

ORPCE Office of Regional Primary Care Education
Practice Profile



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|---|---|---------------|
| NAME OF PRACTICE | SITE ADDRESS | |
| OFFICE PHONE # | CITY AND STATE | |
| OFFICE FAX# | ZIP | COUNTY |
| SCHEDULNG CONTACT (for scheduling student rotations) | MAILING ADDRESS | |
| NAME | CITY AND STATE | |
| PHONE # | ZIP | |
| E-MAIL | | |
| OFFICE MANAGER | PRACTICE TYPE | |
| NAME | <input type="checkbox"/> Solo <input type="checkbox"/> Group (2-3 physicians) <input type="checkbox"/> Group (> 4 physicians) | |
| PHONE # | | |
| E-MAIL | | |
| OFFICE HOURS: | IF YOUR PHYSICIANS PRECEPT, MAKE PRECEPTING PAYMENTS TO: | |
| | <input type="checkbox"/> Practice <input type="checkbox"/> Preceptor | |

| | | |
|--|--|--|
| PRACTICE LOCATION: | SERVICES IN YOUR OFFICE | PROCEDURES PERFORMED IN YOUR OFFICE |
| <input type="checkbox"/> Rural / Small town (population < 2500) <input type="checkbox"/> Small town or city not close to large metropolitan area (population 2500-50,000) <input type="checkbox"/> Large city or suburb or metropolitan area (population 50,000 – 100,000) | <input type="checkbox"/> Lab, Basic Lab <input type="checkbox"/> X-Ray <input type="checkbox"/> Emergency <input type="checkbox"/> Library <input type="checkbox"/> Other | <input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Skin biopsies <input type="checkbox"/> Toe nail removal <input type="checkbox"/> Colposcopy <input type="checkbox"/> Joint injections |
| PRACTICE POPULATION: | RACIAL OR ETHNIC PRACTICE POPULATION: | |
| <input type="checkbox"/> Newborn Infants (0-2 years) _____ % <input type="checkbox"/> Children (3-12 years) _____ % <input type="checkbox"/> Adolescence (13-18 years) _____ % <input type="checkbox"/> Young adult (19-35 years) _____ % <input type="checkbox"/> Middle adult (36-65 years) _____ % <input type="checkbox"/> Older adult (> 65 years) _____ % Total = 100% | <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American _____ % <input type="checkbox"/> Hispanic / Latino _____ % <input type="checkbox"/> Native American _____ % <input type="checkbox"/> White _____ % <input type="checkbox"/> Other _____ % Total = 100% | |
| NUMBER OF PATIENTS IN PRACTICE? _____ | HOW MANY PATIENTS ON AVERAGE ARE SEEN PER DAY? | |
| SPECIALITY | HOW MUCH TECHNOLOGY IS YOUR OFFICE USING? | |
| <input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Ob-Gyn <input type="checkbox"/> Pediatrics <input type="checkbox"/> Multi-Specialty Group <input type="checkbox"/> Other: _____ | <input type="checkbox"/> PC with Internet access? <input type="checkbox"/> Available for computer use? <input type="checkbox"/> Electronic Medical Records: Total, Converting (Circle one) <input type="checkbox"/> PDA's List type _____ <input type="checkbox"/> PDA Medical Software: List _____ <input type="checkbox"/> Other: _____ | |

HOW MANY OF THE FOLLOWING OTHER TYPES OF PERSONNEL WORK IN YOUR PRACTICE?

| CLINICAL STAFF | NUMBERS | BUSINESS STAFF | NUMBERS |
|--|---------|--|---------|
| <input type="checkbox"/> RN | | <input type="checkbox"/> Office Manager | |
| <input type="checkbox"/> LPN | | <input type="checkbox"/> Receptionist | |
| <input type="checkbox"/> Medical Assistant | | <input type="checkbox"/> Billing Clerk | |
| <input type="checkbox"/> Mental Health Counselor | | <input type="checkbox"/> Medical Records Clerk | |
| <input type="checkbox"/> Lab Tech | | <input type="checkbox"/> Other | |
| <input type="checkbox"/> X-Ray Tech | | | |
| <input type="checkbox"/> Phlebotomist | | | |
| <input type="checkbox"/> Other | | | |

- MAXIMUM NUMBER OF STUDENT ROTATIONS PER MONTH _____.
- IF ALL PRACTITIONERS PRECEPT, WHO WILL BE THE PRIMARY PRECEPTOR?
_____.

PLEASE ATTACH A PRACTICE BROCHURE IF AVAILABLE