Resident Clinical Orientation Handbook

2024-2025

Queen's University FAMILY MEDICINE Family Health Team

QFHT CONTACT INFORMATION

Alliance Call Service	1 888 556 6037
QFHT (patient line)	613 533 9303 (press "0 or 2" for switchboard to have anyone paged)
QFHT (physician line)	613 533 9300 Ext: 0
Queen's line – after hours into QFHT	613 533 9300 Ext: 73901
To call in sick or report a delay	613 533 9300 Ext: 73901
IT Support	613 533 9300 Ext: 73966
Hotel Dieu Hospital Switchboard	From any QFHT line: dial 82-0
Kingston General Hospital Switchboard	From any QFHT line: dial 81-0

Name	Title	Email	Ext.
Dr. Jennifer Tranmer	Physician Lead	jennifer.tranmer@queensu.ca	
Dr. Kelly Howse	KTI Site Director	kelly.howse@queensu.ca	
Julia Fournier	Clinic Manager	julia.fournier@queensu.ca	73983
Francine Janiuk	Nursing Manager	janiukf@queensu.ca	79497
Jennifer MacDaid	Clinic Program Manager	jennifer.macdaid@queensu.ca	73015
Terry Black	IT Administrator	blackt@queensu.ca	73966
Steve Coates	Stocking Clerk	s.coates@queensu.ca	73900
Adit Jain	Finance Coordinator	jain.adit@queensu.ca	73943
Bianca Vanderlaak	Finance Coordinator	bianca.vanderlaak@queensu.ca	73943
Scott Feddery	Revenue and Compensation Administrator	feddery@queensu.ca	73991
Renee Lupien	Operations and Risk Management Coordinator	renee.lupien@queensu.ca	73960
Dr. Laura Wells	Program Lead (Residents)	dfm-progrelead@queensu.ca	
Dr. Declan Mulligan	Site Co-Lead (Residents)	dfm-reslead.kti@queensu.ca	
Dr. Joanie Ouellette	Site Co-Lead (Residents)	dfm-reslead.kti@queensu.ca	

If you are sick or delayed, please contact the Sick Line at
613-533-9300, ext. 73901
before 8 a.m. to ensure your message is received.

This line is checked daily and the person checking it will contact the appropriate people in Education and your clinic. In addition, OSCAR-message your clinic team to advise them of your absence and also send an email to Dfm-timeaway@queensu.ca. and complete the Sick Day Reporting form.

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OUR VISION

Leading family medicine through education, research, advocacy, and socially accountable practices.

OUR MISSION

Preparing tomorrow's family physicians to provide exemplary, comprehensive care for all, within the diverse communities they serve.

OUR VALUES

Respect. Leadership. Inquisitiveness. Equity. Diversity. Compassion. Collaboration. Accountability.

Triple C Curriculum

Queen's Department of Family Medicine has embraced the College of Family Physicians of Canada "Triple C" curriculum as our foundational educational framework. Within this we strive to ensure that all residents:

1) receive a comprehensive education and diverse clinical exposures;
2) experience continuity of curriculum, supervision and patient care; and
3) receive an educational program that is centred in family medicine.

While each of the four academic sites utilizes slightly different resources and approaches in order to meet the Triple C objectives, all follow the same general guiding principles.

Comprehensive Education and Patient Care

Each of the four sites formulates its educational program and clinical experiences on centrally set program objectives that are reviewed on a continual basis with representation from each site. Further, each site leverages its available clinical experiences in order to provide a comprehensive clinical exposure with a focus on family medicine.

Continuity of Education and Patient Care

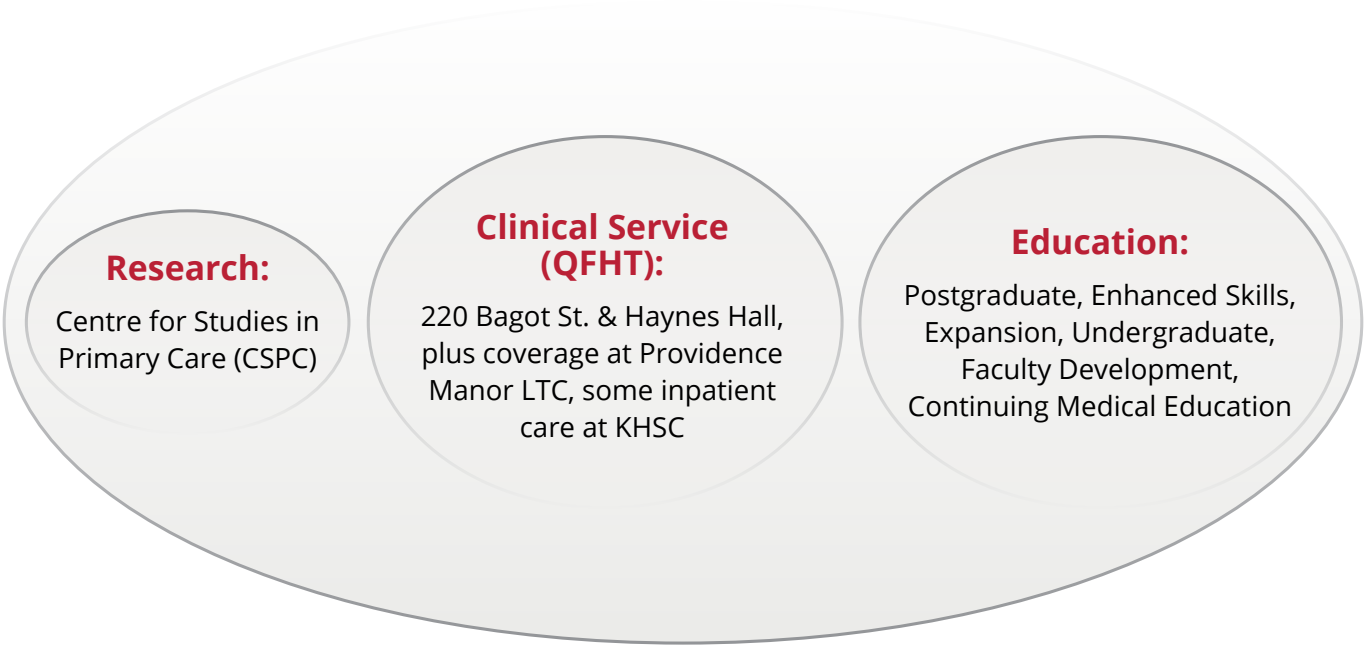
Continuity of education is accomplished through deliberate planning of curriculum to facilitate progressive competency attainment, a delicate balance of supervision and graduated responsibility, and each resident having an academic advisor. All residents are expected to follow their patients through multiple clinical encounters over time. While the particulars of how this is achieved at each site differs, the overall experience of continuity of patient care is similar across sites.

Centred in Family Medicine

Each site, whether it utilizes a block-based or horizontal structure, is focused on family medicine-centred, relevant training experiences. Each site attempts to utilize family medicine preceptors wherever feasible. When this is not possible, there is vigilance to ensuring preceptors understand the types of clinical experiences and teaching that are relevant to family medicine.

WELCOME TO THE QUEEN'S FAMILY HEALTH TEAM!

Welcome to your first-year Core Family Medicine rotation! We hope that you find it to be an enriching, enjoyable and educational experience. As you will see throughout this guide, our staff – and patients – are passionate about resident education and we endeavor to support you through this process.



Queen's Family Health Team in the Department of Family Medicine (DFM)

The Queen's Family Health Team (QFHT) comprises two clinic locations, and residents will be assigned to home teams in one of these two areas. Some of you (from each cohort) have been assigned to the Family Medicine Centre (FMC) located at 220 Bagot St., and some of you have been assigned to Haynes Hall, 115 Clarence St. Similar to other FHTs in Ontario, ours is a multi-disciplinary group with allied health professionals who provide additional care and service to our patients.

During your year with us, your schedule will be based primarily around clinic time in your home team. In addition, you will have numerous horizontal experiences to round out your family medicine experience: long-term care at Providence Manor, prenatal and intrapartum care, procedure clinics, practice improvement projects, journal clubs, lunch and learns, teaching sessions and grand rounds, just to name a few.

We hope your time at the QFHT will enriching, rewarding and fun! We strive to be a dynamic and innovative team, with a commitment to helping residents become excellent family physicians who are dedicated to quality patient care and clinical excellence. As new members of our team – even if only temporarily – we encourage and look forward to your insight, enthusiasm and contributions. *Welcome!*

MEET THE
QUEEN'S FAMILY HEALTH TEAM

1 WEST

- A – Drs. Michael Green, Sean Haffey and Shayna Watson; Jennifer Bouman, Nurse
- B – Drs. Sarah Funnell, Laura Kroeker, and Jiwei Li; Nikki McNeill; Nurse
- Marinelly Villalobos Nieto, Reception
- Michelle Little, Referral Clerk

2 WEST

- A – Drs. Karen Hall Barber, and Jennifer Zlepnig; Jessica Burns, Nurse
- B – Drs. Imaan Bayoumi, Erin Beattie, Jennifer Pope and Matt Simpson; Lynne McQuarrie, Nurse
- Kimberley White, Reception
- Cindy Boyce, Referral Clerk

2 NORTH

- A – Drs. Eva Purkey, Amrita Roy, and Jennifer Tranmer;Maggie Campbell, Nurse
- B – Drs. David Barber, Lindsey Griffith, and Ian Thomson;Leanne Rioux, Nurse
- Carly Bain, Reception
- Lorraine Chick, NP
- Cindy Boyce, Referral Clerk

HAYNES HALL FIRST FLOOR

- Drs. Ed McNally and Christy Stephenson; Jess MacLauchlan, Nurse
- Cecilia Kopecki, Reception
- Ashleigh Van Luven, Referral Clerk

HAYNES HALL SECOND FLOOR

- A – Drs. Mark Braidwood, Alenia Kysela, and Ian Sempowski; Keanna Benton, Nurse
- B – Drs. Kelly Howse, Kathy Pouteau, and Anthony Train; Amy VanKoughnett, Nurse
- Mandy Ashley and Judy Wall, Reception
- Ashleigh Van Luven, Referral Clerk

AFTER HOURS CLINIC

- Ashley Roy, Clinic Clerk/After Hours Clinic (AHC) Assistant
- AHC RPNs

ALLIED HEALTH & MULTI-CLINIC STAFF

- Nicole Nakatsu, Pharmacist
- Erin Desmarais and Jessica Waller, Social Workers
- Allison Little, Dietitian
- Elizabeth Hughson, Programming Nurse and Lactation Consultant
- Rhonda Gauthier, Dominique Pettitt, Julie Rogers and Rachel Wentzell, Programming Nurses
- Alicia Rubia, Foot Care Nurse
- Jennifer Bouman, Lisa Lamont, Jessica MacLauchlan, Lynne McQuarrie, and Amy VanKoughnett, Wound Care Nurses
- Valerie Dewal, System Navigation Nurse
- Jenny MacDonald, Medical Office Assistant
- Steve Coates, Supply Clerk
- Cecilia Kopecki and Tess Smith, Medical Records
- Maria Sherwood and Danieth Pryce, Community Services Worker
- Jeanette Bryant and Judy Wall, Float Clinic Clerks
- Monica Bissonnette, Switchboard
- Scott Feddery, Physician Compensation and Revenue Assistant
- Adit Jain and Bianca Vanderlaak, Finance Co-ordinator

CLINIC MANAGEMENT AND ADDITIONAL STAFF

- Dr. Jennifer Tranmer, Physician Lead
- Julia Fournier, Clinic Manager
- Jennifer MacDaid, Clinic Program Manager
- Francine Janiuk, Nursing Manager
- Renee Lupien, Operations and Risk Management Co-ordinator
- Terry Black, IT Administrator
- Alexis Hamilton, Faculty Support Assistant
- Tammy Parr, Clinical Administrative Assistant
- Nicole Kinsella, Data and Quality Improvement Analyst
- Elizabeth Castillo Baragan & Brooke Lloyd, Administrative Assistants

PROFESSIONALISM AND GETTING STARTED

You will very quickly discover that there is a lot of information to process during the first couple of weeks. To assist you with your transition, you will find that various members of your team have been asked to cover specific pieces of material with you, most of which you can find in checklist form in this manual.

Refer to the appendices. It is your responsibility to ensure that you are comfortable with the processes and tasks outlined on these orientation checklists, so please do not hesitate to ask anyone for clarification or more information.

A Queensu Email Account Must be Maintained

We require all QFHT employees, including residents and locums, to maintain and check the email account we provide you. You will be given a @*queensu.ca* email account, and all clinical and education information will be sent to this account. You may forward your other email accounts to the queensu.ca account.

Residents are discouraged from emailing patients from their individual email accounts; your receptionist may email on your behalf.

QFHT Schedules

You will receive a direct link to a live schedule that will reflect all changes and updates made throughout the year. It is always a good idea to double check your schedule with OSCAR and your clinic receptionist to ensure these changes have been recorded.

Planned Absences

Please give us as much notice as possible for planned absences. Appointments are often booked weeks or months in advance, and patients often make arrangements for work or childcare to attend your appointment, so any last-minute changes are very disruptive to them.

It is your responsibility to cross-reference your clinic schedules with your academic/personal calendars to ensure you have been appropriately blocked from clinic on requested dates. Continually keep an eye on your clinic schedule, watching for conflicts where you may inadvertently have been booked in two places at the same time. If this is identified, please work with your receptionist to adjust the schedule.

Requests for time away, including vacation and educational leave, must be submitted to the education office. Please refer to Elentra for specific instructions on policies and how to submit your request.

The education office will notify the receptionist once your request has been approved. In addition to this, you must also notify your LTC preceptor of your planned absence as well as any other professional responsibilities you might have scheduled during your leave.

YOUR HOME TEAM CLINIC & PATIENTS

Your primary experience during your PGY1 year at QFHT will be managing your own cohort of patients under the supervision of faculty preceptors in your home team. You will be "in clinic" about five to seven half days/week and will work with two or three preceptors through the week, seeing their patients when they are in clinic. Early in the year, you will see their patients while they observe you through a live-stream feed. As you progress through the year, you will strive to work more independently. For the most part, you will be seeing Dr. X's patients on the half days that Dr. X is working in clinic. Dr. X is referred to as the Most Responsible Physician (MRP) for the patients that are rostered to them. In the Electronic Medical Record (EMR), called OSCAR, you will see that you are also tagged as their Most Responsible Resident (MRR). As a patient's MRR, receptionists will try to book these patients specifically with you. Their incoming labs, documents, and prescription requests will arrive in your inbox, and the nurse will bring questions about your patients to you. These same patients are also rostered to their MRP.

Hours of Work

Your hours of work are expected to start **between 8 and 8:30 a.m.**, and sometimes earlier. Please ensure you arrive on time. Typically, the period from 8 to 9 a.m. is devoted to things such as seminars; visits to long-term care, or hospital rounds; or house calls; or in preparation for your day (e.g., addressing labs, incoming results, pre-reading the charts of the patients coming in for the day).

If you are not rounding somewhere else or in a teaching session, it is expected that you will be in the team room preparing. Nurses and reception staff will expect to find you, regarding their needs and questions about patient care, before clinic starts. Patients are booked from 9 a.m. onwards. Afternoon clinic starts at 1:30 p.m. and the last patient is booked at 4 p.m. Charting and managing the inbox and related phone calls continue after the last patient leaves. Noon to 1:30 p.m. is reserved for lunch, teaching, or team meetings.

Name Tag and Professional Introductions

It is important that you wear your QFHT gold name tag at all times, in addition to the one Kingston Health Sciences Centre (KHSC) gives you. The QFHT will provide you with the one we expect you to wear during clinic. You may assume that a patient catches your name or knows easily whom they saw last; this is incorrect. The feedback we get from patients is that they perhaps did not hear clearly, often forget, and in fact are not even sure if the last provider they saw was a physician or another health-care provider. They see many residents over time, and it is not unexpected that they will forget your name. But here is the most important reason to wear your name tag: It is your privilege to hear the private details of a person's life, and to examine their bodies. It is the patient's right to know exactly who is doing this, and what their role is. Please wear your name tags and introduce yourself as "Doctor Jane Smith, first-year resident working with

Dr. X (your supervisor)," not "Jane" or "Jane Smith" or "Dr. Smith." Tell patients exactly who you are, and your role. Re-introduce yourself at the following visits with the whole "Dr. First Name, Last Name" and, of course, "How nice to see you again" until you are certain they know your name.

Your First Few Days

- Introduce yourself to all of your team members (on both sides of the hall, if applicable).
- Meet with your team receptionist on the first day for an orientation to your clinic schedule in the EMR, particularly to discuss the various features of your schedule, time blocked out for horizontals, and how to liaise with the receptionist should your schedule change. Your receptionist will go through a "checklist' of items you need to familiarize yourself with. Refer to the appendices.
- Meet with your team nurse on the first day for a tour around the physical space of your home team, and to review workflow, processes, and identification of key items such as vaccine fridges, supplies, and emergency bags. Your nurse will go through a "checklist" of items you need to familiarize yourself with. Refer to the appendices.
- In the first week, make time to meet with referral clerks to discuss key safety features of referral processes and available resources. You will find additional details farther along in this manual.

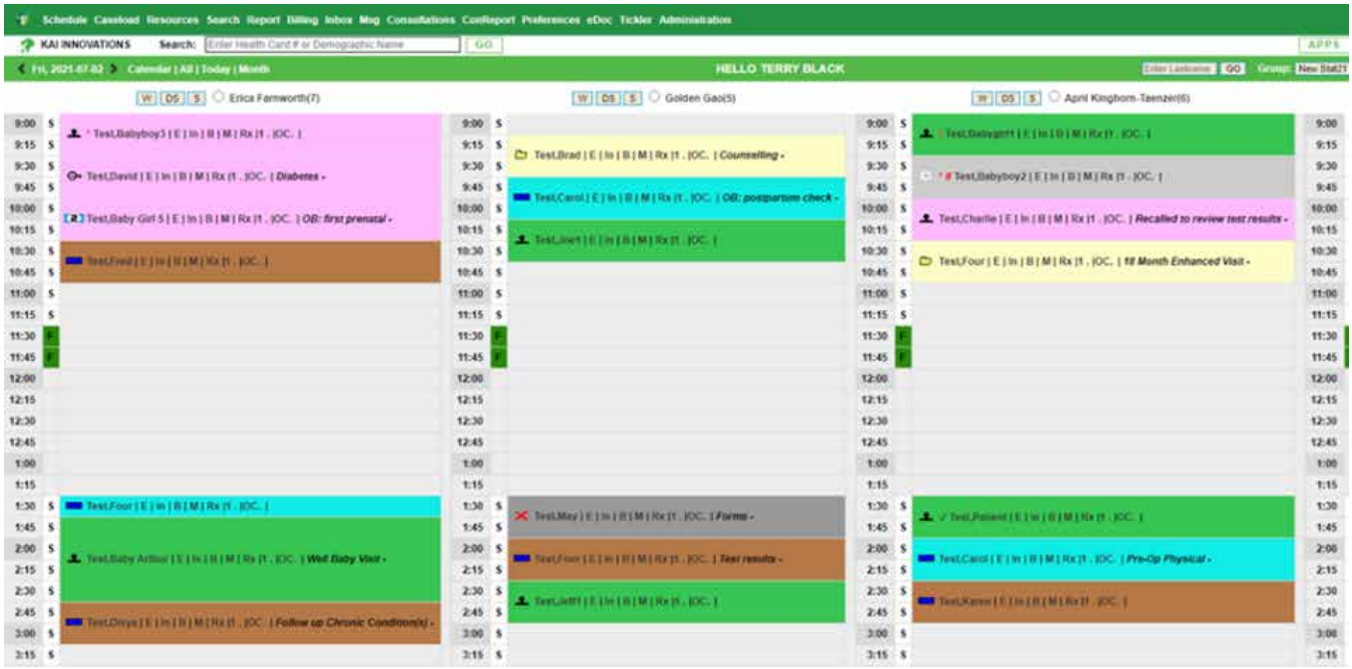
CLINIC FLOW

When a Patient Arrives...

You will see that you have your own IN PERSON column in OSCAR with patients who are booked to see you. Before clinic starts, all of these patients are listed in green boxes for face-to-face appointments and brown boxes for phone appointments. When a patient arrives and checks into reception, the receptionist turns the patient box pink, which lets the nurse know the patient is ready to be brought into an exam room.

The patient initially meets with the nurse to go over vitals and for a brief review of the reason for the visit and medication reconciliation. When the nurse has completed these tasks, they will room the patient and you will see that on the appointment screen the patient box is still pink, but with a number to the left of the patient name. This indicates which exam room the patient is in.

When a patient leaves, you will change the patient box to blue, which indicates that the room is empty, and the nurse can bring in another patient. To do this, you select the patient's name and an appointment window will open. In the top right there is a drop-down menu; select "empty room" and then on the left middle select "update appointment."



When a Patient Is "Seen" Virtually

When you speak to a patient on the phone (or are doing an OTN appointment), the rest of the team cannot tell where you are in the list. In the same way that turning the patient pink means "here," choosing "picked" means you are on the phone with them. Then turn it blue (empty room) when the phone call is done. Same for OTN appointments.

After you have finished your note and billed, the box will turn yellow. If a patient cancels, the receptionist will mark those appointments dark grey with a red X to the left of the name. If the patient is a no-show, the appointment will be turned light grey with a white circle to the left of the name.

Please note that residents will use the "sign, save and bill" feature to sign off their notes. (Your preceptor will "verify" your notes.) Don't forget to submit the appropriate billing for your patient encounter. Your preceptor will review this along with your notes.

At the beginning of clinic, you will notice that if there are many residents in clinic, it will be difficult for the nurse to get all the patients into rooms in a timely fashion. For example, there may be two residents and a faculty member on a Tuesday afternoon clinic that starts at 1:30, and given that the nurse takes vitals one by one for the three patients who have arrived for 1:30 appointments, there will be a delay for the third patient to be roomed. In this instance, if you see that the nurse is busy rooming another patient and your patient is here (is pink on the appointment screen), you are expected to escort your patient to an available room and start recording vitals into the EMR.
Please assist your nursing colleagues.

The nurse will be available to attend and assist with procedures, vaccines, and intimate exams.

Time Management

1. Be on time for the beginning of clinic.
2. There are times when the nurse is occupied with a patient and cannot room your patient immediately. In the spirit of teamwork, and so you do not fall behind, we ask you to room your own patients and do the vitals when the nurse is otherwise detained.
3. Don't keep patients waiting; try to stay on time. Where possible, complete documentation later so patients are not kept waiting. (The most frequent complaints we receive from patients are related to issues of delayed appointments.) Please respect their time as you would like yours to be respected.
4. One of the most important things you can do to improve your time management is to review the patients' charts prior to entering the exam room. Many residents do this the day before clinic or plan that you will do this in the 8 a.m. - 9 a.m. period before the morning clinic. For most encounters, you should be able to piece together a pretty complete picture as to what is bringing the patient into the office beyond what the appointment "reason for visit" notes say. Review nursing notes, recent Subjective Objective Assessment Plan (SOAP) notes, documents, labs, and messages for clues as to why they are coming in. Sometimes you may be able to figure out which labs, tests, or forms to print out prior to entering the room.
5. Most appointments are either 30 or 60 minutes. Keep in mind that this does not mean you spend this entire time face to face with the patient. Roughly speaking, you will want to spend only 15 to 20 minutes with the patient to give yourself 10 minutes to review with your attending supervisor or complete prescriptions, print forms, etc. Over the course of the year, you will get faster and will be able to advise as to which appointments can be booked for 15 minutes.
6. At the beginning of the encounter, clarify each patient's "agenda" as well as your own, if it differs. If you can't accomplish everything, obtain the patient's agreement and plan another visit. Perhaps 50 to 70 per cent of our patients return to our clinic repeatedly for monthly to quarterly visits to review multiple chronic health problems on their active problem list. These patients sometimes say they are here for a "re-check" or for "meds refill" or "I don't know why the doctor told me to come back." This is what we are referring to when we talk about clarifying the agenda at the beginning of an appointment. Sometimes it will take you looking in previous notes to tell what needs to be covered for today's office visit.
7. Do opportunistic screening/preventive health maneuvers at every visit (as time allows). For example, ask about vaccines, preventive screening, and, most importantly, prescription renewals.
8. Another strategy to improve time management is to clarify and merge agendas at the beginning of each appointment. A common cause of time-management upset is the "hand-on-the-doorknob" comment or question such as, "Doc, what was my MRI result from last month?"

   To prevent this from happening, clarify with your patient your understanding of why they are here and get all other items up front at the beginning of the appointment. After you introduce yourself, say something to the effect of, "I see from the nurse's note that you are here to review your recent test result and I also see that you are due for your B12 shot today. Are there other things you wish to cover at today's appointment? Do you need any medications refilled while you are here?" While a technique often taught in medical school that uses an overture such as, "What brings you in today?" is correct, it sometimes backfires in a family medicine setting.

Sometimes patients interpret "what brings you in today?" as an indication that you have not read their file, and a common complaint we receive from patients about residents is that they felt the resident did not know what was in their chart or why they were recalled. To help prevent this misunderstanding, reserve "what brings you in today" for clinical settings such as the ER, where a complete patient file is not available. As mentioned above, for most office visits at QFHT, one can work out why a patient is coming in from pre-reading the chart, and it is best to give the patient the impression that you know their file and why they are here.

9. Another common tactic through which residents can become more efficient with time is to resist the temptation to completely address each problem one at a time as the patient lists them. Instead, take a history for all items up front and "park" the assessment and plan component for the end of the visit. Stick to the SOAP format en bloc, and don't jump back and forth from one segment to another out of order or do SOAPs over and over within one appointment.

   Say, for example, that a patient presents with a new rash, to review recent DM labs, and needs a handicapped parking form completed. Take a complete history of why the patient is here, for all three problems, in the "history-taking" or Subjective portion component of the office encounter, followed by the Objective component (physical exam, lab review, tests, etc.), and then stop, review with the preceptor to solidify the Assessment and Plan. You should present your Assessment for all issues with the corresponding Plan at the end of the visit. You will find that this technique will allow you to cover all three issues far more efficiently than doing three consecutive SOAPs for each problem.

10. Your clinic appointment schedule is your responsibility. Keep an eye out for conflicts as you look ahead at your schedule (e.g., booked when you're not in clinic or during your dinner break). It is your responsibility to ask the receptionist to correct this. Be mindful that it is very labour-intensive and sometimes upsetting for receptionists to reschedule appointments at the last minute, so be ever-vigilant about your schedule a week or so ahead of time.

How Supervision Works in QFHT Clinics

To ensure residents are provided with excellent feedback, there are live-stream video devices in the exam rooms that provide a secure live broadcast of your patient interactions to your preceptors in their team room. While we have sent communications about this to patients and there are signs in the rooms, sometimes patients are surprised to see these devices. Please ensure you are aware of the following information, so you can address any patient concerns:

- These devices only stream information; they do not record or save the information. The broadcast is contained within your region (e.g., 2West) and is only accessible by special computer workstations in the team room.
- An ON/OFF switch for the devices is available in every exam room. The device is focused on the desk area; however, you may wish to turn it off during times when the patient may be changing, or if you are performing certain procedures.

