NorFam residents participating in wilderness medical training.

Northern Family Medicine Education (NorFam)

Rural Family Medicine Handbook

Labrador-Grenfell Health
Labrador Health Centre
Happy Valley-Goose Bay, Labrador

Revised: January 10, 2018

Memorial University

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Welcome to your NorFam Rural Family Medicine Rotation! This handbook will provide you with information to help you navigate through your time in Goose Bay. If you have any questions please ask the Academic Program Administrator or one of the Faculty members for more information.

1. MISSION STATEMENT

Our mission is to prepare family medicine residents to be competent, confident rural physicians.

Annual summer retreat with no cell service/internet.

2. ROTATION OBJECTIVES & COMPETENCIES

2.1 Family Medicine Competencies

There are six essential skills that enable the family physician to deal competently with problems in the domain of family medicine. The competent family physician has **the potential to use all the skills for any problem**, but competence is also characterized by adapting the **choice of the skills** used to the specific needs of the problem at hand.

PATIENT-CENTERED APPROACH: This is a hallmark of family medicine and represents one of the most efficient and effective methods for dealing with problems.

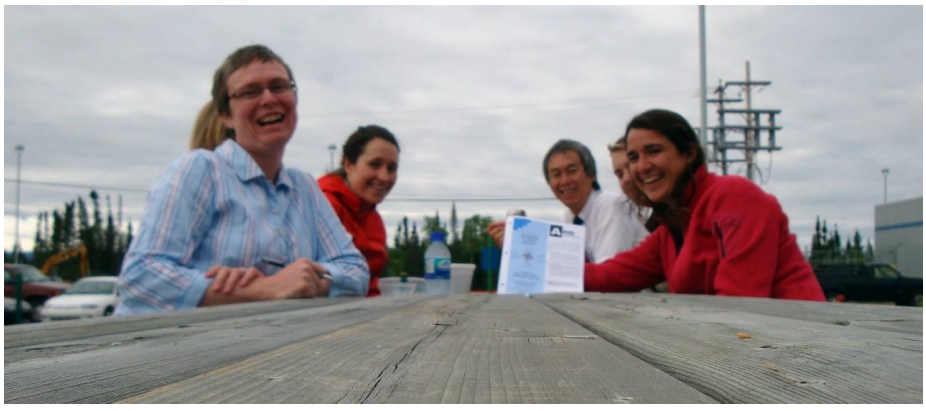
COMMUNICATION SKILLS: Certain skills and behaviors facilitate communication, and **good communication is essential for competence**. Communication can be written or verbal, with patients or colleagues; it also involves listening and watching as much as or more than talking and showing.

CLINICAL REASONING SKILLS: This dimension focuses on the **problem-solving skills** used to deal with the "medical aspects" of a problem. Although obviously knowledge dependent, many of the difficulties in this dimension are related to poor process (the how and why). Assessment of these processes is more important than assessing the final results or answers.

SELECTIVITY: This dimension describes a set of skills that characterize a competent family physician: such a physician does not do things in a routine fashion, but is **selective in their approach, adapting it to the situation and patient**. This physician **sets priorities and focuses on the most important**, knowing when to say something and when not to, gathering the most useful information **without losing time on less contributory data**, or doing something extra when it will be helpful. It is perhaps a subset of all the other dimensions, but it was used frequently enough to merit its own dimension.

PROFESSIONALISM: This dimension was the most frequently cited in the descriptions of competence. It includes all the responses that deal with respect and responsibility to patients, to colleagues, to oneself, to the profession, and to society. It includes ethical issues, as well as lifelong learning and the maintenance of quality of care. It also includes attitudinal aspects such as caring and compassion.

PROCEDURE SKILLS: An individual about to enter independent practice should be able to competently perform certain procedures.



Problem-based learning in the great outdoors.

2.2 CanMEDS Framework Definitions:

MEDICAL EXPERT: As Medical Experts, physicians integrate all of the CanMEDS Roles, **applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care**. Medical Expert is the central physician Role in the CanMEDS framework.

COLLABORATOR: As Collaborators, physicians effectively **work within a healthcare team** to achieve optimal patient care.

MANAGER: As Managers, physicians are **integral participants** in healthcare organizations, **organizing** sustainable practices, making **decisions about allocating resources**, and **contributing to the effectiveness** of the healthcare system.

HEALTH ADVOCATE: As Health Advocates, physicians responsibly use their expertise and influence to **advance the health and well-being of individual patients, communities, and populations**.

SCHOLAR: As Scholars, physicians demonstrate a **lifelong commitment to reflective learning**, as well as the **creation, dissemination, application and translation of medical knowledge**.

COMMUNICATOR: As Communicators, physicians **effectively facilitate the doctor-patient relationship** and the dynamic exchanges that occur before, during, and after the medical encounter.

PROFESSIONAL: As Professionals, physicians are **committed to the health and well-being of individuals** and society through **ethical** practice, profession-led regulation, and high personal standards of behavior.

Interdisciplinary training with SAR Techs.

2.3 MUN Rural Family Medicine Rotation Objectives (NorFam-specific)

DISCIPLINE OF FAMILY MEDICINE
MEMORIAL UNIVERSITY OF NEWFOUNDLAND
NORTHERN FAMILY MEDICINE EDUCATION (NORFAM)
OBJECTIVES/EVALUATION FORM (sample)

Date:
Name of Resident:
Faculty present:

The goal of NorFam is to train residents for rural and remote practice. This enables them to become competent rural physicians and encourages them to choose a rural and remote practice. Training in this setting gives the resident an opportunity to learn areas of special knowledge and associated procedural skills that can appropriately be practiced in the family medicine office, outpatient, inpatient, or emergency setting. The NorFam objectives accomplish this goal as the resident is given opportunities to see the 4 principles of Family Medicine at work in a rural remote practice.

PRINCIPLE 1: THE DOCTOR-PATIENT RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN

Objective One

Develop skills in interviewing and counseling

Process:

- Direct observation of patient interviewing and counseling with feedback from teachers
- Practice simulated office orals
- Discussion around videotaped patient encounters

Evaluation:

a. Demonstrated skill in patient interviewing and counseling
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Satisfactory completed at least three SOO's
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Satisfactory discussion around 3 videotaped encounters
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Two

Understands and appreciates cross-cultural issues by:

- demonstrating compassionate, culturally safe, relationship-centered care for First Nations, Inuit, Metis (FNIM) patients, their families or communities. The groups formerly known as the Labrador Metis have adopted the name Nunatukavut, which means "our ancient land".
- demonstrating effective and culturally safe communication with FNIM patients, their families and peers
- demonstrating the skills of effective collaboration with FNIM and non-FNIM health care professionals/traditional medicine peoples/healers in the provision of effective care for FNIM patients/populations
- developing an appreciation for different approaches to optimizing FNIM health through a just allocation of health care resources, balancing effectiveness, efficiency and access, employing evidence based and indigenous best practices
- being able to identify the determinants of health of FNIM populations and use this knowledge to promote the health of individual patients and their communities
- contributing to the development, dissemination, critical assessment of knowledge and practices that relate to the improvement of FNIM health in Canada
- demonstrating a commitment to engage in dialogue and relationship building with FNIM peoples to improve health through increased awareness and insights of FNIM peoples, cultures, and health practices

Process:

- Observation by facility of interactions with patients
- Case discussions on dynamics in cross-cultural interactions
- Visits to and work in a FNIM community

Evaluation:

a. Demonstrated the aptitude to understand patients from different ethnic backgrounds
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Visited a community and learned its culture
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Three

Demonstrate professionalism in practice

Process:

- Observation by preceptors in clinical settings
- Feedback from patients and other colleagues

Evaluation:

a. Honesty/Integrity
Was truthful with patients, peers, and in professional work in documentation, communication, presentation, and research
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Reliability/Responsibility
Was accountable to patients and colleagues. Can be counted on to complete assigned duties and tasks. Accepts responsibility for errors
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Altruism/Advocacy
Adhered to best interest of the patient, puts best interest of the patient above self-interest and the interest of other parties
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

d. Self-awareness/Knowledge of limits
Recognized need for guidance and supervision when faced with new or complex responsibility; is insightful of the impact of one's behavior on others and cognizant of appropriate professional boundaries
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

