
☐ Yes	☐ No	Dr. Karen O'Keefe
☐ Yes	☐ No	Dr. Suzi Peters
☐ Yes	☐ No	Dr. Emerald Saldanha
☐ Yes	☐ No	Dr. Nicola Smith
☐ Yes	☐ No	Dr. Natalie Soligo
☐ Yes	☐ No	Dr. Jenny Tye
☐ Yes	☐ No	Dr. Sophie Velianou
☐ Yes	☐ No	Dr. Lara Zahra

Comments:

Please provide details regarding any Conflicts of Interest indicated above.

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Name: ____

Signature: ____ Date: ________________________