

PRIVILEGES IN NEONATOLOGY

Name: Dr GUTTA SREE SRAYYA

MEDICAL STAFF CATEGORY REQUESTED

Note – Cross out & 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:- Consultant ☐ Registrar ☒ Postdoctoral ☐ DNB Student ☐
Duty Doctor ☐

INITIAL CRITERIA

Successful completion of MBBS and ☒ MD ☐ DNB ☐ PhD ☐ DM

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"/>	Evaluation, diagnosis, treatment and consultation for term, preterm, and critically ill newborns and infants. Neonatologist management of patients requiring ventilator care, neurological, post-neurosurgical, postsurgical, or post-cardiac / thoracic surgical care for organ dysfunction, patients with issues due to prematurity and / or who are in need of critical care for life threatening disorders	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRIMARY SPECIALTY AREAS				
<input checked="" type="checkbox"/>	High frequency ventilation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Neonatal and Pediatric inter facility transport	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Pulmonary artery catheter insertion and interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Echocardiography (screening echocardiogram)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Nitrous Oxide administration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Parenteral nutrition	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Extracorporeal membrane oxygenation (ECMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Emergency bedside ultrasound / echocardiography	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Screening ultrasound (bedside screening ultrasonography)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Lumbar puncture	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Umbilical artery catheter and umbilical vein catheter line insertion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Thoracentesis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Double volume exchange transfusion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Tube thoracostomy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Suprapubic bladder aspiration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Percutaneous indwelling arterial line	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Pericardiocentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Paracentesis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Exogenous surfactant administration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Venous cut down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Peripheral arterial cut down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Conventional mechanical ventilation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

CORE PRIVILEGES				
REQUESTED	PROCEDURE	GRANTED		
		YES	NO	Under Supervision
<input checked="" type="checkbox"/>	Endotracheal intubation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Emergency tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Intra-umbilical vessel cut down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Therapeutic hypothermia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Non-invasive respiratory support (e.g., CPAP, HHFNC, NIPPV)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL PRIVILEGES (MUST ALSO MEET THE CRITERIA ABOVE)				
ADDITIONAL CREDENTIALING CRITERIA				
In accordance with Hospital Sedation Policy				Yes / No
Documentation of Additional training and experience				Yes / No

REQUESTED	PROCEDURE	YES	NO	Under Supervision
<input checked="" type="checkbox"/>	Administration of Sedation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Extracorporeal Membrane Oxygenation (ECMO)	<input type="checkbox"/>	<input 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: G. Sree Krangan

Date: 6/July/2020

HOD's Signature: [Signature]

Date: 23/July/2020

TO BE COMPLETED BY CHIEF EXECUTIVE OFFICER 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: E. Prasad

Date: 24/July/2020