LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN ORAL AND MAXILLOFACIAL SURGERY

Initial ☐ **Renewed** ☐

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

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

R	G	C	N	**LIMITED PRIVILEGE SITE**
☐	☐	☐	☐	Privileges limited to Cleft Palate Clinic

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	**GENERAL PRIVILEGES**
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,9)
☐	☐	☐	☐	Consulting (1,2,3,4,5,6,7,8,9)
☐	☐	☐	☐	History and Physical (1,2,3,4,5,6,7,8,9)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,4,5,6,7,8,9)
☐	☐	☐	☐	First Assistant at Surgery Only (1,2,3,4,5,6,7,8,9)

R	G	C	N	**DENTOALVEOLAR**
☐	☐	☐	☐	Alveoloplasty (1,2,4,7,9)
☐	☐	☐	☐	Biopsy oral tissue soft/hard (1,2,3,4,7,9)
☐	☐	☐	☐	Dental extractions/impacted wisdom teeth (1,2,3,4,7,9)
☐	☐	☐	☐	Dental implants (1,2,3,4,7)
☐	☐	☐	☐	Laser procedures* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Oral antral fistula closure (1,2,4,7)

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R	G	C	N	**DENTOALVEOLAR**
☐	☐	☐	☐	Removal exostosis/tuberosities (1,2,4,7,9)
☐	☐	☐	☐	Surgical exposure of teeth (1,2,4,7,9)
☐	☐	☐	☐	Tooth reimplantation/transplantation (1,2,4,7,9)
☐	☐	☐	☐	Vestibuloplasty (1,2,4,7,9)

R	G	C	N	**MAXILLOFACIAL PATHOLOGY**
☐	☐	☐	☐	Biopsy of hard/soft tissue lesions (1,2,7,9)
☐	☐	☐	☐	Excision of hard/soft tissue lesions - cysts, tumors, malformations (1,2,7,9)
☐	☐	☐	☐	Excision of lesion by physical or chemical method (1,2,4,7,9)

R	G	C	N	**MAXILLOFACIAL INFECTIONS**
☐	☐	☐	☐	Incision and drainage of maxillofacial abscess - intraoral/extraoral (1,2,3,4,7,9)
☐	☐	☐	☐	Removal of foreign body maxillofacial region (1,2,3,4,7,9)
☐	☐	☐	☐	Sequestrectomy/debridement of hard/soft tissues (1,2,3,4,7,9)

R	G	C	N	**MAXILLOFACIAL GRAFTS**
☐	☐	☐	☐	Soft tissues - skin/fat/mucosa/alloderms (1,2,4,7,9)
☐	☐	☐	☐	Cranial bone grafts (1,2,7)
☐	☐	☐	☐	Iliac crest bone grafts (1,2,4,7,9)
☐	☐	☐	☐	Intraoral bone grafts/allogenic bone grafts (1,2,3,4,7,9)
☐	☐	☐	☐	Rib/costochondral bone grafts (1,2,7)

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R	G	C	N	**MAXILLOFACIAL GRAFTS**
☐	☐	☐	☐	Tibial bone grafts (1,2,7)

R	G	C	N	**MAXILLOFACIAL TRAUMA**
☐	☐	☐	☐	Open/closed alveolar fracture repair (1,4,7,9)
☐	☐	☐	☐	Open/closed mandible fracture repair (1,7)
☐	☐	☐	☐	Open/closed maxillary fracture repair (1,7)
☐	☐	☐	☐	Open/closed nasal fracture repair (1,7)
☐	☐	☐	☐	Open/closed orbital fracture repair (1,7)
☐	☐	☐	☐	Open/closed zygomatic fracture repair (1,7)
☐	☐	☐	☐	Suture facial lacerations (1,7)

R	G	C	N	**TEMPOROMANDIBULAR JOINT PROCEDURES**
☐	☐	☐	☐	Arthroscopy (1,2,4,7,9)
☐	☐	☐	☐	Disc removal/repair (arthroplasty) (1,2,4,7,9)
☐	☐	☐	☐	Open/closed treatment of dislocation (1,2,4,7,9)
☐	☐	☐	☐	Total joint reconstruction (1,2,4,7,9)

R	G	C	N	**SALIVARY GLAND PROCEDURES**
☐	☐	☐	☐	Biopsy major/minor salivary gland tissue (1,2,4,7,9)
☐	☐	☐	☐	Excision ranula/mucoceles (1,2,4,7,9)
☐	☐	☐	☐	Removal submental/sublingual/submandibular glands(1,2,4,7,9)

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R	G	C	N	CORRECTION MAXILLOFACIAL DEFORMITIES
☐	☐	☐	☐	Cleft lip/cleft palate repair (1,7)
☐	☐	☐	☐	Genioplasty (1,2,4,7,9)
☐	☐	☐	☐	Mandibular osteotomies (1,2,4,7,9)
☐	☐	☐	☐	Maxillary osteotomies (1,2,4,7,9)
☐	☐	☐	☐	Osteoplasty - augmentation/reduction (1,2,4,7,9)
☐	☐	☐	☐	Turbinectomy/nasal septoplasty (1,2,7,9)

R	G	C	N	COSMETIC PROCEDURES
☐	☐	☐	☐	Botox/Fillers* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Blepharoplasty* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Facelift* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Rhinoplasty* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Submental/facial lipectomy* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	MAXILLOFACIAL NEUROLOGIC PROCEDURES
☐	☐	☐	☐	Alcohol/steroid nerve injections (1,2,7)
☐	☐	☐	☐	Diagnostic/therapeutic local anesthesia blocks (1,2,7)
☐	☐	☐	☐	Nerve avulsion (1,2,7)
☐	☐	☐	☐	Nerve decompression (1,2,7)
☐	☐	☐	☐	Nerve repair, reconstruction, anastomosis or graft (1,2,7)

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R	G	C	N	ANESTHETIC PRIVILEGES
☐	☐	☐	☐	Analgesia - conscious (1,2,3,7)
☐	☐	☐	☐	IV or IM sedation - conscious (1,2,3,7)
☐	☐	☐	☐	Local (1,2,3,7,9)
☐	☐	☐	☐	Regional block (1,2,3,7)
☐	☐	☐	☐	Moderate Sedation - Pediatric (birth - 25 years)*** (1,2,3,4,5,6,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Moderate Sedation - Adult* (13 years or older)*** (1,2,3,4,5,6,7,8) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Nitrous Oxide administration (Copy of anesthesia permit must be submitted) (1,2,3,7)

R	G	C	N	OTHER
☐	☐	☐	☐	Caldwell luc procedure (1,2,7)
☐	☐	☐	☐	Closure of oral/antral fistulas - primary/secondary (1,2,7)
☐	☐	☐	☐	Tracheostomy/coniotomy (EMERGENCY SITUATIONS ONLY) (1,2,7)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN ORAL AND MAXILLOFACIAL SURGERY

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 ORAL AND MAXILLOFACIAL SURGERY

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