DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
99 Chauncy Street, Boston, MA 02111
Tel: 617-753-8000

CLINIC
Presurvey Report for Licensure

Project Information

Type of Survey:

- ☐ Initial Survey of Parent Site
- ☐ Change of Ownership
- ☐ Change of Location: ☐ Parent ☐ Satellite
- ☐ Addition of Satellite
- ☐ Addition of Service
- ☐ Other: _____

_____ SURVEY REQUEST DATE

_____ PROJECTED START DATE OF SERVICE

Contact Information: Name of person who should be contacted regarding this request.

Name: _____ Title: _____

Telephone #: _____ E-Mail: _____

Please complete **ONE PRESURVEY REPORT FOR EACH CLINIC SITE TO BE SURVEYED**. The applicable sections of this document must be completed and returned to this office prior to survey.

With this form **please attach:**
- Organizational Chart
- Completed Personnel List Form
- Clinic Brochure (if available)
- Directions to the Clinic Site

and **Current Certificates:**
- Fire Safety Inspection Certificate
- Department of Public Safety Certificate
- Certificate of Occupancy
- Division of Food and Drug Certificate
- C.L.I.A./Waiver Certificate

Parent Information

Licensee: _____

Name of **PARENT** Clinic: _____

Street: _____

City: _____ Zip Code: _____

Telephone #: _____ Days & Hours of Operation: _____

SATELLITES

Attach addendum for additional sites, if applicable.

1. Name of Clinic: _____

Street: _____ Suite #/Floor: _____

City: _____ Zip Code: _____

Telephone Number: _____

Days and Hours of Operation: _____

2. Name of Clinic: _____

Street: _____ Suite #/Floor: _____

City: _____ Zip Code: _____

Telephone Number: _____

Days and Hours of Operation: _____

3. Name of Clinic: _____

Street: _____ Suite #/Floor: _____

City: _____ Zip Code: _____

Telephone Number: _____

Days and Hours of Operation: _____

4. Name of Clinic: _____

Street: _____ Suite #/Floor: _____

City: _____ Zip Code: _____

Telephone Number: _____

Days and Hours of Operation: _____

5. Name of Clinic: _____

Street: _____ Suite #/Floor: _____

City: _____ Zip Code: _____

Telephone Number: _____

Days and Hours of Operation: _____

SERVICES

Please check off services offered, by site:

Services	Medical	Surgical	Dental	Mental Health	Physical Rehabilitation	Alcoholism	Birthing Center	Pharmacy	Laboratory	Radiology	Mobile Medical
Parent / Main Site:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Satellite Site(s) (list separately)											
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

LICENSURE INFORMATION – SITE SPECIFIC

Information provided below pertains to the **following Clinic Site**:

_____

Name, address (*xerox this sheet for additional sites)

Clinic Staff:

Clinic Administrator [140.310]: _____

Professional Services Director [140.311]: _____

Responsible M.D. [140.313(A)]: _____

Nursing Director [140.314]: _____

Background Information:

1. Does the licensee provide services separate from the licensed clinic services (e.g., residential services, adoption services)? Yes ☐ No ☐
   Explain:

2. How does the Clinic differentiate licensed clinic services from other non-clinic services offered by the parent agency?
   Explain:

3. Does this Clinic site have a current **Certificate of Inspection** issued by the Massachusetts **Department of Public Safety**?(attach) Yes ☐ No ☐
   Comments:

4. Does this Clinic site have a current **Certificate of Inspection** and approval issued by the **local fire department** (issued within the past two years)? (attach) Yes ☐ No ☐
   Comments:

5. Is verification of current professional licensure provided for all applicable staff? Yes ☐ No ☐
   Comments:

6. Is this Clinic site handicapped accessible (ramps, elevators, bathrooms, etc.)? Yes ☐ No ☐
   Comments:

7. Does this clinic have a written agreement with a nearby hospital providing emergency services? Yes ☐ No ☐
   Identify hospital: _____

   Inpatient psychiatric services (for mental health clinics)? Yes ☐ No ☐
   Identify hospital: _____

8. Does this clinic utilize the services of:
   Nurses in the expanded role? Yes ☐ No ☐
   Physician's assistants? Yes ☐ No ☐

Medication Information [140.340][140.347]

Answer the following for *this* clinic site:

