

PENNSYLVANIA AHEC	PRACTICE SITE PROFILE S-1	AHEC Region Use Only: Code: _ _ _ _ _
------------------------------	--------------------------------------	--

The Pennsylvania-Delaware AHEC is seeking to help meet the primary care needs of our communities and to make health careers training a more valuable experience. Results from this survey will be used to support these goals. **All survey responses are confidential.** Data will only be used within the AHEC program and never for commercial purposes.

PART A

Date Completed: ___/___/___
 Month Day Year

General Site Characteristics:

1. Please provide the following information about your site/facility.

Site/Facility Name _____
 Street Address _____
 City _____
 State _____ ZIP _____

2. Whom should the AHEC contact to obtain information about your site/facility?

Name _____
 Phone Number (____) _____ - _____ Fax Number (____) _____ - _____
 E-mail _____

3. What type of practice/facility is this?

- Solo Medical
- Multi-specialty Medical Group
- Single-specialty Medical Group
- Community Health Center (CHC)
- Hospital
- Dental Office
- Other _____

4. Does this site have any satellite offices?

- Yes
- No
- This site is a satellite

4a. If YES, please list the city/town and ZIP code for each.

City/Town	ZIP Code
City/Town	ZIP Code

PART B

12. How many providers of the following types are providing service at this site? (If none, please enter 0.)

- a. ___ ___ Advanced Practice Nurse (CNMW, CRNP, CNA etc.)
- b. ___ ___ RN
- c. ___ ___ LPN
- d. ___ ___ Physician
- e. ___ ___ Physician Assistant
- f. ___ ___ Dentist
- g. ___ ___ Dental Hygienist
- h. ___ ___ Dental Assistant
- i. ___ ___ Pharmacist
- j. ___ ___ Physical Therapist/Occupational Therapist
- k. ___ ___ Social Worker
- l. ___ ___ Mental Health Professional (other than psychiatrist)
- m. ___ ___ Public Health/Community Health Specialist
- n. ___ ___ Other

13. What languages (other than English) are required for your providers to adequately communicate with your patients?

- a. _____
- b. _____
- c. _____

14. Do you use interpreters?

- Yes No

If YES, please provide more information about what interpreters/services you use.

15. On average, how many patients per day does your site treat? (Please make an estimate of what is typical.)

Site Resources:

16. Which of the following educational opportunities or resources do you have for students to use?

- Computer system
- Internet access
- Medical library
- Medline access

17. Which of the following educational opportunities or resources do you provide for patients?

- Pamphlets for patient education
- Audio tapes for patient education
- Videotapes for patient education
- Computer system

18. Describe any special characteristics, populations served, or opportunities about your office that you would like to share with a student.

19. Is student housing available in your area?

- Yes
- No

19a. If YES, please provide the following information about whom to contact about that housing. (If it is the AHEC representative, just enter "AHEC" on the name line.)

Name _____

Street Address _____

City _____ State _____ ZIP Code _____

Phone Number (____) _____ - _____

E-Mail _____

20. What are your office hours?

Monday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Tuesday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Wednesday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Thursday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Friday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Saturday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Sunday	Open: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM	Close: ___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM

21. Which of the following services and procedures does your facility provide on-site? (Include services not listed that you think are particularly important or that is a high volume procedure for you.)

- | | |
|--|--|
| <input type="checkbox"/> Allergy Testing | <input type="checkbox"/> Office laboratory |
| <input type="checkbox"/> Casting | <input type="checkbox"/> Skin excision |
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Spirometry |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Treadmill testing |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Minor surgical procedures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Other _____ |

21a. If minor surgical procedures are provided by your practice/facility, please indicate the types of procedures.

1. _____
2. _____
3. _____
4. _____
5. _____

Thank you!

<p>AHEC Region Use Only: Date Entered: ___ ___ / ___ ___ / ___ ___ ___ ___ Month Day Year Entered by: _____</p>
--