

Emergency Medicine

Supplemental Questionnaire



INTRODUCTION

Your Full Name:

Policy Number:

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 4.**

SECTION I

LOCATIONS

1. Please identify all locations at which you provide emergency services. Please photocopy the page if you need additional space.

Name and Address of Facility	Freestanding Emergency Center? Yes <input type="checkbox"/> No <input type="checkbox"/>	Average Number of Weekly Hours	Level(s) of Emergency Care Provided (as defined by the JCAHO)
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic) <input type="checkbox"/> IV (Standby)
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic) <input type="checkbox"/> IV (Standby)
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic) <input type="checkbox"/> IV (Standby)
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic) <input type="checkbox"/> IV (Standby)
<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic) <input type="checkbox"/> IV (Standby)

2. If you indicated that any one of the locations identified above is a freestanding emergency center, please identify the following for each center:

- Who owns/operates the center
- The type of accreditation the center maintains (e.g., JCAHO)
- Distance to the nearest acute care hospital with which the center maintains a transfer agreement
- If the center is not owned or operated by a hospital, a listing of the emergency equipment (i.e., crash carts, basic airway equipment, etc.) that is in the center and immediately available to a patient at all times

1. If you have not completed an ACGME- or AOA-approved residency in emergency medicine or are not certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, please provide the following:

- Proof of your emergency medicine training*
- A copy of your hospital privileges in emergency medicine
- An indication of the number of patients to whom you have provided emergency medicine services in the past 12 months

* If you are unable to provide documentation of your emergency medicine training, please describe the training that you have received and the credentialing process used at the hospital where you have been credentialed in emergency medicine:

2. Does the hospital(s) ever require you to attend to patients outside of the emergency department? Yes No

If yes, is it limited to life threatening emergencies and only when there are no other personnel available? Yes No

If no, please explain, identify the frequency with which this occurs and identify the hospital(s):

3. Do you document in the patient's chart a specialist's agreement and/or refusal to come in for consultation? Yes No

If no, please explain how this situation is handled:

4. When the specialist's interpretation of test results differs from the emergency medicine physician's interpretation, is the patient's chart and care reviewed to determine if the new interpretation is a significant finding and further intervention is needed?

Yes No

If yes:

a. Do you contact the patient? Yes No

b. If you disagree with the specialist, do you contact the specialist to discuss the results? Yes No

c. Do you document your follow up in the medical record? Yes No

If you answered no to question 4, 4a, 4b or 4c, please explain and identify your procedure:

5. When you go "off-shift," and there is a patient who requires continued care, do you always discuss the patient's condition with the oncoming physician and document your sign-off to the oncoming physician? Yes No

6. When you are the oncoming physician, do you review the patient's charts prior to transfer or discharge and document the review in the medical record? Yes No

If you answered no to question 5 or 6, please explain:

7. Do you write courtesy admission orders for admitting physicians? Yes No

If yes:

a. Does your hospital/department have a policy that allows emergency medicine physicians to write initial/courtesy admission orders? Yes No

b. Do you discuss the admission and orders with the admitting physician? Yes No

If you answered no to question 7a or 7b, please explain:

SECTION III**INFORMED CONSENT/REFUSAL AND DISCHARGE OF PATIENTS**

1. If a patient requires transfer to another facility, do you always discuss with him or her (or his or her parents or legal guardian) the risks and benefits of the transfer and either document the discussion in the patient's medical record and/or obtain written consent? Yes No

If no, please explain:

2. Do you always attempt to have an individual who has presented for emergency services (or his or her parents or legal guardian) sign an informed refusal form in the following situations:
- a. When the individual refuses examination? Yes No
- b. When the individual refuses treatment? Yes No
- c. When the individual refuses transfer? Yes No

If you are unable to obtain a signature on the informed refusal form, do you always document in the medical record that an attempt was made? Yes No

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

3. Do you provide legible written instructions for each patient whom you discharge from the emergency department?
 Yes No

If yes, are the discharge instructions reviewed with the patient (or his or her parents or legal guardian) by a licensed health care provider? Yes No

If you answered no to either question, please describe your procedure:

SECTION IV

REMARKS

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona 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

(mm/dd/yyyy)

Name (Print)