PRINCIPLE 2: THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN

Objective Four

Become competent in procedural skills

Process:

- Discussion of the indications and demonstration of how to perform the procedures
- On-site supervision of procedures performed by residents
- Review of procedures performed/observation records

Evaluation:

a. Satisfactorily demonstrated the ability and confidence in performing skills listed in category A (list attached)
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Learned to perform some of the skills in category B and C (list attached)
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Five

Becomes competent in emergency medicine and acute care

Process:

- Shifts in the Emergency Department
- Responsibility for inpatients and ICU patients
- Chart reviews, ward rounds

Evaluation:

a. Demonstrated competence in dealing with cases seen in emergency
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Demonstrated an ability to stabilize and maintain patients in ICU
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Assumed responsibility and cared for inpatients
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Six

Gains experience and knowledge in the principles of medical evacuation

Process:

- Medical evacuation workshop or review seminar
- Organization of a medical evacuation

Evaluation:

a. Made good judgments concerning who requires evacuation
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Demonstrated the ability to organize a medical evacuation
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

PRINCIPLE 3: THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION

Objective Seven

Gains confidence in isolated practice and learns to refer appropriately

Process:

- Coastal community visits
- Inpatient rounds, chart reviews and corridor consultations

Evaluation:

a. Demonstrated the ability to give advice by telephone to nursing station staff
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Demonstrated the ability to work independently in a coastal community
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Demonstrated an ability to determine what needs to referred
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

d. Demonstrated the ability to communicate clearly with consultants
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

e. Demonstrated the ability to provide patient care via videoconference
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples Recommendations:

Objective Eight

Learns to use investigative tools judiciously and appropriately

Process:

- Review of cases and investigations ordered
- Discussion on the predictive values of the investigation
- Discussion on the most cost-effective means of investigations locally

Evaluation:

a. Knew what investigations to order and interpreted the results correctly
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Demonstrated an understanding of the cost-effectiveness and predictive value of investigations ordered
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Nine

Learns to critically appraise and assess the literature

Process:

- Presentation and participation at Journal Club
- Patient care discussions

Evaluation:

a. Attended Journal Club regularly
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Satisfactorily formally appraised at least one article at Journal Club
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Ten

Satisfactorily completes an academic project, preferably on a topic relevant to rural/northern health issues

Process:

- Generation of a researchable question or health issue
- Performance of a literature search
- Writing of a proposal and submitting it to the Director for faculty approval (and to the Research Director of Family Medicine, if applicable)
- Submission of the proposal to the LHC Research Review Committee, if necessary
- Writing of the research/academic paper
- Presentation of the paper in either a poster presentation or oral presentation at the Family Medicine Research Day
- Presentation of the paper to local staff and interested parties in Happy Valley-Goose Bay during the rotation

Evaluation:

a. Completed and presented an academic project
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Research Project (title, progress, etc):

Comments, Examples and Recommendations:

Objective Eleven

Learns to organize a practice so as to provide administrative and clinical services efficiently and effectively

Process:

- Attendance at the practice management seminars
- Participation at medical staff meetings
- Involvement in the local practice
- Chart reviews with preceptors

Evaluation:

a. Attended practice management seminars
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Attended at least one medical staff meeting
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Scheduled his/her time in such a way that the rotation ran smoothly and learning opportunities were maximized
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

d. Demonstrated efficiency and effectiveness in the "paperwork" part medical practice e.g. appropriate charting, discharge summaries
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

e. Demonstrated the ability to be manage patients effectively during case discussions in chart review
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Twelve

Develops a sense of self-awareness and an aptitude for self-directed learning.

Process:

- Reading around problems from patients seen
- Usage of the local and online resources

Evaluation:

a. Demonstrated an aptitude for self-directed learning in ward round discussions and chart review
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Utilized local and online resources in patient management
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Thirteen

Demonstrates competence in mentoring others

Process:

- Direct observation of resident in teaching situations
- Feedback from students
- Mentoring of medical students may take place in family medicine clinics (in Happy Valley-Goose Bay or on the coast), on the wards, and/or in the emergency room

Evaluation:

a. Demonstrates ability to organize and present morning teaching sessions
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Participates in mentoring medical students
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments and Recommendations:

PRINCIPLE 4: FAMILY MEDICINE IS COMMUNITY BASED

Objective Fourteen

Exercise under supervision, a practice that is primary, continuous, comprehensive and preventive.

Process:

- Involvement as a team member in the local practice
- Provision of primary, continuous, comprehensive, and preventive care under the supervision of a preceptor

Evaluation:

a. Identified 10 patients who were followed for a medical concern and has updated their cumulative patient profile (including the preventative health care/health maintenance section)
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Provided prenatal, intrapartum or in hospital and postnatal care to four patients
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Identified four patients who were seen in three different locations-e.g. outpatient department, emergency department, in hospital in coastal clinic, home visit, public health department
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

d. Demonstrated the ability to deal with a wide variety of primary care medical problems
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments and Recommendations:

Objective Fifteen

Learns to work with allied health care professionals

Process:

- Feedback from allied health care workers
- Observation of interaction with allied health care workers
- Review of cases and assessment of the appropriateness of referrals

Evaluation:

a. Developed good working relationships with allied health care professionals
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Appropriately made use of allied health care professionals
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

c. Worked well as part of the health care team at a community nursing station
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

Objective Sixteen

Learns to use community resources appropriately

Process:

- Discussion on the availability and the role of community resources
- Review of cases and the appropriateness of referrals to these resources

Evaluation:

a. Demonstrated awareness and appropriateness in the involvement of community resources in patient care
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

b. Presented examples of the involvement of community resources in patient care
Not Applicable ☐ Appropriate Level ☐ Inappropriate Level ☐

Comments, Examples and Recommendations:

The resident has been seen during his/her clinical duties and was under direct observation during parts of this rotation. She/he performed: pass ☐ fail ☐

IF YOU INDICATE FAIL ABOVE, PLEASE ELABORATE BELOW

General Comments (Preceptor):

High fidelity simulated rural critical care training.

2.4 List of Skills Expected of a Rural Family Physician

Categories: A – must have done (here or elsewhere)
B - have to know how to do and may do
C - may have to know how to do

MEDICAL SKILLS CATEGORIES:

A 1. Interpretation of EKG
A 2. Interpretation of Pulmonary function tests
A 3. Arterial puncture and interpretation of blood gases
A 4. Insertion of peripheral venous lines
A 5. Interpretation of x-rays
A 6. Joint aspiration and injection
A 7. Skin biopsy
A 8. Insertion of naso/orogastric tube and gastric lavage
A 9. Insertion of urinary bladder catheter
A 10. Proctoscopy and/or sigmoidoscopy
A 11. Management of stable and unstable angina

B 12. Thoracocentesis
B 13. Lumbar puncture
B 14. Bone marrow biopsy and aspiration
B 15. Peritoneal tap
B 16. Thrombolytic therapy and management of myocardial infarction

PSYCHIATRIC SKILLS

A 1. Management of psychiatric emergency & crisis intervention
A 2. Interviewing

B 3. Psychotherapy
B 4. Management of sexual, spousal, child and elderly abuse
B 5. Alcohol detoxification and rehabilitation
B 6. Management of solvent abuse

SURGICAL SKILLS

A 1. Excision biopsy of lumps and bumps
A 2. Incision and drainage
A 3. Removal of foreign bodies
A 4. Cautery, diathermy or cryotherapy
A 5. Suturing of wounds
A 6. Assisting major surgery

B 7. Wedge resection, removal and ablation of toe nails
B 8. Aspiration of cysts

C 9. Needle biopsy - prostate, liver, breast and muscle
C 10. Care of tracheostomy
C 11. Vasectomy

ANAESTHETIC

A 1. Local anaesthesia

B 2. Procedural Sedation
B 3. Nerve blocks (e.g. digital nerve)

C 5. Regional blocks

PEDIATRIC SKILLS

A 1. Neonatal and pediatric resuscitation
A 2. Insertion of peripheral venous lines
A 3. Endotracheal intubation

