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LANE REGIONAL MEDICAL CENTER
PRIVILEGES APPLICATION FORM
Obsterical

R G A

- Emergency- spont. delivery, vertex presentation
- Low forceps - occiput anterior
- Mid forceps delivery
- Pre-eclampsia - mild
- Pre-eclampsia - moderate
- Pre-eclampsia - severe
- Eclampsia
- Caesarian section - classical
- Caesarian section - low cervical
- Version & extraction
- Manuel removal of placenta
- Non-emergency- spont. delivery, vertex presentation
- Duhrssen's incisions
- Repair of cervical lacerations
- Cesarean hysterectomy
- Cesarean Wertheim
- Hypogastric Aa. ligation
- Ectopic pregnacny - salpingectomy
- Treatment of med. complications of obstertrics-
heart/lungs/kidney/anemia/Dm/etc
- Piper forceps application to aftercoming head
- Repair of uterine lacerations
- Repair of vaginal lacerations
- Episiotomy & repair
- Abdominal pregnancy
- Colpocentesis

___ ___ ___ Colpotomy

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PRIVILEGES APPLICATION FORM

- ___ ___ ___ Emergency cesarean section for hemorrhage
- ___ ___ ___ Anesthesia - pudendal block, local
- ___ ___ ___ Anesthesia - general - emergency
- ___ ___ ___ Anesthesia - spinal - emergency
- ___ ___ ___ Evacuation of vulvar hematoma
- ___ ___ ___ Circumcision of infant
- ___ ___ ___ Repair of 3rd & 4th degree lacerations
- ___ ___ ___ External cephalic version
- ___ ___ ___ Excision of vulvar lesions at delivery
- ___ ___ ___ Excision of vaginal cysts
- ___ ___ ___ Uterine packing
- ___ ___ ___ Curettage
- ___ ___ ___ Abortion
- ___ ___ ___ Abortion (inevitable or incomplete)
- ___ ___ ___ Post-partum
- ___ ___ ___ Resuscitation of infant
- ___ ___ ___ Cervical biopsy during pregnancy/conization of cervix
- ___ ___ ___ Repair of incompetent internal cervical os cerclage, etc.
- ___ ___ ___ Breech delivery- multipara
- ___ ___ ___ Inversion of uterus
- ___ ___ ___ Hemorrhoid excision
- ___ ___ ___ Amniocentesis
- ___ ___ ___ Amnioinfusion
- ___ ___ ___ Management of fetal death in utero - intra-amniotic injection of hypertonic solu.
- ___ ___ ___ Induction of labor - medical
- ___ ___ ___ Induction of labor - surgical

___ ___ ___ Colposcopy

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___ ___ ___ Laparoscopy

___ ___ ___ Anesthesia & Analgesia - local infiltration

___ ___ ___ Breech delivery- primigravida

___ ___ ___ Anesthesia & Analgesia - Pudendal block

___ ___ ___ Anesthesia & Analgesia - Caudal

___ ___ ___ Anesthesia & Analgesia - Paracervical block

___ ___ ___ Anesthesia & Analgesia - Epidural/peridural

___ ___ ___ Suction assist vaginal delivery

___ ___ ___ Amino infusion during labor

___ ___ ___ PGE2 for cervical ripening

___ ___ ___ Laminaria tent insertion

___ ___ ___ Foley bulb induction of labor

___ ___ ___ Breech delivery - frank

___ ___ ___ Breech delivery - footling

___ ___ ___ Multiple pregnancy

___ ___ ___ Anesthesia - pudendal block, local -- spinal - emergency

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 as 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