For more information, please see the signage in the exam room or speak to your preceptor.

Supervision, Presentations and Sign-off

Initially, you will review all patients with your home-team preceptor before you send them out of the clinic. As you gain more experience, you and your preceptor may agree that you no longer need to review every patient prior to their discharge. Once this has been decided, you may send them out on your own and review them with your preceptor later.

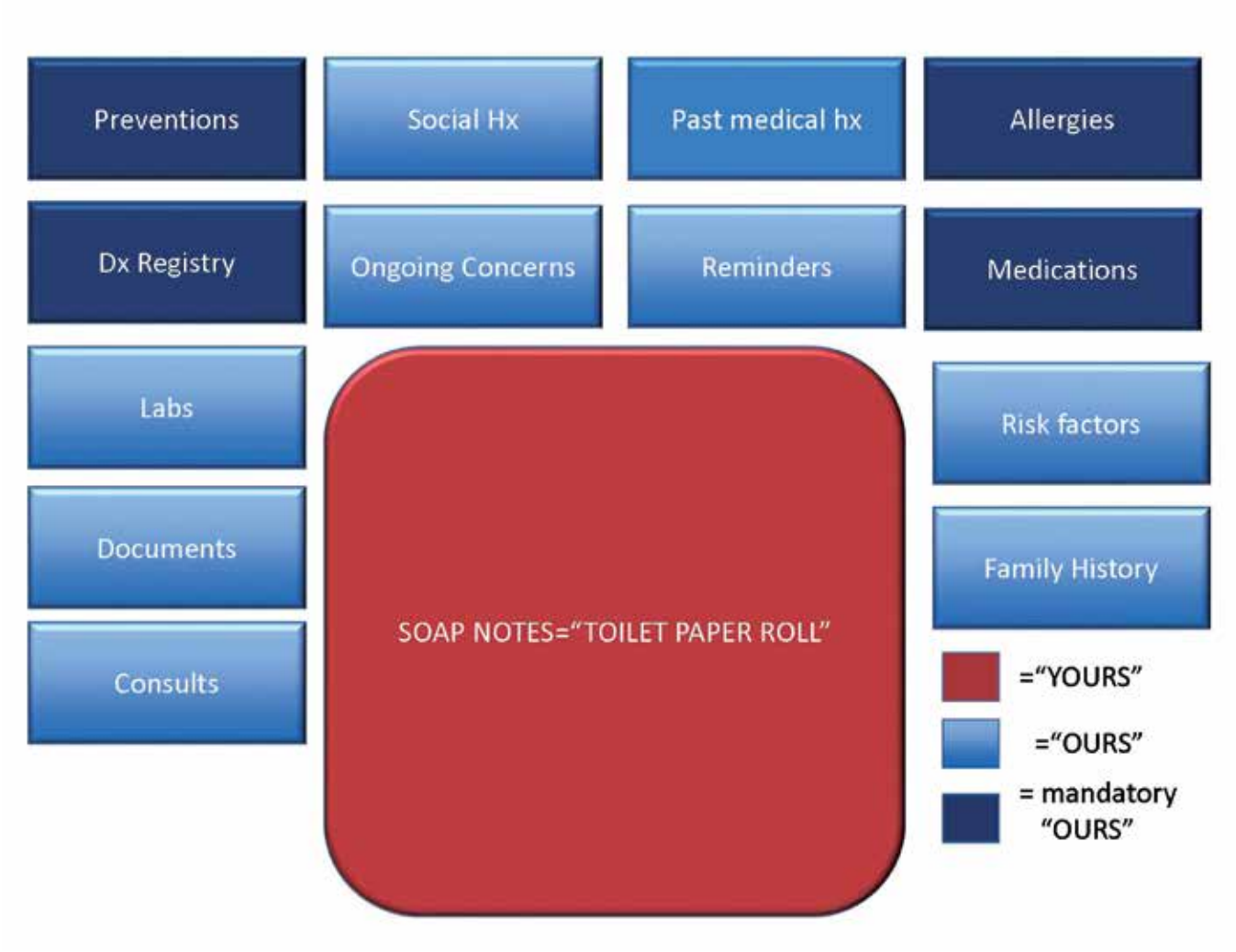
A different set of guidelines applies to the after hours clinic (AHC). When you are on call in the after hours clinic, typically you will be working with a preceptor who has not previously observed you. In this instance, please be prepared to describe the level of supervision you have in your home team. For example, if your home team preceptors still wish you to review every patient with them prior to discharge, then make this clear to your on-call supervisor — that you are not yet seeing patients entirely independently in your home team.

In contrast to the kind of case presentations you may have made as a clerk or in other settings where patient flow is not as quick as in a family medicine clinic, please make your case presentations to your supervisor brief. Rather than starting with the history, then the physical findings, etc., start with your diagnosis and/or management suggestions and then tell us how confident you are about the situation. Then expect to be asked for supporting information.

If at the AHC, ensure to also let us know some context, as we don't know the patient. Just as you do in the ER: report the age, the patient's MRP, and their key co-morbidities. (I saw XY, a 65-year-old patient of Dr. X, who has complex list including DM, CHF, and Parkinson's … and tonight has presented with…."

Your supervisor will review and sign off your EMR notes. Please try to have them done by the end of clinic so your supervisor can go over them and give you timely feedback. EMR notes must be completed within 24 hours.

Please note that residents will use the "sign, save, and bill" (or "sign, save, and exit" in the beginning) feature to sign off their notes. (Your preceptor will "verify" your notes.)



Data Discipline: Documenting in OSCAR

"Garbage in = garbage out." Imagine you are working on the internal medicine service and are charged with doing the admission history and physical in the middle of the night for a patient who is non-verbal. Remember how it feels when you find that great document — perhaps a previous history and physical — that has all the information you need to be able to put the pieces together?

At QFHT, we are committed to keeping our charts up to date and accurate in a similar manner. QFHT is a very large and complex family health team. When we look at deprivation indices of patients rostered to QFHT, we find that our largest group is the folks with the highest deprivation scores. This means these patients often have multiple providers at QFHT, often have issues with literacy or numeracy, are frail elderly, or have an intellectual development delay. In this regard, many of our patients are not able to give a reliable history at each appointment, so the integrity of the information with respect to completeness and accuracy is essential for the provision of safe patient care.

It is very important that you are as thorough and complete as possible for each OSCAR entry such that the next person can pick up where you left off with your train of thought and can completely understand the key issues/next steps. The patient's EMR chart is only as useful as the information it contains; a high level of "data discipline" cannot be underscored enough. Familiarize yourself with the QFHT Documentation Policy (P-2014-003) stored on the DFM Shared Drive in the Policies-Medical Directives folder.

Documentation Expectations at QFHT

- Pre-read the EMR to get an "at-a-glance" overview of your patients before you see them.
- The SOAP note is your place to document your actions

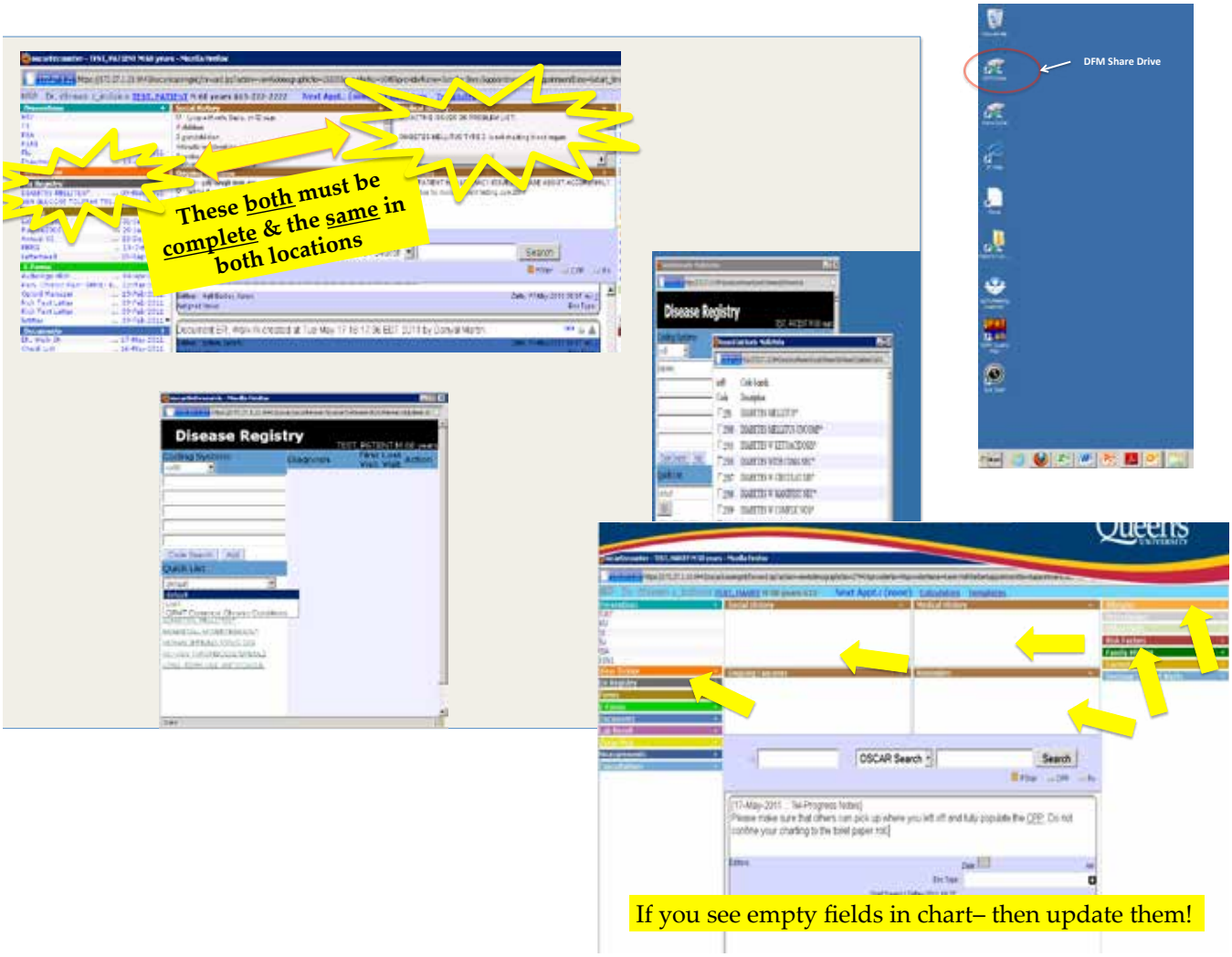
and thoughts of an encounter. In your future practice, you may err on the side of brevity when documenting a patient encounter, but for the purposes of a teaching clinic with multiple providers, we ask that your SOAP notes include as much information as possible, particularly with respect to next steps and plans, given that you may not be the next person seeing the patient.

- The portion of the chart where one can scroll through all the previous SOAP notes is called the "toilet paper roll." If you want to search through all notes, first you must click the "Show all Notes" button. If you do not click this button, it will only search the few notes that are loaded at the end of the "toilet paper roll." You can then search by hitting Ctrl F and search for a key word.
- The fields in a patient's chart that are not the toilet paper roll of contained SOAP notes are called the Cumulative Patient Profile (CPP). Keeping the CPP up to date and accurate is the responsibility of everyone every time they enter the chart. CPPs are meant to be the real-time summaries of a patient's history rather than a signed and closed static SOAP note. The CPSO tells us that the CPP must be up to date at all visits and not something that is reviewed, say, once a year at a general assessment. For example, say you get an OR note about a patient who had a colonoscopy and was found to have colon cancer, you would open the Preventions field of the CPP to enter the colonoscopy, the Disease (Dx) Registry to enter colon cancer, and the Medical History box to enter the free text particulars about when colon cancer was diagnosed and the plan for treatment. Similarly, if you get information about a family member who died of colon cancer, don't bury that information in a SOAP note; rather, update the Family History field of the CPP.
- Update fields that are incomplete or not accurate as you identify them (e.g., allergies, smoking status, social history for new job, recent divorce, etc.).
- Enter information into quantifiable field in addition to the progress or SOAP notes. For example, add any immunizations to the preventions module as well as to the progress/SOAP notes.
- Update the Dx Registry (a hard-coded disease registry that triggers other flowsheets and reminders for patients) when you notice something is missing from the list.
- Don't assume that every old issue is up to date and/or fully addressed; revisit and update as necessary.
- Phone conversations with patients/guardians are encounters and must be recorded in the EMR.
- Management of inbox items, fax-backs from pharmacies, etc., should be recorded in the EMR.
- Medication reconciliation is a key quality-improvement project within the QFHT; don't forget to review and update medication lists at every visit. Remember ASAP:
    - o Add any new medication. If prescribed by a specialist, add that medication with a Mitte 0 and ensure to add the outside provider under More/outside provider.
    - o Stop any discontinued medication. If you discontinue a medication, inform the pharmacist of record (send a Mitte 0 prescription, with the directions stating "Please note this medication is now discontinued." And then discontinue it from the EMR.
    - o Add in allergies (including"NKDA" for "no known drug allergies").
    - o Print off a new list for the patient to take home.

If you print off any documents for the patient, you must stamp them with "Patient Copy." (Stamps are found in the team rooms.)

Clinic Flow Odds and Ends

Use the yellow "next appointment" pads available in the exam rooms. As patients leave, give them the appointment slip for their next appointment. Indicate the interval range for their return appointment (2-4 weeks? 6-10 weeks? 4-6 months?). Indicate the reason for visit. Do NOT use "follow up" or "recheck." Include useful words so it is clear what they are coming for, when looking at the schedule, on the day of the next appointment. Attempt to maximize your continuity of care by putting your name ("with - your name") and look to see if you can have the visit occur in this or your next rotation vs just before or after it, if the interval in which they need to be seen has that flexibility. After the patient leaves your exam room, they will stop at reception and hand the receptionist the appointment slip. They will be given a new date and time; it will be with you (if possible), and the reason for the visit will be clear to the receptionist. Sometimes it is helpful to walk the patient out to the receptionist's desk and explain what you want. As you get more familiar with OSCAR, you may start booking future appointments with patients yourself while still in the exam room with the patient. If you are the one booking a future appointment with a patient, put key details such as "review increasing A1C," rather than, "recheck."



Inboxes

INBOX MANAGEMENT — GRADATIONS OF RESPONSIBILITY THROUGHOUT THE YEAR

One of the required competencies of being a family physician is being able to manage incoming information and requests about your patients that occurs outside of face-to-face office encounters. This includes items such as incoming labs, test results, consultations, ER visit summaries, forms, and prescription requests. For simplicity, this is known as "inbox management." Aligned with the CanMEDS-FM framework, curriculum and assessment for this competency have been developed to assess inbox management that is safe, effective, and timely.

Expectations for active management of your inbox will increase incrementally as you progress through your first year of training, as you gain more experience and get to know your patients.

Responsibility for your inbox management will initially be lighter, but will progress as you start ordering investigations, know more of your patients, and become more familiar with processes at QFHT and OSCAR functionality. Towards the end of your family medicine PGY1 training, you will be expected to manage items attached to all of your patients — even those you do not know — and to address items for colleagues who are unavailable. This ability is an essential skill you will use in your future practice whether you do locums, start building a practice, or take over a practice.

In line with our inbox expectations for faculty, you are expected to check your inbox preferably every 24 hours, but allow no longer than 48 hours between Monday to Friday while on service. Inboxes are to be

signed off/emptied or commented on by Friday of a given week.

Expectations for Management of Inbox

First Rotation at QFHT

Start working with the inbox to get acquainted with its functionality and QFHT processes. Observe how your patient's MRP and colleagues manage items in the inbox.

If a patient is booked with you in the next week or two, review their inbox item as it will help you start planning their upcoming care. For patients whose inbox results you do manage, always pause and consider: based on this information, what needs to be updated in the patient's EMR CPP fields for all appropriate inbox items? Examples include updating medication lists, updating preventions in the prevention module (such as immunizations given elsewhere, cancer screenings, BMD and colonoscopies), adding new diagnoses to the "Dx Registry," updating the Medical History field of the CPP, updating the diabetes "indicators" form for retinal examinations by optometrists, and billing exclusion codes for cancer screening should a patient have a total hysterectomy, etc. Ask for guidance as needed. If something is of particular interest to you in the inbox, review that item and start formulating a management plan for that patient.

When investigations or consultations you have requested start appearing in the inbox, you are responsible for formulating a plan for them, updating the EMR as needed, and writing a brief plan in the acknowledgement box. If any prescriptions you have written require clarification, you are responsible for this. Initially, start renewing prescriptions for patients known to you. As you get more settled into your clinic, start doing ones for those unknown to you as time permits. For other patients unknown to you, inbox items may be filed with a comment in the inbox acknowledgement box indicating "unknown to resident." These will be managed by the MRP or locum. For educational purposes, please try to manage, or discuss with your preceptor, as many of these as you reasonably can.

If inbox management seems overwhelming, speak to your academic advisor early in rotation to develop a progression that is more manageable for you.

See below for "going-off service" instructions.

Second Rotation at QFHT

See below for "coming on-service" instructions.

At this point you will be more familiar with clinic flow, functionality of OSCAR, and patients you have seen, so advancement in the scope of inbox management is expected such that you are attempting to address most items in the inbox (even for patients unknown to you) as time permits and under the guidance of your supervisors.

Third (and Final) Rotation at QFHT

It is expected that you manage all items in the inbox.

Going off and coming on-service/leaves and vacations:

Going off-service

As with all good patient care, if there is an issue of concern that needs close follow-up, notifying your matched MRR and the MRP by a message or tickler before going off-service is important.

When you are off-service or on leave, you are not responsible for managing your inbox. This responsibility will fall to your matched MRR in the other cohort, or in the absence of such, the MRP. Even though you will have "off-site" access to QFHT when you are not on a two-block family medicine rotation, you must not address inbox items while off-service. This can lead to errors and confusing duplication of orders. Assume that when you are off-service, your resident or MRP counterparts who are on-service are responsible for all inbox management.

Coming on-service

At the start of each two-block rotation, *ideally the night before*, you may "file" all inbox items without reviewing them. (Ask your preceptor if you are unsure how to do this.) However, for good patient care and for your education, it may be of benefit to scan your inbox looking for patients you are familiar with or who have upcoming appointments.

Holidays

For vacations or extended conference leave of less than one week, you are expected to leave your inbox empty before you leave, and if there is an issue of concern that needs close follow-up, notifying the MRP by a message or tickler before going away on leave is important. You must still review the inbox items upon return. You are not expected to address inbox items while you are absent, as others onsite will cover these for you, but you must review them upon return in a timely fashion, as some items may have been intentionally left for your review. Unlike coming on-service, you may not batch "file" inbox items that accumulated while you were away on vacation or educational leave, unless the leave is for one week or greater. In this situation, MRPs will send you a message or tickler if they would like you to review a specific inbox item that arrived while you were on leave.

Please ensure you enable "vacation responder" in OSCAR (found under the Settings tab near the top right when you open your messages section) when appropriate.

Prescription Writing

This will be reviewed during orientation. Please contact our pharmacist if you have any questions.

Check List for Quick OSCAR Rx Overview

- The default screen in OSCAR Rx is set to show "Current" medications (i.e., everything we haven't stopped). To see all medications (current and discontinued), click the "Show All" button beside the Profile Legend.
- Don't forget to confirm the patient's pharmacy and their allergies!
- ***DO NOT create a new pharmacy! DO NOT change the fax or phone number of a pharmacy. If you need a pharmacy added or number changed, you MUST message the QFHT pharmacist and IT. The errors made in doing this on your own cause huge problems and much time to repair, as we then must resend all prescriptions sent to the faulty pharmacy.
- NB: drugs that are highlighted in grey (in the box drop menu) have been removed from the market. Most of the time, this is not a problem, as they are available as another brand. Feel free to select them, if appropriate.
- You can add as many meds as you like to the script; just start typing in the Search box to load another medication.
- Make sure you include a quantity! Missing or incorrect quantities are one of our most common errors.
- To prescribe compounds, compressing stockings, massages, or other non-drug items, click the "Custom Drug" button and type in the name of the item. Insert any pertinent instructions then complete the Rx.
- Please remember that we DO NOT give patients narcotic scripts. You must fax these scripts to their pharmacy.
- Do not use the "Other Meds" box, as information added here does not trigger the interactions database and, more importantly, fragments the medication list. All prescription information should be added to OSCAR Rx.
- Refill requests and corrections from the pharmacy must be updated in the Rx module.
- Don't forget to use the "Favourites" feature; this will save you time when prescribing and will reduce the number of "fax backs."
- Ask patients about refills at every visit; do today's work today!

***Important: Please check every drug you prescribe for potential interactions and allergies!

Allergies

- To enter NKDA or non-drug allergies, click the "Custom Allergy" button and type "NKDA" or the non-drug allergy in the box. Click "Add Allergy."
- To enter a drug allergy, begin typing the drug name in the Search box and hit "Enter" on your keyboard. From the Allergy Search Results, select the appropriate entry.
- To code an allergy to a single drug, select the Generic Name.
- To code a class of allergies (e.g., sulfonamides), scroll down to the Brand Name section and click the orange class designation (to the right of the Brand Name).

  (Contact IT if you require access to a particular folder.)

OBSTETRICS

Maternity and Newborn Care

The maternity and newborn curriculum identifies competencies that you are expected to develop to successfully complete your family medicine residency. One of the 105 Priority Topics for family medicine is "Pregnancy" and another is "Newborn". The main resources for developing competence in these areas are your family medicine rotations and your obs/gyn rotation, supported by the ALARM course and NRP course. In your obstetrics rotation, you will have a concentrated exposure to intrapartum care. During your family medicine rotations at QFHT and elsewhere, you will have experience in prenatal care, postpartum care, and newborn care, and you may have some experience with intrapartum care depending on your clinic area. Maternity and newborn care within your family medicine rotations will provide a unique opportunity to learn about and practice continuity of care.

PRO-TIP: For information, care checklists, and how to order obstetrical-related tests and ultrasounds in Kingston, please refer to the helpful prenatal/antenatal visit checklists located in OSCAR's e-doc section.

Maternity and Newborn Care at the QFHT

All family doctors at QFHT provide prenatal care until 28 weeks, postpartum and newborn care. Three QFHT physicians, Drs. Laura Kroeker, Eva Purkey, and Christy Stephenson, currently practice low risk obstetrics (FMOB), meaning that we follow patients for the entirety of their pregnancy, and provide intrapartum, newborn, and postpartum care out of KGH. Our QFHT FMOB providers are part of a larger group of FMOB providers in Kingston. Historically, FMOB providers in Kingston have delivered their own patients, meaning we are on call 24/7 for prenatal patients unless we sign out to the larger group. However, given the on-call rota, please do not guarantee to patients that their QFHT OB provider will be present for their delivery.

As "low-risk" OB providers, we work collaboratively with our obs/gyn colleagues should complications arise during the prenatal, intrapartum, or postpartum period, and may either consult OB for advice/technical assistance, or transfer care to OB if deemed necessary. Due to the nature of FMOB practice and our call schedule, each of us has limited capacity for the number of prenatal patients that we will take on each month.

Patients should be made aware of the prenatal care options in Kingston early in their pregnancy. These include

FMOB providers, obstetricians, and midwives. Patients who are high-risk should be referred to an obstetrician, whereas those who are low risk can be managed by any of the above providers. Referrals to FMOB and obs/gyn should be made early in the second trimester, once the conversation about choice of provider has happened. Patients choosing midwifery care can self-refer to Kingston Community Midwives through their website or by calling their office. They should be encouraged to do this as early as possible as capacity is limited. For patients who have a history of a caesarian section, it is important to have an initial discussion about preferences for delivery – trial of labour after c-section (TOLAC) vs. Elective repeat C. Section (ERCS) – prior to referring to FMOB. Patients who choose an ERCS are better served by a referral to OB.

Except for those being followed by a midwife, all deliveries in Kingston occur at KGH on the labour and delivery unit known as "Connell 5". On labour and delivery, you will find trained labour and delivery nurses, obstetricians, as well as obs/gyn residents who are part of Queens' Ob/Gyn residency program, and Queens Medical Student Clerks who are performing their core clerkship obs/gyn rotation. KGH also has in-house pediatrics, as well as a level II NICU. Following delivery at KGH, patients move to the Parent/Baby unity, "Kidd 5", where they receive newborn and postpartum care in hospital. FMOB providers continue to see patients (birthing person and baby) in hospital, whereas babies delivered by obstetrics will be followed by the inpatient newborn service (staffed by midwives). Upon discharge, the patients will follow up with their family physician in the community within a couple of days for ongoing care. Patients followed by a midwife may deliver their baby either at KGH or at home and will be followed by their midwife until 6-weeks postpartum.

Once a patient returns to QFHT for their newborn care, we have additional resources to offer them, including a lactation consultant (Liz Hughson), a breastfeeding drop-in clinic, which runs every Tuesday morning from 9-12, a tongue-tie clinic run by Liz Hughson and Dr. Kroeker, and a Circle of Support for new moms, which runs on Thursday afternoons. Each clinic area is also equipped with a transcutaneous bilimeter to facilitate follow-up of newborns at risk of hyperbilirubinemia.

Attending deliveries and in-hospital care

It is strongly encouraged to attend deliveries where possible and attend follow-up visits in hospital for both postpartum and newborn care. This provides an invaluable opportunity to experience and demonstrate continuity of care. If you are interested in attending a delivery, discuss this with your OB preceptor and with the patient when you meet them. If the patient is agreeable, add your name and contact information to the "Plan of Management" section on the third page of the perinatal record. Discuss your preferred method of contact with your preceptor and be sure to notify them if you will be unavailable in the days/weeks surrounding the delivery. Your preceptor will then endeavor to call you for delivery. If your OB preceptor is signed out, then the covering FMOB will be aware to call you. Interested residents who desire additional FMOB experience should identify themselves to the FMOB preceptors early in the year, so that they can be "second call" if a resident following a prenatal patient is unavailable. Please be advised that we do not guarantee that each resident will be able to attend a delivery.

To attend a delivery at KGH, you will need your KGH badge, and scrubs. Scrubs can be obtained using your badge via the scrub machines on Connell 5 beside the elevator. It is worthwhile confirming that you do indeed have scrub access before you are called for your first delivery.

Please be aware that FMOB providers are also responsible for training Queens clinical clerks who are on their core obs/gyn rotation. As such, hands-on participation in deliveries will be shared between yourself and the clerk if you are both in attendance. If this is the case, you may be asked to teach the clinical clerk, under the supervision of your preceptor.

If you are called to attend a delivery, you should leave right away. If you need to leave your clinic to attend a delivery, please communicate to your preceptor, nurse, and receptionist that you are leaving. If possible, please communicate when you expect to be back in the clinic. If a delivery occurs outside of office hours, you are encouraged to attend, however you are not obliged to attend a delivery outside of regular hours (i.e. 0800-1700). If you do come to the hospital outside of work hours to attend a delivery, you can claim a "home call" stipend. If you spend a minimum of four hours at KGH, and one of these hours is between midnight and 0600, you can claim an "in-hospital call" stipend.

