Medical/Surgical Facility

CONFIDENTIAL

FACILITY INFORMATION

Facility name: _____

NHID: _____ Submission date: _____

APPLICANT INFORMATION

Applicant name: _____ CPSID: _____

REFEREE INFORMATION

Referee name: _____

Address: _____

City: _____ Province/state: _____

Postal code/zip code: _____ Country: _____

Telephone: _____ Email: _____

REFERENCE QUESTIONS

	Meets expectations	Does not meet expectations	Cannot comment
Counsels patients and families			
• Provides necessary information	☐	☐	☐
• Encourages participation	☐	☐	☐
• Provides comfort and allays fear	☐	☐	☐
• Obtains informed consent	☐	☐	☐
MEDICAL KNOWLEDGE			
• Uses information technology to optimize patient care	☐	☐	☐
• Critically evaluates current medical information	☐	☐	☐
• Is a self-directed learner	☐	☐	☐
• Recognizes complex relationships and development of unifying disease	☐	☐	☐
• Knows basic and clinical sciences appropriately	☐	☐	☐
Makes informed decisions and therapeutic decisions based on patient information, current scientific evidence and clinical judgement			
• Uses effective and appropriate clinical problem-solving skills	☐	☐	☐
• Understands the limits of one's knowledge and expertise	☐	☐	☐
INTERPERSONAL AND COMMUNICATION SKILLS			
• Communicates effectively with patients and families	☐	☐	☐
• Creates a professional/therapeutic relationship with patients	☐	☐	☐
• Is responsive across the broad ranges of socioeconomic and cultural backgrounds	☐	☐	☐
• Works effectively as a member or leader of health-care team	☐	☐	☐
• Communicates effectively with: o Physicians o Other health-care workers o Administrative staff	☐	☐	☐
• Maintains medical records that are: o Comprehensive o Timely o Legible o Accurate	☐	☐	☐

	Meets	Does not meet expectations	Cannot comment
PROFESSIONALISM			
Demonstrates respect for and responsiveness to the needs of patients and society			

In the event that your comments have provoked further interest by us, we may wish to contact you for further information.

SIGN-OFF

Referee signature: _____ Date: _____

SUBMISSION

This form must be returned to the facility.

◯ Mail—facility address:

◯ Fax—fax number: _____

The information in this form is collected under the authority of part 5, section A of the Bylaws under the Health Professions Act RSBC 1996, c.183. The information provided will be used to process this application for privileges. If you have any questions about the collection and use of this information, please contact the College at 300–669 Howe Street, Vancouver, BC, V6C 0B4 or by phone at 604-733-7758 or 1-800-461-3008 (toll free in BC).