LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN OPHTHALMOLOGY

Initial ☐ **Renewed** ☐

Name_____ **Effective from** ___/___/___ **to** ___/___/___

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

R	G	C	N	POPULATION
☐	☐	☐	☐	Pediatric: Birth - 25 Years (Fairgrounds Surgical Center, LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year)
☐	☐	☐	☐	Adults: 13 - 65 Years
☐	☐	☐	☐	Geriatrics: Over 65 Years

R	G	C	N	NO CLINICAL PRIVILEGES (In Hospital)
☐	☐	☐	☐	No Clinical Privileges

R	G	C	N	GENERAL PRIVILEGES
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,9,10,11,12)
☐	☐	☐	☐	Consultation Privileges (1,2,3,4,5,6,7,8,9,10,11,12)
☐	☐	☐	☐	History and Physical (1,2,3,4,5,6,7,8,9,10,11,12)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,4,5,6,7,8,9,10,11,12)

R	G	C	N	EYEBALL
☐	☐	☐	☐	Enucleation of eye; with or without implant (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Evisceration of ocular contents; with or without implant (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Exenteration of orbit (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Exploration of orbit (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Removal of extraocular foreign bodies (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of orbital fractures (1,2,4,7,8,9,10)
☐	☐	☐	☐	Repair of ruptured globe (1,2,3,4,7,8,9,10,12)

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R	G	C	N	ANTERIOR SEGMENT
☐	☐	☐	☐	Anterior lamellar keratoplasty (1,2,4,7,8,10,12)
☐	☐	☐	☐	Endothelial keratoplasty (1,2,4,7,8,10,12)
☐	☐	☐	☐	Penetrating keratoplasty (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Aqueous shunt (e.g., Molteno, Ahmed) (1,2,4,7,8,10,12)
☐	☐	☐	☐	Cyclocryotherapy or diathermy (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Excision/destruction of conjunctival lesion (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Excision/destruction of corneal lesion (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Excision of pterygium (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Iridectomy/Iridotomy (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Lensectomy, pars plana approach (1,2,3,4,7,8)
☐	☐	☐	☐	Radial keratotomy/corneal relaxing incision (1,2,4,7,8,10,12)
☐	☐	☐	☐	Removal of lens material; phacofragmentation (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Removal of lens material; other than phacofragmentation (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of conjunctival laceration (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of corneal laceration (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repositioning or exchange of intraocular lens (1,2,4,7,8,10,12)
☐	☐	☐	☐	Trabeculectomy (1,2,3,4,7,8,9,10,12)

R	G	C	N	POSTERIOR SEGMENT
☐	☐	☐	☐	Removal of intraocular foreign body (1,2,4,7,8,10,12)
☐	☐	☐	☐	Repair of retinal detachment; scleral buckling (1,2,7,8,9,10)

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CLINICAL PRIVILEGES IN OPHTHALMOLOGY

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R	G	C	N	POSTERIOR SEGMENT
☐	☐	☐	☐	Repair of retinal detachment; vitrectomy (1,2,7,8,10)
☐	☐	☐	☐	Retinocryopexy, diathermy (1,2,7,8)
☐	☐	☐	☐	Vitrectomy, anterior; open-sky or limbal incision (1,2,4,7,8,10,12)
☐	☐	☐	☐	Vitrectomy, pars plana approach (1,2,3,4,7,8,10,12)

R	G	C	N	OCULAR ADNEXA
☐	☐	☐	☐	Blepharoplasty (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Dacryocystorhinostomy (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Optic nerve decompression (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Orbitotomy; for exploration (1,2,4,7,8,9)
☐	☐	☐	☐	Orbitotomy; removal of lesion or foreign body (1,2,4,7,8,9)
☐	☐	☐	☐	Plastic repair of canaliculi (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Probing of nasolacrimal duct, with or without irrigation (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Ptosis repair (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Reconstruction of eyelid (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of ectropion (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of entropion (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Repair of lid laceration (1,2,4,7,8,9,10,12)
☐	☐	☐	☐	Strabismus surgery (1,2,3,4,7,8,9,10,12)
☐	☐	☐	☐	Tarsorrhaphy (1,2,3,4,7,8,9,10,12)

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CLINICAL PRIVILEGES IN OPHTHALMOLOGY

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R	G	C	N	LASER PRIVILEGES/PROCEDURES
☐	☐	☐	☐	Argon or selective laser trabeculoplasty* (1,2,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Discission of secondary membranous cataract; laser surgery* (1,2,3,4,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Iridotomy/iridectomy by laser surgery* (1,2,3,4,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Laser photocoagulation, retina* (1,2,3,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Laser photocoagulation, retinopathy of prematurity* (1,2,7,8) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	OTHER PRIVILEGES
☐	☐	☐	☐	Temporal Artery Biopsy (1,2,3,4,5,6,7,8,9,10)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN OPHTHALMOLOGY

Name_____

Privileges by Location:

1 – LVH-Cedar Crest
2 – LVH-Muhlenberg (includes the Behavioral Health Center and Cancer Center)
3 – LVH-17th & Chew (includes TSU)
4 – Fairgrounds Surgical Center
5 – LVH-Tilghman
6 – LVHN Surgery Center-Tilghman
7 – LVH-Hazleton
8 – Health and Wellness Center at Hazleton
9 - LVHN Children's Surgery Center
10-LVH-Schuylkill East Norwegian
11-LVH-Schuylkill South Jackson
12 - LVH-Schuylkill Surgery Center

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA OPHTHALMOLOGY

Name_____

Acknowledgement of Practitioner

I hereby request the privileges noted.

Practitioner Signature:_____Date:_____/_____/_____

*****Recommendations*****

I have reviewed the request for clinical privileges and supporting documentation and

☐ **Recommend As Requested** ☐ **Recommend with Exceptions** ☐ **Do Not Recommend**

the privileges requested above.

EXCEPTIONS

Exception to Privilege:	Conditions/Modifications

Explanation:

SUPERVISING PHYSICIAN (AHPs ONLY)	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date