Even if you do not manage to attend a delivery, you are still expected to round on the birthing patient and baby daily, ideally in the morning, especially on the day of discharge. You may see them alone or with your preceptor, but please discuss this with your preceptor in advance. Notify your preceptor if exceptional circumstances will not allow you to see the patients (i.e. if the patient delivers on a Friday, and you are out of town on the weekend). Care provided to the birthing patient/baby in hospital should be documented in the patient charts, located outside their rooms.

PRO-TIP: If you are considering including low-risk obstetrics in your future practice, please discuss this with your AA and/or one of the QFHT FMOB preceptors early-on in your residency so that we can help you choose rotations and find experiences to prepare you well!

IMMUNIZATIONS

Immunization is one of the most valuable public health interventions available to prevent and control infectious diseases. Ontario Public Health has delegated the task of immunization to primary care.

At the Queen's Family Health Team, we strive to ensure that all our patients are kept up-to-date with their immunizations per the most recent version of the Ontario Public Health's Publicly Funded Immunization Schedule (June 2022), and that all vaccines are provided in a safe and timely manner.

Education for both vaccine preparation and administration will be provided by the nurse in your area. You must be supervised for both preparation and administration.

Below are some helpful instructions for vaccine preparation and administration.

Choosing the Right Vaccine

Choosing the right vaccine for the right patient at the right time is imperative. Refer to Ontario's Publicly Funded Vaccine Schedule, June 2022. (Copies are available in each clean utility room, in the team rooms, in the nurses' office, and on the web at: https://www.ontario.ca/files/2024-01/moh-publicly-funded-immunization-schedule-en-2024-01-23.pdf)

The schedule helps determine which vaccines **should** already have been administered and which vaccines are due, and can also guide decision-making when patients have missed scheduled vaccines.

The next step is to open the Preventions Module in OSCAR to determine which vaccines have already been administered. This will only be determined once the module is opened. This step should be completed prior to seeing your patient so you are prepared to provide correct information and obtain informed consent from the patient/substitute decision-maker prior to vaccine administration.

Please utilize the Publicly Funded Schedule and compare to what the patient has already received to determine which vaccines are required.

When preparing to administer vaccines (or any medication), always ask the nurse in your area for assistance.

The name of the vaccine and the expiry date should be checked three times:

1) Once as the vaccine is selected from the refrigerator shelf
2) A second time as the vaccine is drawn up or reconstituted
3) One last time immediately before administration

Safe Storage and Handling of Vaccines

Vaccines are sensitive biological substances that can lose their potency and effectiveness if they are exposed to temperatures (heat and/or cold) outside the "cold chain," (the required temperature range of +2 degrees Celsius to +8 degrees Celsius) and/or light.

We also store COVID vaccines (including mRNA vaccines). These vaccines are not to be disturbed and are only handled by the COVID vaccine team.

Please keep vaccines in the refrigerator until just before use.

Multi-dose vials must be replaced in the refrigerator as soon as the dose has been drawn up.

Do not leave vaccines at room temperature.

Make sure to verify if the vaccine you are giving needs to be reconstituted and, if so, ensure you are using the correct diluent that is supplied with the vaccine. Some vaccines come as powders and must first be mixed with the diluent provided.

About Vaccines

Medication administration guidelines state that the individual who administers the vaccine/medication should be the one to draw it up and prepare it. This person is also responsible for ensuring that it is the correct vaccine and that it is not past expiry date.

Preparing or filling syringes in advance is not advisable because of:

1) possible decrease in potency of the vaccine;
2) increased risk of administration errors
3) vaccine wastage; and
4) possible bacterial growth in vaccines that do not contain a preservative.

Some vaccines are prepared in a lyophilized form that requires reconstitution. Diluent solutions vary; use only the specific diluent supplied for the vaccine you are administering.

Each vaccine vial should be carefully inspected for damage or contamination prior to use. The expiration date on the vial (not the box) must be checked. Vaccines can be used through the last day of the month indicated by the expiration date unless otherwise stated on the package labelling. Expired vaccine should not be administered. Instead, remove the expired vaccine from the refrigerator and place it in a paper bag with the supply clerk's name on it. The supply clerk should be advised to collect the vaccine and properly discard it.

When opening a multi-dose vial for administration, **please label the vial with the date it was opened and with your initials**. If using a vial that was previously opened, please verify the vaccine is still viable. Once opened, multi-dose vials should only be used for the period specified by the manufacturer (e.g. 7 days, 30 days). When vials are not properly labelled, it is not possible to know whether the vaccine is beyond its expiration and the bottle must be discarded. This practice eliminates unnecessary and costly vaccine wastage.

Administering Vaccines

When administering multiple vaccines, **NEVER mix vaccines in the same syringe**. Deviation from the recommended route, site and dosage of vaccine can result in inadequate protection. Deviation from the recommended route of administration might reduce vaccine efficacy and/or increase the risk of local reactions. Vaccines must reach the desired tissue site for optimal absorption. Therefore, needle selection should be based upon the prescribed route, size of the individual, volume and viscosity of the vaccine, and injection technique. Typically, vaccines are not highly viscous, therefore a fine gauge needle (25 gauge) can be used.

When giving all medications, including vaccines, be sure to adhere to the "8 Rs": right patient, right vaccine, (including verification of expiration date), right dose, right route, right time, right patient education, right documentation and right to refuse.

Intramuscular injections are administered into muscle tissue below the dermis and subcutaneous tissue. Although there are several IM injection sites on the body, the recommended IM sites for vaccine administration are the vastus lateralis muscle (anterolateral thigh) for infants up to 12-15 months of age and then the deltoid muscle (upper arm). The site depends on the age of the individual and the degree of muscle development.

Needle Gauge and Length: 1- to 1.5-inch (2.5-3.8cm); 22- to 25-gauge needle: For all intramuscular injections, the needle should be long enough to reach the muscle mass and prevent vaccine from seeping into the subcutaneous tissue, but not so long as to involve underlying nerves, blood vessels or bone. Do not use less than a one-inch needle for any IM injection.

Subcutaneous (Sub-Q or SC) injections are administered into the fatty tissue found below the dermis and above the muscle tissue. Although subcutaneous tissue can be found all over the body, the recommended site for SC vaccine administration is the upper outer triceps of the arm for persons older than 12 months of age.

Needle Gauge and Length: 5/8 inch, 23- to 25-gauge needle. Please review the QFHT policy on Vaccine Storage, Handling and Disposal, on the Shared Drive in the Policies-Medical Directives folder. Your team nurse is a valuable resource for vaccine administration. Please refer your questions to your team nurse.

Immunization Lead: Liz Hughson

1 West A: Jennifer Bouman	**HH 1st Floor:**
1 West B: Nikki McNeill	**Jess MacLauchlan**
2 West A: Jessica Burns	**HH 2nd Floor A:**
2 West B: Lynne McQuarrie	**Keanna Benton**
2 North A: Maggie Campbell	**HH 2nd Floor B:**
2 North B: Leanne Rioux	**Amy VanKoughnett**

Documentation of vaccines in the OSCAR Preventions module can be challenging, as there are many similar documentation codes. A cheat sheet has been prepared to assist clinicians with documenting vaccines in OSCAR. These cheat sheets are posted in the team rooms. See next page.

Vaccines Frequently Administered at QFHT

Vaccine Name	Documentation Code in OSCAR	Diseases	Route of Administration	Stock / Order
Pediacel	DTaP-IPV-Hib	Diphtheria, Tetanus, acelullar Pertussis, inactivated Poliomyelitis vaccine, Haemophilus influenza type B	IM	Stock
MMR II, Priorix	MMR	Measles, Mumps, Rubella	SC	Stock
Boostrix, Adacel	Tdap	Tetanus, Diphtheria and acelullar Pertussis	IM	Stock
Imovax	IPV	Inactivated Poliomyelitis vaccine	IM	Stock
Menjugate	MenC-C	Meningococcal conjugate C	IM	Stock
Priorix Tetra	MMRV	Measles, Mumps, Rubella, Varicella	SC	Stock
Pneumovax	Pneumovax	Pneumococcal 23(strains)	IM	Stock
Prevnar 13	Pneu-C	Pneumococcal 13 valent	IM	Stock
Adacel-Polio Boostrix-Polio	Tdap-IPV	Tetanus, Diphtheria, acelullar Pertussis, inactivated Poliomyelitis vaccine	IM	Stock
Rotarix	Rotavirus	Rotavirus	PO	Stock
Td Adsorbed	Td	Tetanus, Diphtheria	IM	Stock
Varivax III, Varilrix	VZ	Varicella	SC	Stock
Shingrix	Shingrix	Shingles	SC	Stock
Avaxim/Havrix	HepA	Hepatitis A	IM	Special order
Recombivax HB/Engenerix B	HepB	Hepatitis B	IM	**Limited stock ** or prescription
Twinrix	HepAB	Hepatitis A & B	IM	Special order or prescription
Menactra, Nimerix, Menveo	Men-C-ACYW-135	Invasive Meningococcal Disease	IM	**Limited stock**
Gardasil 9	HPV Vaccine	Human Papillomavirus	IM	**Limited stock**
Agriflu, Vaxigrip, Fluviral (can vary each year)	Flu	Influenza	IM	Seasonal

** Limited stock - report use to KFL&A**

MAKING REFERRALS AND ORDERING TESTS

All tests (aside from labs ECGs and plain xrays) are processed through the referral clerk assigned to your clinic area, including internal and external referrals.

Cindy Boyce ext. 78123	Referral Clerk 220 Bagot St., 2nd floor	cindy.boyce@queensu.ca
Michelle Little ext. 73913	Referral Clerk 220 Bagot St., 1st floor	michelle.little@queensu.ca
Ashleigh Van Luven ext. 73050	Referral Clerk Haynes Hall	ashleigh.vanluven@queensu.ca

How to Create and Send a Consultation

- When you are writing your letter, put yourself in the position of the person receiving it. Is it clear what you are looking for? Is any information missing? Try to make your letters as thorough as possible!
- When possible – i.e. if it has already been scanned into the patient's chart – attach labs and documents to the consult via the "attach files to consultation" link. From here you can choose the appropriate file, similar to an email attachment.
- If the item is not in OSCAR, note the required item in the "Additional Notes" part of the consult section (please provide clear instructions so that the referral clerks know which lab, document, etc.). If the document you want attached is in the paper chart and you have it in front of you PLEASE FLAG IT AND PUT IT IN THE REFERRAL BOX. In the "Additional Notes" section you can add "Please see U/S in inbox." If it is not clear what you want sent, the referral will be delayed and we will have to contact you to confirm.
- When you hit "Submit Consultation Request," your referral will automatically be sent to the referral clerk. There is no need to print off the referral and send us a signed copy. (Please do not hit "submit and fax.")
- Don't forget to sign your consultation – e.g. "Dr. Jane Smith PGY1 for Dr. Staff Doctor"

***Note:** If you have a question for the referral clerks, please send it via tickler or message. Please do not create a consultation request as a way of sending a message.

General Referral Tips

- If you have an URGENT referral, please come and talk to one of us directly, as there are times when one of us is away, it is really busy, etc. For example, if you need to send a patient for a Doppler to rule out a DVT, please do not leave it in the inbox. Come and talk to a referral clerk so it is booked in a timely manner. If you are unable to locate a referral clerk, please alert the URGENT referral to the attention of the nurse/ receptionist in your area.
- If you are sending a patient for further tests because a result came back that requires follow-up, you MUST inform the patient first so that they are not surprised when we speak to them about a follow-up appointment (this makes us appear disorganized and can cause distress for the patients as the referral clerks may not be able to answer clinical questions about the reason for referral).

- Make sure you check your Ticklers and Messages often. If you send us something that requires follow-up, feedback or for you to change something, these are two of the ways we can communicate with you. The referral clerks may also leave comments – especially about appointment confirmations – in the "acknowledgements" section of the document inbox.
- If there are procedures or referrals that you think should be done, please ask your MRP before committing to a patient whether/where/how it can be done and who would do it.
- Please give your MRP copies of the letters you are sending to request consultations, at least initially in the rotation, to review with you before sending.
- There are many, many services available to patients. If you have questions about what is available for your patients, please ask the referral clerk in your area.
- Residents are reminded that they are responsible for watching for pending labs/documents and sending them to the appropriate referral clerk when they arrive to ensure that the items are directed to the appropriate specialist office.
- All referrals for long term care patients (Providence Manor) are to be completed, submitted and tracked through Providence Manor. Please note that long term care patients should not be booked into QFHT for appointments. All medical appointments should take place at Providence Manor.

How to Access and Use Requisitions (or How to Use "E Forms")

- Make yourself familiar with all the requisitions (E-Forms). There are many places that do not require a letter (e.g. Audiology, Diabetes Education and Sleep Studies @ KGH), but they prefer to have their requisitions filled out. There are facilities that require a specific requisition (mandatory e-forms). Remember to SAVE the e-form in the patient's EMR. (This way, it will stay in their record and will not have to be scanned in the chart.)
- When you fill out a requisition (E-Form) for any type of imaging, please make sure to fill out the form that is location-specific (HDH, KMI or KIS). It will be sent to the facility it is addressed to.
- Please print off the E-form, sign as appropriate and put it in the referral clerks' inboxes.

Ocean

- We now use a system called Ocean for submitting requests for imaging and some referrals. Please familiarize yourself with the Ocean options available to you. You will receive an invite and instructions to sign up for this service. Patients can be involved with the process through email.

Tips on Specific Specialties, Forms and Clinics

- Labs, ECG and plain X-ray requisitions can be given directly to the patients as they do not require booked appointments (i.e. patients can just walk in).
- Staff physicians MUST sign all MRI requisitions (E-Form).
- MRIs of the knee – Patients over 50 have to have a knee X-ray first, otherwise it will not be booked.
- KGH and Kingston MRI are the only two places for MRI.
- Breast imaging (men included) should go on a Breast Assessment e-form. For routine screening for patients 50-74 years, self-refer to OBSP.
- There are many different options for pain clinics, including the HDH Pain Clinic, self-management programs, etc. If you are not sure to which clinic you should be sending your patient, please speak to a referral clerk or your preceptor.
- BP monitors: If you send patients to HDH or Kingston Heart Clinic, there are fees for BP monitors at both locations.
- Fetal Assessment requisitions MUST have the LMP or EDD and GRAVIDA, and should be filled out well in advance of when they would need the appointment. Otherwise, there will not be any available appointments. (Especially NT/eFTS ultrasounds, as there is only a specific window to have this ultrasound completed.)
- In-house referrals: Asthma, psychiatry, social work, foot care, and procedures will stay in-house unless otherwise specified. Other internal referrals/programs include: lactation support; smoking cessation; sleep therapy; dietitian services; diabetes program; anti-coagulation management; system navigation; Introducing Solid Foods to your Baby; Talk about Medications; Connecting Moms-Circle of Support; Coping with Anxiety and Depression; Mindful Eating: Emotional Eating and Food Craving Management Program; Managing your Blood Pressure; Healthy Aging; Substance Use Disorder clinic; and Sexual Health clinic.
- When working the AHC, all requisitions must be placed in the referral inbox in the AHC team room.

E-Consults

- E-consults are a great way to seek information or advice from a specialist with expertise in a particular area. Specialists usually reply in approximately five to seven days, if not sooner. Depending on the results, you may be able to treat your patient without the long wait for a clinic appointment. To create an e-consult, go into the consultation module in OSCAR and the referral clerks will process the e-consult.

LABS

- Labs Services can only process labs under providers with OHIP billing numbers. Please check to ensure that the correct name and billing number is listed on the lab requisition. If the patient is one of "your" patients, the EMR will automatically send you a copy when the results come in.
- We recommend that patients use LifeLabs, as we can receive Lifelabs results electronically. The EMR is is not yet able to accept Dynacare electronic submissions. We receive those labs in paper format. Advise patients to allow up to five days before the local laboratory office receives the requisition. Lifelabs locations are at 255 Bagot St. (at Brock); at 1473 John Counter Blvd. (at Sir John A.), Suite 100 (City Place 2); and at 791 Princess St., Suite 102. Dynacare is located at 690 Gardiners Rd., Unit B006A (Riocan Centre).
- **The person collecting the specimen is responsible for labelling it.**
- Please generate the lab requisition from the EMR rather than filling out a paper requisition. Send the requisition directly via OSCAR. This way, the lab order is stamped into the EMR. Label all specimens immediately. Specimens should not be left on counters without a label.
- Labelled specimens should be placed in the LifeLabs/ Dynacare bin in the Dirty Utility Room unless it requires refrigeration, in which case the specimen should be placed in the specimen refrigerator (the specimen refrigerators are located in the Soiled Utility Room).
- Urine specimens for culture go in the specimen refrigerator until transported to the laboratory by a porter/courier.
- If you are ordering future labs for patients – e.g. ordering a future lipid panel or TSH – please send the requisition directly via OSCAR to the lab and they will have it on hand when the patient visits the laboratory.
- Make sure you are using the correct lab requisition for public health tests, which is stored under "forms" in OSCAR. Do not use the regular LifeLabs/Dynacare requisition for public health tests.
- Please try to avoid handwriting labels on specimens, as sometimes these are difficult to read or are missing the specific patient identifiers required for LifeLabs/ Dynacare. If you must handwrite a label, please make sure you have included at least two of the following: patient's first and last name, health card (including version code) and date of birth.

Some health cards only show initials rather than full names. If this is the case, it is necessary to hand write the full names on the requisition and on the specimen label, as LifeLabs will not process the request without having a full name written in.

It is your responsibility to address lab results and consults that you have ordered. Start by assessing the urgency, review any relevant literature and note action needed. Make sure to document the indication for the test and the next step and what you have arranged in the comments section of the lab. One could document: "Indication: General Assessment, no action needed; file." Or, you could write: "Indication: anemia, patient needs more labs, patient notified of results by phone, and follow-up appointment booked." Please note that there is no "comment" button for labs and if you acknowledge the lab it disappears from the inbox. Once a comment is made on a lab req, there is no way to go back and overwrite (or correct) a statement.

You may proceed with action on abnormal labs if you are comfortable or you may write your thoughts on it and discuss with your supervisor at a later time. Where appropriate, please also note an important new diagnosis in the diagnosis registry or medication change in the prescription module of the EMR.

Weekend Lab Specimen Pickup

Weekend pickups occur on Saturdays and Sundays at 11:45 a.m. If left in the regular MDS lab pickup trays, specimens collected at end-of-day appointments (after 4 p.m.) will not be picked up until the next business day.

INTERPROFESSIONAL CARE

Nurses – Francine Janiuk, Nursing Manager

Patient-centred care is one of the most important goals for the care team. Nursing team members contribute to achieving this goal by using a collaborative approach with other team members in assessing and providing care. QFHT nurses work within their professional capacity to the maximum of their scope of practice and are involved in daily patient care. During your orientation, your team's nurse will review nursing functions with you, including immunizations and emergency procedures.

Nurse Practitioners

Our nurse practitioner (NP), Lorraine Chick, is an advanced practice nurse with additional knowledge and decision-making skills in assessment, diagnosis and health-care management, and is a Certified Diabetes Educator. She provides comprehensive primary health-care services encompassing health promotion, prevention of diseases and injuries, care, rehabilitation and support services. Scope of practice is directed by knowledge, skill, and judgement. Lorraine can autonomously order diagnostics, laboratory tests, and medications. Patients are commonly booked with an NP for monitoring of chronic conditions, elder care, regular health examinations and health teaching. Lorraine also has additional experience and training in diabetes management and pessary fittings/care.

As a resident, there are many ways you may collaborate with NPs. For example, Lorraine can assist and guide you with specific questions about diabetes (including insulin starts). Other opportunities for collaboration could include insertion of IUDs. NPs can share ideas about case management, and you can refer patients to NPs for routine aspects of follow-up care, for health teaching. Forming a collaborative relationship with your NP will prepare you for your future role in a multi-disciplinary practice.

Social Worker/Psychiatrist

Social Workers: Erin Desmarais, Jessica Waller
Psychiatrists: Dr. Amanda Richer, Dr. Archana Patel
Behavioural Medicine Lead: Dr. Kathy Pouteau

The goal of social work practice is to restore, maintain and enhance emotional and social functioning. This involves focusing on strengths, developing coping strategies, cognitive and behavioural modification and linking people to necessary resources. Within the QFHT, social workers provide direct patient care, including assessment, treatment, and psychoeducation. Working within a collaborative model, social workers are available to consult with physicians and primary care staff related to supporting patients experiencing mental health difficulties.

Referrals are submitted in the "consultations" tab in the EMR.

Behavioural medicine sessions are co-facilitated with residents and scheduled as part of the mental health horizontal.

Pharmacist – Nicole Nakatsu

The pharmacist is your key source of information around safe prescribing practices. The pharmacist's various roles include providing guidance in the following areas:

- Drug treatment options for various medical conditions
- Dosing adjustment in renal or hepatic dysfunction
- Prescribing for special populations (e.g. pediatrics, pregnancy and breastfeeding, geriatrics)
- Managing drug interactions, drug allergies, compliance issues and simplifying medication regimes;
- Navigating drug coverage options and compassionate supply
- EMR training and orientation, with emphasis on how to use the prescription module

Residents are encouraged to find answers to their drug information questions from the available resources in their team rooms. These include RxFiles and Anti-infective Guidelines for Community Acquired Infections (aka The Orange Book).

Your pharmacist is also available to meet with patients for a comprehensive medication review. Consider a referral for patients with these characteristics:

- Those on five or more chronic medications
- Those with three or more chronic medical problems
- Those who take 12 or more doses per day
- Recent (< one month) hospital admission
- Patients on medications with a narrow therapeutic index, (e.g. carbamazepine, lithium, phenytoin)
- Patients on high-risk medications (warfarin, insulins, opioids)
- Those who have had four or more medication changes in the last year
- Those needing in-depth medication counselling (for example warfarin, risk benefit assessment)
- Those with altered drug absorption (e.g. post bariatric surgery)

Patients with the above characteristics have been shown to benefit most from a medication review by a pharmacist to help address any potential drug-related issues and problems.

Contact information for the pharmacist:

- OSCAR message/consult: Ext. 73027, nicole.nakatsu@queensu.ca

Registered Dietitian – Allison Little

Our family health team dietitian, Allison, provides individualized nutritional assessments and counselling based on current evidence-based nutrition practice. She counsels patients on improving their diets and on many different nutrition-related health conditions, including:

- Allergies and Food Intolerances
- Diabetes (Type 2), Pre-Diabetes
- Dyslipidemia
- Gastrointestinal Diseases and Digestive Issues: Celiac Disease/Crohn's Disease/Diverticular Disease/ GERD/ Inflammatory Bowel Disease/Irritable Bowel Syndrome/ Ulcerative Colitis
- Hypertension
- Iron Deficiency
- Obesity-Related Health Risks and Comorbitities
- Osteoporosis
- Pediatric Nutrition and Growth Monitoring (infant & toddler feeding, nutrition & picky eating)
- Malnutrition
- Prenatal Nutrition
- Vegetarian Diets

Group Programs

Mindful Eating: Emotional Eating and Food Craving Management Program. This six-week program, co-facilitated by our dietitian, Allison Little, and social worker Jessica Waller, focuses on CBT and mindfulness strategies that patients can incorporate into their lives and work towards developing/improving their relationship with food.

Introducing Solid Foods to your Baby: Held on the last Monday of every month, this class teaches everything from food allergens and timing of introducing solids to the importance of iron-rich foods and how to create positive feeding environments.

To refer your patient to the dietitian, complete a consultation request in OSCAR.

Contact information for Allison Little:

- OSCAR message
- Ext. 73052
- allison.little@queensu.ca

Clerical Team – Jennifer MacDaid Clinic Program Manager

The clerical team is committed to supporting the highest levels of patient-centred care, along with positive learning experiences for our residents. The clerical group acts as a team, but there are several sub-teams within the group:

- **Medical Records** – Tess Smith and Cecilia Kopecki
  - How medical records can help you – following up with missing labs; requesting documents from the hospitals and other organizations; processing requests from insurance companies and transfer of records; pulling paper charts from the basement
- **Referrals** – Cindy Boyce, Michelle Little, Ashleigh Van Luven
  - How referral clerks can help you – if you have a question about what services exist and where; what documents are required; wait times or the status of an existing referral; confirmation of patient appointments with specialists (when we receive them); bookings for some internal clinics (procedure clinics, etc.) and e-consults
- **Switchboard**
  - How switchboard can help you – if you hear your name on the overhead page, press 0 on any phone or call back to 73900. The Switchboard / 1 North receptionist is also books appointments for Tongue Ties, Newcomer Clinic, Asthma, Physiotherapy Study, Psychiatry, Smoking Cessation, Community Services Worker, Substance Use Disorder Clinic
- **Reception**
  - How reception can help you – ensuring continuity of care between you and your patients, assigning OB visits, faxing documents, recalling patients, printing labels, blocking holidays (please let them know ASAP once vacation days are approved), etc. They can also book patients directly into the specialty clinics and they manage the bookings for the well-baby visits.
  - To assist them with booking follow-up appointments, please remember to give patients appointment slips with information about the appropriate timeframe for follow-up.

Medical Office Assistants & Supply Clerks – Francine Janiuk, Nursing Manager

The Medical Office Assistants (MOA) provide support to the nursing teams during absences and particularly busy clinics. They also support the procedure clinics and oversee recall procedures (especially diabetes) and preventions (e.g. cancer screening) programs. The supply clerks stock clinic areas; order and distribute medical supplies, linens, and vaccines; and oversee inventory management and maintenance of some of our clinical equipment.

PROGRAMS AND SERVICES

Anticoagulation Management Program (INR); Elizabeth Hughson, RN, Rhonda Gauthier, RN and Rachel Wentzell, RN

This program is managed by three specially-trained RNs who manage patients at QFHT who are on warfarin.

The INR clinic is run every Wednesday from 9:00-12:00 and the INR is checked using a point of care CoagChec INR meter. Additional arrangement can be made to see patients outside these standard appointment clinic days as needed. For example, a new start or a patient with unstable INRs may be seen more frequently.

Home visits are also available to home-bound patients. Warfarin initiation and doses are adjusted as needed by the INR team, taking the following into consideration:

- Patients' indication for warfarin (e.g. A Fib, Recurrent DVTs, Mechanical Valve)
- Risk factors (e.g. recent DVT, previous history of stroke)
- Recent clinical changes (e.g hospitalization, diarrhea)
- Drug interactions (e.g. antibiotics)
- Dietary changes (e.g. alcohol / green leafy vegetable)
- Adherence

For patients who are unable to attend the INR clinics and go to the lab the nurses will follow up with the patient and adjust warfarin doses as required. The nurse will co-ordinate with physicians or other clinics (pre-op assessment, bridging consult) as required to ensure patients' warfarin is managed optimally.

Diabetes Program

The QFHT offers a comprehensive team approach for patients living with Type 2 diabetes. The diabetes program works on a consultative model and encourages intraprofessional collaboration.

Certified Diabetes Educators

Our team includes a nurse practitioner (NP), registered dietitian (RD), and pharmacist (RPh) who are all Certified Diabetes Educators (CDE). This enables us to support the needs of patients with complex diabetes, including those requiring nutritional counselling, optimization of medical management, initiation of insulin, and/or intensification of existing insulin regimens.

