

FAMILY/GENERAL PRACTICE SUPPLEMENTAL QUESTIONNAIRE

Name (please print)

Policy Number (if currently insured with NORCAL)

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 7.**

SECTION I PROCEDURES

1. Do you perform biopsies? Yes No

If yes, please complete the following table regarding the types of biopsies that you perform:

Name of Organ or Tissue	Type	Estimated Number Performed Per Year
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	

2. Do you perform endoscopic procedures? Yes No

If yes, please complete the following table regarding the endoscopic procedures that you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Anoscopy		<input type="checkbox"/> Laryngoscopy	
<input type="checkbox"/> Bronchoscopy		<input type="checkbox"/> Sigmoidoscopy	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Colposcopy		_____	
<input type="checkbox"/> Esophagogastroduodenoscopy		_____	

3. Do you perform cardiac and/or vascular procedures? Yes No

If yes, please identify the procedures and the number of each that you perform per year:

4. Do you perform orthopedic procedures? Yes No

If yes, please complete the following table regarding the orthopedic procedures you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Amputation Surgery		<input type="checkbox"/> Fracture Repair - Surgical	
<input type="checkbox"/> Arthrocentesis		<input type="checkbox"/> Tendon Repairs	
<input type="checkbox"/> Carpal Tunnel Surgery		<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Fracture Reduction – Closed Reduction of Simple Fractures		_____	
<input type="checkbox"/> Fracture Reduction – Closed Reduction other than Simple		_____	

5. Do you perform gynecologic and/or urologic procedures? Yes No

If yes, please complete the following table regarding the gynecologic and/or urologic procedures you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Anterior and/or Posterior Vaginal Wall Repair		<input type="checkbox"/> Hysteroscopy – Operative	
<input type="checkbox"/> Circumcision		<input type="checkbox"/> IUD Insertion	
<input type="checkbox"/> Conization of the Cervix		<input type="checkbox"/> Leeps/Leetz Procedure	
<input type="checkbox"/> Cryosurgery of the Cervix		<input type="checkbox"/> Oophorectomy	
<input type="checkbox"/> Culdocentesis		<input type="checkbox"/> Salpingectomy	
<input type="checkbox"/> Dilation and Curettage of the Uterus (other than for termination of pregnancy)		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Hydrocelectomy		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Hymenotomy		<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Hysterectomy		_____	
<input type="checkbox"/> Hysteroscopy – Diagnostic		_____	

6. Do you perform any other procedures? Yes No

If yes, please complete the following table regarding the other procedures that you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Adenoidectomy		<input type="checkbox"/> Lumbar Puncture/Spinal Tap	
<input type="checkbox"/> Anal Fistulectomy		<input type="checkbox"/> Manipulation Under Anesthesia	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Myofascial Trigger Point Injection	
<input type="checkbox"/> Arterial Line Placement		<input type="checkbox"/> Myringotomy	
<input type="checkbox"/> Central Line Placement		<input type="checkbox"/> Paracentesis	
<input type="checkbox"/> Cholecystectomy – Open		<input type="checkbox"/> Pulmonary Function Testing and Interpretation	
<input type="checkbox"/> Cholecystectomy – Laparoscopic		<input type="checkbox"/> Thoracentesis/Pleuracentesis	
<input type="checkbox"/> Hemorrhoid Treatment (specify types): _____		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Other (specify): _____	
<input type="checkbox"/> Joint Injection (non-spinal)		_____	

7. Do you have hospital privileges for all procedures that you perform? Yes No

If no, please identify the procedure(s) and explain:

SECTION II OBSTETRICS

Note: Please skip this section if you do not practice obstetrics, which is defined as the care and treatment of pregnancy including, but not limited to, prenatal care, labor, delivery, cesarean section and/or postnatal care.

1. Please identify the obstetrical services that you provide:

- First Trimester Prenatal care Second Trimester Prenatal Care Third Trimester Prenatal Care
 Deliveries Cesarean Section Episiotomy Repair Other (specify): _____

2. If the obstetrical services that you provide are other than first trimester prenatal care:

- a. Please provide proof of your hospital privileges for obstetrics.
- b. If your obstetrics training was not the completion of a fellowship program in obstetrics or was not a combined family practice and obstetrics residency, please provide a description of the proctoring procedure used at the hospital where you maintain privileges for obstetrics, including the credentials of the proctoring physician:

Ultrasonography and Prenatal Care

1. Do you, your employees or anyone on your behalf perform ultrasonography for nonmedical purposes (e.g., solely to create keepsake or entertainment photographs or videos)? Yes No

If yes, please explain:

2. Do you interpret ultrasound images? Yes No

If yes:

- a. Do you always issue a written report? Yes No

If no, please explain:

- b. Do you interpret ultrasound images that were performed by others? Yes No

If yes, please identify those on behalf of whom you interpret the images, as well as under what circumstances this occurs and the frequency with which this occurs:

3. Do you perform amniocentesis, chorionic villus sampling or percutaneous umbilical blood sampling? Yes No

If yes, do you always perform it/them using ultrasound guidance? Yes No

If you do not always use ultrasound guidance, please explain:

4. Do you follow the current American College of Obstetrics and Gynecology's guidelines for genetic screening? Yes No

If no, please explain:

Deliveries

1. Please identify the estimated number of the following deliveries that you perform per year:

Uncomplicated deliveries: _____

High-risk deliveries including, but not limited to, cesarean delivery, VBAC, identifiable prospects of multiple births, preeclampsia, insulin-dependent diabetes, cardiac disease, renal disease, morbid obesity or other life threatening conditions: _____

