

CTDHP Provider Office Perinatal Survey

1 Office Name: _____

Tax ID: _____

Date: _____ Person completing this form: _____

Person Spoken to: _____ Phone #: _____

Person Spoken to Title: _____

2 If they refused to answer, place an 'X' in this box and go to question #19:

YES **NO** (place an 'X' in the appropriate box)

3 Will your office treat pregnant patients? (Probe for any case.)
(If YES go to question # 4. If NO go to question # 19)

4 Will your office treat any pregnant patients under the age of 21 years?

5 Will your office treat any pregnant patients aged of 21 years or older?

6 To treat does your office need a letter from the patient's OB/GYN or Midwife?
(If YES go to question # 8. If NO go to question # 7, for all others continue)

Only need OB/GYN letter in certain circumstances: _____

7 Will your office contact the OB/GYN or Midwife before treatment?
(If YES go to question # 8. If NO go to question # 9.)

8 If the OB/GYN indicates that there are no restrictions in treating the pregnant patient:

- | | | |
|----|---|--|
| 9 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office provide Preventive services |
| 10 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office provide Restorative services |
| 11 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office provide Urgent care |
| 12 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office provide Emergency care |
| 13 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office treat in first trimester |
| 14 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office treat in second trimester |
| 15 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office treat in third trimester |
| 16 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office use local anesthesia |
| 17 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Will your office take x-rays if medically necessary with lead apron |
| 18 | <input style="width: 40px; height: 20px;" type="checkbox"/> <input style="width: 40px; height: 20px;" type="checkbox"/> | Are there any other restrictions on your treating a pregnant patient? If YES please specify: |

19 Thank them for their time today.

- Answer all questions.
- Answer yes if there are any providers in that office who will do so.
- Answer yes if the answer to the question is mostly yes, or yes at least half of the time.
- If after four attempts you are unable to reach the office, write "Unable to Reach" in question 18 and the four dates and times you called.