

PRIVILEGES IN GYNECOLOGY

Name: Dr. Padmaja Velisetty

MEDICAL STAFF CATEGORY REQUESTED

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

☒ **FullTime**—Uses Fernandez Hospital as a primary hospital and regularly treats, consults, patients at this facility, and is regularly involved in medical staff functions.

Appointment as: ☒ **Consultant** ☐ **Registrar** ☐ **Duty Doctor**

INITIAL CRITERIA

Successful completion of MBBS and ☐ DGO ☐ DNB (Obstetrics & Gynaecology) ☒ MD/MS (Obstetrics & Gynaecology)

☒ 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 checked="" type="checkbox"/>	Gynecology Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide pre-operative, intraoperative, and post-operative care necessary in the outpatient clinic and hospital for management of female patients presenting with illness, injuries, and disorders of the gynecologic or genitourinary system, and non-surgical treatment of illnesses and injuries of the mammary glands. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRIMARY SPECIALTY AREAS				
Vulval/Cervical				
<input checked="" type="checkbox"/>	Vulval biopsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Labial repair / Labiaplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Peritoneal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Hymenotomy/hymenectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Treatment of Bartholin /Skenes gland problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Loop excision of dysplastic tissue/cone biopsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Simple /partial vulvectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Repair of fistula	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Intrauterine				
<input checked="" type="checkbox"/>	Endometrial biopsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Placement of IUD	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Cervical dilation and curettage	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hysteroscopic				
<input checked="" type="checkbox"/>	Diagnostic hysteroscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Hysteroscopic biopsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Removal of small polyps	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Removal of large polyps	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Removal of myomas	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Endometrial ablation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REQUESTED		PROCEDURE	GRANTED		
			YES	NO	Under Supervision
Laparoscopic					
<input checked="" type="checkbox"/>		Diagnostic laparoscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Chromotubation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Salpingectomy, salpingostomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Ovarian Cystectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Oophorectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Hysterectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Ablation of endometriosis and adhesions by any modality	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Pelvic sidewall dissection, pre-sacral neurectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>		Uteral sacral colpopexy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		Myomectomies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Laparoscopic total hysterectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Tuboplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laparotomy					
<input checked="" type="checkbox"/>		Exploratory laparotomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Salpingostomy/salpingotomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Ovarian Cystectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Oophorectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Hysterectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Enterocoele repair	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal					
<input checked="" type="checkbox"/>		Repair of lacerations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Perineoplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Hymenoplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Labioplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Laparoscopic total hysterectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Tuboplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Cystocoele repair (without mesh)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Rectocoele repair(without mesh)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Hysterectomy/Oophorectomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>		Enterocoele repair	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric/Adolescent Gynaecology					
<input checked="" type="checkbox"/>		Privileges to admit, treat, obtain history and physical exam, perform surgical procedures, or provide follow-up care for inpatients ages 14 years or younger	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

REQUESTED PROCEDURE		GRANTED		
		YES	NO	Under Supervision
Reproductive Endocrinology and Infertility				
<input checked="" type="checkbox"/>	Admit, evaluate, diagnose, treat and provide inpatient or outpatient consultation to adolescent and adult patients with problems of fertility.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Fertility restoration including: laparoscopy and laparotomy techniques used to reverse sterilization	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Diagnostic and therapeutic techniques including: hysterosalpingography, sonohysterography, tubal canalization and endoscopy (laparoscopy and hysteroscopy)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urogynecology and Pelvic Reconstructive Surgery				
<input checked="" type="checkbox"/>	Privileges to admit, evaluate, diagnose, consult, obtain history and physical exam and provide surgical and medical management for the care of women with pelvic floor disorders.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Perform and interpret diagnostic tests for urinary incontinence and lower urinary tract dysfunction, fecal incontinence, pelvic organ prolapse	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Continence procedures for genuine stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Continence procedures for overflow incontinence due to anatomic obstruction following continence surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Other surgical procedures for treating urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Urethral closure and suprapubic cystotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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: Y. Padmaja

Date 17-2-2020

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: L. Parakeeran

Date 20-Feb-2020