2. What percentage of your deliveries arises from your on-call work and coverage for others? _____ %

What percentage of the on-call deliveries is performed on patients for whom you do not have access to the patient's medical record and medical history information? _____ %

3. Do you provide all of the prenatal care for your patients? Yes No

If no, please identify the percentage of the prenatal care that is provided by others, provide the names and designations of these individuals and identify the type of association that you maintain with them:

4. If a patient has had a prior cesarean delivery, do you always discuss with the patient the risks and benefits of a trial of labor versus repeat cesarean delivery? **Yes** **No**

If yes, after the discussion, do you have the patient sign a written informed consent and/or do you document the discussion in the medical record? **Yes** **No**

If you answered no to either of the above questions, please explain:

5. Do you discuss with every patient the possibility of cesarean delivery? **Yes** **No**

If no, please explain:

6. Do all of the obstetric units where you perform your deliveries have the appropriate anesthesia and surgical personnel available to permit the start of a cesarean delivery within 30 minutes of the decision to perform it? **Yes** **No**

7. Do all of the obstetric units where you perform VBACs have the appropriate facilities and personnel available within 5 minutes during active labor to perform an emergency cesarean delivery? **Yes** **No**

If you answered no to question 6 or 7, please identify the hospital(s) that does not satisfy the applicable requirement(s) and explain or attach each hospital's protocol for these situations:

8. If a patient has been administered regional analgesia for labor, is there always an anesthesiologist, a physician trained in anesthesia or a CRNA in the hospital or on call with a maximum response time to the hospital of 10 minutes until the patient has delivered and the patient's condition has stabilized? **Yes** **No**

If no, please identify the hospital(s) at which this does not occur and attach or explain each hospital's protocol regarding the availability of these services:

9. For each patient with known shoulder dystocia risk factors, do you always do the following:

- a. Discuss with the patient the risks of shoulder dystocia? **Yes** **No**
- b. Discuss the potential need for a cesarean delivery, including its risks, benefits and alternatives? **Yes** **No**
- c. Develop and share a delivery plan for these patients with other covering physicians? **Yes** **No**
- d. Discuss the delivery plan with the patient? **Yes** **No**

If you answered no to anyone of the above, please explain:

10. Do you use fundal pressure to relieve shoulder dystocia? **Yes** **No**

If yes, please explain under what circumstances you use it and how often you use it:

Miscellaneous

1. Do you utilize an OB hospitalist other than in emergencies? **Yes** **No**

If **yes**, please describe your protocol for handling the patient's continuity of care:

2. Do you provide obstetrical care to any patient who has any one of the factors identified below *without sharing the care with a board-certified OB/GYN or perinatal specialist*? **Yes** **No**

If **yes**, please identify the factors:

Initial Prenatal Factor

- Multiple Pregnancy
- Insulin Dependent Diabetes
- Chronic Hypertension
- Renal Failure
- Heart Disease (Class II or higher)
- Hyperthyroidism
- RH Isoimmunization
- Chronic Active Hepatitis
- Convulsive Disorder
- Isoimmune Thrombocytopenia

Subsequent Prenatal and Intrapartum Factor

- Abnormal Fetal/Placental Tests
- Mid Forceps Delivery
- Vaginal Bleeding – Second or Third Trimester
- Preeclampsia (toxemia) – Moderate or Severe
- Fetal Malformation by AFP Screening, Ultrasound or Amniocentesis
- Cord Prolapse
- Abnormal Presentation: Breech, Face, Brow or Transverse
- Intrauterine Growth Retardation
- Hydramnios
- Deliveries Performed <37 weeks
- Deliveries Performed >43 weeks
- Persistent Severe Variable or Late Decelerations
- Macrosomia

If you marked any one of the factors listed above, please explain why you do not share the care with a board-certified OB/GYN or perinatal specialist:

3. Do you provide obstetrical care to any patient who has any one of the factors identified below *without obtaining consultation from a board-certified OB/GYN*? **Yes** **No**

If **yes**, please identify the factors:

Initial Prenatal Factor

- Age <16
- Age >40
- Drug Dependency
- High Risk Family/Lack of Family or Social Support
- Severe Anemia (unresponsive to Fe)
- Uterine or Cervical Malformation or Incompetency
- Pelvic Mass or Neoplasia
- Contracted Pelvis
- Previous Caesarean Section
- Multiple Spontaneous Abortions (more than 3)
- Grand Multiparity (more than 8)
- History of Gestational Diabetes
- Previous Fetal or Neonatal Demise
- Hypothyroidism
- Heart Disease (Class 1)

Subsequent Prenatal and Intrapartum Factor

- Gestational Diabetes
- Preeclampsia (toxemia) – Mild
- Active Genital Herpes
- Positive High or Low AFP Screen
- Estimated Fetal Weight > 10 lbs or <6 lbs
- Abnormal Non-stress Test
- Arrest of Normal Labor Curve
- Persistent Moderate Variable Decelerations or Poor Baseline
- Ruptured Membrane Beyond 24 Hours
- Second Stage Beyond 2 hours
- Induction of Labor

If you marked any one of the factors listed above, please explain why you do not obtain consultation from a board-certified OB/GYN:

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b):

Page Number	Section Number	Question Number	Remarks
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Please provide any additional information material to the risk that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

Print Name