1. Does this Clinic have a pharmacy? Yes ☐ No ☐

2. Name of Pharmacy Director [140.342(A)]:
   _____

3. Are any stock prescription medications (including emergency and/or sample drugs) purchased and/or stored at this Clinic site? Yes ☐ No ☐

4. Does this Clinic have the following:
   Mass. Board of Pharmacy Registration: Yes ☐ No ☐
   #: _____ Exp. date: _____

   Mass. DPH Food and Drug Registration: Yes ☐ No ☐
   #: _____ Exp. date: _____

   US Drug Enforcement Administration (DEA) Registration: Yes ☐ No ☐
   #: _____ Exp. date: _____

5. If this is an initial survey, have the above applications (if applicable) been filed with the respective agencies? Yes ☐ No ☐

Comment:

Laboratory (140.350)

Laboratory Tests: Includes ALL types of testing (e.g., dipstick, tablet, fingerstick, Point-of-Care, moderate/high complexity) performed on any body fluid (e.g., blood, serum, urine, feces, culture).

1. Are laboratory services offered at this clinic site:

☐ Directly ☐ Under arrangement ☐ Not offered

Name of Laboratory Director: _____

If "Not Offered", please continue to next section, Diagnostic Radiology

2. Does the clinic contract for the provision of all or part of its clinical laboratory services with a laboratory independent of this clinic? Yes ☐ No ☐

If YES:

Name of Laboratory: _____

Address: _____

_____

3. Are any of the Clinic's patients' laboratory tests performed on-site? Yes ☐ No ☐

4. Are on-site laboratory testing services offered to other health care facilities? Yes ☐ No ☐

5. Has the clinic applied for a CLIA (Clinical Laboratories Improvement Act) registration? Yes ☐ No ☐

Which certificate type?
- ☐ Waiver
- ☐ Regular
- ☐ PPMP

CLIA #: _____

6. Check laboratory tests performed in the clinic (e.g., treatment room laboratory, physician offices, etc.):

Chemistry

- ☐ Glucose (any method)
- ☐ Cholesterol, HDL, LDL
- ☐ Na, K, Cl, CO_2

Hematology

- ☐ Hgb, Hct, RBC, WBC, Platelets, Indices (any parameter, any method)
- ☐ Differential (manual, automated)
- ☐ SED rate
- ☐ Reticulocytes
- ☐ Coagulation (PT/PTT)
- ☐ Sperm count
- ☐ Sickle cell

Serology

- ☐ Mono Test
- ☐ RPR, Syphilis
- ☐ Rheumatoid Factor

Microbiology

- ☐ Strep screen
- ☐ Cultures (urine, throat, other)
- ☐ Sensitivities
- ☐ Scotch Tape, Wet prep, KOH prep
- ☐ GC, Chlamydia screens

Urine / Feces

- ☐ Dipstick urine
- ☐ Urine microscopic
- ☐ Pregnancy test
- ☐ Occult blood

	Yes	No
7. Are transfusions offered at this site?	☐	☐
8. Are procedures other than those listed above performed on-site?	☐	☐

If YES, briefly describe the types of procedures performed in the space below:

	Yes	No
9. Are any laboratory specimens collected by personnel not employed by the clinic?	☐	☐

If YES, name of Laboratory/Facility supplying phlebotomy/specimen collection services:

_____

	Yes	No
10. Is there a separate specimen collection area?	☐	☐

Diagnostic Radiology (140.360)

1. Are **Diagnostic Radiology Services** provided at this Clinic site? Yes ☐ No ☐

   Are **Therapeutic Radiology Services** provided at this Clinic site? Yes ☐ No ☐

   If "NO", please continue to next section, Mental Health Services

   If YES, type(s) of services:
   - ☐ X-ray
   - ☐ Laser
   - ☐ MRI
   - ☐ Fluoroscopy
   - ☐ Mammography
   - ☐ Other: _____

2. Does this site have a registration or application on file with the Department of Public Health, Division of Radiation Control, to provide such services? Yes ☐ No ☐

   Registration #: _____

   Expiration date: _____

3. Radiologist responsible for the proper performance of Radiological Services:

   Name: _____

   Board Certification Status: _____

Mental Health Services (140.500)