Key components of the program include:

1) Joint Resident and CDE Team Visits – Referral to the QFHT Diabetes Program via the QFHT consultation module provides the opportunity to create joint visits with residents and CDE team members. This is strongly encouraged to build knowledge related to management of complex diabetic patients. Many of the QFHT DM referrals will be scheduled into a DM horizontal clinic.
2) DM horizontal clinics, scheduled every second Tuesday afternoon, provide a half-day clinical opportunity for select residents to spend time with the QFHT DM seeing complex diabetic patients.
3) Informally, your diabetes team is happy to answer questions via Oscar messaging. If we feel the patient would be better served by an appointment, the patient will be triaged and booked into the DM horizontal or the regular Oscar schedule with the appropriate provider.

Other Resident Learning Opportunities

Didactic seminars focused on insulin initiation and titration are offered at the beginning of each new academic year as part of the resident orientation.

Informal, case-based brown-bag lunch sessions are offered throughout each cohort rotation. Residents are encouraged to attend, and to bring questions and clinical cases to share with the group.

Electronic Resources and Group Programming

Consider the following resources to help guide your clinical practice:

Diabetes Canada 2018 Clinical Practice Guidelines (Includes 2020 updates to select chapters): www.guidelines.diabetes.ca

Freestyle Libre: Continuous glucose monitoring continues to become more popular with patients. This site provides information that will be helpful in learning about this system and its various applications. https://bit.ly/3hY7N0N

For patients, consider the following:

The ABCs of Diabetes, delivered by Maple FHT. This a free, two-part education series that discusses many of the basic concepts required to live well with Type 2 diabetes mellitus. Referral form under eforms — Diabetes (in-person group programs are currently on hold).

Hotel Dieu Hospital Diabetes Education and Management Centre offers a variety of pre-diabetes and diabetes educational programs. The referral form is in eforms — Diabetes (currently offering phone support only).

Loyalist Family Health Team offers several informative YouTube videos for patients living with Type 2 diabetes. www.Loyalistfht.com

Diabetes Canada has developed a free two-part online diabetes education series on managing type 2 diabetes. Classes take place on Tuesdays or Thursdays from 1 p.m. – 2 p.m. (all times are in Eastern Standard Time). In addition, Diabetes Canada is partnering with Shoppers Drug Mart to offer the PC health app, which will provide diabetes information to patients via their smart phone. www.diabetes.ca

Foot Care Services: Alicia Rubia, RPN

Trained in advanced foot care and specializing in diabetic foot care, this nurse offers health teaching, maintenance, and ongoing care to patients at high risk of wounds that can lead to morbid outcomes. The foot care office is located on the first floor at Haynes Hall. Referrals are made by completing the QFHT Foot Clinic Referral Form in the Consultations module in OSCAR. Program lead Alicia Rubia can be reached through OSCAR message or at extension 73994.

Healthy Aging, Dominique Pettitt, RN, and Rachel Wentzell, RN

Healthy Aging is open to QFHT patients 65 years of age and older. Held several times a year (both virtually and in person), this free five-week series focuses on a variety of topics including:

- Falls and safety, including polypharmacy and understanding medications
- Exercise and nutrition, including cost, food preparation, and brain health
- Coping with life transitions and changes
- Advance care planning, patient advocacy and social services, and supports

Send an OSCAR message to Rachel and Dominique if you have a patient who would benefit from this program.

Immunization Program: Elizabeth Hughson, RN

Immunization is one of the most valuable public health interventions available to prevent and control infectious diseases. The immunization program is steered by the QFHT Immunization Committee, which comprises nurses, the nursing manager, the physician lead and the pharmacist. The committee meets bi-monthly to review any recent changes or recommendations made by public health, and communicates these changes to QFHT clinical staff.

We strive to ensure all patients' immunizations are up to date as per the Ontario Publicaly Funded Immunization Schedule, and that all vaccines are provided in a safe and timely manner. This involves the entire team, starting with our clerical staff members, who schedule infants and children for appointments. Every fall, the QFHT staff actively promotes the flu vaccine for all patients over six months of age, especially targeting high-risk populations. All residents are to be supervised by a clinic nurse when handling any vaccine. Patients can receive a flu shot in a number of ways, including opportunistically when they are in clinic, through home visits for patients who can't get in, and through flu shot clinics. We also offer COVID-19 vaccines to both patients and staff.

Managing Your Blood Pressure, Liz Hughson, RN, and Dominique Pettitt, RN

Held several times a year, this four-week program addresses the following topics:

- Week 1: Overview of blood pressure and hypertension (high blood pressure), risk factors and adverse health outcomes, measuring blood pressure, including home monitoring, and related health conditions
- Week 2: Nutrition, exercise, and other lifestyle changes
- Week 3: Stress management
- Week 4: Medications

All patients are welcome.

Send an OSCAR message to Liz or Dominique if you have a patient who would benefit from this program.

Medication Safety Program: Nicole Nakatsu

The QFHT's medication reconciliation initiative ensures the best possible record of patients' medications. Patients are encouraged to bring all medications (including over-the-counter medications, vitamins and supplements, eye drops and inhalers) to each appointment to ensure all are recorded and up-to-date.

Patients are also encouraged to ask the five questions as developed by ISMP Canada: Changes? Continue? Proper Use? Monitor? Follow-Up?

For more information, please check out the following resources:

https://www.youtube.com/watch?v=BJI1ToB-Dv8

https://www.ismp-canada.org/download/MedRec/5questions/formats/MedSafetyNotepad_enmodifiable.pdf

https://www.ismp-canada.org/download/MedRec/5questions/MedSafetyNotepad_frmodifiable.pdf

Mental Health Care and Counselling: Erin Desmarais, MSW, Jessica Waller, MSW

The QFHT social workers offer time-limited, supportive counselling in response to patients' psychosocial and

mental-health needs. Working within a collaborative team model of care, they address a variety of mental-health challenges such as anxiety and depression, grief and loss, stress management, and navigation of local supports and services. Urgent appointments are available.

Group programs include our Understanding and Coping with Anxiety and Depression and Cognitive Behavioural Therapy for Insomnia.

Understanding and Coping with Anxiety and Depression Program

This five-week group program is based on a Cognitive Behavioural Therapy model, and aims to introduce patients to a number of tools that will help them build up their "tool box" and give them skills to manage their mood. Each session is focused on learning new strategies, and participants are given "homework assignments" to utilize these strategies in their daily life. Cognitive-behavioural interventions covered include, but are not limited to, education, self-monitoring, behavioural activation, problem solving, cognitive restructuring, relaxation, and relapse planning. Group sessions in both are offererd quarterly to patients and community members in both in person and virtual format.

Sleep Therapy Program

The six-week Sleep Therapy group program is for adults who have chronic insomnia and who wish to learn strategies to restore good sleep. This program is based on a Cognitive Behavioural Therapy for Insomnia (CBT-I) approach, which is the first-line treatment for chronic insomnia in medical guidelines in North America and Europe. This program, open to QFHT patients only, involves learning an effective set of techniques including sleep scheduling and learning strategies to deal with thoughts that interfere with sleep.

Minor Procedures and Sports Medicine Programs: Drs. Edward McNally, Ian Sempowski and Ian Thomson

Our main procedure clinic is run by Drs. Sempowski and McNally. Minor procedures such as lumps and bumps and injections should still be performed in your home team, but Drs. Sempowski and McNally offer a broad range of more extensive procedures in these clinics. Please speak to your preceptor if you are not sure whether a patient should be seen in your home team or in the procedure clinic.

Dr. Thomson treats a variety of conditions related to sports injuries and chronic musculoskeletal conditions, including acute sports injuries, overuse sports injuries, chronic musculoskeletal conditions, acute sports concussions, exercise counselling, and procedures such as US guided and unguided joint, tendon, and bursal injections.

If a patient should be seen in the procedure clinic, a referral MUST be made and the referral clerk will contact the patient once the referral has been triaged by Dr. Sempowski.

Newcomer Clinic, Dr. Eva Purkey

Under the guidance of Dr. Eva Purkey, newcomer patients are seen initially in this special Newcomer Clinic. Patients are accepted through KEYS only and are refugees. The patients are seen for initial intake appointments with QFHT residents and a nurse to ensure their charts are properly populated and that health concerns and immunizations are organized and addressed. After the patients are considered stable with their records and intake, they will be redistributed to another physician within QFHT for their care.

Obstetrics and Prenatal Care: Drs. Laura Kroeker, Eva Purkey, and Christy Stephenson

All QFHT family physicians provide prenatal care. Pregnant women can also be referred to one of several family physician obstetrics providers at the QFHT who deliver babies and provide care to both women and their newborns at KGH.

Primary Care Asthma Program (PCAP)

The Primary Care Asthma and COPD Program (PCAP) is a provincial evidence-based education and management program funded through the Ministry of Health and administered by the Kingston Health Sciences Centre Asthma Program under the medical direction of Dr. Diane Lougheed. The program has proven positive outcomes with tools and resources that are aligned with the Canadian Thoracic Society guidelines. The PCAP is a part of the Ministry's Asthma Program mandate to reduce health services utilization through an integrated plan including prevention, health promotion, education, management, surveillance, and research. PCAP is delivered by a certified respiratory educator (CRE) who visits QFHT on a monthly basis. The CRE provides current evidence-based patient and family education and assists with on-site objective measurement via spirometry in order to facilitate accurate diagnosis and management of asthma and COPD. The program is modeled on fostering patient and family self-management. Topics include pathophysiology of asthma +/- COPD, medications, inhaler device technique, trigger reduction, smoking cessation, and early identification of loss of symptom control. The CRE will develop an Asthma or COPD Action Plan for prescriber approval and prescriptions. It will also make suggestions for therapy changes or diagnostics based on the Canadian Thoracic Society Guidelines. Patients to refer include:

- Any adult or paediatric patient with confirmed or suspected asthma
- Any adult patient with confirmed or suspected COPD

- Patients for spirometry screening for asthma or COPD. Please note we are unable to offer spirometry for other conditions.

Please send referrals through OSCAR.

Sexual Health Clinic: Rhonda Gauthier, RN.

The SH clinic is a rapid-testing barrier-free clinic where patients may receive assessment, counselling, and testing for the following: gonorrhea, chlamydia, syphilis, trichomonas, HIV, hepatitis B, and hepatitis C. Clinic is for patients who are 14 years of age and older and offers booked and drop-in appointments.

Smoking Cessation Program: Rhonda Gauthier, RN; Dominique Pettitt, RN; and Dr. Ed McNally

QFHT adopted the Ottawa Model for Smoking Cessation for primary care in September 2011. The registered nurses working in this program have completed specialized training in smoking cessation counselling through CAMH and the University of Ottawa Heart Institute.

The Smoking Cessation Program involves all members of the clinical team working together to help identify and support patients who are interested in quitting or reducing smoking. We are also able to provide support with respect to the use of e-cigarettes and vaping. Patients receive education and individual counselling. They may also receive nicotine replacement therapy (NRT), at no cost to them, by participating in the Smoking Treatment for Ontario Patients (STOP) program. Patients must see a smoking cessation counsellor for an intake appointment (individually or in a group) and enroll in this study before they can receive free NRT. Refer your patients by sending a consult from the EMR. Patients may also self-refer. We can also work with non-QFHT patients who are friends/family members of QFHT patients who are working towards reduction of nicotine intake or cessation of smoking or vaping. There is some flexibility in scheduling for more urgent consults, such as prenatal patients and patients recently discharged from hospital.

Substance Use Disorder Clinic, Dr. Sean Haffey

The Substance Use Disorder (SUD) Clinic is for QFHT patients only; this is not a Rapid Access Addiction Medicine (RAAM) or walk-in clinic. The SUD Clinic is accepting referrals for:

- Diagnostic assessment/confirmation for any of the following SUDs:
  - o Alcohol
  - o Opioids
  - o Stimulants (cocaine, meth/amphetamine, MDMA)
  - o Cannabis (including vaping)
  - o Benzodiazepines / hypnotics / Z-drugs
- Initiation of Opioid Agonist Therapy (suboxone, sublocade, methadone, slow-release oral morphine, etc.)
- Initiation of anti-craving pharmacotherapy in the treatment of alcohol use disorder
- Management of challenging BZD or opioid tapers
- Consideration of pharmacotherapy in the treatment of cannabis and stimulant use disorders
- Counselling informed by Motivational Interviewing and Acceptance and Commitment Therapy (ACT) principles

Patients will be seen for an initial comprehensive SUD assessment (60-90 minutes), after which a proposed plan will be sent to the referring team. No standardized limits will be imposed on the number of follow-up assessments a patient will be booked for. Depending on the patient, their SUD and the treatment plan, they may be discharged back to the referring team immediately with recommendations, seen in follow-up a handful of times, or followed by the clinic on a long-term basis. Every patient is different, every SUD is different — follow-up will be guided by patients' personalized needs. Referrals can be submitted via the Oscar Consultations module under Addictions Medicine.

System Navigation, Valerie Dewal, RN, and Maria Sherwood, CSW

The System Navigation program staff members support patients who have a range of conditions that often require health care and social supports. The approach is to assist patients in navigating the health-care system, social and economic supports, care co-ordination, advocacy, linkage to community resources, and co-ordinating care with the primary care provider. Appointments may be scheduled in clinic, over the telephone, in the community, and/or in the patient's home.

Talking About Medications, Nicole Nakatsu, RPh

Talking About Medications is a series of interactive workshops that aims to help older adults and caregivers gain knowledge about medications and to encourage them to take an active role in making decisions about medications. The educational tools and supports that have been designed for these workshops will allow participants to confidently manage medications and have a voice in healthcare decisions that impact quality of life. Contact Nicole with any questions or to register patients for this program via OSCAR message or by phone at ext 73890. This program is held several times throughout the year.

Well Baby Well Child (Newborn to Age 6) Liz Hughson, RN, IBCLC Breastfeeding / Infant Nutrition

The goal of this program is to promote and support breastfeeding by providing evidence-based information to women to enable them to make an informed decision about how they will feed their baby. The program provides clinical experiences that facilitate residents' learning and provides them the knowledge and skills needed to

competently and confidently support the breastfeeding mother-baby dyad and know where to refer for ongoing support. This is a program is facilitated an International Board Certified Consultant and RN with extra training in mother-infant feeding. The lactation consultant will see patients prenatally to discuss infant feeding, focusing on breastfeeding. Newborns can be booked jointly with the lactation consultant and physician for their first clinic visit, and any visits after that as needed. The lactation consultant is in clinic Monday through Friday, and can be paged any time to see patients opportunistically in clinic. Individual consultations can also be arranged. We offer a weekly breastfeeding drop-in and a weekly peer support Connecting Moms group. We also offer a monthly Prenatal Breastfeeding Class alternating with Preparing for Baby class. All are open to the community.

We also hold a weekly tongue-tie clinic.

The Breastfeeding Dropin and the Tongue-tie clinic are both offered as resident horizontal and offers an excellent learning opportunity.

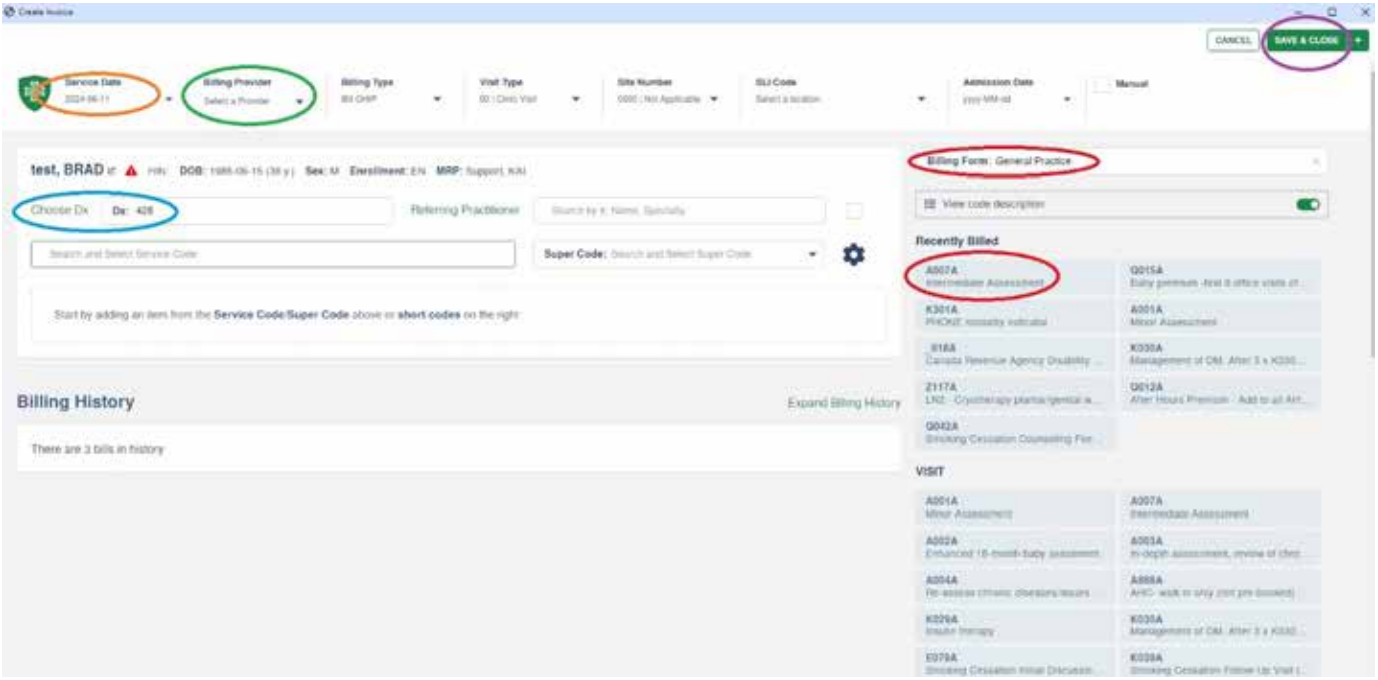
Well Baby Well Child Checks

This is a collaborative program that aims to support healthy development and well-being of children by early identification and intervention of physical, bio-psychosocial, communication and developmental disorders. The program involves a wide variety of staff at the QFHT: receptionists, nurses, NPs and residents. The program includes the "Enhanced 18-Month Well Baby Check." This visit is specifically focused on ensuring that toddlers are school-ready, meaning they have a level of self-regulation, are meeting speech milestones, have adequate nutrition and are preparing to become toilet trained. The program stresses the importance of early literacy and linkages in the community. It also seeks to build partnerships between parents, primary care providers and these resources.

Wound-Care Services: Jennifer Bouman, Lisa Lamont, Jessica MacLauchlan, Lynne McQuarrie, and Amy VanKoughnett, Advanced Wound Care RPNs

Trained in advanced wound care, these nurses offer wound care services to patients for whom there are no other service alternatives. Jennifer (ext. 73910), Lisa (ext. 73094), Lynne (ext. 73962), Amy (75889), and Jessica (75875) are available at 220 Bagot St.; Amy (73025) and Jessica (79342) work out of Haynes Hall. Referrals are sent through the "Consultations" module or via OSCAR message. Ankle-Brachial testing can be performed in special clinics offered monthly. Speak to your nurse if you would like to arrange testing on a non-urgent basis.

OVERVIEW OF DFM QFHT BILLING



Role of Residents in Billing

One of our goals at DFM is to help our residents learn about becoming skilled practising physicians and this includes learning how to bill. Residents are asked to bill for patients they see and, given that residents do not yet have a billing number, office encounters are billed under the physician supervising them. There are two purposes of billing serves: the first is reimbursement for work done to pay overhead and the second is to capture and track important work done even where no invoice has been issued for reimbursement. This includes tracking some preventions for annual billing or resident work done such as house calls done without a faculty member.

Four Types of Billing

1. Billing OHIP for reimbursement of services rendered to patients: remuneration is paid at rates determined bythe Ministry of Health (MoH) from the "Ontario Schedule of Benefits."
2. Billing patients for uninsured services: direct billing of those without OHIP or for services not covered by OHIP such as notes, cosmetic procedures, forms, or patients without OHIP.
3. Billing a "Third Party" such as UHIP, WSIB, Blue Cross or other provincial plans.
4. Billing zero dollar codes – $0.00 – that are used for tracking certain diseases or workloads

How to Bill

Once you have finished a SOAP note, you can access the billing module through the $ icon at the bottom right of the SOAP note. When you are in the billing module, the default page that opens is the one for general practice billing. There are other billing pages you may be using such as Third Party, UHIP, Procedures, Preventions, etc. You can access these other billing pages by clicking 'x' to the right of 'Billing Form', then the down arrow and then select the billing page of choice.

There are Four Steps to Billing:

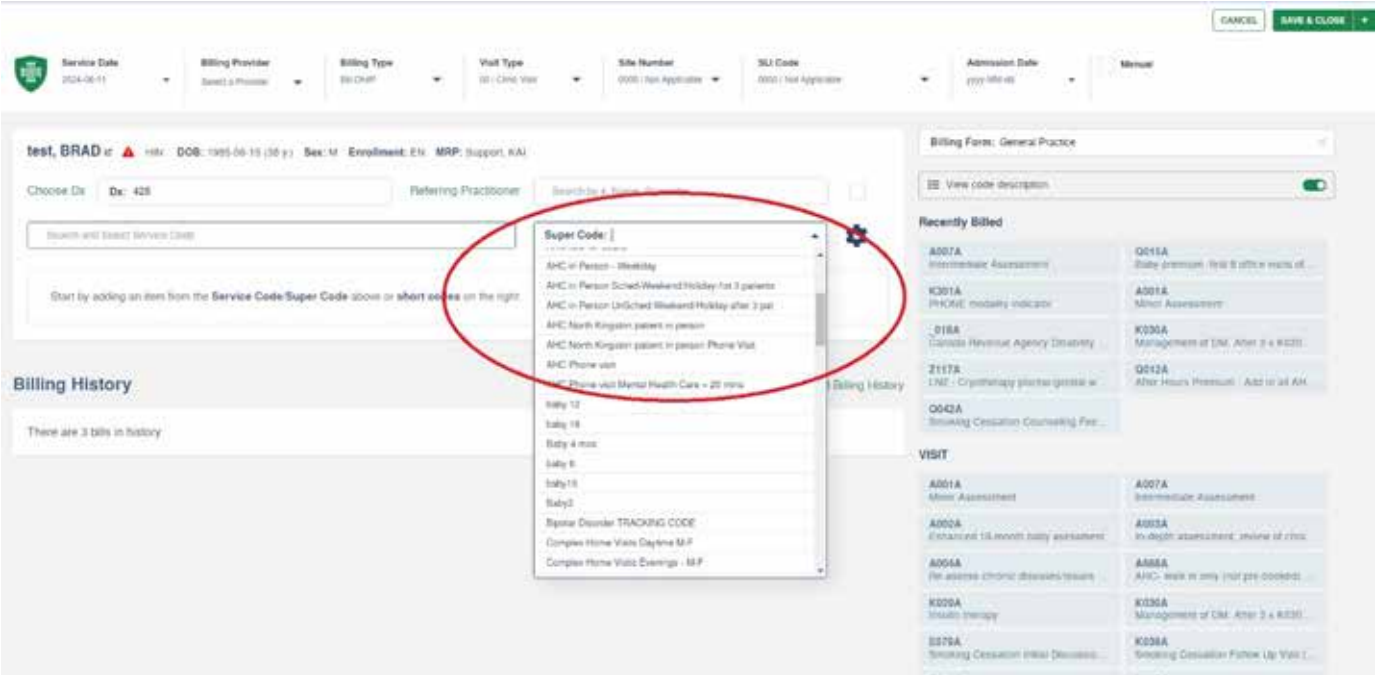
Step 1: Click ***What/which*** service code(s) performed under the Billing Form section (i.e. the billing codes, e.g. A007A = intermediate visit), or enter a description into the 'Search and Select Service Code' box

Step 2: Enter ***Why*** you billed it in the 'Choose Dx' box (i.e. the corresponding diagnosis code, e.g. 401 = hypertension)

Step 3: Enter ***Who*** you are billing on behalf of under Billing Provider section (the physician supervising you who has a billing number)

Step 4: Enter ***When*** and/or Where you are billing (usually you do not have to adjust this past the default for Service Date and Visit Type sections)

Step 5: Click '***Save and Close***'.



Advanced Billing Techniques

1. Time-based codes (e.g. K codes) or Out of Basket codes that are higher paying: e.g. Diabetes Codes

Some office visits should be billed based on time. These are called K codes. Generally, these are appointments where you are giving patients educational instruction on how to start certain medications, and mental health counselling visits. They are reimbursed on units of time, usually one or two units of time where each unit is 20 minutes. K codes are reimbursed at almost double the rate, so it is important to remember to use where appropriate. K007A or K005A are for counselling mental health visits and K013A is for medical counselling about lipids, weight loss, BP or osteoporosis.

To change the number of units for time-based entry, simply change the # after the dollar amount of the billing code you enter (e.g. change to 2 if you provide two units of time).

For diabetes visits, you can bill K030 up to four times per year. K030 is out of basket and should be preferentially billed for diabetes visits.

2. Add-ons

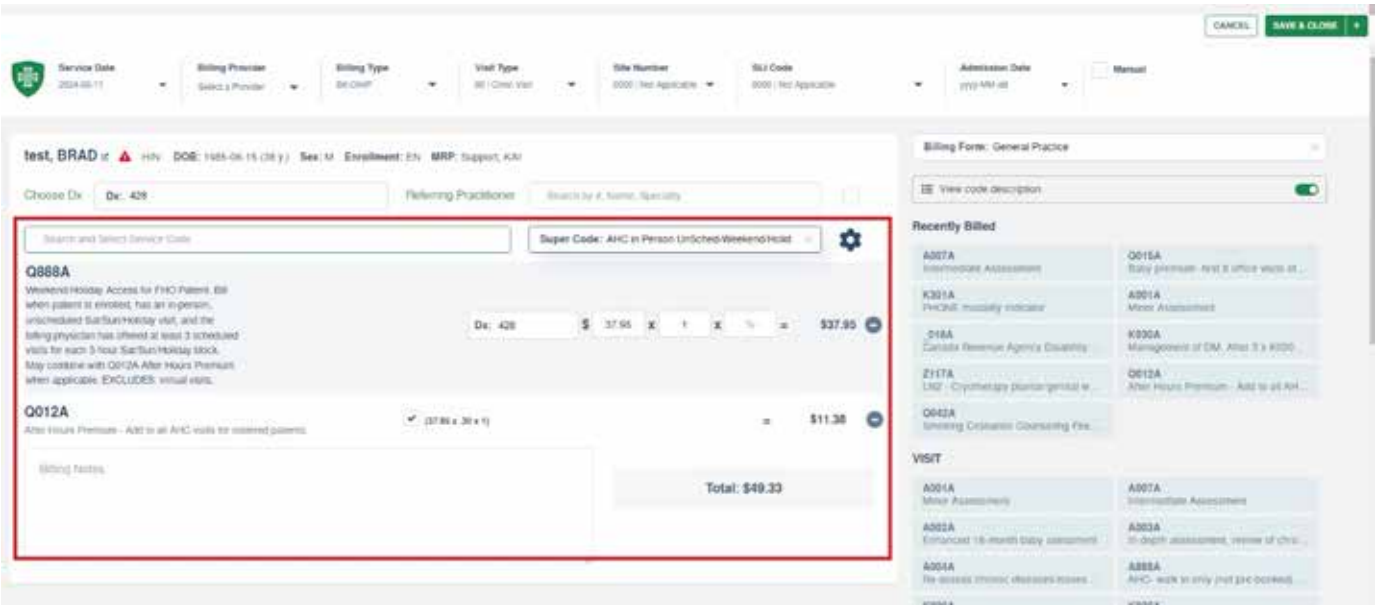
Some office visits cover extra ground or include other procedures for which OHIP has dedicated codes for reimbursement over and above the A007A or K005A. Examples of this would be pregnancy tests: G005A; point of care FOBT testing (not colon cancer screening kit): G004A; rapid strep tests: G014A; giving colon cancer stool kit: Q150A; glucometer: G002A; ECG: G310A/313A; pap & procedure trays, injections: G372A with visit, G373A without; immunizations, ear syringe: G420A per ear; and oximetry or Epley Otolith reposition: G403A. Verify with the nurse that either they bill it or you bill it, but make sure it does not get lost or duplicated. Smoking cessation initial counselling (E079A) and follow-up counselling (K039A + Q042A) can also be added to a basic encounter code. Remember to add the After Hours Premium to all encounters seen in After Hours Clinic (Q012A), a first post-hospital office visit premium (E080A) and newborn premium (Q015A), where applicable.

