DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

OUTPATIENT SURGERY QUESTIONNAIRE

Reporting Period: (*Please provide data for* **Calendar Year 2010**)

(Number of operating rooms, utilization and health care services provided are for this physical location only – if another campus or satellite office is owned and operated by the same facility in a different town, complete an additional questionnaire for that location – e.g., West Hartford Surgery Center in West Hartford should be completed on a separate questionnaire from Hartford Hospital)

1) Facility Name:____

2) Facility Address:____

3) Facility City:_____________________________ **CT** **4) Facility Zip Code:**____________

5) Date Completed:______________ **6) Contact Name:**____________________________

7) Contact Title:___________________________ **8) Contact Phone:**__________________

9) Contact Fax:____________________ **10) Contact Email:**_________________________

(Please list name and contact information for provider)

11) Provider Type: Outpatient Surgery Ctr. ☐ Hospital Main Campus ☐ Hospital Satellite ☐

Other:____________________________

(Please check appropriate box or list alternative facility type where outpatient surgery is performed)

12) Hours of Operation: Day(s):__________ From:_________ To:__________

Day(s):__________ From:_________ To:__________

Day(s):__________ From:_________ To:__________

(Please list hours of operation for facility – e.g., M-F 8am to 5pm)

13) Average wait time from appointment request to appointment date:_________*day(s)*

14) Operating Rooms/Volumes:
(Please list the number of operating room(s) at this facility as of 12/31/2010 and the number of patients treated and procedures performed for calendar year2010)

Number of Operating Rooms as of 12/31/2010:_________

*** Need Operating Room Definition**

Surgery Type: *(Roll-up to broad category: cosmetic, endoscopy, eye, orthopedic surgery, etc)*	**# Of Patients Treated CY 10**	**# Of Procedures CY 10**
Total		

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15) Primary Payer Source *(Please list patient's primary payer source)*

Payer Source	# Of Patients Treated CY 10
Commercial	
Medicare	
Medicaid	
Other Government	
Uninsured	
Total	

16) Clinical Staff *(Please list the type and number of clinical staff members at your location as of 12/31/10)*

Clinical Staff	# of Staff

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PLEASE COMPLETE AND RETURN QUESTIONAIRE BY XX/XX/XXXX

If you have any questions pertaining to this questionnaire, please contact:

Brian Carney
Phone: 860-418-7014
Email: brian.carney@ct.gov

Or

Karen Roberts
Phone: 860-418-7041
Email: karen.roberts@ct.gov