B 4. Insertion of intraosseous line
B 5. Thoracocentesis
B 6. Lumbar puncture

C 7. Bone marrow aspiration

EMERGENCY MEDICINE AND INTENSIVE CARE

A 1. Advanced Cardiac Life Support
A 2. Neonatal resuscitation
A 3. Trauma Life Support
A 4. Endotracheal intubation

B 5. Use of mechanical ventilator
B 6. Cricothyroidotomy
B 7. Intraosseous infusion
B 8. Overdose and poisonings
B 9. Medevac

C 10. Central venous access
C 11. Venous cut-down

ORTHOPEDIC SKILLS

A 1. Application of splints and casts

B 2. Closed reduction of common fractures and dislocations

C 3. Taping and strapping procedures

ENT SKILLS

A 1. Removal of wax from the external auditory canal

B 2. Anterior and posterior nasal packing
B 3. Cautery for epitaxis
B 4. Removal of foreign body from ears, nose and throat

C 5. Audiometry and tympanometry
C 6. Reduction of nasal fractures
C 7. Drainage of quinsy
C 8. Indirect laryngoscopy and posterior pharyngo-rhinoscopy

OPHTHALMOLOGY SKILL

A 1. Use of the slit lamp
A 2. Removal of foreign body
A 3. Testing of visual acuity, visual fields and color vision
A 4. Fundoscopy

B 5. Tonometry

OBSTETRIC AND GYNAECOLOGICAL SKILLS

A 1. Diagnosis of the onset of labor, assessment of the progress of labor and recognition of significant deviation from the normal.
A 2. Interpretation of non-stress test
A 3. Fetal heart monitoring & recognition of abnormal patterns
A 4. Local anaesthesia by perineal infiltration or pudendal nerve block
A 5. Normal vaginal delivery
A 6. Episiotomy and/or repair of vaginal and perineal wounds
A 7. Assisting in Cesarean section
A 8. Bimanual pelvic examination
A 9. Collection of pap smears

B 10. Sterile speculum examination for ruptured membranes
B 11. Induction of labor

B 12. Vacuum extraction
B 13. Endometrial biopsy
B 14. Insertion and removal of intrauterine device
B 15. Manual removal of retained placenta and exploration of uterus
B 16. Management of shoulder dystocia
B 17. Management of inverted uterus
B 18. Management of cord prolapse
B 19. Management of post-partum hemorrhage

C 20. Breech delivery
C 21. Delivery of twins
C 22. Low forceps delivery

Training to lead resuscitation via robotic telemedicine.

3. NORFAM ORIENTATION CHECKLIST

- Coastal Communities/Information
  - ☐ Booking flight with RT
  - ☐ Bring food
  - ☐ Bill for expenses
  - ☐ Fax notes, chart reviews
  - ☐ Coastal Chart reviews
  - ☐ Stamp with reviewing preceptors name to confirm identity of supervisor
  - ☐ Videoconference links to all coastal communities

- Leave requests
  - ☐ In advance (same as regular staff)
  - ☐ This applies to leave and non-leave absences (e.g. LMCC, etc)

- Teaching
  - ☐ Morning Teaching Schedule
  - ☐ Academic half days
  - ☐ Journal Club
  - ☐ SOOs
  - ☐ Bricks and Bouquets
  - ☐ Videotape review sessions
  - ☐ Chart reviews at the end of the day
  - ☐ Ward rounds 9:00-10:00 am, meet preceptor 9:30 am – come if no inpatients
  - ☐ Practice management (occasional Friday morning)
  - ☐ Residents teach some morning sessions

- Emergency Room Shifts
  - ☐ Day 9:00 am – 5:00 pm
  - ☐ Evening 5:00 pm – 9:00 am
  - ☐ Weekend 9am-9pm, 9pm-9am
  - ☐ Medevac calls
  - ☐ To add inpatients in need of follow-up e.g. ER
  - ☐ Day off in lieu of 3 weekends, tied up in ER

- Backup coverage
  - ☐ Inpatients – ward round
  - ☐ Obstetrical

- Intrapartum Obstetrics – midwives, case room nurses etc.

- Need to arrange coverage for resident' s inpatients and lab results during time away

- Discuss with the preceptor before:
  - ☐ Calling in lab and xray after hours
  - ☐ Arranging medevacs and CT scans

- Mileage & Expense Claim Forms
- Mentoring of Medical Students
- Educational Objectives of MUN Clinical Clerks
- Critical Incident debriefing
- NORFAM contacts:
  - ☐ Secretarial – Joanne x2154
  - ☐ Administrative Program Coordinator – Fatima x2033
  - ☐ Suggested order of contacting if troubles:
    1. Robert Forsey
    2. Michael Jong
    3. Other NorFam preceptors: Dr. Karaivanov, Dr. Woollam etc.
- Behavioral Medicine
- Notify Joanne/ preceptor if sick/away/coastal delay (it is not enough to notify OPD staff)
- Clinic times
- Shared resident drive (data files)

Financial Counselling

Q: Who can Residents contact for financial counseling?

A: Philip Kearley is the Financial Counselor in the Student Affairs Office.
Philip.kearley@med.mun.ca Room M2M121 Tel: 709-864-6395

Q: Can residents contact the NLMA in confidence program for personal issues?

A: Yes, residents can access this service; they can self-refer using links on the NLMA website:
Username: nlma
Passcode: inconfidence
This service can be accessed 24/7 by calling 1-877-418-2181

Q: Do Residents have family doctors they can access?

A: It is recommended that residents have their own family doctor located in their primary site. A list of family physicians willing to take residents as patients is available for residents on One45. Preceptors should maintain good boundaries with their trainees and not provide medical care if they are teaching.

Coastal Chart Review

- Usually held Tuesday-Friday sometime between 9-10 AM

- At the end of each day please fax out the days notes (make sure each sheet has patients name, date of birth and community so Health Records can file them properly)

- Review Monday's clinics on Tuesday morning (the Tuesday schedule has a physician booked for this "e.g. CR Nain- Forsey"); review Tuesday's clinic Wednesday AM; review Wednesday's on Thursday AM; Review Thursday's on Friday AM*

- If any patients are seen on Friday bring out the notes to review with the physician scheduled for Goose Bay chart reviews that afternoon

*the Friday AM review time will need to be flexible as flight times from the coast will vary

Early morning physical/mental wellness activity before clinic in Nain.

4. CONTRACTING

4.1 Initial Contracting Points for Residents

- One of the goals of the NorFam Program is to encourage residents to move into the role as the main provider of care. The preceptors are here to give you backup at all times but the patients (on the ward and in OPD/ER) will identify you as their main care provider.

- Under the supervision of your preceptor you are expected to take responsibility in a wide variety of areas.

- Inpatients admitted under your care should be assessed regularly, and if you are unable to care for them (e.g. travel out of town, etc.) please make arrangements for this to be done by a colleague. If you are leaving town for a period of time they should be formally transferred to someone else.

- It is also important that you make arrangements to have your laboratory tests reviewed while you are away. Generally it is not difficult to get a coworker or two to cover this for you. This minimizes the possibility of such things as untreated strep throat, non-therapeutic INR's, etc. being undetected.

- Leave requests must be received in writing by the NorFam Coordinator. Communicate all time away in writing as far advance as possible and at minimum before the call schedule is released (usually 6 weeks in advance). The NorFam Coordinator will also need to know your non – leave time away eg. LMCCs, Exams, Core Content, etc.

- At times it is possible to switch the schedule around afterwards but it is usually very difficult and can make things difficult for your colleagues. You are expected to be present for your scheduled emergency room shifts – if you have to be away after the schedule is released please arrange to have your shift covered by another resident.

- Obstetrical backup/Inpatient backup - the faculty assigned to ward rounds for the week is your backup should after hours emergencies arise on your inpatients, or if labor and delivery care is required after hours. The backup faculty will carry a beeper or inform the switchboard of their whereabouts. It is important to emphasize you should never have to work in a situation where there is no backup. If this unlikely situation does occur you would be best advised to discuss this situation with the physician covering the emergency department and consider turning over the patients care to that doctor (this would normally happen anyway if you were unavailable) or possibly continue to manage the patient under the supervision of the emergency room physician. The above noted situation is extremely infrequent but could potentially arise if your faculty backup has been called away e.g. on a medevac.

