



## Obstetrics Supplement to Application for Medical Professional Liability Insurance

AZ CO NV UT (80153)

*Completion and submission of this supplement is being used for data collection and statistical purposes to help us better understand how obstetrical practice is evolving.*

1. Please check one of the following that best describes your practice:

- OB/Gyn (office based ob/gyn practice to include the performance of deliveries; prenatal care; performance of gynecological procedures and surgery; and obstetrics call)
- Laborist only (perform deliveries only; no office based practice; no prenatal care; no gynecological procedures or surgery)
- Office based ob/gyn practice only (prenatal care provided; no deliveries performed; refer all deliveries to laborist; does include performance of gynecological procedures and surgery)
- Other – please describe \_\_\_\_\_

2. Please indicate the following:

Total hours worked per month: \_\_\_\_\_

Number of new patients per month: \_\_\_\_\_

Average number of deliveries per month for the most recent year: \_\_\_\_\_

Of this number, what percentage are High Risk: \_\_\_\_\_

C-Section: \_\_\_\_\_

Uncomplicated: \_\_\_\_\_

Average number of gynecological procedures per month: \_\_\_\_\_

3. Do you utilize ancillary healthcare personnel (NP's; PA's; Nurse Mid-Wives (certified and/or lay); etc.) in your practice or do you support a midwife partnership at your hospitals?  Yes  No

If yes, please explain how they are utilized, including whether or not they have any call responsibilities; indicate the number of personnel in each position; and indicate whether or not they are employed by you.

\_\_\_\_\_

4. Please list all hospitals and any other facilities where you practice.

Name of Hospitals and Other Facilities

_____	_____
_____	_____
_____	_____

5. From the list below, please check those that apply to your practice:

- Abortions – 1st trimester
- Abortions – 2nd trimester
- Abortions - 3rd trimester
- Assisted Reproductive Technologies such as IVF, GIFT, etc.
- Cosmetic Procedures – please describe on your letterhead
- C-Sections
- Gynecological Surgery
- Home Deliveries
- Hospital Deliveries
- Multiple Births
- Prenatal Care (all trimesters)
- Refer all deliveries to laborist
- VBAC's

6. Do you provide Obstetrical care involving women with: (a) severe chronic disease that may adversely affect pregnancy, (b) fetal abnormalities by ultrasonography, (c) genetic disorders identified by history, and (d) CDE (Rh) or other blood group isoimmunization excluding ABO, Lewis?  Yes  No
7. Please complete the following section if you are currently practicing as a laborist only (refer to definition under question #1). If you are not, please proceed to the end of this supplement and include your signature and date.
- a. Are you practicing as part of a laborist group?  Yes  No  
If yes, name of group. \_\_\_\_\_
- b. Please note your laborist practice structure
- Shift Based (on site at hospital);
  - Call Based, single hospital (not on site);
  - Call Based, multiple hospitals simultaneously (not on site);
  - Support a midwife partnership at your hospitals.
  - Combination of above – please explain.
- \_\_\_\_\_
- c. What is your average number of deliveries per shift? \_\_\_\_\_
- d. Do you cover only one hospital during any given shift?  Yes  No
- e. Does the hospital where you practice have 24 hour anesthesia coverage?  Yes  No
- f. Does the hospital where you practice have the resources to do an immediate emergency C-section per ACOG guidelines?  Yes  No
- g. Do you have a formal or written plan in place for timely consultation with subspecialties (including transfer arrangements to appropriate level facility) for high risk situations?  Yes  No
- h. Are you in house during your shift and do you remain within 5 minutes of the labor and delivery unit?  Yes  No
- i. Do you have a formal or written plan in place for additional coverage with a similarly qualified physician if you are tied up with a case and unable to respond to other emergencies?  Yes  No
- j. When handing off patients to another physician, do you review the patient's history, course and treatment plan with the oncoming physician?  Yes  No
- k. Do you introduce yourself to all patients for whom you are responsible and meet family members where possible?  Yes  No
- l. Do you obtain and utilize available prenatal records on each patient to perform a pertinent H&P when seen for the first time?  Yes  No
- m. Do you obtain written informed consent for both planned and unplanned surgical interventions except when to do so would delay care?  Yes  No
- n. Do you document the treatment course and provide sufficient information for another clinician to assume continuity of the patient's care at any point in the course of treatment?  Yes  No
- o. Do you participate in the coaching/training of nurses and other patient care personnel in order to enhance patient care in the hospital where you practice?  Yes  No
- p. Do you dictate surgery/delivery notes within 24 hours?  Yes  No
- q. Do you have a plan for maintaining currency in the interpretation of fetal heart rate monitoring and the assessment and treatment of high risk pregnancy?  Yes  No

Please explain any "no" response to questions 7d-q above.

\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

I certify that all statements in this application are true, material, and complete.

\_\_\_\_\_  
NAME