RICHMOND PRIMARY CARE NETWORKS

Application to become a PCN Host

Expression of Interest in Host FP/NP Contracts within Primary Care Networks in Richmond

[PLEASE PRINT CLEARLY USING CAPITAL LETTERS]

HOST CLINIC INFORMATION

Name of Host Clinic

Unit/Suite | Street Number | Street

City | Prov | Postal Code

CLINIC MANAGER OR PRIMARY ADMINISTRATIVE CONTACT

Last Name | First Name

Telephone Number (including area code) | Alternate Telephone Number (including area code)

Email

PRIMARY PHYSICIAN CONTACT FOR THE EXPRESSION OF INTEREST

Last Name | First Name

Telephone Number (including area code) | Mobile Telephone Number (including area code)

Email

How many PCN FPs are you seeking to host at this time? ☐ 1 ☐ 2 ☐ 3 or more

How many PCN NPs are you seeking to host at this time? ☐ 1 ☐ 2 ☐ 3 or more

From now through 2022, are there any plans to move the clinic to a different location?

☐ No ☐ Yes ➢ Please explain: _____

_____

_____

From now through 2022, do any of the health professionals working at the clinic have plans to change practice (e.g., expand practice, reduce hours, etc.)?

☐ No ☐ Yes ➢ Please explain: _____

_____

_____

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From now through 2022, do any of the health professionals working at the clinic have plans to retire?

☐ No ☐ Yes ➢ Please explain: ____________________

____

____

Which EMR is used in the clinic? ____________________

Are any paper charts still associated with the clinic?

☐ No ☐ Yes ➢ Please explain: ____________________

Have the physicians in the clinic completed PSP Panel Management?

☐ No ☐ Yes ➢ Physician(s) name(s): ____________________

Completion date(s): ____________________

Would the physicians within the clinic agree to work with the Practice Support Program to strengthen EMR use?

☐ Yes ☐ No ➢ Please explain: ____________________

____

PLEASE PROVIDE DETAILS ABOUT EACH PHYSICIAN WORKING IN THE CLINIC

Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	

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PLEASE PROVIDE DETAILS ABOUT ALL OTHER HEALTH PROFESSIONALS WORKING IN THE CLINIC			
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	
Last Name:		First Name:	
Role:			
In-clinic hours/week:		Virtual care hours/week	

PLEASE PROVIDE DETAILS ABOUT EACH MEMBER OF THE CLINIC SUPPORT STAFF			
Last Name:		First Name:	
Role:		In-clinic hours/week:	
Last Name:		First Name:	
Role:		In-clinic hours/week:	
Last Name:		First Name:	
Role:		In-clinic hours/week:	
Last Name:		First Name:	
Role:		In-clinic hours/week:	
Last Name:		First Name:	
Role:		In-clinic hours/week:	
Last Name:		First Name:	
Role:		In-clinic hours/week:	

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DETAILS ABOUT THE PRACTICE

Describe the on-call arrangements presently in place for practice coverage:

☐ **Neighbourhood Network Call Group** ☐ **Physician Call Group Name:** _____

Approximate number of participants sharing the call: _____

☐ **Cover Own Call** ➢ **Describe the contact arrangements in place (office phone system alerts, cell pager, etc.):**

_____

_____

_____

_____

_____

Describe your experience with clinic team development: _____

_____

_____

_____

_____

_____

Describe your experience with attachment for your clinic, including any challenges. _____

_____

_____

_____

PLEASE COMPLETE ONLY THE SECTION(S) THAT APPLY TO YOU

Attachment Requirements of PCN FPs
I understand the attachment requirements of the FP contract: ☐ **Yes** ☐ **No**

Requirements: Attachment of _____ patients for Year 1 and an attachment of _____ patients for Year 2 of the FP contract.

Attachment Requirements of PCN NPs
I understand the attachment requirements of the NP contract: ☐ **Yes** ☐ **No**

Requirements:
Attachment of _____ patients for Year 1, _____ patients for Year 2 and _____ patients for Year 3 of the NP contract.

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If there is any further information that will support your Expression of Interest, please add it here: _____

IMPORTANT: By submitting this application, I acknowledge that I have reviewed the PCN FP/NP contracts in detail and understand PCN contract deliverables. Please submit your EOI to support@rdfp.ca. We will confirm the receipt of all submissions by email.

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