

OPHTHALMOLOGY 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 4.**

SECTION I PROCEDURES

1. Please identify which of the following procedures you perform and provide the estimated number that you perform per year.

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Biopsy (specify areas): _____		<input type="checkbox"/> Iridectomy/Iridotomy	
<input type="checkbox"/> Blepharoplasty		<input type="checkbox"/> Laser Ablation of Corneal Lesions	
<input type="checkbox"/> Botulinum Toxin Type A Injections for Blepharospasms or Strabismus		<input type="checkbox"/> Laser Capsulotomy	
<input type="checkbox"/> Cataract Removal Surgery <input type="checkbox"/> Extracapsular Cataract Extraction <input type="checkbox"/> Phacoemulsification <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Laser Iridoplasty	
<input type="checkbox"/> Chalazion Excision from Eyelid		<input type="checkbox"/> Laser Trabeculoplasty	
<input type="checkbox"/> Clear Lens Extraction		<input type="checkbox"/> Lid Repair – Ectropian/Entropion	
<input type="checkbox"/> Conjunctivoplasty		<input type="checkbox"/> Orbitotomy	
<input type="checkbox"/> Corneal Transplantation		<input type="checkbox"/> Pterygium Excision	
<input type="checkbox"/> Cryotherapy		<input type="checkbox"/> Punctal Closure (specify techniques): _____	
<input type="checkbox"/> Enucleation		<input type="checkbox"/> Retinal Surgery	
<input type="checkbox"/> Eyelid Ptosis Surgery		<input type="checkbox"/> Silicone Injections for Retinal Detachment	
<input type="checkbox"/> Fluorescein Angiography		<input type="checkbox"/> Strabismus Surgery	
<input type="checkbox"/> Foreign Body Removal – Non-intraocular/Superficial		<input type="checkbox"/> Tarsorrhaphy	
<input type="checkbox"/> Foreign Body Removal – Intraocular		<input type="checkbox"/> Trabeculectomy	
<input type="checkbox"/> Intraocular Lens Implants – After Removal of Natural Lens		<input type="checkbox"/> Vitrectomy	
		<input type="checkbox"/> Wedge Resection for Tumors	

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Refractive Surgery		<input type="checkbox"/> Refractive Surgery continued	
<input type="checkbox"/> CK (Conductive Keratoplasty)		<input type="checkbox"/> Phakic Intraocular Lens Implants	
<input type="checkbox"/> INTACS Implants		<input type="checkbox"/> PRK (Photorefractive Keratectomy)	
<input type="checkbox"/> LASEK		<input type="checkbox"/> Other Refractive Surgery (specify):	
<input type="checkbox"/> LTK (Laser Thermal Keratoplasty)		_____	
<input type="checkbox"/> LASIK		_____	

2. Other than blepharoplasty or eyelid ptosis surgery, do you perform any cosmetic procedures? Yes No

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

3. Do you perform any procedure(s) not already specified above? Yes No

If yes, please identify the procedure(s) and the estimated number of each that you perform per year:

4. Do you have hospital privileges for all surgical procedures you perform? Yes No

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

5. Do you use lasers in your practice? Yes No

If yes, do you always either set the adjustments for the laser yourself or verify the adjustments before surgery if they were set by a technician? Yes No

If no, please explain:

SECTION II REFRACTIVE SURGERY

NOTE: Please skip this section if you do not perform refractive surgery.

1. Do you perform refractive surgery on patients who are less than 18 years of age? **Yes** **No**

If yes, please explain under what circumstances this occurs, the minimum age of the patients and the type(s) of refractive surgery(ies) performed on these patients:

2. Do you *personally* do the following for all patients on whom you will be performing refractive surgery?

a. Perform an independent evaluation of the patient's eligibility for surgery? **Yes** **No**

b. Conduct the informed consent discussion and obtain written consent that is procedure specific? **Yes** **No**

3. Do you *personally* conduct the first postoperative visit for all patients on whom you have performed refractive surgery?
 Yes **No**

If you answered no to any item in question 2 or 3, please explain under what circumstances you do not perform the applicable item(s) and provide the name(s) and designation(s) of the person(s) who performs them:

4. Does each patient on whom you perform refractive surgery have refractive stability over at least a twelve-month period before the surgery? **Yes** **No**

If no, please explain:

5. When you perform laser refractive surgery, do the criteria for degree of myopia, hyperopia and astigmatism fall within FDA-approved guidelines? **Yes** **No**

If no, does the written consent form signed by the patient state that you will be using the laser off-label? **Yes** **No**

If no, please explain:

6. If you did not complete the training during your ophthalmology residency for the refractive surgery procedure(s) that you are currently performing, please provide the following for each such procedure:

- Proof of training
- An indication of the number of these procedures for which you were the primary surgeon during and following the training program
- Proof of hospital privileges and a description of the credentialing process used at the hospital

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 in this questionnaire.

Signature

Date

Print Name