1. **Practice name**

2. **Completed by** (name)

3. **Position**

4. **Phone**

5. **Fax**

6. **Email address**

7. **Date completed**

8. **Practice Manager's name**

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1. Is your Practice PIP (Practice Incentive Program) Registered?
   - Yes
   - No (Go to Question 2)

4. If yes, which PIP programs does your practice use?
   - Practice Nurse ie PNIP
   - Diabetes ie Threshold payment for annual cycle of care

2. Please shade the circles that describe your practice (Please shade as many as apply)
   - Corporate General Practice
   - Accredited
   - Community Health Centre
   - Bulk billing
   - Private GP-owned
   - Private billing
   - Involved in Australian Primary Care Collaboratives
   - Combination private/bulk billing

3. Number of Staff in practice (Please write answers in the boxes provided)
   - Total Number of GPs in the Practice
     - Vocationally registered (FRACGP OR FACRRM)
     - Non-vocationally registered
   - Total number of EFT* GP's
   - Total number of practice nurses (RN)
   - Total number of practice nurses (EN) - non medication endorsed
   - Total number of practice nurses (EN) - medication endorsed
   - Total number of EFT* PNs
   - Total number of support staff (including administrative staff)

4. Does your practice provide organised care to patients with type 2 diabetes - that is regular 3 or 6 monthly pre-planned appointments to provide components of the Annual Cycle of Care?
   - Yes
   - No

5. a. How many patients are registered at your practice and have attended in the last 12 months?

5. b. If your practice is accredited, how many standardised whole patient equivalents (SWPE) are allocated to your practice?

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Note: * EFT = Equivalent full time
6. How many patients at your practice are known to have type 2 diabetes?
7. How many of your patients with type 2 diabetes have had a General Practice Management Plan +/- Team Care Arrangement in the last two years?
8. Does your practice have any published protocols by which to guide review and management of patients with type 2 diabetes?
   If yes, please state what the protocol is

9. Access to Allied Health or specialist provided to patients:
   (Please complete the table below for each allied health professional)

<table>
<thead>
<tr>
<th>Allied Health or Specialist</th>
<th>Onsite</th>
<th>Hours at your practice per week</th>
<th>Offsite</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Dietitian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Podiatrist</td>
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<tr>
<td>c. Diabetes Educator</td>
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<tr>
<td>d. Visiting Endocrinologist/ general physician</td>
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<tr>
<td>e. Optometrist</td>
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<td>f. Psychologist</td>
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<tr>
<td>g. Other (name) e.g., Social Worker, Occupational Therapist, Exercise Physiologist</td>
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</tr>
</tbody>
</table>

Thank you for your time in completing this survey. Please store this form in the Stepping Up Study box at your practice. Please ring the Department of General Practice on 8344 3373 for collection.