

Pediatrics and Neonatology

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 3.**

SECTION I

PEDIATRICS

NOTE: Please skip this section and go to Section II if your practice is limited to neonatology.

1. Please identify the procedures that you perform in your practice:

2. Do you reduce or cast fractures other than closed or simple fractures? Yes No

If yes, please identify the types of fractures that you reduce and describe the training that you have received for this:

3. Is your practice limited to the treatment of patients who are under 22 years old? Yes No

If no:

a. What percentage of your practice is devoted to the treatment of patients who are 22 or older? %

b. Is your treatment of adults limited to continuing treatments for patients whom you had treated before they turned 22?

Yes No

If no, please identify the treatments that you provide, under what circumstances this occurs and where you received your training for this:

SECTION II

NEONATOLOGY

NOTE: This section should be completed by pediatricians and neonatologists.

1. Do you treat neonates? Yes No

If yes:

a. What percentage of your practice is devoted to the treatment of neonates? %

b. Please check all of the following that apply regarding the treatment that you provide to neonates:

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> Routine care of a healthy neonate | Percentage of overall practice: | % |
| <input type="checkbox"/> Treatment in the continuing care unit | Percentage of overall practice: | % |
| <input type="checkbox"/> Treatment in the intermediate care unit | Percentage of overall practice: | % |
| <input type="checkbox"/> Treatment in the intensive care unit | Percentage of overall practice: | % |

c. If you indicated that you treat neonates in the intensive care unit, and you have not completed an ACGME or AOA-approved residency/fellowship in neonatology, please provide proof of your neonatology training.

NOTE: Please complete this section only if you care for neonates in the intermediate or intensive care units. Otherwise, please go to Section IV.

1. Do you personally provide the patient's family with specific printed or legibly written aftercare instructions for the patient after discharge? Yes No
2. Do you personally review the written discharge instructions and follow-up actions with the patient's family member to reinforce the instructions? Yes No
3. Do the discharge instructions include:
 - a. Patient's diagnosis and treatment? Yes No
 - b. Medication(s) prescribed? Yes No
 - c. Instructions about obtaining ongoing treatment? Yes No
 - d. Name, address and telephone number of the physician the patient is being referred to, and when the patient's family needs to make an appointment with the referral physician? Yes No
 - e. A statement instructing the family member to return the patient to the emergency department if he or she is unable to find a physician or other health care provider for the patient, or if the patient experiences complications prior to the appointment? Yes No
4. Do you obtain a signed acknowledgement from the patient's family member that the discharge instructions were explained and that he or she understood the instructions? Yes No
5. If the patient does not have a pediatrician or primary care physician for follow-up care, do you include in the discharge instructions the name and phone number of a referral physician who is available to provide care to the patient? Yes No
6. Do you assume responsibility for your patient's follow-up care and the coordination of necessary referrals? Yes No
7. Do you personally call the referral physician or the patient's pediatrician for coordination of the patient's subsequent care after discharge? Yes No

If you answered no to any one of questions 1 – 7, please explain:

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)