For Office Use Only
Process Date
Analyst

Physician Patient Profile Report Request Form

"I, ____ *(please print your full name),* would like to request my **Physician Patient Profile Report** from the Primary Health Care Branch, Ministry of Health.

I understand that this Report 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 my practice. Only patients with three or more GP services, over all GPs, can meet the MSOC rule. This request is for summary and the patient specific information. The Physician Patient Profile Report has been compiled by the Ministry of Health to provide information on my MSOC patients in priority populations (e.g., patients with Chronic Conditions like diabetes mellitus, patients with Mental Health Condition or Frail Elderly patients).

Type of Information Contained in the Physician Patient Profile Report:

- Personal Health Number
- Patient Name
- Patient Gender
- Patient Date of Birth and Age
- Patient Diagnosis
- Patient Number of Chronic Conditions
- Patient Number of Hospitalizations in previous year
- Patient Resource Utilization Band & Breakdown Figures for the Practice and Province
- Patient Predictive Modeling Score & Percentile
- Incentive Billed & Date of Billing
- Patient Proxy Measure for Recommended Care received & for the Practice and Province

I agree that the Report will be used by me solely to assist me in providing recommended care to my patients. I agree to keep the Report, 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 Report will be stored in a secure location in the same manner as all other patient medical records.

____ ______________ ______________

* Signature of Requesting Physician * MSP Practitioner # Date

* Clinic Name: ____

Other Name - e.g. IHN, Division *(if applicable)*: ____

* Street Address: ____

* City: ______________________________ Postal Code: ______________________

*Email: ______________________ Telephone: ______________________ Fax: ______________________

* *Mandatory*

You may submit this form via fax to (250) 952-1417 or by mail to the address below.
If you have any questions, please contact:

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

Personal information on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act*. The information submitted will be used to provide analysis data to requesting physicians for the diagnosis and treatment of patients within their care. All information provided will be used in a manner that complies with the terms of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection and use of this information, please contact Primary Health Care Branch at the address listed above.