



**OBSTETRICS AND GYNECOLOGY, GYNECOLOGY ONLY AND PERINATOLOGY
SUPPLEMENTAL QUESTIONNAIRE**

Your Full Name: _____ Policy Number: _____
(Please Print)

Directions: Please complete the following questions regarding your practice. 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. **Your signature is required on page 5.**

SECTION I: Ultrasonography

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:

2a. Do you always issue a written report? Yes No

If no, please explain:

2b. 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:

SECTION II: Prenatal Care

1. 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:

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

If no, please explain:

SECTION III: Deliveries

Note: Please skip this section if you do not perform 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 these 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 immediately available 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:

9a. Discuss with the patient the risks of shoulder dystocia? Yes No

9b. Discuss the potential need for a cesarean delivery, including its risks, benefits and alternatives? Yes No

9c. Develop and share a delivery plan for these patients with other covering physicians? Yes No

9d. Discuss the delivery plan with the patient? Yes No

If you answered no to any one 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:

11. 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:

SECTION IV: Artificial Insemination and Assisted Reproductive Technology

1. Do you perform the following:

1a. Artificial insemination? Yes No

1b. Assisted reproductive technology procedures (i.e., IVF, GIFT, etc.)? Yes No

If you answered yes to question 1a only, please complete questions 2, 3 and 4 only and skip the remaining questions.
If you answered yes to question 1b, please complete all of the remaining questions.

2. Do you use fresh donor semen other than when donated by the female's partner? Yes No

3. Are all donors screened and all donor semen tested in accordance with federal and state regulations? Yes No

4. Before the process begins, are all patients required to sign a consent form that states (among other things) that pregnancy may not result/is not guaranteed? Yes No

If you answered yes to question 2 and/or no to questions 3 or 4, please explain:

5. If you have not completed an American Board of Obstetrics and Gynecology (ABOG) or American Osteopathic Association-approved fellowship in reproductive endocrinology and infertility or you are not certified by the ABOG or American Osteopathic Board of Obstetrics and Gynecology with a certificate in reproductive endocrinology, please submit proof of your training and hospital privileges for assisted reproductive technology and describe your experience with these procedures (i.e., the number of these procedures you have performed, etc.).

6. Please complete the following regarding the embryology laboratories that you utilize. Please photocopy the page if you need additional space:

Name and Address of Laboratory	Who Owns the Laboratory?	Laboratory Accreditation
	<input type="checkbox"/> Hospital <input type="checkbox"/> You/Your Entity <input type="checkbox"/> Your Group/Group's Entity <input type="checkbox"/> Other: _____	<input type="checkbox"/> CAP/ASRM Reproductive Laboratory Accreditation <input type="checkbox"/> JCAHO <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Hospital <input type="checkbox"/> You/ Your Entity <input type="checkbox"/> Your Group/Group's Entity <input type="checkbox"/> Other: _____	<input type="checkbox"/> CAP/ASRM Reproductive Laboratory Accreditation <input type="checkbox"/> JCAHO <input type="checkbox"/> Other: _____

6a. If you indicated that a laboratory is not accredited, please explain and identify if the laboratory is scheduled for inspection. If scheduled for an inspection, please specify the date:

6b. If you indicated that a laboratory is not owned by a hospital, do physicians other than yourself use it? Yes No

If yes, please identify the physicians and your professional relationship with the physicians:

7. Do you follow the guidelines established by the Society for Assisted Reproductive Technology and the American Society for Reproductive Medicine for patient selection, prerequisite testing, number of embryos transferred, etc? Yes No

If no, please explain:

SECTION V: Perinatology/Maternal-Fetal Medicine

1. Do you hold yourself out as a perinatologist/maternal-fetal medicine specialist? Yes No

If yes, and you have not completed an American Board of Obstetrics and Gynecology (ABOG) or American Osteopathic Association-approved fellowship in perinatology/maternal-fetal medicine or you are not certified by the ABOG or American Osteopathic Board of Obstetrics and Gynecology with a certificate in maternal-fetal medicine, please provide proof of your training and hospital privileges in perinatology/maternal-fetal medicine.

SECTION VI: Remarks

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

For California and Rhode Island Physicians Only

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

For Alaska Physicians Only

I represent 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