

ANAESTHETIC SUPPLEMENTARY QUESTIONNAIRE

Please use the data from your last successfully submitted annual appraisal to complete this questionnaire.

1.1 Please state whether you are employed by the NHS as a Consultant Anaesthetist: Yes No

1.2 Please state the number of PAs, or equivalent time in Private Practice, spent in ITU and HDU during the last year:

	Private Practice	NHS
ITU:		
HDU:		
Total:		

1.3 Please state the number of PAs, or equivalent time in Private Practice, spent on pain work during the last year in Private Practice and the NHS:

	Private Practice	NHS
Pain work:		

1.4 Please state how many PAs, or equivalent time in Private Practice, spent anaesthetising patients who underwent the following procedures during the last year in Private Practice and the NHS:

Procedure	Private Practice	NHS
Bariatric surgery:		
Cardiothoracic surgery:		
Neuro surgery:		
Obstetric procedures:		
Spinal surgery:		
Upper respiratory tract procedures:		
Total:		

1.5 Please state whether you anaesthetise any patients under 16 years of age: Yes No

If yes, please state the number of patients you anaesthetised during the last year and the procedure performed or condition treated:

Age	Number of patients	Procedure or condition
0-2 years:		
2-5 years:		
5-10 years:		
10-16 years:		

1.6 Please provide a breakdown of the number of cases you anaesthetised during the last year in Private Practice and the NHS:

	Private Practice	NHS
Day cases:		
Overnight cases:		
Total:		

1.7 Please provide a breakdown of your activities during the last year for the following surgical procedures in Private Practice and the NHS:

Surgical procedure	Private Practice	NHS
Cardiothoracic surgery:		
ENT surgery:		
General surgery:		
Gynaecology:		
Neurosurgery:		
Orthopaedic surgery:		
Paediatric surgery:		
Plastic surgery:		
Urology:		
Vascular surgery:		
Other:		
Total:		

If other, please provide full details:

1.8 Please state the types of surgical procedures you performed in respect of any cardiothoracic and paediatric surgery:

1.9 Please state whether you perform any aesthetic procedures in Private Practice: Yes No

If yes, please provide a breakdown of the number of procedures you performed during the last year and the product or system used:

Procedure	Number of procedures	Product or system used
Body contouring:		
Botox - face:		
Botox - platysmal bands:		
Dermal fillers - permanent:		
Dermal fillers - semi-permanent:		
Dermal fillers - temporary:		
Laser lipolysis:		
Laser/IPL hair removal:		
Laser/IPL skin tightening or resurfacing:		
Lipotherapy:		
Mesotherapy:		
Sclerotherapy:		
Other:		
Total:		

1.10 Please state whether you:

- a) maintain records of the assessment of a patient's upper airway and dentition before anaesthesia, including any warnings given: Yes No
- b) personally obtain written consent to anaesthesia from the patient or ensure that the patient has otherwise given fully informed consent to anaesthesia: Yes No
- c) maintain records of pre-operative warnings (e.g. dental injuries) Yes No
- d) maintain records of all steps taken to protect the anaesthetised patient from harm (e.g. the use of specialised mattresses for prone patients): Yes No

1.11 Please state when you were last certified in Advanced Life Support or Paediatric Advanced Life Support:

1.12 Do you anticipate any changes to your activities during the next 12 months? Yes No

If yes, please provide full details.

DECLARATION

I declare that:

- after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed: _____ Full name: _____

Date: _____ DD / MM / YY

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