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Process
Date
Analyst

Practice Support Program Profile Analysis Request Form
INDIVIDUAL PHYSICIAN

"I, _____ *(please print your full name),* would like to request my **Practice Support Program (PSP) Physician Profile Analysis** from the Primary Health Care Branch, Ministry of Health.

I understand that this Analysis will contain information relating to patients currently in my care as determined by the rule of majority source of care (MSOC) – MSOC patients received the majority of their General Practitioner (GP) services from the practice. Only patients with three or more GP services, over all GPs, can meet the MSOC rule. This request is for a five year summary and the patient specific information for the previous fiscal year period. The PSP Physician Profile Analysis has been compiled by the Ministry of Health to provide feedback on recommended care performance for patients in priority populations (e.g., Congestive Heart Failure, Diabetes Mellitus).

Type of Information Contained in the PSP Physician Profile Analysis:

- Personal Health Number
- Patient Name
- Patient Date of Birth
- Patient Age
- Patient Gender
- Diagnosis
- Incentive Payments Billed
- Date of Billing
- Resource Utilization Band Breakdown Figures for the Province and Practice
- Recommended care received, by priority population group for the Province and Practice

I agree that the Analysis will be used by me solely for evaluation purposes and to assist me in providing recommended care to my patients. I agree to keep the Analysis and, all personal information contained therein, confidential and secure in accordance with the requirements of both the *Personal Information Protection Act* and the College of Physicians and Surgeons of British Columbia. The Analysis will be stored in a secure location in the same manner as all other patient medical records. My Health Authority Regional Support Team will be notified of my application for this Report (the report itself will not be shared). The Regional Support Team uses this information to monitor uptake and engagement in regional Practice Support Program and related health system improvement initiatives.

[Check if applicable]

☐ **I do not wish to have my Health Authority Regional Support Team notified of my application for this report.**

_____ _____ _____
Signature of Requesting Physician Practitioner Number Date

Clinic Name _____

Street Address: _____

City _____Postal Code _____

Tel: _____Fax:_____

*Email: _____

** Mandatory – your password for the encrypted CD will be sent to you via email.*

You may submit this form via fax to (250) 952-1417 or 1-800-952-2895 or by mail to the address below.

If you have any questions, please contact:

Primary Health Care Branch, Ministry Of Health Services, 3-2, 1515 Blanshard Street, Victoria, BC V8W 3C8
E-mail: hlth.cdm@gov.bc.ca; Telephone: (250) 952-3124; Fax: (250) 952-1417 or 1-800-952-2895