1. Are Mental Health Services provided at this site? Yes ☐ No ☐

   If "NO" please continue to next section, Substance Abuse Services

2. Average number of patient visits per week: _____

3. DMH area in which the Parent Clinic is located:

   _____

Yes No

4. Does this Clinic site operate a Psychiatric Day Treatment Program? ☐ ☐

Hours of operation: _____

Average # of clients: _____

5. MD responsible for the establishment of medical policies and supervision of medical services [140.530(D)].

Name: _____

Qualifications (Licensure, Board Certification):

_____

Multidisciplinary Staff [140.530]

6. Which of the following clinical disciplines are involved in developing client treatment plans? (see definitions 140.020)

- ☐ Mass. licensed MD, board certified/eligible in Psychiatry and Neurology
- ☐ Psychiatric Social Worker (Mass. LICSW, LCSW, at least one year post-grad. mental health experience)
- ☐ Mass. licensed Psychiatric Nurse (R.N., Master's degree in Psychiatric Nursing)
- ☐ Mass. licensed Clinical or Counseling Psychologist
- ☐ Other: _____

Outreach Services [140.560]

Yes No

7. Are Mental Health Outreach Services offered at outreach locations? [140.560] ☐ ☐

Location	DMH Area	Total Hrs of Operation/Wk	Total Staff Hours/Week
1.			
2.			
3.			
4.			
5.			

Yes No

8. Are any of the above in commercially rented office space? ☐ ☐

Explain:

	Yes	No
9. Is an agreement provided with each outreach site?	☐	☐

10. Where are the records of outreach patients stored?
Explain:

	Yes	No
11. Are medications stored or administered at any outreach site?	☐	☐

Explain:

Substance Abuse Services [140.800]

	Yes	No
1. Does the clinic provide a separate, identifiable program specifically designed to care for persons suffering from Alcoholism/Substance Abuse?	☐	☐

If "NO", please continue to next section, Surgical Services

	Yes	No
2. If YES, does the clinic have an approval or license issued by the Department of Public Health's Bureau of Substance Abuse Services (BSAS)? (attach copy)	☐	☐

Expiration date: _____

Copy attached: ☐

Surgical Services [140.600]

	Yes	No
1. Are Surgical Services provided at this site?	☐	☐

If "NO", please continue to next section, Dental Services

2. If YES, type of anesthesia used:
   - ☐ Local
   - ☐ Regional
   - ☐ Conscious IV sedation
   - ☐ General
   - ☐ Other: _____

	Yes	No
3. Is this Clinic site a Medicare Certified Ambulatory Surgical Center?	☐	☐

4. Does this Clinic use services of:

	Yes	No
Nurse Anesthetists	☐	☐
Nurse Midwives	☐	☐
Physician Assistants	☐	☐

5. Surgical Director [140.603]:

Name: _____

Qualifications (Licensure, Certification status):

_____

6. Anesthesia Director [140.606]:

Name: _____

Qualifications (Licensure, Certification status):

_____

7. Number of operating rooms: _____

8. Average number of surgical cases per week: _____

9. Please attach a list of approved surgical procedures [140.604]. Yes ☐ No ☐

Dental Services [140.400]

1. Are Dental Services provided at this site? Yes ☐ No ☐

If "NO", please continue to next section, Physical Rehabilitation Services

2. If YES, type of anesthesia used:
   - ☐ Local
   - ☐ Conscious IV Sedation
   - ☐ General
   - ☐ None
   - ☐ Other: _____

3. Dental Services Director:

   Name: _____

   Qualifications (Licensure, Certification status):

   _____

Physical Rehabilitation Services [140.700]

	Yes	No
1. Are Physical Rehabilitation Services provided at this site?	☐	☐

2. If YES, type of service(s)

   Physical
   ☐ Therapy: _____
   ☐ Occupational Therapy: _____
   ☐ Speech Therapy: _____
   ☐ Other: _____

3. Name of the M.D. responsible for assisting in implementing patient care policies and providing medical consultation, as needed [140.701]:

   _____

Signatures:

To the best of my knowledge, the information in this Pre-survey Report is accurate.

Name of person completing form: _____

Signature: _____

Title: _____

Date: _____

Reviewed and Revised at Survey, as applicable:

Signed: _____

Title: _____

Date: _____

Information reviewed by:

Surveyor Name: _____

Date: _____