3. Supercodes: use them!

Super codes help make billing faster and more accurate. They have been pre-programmed to capture common encounters with multiple billing codes, as some billings can be complicated or done frequently in code bundles. Super codes automatically populate the billing form with the correct codes.

In the After Hours Clinic, always use the Super Code: AHC menu for all billing options, for example: AHC In Person – Weekday: will automatically populate A007A and Q012A (after hours premium) AHC In Person – Unscheduled-Weekend/Holiday: will automatically populate Q888A + Q012A

You then complete the billing process as you did with the other OHIP billings by ensuring the diagnostic code (why), the provider (who), where, etc., are there. Click



'save and close' the bill, which adds it to the billing clerk's queue to verify and submit to OHIP.

4. Billing Common Office Procedures

Many of these can be found on the "Procedures" Billing Form section. Remember to include a "tray fee" E542A to appropriate procedures when used.

5. Forms Reimbursed by OHIP

You will process two types of forms: those that are reimbursable from OHIP and other forms for which you will directly invoice the patient to pay. The following are the forms OHIP pays for and they are found in the OHIP Billable Forms section on the Billing Form field: Ministry of Transportation reporting - K035A, Long Term Care application - K038A, Homecare (CCAC) application - K070A, Ontario Disability application - K050A, Special diet form- K055A, etc.

6. OHIP Uninsured Services or Third Party Claims

Sometimes we provide medical services that OHIP does not reimburse us for, or a third party is invoiced such as UHIP (University insurance), another province or WSIB. This is called a "Third Party Claim" and is processed by printing out an invoice through the billing module and giving it to the patient and receptionist for payment onsite through a credit card or debit transaction. You generate these invoices through the list on various Billing Forms.

Examples of Third Party Claims are:

- Patient without insurance who pays out of pocket for services (e.g. a visitor from United States)
- Patient with UHIP or Quebec coverage
- Procedures not covered by OHIP (e.g. for removal of skin tags for cosmetic reasons, some cryotherapy, travel medicine, employment or school physicals)
- Steroid medications that we stock use at point of care that need to be replaced to cover our overhead and operating expenses • Forms for employment or school, insurance forms, disability tax credits

7. What are "Q codes" and when are they used?

Q codes are important "$0.00 codes" that are submitted to OHIP for tracking certain preventions such as immunizations and cancer screening and times when patients are to be excluded from some preventative interventions. For example, if a patient has a pap, mammogram or FIT, go to the billing form page called "Preventions/Exclusions" and click on the intervention (Q011A, Q131A, Q133A). Conversely, if a patient has indication to be excluded from pap, mammogram or FIT, click on the exclusion Q code on same page (Q140A, Q141A, Q142A). On the same page, you can also enter the Q code for a child who has completed his/her well-baby series at age 18 months to 30 months (Q132A). For a flu shot documented for a senior over 65 years old (either given by us, or recorded that it was given elsewhere like at a pharmacy), enter Q130A. Always double check the "Dx Registry" and make sure it is up to date for all your patients' chronic conditions. This allows for easy annual or monthly billing of certain conditions.

If you have any questions about billing, please contact

Scott Feddery at extension 76238.

ON CALL: THE AFTER HOURS CLINIC (AHC) AND ON CALL SHIFTS

Laura Wells	Program Resident Lead	dfm-progrelead@queensu.ca
Declan Mulligan	KTI Co-Lead Resident	dfm-reslead.kti@queensu.ca
Joanie Ouellette	KTI Co-Lead Resident	dfm-reslead.kti@queensu.ca
Alliance		1-888-556-6037

Two residents are on call: QFHT call and long-term care (LTC) (Providence Manor).

- QFHT call resident answers pages from QFHT and Kingston Community Health Centre (KCHC)
- LTC call resident answers pages only from Providence Manor Long-Term Care.
- Both are "home call" and both attend the after hours clinic.
- Note that OB pages are directed to the OB faculty and do not go through the residents.

Cell and personal pager numbers are collected at the beginning of the academic year and added to the contact list. It is your responsibility to ensure that the KTI co-lead knows of any changes, and these have been added to the contact list. Each resident must have a mobile "cell" phone. The LTC and QFHT call pages will be sent to your cell as brief text messages from Alliance or possibly from staff at Providence Manor. You will receive a text numeric code to confirm receipt. If you do not return that text, Alliance will call you directly. Attend to your text-pages, and send that confirmation-of-receipt code back in a timely manner. (Never more than 10 minutes.) Ensure your cell phone is fully charged prior to the scheduled call shift.

Call Schedule

The call schedule is made by the co-lead residents for the Kingston Thousand Islands (KTI) site. The co-leads will send the residents and the operations and risk management co-ordinator the next block's schedule two weeks prior to the end of the current block — this is mandated in the PARO agreement. These are then married up with the faculty schedule and the Master Schedule is then circulated to all clinic staff, residents, nursing home staff, and Alliance the last week of the month.

The Elentra website will have the latest version of the schedule. Please check this version to identify any potential conflicts and to learn more about with whom you'll be working. The CALL will also be visible to you in MetricAID and that will be considered the up-to-date source of all call.

IMPORTANT NOTE:
Call starts at 8 a.m. and lasts until the following 8 a.m.

Please check the schedule to see if you have been scheduled for an on-call shift on an already approved vacation day — if that happens please contact the site lead residents at dfm-reslead.kti@queensu.ca.

You can swap call shifts between each other. When you do so, please contact the following individuals if you make any call switches:

Any changes emailed to:

1) Alexis Hamilton (alexis.hamilton@queensu.ca)
2) dfm-teaching@queensu.ca
3) Jennifer MacDaid, who will update OSCAR (jennifer.macdaid@queensu.ca)
4) Attending/s (if the change is after the schedule has been published and sent out)
5) KTI Site Co-Leads (DFM-Reslead.KTI@queensu.ca)
6) Michelle Dupuis - if LTC (dupuism@providencecare.ca) - please also send LTC daytime coverage changes to this email

For same-day changes, please ALSO notify:

Jennifer MacDaid (jennifer.macdaid@queensu.ca), who will update OSCAR and Alexis Hamilton (alexis.hamilton@queensu.ca), who will update Metricaid

*QFHT Switchboard (+0 at QFHT) if cannot reach Jennifer MacDaid and Alliance (1-888-556-6037)

House Call Policy

Please be reminded of a very important policy regarding residents conducting house calls.

During block time in community-based practices, residents may be required to attend patients in doctors' offices or patients' homes. No home visit should be made or expected unless the resident feels totally assured of safety.

For **DAYTIME** home visits: residents may attend home visits on their own, even if they have not been to that particular patient's home with a supervisor before, if the following three conditions are met:

1) The resident has had an orientation to home visits and has been on at least one home visit with a supervisor. If you are on call over a weekend, you must contact the staff physician during the day on Friday.
2) The supervisor has been to the home and feels it is safe.
3) The resident feels safe going alone.

For **AFTER HOURS** home and clinic visits: residents must be accompanied by a supervisor.

OF NOTE:

*This is to maximize resident home visit learning opportunities, as well as patient care.

*This policy applies to visits to private residences. Although visits to care facilities (e.g., nursing homes, group homes, retirement homes, and long-term care facilities) also require being alert and observant to your environment, the presence of other health- care personnel at the facility may mean a resident may make a first-time visit independently after discussion with a supervisor.

Communication with Your Supervising Faculty Physician

When you are on call, you should touch base with your supervising faculty physician at the beginning of the day. This is partly a matter of professional courtesy; however, you also need to confirm with that faculty member exactly how and when they wish to be contacted about issues. Doing it early in the day ensures you know how to reach them should you be required (e.g., to contact or attend to a patient over the lunch hour on a weekday). If you are on QFHT call on a weekday, it is generally fine to simply contact your supervising physician via email, as you will be meeting them that night in the AHC as well. There are two particular situations when it is essential that you contact your supervising physician in advance, and this should be done verbally (i.e., in person or over the phone):

1. If you are on call over a weekend, you must contact the staff physician during the day on Friday, as there is no AHC that night, but you may still be paged that night.
2. If you are on LTC (Providence Manor) call and the LTC supervising physician is not the staff physician covering the AHC, you must contact the LTC supervising physician before the AHC starts, as you will not be meeting them at the AHC that night.

Report to the QFHT faculty and the LTC faculty. There is another faculty on the list, "2nd Call Faculty. This faculty is for the QFHT faculty to contact in such situations as illness, needing to be called to a delivery, or other reasons. This role is solely for the QFHT 1st Call Faculty to communicate with. There is nothing you need to do with the 2nd Call Faculty unless you have been directed to do so.

On Call Phone Calls

Call starts at 8 a.m. and lasts until the following 8 a.m. This includes the lunchtime period. You may receive text pages during the day, but patients usually call their

doctor's office directly during office hours. You are, however, responsible for pages that come in during the day, and there are times when members of QFHT staff need to reach the on-call physician, so make sure your phone and pager are with you at all times.

Alliance is our pager answering service. When a patient phones into our office after hours, the phones are directed to Alliance.

When on call, Alliance will enter patient demographics into the pager. Clarify with the calling patient who their Most Responsible Physician (MRP) is. (Sometimes they get it wrong, and you don't have to take that call. In this situation, please remind them that the MD is not in our call group.) Please note that we DO take calls regarding Kingston Community Health Centre patients. KCHC physician faculty are in our faculty call group.

All calls and plans must be documented. This is a basic medico-legal standard of care. Make sure you record the name of the patient. Make the entry in the patient's EMR, not necessarily the same as the caller. Do not record information under the caller. For example, the mother or partner often calls, but make sure the patient is known, open their EMR, and document the encounter in their EMR. This includes calls received during the AHC time period — i.e., not just those received outside of the actual AHC clinical hours. You must also ensure that your supervising faculty member is aware of any plans or recommendations you've made.

QFHT Call – Documentation of Telephone Triage

- For QFHT patients: These entries are to be made directly into our EMR right away. Once you have completed the note, you must send an OSCAR message to (a) the patient's doctor, (b) the patient's team nurse, (c) the patient's MRR, and (d) your supervising physician to inform them of the EMR entry.
- KCHC patients must also have entries made. If they have an existing chart in OSCAR (please check both active and inactive charts), enter it there. If they do not have a chart, create one in OSCAR as follows:
  1. From the Appointment screen, click on the "SEARCH" tab.
  2. Click on the link "Create a new Demographic."
  3. Fill in the patient's information and click "Add Record."
  4. You MUST, at minimum, fill in the following fields: First Name, Last Name, and Date of Birth.

It is imperative that a copy of these notes be sent over to KCHC. If possible, please print off the note and leave it for the Haynes Hall second-floor clerk to fax

QFHT Billing Numbers		
Barber	David	021362
Bayoumi	Imaan	055327
Beattie	Erin	026338
Bigelow	Stephanie	047165
Borins	Carolyn	010844
Braidwood	Mark	044562
Delva	Dianne	215707
Funnell	Sarah	033655
Geddes	John	188714
Green	Michael	010293
Greenfield	Julia	045192
Griffith	Lindsey	036718
Haffey	Sean	045687
Hall Barber	Karen	012201
Howse	Kelly	024285
Kalra	Sameer	043788
Kirwan	Chris	047223
Kroeker	Laura	038363
Kysela	Alenia	012777
Li	Jiwie	047815
McNally	Ed	030896
Pope	Jennifer	031447
Purkey	Eva	018765
Sempowski	Ian	130625
Simpson	Matt	023534
Stephenson	Christy	043519
Surmawala	Ambreen	047089
Thomson	Ian	046348
Train	Anthony	039790
Tranmer	Jennifer	046783
Watson	Shayna	200295
Webb	Katie	023086
Zlepnig	Jennifer	048648
KCHC Physicians		
Falardeau	Brandi	032701
Garg	Anirudha	046865
Kinghorn	April	033855
Patel	Rupa	010182
Rowland	Mary	018241

to KCHC, or if you're off-site, please contact switchboard to have the note faxed over. In addition, there is a nurse available at KCHC to take any calls during the day. The "back-door" phone number is 613-542- 7699. The regular clinic number is 613-542-2949. Please identify yourself as "Dr. X" to be put through to the MD in clinic. The MDs are usually in by 9 a.m. Any urgent issues should be handed over by speaking directly to the MD working the next day. There is always either an NP or an MD at clinic and they can take calls. If the issue does not need direct verbal handover, the nurses can take the call and the message.

QFHT Call — Accessing Patient Lab Results While on Call

Sometimes, you may be fielding phone calls that require you to access patient lab results directly from our usual lab vendor, LifeLabs. To get patient results over the phone, call LifeLabs at 1-877-849-3637. To verify your identity and provide authorization to LifeLabs to release the information, you will be required to provide the billing number of the staff physician to whom the patient is rostered. (Billing numbers are listed on this page.)

Providence Manor/LTC Call

The LTC call resident answers pages from Providence Manor Long-Term Care. The faculty member on call with you is often different than the faculty member on call with the QFHT call resident. Please refer to the Master Call schedule on MetricAID for an up-to-date listing of the call schedule, including which faculty members are on call. Please remember that before call starts (i.e., before the start of the AHC) you are responsible for touching base with the faculty member covering long-term care. More comprehensive details about the duties of the LTC call resident are reviewed at the long-term care orientation.

If you are also in AHC, you may be called by the nursing staff of Providence Manor with a request to assess a patient. You would never make a plan to leave the AHC without first confirming with the AHC faculty physician as to the prioritization of the AHC patients vs the Providence Manor patient. You will rarely need to leave during the AHC, as anything that urgent would likely require the patient to be "sent out." You should anticipate that you will almost always manage these visits by going to Providence Manor at the end of the AHC.

When you are called about a patient at Providence Manor, please confirm that the patient's attending physician is within our call group. On occasion, nurses at Providence will ask about patients who are not in the group of physicians' patients with whom we share call duties. In these cases, please direct the nurses to contact the patient's MRP.

After Hours Clinic (AHC)

While call runs from 8 a.m. to 8 a.m., the AHC runs Monday to Thursday, 5 p.m. to 8 p.m.; Saturday, 9 a.m. to 12 p.m. and 1 p.m. to 4 p.m.; and Sunday 9 a.m. to 12 p.m. It is imperative that the AHC starts on time; arriving at the AHC on time takes priority over charting from the daytime clinics. When you're on call, please also double check to ensure your schedule has been blocked at 4 p.m. stating ON CALL to allow you time for dinner, finishing up any charts, etc. Ideally, you should be there for the huddle with the nurses / receptionists by 4:50 p.m. / 12:50 p.m. Arrive no later than 4:55 p.m. and 12:55 p.m.

Your level of independence in the AHC might not be exactly the same as in your home team because the supervising physicians have likely not previously observed your style and skill level. Therefore, clarify with your on-call supervisor at the start of the AHC how they would like you to proceed (e.g., see patients totally independently unless you have questions vs reviewing all patients before they are discharged, or a hybrid).

There are often one or two medical students in the AHC. These students will be shadowing you and very much appreciate the resident teaching that occurs. This is one of your teaching opportunities during this rotation. The faculty member on call is expected to fill out a field note for you during each AHC. Remind them to comment on your teaching, as well as your clinical care.

General AHC Clinic Flow

- Generally speaking, the residents run the AHC. Patients are to be seen by the residents, and the faculty member is there in a supervisory capacity. The faculty member and the nurse will triage patients according to need; it is not a "first come, first served" clinic.
- Time management is very important in the AHC. Be mindful of patients waiting and document with skeleton notes as you go. Finish your SOAP notes and billing after all the patients have been seen.
- If there are medical students in the AHC, this is a great opportunity for you to teach. Each student is to be paired with a resident. To ensure patients are not telling their story to a student, and then a resident and then again to a faculty member, it is best to work as a duo and go see the patient with the student. Direct the student to take the history and do the physical exam as far as they can (be mindful that these are often first-year medical students) while you type the SOAP note and take over when the student runs out of questions.
- The Ministry of Health requires family health teams to have appointments available for patients after hours for all types of problems. For this reason, you will see

that there are pre-booked appointments in every after hours clinic and that sometimes some "non-urgent" requests are made. All types of visit requests are to be accommodated in the AHC, at the discretion of the MRP running the AHC. We do our best to safely accommodate patients' needs in the AHC in this regard.

- Remind yourself of our controlled substance policy, which says that medication that is prescribed for chronic, non-malignant pain (CNMP) can only be refilled during daytime home-team office visits and not in the AHC. THIS DOES NOT APPLY TO PALLIATIVE PATIENTS OR ACUTE PAIN.
- We share call with KCHC. When their patients are seen in our AHC, the EMR note needs to be printed out and the clinic clerk/AHC assistant will fax it to KCHC.
- During evening clinics: LifeLabs will pick up specimens, Monday to Thursday at 6 p.m. There is also a weekend pickup on Sunday morning at 11:20 a.m. Please refer to the weekend lab-specific pickup process in the Labs section of this handbook.
- Specimens: Label the specimen, fill out the requisition, and place in plastic bag. Urines go in refrigerator lab pickup spot. Swabs and other specimens go in lab pickup spot on counter. If urine will be >24 hours, put it in red containers with preservative.
- On-call residents and faculty members are to ensure that all AHC staff members leave the clinic and exam rooms clean and tidy. Discard all garbage and remove all food items.
- Last person to leave: Check that the office doors are closed prior to leaving.

Please remember that the team NURSE is THE key person for a team in terms of communication and handover. If something is really important, you should tell that team's residents and the proper MD, but the NURSE MUST KNOW ALL, as they are the people who are there daily.

On-Call Resident Meal Break

Residents who have an afternoon clinic the same day as being on call in the AHC must co-ordinate their time so they have time to eat prior to the start of the AHC. Receptionists will try to block their residents who are on call, starting at 4 p.m., as per the first version of each month's call schedule. This blocking will clearly state "Do not book, ON CALL." Please check to see that this has been blocked off in your schedule. All staff will endeavour to protect this block. Residents who change their assigned call are to work with the receptionist to see if bookings can be reassigned to others in clinic so patients do not have to be called and rebooked. Call switches may result in the resident not having a protected dinner hour.

It is a good idea to scan the schedule ahead of time to make sure you are blocked out appropriately. Note that arriving at the AHC on time takes priority over charting from the daytime clinics. If you have incomplete charts, this must wait until after the AHC.

Medical Certificates of Death (MCOD)

Medical Certificates of Death (MCoD) is documentation of the identity of the deceased, date and location of death, and, most importantly, the cause of death. In Ontario, only an MD or an RN-EC can complete this. It is a legal document that must be completed on the official form issued by the province — an official "Form 16." These forms are at QFHT reception/switchboard. The forms must be completed in blue or black ink and be legible, accurate, and completed in a timely fashion. The forms are required for a burial permit, to settle estate insurance, and to commence pension settlements.

An MCoD is a key document used for provincial and federal Mortality Statistics (Vital Statistics Act) and as such must be completed accurately. In aggregate these documents are used for vital population statistics. "It may truthfully be said that virtually every large-scale problem in preventative medicine has been brought to light — in part at least — by statistics of death" (United Nations handbook of Vital Statistics Methods, 1955). Importantly, completion of this document is the final legal document about a patient and is our legislated professional duty:

21. (1) The death of every person who dies in Ontario shall be registered in accordance with the regulations. 1994, c. 27, s. 102 (17).

35. (2) Subject to subsections (3) and (4), any legally qualified medical practitioner who has been in attendance during the last illness of a deceased person or who has sufficient knowledge of the last illness shall immediately after the death complete and sign a medical certificate of death in the form approved by the Registrar General, stating the cause of death according to the classification of diseases adopted by reference in section 70, and shall deliver the medical certificate to the funeral director. O. Reg. 68/09, s. 2.

Practically speaking, an MCoD should be completed at time and place of death. However, should a death occur in the middle of the night, or in the middle of a clinic day, the decedent may be released to the funeral home prior to the MCoD being completed if you are willing to go to the funeral home at the end of clinic or first thing in the morning to complete it. Funeral homes may tell you otherwise, but the local coroner has indicated that this is legally permissible.

The MCoD is the last document completed for a person and, as such, attending to this form must be done with

professionalism and dignity.

Completing much of the form is self-explanatory. The top section asks for information about the deceased. The next sections, Cause of Death, Parts I and II, call for more attention to detail.

Cause of Death - Part 1

The underlying cause of death is defined by the World Health Organization (WHO) as the disease or injury that initiated the train of morbid events leading directly or indirectly to death. If the certificate has been completed properly, the condition reported alone on the lowest completed line of Part I will:

- Have caused all of the conditions on the lines above it
- Have the longest duration
- Be the diagnosis of a terminal illness made by a medical practitioner

Example for Part I

A 65-year-old male presents with chest pain in long-term-care facility, then has a witnessed cardiac arrest and a brief resuscitation, ultimately dying in the nursing home:

Cause of Death, Part I:

(a) Atherosclerotic Heart Disease

Or

Part I: (a) Acute Myocardial Infarction

(b) Atherosclerotic Heart Disease

Part II: Diabetes Mellitus

Cause of Death – Part II

This section asks for a listing of significant contributing factors. These are conditions that did not cause death but helped or made the person more likely to succumb. Some examples may include diabetes in infectious disease, smoking in setting of coronary artery disease, or intravenous drug abuse with HIV infection.

If a condition is not relevant to the death, leave it out of Part II. Avoid the urge to put all of past medical history in here.

When completing the MCoD:

- Do not use medical abbreviations, as they can have multiple meanings and may be misinterpreted.
- Record all entries in a legible manner in blue or black ink. Illegible entries will be returned to you for correction.
- Qualifying expressions such as apparently, presumably, possibly, etc., will not be accepted.
- Avoid reported organ or (multi) system failure alone. Failure of most organs must be due to an underlying disease or condition. If an organ or system failure is listed as an immediate cause of death, always report its etiology on the line(s) beneath.
- Modes of dying should not be entered as the sole entry in Part I or used as the underlying cause of death, including terms such as cardiac arrest, respiratory arrest, hypoxia, asphyxia, syncope, shock, etc.
- Avoid vague statements such as cardiovascular event, debility, or frailty.

IMPORTANT POLICIES TO KNOW DURING YOUR FIRST YEAR AT QFHT:

GIVING VACCINES AND INJECTIONS

- Errors from mistakes occurring related to administering immunizations and injections are the number one "critical incident' at QFHT.
- Nurses are experts in injections and immunizations.
- DO NOT GIVE ANY IMMUNIZATIONS WITHOUT A NURSE AT YOUR SIDE UNTIL YOU HAVE BEEN GIVEN THE OK TO DO SO.
- After you give approximately five injections with a nurse signing off on the vaccine readiness sign-off form, you may give vaccines independently provided the nurse is present when vaccines are removed from the vaccine refrigerator.

SAFETY:

- After all procedures, you must check the trays for sharps, remove all sharps and place in sharps disposal boxes, and have another person inspect the tray for verification. Once two people are certain that no sharps remain, affix a sticker that says, "Sharps check has been conducted." This step may seem redundant, but you may be surprised by the number of phone calls we get from our autoclaving service that sharps were missed and needle stick risk was present for their workers processing our trays.
- Refer to the House Call Policy on Page 36.

NARCOTICS:

- After Hours Clinic: Narcotics are never refilled in the AHC or on-call for patients with chronic non-malignant pain (CNMP); they are only to be managed by daytime, home-team doctor.
- Palliative: Always refill or prescribe narcotics for palliative situations/acute pain situations.
- Contracts: Outline of "the rules:" one pharmacy, one prescriber, random urine testing upon request, no refills after regular daytime clinic hours including in after hours clinic, and no dose increase.

Note: Patients with CNMP should have a narcotic contract signed and scanned into their chart. If you notice it's not on file, print it out from eform and go through it with the patient and scan it into the chart.

PATIENT SAFETY AND CRITICAL INCIDENTS:

- Tell us! We want to hear about mistakes that happen and near misses such as vaccines that were incorrectly given, medication errors, etc. Critical Incident forms are located in the DFM Shared Drive and on your desktop.
- Non-Punitive: These cases are not uploaded to your education portfolio. We work to create a culture of safety for patients and staff; people must feel comfortable bringing forth errors, mistakes, near misses, and hazards, etc.
- Vaccines/injections are our number-one type of critical incident. Therefore, they are ONLY TO BE GIVEN WITH A NURSE AT YOUR SIDE.
- Patient-Confidential Drive: On your desktop is a link to the Patient-Confidential drive (Z drive). You may store patient-related information in this space, including any project-related data. Contact Terry Black (IT co-ordinator) if you require access to a particular folder.

SAFETY IN THE CLINIC

The Department of Family Medicine and the Queen's Family Health Team take safety – in terms of our staff, faculty and residents, as well as our patients – very seriously. As a valued member of our team, you are a critical component of our approach to patient and staff safety. If you have any concerns regarding an actual incident, a near miss, or something that could potentially become an issue, please speak to your supervisor, our operations and risk management co-ordinator, or a member of the management team. Our approach to safety is based on the principles of a just culture and an internal responsibility system. Our approach is non-punitive and is focused on supporting the people involved, understanding what happened and learning what we can so that it doesn't happen again. We can only address and prevent issues if we are aware of them – please talk to us!

Confidentiality at QFHT

You have signed confidentiality agreements with QFHT and we would like to take a moment to underscore the importance of this topic. Over and above the imperative of patient privacy and confidentiality, there are provincial laws that have recently been passed that emphasis the importance of attending to patient confidentiality as they include severe penalties for breaches in confidentiality. Recent Personal Health Information Protection Act (PHIPA) law changes include the following:

- It is now mandatory to report health information breaches to the Information and Privacy Commissioner as well as to professional medical colleges.
- Privacy violation fines have doubled – individuals can be fined up to $100,000 and health-care facilities up to $500,000.
- Personal prosecutions are now allowable for privacy violations. For example, two health-care workers who snooped into (former Toronto Mayor) Rob Ford's medical chart were fined and charged for their violations.
- QFHT employees have been terminated for inappropriately accessing patient charts in OSCAR or Mysis/PCS.