- Direct Observations – We will maintain a record of these. It would be helpful if you keep a diary of your medevacs, inpatients, procedures, and deliveries as it could be helpful at midterm and final evaluation sessions.

- Videotape – approximately once a month there will be a scheduled videotape review session. Residents are required to bring one videotaped patient encounter for review. The camera is wall mounted in Dr. Valdes' examination room. If this room is not available, the NorFam secretary has a camera in the NorFam office that you can use. Verbal consent for taping should be recorded. For example, "Mr. Smith – as we just discussed you have agreed that I may tape this visit for review with the other doctors. It will be reviewed by them for teaching purposes only and the tape will be erased afterwards".

- Academic ½ day: Depending on your availability, Tuesdays afternoon will be booked off for you to attend this session. It will not be possible for you to attend all these session (ER shifts/coast/etc.) but we will endeavor for you to have you attend as many as possible. These sessions are archived through MUN Family Medicine and can also be accessed after hours.

- Research afternoon: Two half days per month will be set aside by the NorFam secretary for this.

- Medical Student Objectives – residents and medical staff are involved in teaching MUN clinical clerks during their Rural Family Medicine rotations. This teaching may occur in clinics, the emergency room and in morning teaching sessions. The MUN Clerkship objectives are part of your orientation packet-it is very useful to know what the student objectives are.

- Behavioural Medicine log sheet – MUN Family Practice has requested that a log be completed to verify that the required number of mental health cases are seen and managed. This log sheet is appended.

4.2 Resident Contract

All residents will be expected to meet with their faculty advisor to review and sign a resident contract at the beginning of their Rural Family Medicine training.

Expedition to winter camp.

Winter camp in February.

5. RESIDENT FEEDBACK – FIELD NOTES

The field note tool, located in the ePortfolio system, is a tool used to drive resident feedback (both positive and negative) and future learning.

A field note is a report on a discussion, direct observation, complete examination observed, complete procedure observed, or some other clinical or professional encounter focusing on a single modifiable behavior. They can be initiated by the resident or by the preceptor.

The purpose of field notes is to document the progress of residents as they acquire the required competencies to complete their training.

Residents are required to complete a minimum of 100 field notes per academic year. This is best achieved by doing one for each day of clinical work.

Complete instructions on how to complete a field note can be found in the *Resident Manual pdf* located in the ePortfolio system.

6. ROTATION INFORMATION

6.1 Weekly Schedule

NORTHERN FAMILY MEDICINE EDUCATION
WEEKLY SCHEDULE – RESIDENTS

Start Time	Monday	Tuesday	Wednesday	Thursday	Friday
0800-0830/45	Teaching Session	Teaching Session	Teaching Session*	Teaching Session	Teaching Session
0830-1000	Ward Rounds	Ward Rounds	Inter-disciplinary Rounds Ward Rounds		Ward Rounds
1000-1200	Clinic	Clinic	Clinic	Clinic	Clinic
1230-1330	Lunch	Lunch	Lunch	Lunch	Lunch
1330-1600	Clinic	Study	Clinic	Clinic	Clinic
1630**	Chart Review	Chart Review	Chart Review	Chart Review	Chart Review

- *Wednesday session is shortened (half an hour) to allow time to review inpatients before Interdisciplinary Rounds at 0900h.
- **Timing flexible
- PGY1 learners will do clinic with assigned staff members

6.2 Statutory Holidays for Residents

Designated Statutory Holidays

1. New Year's Day
2. Good Friday
3. Commonwealth Day (Victoria Day)
4. Memorial Day (Canada Day)
5. Labour Day
6. Thanksgiving Day
7. Armistice Day (Remembrance Day)
8. Christmas Day
9. Boxing Day

Learners engaging youths at a land-based camp.

6.3 Support Staff Roles & Contact Information

Steno's (Barb Ext. 2265 & Lori Ext. 2172-Health Records Dept.):

- outside referrals to medical specialists
- accepts a wide variety of forms (with the exception of WHSCC forms)
- transcribes dictated letters in reply to law firms, insurances, miscellaneous letters, etc.
- responsible for transcribing discharge summaries & visiting specialist consultation letters

Release of Information Technician (Donna Michelin-Health Records Dept.), Ext. 2127:

- obtains or distributes medical information from patient's charts (usually in bulk) requested by other health facilities, insurance companies, law firms, etc.
- obtains signature and various information on a release of information form

"Quick" Request for Medical Information from Other Health Facilities - Doreen Brown (Health Records Dept.), Ext. 2240:

- obtains faxed copies of patients records from other facilities within the province when needed ASAP & in a low volume, ie: a bone scan report from Corner Brook, an MRI report from St. John's, etc. *Please ensure she is provided with the following information in order to obtain such documents: Where (hospital, city/town)? When (month & year if possible)? Who (what type of specialist or specialist name if known)?*

Admitting Clerk (Ed Hedderson), Ext. 2384:

- receives referrals for appointments for visiting specialists, schedules these appts once a visiting clinic date has been established & notifies pts of their appt time

PCA (Personal Care Attendant) for OPD (Michelle Hodder), Ext. 2230:

- receives telephone messages for local physicians regarding prescription inquiries, test results/orders, sick/off work notes, patients who need to speak to or see their regular physician urgently but cannot get an appt, etc.
- faxes prescriptions to pharmacies, special drug authorization forms, etc.

6.4 Telephone Dictation Information

Labrador-Grenfell Health

TELEPHONE DICTATE INSTRUCTIONS

LIST OF VALID WORK TYPES:

01 = Operative Report
02 = Critical Letter
03 = In-Patient Consult
04 = Outpatient Consult
05 = Routine Letter
06 = Discharge Summary
07 = Stress Test

TO CREATE A NEW DICTATION:

1. Dial 1-877-884-4280

2. Enter your 4 digit User ID number

3. Enter your 5 digit Patient ID (Chart Number)

4. Enter Site digit Work Type

5. Enter Site ID:
   1 for Charles S. Curtis Memorial Hospital
   2 for Labrador Health Centre
   3 for Captain William Jackman Memorial Hospital

6. To prioritize dictation, press #9 at beginning or end of your dictation

7. When finished, PRESS 9 to disconnect the line - you will receive the (Reference Number) job number for your dictation.

8. When finished, PRESS # 9 to disconnect the line – you will receive the (Reference Number) Job number for your dictation.

PLEASE DICTATE THE FOLLOWING INFORMATION:

Your name and **location** of patient
Patient name (please spell if unusual)
Type of report (including name of procedure) and **date of visit**
Any **additional copies** (please spell out of town physicians and location)

TELEPHONE REVIEW INSTRUCTIONS

LIST OF VALID WORK TYPES:

01 = Operative Report
02 = Critical Letter
03 = In-Patient Consult
04 = Outpatient Consult
05 = Routine Letter
06 = Discharge Summary
07 = Stress Test

TO REVIEW A DICTATION:

1. Dial 1-877-884-4280

2. Press # + 1 (Pound sign and 1)

3. Enter your **4 digit** User ID number

4. Enter your **4 digit** password

5. Enter **5 digit** Patient ID (Chart Number).

6. Enter **2 digit** Work Type. If this is not the dictation you are looking for, then press 5 to get the next report on the same client. Continue until you find the correct report. **When finished, PRESS 9 to disconnect the line**.

Dictation Educational Tips – "Did You Know"

COMMAND	FUNCTION PERFORMED
1 Listen	Plays dictation from the current position.
2 Dictate (Record)	Allows you to start dictating. Please **wait for the beep** before dictating.
3 Short Rewind and Playback	The rewind increment is set to **X** seconds. If you press it repeatedly or hold down the key it will keep rewinding in **X** second intervals.
4 Pause	You can pause for **X** minutes after which time you will be disconnected. While in pause every **X** seconds there is a prompt notifying you that you are in pause mode.
5 Separate Reports	Allows you to End your current report and Start a new one under the same work type.
6 Go To End (of dictation)	Takes you to the end of the dictation.
7 Fast Forward	The Fast Forward increment is set to **X** seconds. If you press it repeatedly or hold down the key it will keep fast forwarding in **X** second intervals.
8 Rewind to Beginning	Takes you to the very beginning of the dictation.
9 System Disconnect	Hangs up the call.
#9 To prioritize dictation	Each dictation is a Non-Priority by default. You need to press #9 at beginning of end of your dictation in order to Prioritize it.

