LANE REGIONAL MEDICAL CENTER
PRIVILEGES APPLICATION FORM
Gynecological

R G A

__ __ __ Cystoscopy

__ __ __ Laproscopic Hysterectomy

__ __ __ D&C diagnostic

__ __ __ Repair of rectocele

__ __ __ Repair of enterocoele

__ __ __ Repair of cysto-urethrocele

__ __ __ Excision of Skene's duct cyst

__ __ __ Excision of urethral caruncle

__ __ __ Vulvectomy - simple

__ __ __ Hysterectomy - vaginal

__ __ __ Hysterectomy - abdominal (total with/without adnexa)

__ __ __ Hysterectomy - abdominal (subtotal with/without adnexa)

__ __ __ Uterine suspension

__ __ __ Pre-sacral neurectomy

__ __ __ I&D Bartholin duct abcess

__ __ __ Hysterectomy - radical, Wertheim

__ __ __ Salpingectomy

__ __ __ Oophorectomy

__ __ __ Hypogastric Aa. ligation

__ __ __ Appendectomy (incidental)

__ __ __ Hymenotomy

__ __ __ Incompetent os surgery

___ ___ ___ Repair surgical rent. of bladder, bowel

___ ___ ___ Ureteral repair

___ ___ ___ Ureteral transplant

___ ___ ___ Bartholin duct cystectomy

___ ___ ___ Incisional hernia repair

___ ___ ___ Fundectomy

___ ___ ___ Salpingostomy

___ ___ ___ Skin grafting

___ ___ ___ Ureteral caruncle - fulguration

___ ___ ___ Umbilical hernia repair

___ ___ ___ Umbilical hernia repair - with surgery assistance

___ ___ ___ Repair/recto-vaginal fistula

___ ___ ___ Repair/vesico-vaginal fistula

___ ___ ___ Sturmdorf repair of cervix

___ ___ ___ Hystero salpingogram

___ ___ ___ Biopsy of vulva

___ ___ ___ Meckel's diverticulum

___ ___ ___ Hymenectomy

___ ___ ___ Wedge resection of ovaries

___ ___ ___ Hydatid mole evacuation

___ ___ ___ Salpingoplasty

___ ___ ___ Tubal implantation into uterus

___ ___ ___ Closure of vaginal fistula

___ ___ ___ Evacuation of pelvic abscesses

___ ___ ___ Evisceration repair

___ ___ ___ Colpectomy

___ ___ ___ Biopsy of cervix

___ ___ ___ Pessary insertion

___ ___ ___ Plastic construction of vagina with skin graft for cogenital absence

__ __ __ Colpotomy - exploratory

__ __ __ Colpocleisis

__ __ __ Trachelectomy

__ __ __ Perineoplasty

__ __ __ Removal of foreign body from vaginal & uterus

__ __ __ Laparoscopy/Pelvoscope

__ __ __ Endometrial ablation

__ __ __ Lower GU laser

__ __ __ Intro abd laser

__ __ __ Endometrial Biopsy

__ __ __ Conization of cervix - cold knife

__ __ __ Burch procedure

__ __ __ Raz procedure

__ __ __ Parreya procedure

__ __ __ A&P repair

__ __ __ Pelviscopy surgical procedure

__ __ __ Hysteroscopy

__ __ __ Myomectomy (intra abd & hysteroscopic)

__ __ __ Trans abd/transvag vaginal suspension

__ __ __ Tubal reanastamosis

__ __ __ Staging laparocomy node sampling

__ __ __ Conization of cervix - hot knife

__ __ __ LLETZ (large loop excision of the transformation zone

__ __ __ Omentecomy

__ __ __ Abdominoplasty

__ __ __ Ureteral - cystoscopy

__ __ __ Assist in surgery only

__ __ __ Wide local excision - vulva

___ ___ ___ Perineotomy

___ ___ ___ Perineorrhaphy

Applicant signature ______________________________ Date ____________

STATEMENT OF CONFIDENTIALITY

It is the policy of Lane Regional Medical Center and the Medical Staff that any and all information concerning a patient of the facility is of a strictly confidential nature. THIS APPLIES TO VERBAL, WRITTEN OR FAX TRANSMISSIONS. Confidentiality is a right entitled to each patient beginning at admission or upon making a reservation for admission and the right is never terminated. It is the duty and responsibility of every physician, employee and volunteer of Lane Regional Medical Center to ensure that right, both at work and off duty.

By signing below, I signify that I understand and agree to the following:

1. I acknowledge that all information in the patient record (a medical/legal document) including evidence of patient identity as well at the course of clinical treatment is strictly confidential. I will abide by the policy of Lane Regional Medical Center and I will not jeopardize the patient's right to confidentiality (either verbally, in writing or via Fax transmission) of any information which may be used to identify a patient.

2. I agree that in reviewing records, data or hospital documents containing patient information that this information will be used only for the treatment of the patient.

3. I further understand that I could be subject to legal action for violation of any confidences related to patient information.

Name ______________________________
(Please Print)

____
Signature

____
Date

PHYSICIAN

STATEMENT OF ACKNOWLEDGMENT

This is to verify that I have received a copy of the following notice to physicians:

NOTICE TO PHYSICIANS: Medicare/Champus payments to hospital is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds may be subject to fine, imprisonment, or civil penalty under applicable Federal law.

______________________________ ____________________________

Signature Date

______________________________, M.D.

Printed Name