Health-care workers must be able to explain why their digital fingerprints are in each chart. To this point, QFHT conducts routine audits of privacy surveillance. Please be aware that you are only permitted to electronically enter charts of patients for which you have a clinical reason to review. Details are as follows:

- Do not look at any charts for which you are not in the circle of care. Do not browse charts of famous people, fellow employees, family members or your own chart.
- Do not discuss cases outside of the circle of care.
- Patient information should never leave the premises of QFHT, including thumb drives, paper with patient information on it, email files or excel spreadsheets on laptops.
- Care must be taken when accessing OSCAR or Mysis/PCS remotely such that those not in the circle of care cannot see patient information. For example, do not access patient files remotely from public places, or in areas where others can see confidential patient information on your laptop.
- Paper documents with patient information must be recycled in the bin in your team room that is for confidential shredding.
- The Patient-Confidential drive (Z drive) may be used to store any files that contain patient information.

Incident Reporting

Incident reporting is important to ensuring quality patient care and providing a safe environment. Categories of incidents include documentation errors, health/safety hazards, stick/splash injury, falls, equipment failures, medication errors, procedural errors and patient concerns. All such incidents – even if you're not sure if it's an actual incident – should be recorded on an

incident form and forwarded to our operations and risk management co-ordinator. Critical incidents should be reported immediately to a supervising physician or team member. Incident reporting forms can be found in the appendices of this handbook, on the shared drive, on the desktop or from our operations and risk management co-ordinator. In the event of a stick or splash incident, note that we have an agreement with Hotel Dieu Occupational Health and Safety, who will take over your care once notified of the event.

Scenario 1:

You provide an immunization and realize afterward that the incorrect dose or vaccine was given. This incident should be reported via an incident report and reported to your preceptor so you can review any necessary clinical issues and disclose the incident to the patient.

Scenario 2:

You are reviewing a patient chart and come across another patient's consult note from a specialist. As this has the potential to do harm and requires steps for correction, it should be noted on an incident report. Also, if it is a document, please contact your receptionist, who can ensure that the document is removed from the incorrect chart and added to the correct one.

Incident forms will be reviewed by our operations and risk management co-ordinator, appropriate team members, the broader management group and appropriate committees. On occasion, we review the learnings from these incidents back to the general clinic through regular team de-briefs.

Personal Protection

- All residents are encouraged to wear personal protective equipment in clinical situations where there is a risk of stick or splash injuries (e.g. procedure clinic). Gloves, shields and eye protection are readily available in your clinics. Eye wash stations are available at both Haynes Hall and 220 Bagot St.
- Familiarize yourself with the location of the fixed panic buttons in your clinic's reception area, as well as the remote panic buttons located in each physician team room. As well, two portable panic buttons – at the front desk – are available to residents, faculty and staff working in the regular and after-hours clinics. When activated, these buttons will alert City Police as well as Security. Clinic phones display stickers with extensions to contact Security directly. For potentially life-threatening events, call 911.
- Residents are encouraged to use the *67 telephone function when calling patients from their personal phones. This blocking feature will reduce your chance of vulnerability by keeping your phone number private and preventing you from receiving inappropriate calls.
- Please ensure that you dispose of sharps, scissors, scalpels, etc., in appropriate sharps containers in the clinics. Others are at significant risk if sharps are left in the open or in inappropriate containers.
- Refer to the House Call Policy on Page 36.

Safety Outside of Regular Work Hours

- Faculty will accompany learners if a patient assessment is required after hours in the clinics. If access to the clinics is required to retrieve information or to do work, please remember that your safety is paramount. Residents and FMC faculty can contact security as directed below if they feel they need it.
  - o Hospital Security staff are available to escort someone to the FMC after hours if needed. That person would need to have identification and keys to access areas within the building. Security staff members are readily available in the hospital and most often found in the emergency department area. Please call the central hospital Security office at 613-548-3232, Ext 4142, for assistance.
  - o Queen's Security is available to assist staff working at Haynes Hall. To reach them, please call their emergency line at 613-533-6111. To arrange an escort to Haynes Hall (or another location on campus), please call 613-533-6080. Those wishing assistance would need to have identification available.
  - o Further information on being safe during off-site visits can be found in the QFHT Offsite Clinical Visit Policy on the DFM shared drive in the Policies-Medical Directives folder.

Emergency Situations

- For fire and medical emergencies, all staff members are instructed to call 911. There is a paging system whereby in-house medical emergencies are broadcast and staff, physicians and residents will respond to the appropriate area of the emergency. AED machines have been installed at 220 Bagot and Haynes Hall, so please be aware of their locations. Emergency equipment bags are available and are located in the clean utility rooms within the clinic.
- In the event of a fire or other emergency requiring evacuation, you are asked to assist with patient evacuation as appropriate, close all doors nearest to you and proceed with evacuation via stairways , do not use the elevators. All are asked to wait with staff outside the building so we can ensure you have safely left the building.

*The resident travel safety policy is posted in the resident policies section of Elentra.

IT Information

Contact Terry Black or Kent Hamilton at DFM-ITHelp@queensu.ca with any IT-related questions , Monday to Friday 8:30am to 4:30pm (setup of user devices, Oscar issues, IT issues).

You will need:

Computer

- The latest OS and be patched monthly. Currently that is Windows 10/11 build 23H2 or MAC OS Sonoma (14.4.1).
- An up-to-date antivirus that gets daily updates (example Windows defender)
- Camera with good-quality picture
- Zoom video conference software (https://zoom.us then Resources and Download)
- Microphone and speakers or headset that does not crackle or make noise when used
- Wi-Fi is required if you bring it into the office to use. Wi-Fi Name: QueensU-Secure — use your NETID and password to log in
- Internet at your home needs to be a minimum of 20Mbps for video to work seamlessly. If you have more than one person in the home using it, you may need faster speeds. To test your internet: https://www.speedtest.net/

Mobile Phone

- While at DFM you will require a smart phone. To remotely access your DFM desktop you will be required to install an app on your phone for two-factor authentication. If your smart phone is too old to install the app, you will need a new one.
- Your iPhone needs to be version 15 or later and Android 12. You are required to keep your phone patched and up to date with the vendor.
- You are required to have a pin on your phone and a screen lock after inactivity; five minutes is recommended.
- If your phone does not have unlimited minutes, you may need to load a free Wi-Fi phone app like Fongo on your cell. It will also load on iPods as long as they have a microphone. Fongo will give you a Kingston phone number and allows unlimited calling, voicemail, and texting. Just go to your app store on your phone and search for Fongo and load Fongo — talk and text. If you don't see the app your phone may be too old to run the app and you would have to upgrade your phone.

NetID Activation

- NetID Profile Manager: Netid.queensu.ca
- Your NetID is your main email account for Queen's
- You will use it to log in to the terminals, Queen's email and O365
- You can select an alias at netid.queensu.ca

DFM Computer Environment

- Virtual desktops
- Two-factor authentication from off site
- Locked down and secure
- Only approved apps are installed
- DO NOT SELECT HIDE YOURSELF IN THE Global Address List (GAL). If you do you will not get required emails sent to the distribution lists.

Remote Access to DFM

- Instructions will be provided
- Access will be provided July 2, 2024
- Access will be removed June 30, 2025

Imprivata Tap and Go Access

- Terminals in the clinic have fob access
- Still need to enter your password at the beginning of your shift
- Once logged in, tap and the computer will disconnect. In the next room, tap again and it will connect back to desktop.
- Press F4 or blue power button if tap doesn't work to disconnect

OSCAR Access

- Oscar access is a separate login name due to security restrictions
- Requirements are username, password and two-factor authorization using Google Authentication (recommended) or SMS
- Only accessible from DFM virtual desktop

Queen's Email & Office 365

- Queen's email is netid@queensu.ca
- To log in, go to www.queensu.ca, select "Search and Sign In" then choose Office 365
- Enter netid@queensu.ca and your password
- You can select an alias at netid.queensu.ca
- O365 apps like OneDrive, Office suite also available online
- You will be required to enable multifactor authentication on your email
- Do not hide your name from the Global Address List (GAL)

Remote Access to KHSC

- Support handled by KGH, including password resets
- Contact: 613-549-6666, Ext 4357

OTN Access Instructions

Refer to the detailed instructions at the end of this handbook.

OLIS Search Instructions

Refer to the detailed instructions at the end of this handbook.

MetricAid

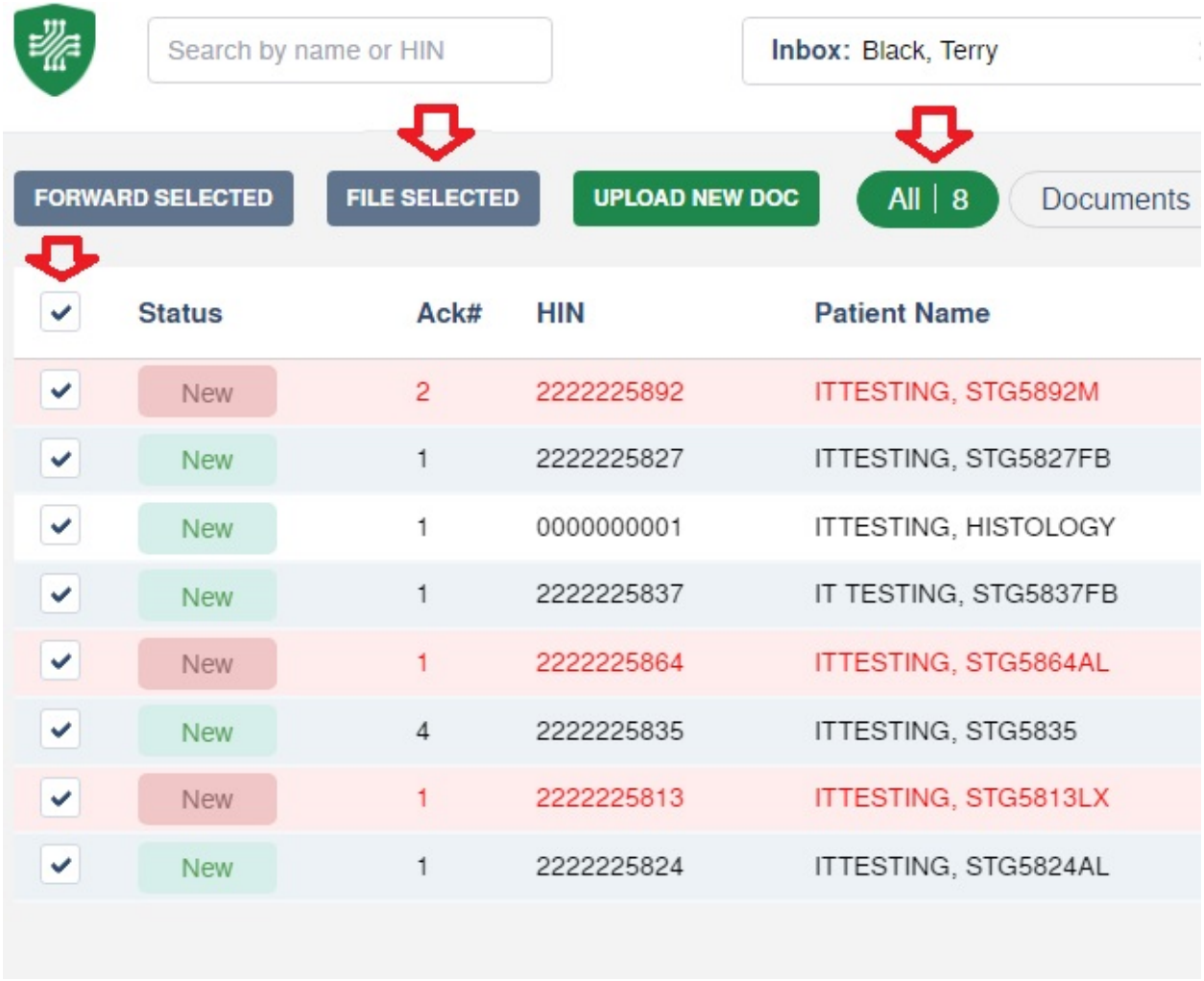
MetricAid is a scheduling application where your call schedule will be hosted. You can view the schedule on a web browser, on the MetricAid mobile app, or in Outlook by subscribing to your MetricAid calendar. MetricAid also allows cross-schedule viewing so that faculty can view the resident call schedule.

Mass Filing Inbox

How to bulk file your inbox:
Open your inbox and click on the box beside status to select all items. A check will now show up in all the the boxes below.

Now click file selected button at top left and they will file.

Note make sure the All button is selected (it is usually done by default)



Checklist

Core Orientation Checklist – Reception

Please review these items with the new residents. You may find it helpful to re-visit this list after they have had time to learn about Oscar and adjust to the flow of clinic.

- ❑ Role of receptionists, referral clerks, and medical records clerks, including whom to contact for specific requests and where to direct certain forms (e.g., XR vs. U/S reqs, records request forms, blood work reqs, completed insurance forms, etc.)
- ❑ Show residents where to find your clinic ext. and email address; let them know what the clinic email is used for
- ❑ Overview of appointment types (follow-up visits, driver's physicals, injections, biopsies, etc.), and how they should be booked, including joint with staff physicians and length of appointment
- ❑ Review having patients book follow-up when they leave an appointment by providing patient with appointment slip (e.g.: circle number of weeks/ months for patient to return, add which physician it should be booked with, ask patient to bring card to reception on their way out to book appointment) BE CONSCIOUS OF WAIT TIMES.
- ❑ How and when to request records from external providers, including hospitals, specialists, and previous physicians
- ❑ Review uninsured services, including when to charge a patient for notes, prescriptions, forms, and services, and how to create a third-party invoice
- ❑ How to report a resident absence or delay (sick line phone number, email preceptors/staff)
- ❑ Comparing Oscar and RSS schedules and notifying reception of any conflicts as soon as possible
- ❑ OB assignments: Seeing patients in the home team vs. the OB preceptor's team
- ❑ Check DFM email while off cycle
- ❑ Review that lab requisition efaxes can take up to three days to process into the LifeLabs system; reqs can be directly emailed or mailed to patients if necessary
- ❑ Notify reception of new controlled substance forms; have forms scanned
- ❑ Document all phone calls, no matter what! Even if you did not leave a voicemail, many patients will see our number on caller ID and call the office for an explanation
- ❑ Vacation days – PLEASE REMIND RESIDENTS TO NOTIFY RECEPTION OF ANY TIME OFF WELL IN ADVANCE
- ❑ How to use the fax machine, photocopier, and where to find extra paper

Core Orientation Checklist – Nursing

During orientation for residents and other learners, you will have a few scheduled periods of time when you can work through this tick sheet as slowly or as quickly as you think appropriate.

- ❑ Intro to team and the role of the nurse
- ❑ PPE requirement for working in clinics and location of PPE storage areas
- ❑ Review of vitals and intake policy and of the vital sign equipment and their location
- ❑ If the resident takes vital signs, enter vitals on the intake form
- ❑ Review of the intake form including where to document smoking cessation "ask" and "advise" rates.
- ❑ ROOM YOUR PATIENTS DURING BUSY PERIODS OR WHEN THE NURSE IS BUSY.
- ❑ Review of controlled substance policy
- ❑ Review of the Infection Prevention and Control Policies
- ❑ Review of the Inspection of Reusable Procedure Trays Policy and the sharps check stickers' procedure
- ❑ Location of the emergency equipment: red bags, O2 tank, suction, AED and eye wash station, and urgent-care cards, and locations of the panic buttons

- ❑ ECG and Ultrasound probe — location
- ❑ Exam room setup
- ❑ Clean and soiled utility rooms — equipment returns and laundry
- ❑ Labelling of specimens (specimens are labelled before they leave the exam room)
- ❑ Where to put labs awaiting pickup — in basket and fridge
- ❑ Timing of lab pickup
- ❑ Reminder of adding patient labels on requisitions if not printed from EMR
- ❑ Stock medications available in medication room
- ❑ Precautions to be taken when handling / reconstituting / administering / disposing of / managing spill cleanups of medications / biologics that are considered hazardous according to policy Safe Handling and Disposal of Drugs / Biologics
- ❑ Immunization refrigerators; publicly funded immunization schedule for Ontario.
- ❑ Urine testing, rapid strep, pregnancy test, fecal occult blood testing kits
- ❑ Glucometer kits
- ❑ Phlebotomy kits
- ❑ Home visit bags

Core Orientation Checklist – EMR

- ❑ Review of scheduling/calendar view
  - ❍ Booking templates
  - ❍ "E B M Rx"
  - ❍ Tabs at the top of the screen
  - ❍ Intake form
  - ❍ Colours and icons (e.g. *,#,! and hazard sign)
- ❑ Review of the E-Chart
  - ❍ Preventions & immunizations
  - ❍ E-forms – don't forget to save!
  - ❍ Rourke
  - ❍ Forms – how to find previous
  - ❍ Forms – perinatal record
  - ❍ Consults
  - ❍ Social history, ongoing concerns, medical history, reminders, risk factors, family history
- ❑ Ticklers
  - ❍ Don't forget to add initials
  - ❍ How to view your preceptor's
- ❑ OSCAR Message – remember that only the person to whom the message has been sent can see them!
- ❑ How to review labs and documents
  - ❍ Unmatched or yellow tabs
  - ❍ What to do if you find a lab or document in the wrong chart
  - ❍ How to acknowledge (don't hit "file")
  - ❍ How to review in patient's chart
  - ❍ How to order (especially pap cytology) yellow and red results – what do they mean?
- ❑ Entering a diagnosis
- ❑ Progress notes
  - ❍ Updating reason for visit
  - ❍ Templates
  - ❍ Saving your note before leaving the room
  - ❍ How to edit
  - ❍ Signing off on notes ("sign, save & bill")
- ❑ Measurements & vitals
- ❑ Flow sheets – especially the diabetes flow sheet!
- ❑ Billing under your preceptor
  - ❍ Third-party billing
- ❑ OSCAR Rx
  - ❍ Don't use "other meds"
  - ❍ Searching for drugs – tips
  - ❍ Represcribing
  - ❍ Updating and printing med list
  - ❍ Creams and compounds
  - ❍ Interactions
  - ❍ What the colours mean
  - ❍ How to fax and paste into EMR
  - ❍ Active vs. current
- ❑ Allergies (especially NKDA)
- ❑ How to find "appointment history"

Department of Family Medicine/Queen's Family Health Team

INCIDENT REPORT – STAFF MEMBER OR LEARNER

This form is to be used by any staff member or learner to report any unusual occurrence or incident as part of the Departmental Risk Management program. This includes any Medication incidents. **ALL INCIDENTS RESULTING IN INJURY MUST BE REPORTED TO A MANAGER IMMEDIATELY.** All other incident reports are to be submitted to a Manager within 1-2 working days of the incident.

<table>
<tr><td>Report Initiated by:</td><td>Position:</td></tr>
<tr><td>Date of Event:</td><td>Time of Event:</td></tr>
<tr><td colspan="2">Site where event occurred/originated:</td></tr>
<tr><td>Patient Involved: Yes ☐ No ☐ Unsure ☐</td><td>If yes, provide demographic number:</td></tr>
<tr><td colspan="2">If an injury was sustained, please provide details of the degree of injury and any medical intervention required. Also indicate specific location of injury (eg. left arm, right foot) and anyone else notified of the injury. For medication incidents, describe medication, route given and if patient was involved.

<u>Patient</u>
☐Head ☐Right arm/hand
☐Neck ☐Left arm/hand
☐Back ☐Right leg/foot
☐Torso ☐Left leg/foot
☐Other (specify)

<u>Medication</u>
☐Unordered drug ☐Failure to note allergy
☐Incorrect preparation ☐Omitted dose
☐Incorrect patient ☐Incorrect medication
☐Incorrect dose ☐Incorrect route
☐Other (specify)</td></tr>
<tr><td>Has event been recorded in the EMR record?
Yes ☐ No ☐</td><td>Patient/family notified Yes ☐ No ☐</td></tr>
<tr><td colspan="2">Was the incident observed? Yes ☐ No ☐ Not Sure ☐ By Whom:</td></tr>
<tr><td colspan="2">Provide a brief and accurate account of the incident. DO NOT report conclusions or opinions, only fact.</td></tr>
<tr><td colspan="2">Reporter's Name/Signature: Date:</td></tr>
</table>

Department of Family Medicine - 2024 QFHT Contact List

QUEEN'S FAMILY HEALTH TEAM			
Tel: 613-533-9303 Fax: 613-544-9899 AHC: 613-533-9303 ext.73915			
	Home	Cell	Pager
Barber, David	613-767-6422	613-583-9922	
Bayoumi, Imaan	613-353-4441	613-331-2371	
Beattie, Erin		613-449-4548	
Braidwood, Mark		647-283-3041	
Funnell, Sarah		613-293-9336	
Green, Michael	613-545-7822	613-329-5629	
Griffith, Lindsey	613-893-5574		
Haffey, Sean		647-526-1150	
Hall-Barber, Karen	613-767-6422	613-583-9936	Alt. 613-387-8683
Howse, Kelly	613-544-5806	613-453-1826	
Kroeker, Laura		343-333-3307	
Kysela, Alenia		902-748-4924	
Li, Jiwei		604-375-6205	
McNally, Ed		613-876-6765	
Pouteau, Kathy	613-546-4594	613-876-5834	
Purkey, Eva	613-767-4127	613-484-2020	
Roy, Amrita		613-929-9384	
Sempowski, Ian		613-328-5909	
Simpson, Matt		613-453-1864	
Stephenson, Christy		506-292-6114	
Thomson, Ian		613-608-4437	
Train, Anthony		587-577-9676	
Tranmer, Jennifer		250-886-6987	
Watson, Shayna		613-532-1724	
Zlepnig, Jennifer	613-548-4828	613-371-4855	

PROVIDENCE MANOR LONG-TERM CARE			
Tel: 613-549-4164 Fax: 613-549-1018			
Barber, David	613-533-9303	(c) 613-583-9922	(h) 613-767-6422
Beattie, Erin	613-354-9227	(c) 613-449-4548	
Kysela, Alenia		902-748-4924	
Porter, Sara		613-876-0154	
Zlepnig, Jennifer		613-371-4855	

KINGSTON COMMUNITY HEALTH CENTRE		
Tel: 613-542-2949 Fax: 613-542-7657 Contact: Josee Conway		
	Home	Cell
Garg, Anirudha		343-363-4274
Falardeau, Brandi		613-483-1841
Kinghorn, April		647-939-1981
Patel, Rupa	613-545-7825	613-888-8242
Rowland, Mary	613-548-0935	613-331-0772

LOCUMS		
	Cell	Home
Bigelow, Stephanie	902-760-0539	
Borins, Carolyn	613-540-4322	613-453-8365
Boudreau, Jordan	902-789-2897	
Chan, Alvin	647-929-7156	
Delva, Dianne	613-552-5556	
Gao, Golden	343-884-9000	
Geddes, John	613-483-8762	
Greenfield, Julia	514-622-3815	
Kalra, Sameer	647-407-6204	
Kirwan, Chris	226-961-2085	
MacDonald, Susan	613 876-2559	
MacPherson, David	613-929-8413	613-766-8758
Polle, Emma	778-678-6376	613-536-7516
Saab, Dima	647-785-4005	
Surmawala, Ambreen	780- 278-1136	
Webb, Katie	613-484-5967	

ALLIANCE After Hours Service
Tel 1-888-556-6037 Fax 613-549-0701

QUEEN'S TELECOM
Tel: 613-533-2603 Alt: 613-453-0674

OLIS Search - OSCAR EMR

Find the "OLIS Search" button at the top of each patient Echart.
(This option will automatically fill the Patient field)

OR Alternate Method

Click on the "Inbox" tab and navigate to "OLIS Search" located in the top right corner

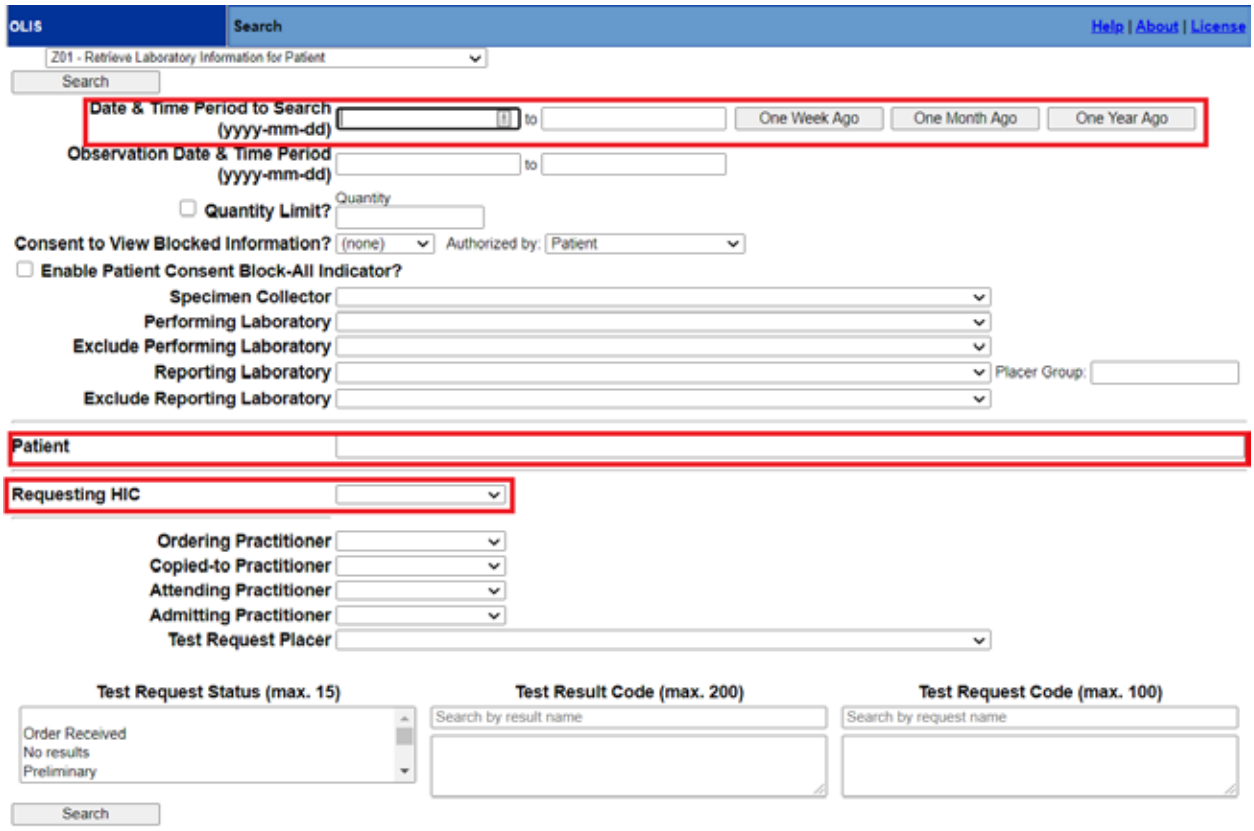
There are only 3 fields that are mandatory to fill out to get a patient's lab results;

1. "**Date & Time Period to Search (yyyy-mm-dd)**" to have a date range to search, the larger the search range the longer it will take to load results.

2. "**Patient**" - You type in the patient's name as "lastName, firstName", this field will attempt to autocomplete after 3 letters have been entered for your selection.