7. MEDICAL STUDENT INFORMATION

7.1 Educational Contract

RURAL FAMILY MEDICINE CLINICAL CLERKSHIP EDUCATIONAL CONTRACT

Initial Contract: _____

Clinical Duties: Please note expectations; i.e. 8 X per week or 1X/month, etc.

Clinic: as per schedule(approx.. 5 per week) House calls: as opportunity arises
E.R.: as scheduled (approx 2 per week) Obstetrics: as opportunity arises
Personal care home: on request
Inpatients: on all patients you admit, please round daily (with documentation)
Allied health clinics: on request O.R: approximately once a week
Other (please specify): Written report on coastal visit is required prior to final evaluation
Personal learning objectives: _____

Academic Duties:

	Not Discussed	Discussed
Videoconference each Thursday 9:30am-11:00am Lab		
Online FM Cases - # (approximately 1 per week)		
Online final exam (last Thursday am of rotation)		
Recording of prescribed clinical cases on T- Clerk (see list		

Preceptor: _____ **Student:** _____
Date: _____

Mid-rotation Review:
Are prescribed clinical experiences being achieved?
If not, please outline a plan to ensure these experiences will be achieved by the end of the rotation: _____
Please comment on the student's overall performance to date: _____
_____

Prescribed Clinical Cases (Check if seen, make plan to complete any pending):

Anxiety and Depression		Hypertension	
Abdominal Pain		Diabetes	
CAD and Chest Pain		Cough, Dyspnea, Asthma	
Contraception		Fatigue	
Dizziness/Vertigo		Low Back Pain	
Prenatal and well baby care		Headache	
Fever		Preventive Medicine	

Preceptor: _____ **Student:** _____

Date: _____

7.2 Feedback Form

MEDICAL STUDENT FEEDBACK FORM

NORTHERN FAMILY MEDICINE EDUCATION

(Please be as specific as possible)

DATE: _____

Medical Student: _____

Occasion: ☐ Clinic ☐ ER Shift ☐ Other:_____

Things Done Well:

_____
_____
_____
_____
_____
_____
_____

Improvement Suggestions:

_____
_____
_____
_____
_____
_____
_____

Faculty: _____

8. POLICIES & GUIDELINES

8.1 Respectful Learning Environment for Medical Education Policy

The official document is available online at http://www.med.mun.ca/getdoc/64574def-d85f-4dd3-ac1b-7f3f5e283372/Respectful-Learning-Environment-for-Medical-Educat.aspx

8.2 Respectful Learning Environment for Medical Education Procedure

The official document is available online at http://www.med.mun.ca/medpolicies/documents/Respectful%20Learning%20Environment%20for%20Medical%20Education%20Procedure%20-%202016%208%2019%20OV.pdf

8.3 Respectful Workplace Policy

The official document is available at http://www.mun.ca/policy/site/policy.php?id=167

8.4 Sexual Harassment and Assault Policy

The official document is available at http://www.mun.ca/policy/site/policy.php?id=192

8.5 Boundary Violation Policy (College of Physicians and Surgeons of Newfoundland & Labrador)

The official document is available at https://www.cpsnl.ca/WEB/CPSNL/Policies/Policy_-_Boundary_Violations.aspx?WebsiteKey=5aa40243-c5bc-4d65-8700-ec72b9c7cb44

8.6 Medical Student and Resident Safety Supervision Policy - NorFam

MEDICAL STUDENT AND RESIDENT SAFETY SUPERVISION POLICY - NORFAM

Policy statement: NorFam desires to ensure that learners at NorFam are safe and adequately supervised in all of their learning activities.

Requirements:

1. All learners at NorFam have a copy of this policy at the first week of their training.

2. **Ambulatory care**:
   - A preceptor is assigned to a learner for all ambulatory care clinics.
   - A preceptor is in house whenever there is a learner in emerg.
   - A preceptor is available by phone when the learner is in the clinic.
   - All outpatient and emerg charts are reviewed and signed off by a preceptor.

3. **Wards**:
   - A preceptor is assigned for ward rounds.
   - Ward rounds are done every morning, usually at 9am to 10am,
   - The preceptor will be available for teaching at 9:30-10:00am Monday to Friday and can be reached at any time by phone.

4. **Coastal Clinics**:
   - A preceptor is assigned to a learner when they are in the coastal nursing station and is available by phone or video.
   - A preceptor reviews all patient charts.
   - The charts may be faxed ahead of time for review by the preceptor or be reviewed on site via video.
   - The charts will be signed off as having been reviewed with the name of the preceptor on the chart.

5. **Medevacs**:
   - A preceptor is assigned to a learner who is on medevac call.
   - The learner who is on medevac call must discuss the case with a preceptor before leaving.
   - The preceptor may go with the learner if the learner or the preceptor feels this is the safest option.
   - Learners may go on medevac if they chose to as an observer. Permission must be obtained from the flight team,
   - Video and telephone consults are available to the learner at the nursing station at all times.

6. **House Calls**:
   - The learner must review all house calls with a preceptor. This ideally is the preceptor who is conjointly looking after the patient. The other options are to review with the preceptor who is on chart review, emerg, or ward rounds.

7. **Safety**:
   - A learner must discuss with a preceptor if they feel unsafe. The learner has the right to not participate in any activity if they feel unsafe and this must have no negative consequences on the evaluation.
   - A preceptor can prevent a learner from participating in any learning activity if this is felt to be not safe. This must be discussed with the learner.
   - Learner can get a free cab ride from the Labrador Health Center to home and vice versa. Vouchers are available at the reception desk.

- Learners must not go out on snowmobiles belonging to Labrador-Grenfell Health without permission. If they go outside the community, they must have an escort from a local staff member.
- Safety issues should be discussed at the monthly meeting between learners and faculty.

Signed by:

Michael Jong
Professor Family Medicine
Memorial University
VP Medical Services
Labrador-Grenfell Health

Reviewed 2014 April 4th

8.7 PGME Post Call Guidelines

PGME POST-CALL GUIDELINES: HOME CALL

In the interest of safe patient care and respect for the personal safety, wellbeing, and educational requirements of the Resident, duty hour restrictions must be considered.

A Resident who is scheduled on out-of-hospital duty (i.e. "home call") but who works more than one hour in hospital or otherwise providing patient care (i.e. home visits) between midnight and 0600hrs, is entitled to the post-call provision outlined below:

Sign-over of patient care responsibilities and pertinent patient information shall begin no later than the 24th consecutive hour of duty. Apart from hand-over of patient care responsibilities, no Resident shall be required to assume new responsibilities following the 24th hour of duty. Such handover shall not exceed 2 hours.

PGME POST-CALL GUIDELINES: IN-HOSPITAL CALL

Any Resident or Fellow who is required to provide care of a continuous or intensive nature during his/her in-hospital duty period, shall be permitted to be relieved of his/her duties at 1000 hours of a regular work day which follows the in-hospital call period after handover of patient care responsibilities, satisfactory to the Employer and the attending Physician responsible for the patient to ensure continuity of patient care. It is understood that by allowing the Resident or Fellow to leave at 1000 hours, there is no additional cost to the Employer.

Apart from the handover of patient care responsibilities, no Resident shall be required to assume new responsibilities following the 24th hour of duty.

