

## PRIVILEGES IN OBSTETRICS

Name: Dr. T. Lakshmi Sowjanya

### 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.

Appointments as: - 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
<input type="checkbox"/>	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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRIMARY SPECIALTY AREAS				
Labor and Delivery				
<input type="checkbox"/>	Perform history and physical exam	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Amnioinfusion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Amniocentesis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Amniotomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Application of internal fetal and uterine monitors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Augmentation and induction of labor	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Cesarean hysterectomy, cesarean section	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Cerclage	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cervical biopsy or conization of cervix in pregnancy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	External version of breech	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Immediate care of the newborn (including resuscitation and intubation)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Interpretation of fetal monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

**SPECIAL PRIVILEGES  
(MUST ALSO MEET THE CRITERIA ABOVE)**

**ADDITIONAL CREDENTIALING CRITERIA**

Training in fetal medicine

Yes / No

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



### 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: [Signature]

Date 5/10/20

HOD's Signature: [Signature]

Date 5/10/20

### 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: [Signature]

Date 6/10/20