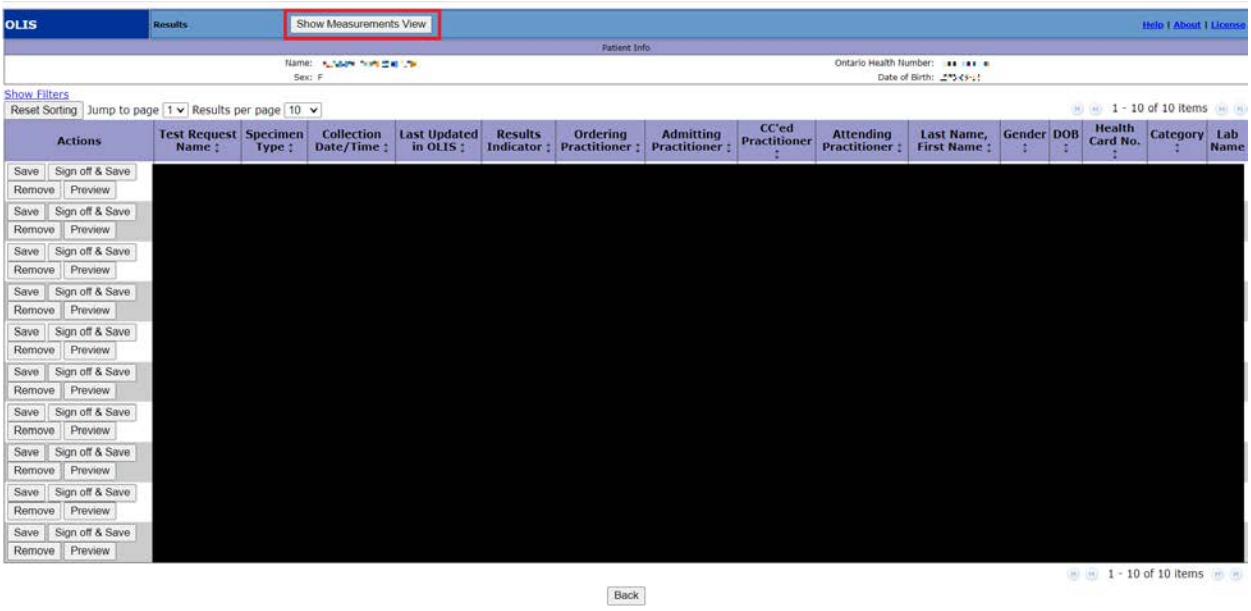
3. "**Requesting HIC**" - Is drop-down menu that contains all of providers in your system, please select a doctor who has the previously listed prerequisites complete.

**Anyone with access to the OLIS search screen can preform a search but the results will only be uploaded into the selected physician's inbox.*



Once those fields are completed click the "**Search**" button.

Example results:



The four buttons will allow you to do the following:

- Save: Add to the Physician's Inbox as New
- Preview: Preview the lab report
- Sign & Save: Add to the Physician's Inbox as Filed
- Remove: Remove the Lab result from the list permanently

The Show Measurement View will switch the view from all lab tests to all lab measurements.

Common Billing Codes

Periodic health exam

No diagnostic code necessary

K017 age 2-15 **K130** age 16-17

K131 age 18-64 **K132** age 65+

Screening

Q150 FIT -Counsel + distribute (once per 24 months)

Q133 colorectal tracking code

G365 pap (once every 33months)

G394 if previous pap abnormal

Q011 pap tracking code

Q131 mammogram tracking code

Pediatrics

A007 well baby care

+Q015 <12mo visit bonus (max 8)

A002 18-month visit (17-24mth)

Medical abortion

A920 medical abortion

A921 f/u visit medical abortion

Antenatal care

P005 antenatal prev health assessment (bill with P003 orP004)

P003 full hx + exam (once per preg)

P004 routine prenatal visit

G005 pregnancy test

P008 post natal care

Injections (not immunizations)

G372 injection (IM, SC, ID) with visit

G373 injection (sole reason for visit)

G370 joint, bursa, ganglion injection

+G371 subsequent injections (max 5)

General assessment

A001 minor assessment

A007 intermediate assessment

A003 general assessment (Not PHE, up to once/yr)

A901 house call assessment

K032 neurocognitive assessment

E080 1st visit <14 days post-discharge from hospital (add on fee)

Chronic Disease Management

K030 diabetes mgmt (4x per 12mo)

K029 insulin therapy

K037 fibromyalgia/chronic fatigue syndrome

K022 HIV primary care

K023 palliative care

K028 STD or needlestick injury management (per unit)

Major illness tracking

Q020 services for pt w/bipolar

Q021 services for pt with schizophrenia

Consult

A905 limited consult (need consult billing#)

K731 call to consultation (>10min)

K735 call to ED physician (>10min)

K738 e-consultation (OTN)

Telephone codes

K080 <10 minutes

K081 10-20 minutes

K082 >20 minutes

K301 tracking code for phone

After hours

Q012 after hours premium

A888 walk-in appt wknd/holiday

Counselling

K005 primary mental health care (cannot bill with other codes)

K013 (educational) counselling

Use **K033** after first 3 units of K013

K007 psychotherapy

K008 ADHD diagnostic interview

K002 interview with relative/POA

C010 supportive care (visiting own pt in hospital)

Units	Time
1	20 min
2	46 min
3	76 min
4	106 min

Smoking cessation (MRP only)

E079 initial visit (1 per 12 months)

K039 follow up (2 in 12 months; use dx code 305; subsequent visits A007 or K013)

+Q042 must add to K039

Office procedures

E542 tray fee

Z117 cryotherapy (wart)

Z119 LN2 to 5 or more AKs (use dx code 232)

Z111 rapid strep

Z770 endometrial biopsy

G378 IUD insertion

G384 trigger pt injection

G420 ear syringe/curetting

G403 Epley's maneuver

Derm procedures

Z101 I&D abscess/hematoma

Z113 skin biopsy (no sutures)

Z116 skin biopsy (with sutures)

R048 malignant lesion (face/neck)

R094 malignant lesion (body)

SGFP
GENERAL & FAMILY PRACTICE

Common Billing Codes APRIL 2022

Common Fee Codes

A001	Minor Assessment	23.75
A007	Intermediate Assessment	36.85
A003	General Assessment with diagnosis other than 917, all ages	84.45
A004	General Reassessment	38.35
K013	Counselling - Up to 3 units/yr	67.75
K033 n o	Counselling - When billing more than 3 units/yr	47.70
K040 n o	Group counselling, per unit, where no group member received more than 3 units K013 or K040 per 12 months period	69.10
K041 n o	Group counselling additional units where any group member received more than 3 units K013 or K040 per 12 months period	79.45
A005 n o	Consultation family practice and practice in general	86.15
A911 n o	Special family and general practice consultation (minimum 50 minutes)	147.65
A912 n o	Comprehensive family and general practice consultation (minimum 75 minutes)	221.50
A008	Mini Assessment - Billed with WSIB minor assess.	13.30
A888 n o	Emergency Dept Equivalent	37.60
A903	Preoperative Assessment	65.05
E080 n o	First Post Hospital Premium - within 2 weeks	25.75
A900n	House Call Assessment Complex + Premiums	46.05

MENTAL HEALTH

K005	Primary Mental Health Care	69.10
K002 n	Interview with authorized individual	69.10
K007	Psychotherapy	69.10
K623 n o	Form 1 - Application for Psychiatric Assessment	115.65

SCREENING, HEALTH PROMOTION, CHRONIC DISEASE MANAGEMENT

A002 n o	18 Month Developmental Assessment	63.45
K017	Child Periodic Health Visit 2 to 15 years - no diagnostic code needed	44.50
K130	Adolescent Periodic Health Visit 16 or 17 years - no diagnostic code needed	78.75
K131	Adult Periodic Health Visit age 18-64 - no diagnostic code needed	55.10
K132	Adult Periodic Health Visit age 65 and older - no diagnostic code needed	78.75
K030 n o	Diabetic Management Assessment 4 per year	41.35
K032 n o	Neurocognitive Assessment	69.10
K037 n o	Chronic fatigue/ fibromyalgia care	69.10
Q150 n o	FOBT distribution and counselling	7.15
Q152 n o	FOBT completion (see restrictions)	5.10

FOCUSED PRACTICE

A957	Addiction Medicine - focused practice assessment	37.60
A927	Allergy - focused practice assessment	37.60
A967	Care of the Elderly - focused practice assessment	37.60
A937	Pain Management - focused practice assessment	37.60
A947	Sleep Medicine - focused practice assessment	37.60
A917	Sports Medicine - focused practice assessment	37.60

SUBSTANCE ABUSE

E079 n o	Smoking Cessation Premium	15.85
K039 n o	Smoking Cessation Followup	34.10
A680 n o	Initial Assessment - Substance Abuse	147.65
K680 n o	Extended Assessment- Substance Abuse	69.10
A957	Family practice - focused practice assessment- Addiction Medicine	37.60
K683 n o	Family practice - focused practice assessment- opioid agonist maintenance (per month)	38.75

SEXUALLY TRANSMITTED ILLNESS

K022 n o	HIV - Primary Care	69.10
K028 n o	STD Management Max 2 Unit/Patient/Doc/Day & 4 Units/Patient/Doc/Yr	69.10

OBSTETRICS

P004 n o	Minor Prenatal Assessment	37.60
P003 n o	Major Prenatal	78.75
P005 n o	Antenatal Preventative Assessment	46..05
P007 n o	Postnatal Care Hospital	56.25
P008 n o	Postnatal Care Office	37.60
P006 n o	Vaginal Delivery	508.70
P009 n o	Attendance labour and delivery, c-section	508.70
P023 n o	Oxytocin Stimulation	69.10
P030 n o	Cervical Ripening (max 1 per pregnancy)	59.80
C989 n o	Sacrifice Office Hours	77.95
E409 n o	Premium Days (0500-1200), 24 hours Sat. Sun * 50%	254.35
E410 n o	Premium Nights (midnight-0700) *75%	381.53
E411 n o	Sole Del Premium * 100%	508.70

* dollar value calculated for P006
n common fees outside the FHN basket
o common fees outside the FHO basket

For further information on CCMs, FHGs, FHNs and FHOs, you may access the OMA Primary Care Renewal Tutorials at www.oma.org/Member/Resources/PrimaryCareModels/Pages/default.aspx or contact your Primary Health Care Team Ministry Site at 1-866-766-0266

OHIP Information: 416.314.7444

Common Fees - Palliative Care

COMMON FEES-PALLIATIVE CARE

K023	n o	Palliative Care Support (>20 min)	73.60
K015	n o	Counseling of Relatives (scheduled visit)	69.10
G512	n o	Palliative Care Case Management (weekly)	69.10
G511	n o	Telephone Management of Palliative Care (per call)	18.10
A945	n o	Special Palliative Care Consultation (office, home, OPD)	162.40
C945	n o	Special Palliative Care Consultation (hospital)	162.40

CASE CONFERENCE, TELEPHONE MANAGEMENT, FORMS-PALLIATIVE CARE

K121	n o	In-Hospital Case Conference - acute, chronic or rehab (per unit)	32.00
K700		Outpatient Palliative Case Conference (per unit)	32.00
K708	n o	Multidisciplinary Cancer Conferences (per patient)	32.00
G511	n o	Telephone Management of Palliative Care	18.10
K070	n o	Home care application	32.40
K071	n o	Acute home care supervision	21.85

***Can be billed concurrently for a home visit to a palliative care patient**

HOME VISITS-PALLIATIVE CARE

B998	n o	Special visit, first person seen, for purpose of providing palliative care (0700-2400)*	84.15
B997	n o	Special visit, first person seen - nights (2400-0700)*	112.20
B966	n	Travel premium*	37.15
K023	n o	Palliative Care Support (>20 min)	73.60
A900	n	Complex Housecall Assessment	46.05

HOSPITAL VISITS-PALLIATIVE CARE

C122	n o	Most Responsible Physician Day 1	62.40
C123	n o	Most Responsible Physician Day 2	62.40
C124	n o	Subsequent visit – day of discharge (not for deceased patients)	62.40
C945	n o	Special Palliative Care Consultation (hospital)	162.40
C882	n	Palliative Care Assessment - GP, acute care	31.60
C982	n o	Palliative Care Assessment Specialist, acute care	31.60
W882	n o	Palliative Care Assessment GP, chronic care/rehab	32.85
W982	n o	Palliative Care Assessment Specialist, chronic care/rehab	32.85
W872	n o	Palliative Care Assessment - GP, LTC	32.85
W972	n o	Palliative Care Assessment - Specialist, LTC	32.85
K023	n o	Palliative Care Support (>20 min)	73.60

PRONOUNCEMENT AND DEATH CERTIFICATES

A902	n o	Pronouncement of death in the home (includes death certificate)	46.05
A777	n	Pronouncement of death other than patients home (includes certificate)	37.60
A771	n o	Certification of death (Completion of death certificate alone)	21.00
C777	n o	Hospital Pronouncement of death - subject to the same conditions as A777 (includes certificate)	37.60
C771	n o	Certification of death - subject to same conditions as A771	21.00
W777	n o	Long Term Care Pronouncement of death - subject to the same conditions as A777 (includes certificate)	37.60
W771	n o	Certification of death - subject to same conditions as A771	21.00

Special Visit Premiums

				Maximum Patients	Maximum Travel	Additional Patient	Travel Premium
HOME VISIT PREMIUMS					**ADD TRAVEL PREMIUM**		37.15
B990	n	28.05	Daytime Monday-Friday elective home visit	10	2	visit fee	B960
B994	n	67.35	Evenings Monday - Friday	10	2	visit fee	B962
B996	n	112.20	Night every day	no limit	no limit	visit fee	B964
B997	n o	112.20	Palliative care patient - night	no limit	no limit	no limit	B966
B998	n o	84.15	Palliative care patient (all other times)	no limit	no limit	no limit	B966
B992	n	44.90	Sacrifice office hours	10	2	visit fee	B961
B993	n	84.15	Saturday, Sunday, Holidays	20	6	visit fee	B963
OFFICE VISIT PREMIUM					**ADD TRAVEL PREMIUM**		37.15
For other non-professional sites substitute "Q" for "A"							
A990		20.40	Day Monday - Friday	1	1	visit fee	A960
A994		61.20	Evenings Monday - Friday	1	1	visit fee	A962
A996		102.00	Night every day	no limit	no limit		A964
A998		76.50	Saturday, Sunday, Holidays	1	1	visit fee	A963
HOSPITAL PREMIUM C=HOSP, K=ER, U=OPD, W=LTC - Substitute appropriate site prefix for "C"					**ADD TRAVEL PREMIUM**		37.15
C990	n o	20.40	Day Monday - Friday	10	2	C991	C960
C994	n o	61.20	Evenings Monday - Friday	10	2	C995	C962
C996	n o	102.00	Night	no limit	no limit	C997	C964
C992	n o	40.80	Sacrifice office hours	10	2	C993	C961
*C986	n o	76.50	Sat, Sun, Holidays	20	6	*C987	C963

**Please note that the numbers and C987 apply only to the "C" codes because C998 and C999 were already assigned to Surgical Assistants. For all other letters i.e. A, B, K, U & W the numbers remain 998 and 999.*

Geriatric Premiums (automatically applied)

The amount payable for the following services to an insured person who is at least 65 years of age increases by 15%: (A003, A903, C003, W102, W109, or W903) (A004, C004, W004) (A007) (A901) (A917, A927, A937, A947, A957 or A967) (K132)

Forms

K071	n	o	Acute Home Care Supervision (1 per patient per week per MD for 8 weeks)	21.40
K072	n	o	Chronic Home Care Supervision (2 per month per patient per MD after 8 weeks)	21.40
K051	n	o	Health Status Report (HSR) Form	80.00
K070	n	o	Home Care Application	31.75
K038	n	o	Long Term Care Application	45.15
K052	n	o	MCFSC Activities Of Daily Living (ADL) Index	20.00
K050	n	o	MCFSC HSR & ADL Amalgamated Form	100.00
K054	n	o	MCFSC Mandatory Special Necessities Benefit Form	25,00
K056	n	o	MCFSC Pregnancy, Breast Feeding Allowance Application Form	20.00
K055	n	o	MCFSC Special Diet Application Form	20.00
K035	n	o	MTO Mandatory Reporting Medical Condition	36.25
K036	n	o	Northern Travel Grant Application	10.25
K053	n	o	Ontario Works Program - Limitation to Participation	15.00

Sports Medicine and MSK

CONSULTATIONS AND VISITS

	A917		Sports medicine focused practice assessment	33.70
	A937		Pain management focused practice management	33.70
	A005	n o	Consultation	77.20
	K013		Counselling up to 3 units/year	62.75
	K033	n o	Counselling - When billing more than 3 units/year	38.15
+	G700	x x	Basic Fee	5.10
>	E542	n	Office Premium (tray fee)	11.15

INJECTION & ASPIRATION

>	E542	n	Outside of hospital: injection, aspiration of joint, ganglion,tendon or bursa add	11.15
>+	G370	n	Injection Bursa, Aspiration joint, ganglion, tendon sheath	20.25
>	G371	n	each additional injection, aspiration up to 5	19.90
>	G328	n o	Aspiration bursa or complex joint, with or without injection	39.80
>	G329	n o	Each additional bursa/complex joint up to 2	20.25
	E446	n o	Injection joint with image guidance, (following a failed attempt without imaging) add to G370/G371	30.00
	G372		Injection im, sc, intradermal, with visit	3.89
	G373		Injection, sole reason	6.75
	G372		Each additional injection	3.89
	G384		Infiltration of tissue for trigger point	8.85
	G385		Infiltration of tissue for trigger point, each additional site, max 2, add	4.55

Notes: Only one of G370, G371, G328, G329 are payable for the same site

NERVE BLOCKS

G227		n	Cranial nerve block	54.65
G243		n o	Femoral nerve unilateral	54.65
G244		n o	Femoral nerve bilateral	81.95
G264	*	n o	Occipital nerve first block per day	34.10
G265	**	n o	Occipital nerve, each additional per spinal level, max 3/day	17.10
G238		n o	Scapular nerve	34.10
G230		n o	Sciatic nerve, unilateral	54.65
G226		n o	Sciatic nerve, bilateral	82.45
G231		n	Somatic or peripheral nerve, one nerve or site, not otherwise specified	34.10
G223		n	Somatic or peripheral nerve, nerve(s) or site(s), not otherwise specified, additional	17.10
G228		n	Spinal: paravertebral, cervical, thoracic, lumbar, sacral, coccygeal	34.10
G123		n	Spinal: peripheral, cervical, thoracic, LS, for each additional one, max 4	17.10
E958		n o	When alcohol or other sclerosing agents are used	add 50%

Notes: *G264 maximum one per day, up to 16 per calendar year. Use G291/G292 when more than 16 per year.

**G265 for each additional, up to 3, when G264 is payable in full.

REDUCTION OF FRACTURES SEE SCHEDULE OF BENEFITS

DISLOCATIONS

D009	n o	Elbow closed reduction	84.45
D012	n o	Radial head, closed reduction pulled elbow	39.00

CASTS

E584	n o	Application of plaster cast outside of hospital	11.15
Z201	n o	Cast finger	10.25
Z202	n o	Cast hand	14.90
Z203	n o	Cast, forearm or wrist	24.10
Z208	n o	Cast, shoulder spica	97.35
Z205	n o	Cast, head and torso	97.35
Z213	n o	Cast below knee, knee splints	24.10
Z211	n o	Cast whole leg	28.80
Z199	n o	Cast foot	14.90
Z198	n o	Cast toes	10.25
Z200	n o	Unna's paste	14.90
Z204	n o	Cast removal	10.25

> E542 may be charged with these fees
+ add G700 to these fees if sole reason for visit
n common fees outside the FHN basket
o common fees outside the FHO basket
x Pays 15% for FHN/FHO on rostered patients

Hospital Care, Surgical Assists, LTC and Continuing LTC

HOSPITAL CARE

C002	n o	Hospital Care - subsequent visit for first 5 weeks	34.80
C008	n o	Concurrent Care	34.80
C010	n o	Supportive Care	19.25
C122	n o	Most Responsible Physician Day 1	62.40
C123	n o	Most Responsible Physician Day 2	62.40
C124	n o	Most Responsible Physician Discharge Day	62.40
C933	n o	On-Call Admission Assessment	81.50
E082	n o	Admission assessment by the MRP, to admission assessment	add 30%
E083*	n o	Subsequent visit by the MRP to subsequent visit	add 30%
H001	n o	Newborn Care (In hospital or in home)	53.25

SURGICAL ASSISTS - per unit (x2 after 1 hour; x3 after 2.5 hours) 12.04

E400B	n o	**Evenings** Monday - Friday (5 pm - 12am), Saturday/Sunday/Holidays	50%
E401B	n o	**Nights** - Midnight to 7 am	75%

LONG TERM CARE (LTC)

K124	n o	LTC Case Conf./10 min. unit max. 4/year	32.00
W003	n o	First 2 visits/month	32.85
W008	n o	Additional 2 subsequent visits/month	21.65
W010**	n o	Monthly Management Fee	111.05
W102	n o	Admission Assessment Type 1	70.75
W107	n o	Admission Assessment Type 3/readmit from acute	31.30
W109	n o	Periodic Health Visit	71.90
W121	n o	Intercurrent illness additional visit	31.60
W771	n o	Cert. of Death (other HP pronounced) (LTC)	21.00
W777	n o	Pronouncement of Death (LTC)	37.60
W872	n o	Palliative Care visit -no limit	32.85
W903	n o	Preoperative general assessment (2 per year)	66.35

COMPLEX CONTINUING CARE & CONVALESCENT CARE IN LTC

W002	n o	First 4 visits/month	32.85
W001	n o	Additional Subsequent Visits - 4/month	21.65
W882	n o	Palliative Care Visit - no limit	32.85

***E083 applies to C002,C007,C009,C122,C123,C124,C143 C882 or C982**

**If you are billing the W010 monthly LTC code, the following services are included in the code and may not be billed as separate services: W003; W008; W121; W872; W102; W104; W107; W903; W109; W004; W777; W771; G271; K070; K071; K072; G489; G372; G373; G538; G539; G590; G365; G394; E430; G379; G001; G002; G481; G003; G004; G005; G006; G007; G008; G009; G010; G011; G012;& G014.

n common fees outside the FHN basket
o common fees outside the FHO basket

Home Care, Case Conferences, Telephone and E-Consultations

CCAC HOME CARE FORMS

K070	n o	Home care application	32.40
K038	n o	Long-Term Care health report form	46.05

CCAC HOME CARE SUPERVISION

K071	n o	Acute home care supervision (first 8 weeks)	21.40
K072	n o	Chronic home care supervision (after 8 weeks)	21.40

CASE CONFERENCES OUT-PATIENTS* (MAY INVOLVE CCAC) 31.35 PER UNIT

K703	o	Geriatric out-patient case conference
K700		Palliative care out-patient case conference
K707	n o	Chronic pain out-patient case conference
K701	n o	Mental health out-patient case conference
K704	n o	Paediatric out-patient case conference
K702		Bariatric out-patient case conference

CASE CONFERENCES LTC PATIENTS* (MAY INVOLVE CCAC) 31.35 PER UNIT

K124	n o	Long-term care/CCAC-client case conference
K705	n o	Long-term care - high risk patient conference

CASE CONFERENCES CONVALESCENT CARE* (MAY INVOLVE CCAC) 31.35 PER UNIT

K706	n o	Convalescent care program case conference

CASE CONFERENCES IN-PATIENTS* (MAY INVOLVE CCAC) 31.35 PER UNIT

K121	n o	Hospital in-patient case conference

TELEPHONE CONSULTATION

K730	Referring physician	32.00
K731	Consulting physician	40.45

E-CONSULTATION

K738	n o	Referring physician	16.30
K739	n o	Consulting physician	20.90

CRITICALL TELEPHONE CONSULTATION

K732	Referring physician	32.00
K733	Consulting physician	41.25

*Physicians are advised to consult with the OHIP Schedule of Benefits for the specific details of each of these codes. The Schedule of Benefits describes mandatory service requirements and billing restrictions.

See www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

Commonly Billed Q Codes

ENROLLMENT Q CODES - MANDATORY FOR ROSTERING PATIENTS

Q200A	Per Patient Rostering Fee	no payment*
Q202A	FHN and FHO Long Term Care Patient Rostering	no payment*

CCM, FHG, FHN & FHO (ALL MODELS):

Q023A	Unattached pt. fee, from hospital, no max	150
Q043A	New patient fee FOBT + or colorectal increased risk	150-230**
Q053A	HCC Complex vulnerable new patient	350***
Q150A	FOBT distribution and counselling fee	7
Q050A	Heart Failure Management Incentive	125
Q040A	Diabetes Management incentive - Annual Flow Sheet	60/yr
Q042A	Smoking Cessation Counselling Fee	7.50

AFTER HOURS PREMIUM

Q014A	Newborn Episodic Care (<1year old, max 8)	15.05

FHO ONLY:

Q015A	Newborn Episodic Care (<1year old, max 8)	13.99

FHG ONLY:

FHGS - 10% PREMIUM AUTOMATICALLY ADDED TO

A001, A002, A003, K130, K131, K132, A007, A008, A888, A900, A901, A902, C010, C882, G365, G538, G539, G590, G840, G841, G842, G843, G844, G845, G846, G847, G848, K005, K013, K017, K022, K023, K030

Q012A/Q016A APPLY TO:

A001A, A003A, K130A, K131A, K132A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, K033A, Q050A

Q043A

Patients 75 years and over:	230.00
Patients over 64:	170.00
Patients up to 64:	150.00

***Q053**

Same payment regardless of age.
Requires patient be registered with Health Care Connect.
No maximum number

* reduced from $5.00 as part of MOHLTC unilateral action

Telephone/Criticall Consultations

Minimum 10 minutes

Type and/or Location of Call	Referring Physician 31.35	Consulting Physician $40.45
Office or other Locations	K730 One/ patient/day	K731 One/patient/day
Emergency, Hospital, Urgent Care Clinic	K734 One/patient/day	K735 One/patient/day
Criticall	*K732 Two/patient/day	*K733 One/MD/ patient/day
Criticall, Emergency, Hospital, Urgent Care Clinic	*K736 Two/patient/day	*K737 One/MD/ patient/day

Consultant physicians can bill these fees for referrals and e-consults from physicians or nurse practitioners.
Review preamble for detailed payment rules 3 K733 or K737 (any combo)/patient/day. *No time restrictions

E-Consultation

Only eligible if provided within 30 days of e-consult request		
K738	no Referring Physician	16.00
K739	no Consulting Physician	20.50

Consultant physicians can bill these fees for referrals and e-consults from physicians or nurse practitioners.

Review Schedule of Benefits for all Payment Rules

Preventive Care Tracking Codes

(optional to use) (Enrolled Patients Only)

Q130A	Influenza Vaccine	65 and over
Q011A	Pap	age 21-69 years
Q131A	Mammogram	age 50-74 years
Q132A	Immunization	age 18-24 months
Q1331	Colorectal Screening	age 50-74 years

EXCLUSION CODE:

(Improves efficiency when calculating yearly bonus payments)

Q140A	Pap	age 21-69 years
Q141A	Mammogram	age 50-74 years
Q142A	Colorectal Screening	age 50-74 years

SERIOUS MENTAL ILLNESS

Q020	Bipolar
Q021	Schizophrenia (for FHG Diagnostic Code 295)

5-9 Patients: $1,000/year
10+ patients: $2,000/year

Preventive Care Service Enhancement Fees

FHN, FHO, FHG & CCM Paid annually based on percentage of enrolled patients serviced.