8.8 Handover Protocol 2017

CMPA ON HANDOVER:

- No interruptions AND face to face
- Standardize = SBAR

- Start with sickest first
- Document essential points
- Read back
- Pending tasks and contingency plan

OUR INPATIENT HANDOVER FORM:

- Name/ Room
- Admission date
- Diagnosis
- Management
- New meds/ changes since hospitalization
- Major investigations and results
- Pending investigations
- Disposition

8.9 Guidelines for Video Recording and Direct Observation of Clinical Interviews

Discipline of Family Medicine
Faculty of Medicine

Guidelines for Video Recording and Direct Observation of Clinical Interviews

The recording or direct observation of patient encounters made during a resident's family medicine rotation, and their subsequent reviews, are important learning tools for residents. It is impossible to predict which visits will provide useful teaching material so it is suggested that residents continuously record specified entire clinical half-days. In most cases, this would be a minimum of two half-days for first year residents and one half-day for second year residents per week. These recordings should be reviewed with faculty during the academic family medicine teaching rounds at each site.

The goal in using recording and direct observation for teaching purposes is to have the most accurate reflection of resident encounters with patients. Implicitly, at the same time, it is of the utmost importance for residents to understand the patient's right to respect, privacy and confidentiality.

Prior to each clinic, the resident must discuss with his/her preceptor for that particular clinic if direct observation or recording will be done. It is then the resident's responsibility to obtain each patient's consent for either process. If the patient declines, it will be the preceptor's responsibility to follow-up with the patient, if indicated, to further explain the process.

In view of the above, the following should be noted:

1. Each clinic waiting room must have a notice informing patients that patient encounters may be recorded or viewed for resident training but that these are done only with the expressed consent of the patient.[1, 2]

2. Each clinic exam room with a camera must have signage directly below the camera indicating that patients are only recorded or viewed with their expressed consent.

3. Under no circumstances should a resident/faculty member record or view a patient encounter without the expressed permission of that patient, or parent/guardian in the case of a child.

4. The resident should introduce herself/himself to a patient as a family medicine resident and state the name of the supervising faculty member. At this point, the resident should ask for verbal consent for recording or direct viewing. If recording, the resident must specify that the recording is for training purposes only, with restricted viewing (see introduction example below) and that it will be erased at the end of the resident's rotation. The resident should record the patient's consent on the video recording. [1, 2]

5. When recording, the resident must ensure that the recorded equipment is turned off before the physical examination is carried out and that he/she informs the patient of this fact. (Note: the cameras have been positioned in the exam rooms so that the examination tables are not captured on recordings.)

6. Recordings must be erased after they are finished for educational purposes. At the end of a resident's family medicine rotation, any video recordings must be entirely erased.

"Introduction" example:

Hi,
I'm Dr. X, a family medicine resident working with Dr. Y. Dr. Y has asked me to record my interview with you today (OR Dr. Y might be directly observing the interview today) so that he/she can observe my interviewing skills. Sometimes, if we record, other colleagues in this clinic also review the recording to help us in our training. Would this be ok with you? Do you have any questions?

1. Using clinical photography and video for educational purposes, *The Canadian Medical Protective Association*, March 2011.
2. Personal Health Information Act: What Custodians Need to Know About Consent. http://www.nlma.nl.ca/Physicians/PHIA/. Accessed: September 20, 2013.

Approved by the RTC: July 19, 2017

8.10 Vacation for Residents

VACATION MANAGEMENT GUIDELINES:

- PGY1 trainees are entitled to twenty (20) days of annual leave per year.
- No rotation is exempt from granting vacation. Each service should define a minimum number of residents needed for adequate patient care on service. Leave requests may be denied if the service would be short-staffed during the requested time period.
- Leave requests must be submitted in writing no later than three (3) months in advance of the requested vacation time. All vacations will be processed through the PGME office. (Exceptions will be made for the first three months of the academic year only.)
- It is the resident's responsibility to obtain signatures from the administrative resident of the service from which they are requesting leave, their staff supervisor on that service and their own program director before submitting their vacation requests.
- Trainees must take two (2) weeks during the six (6) months prior to the Christmas break and two (2) weeks in the six (6) months after the Christmas break.
- Leave cannot be taken one (1) week prior to, or one (1) week following the Christmas break.
- Leave cannot be taken within the last two (2) weeks of June or first two (2) weeks of July.
- Leave can only be taken within the first week of a new rotation if approved by your preceptor. If approved, residents must contact the site to re-arrange their orientation.
- Unused leave time cannot be carried over to the next academic year.
- Though all requests will be considered, if leave requests cannot be accommodated, the trainee will be notified by the administrative resident/service within a two week period with explanations as to why a request cannot be granted. Alternative dates can then be discussed.
- Trainees must complete 2/3rds of any given rotation for a pass. Time away from the service includes the following: vacation, family leave, sick leave, compassionate leave, stat days, conference leave, Core Content, etc. For example, in a four (4) week rotation (28 days) a trainee can only miss 9 days which includes weekends. In an eight (8) week rotation (56 days) a trainee can only miss 19 days. When calculating time away from the service it is 9 or 19 days including weekends.
- Vacation may be deferred to accommodate remedial/probationary rotations.
- Changes to approved vacation leave will only be considered given significant extenuating circumstances, provided to the PGME office in writing.
- Residents should not assume to have weekends off at both the beginning and end of their vacation requests. Only one (1) weekend should be guaranteed so as not to put undue call responsibilities on other residents.
- There will not be a travel day for residents at the beginning or end of vacation!
- Traditionally, residents receive five (5) consecutive days off during the Christmas season (either over Christmas or New Year's). The understanding of five days off at Christmas replaces any request for payment or time off in lieu for working the Christmas or New Year's Statutory Holidays. If you are on vacation during Christmas, you will not receive five extra days off at another time, but you are entitled to the stat holidays included during that time (3 days).

8.11 Courses Covered by Family Medicine

Discipline of Family Medicine
Faculty of Medicine
The Health Sciences Centre
St. John's, NL Canada A1B 3V6
Tel: 709 864 6493 Fax: 709 777 7913
www.med.mun.ca/familymed/

Courses

The Family Medicine program covers the costs of the following courses when scheduled by the program:

1. ALARM
2. NRP
3. PoCUS

Each resident has $1000 that they can use towards attendance at any approved conference or towards the completion of ATLS. Additional courses may be completed by residents at their own expense.

All conferences and courses must comply with PGME regulations for Conference Leave.

Approved by the RTC: July 18, 2017

APPENDIX

Fishing at summer camp.

NORTHERN FAMILY MEDICINE EDUCATION

LABRADOR HEALTH CENTRE

EMERGENCY CONTACT INFORMATION

Name: _____ DOB: _____

Contact #: _____ Cell #: _____

Address: _____

Preferred email address: _____

In case of emergency please contact the following:

First Contact

Next of Kin: _____

Relationship: _____

Telephone Number: _____

Address: _____

_____

Alternate Telephone #: _____

Second Contact

Next of Kin: _____

Relationship: _____

Telephone Number: _____

Address: _____

_____

Alternate Telephone #: _____

Third Contact

Next of Kin: _____

Relationship: _____

Telephone Number: _____

Address: _____

_____

Alternate Telephone #: _____

Cumulative Patient Profile

Allergies and Drug Intolerances **Drug:** **Reaction:**
Social & Environmental History
Occupation : Marital status : Reg. Exercice : __ Y __ N Recreational Drugs : __ Y __ N Smoking : __ Y __ N ETOH : __ Y __ N Advanced directive ? __ Y __ N
Past History **Date:**
Active Chronic Conditions **Date**
Name **Chart #** **DOB** **MCP** **Next Of Kin** **Address** **Phone Number**

Family History

Preventative Health/Screening Interventions
TB status(yearly review if positive): Hepatitis status: MSRA status: + - n/a Tetanus boost: Pneumococcal vaccine:

