FERNANDEZ HOSPITAL

A unit of FERNANDEZ FOUNDATION

PRIVILEGES IN OBSTETRICS

Name: Dr. Sreedevi

MEDICAL STAFF CATEGORY REQUESTED

Note – Cross out and INITIAL any privilege/s you are not applying for in this set of Basic Privileges

☑ **Full Time** – Uses Fernandez Hospitals as a primary hospital and regularly treats, consults, patients at this facility, and is regularly involved in medical staff functions.

Appointment as: - ~~Sr~~/Jr *Consultant* ☑ *Registrar* ☐ *Postdoctoral* ☐ *DNB Student* ☐ Duty Doctor ☐

INITIAL CRITERIA

Successful completion of MBBS and

☐ MBBS ☐ DGO ☐ DNB (Obstetrics ☐ MD/MS (Obstetrics and Gynecology) ☐ MRCOG

From a MCI recognised medical college or university. Should be registered with **AP Medical Council**

CORE PRIVILEGES				
REQUESTED	PROCEDURE	GRANTED		
		YES	NO	Under Supervision
☐	Antepartum Care Ambulatory, routine, urgent, and emergency care in the hospital setting, through the Emergency Department or hospitalization and in-patient care for obstetric, medical, and/or surgical problems/ complications of pregnancy	☑	☐	☐
PRIMARY SPECIALTY AREAS				
Labor and Delivery				
☐	Perform history and physical exam	☑	☐	☐
☐	Amnioinfusion	☐	☑	☐
☐	Amniocentesis	☐	☑	☐
☐	Amniotomy	☑	☐	☐
☐	Application of internal fetal and uterine monitors	☐	☑	☐
☐	Augmentation and induction of labor	☑	☐	☐
☐	Cesarean hysterectomy, cesarean section	☐	☐	☑
☐	Cerclage	☑	☐	☐
☐	Cervical biopsy or conization of cervix in pregnancy	☐	☐	☑
☐	External version of breech	☑	☐	☐
☐	Immediate care of the newborn (including resuscitation and intubation)	☑	☐	☐
☐	Interpretation of fetal monitoring	☑	☐	☐
☐	Management of high risk pregnancy inclusive of such conditions as pre-eclampsia, post-datism, third trimester bleeding, intrauterine growth restriction, premature rupture of membranes, premature labor, and placental abnormalities	☑	☐	☐
☐	Management of patients with/without medical, surgical or obstetrical complications for normal labor including toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications, fetal death.	☑	☐	☐

REQUESTED	PROCEDURE	GRANTED YES	NO	Under Supervision
☐	Manual removal of placenta, uterine curettage	☑	☐	☐
☐	Medication to induce fetal lung maturity	☑	☐	☐
☐	Normal spontaneous vaginal delivery	☑	☐	☐
☐	Episiotomy, repair of obstetrical laceration	☑	☐	☐
☐	Obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques	☑	☐	☐
☐	Operative vaginal delivery (including the use of obstetric forceps and/or the vacuum extractor)	☑	☐	☐
☐	Perform breech and multifetal deliveries	☑	☐	☐
☐	Repair of 4th degree perineal lacerations or of cervical or vaginal lacerations	☐	☐	☑
☐	Treatment of medical and surgical complications of pregnancy	☑	☐	☐
☐	Vaginal birth after previous Cesarean section (VBAC)	☑	☐	☐
☐	Obstetric Anesthesia : Paracervical block, pudendal block, local infiltration	☑	☐	☐
☐	Amniocentesis : Second trimester (e.g. amnionitis, ruptured membranes evaluation), third trimester (eg fetal maturity studies)	☑	☐	☐
☐	Other procedures: Tubal sterilization with cesarean delivery, dilation and curettage for retained placenta and/or products of conception	☑	☐	☐
☐	Reproductive Endocrinology and Infertility : Special procedures required for and microsurgery related to infertility	☑	☐	☐

SPECIAL PRIVILEGES (MUST ALSO MEET THE CRITERIA ABOVE)

ADDITIONAL CREDENTIALING CRITERIA

Training in fetal medicine — Yes / No

REQUESTED	PROCEDURE	YES	NO	Under Supervision
OBSTETRICS / MATERNAL FETAL MEDICINE				
☐	Chorionic Villus Sampling (CVS)	☐	☑	☐
☐	Amniocentesis (1st and 2nd trimester)	☐	☑	☐
☐	Umbilical cord blood sampling (PUBS)	☐	☑	☐
OBSTETRIC IMAGING				
☐	Basic Obstetric Imaging (fetal position, fetal heart rate, AFI, placental location)	☑	☐	☐
☐	Complex Obstetrical Imaging	☑	☐	☐
☐	Level II anatomy ultrasound	☐	☐	☑
☐	Cervical length	☑	☐	☐
☐	Doppler	☑	☐	☐

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Fernandez Hospital. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature: _____ Date 16/2/20.

HOD's Signature: _____ Date _____

TO BE COMPLETED BY MEDICAL DIRECTOR FERNANDEZ HOSPITAL AT TIME OF REVIEW AND APPROVAL

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Signature: _____ Date 18/2/20.