CHANGES TO PREVENTATIVE CARE FEES ARE PENDING AS PER 2021 PSA

INFLUENZA VACCINE

Q100A	60%	220
Q101A	65%	440
Q012A	70%	770
Q103A	75%	1,100
Q104A	80%	2,200

PAP SMEAR

Q105A	60%	220
Q106A	65%	440
Q107A	70%	660
Q108A	75%	1,320
Q109A	80%	2,200

MAMMOGRAM

Q110A	55%	220
Q111A	60%	440
Q112A	65%	770
Q113A	70%	1,320
Q114A	75%	2,200

CHILDHOOD IMMUNIZATIONS

Q115A	85%	440
Q116A	90%	1,100
Q117A	95%	2,200

COLORECTAL SCREENING

Q118A	15%	220
Q119A	20%	440
Q120A	40%	1,100
Q121A	50%	2,200
Q122A	60%	3,300
Q123A	70%	4,000

APPLIES TO FFS OR PATIENT ENROLLED MODEL WITH LESS THAN MINIMUM ROSTER SIZE

Q152	FOBT completion fee	5.00

Immunization Codes

G840		DTaP-IPV (Quadracel)	4.50
G841		DTaP-IPV-Hib (Pediacel)	4.50
G538		Hepatitis A (Havrix)	4.50
G842		Hepatitis B (Engerix)	4.50
G538		Hepatiis A and B (Twinrix)	4.50
G843		Human Papilloma Virus (HPV) (Gardasil, Gardasil-9, Cervarix)	4.50
G844		Meningococcal C Conjugate (Men-C) (Menjugate, NeisVac-C, Meningitec)	4.50
G538		Meningococcal conjugate quadrivalent (Men-C-ACYW) (Menactra, Menveo, Nimenrix)	4.50
G538		Meningococcal polysaccharide quadrivalent (Men-P-ACYW-135) (Menomune)	4.50
G538		Meningococcal B (4CMenB) (Bexsero)	4.50
G845		Measles, Mumps, Rubella (MMR, Priorix)	4.50
G538		Measles, Mumps, Rubella, Varicella (MMRV)	4.50
G846		Pneumococcal Conjugate (Prevnar-13)	4.50
G538		Pneumococcal Polysaccharide (Pneumovax)	4.50
G847		Tdap (Adacel, Boostrix)	4.50
G538		Tdap-IPV (Adacel-Polio, Boostrix-Polio)	4.50
G538		Td-IPV	4.50
G538		Td	4.50
G848		Varicella (Varilrix, Varivax)	4.50
G538		Varicella (Zostavax)	4.50
G538		Other immunizing agents	4.50
G590	o	Influenza	4.50
Q590	n o	FHO/FHN ONLY If Infuenza immunization is sole reason add to G590	5.10
G700		Basic fee per visit premium if sole reason for procedure	5.10

Emergency Room Codes

D= Day E=Evening N=Night
W=Holidays & Weekends

	A100	n o	Family Physician ER Department Assessment	76.90
D	H101	n o	Minor Assessment	15.00
D	H102	n o	Comprehensive Assessment	37.20
D	H103	n o	Multiple Systems Assessment	35.65
D	H104	n o	Reassess	15.00
N	H121	n o	Minor Assessment	29.80
N	H122	n o	Comprehensive Assessment	73.90
N	H123	n o	Multiple Systems Assessment	65.95
N	H124	n o	Reassess	29.80
E	H131	n o	Minor Assessment	18.70
E	H132	n o	Comprehensive Assessment	46.30
E	H133	n o	Multiple Systems Assessment	42.40
E	H134	n o	Re-Assessment	18.70
W	H151	n o	Minor Assessment	25.50
W	H152	n o	Comprehensive Assessment	63.30
W	H153	n o	Multiple Systems Assessment	56.95
W	H154	n o	Reassess	25.50
	H105	n o	Inpatient Interim Orders	26.25
	G521	n o	Life threatening emergency situation - first 1/4 hour	110.55
	G522	n o	Life threatening emergency situation after 1st half hour per 1/4 hour	36.35
	G523	n o	Life threatening emergency situation - 2nd 1/4 hour	55.20
	G391	n o	Other resuscitation after first 1/4 hour	28.35
	G395	n o	Other resuscitation - first 1/4 hour	56.80
	E412	n o	Premium evenings Monday - Friday (1700-2400) Saturday, Sunday, Holidays	***20%**
	E413	n o	Premium nights 7 days (midnight-0700)	***40%**

n common fees outside the FHN basket
o common fees outside the FHO basket
***percentage Increase to procedural fee(s)**

Office Procedures

OFFICE PROCEDURES

+	G700	x x	Basic Fee	5.70
>	E542	n	Office Premium (tray fee)	11.80
	G271		Anticoagulation supervision	13.00
	G202		Allergy inj. (1 or more) with visit	4.55
	G212		Allergy injection alone	9.95
+	Z117	n	Chemical rx wart (plantar, genital)	11.90
>	D012	n o	Pulled elbow	39.80

Immunization- see unique codes

+	G538		Other immunization with visit if sole reason add G700	5.05
+	G590	o	Flu shot with visit - sole reason + Q590	5.05
	G372		Injection with visit	3.97
	G373		Injection - sole reason	6.90
+	G365		Pap - ages 21-69 every 33 months	8.80
+	G394	n o	Pap - if prev abnormal/inadequate	8.80
	E431		When Pap performed outside hospital/G394	12.20
	E430	n o	Pap Smear Tray Fee Not payable if uninsured	12.20
>	Z770	n o	Endometrial sampling	34.75
>	G378	n	I.U.D. insertion	31.75
	Z139	n	Breast cyst aspiration	37.95
+	G420		Ear syringe, curette	11.60*
	Z314	n	Epistaxis - nasal cauterization	11.75
	Z315	n	Epistaxis - unil. anterior packing	15.65
	G403	n o	Epley (BPV) particle repositioning	21.60
	Z543	n	Proctoscopy	8.85
>	Z104	n o	Haematoma, perianal	20.50
>	Z106	n o	Abscess, ischiorectal/pilonidal I&D	45.25
+	G375		Intralesional infiltration - 1 or 2 lesions	9.05
+	G377		Intralesional infiltration- 3 or more	13.55
	G384		Injection trigger point	9.05
	G385		Injection each additional trigger point (2 max) add	4.65
>	G370	n	Injection bursa, joint, ganglion and/or aspiration	20.65
>	G371	n	Each additional bursa, joint, ganglion, tendon up to 5	20.30
>	Z114	n	Foreign body removal - local anesthetic	25.75
>	Z101		Abscess, haematoma I&D (one)	26.25
	Z080	n o	Debride wound or ulcer to s.c tissue 10 min 1	20.40
	Z081	n o	Debride wound or ulcer to s.c tissue 10 min 2	30.60
	Z082	n o	Debride wound or ulcer to s.c. tissue 10 min 3	45.90
	Z113	n	Biopsy without sutures	30.20
>	Z116	n	Biopsy with sutures	30.20
>	R048	n	Malignant lesion Face - single, simple excision	94.00
>	R094	n	Malignant lesion Other - single, simple excision	58.15
>	Z176		Suture	20.40
	Z154	n	Suture - Face, layers, bleeders	36.60
>	Z128	n	Nail resection	33.75

* G420A - only payable when medically necessary.

LABORATORY IN GP'S OFFICE

	G010		Urinalysis	2.18
	G002		Glucose	2.31
	G012		Wet prep	1.97
	G004		Stool for O.B.	1.61
	G005		Pregnancy test	3.96
	G014		Rapid Strep	5.80
+	G480	n o	Venipuncture - Infant - <2 years	10.10
+	G482		Venipuncture - Child 2 - 15 years	7.50
+	G489		Venipuncture - Adult 16+ years	3.61

CARDIAC, PULMONARY FUNCTION

J301**	n	Simple Spirometry P	8.00
J301**	n o	Simple Spirometry T	9.85
J324**	n	Repeat After Bronchodilator P	4.30
J324**	n o	Repeat After Bronchodilator T	2.97
J304**	n	Flow Volume Loop P	11.55
J304**	n o	Flow Volume Loop T	19.60
J327**	n	Repeat After Broncholdilator P	6.90
J327**	n o	Repeat After Broncholdilator T	2.97

** Not payable without indication-see A2 Schedule of Benefits
> E542 may be charged with these fees
\+ add G700 to these fees if sole reason for visit
n common fees outside the FHN basket
o common fees outside the FHO basket
x pays 15% for FHN/FHO on rostered patients

OMA ONTARIO MEDICAL ASSOCIATION
section on General and Family Practice

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SGFP Diagnostic Codes

SGFP GENERAL & FAMILY PRACTICE

Abdominal pain	787
Abortion (incomplete)	634
Abortion (therapeutic)	635
Abortion (threatened)	640
Abrasions, contusions	919
Abscess	685
Acne	706
Adenitis	289
Adjustment reaction	309
Adrenal	255
Adverse drug reaction	977
AIDS	042
Alcoholism	303
Alopecia	704
Amenorrhea	626
Anemia (aplastic)	284
Anemia (iron deficiency)	280
Anemia (pernicious)	281
Angina	413
Animal bite	919
Ankle strain	845
Ankylosing spondylitis	720
Ankylosis	718
Anorexia	787
Anxiety	300
Appendicitis	540
Aphthous ulcer	528
Arrythmia	427
Arteriosclerosis	440
Arteritis temporal	446
Arthritis (osteo)	715
Arthritis (rheumatoid)	714
Asthma	493
Astigmatism	367
Ataxia	780
Athletes foot	110
Bakers cyst	727
Balanitis	608
Behaviour disorder	313
Biliary calculus	576
Biliary colic	574
Birth control	895
Bleeding (post menopausal)	627
Bleeding (rectal)	569
Blepharitis	373
Blocked tear duct	375
Boil	680
BPH	600
Breast abscess	611
Breast disorder	611
Breast lump (benign)	217
Bronchitis (acute)	466
Bronchitis (chronic)	491
Bunions	727
Burns	949
Bursitis	727
CAD (acute)	413
CAD (chronic)	412
Cancer Bladder	188
Cancer Bone	170
Cancer Brain	191
Cancer Breast	174
Cancer Colon	153
Cancer Kidney	189
Cancer Lung	162
Cancer Other	187
Cancer Ovarian	183
Cancer Pancreas	157
Cancer Prostate	185
Cancer Rectal	154
Cancer Skin	173
Cancer Stomach	151
Cancer Thyroid	193
Cancer Uterine	182
Candidiasis	112
Cardiac arrest	427
Carpal tunnel syndrome	739
Cataracts	366
Cellulitus	682
Cervical disc disease	847
Cervicitis	616
Cervix dysplasia	622
Chalazion	373
Chest pain	785
CHF	428
Chicken pox	052
Chlamydia	099
Cholelithiasis	574
Chronic kidney disease	585
Cirrhosis	571
Coccydynia	774
Colon cancer +FOBT	545
Colon cancer, fhx	547
Colon screening	548
Concussion	850
Condylomata	079
Conjunctivitis	372
Constipation	564
Contraception	895
Contusion	919
COPD	496
Corneal ulcer	370
Corns, calluses	700
Costochondritis	733
Cough	786
CPD	653
Crohn's disease	555
Croup	464
CVA	436
Cystitis	595
Cystocoele	618
Deafness	389
Dementia	290
Dental abscess	525
Dental caries	521
Depression	311
DeQuervain's	727
Dermatitis (contact)	692
Dermatitis (seborrhea)	690
Detached retina	361
Deviated nasal septum	470
Diabetes	250
Diabetes ('prediabetes')	249
Diaper rash	691
Diarrhea	009
Disc disease	722
Dislocation shoulder	831
Diverticulitis	562
Divorce, family disruption	901
Dizziness	780
Drug addiction	304
Drug dependence	304
Drug reaction	977
Dupuytren's	728
DVT	451
Dysmenorrhea	625
Dyspareunia	625
Dyspepsia	536
Dysphagia	787
Dyspnea	786
Economic problems	897
Eczema	691
Edema	785
Educational problems	902
Emphysema	492
Endometriosis	617
Enuresis	306
Epididymo-orchitis	604
Epilepsy	345
Epistaxis	786
Erectile dysfunction	306
Esophagitis	530
Failure to thrive	799
Fatigue	796
Feeding problem (infant)	799
Fetal distress	656
Fever	796
Fibroids	218
Fibrocystic breast	610
Fibrositis	729
Fissure in ano	565
Flatfeet	734
Flu	487
Food poisoning	005
Foreign body	930
Fracture ankle	824
Fracture clavicle	810
Fracture Colles'	813
Fracture elbow	832
Fracture femoral neck	820
Fracture femur	821
Fracture fibula/tibia	823
Fracture finger	816
Fracture humerus	812
Fracture metacarpal	815
Fracture metatarsal	825
Fracture other	829
Fracture patella	822
Fracture pelvis	808
Fracture phalanges, foot	826
Fracture rib	807
Fracture vertebrae	805
Fracture wrist	814
Frostbite	998
Frozen shoulder	729
Fungal infection	117
Furunculosis	680
Gall stone	574
Ganglion	727
Gastric ulcer	531
Gastritis	535
Gastroenteritis	009
Gastrointestinal	787
Gingivitis	523
Glaucoma	365
Glossitis	529
Goitre	240
Gout	274
Grief reaction	300
Gynecomastia	611
Hair loss	704
Hallux valgus	735
Head Injury	854
Headache	307
Headache (migraine)	346
Headache (tension)	307
Headache NYD	780
Heart failure	428
Heart murmur	429
Heartburn	787
Hemangioma	228
Hematology, other	285
Hematoma	919
Hematuria	599
Hemiplegia	342
Hemoptysis	786
Hemorrhoids	455
Hepatitis	070
Hernia (inguinal)	550
Hernia (other)	553
Herpes genitalis	099
Herpes simplex	054
Herpes zoster	053
HIV	043
Hives	708
Hodgkins	201
Hydrocele	603
Hyperactivity/ADD	314
Hypercholesterolemia	272
Hyperemesis	643
Hypertension	401
Hypertensive heart	402
Hyperthyroid	242
Hyperventilation	786
Hypothyroid	244
Iatrogenic	998
Immunization	896
Impetigo	684
Incontinence	599
Indigestion	536
Infertility (female)	628
Infertility (male)	606
Influenza	487
Ingrown toe nail	703
Insect bite	919
Insomnia	327
Intertrigo	695
Iritis	364
Irritable bowel	564
ISHD (acute)	413
ISHD (chronic)	412
Jaundice	787
Joint derangement	718
Joint pain	781
Keloid	701
Keratitis	370
Keratosis	701
Kidney stone	592
Knee pain	844
Labyrinthitis	386
Laceration arm	884
Laceration leg	894
Laceration other	879
Laryngitis	464
Leg cramps	781
Legal problems	906
Leukemia	204
Leukocytopenia	288
Leukorrhea	629
Leukorrhea	629
Lipoma	214
Liver disease (other)	573
Low back pain	724
Lupus	695
Lymphangitis	457
Lymphoma	202
Malaise	799
Malnutrition	263
Manic depression	296
Marital problems	898
Mastitis (abscess)	675
Measles	055
Melanoma	172
Melena	787
Meniscal tear	718
Menopause	627
Menorrhagia	626
Menstrual disorder	626
Mental retardation	319
Migraine	346
Miscarriage	634
Mitral valve prolapse	429
Mole	709
Mononucleosis	075
MSK, not yet diagnosed	781
Multiple myeloma	203
Multiple sclerosis	340
Mumps	072
Muscle spasm	728
Myalgia	781
Myopia	367
Nausea or vomiting	787
Nephritis	580
Neuralgia (trigeminal)	350
Neuritis	365
Neuropathy	356
Nevus	216
Nevus (pigmented)	709
Nosebleed	786
Obesity	278
Occupational problem	905
Ophthalmology, other	379
Oral ulcers	528
Osteoarthritis	715
Osteomyelitis	730
Osteoporosis	733
Otitis externa	380
Otitis media	381
Ovarian cyst	220
Overdose	977
Pain (chest)	785
Pain (joint,leg,muscle)	781
Pancreatitis	577
Paranoia	297
Parkinson's	332
Paronychia	686
PAT	427
PCOS	256
Pediculosis	132
Peripheral vasc. disease	443
Personality disorder	301
Pharyngitis	460
Phimosis	605
Phlebitis	451
PID	614
Pilonidal abscess	682
Pinworms	127
Pituitary	253
Placentia previa/abruptio	641
Pleurisy	511
Pneumonia	486
Poison ivy, poison oak	692
Poliomyelitis	045
Polymyalgia rheumatica	725
Post partum hemorrhage	660
Pre-eclampsia	642
Pregnancy (ectopic)	633
Pregnancy (normal)	650
Pregnancy, other	646
Premature labor	644
Premature/low birth wt.	765
Problem, aged parents	900
Prolapse uterus	621
Prostate hypertrophy	600
Prostatis	601
Pruritus	698
Psoriasis	696
Pulmonary embolism	459
Pyelonephritis	590
Pyrexia	780
Pyuria	599
Rash	691
Raynauds	443
Rectal bleeding	569
Reflux esophagitis	530
Renal calculi	592
Renal colic	788
Renal failure	584
Rheumatoid arthritis	714
Rhinitis	477
Ringworm (other)	117
Ringworm (scalp, beard)	110
Rosacea	695
Rubella	056
Scabies	133
Scarring	709
Schizophrenia	295
Sciatica	724
Scoliosis	737
Sebaceous cyst	706
Seborrhea	690
Seizure disorder	345
Sexual dysfunction	306
Shingles	053
Shortness of breath	786
Sickle cell	282
Sinusitis (acute)	461
Sinusitis (chronic)	473
Skin, other	709
Sleep disorder	327
Smoking addiction	305
Smoking cessation	491
Social maladjustment	904
Social problems,other	909
Spinal stenosis	724
Sprain (foot, ankle)	845
Sprain (leg, knee)	844
Sprain (lumbar)	724
Sprain (neck)	847
Sprain (shoulder)	840
Sprain (wrist)	842
Sprain, strain (other)	848
STI/STD	099
Stomatitis	528
Strabismus	378
Strep throat	034
Stress incontinence	625
Stroke	436
Stye	373
Sunburn	691
Syncope	785
Synovitis, tenosynovitis	727
Tachycardia	427
TB test, conversion	010
Tendonitis	727
Tennis elbow	739
Tenosynovitis	727
Threatened abortion	640
Thrombocytopenia	287
Thrush	112
Thyroiditis	245
Thyrotoxicosis	242
TIA	435
Tinea pedis	110
TMJ	524
Tonsillitis	463
Toothache	525
Torticollis	723
Tracheitis	464
Trichomonas	131
Trigger finger	727
Ulcer (duodenal)	532
Ulcer (gastric)	531
Ulcerative colitis	556
Umbilical hernia	553
Undescended testicle	608
Unemployment	905
Unknown	999
Uremia	585
Uremia	585
Urethral stricture	598
Urethritis	597
URI	460
Urinary Infection	599
Urticaria	708
Vaginal bleeding	626
Vaginitis	616
Varicose vein, ulcer	454
Vasovagal attack	780
Vertigo	780
Viral illness	079
Viral rash	057
Vomiting	787
Vulvitus	616
Warts	078
Wax	388
Weight loss	796
Well adult	917
Well baby	916
Whiplash	847
Whooping cough	033
Wound infection	998
Yeast vaginitis	616

OMA ONTARIO MEDICAL ASSOCIATION

section on **General and Family Practice**

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Diagnostic Codes by System

GENERAL

Well baby visit	916
Well adult	917
Immunization	896
Abdominal pain	787
Adverse drug reaction	977
Chest Pain	785
Cough	786
Dizziness	780
Drug dependence	304
Drug reaction	977
Dyspnea	786
Edema	785
Failure to thrive	799
Fatigue	796
Fever	796
Headache	307
Hyperventilation	786
Insomnia	307
Malaise	799
Mental retardation	319
Myalgia	781
Nausea or vomiting	787
Obesity	278
Pain (chest)	785
Pain (joint, leg, muscle)	781
Pyrexia	780
Rash	691
Sleep disorder	307
Smoking addiction	305
Smoking cessation	491
Vertigo	780
Viral illness	079
Viral rash	057
Vomiting	787
Weight loss	796
Unknown	999

SOCIAL AND FAMILY

Divorce, family disruption	901
Economic problem	897
Educational problem	902
Legal problem	906
Marital difficulties	898
Occupational problem	905
Other social problems	909
Problem with aged parents	900
Social maladjustment	904
Unemployment	905

CANCER

Bladder	188
Bone	170
Brain	191
Breast	174
Colon	153
Hodgkins	201
Kidney	189
Leukemia	204
Lung	162
Lymphoma	202
Melanoma	172
Multiple myeloma	203
Ovarian	183
Pancreas	157
Prostate	185
Rectal	154
Skin	173
Stomach	151
Thyroid	193
Uterine	182
Cancer, other	187
Colon cancer, family hx	547
Colon cancer +FOBT	545
Colon screening	548

CARDIOVASCULAR

Angina	413
Arrythmia	427
Arteriosclerosis	440
Arteritis temporal	446
ASHD	412
Cardiac arrest	427
Congestive heart failure	428
Coronary artery disease	412
DVT	451
Edema	785
Heart failure	428
Heart murmur	429
Hypertension	401
Hypertensive heart	402
Mitral valve prolapse	429
PAT	427
Peripheral vasc. disease	443
Phlebitis	451
Pulmonary embolism	459
Raynauds	443
Shortness of breath	786
Tachycardia	427
TIA	435
Varicose vein, ulcer	454
Vasovagal attack	780

ENT

Apthous ulcer	528
Deafness	389
Dental abscess	525
Dental caries	521
Deviated nasal septum	470
Epistaxis	786
Gingivitis	523
Glossitis	529
Labyrinthitis	386
Laryngitis	464
Nosebleed	786
Oral ulcers	528
Otitis externa	380
Otitis media	381
Pharyngitis	460
Rhinitis	477
Sinusitis (acute)	461
Sinusitis (chronic)	473
Stomatitis	528
Tonsillitis	463
Toothache	525
Tracheitis	464
URI	460
Wax	388

GASTROENTEROLOGY

Appendicitis	540
Biliary calculus	576
Biliary colic	574
Bleeding (rectal)	569
Cholelithiasis	574
Cirrhosis	571
Constipation	564
Crohn's disease	555
Diarrhea	009
Diverticulitis	562
Dyspepsia	536
Dysphagia	787
Esophagitis	530
Fissure in ano	565
Food poisoning	005
Gall stone	574
Gastric ulcer	531
Gastritis	535
Gastroenteritis	009
Heartburn	787
Hemoptysis	786
Hemorrhoids	455
Hepatitis	070
Hernia (Inguinal)	550
Hernia (other)	553
Indigestion	536
Irritable bowel	564
Jaundice	787
Liver disease (other)	573
Melena	787
Pancreatitis	577
Pilonidal abscess	682
Rectal bleeding	569
Reflux esophagitis	530
Ulcer (duodenal)	532
Ulcer (gastric)	531
Ulcerative colitis	556
Umbilical hernia	553

GENITOURINARY

Balanitis	608
BPH	600
Chronic kidney disease	585
Cystitis	595
Cystocoele	618
Enuresis	307
Epididymo-orchitis	604
Erectile dysfunction	306
Hematuria	599
Hydrocele	603
Incontinence	599
Infertility (female)	628
Infertility (male)	606
Kidney stone	592
Nephritis	580
Phimosis	605
Prostate cancer	185
Prostate hypertrophy	600
Prostatis	601
Pyelonephritis	590
Pyuria	599
Renal calculi	592
Renal colic	788
Renal failure	584
Sexual dysfunction	306
STI/STD	099
Stress incontinence	625
Undescended testicle	608
Uremia	585
Urethral stricture	598
Urethritis	597
Urinary Infection	599

GYNECOLOGY

Amenorrhea	626
Birth control	895
Bleeding (post menopausal)	627
Breast abscess	611
Breast disorder	611
Breast lump (benign)	217
Candidiasis	112
Cervix dysplasia	622
Cervicitis	616
Contraception	895
Dysmenorrhea	625
Dyspareunia	625
Endometriosis	617
Fibroids	218
Leukorrhea	629
Menopause	627
Menorrhagia	626
Menstrual disorder	626
Ovarian cyst	220
PID	614
Prolapse uterus	621
STD	099
Vaginal bleeding	626
Vaginitis	616
Vulvitus	616
Yeast vaginitis	616

HEMATOLOGY

Anemia (aplastic)	284
Anemia (iron deficiency)	280
Anemia (pernicious)	281
Leukocytopenia	288
Hematology, other	285
Sickle cell	282
Thrombocytopenia	287

INFECTION

Adenitis	289
AIDS	042
Candidiasis	112
Cellulitus	682
Chicken pox	052
Chlamydia	099
Condylomata	079
Croup	464
Flu	487
Fungal infection	117
Herpes genitalis	099
Herpes simplex	054
Herpes zoster	053
HIV	043
Impetigo	684
Influenza	487
Leukorrhea	629
Lymphangitis	457
Measles	055
Mononucleosis	075
Mumps	072
Osteomyelitis	730
Paronychia	686
Pediculosis	132
Pinworms	127
Poliomyelitis	045
Ringworm (scalp, beard)	110
Ringworm (other)	117
Rubella	056
Scabies	133
STI/STD	099
Shingles	053
Strep throat	034
TB test, conversion	010
Thrush	112
Trichomonas	131
Viral illness	079
Whooping cough	033
Wound Infection	998

METABOLISM

Adrenal	255
Diabetes	250
Diabetes ('prediabetes')	249
Goitre	240
Gout	274
Gynecomastia	611
Hypercholesterolemia	272
Hyperthyroid	242
Hypothyroid	244
Lupus	695
Malnutrition	263
Obesity	278
Osteoporosis	733
PCOS	256
Pituitary	253
Rheumatoid arthritis	714
Thyroiditis	245
Thyrotoxicosis	242

MUSCULOSKELETAL

Ankle strain	845
Ankylosing spondylitis	720
Ankylosis	718
Arthritis (osteo)	715
Arthritis (rheumatoid)	714
Bakers cyst	727
Bunions	727
Bursitus	727
Cervical disc disease	847
Coccydynia	774
Costochondritis	733
DeQuervain's	727
Disc disease	722
Dislocation shoulder	831
Dupuytren's	728
Fibrositis	729
Flatfeet	734
Fracture ankle	824
Fracture clavicle	810
Fracture Colles'	813
Fracture elbow	832
Fracture femoral neck	820
Fracture femur	821
Fracture fibula/tibia	823
Fracture finger	816
Fracture humerus	812
Fracture metacarpal	815
Fracture metatarsal	825
Fracture other	829
Fracture patella	822
Fracture pelvis	808
Fracture phalanges, foot	826
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