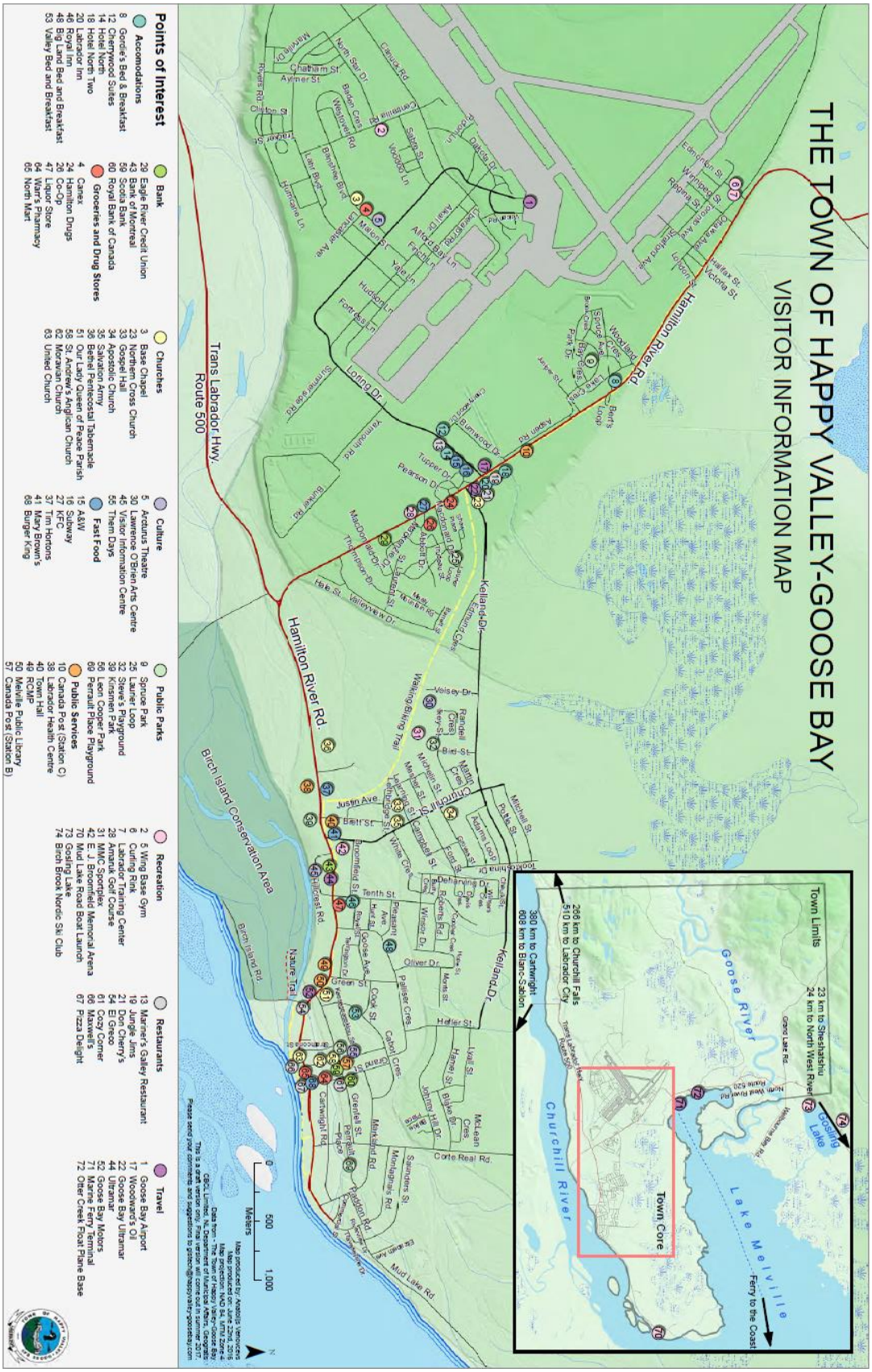
Blood Pressure								
Colorectal screen								
Fasting Glucose								

