LIST OF CLINICAL PRIVILEGES – OB/GYN - MATERNAL FETAL MEDICINE

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Clinical Supervisor
CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, or 4 in in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form and forward the form to the Credentials Office.
CODES: 1. Fully competent within defined scope of practice.
2. Supervision required. (Unlicensed/uncertified or lacks current relevant clinical experience.
3. Not approved due to lack of facility support. (*Reference facility master Strawman. Use of this code is reserved for the Credentials Function.***)**
4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.
CHANGES: Any change to a verified/approved privileges list must be made in accordance with Service specific credentialing and privileging policy

NAME OF APPLICANT	NAME OF MEDICAL FACILITY

PROVIDERS REQUESTING PRIVILEGES IN THIS SPECIALTY MUST ALSO REQUEST PRIVILEGES IN THEIR PRIMARY OB/GYN SPECIALTY

I Scope		Requested	Verified
P425413	The scope of privileges for obstetrics maternal fetal medicine include the evaluation, diagnosis, treatment and consultation of patients with complex medical conditions as well as prenatal diagnosis and management of fetal anomalies and other fetal conditions, and management of high risk and critically ill antepartum, intrapartum and postpartum patients.		

Procedures		Requested	Verified
P425414	Provide Maternal-Fetal Medicine and Genetic Consultation (Outpatient and Inpatient)		
P425415	Genetic and or Targeted fetal surveys (LEVEL II Ultrasound) (Interpret)		
P425416	Genetic and or Targeted fetal surveys (LEVEL II Ultrasound) (Perform)		
P425417	Fetal artery Doppler interrogation (Perform and Interpret)		
P425418	Antenatal Testing (NST, CST, BPP)		
P425419	Amniocentesis (Genetic and Non-Genetic)		
P425420	Amnioreduction		
P388622	Amnioinfusion		
P425421	Trans-vaginal Cervical Cerclage (both Prophylactic and Emergent/Rescue)		
P425422	Trans-abdominal cervical cerclage		
P425423	Supervision and management of Critical Care Obstetric patients		
P425424	Breech vaginal delivery		
P425425	Cesarean hysterectomy		
P425426	Medical and surgical management of postpartum hemorrhage		
P425427	Antepartum management of multiple gestation		
P425428	Nuchal Translucency Screening (Perform and Interpret)		
P425429	Percutaneous Umbilical Blood Sampling and transfusion		
P425430	Intra-amniotic fetal therapies (e.g. Fetal Thoracentesis, Fetal Bladder Shunt Placement, Vesicocentesis)		
P425431	Fetal Echocardiography (perform)		
P425432	Fetal Echocardiography (Interpret)		

LIST OF CLINICAL PRIVILEGES – OB/GYN - MATERNAL FETAL MEDICINE (CONTINUED)			
Procedures (Cont'd)		**Requested**	**Verified**
P425433	In -Utero fetal surgery		
P425434	Placement of central lines of critical care obstetric patients		
P425435	Dilation and Evacuation >14 weeks		
P425436	Rotational forceps delivery		
P385328	Chorionic villus sampling		

SIGNATURE OF APPLICANT	**DATE**

II CLINICAL SUPERVISOR'S RECOMMENDATION

☐ **RECOMMEND APPROVAL** ☐ **RECOMMEND APPROVAL WITH MODIFICATION (Specify below)** ☐ **RECOMMEND DISAPPROVAL (Specify below)**

STATEMENT:

CLINICAL SUPERVISOR SIGNATURE	**CLINICAL SUPERVISOR PRINTED NAME OR STAMP**	**DATE**