

Hospitalist 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

PRACTICE INFORMATION

1. What percentage of your practice time is devoted to hospitalist work? %
2. Have you completed additional training programs and/or CME courses in hospital medicine? Yes No

If yes, please identify the types of programs and/or courses and the length of time and/or CME credits earned and attach any supporting documentation:

3. Please complete the following regarding each facility where you function as a hospitalist. Please photocopy this page if additional space is needed:

Name and Address of Facility	Type of Relationship Between You and the Facility	Percentage of Practice
<input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>	<input type="text"/>

- a. Please provide a copy of the contract you maintain with each facility.
- b. If you identified more than one facility, on a separate sheet of paper please provide your weekly schedule at each location (i.e., days and hours per week).
- c. Do you maintain active privileges at each facility identified above? Yes No

If no, please identify each facility where you do not maintain active privileges and explain:

- d. Are you thoroughly familiar with each facility's policies and procedures? Yes No

If no, please explain:

4. Do you perform additional duties at any facility where you function as a hospitalist or that are associated with your hospitalist contract (e.g., covering the emergency room or providing utilization reviews)? Yes No

If yes, please identify each facility and provide a full explanation of the duties:

5. Please check the appropriate box pertaining to the clinical focus of your hospitalist work:

Adult Medicine Only Pediatrics Only Both Adult Medicine and Pediatrics

- a. If you are a pediatrician and your focus involves adult medicine, please explain below what this entails, describe where you obtained your training in adult medicine and provide proof of that training (e.g., certificates of course completion, etc.).
- b. If you are not a pediatrician and your focus involves pediatrics, please explain below what this entails, describe where you obtained your training in pediatrics and provide proof of that training (e.g., certificates of course completion, etc.).

6. Will you provide care to patients with special needs, such as obstetric or critical care? Yes No

If yes, please explain below and describe where you obtained your training:

7. Are any of the hospitalist patients that you treat admitted to you through prearranged relationships with physicians and/or medical groups? Yes No

If yes, please complete the following:

a. What percentage of your hospitalist patients are admitted by these physicians/medical groups? %

b. Please list each of these physicians/medical groups. Please photocopy this page if additional space is needed:

Name and Address of Physician/Group	Physician's/Group's Specialty	Type of Relationship Between You and the Physician/Group
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (please specify) <input type="text"/>

c. Please provide a copy of each contract and proof of professional liability insurance for each physician/medical group identified in 7b.?

d. If you have a prearranged relationship with a physician or medical group, do you always have access to an admitted patient's medical history and records?

If no, please explain:

8. Please answer the following questions regarding admitted patients with primary care physicians:

- a. Do you always maintain an open dialogue with the primary care physician? Yes No
- b. Do you always provide the primary care physician with a *written* discharge summary? Yes No
- c. Do you document in the patient's medical record all of your communication with the primary care physician? Yes No

If you answered no to 8a, 8b or 8c, please explain:

9. Do any of the patients that you treat in your hospitalist capacity not have a primary care physician? Yes No

If yes, please complete the following:

- a. What percentage of the patients do not have a primary care physician? %
- b. How is the follow-up care handled for these patients?

10. If you discover an incidental finding during the patient's hospitalization, do you either do the workup before the patient is discharged or ensure that the physician who has assumed the patient's care after discharge has assumed responsibility for following up on the finding? Yes No

If no, please explain:

11. If a patient's test results arrive after the patient has been discharged, do you ensure that the primary care physician or the physician who has assumed the patient's care is made aware of the results? Yes No

- a. If yes, how are the test results communicated to the physician?

- b. If no, please explain:

SECTION II**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)