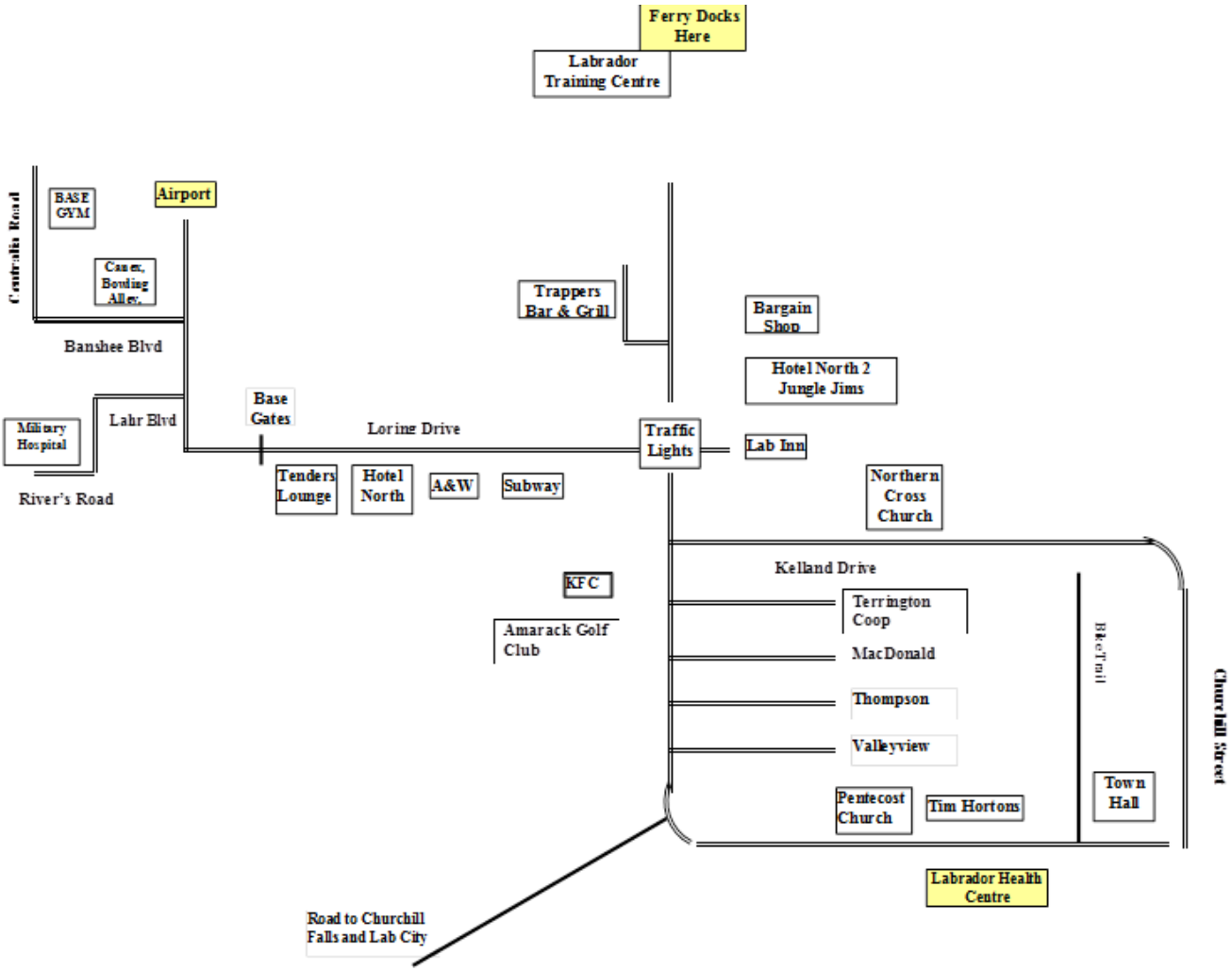
ORDER ENTRY SHORTCUTS

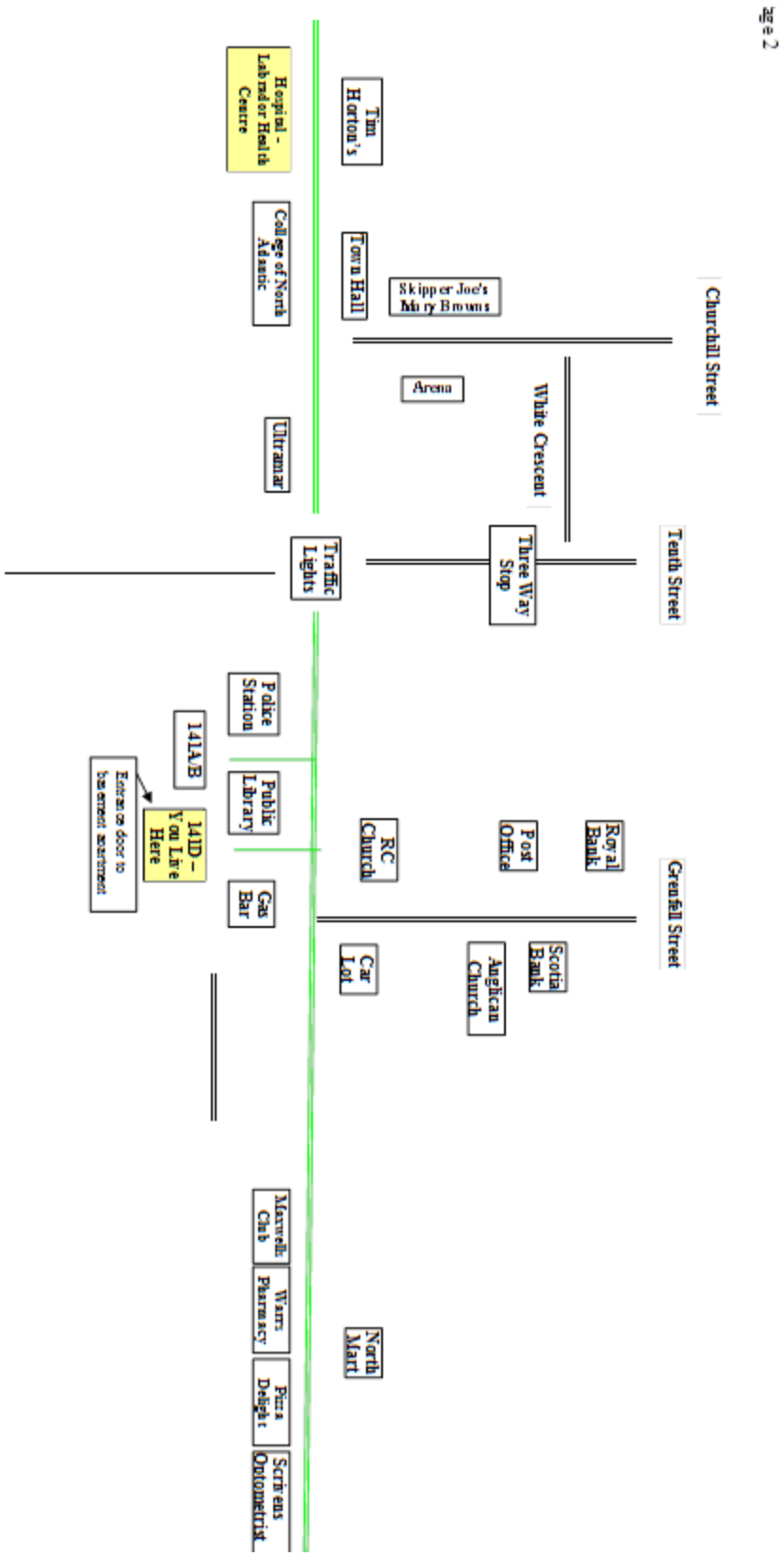
SU	Surgeon
O	Ob Gyn
VS	Visiting Specialist
ST	Stress Testing
PHN	Public Health
HCMED	Home Care Medications
SP	Speech Language Pathology
RT	Respiratory Therapist
PT	Physiotherapist
OT	Occupational Therapist
MH	Mental Health
DC	Dietitian Consult
DE	Diabetic Education
M	Mammogram
CAT	CT Scan
OU	Outside Specialist referral

Lab – most are as expected eg: CBC, AST, ECG etc.

BLC	BUN, Lytes, Creatinine
GLU	Glucose (random, fasting, etc)
GTT	Glucose tolerance test
MIC	Urine for microalbumin
HBA	Hemoglobin AIC
LI	Lipids


THE TOWN OF HAPPY VALLEY-GOOSE BAY
VISITOR INFORMATION MAP
Points of Interest
Accomodations
8 Goncie's Bed & Breakfast
12 Cherrywood Suites
14 Hotel North
16 Hotel North Two
20 Labrador Inn
46 Big Land Bed and Breakfast
53 Valley Bed and Breakfast
Bank
29 Eagle River Credit Union
43 Bank of Montreal
58 Scotia Bank
60 Royal Bank of Canada
Groceries and Drug Stores
4 Ganesi
24 Hamilton Drugs
26 Co-Op
47 Liquor Store
64 Wan's Pharmacy
65 North Mart
Churches
3 Base Chapel
23 Northern Cross Church
33 Gospel Hall
34 Apostolic Church
35 Salvation Army
36 Bethel Pentecostal Tabernacle
58 Our Lady Queen of Peace Parish
62 St. Andrew's Anglican Church
63 United Church
Culture
5 Arcturus Theatre
30 Lawrence O'Brien Arts Centre
45 Visitor Information Centre
55 Them Days
Fast Food
15 A&W
16 Subway
27 KFC
37 Tim Hortons
41 Mary Brown's
68 Burger King
Public Parks
9 Spruce Park
25 Launer Loop
32 Steve's Playground
39 Kinsmen Park
56 Leon Cooper Park
69 Perrault Place Playground
Public Services
10 Canada Post (Station C)
38 Labrador Health Centre
40 Town Hall
49 RCMP
50 Melville Public Library
57 Canada Post (Station B)
Recreation
2 5 Wing Base Gym
6 Curling Rink
7 Labrador Training Center
28 Amaruk Golf Course
31 MMC Sportsplex
42 E. J. Broomfield Memorial Arena
70 Mud Lake Flood Boat Launch
73 Gosling Lake
74 Birch Brook Nordic Ski Club
Restaurants
13 Marmer's Galley Restaurant
19 Jungle Jims
21 Don Cherry's
54 El Greco
61 Cozy Corner
66 Maxwell's
67 Pizza Delight
Travel
1 Goose Bay Airport
17 Woodward's Oil
22 Goose Bay Ultramar
44 Ultramar
52 Goose Bay Motors
71 Marine Ferry Terminal
72 Otter Creek Float Plane Base
Trans Labrador Hwy.
Route 500
Hamilton River Rd.
Hamilton River Rd
Birch Island Conservation Area
Walking/Biking Trail
Nature Trail
Mud Lake Rd.
Corte Real Rd.
Kelland Dr.
Loring Dr.
Lake Melville
Goose River
Churchill River
Town Limits
23 km to Sheshatshiu
24 km to North West River
Ferry to the Coast
Town Core
288 km to Churchill Falls
510 km to Labrador City
380 km to Cartwright
608 km to Blanc-Sablon
Meters
0
500
1,000
N
Map produced by: Anastasiy Vasilyeva
Map produced on: June 22nd, 2015
Map projection: NAD 84, MTM Zone 4
Data from: The Town of Happy Valley-Goose Bay
GIS Limited No. Data Available
This is a draft version only. Final version will come out in summer 2017.
Please send your comments and suggestions to gistech@happyvalley-goosebay.com


Ferry Docks Here
Labrador Training Centre
Airport
BASE GYM
Canex, Bowling Alley
Banshee Blvd
Trappers Bar & Grill
Bargain Shop
Hotel North 2 Jungle Jims
Base Gates
Military Hospital
Lahr Blvd
Lorine Drive
Traffic Lights
Lab Inn
River's Road
Tenders Lounge
Hotel North
A&W
Subway
Northern Cross Church
KFC
Kelland Drive
Terrington Coop
Amarack Golf Club
MacDonald
Thompson
Valleyview
Bike Trail
Churchill Street
Pentecost Church
Tim Hortons
Town Hall
Labrador Health Centre
Road to Churchill Falls and Lab City


Page 2
Hospital - Labrador Health Centre
Tim Horton's
College of North Atlantic
Town Hall
Skipper Joe's Mary Browns
Churchill Street
Arena
White Crescent
Ultramar
Traffic Lights
Three Way Stop
Tenth Street
Police Station
141A/B
Public Library
141D - You Live Here
Entrance door to basement apartment
Gas Bar
RC Church
Post Office
Royal Bank
Grenfell Street
Car Lot
Anglican Church
Scotia Bank
Maxwells Cleb
Warrs Pharmacy
Pizza Delight
Scrimgeus Optometrist
North Mart