



VitalityHealth  
PO Box 617  
Darlington  
DL1 9FF

### Facility Recognition Profile Form – Surgical

<b>Facility Name:</b>
<b>Facility Manager:</b>
<b>Facility Business Office Manager:</b>
<b>Website:</b>

<b>Facility Address:</b>	<b>Telephone No:</b>
	<b>Fax No:</b>
	<b>Email:</b>

<b>Facility Owner:</b>
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<b>Facility Owner Address (if different):</b>	<b>Telephone No:</b>
	<b>Fax No:</b>
	<b>Email:</b>

#### Registration

<b>Is the facility registered with the CQC/HIS/HIW/RQIA? (Delete as applicable)</b>	<b>Yes/No</b>
<b>If no, please provide further detail:</b>	
<b>If yes, please provide relevant registration/certificate number and CQC Provider ID number (where applicable):</b>	
<b>Companies House registration number:</b>	



### Facility Services

Please list the specialities provided at the Facility:

Please list all Consultants / Doctors who work from this facility (including GMC numbers):

Does the facility offer paediatric services? (Delete as applicable)

Yes / No

If yes, please provide details:

### Accommodation

Single with en-suite bathroom:	Yes / No	No. of rooms	<input type="text"/>
Single with en-suite W/C:	Yes / No	No. of rooms	<input type="text"/>
Single:	Yes / No	No. of rooms	<input type="text"/>
Shared rooms:	Yes / No	No. of rooms	<input type="text"/>
Day case beds:	Yes / No	No. of beds	<input type="text"/>
Other (please provide details):		No. of rooms	<input type="text"/>



### Critical Care

CCU:	Yes / No	No. of beds	<input type="text"/>
HDU:	Yes / No	No. of beds	<input type="text"/>
ITU:	Yes / No	No. of beds	<input type="text"/>
PICU:	Yes / No	No. of beds	<input type="text"/>
SCBU:	Yes / No	No. of beds	<input type="text"/>

### Clinical Staff

What is the RGN:patient ratio?

What is the EN:patient ratio?

What is the untrained nursing staff:patient ratio?

How many other specialised nurses?

How many RMO's are on duty:                      Day:  
   Night:

What is the nurse:patient ratio:                      Day:  
   Night:

What checks are made to ensure that nurses are appropriately registered?

### Theatres

Number of major GA theatres with laminar air flow:

Number of major GA theatres without laminar flow:

Number of Day case only theatres:

Number of minor LA theatres:

Number of Endoscopy Suites:

Number of recovery bays:

Other (please provide detail):



### **Out Patient Facilities**

Number of consulting rooms:

Number of minor treatment rooms:

#### **Therapies**

Physiotherapy:	Yes / No
Osteopathy:	Yes / No
Chiropractic:	Yes / No
Acupuncture:	Yes / No
Homeopathy	Yes / No
Podiatry:	Yes / No

Ultrasound:	Yes / No	
General x-ray	Yes / No	
ECG:	Yes / No	
Mammography:	Yes / No	
OPG:	Yes / No	
MRI scanner:	Yes / NoStatic: Yes / No	Mobile: Yes / No
CT scanner:	Yes / NoStatic: Yes / No	Mobile: Yes / No
PET scanner:	Yes / No	
PET – CT Scanner	Yes / No	
Nuclear medicine	Yes / No	
Bone densitometry	Yes / No	
Interventional Radiology	Yes / No	
Fluoroscopy Unit	Yes / No	
EEG	Yes / No	
Echocardiogram	Yes / No	
Pathology Lab	Yes / No	

#### **Other Information**

Is there free parking?	Yes / No
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Please provide details of any planned developments for the facility:



**Mandatory BACS Payment Details**

Account/Payee Name (as it appears on your cheque book or invoice):

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Sort Code:

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Account Number:

--	--	--	--	--	--	--	--

Bank Name: \_\_\_\_\_

Please state preferred payment date (Payment frequency is monthly):

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Email address for provider statements (Provider Statements will be emailed where possible)

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Postal address for provider statements:

\_\_\_\_\_

Will the Facility/clinic be billing VitalityHealth using EDI? (Further information on EDI billing is available at [www.healthcode.co.uk](http://www.healthcode.co.uk)): Yes / No

Name:

Date:

Job Title:

**Thankyou for completing the VitalityHealth Surgical Facility Profile Form**

Please return the completed form via email to [hospital\\_recognition@vitality.co.uk](mailto:hospital_recognition@vitality.co.uk)