PCF Procedure Questionnaire for practitioners with "minor" surgery or "major" surgery designation

Complete Name: _____

Complete Name - Required

Professional Specialty: _____

Professional Specialty - Required

Date of Birth: _____ **License #:** _____

Date of Birth - Required License Number - Required

Please indicate which of the following medical/surgical procedures you engage in:

	Acupuncture		Hysterectomies		Otorhino/Plastic
	Administer General Anesthesia		Intensive Care Medicine		Otorhino/Surgery
	Amputations - Specify		Laparoscopy		Pain Management
	Angiography		Laser Proceures - explain		Plastic Surgery
	Appendectomies		Liposuction		Saddle Blocks
	Assist in Surgical Procedures		Major Surgery in E.R.		Skin Grafts
	Bariatric/Obesity Surgery		Needle Biopsies		Spinal Anesthetics/Epidural
	Cardiac Catheterization		Nerve Blocks		Spinal Surgery
	Cardiovascular Surgery		Neurosurgery		Tonsilectomies and/or Adenoidectomies
	Cesarean Sections		Obstetrical Deliveries		Telemedicine/Teleradiology
	Colon & Rectal Surgery		Obstetrical Procedures		Thoracic Surgery
	Colonoscopy		Open Reductions of Fractures		Traumatic Surgery
	D & Cs / Abortions		Open Spinal Procedures (Non-Diagnostic)		Tubal Ligations
	Dermabrasions		Ophthalmology Surgery		Urological Surgery
	Electroshock Therapy		Oral Surgery		Vascular Surgery
	Emergency Medicine		Orthopedic Surgery w/Spine		Vasectomies
	Hand Surgery		Orthopedic Surgery - No Spine		
	Hemorrhoidectomies		Orthopedic - Minor Surgery		

Amputation Specify:

Explanation of Laser Procedures:

After form has been completed, printed and signed, please mail or fax to:

LOUISIANA PATIENT'S COMPENSATION FUND
P. O. BOX 3718
BATON ROUGE, LA 70821
FAX: (225) 342-5593

Any questions regarding this form may be emailed to: pcf-surcharge@la.gov

A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.

Save & Print