

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN VASCULAR AND ENDOVASCULAR SURGERY

Initial Renewed
 Effective from ___/___/___ to ___/___/___

Name _____

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

R G C N POPULATION

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric: Birth - 25 Years (LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adults: 13 - 65 Years |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Geriatrics: Over 65 Years |

R G C N GENERAL PRIVILEGES

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consulting Privileges (1,2,3,4,5,6,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History and Physical (1,2,3,4,5,6,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescribing Privileges (1,2,3,4,5,6,7,8) |

R G C N PROCEDURES ASSOCIATED WITH ARTERIAL OCCLUSIVE DISEASE

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aorta or iliac artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Carotid artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Femoral, popliteal or tibial artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Innominate subclavian, axillary, brachial, radial or ulnar artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Renal artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vertebral artery bypass or repair (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visceral artery repair, thrombectomy, endarterectomy or bypass (1,2,5,6,7) |

R G C N PROCEDURES ASSOCIATED WITH ARTERIAL ANEURYSMAL DISEASE

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal aortic aneurysm repair or resection (1,2,7) |
|--------------------------|--------------------------|--------------------------|--------------------------|---|

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- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracoabdominal aortic aneurysm repair or resection (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Iliac artery aneurysm repair or resection (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Renal artery aneurysm repair or resection (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visceral artery aneurysm repair or resection (1,2,7) |

R G C N PROCEDURES ASSOCIATED WITH VENOUS DISEASE

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endoluminal ablation greater or lesser saphenous vein (laser or radiofrequency)* (*Must satisfy certain credentialing criteria to be approved) (1,2,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excisional phlebectomy, any method (1,2,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inferior vena cava ligation (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Injection sclerotherapy (1,2,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ligation/division with or without stripping greater or lesser saphenous vein (1,2,4,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perforator vein ligation, endoscopic (SEPS) (1,2,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perforator vein ligation, open (Linton procedure) (1,2,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Placement of inferior vena cava (IVC) interruption filter (1,2,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TRIVEX procedure (Transilluminated Powered Phlebectomy)* (1,2,7) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venous bypass or repair (1,2,7) |

R G C N ENDOVASCULAR PROCEDURES

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal aortography with selective branch vessel catheterization (1,2,5,6,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angioscopy (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aorto-iliac angioplasty and stenting* (1,2,5,6,7) (*Must satisfy certain credentialing criteria to be approved) |

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carotid angioplasty and stenting (CAS)* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cavography, venography (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Embolization of peripheral vessel, catheter directed (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endovascular aortic aneurysm repair (EVAR)* (1,7) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endovascular thoracic aortic aneurysm repair (TEVAR)* (1,7) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endovascular trans carotid artery revascularization (TCAR) * (1,7) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Femoral-popliteal-tibial artery angioplasty and stenting (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral arterial atherectomy, catheter based, mechanical or laser (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral arterial catheterization (Seldinger technique) (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement of percutaneous central venous catheter (Seldinger technique) (1,2,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement of tunneled central venous catheter or port (1,2,3,4,5,6,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal artery/viseral artery angioplasty and stenting* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA)* (1) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swan-Ganz catheterization (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic aortic/arch aortography with selective supra-aortic trunk catheterization (carotid, vertebral, upper extremity) (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombolytic therapy, catheter based, intracranial (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombolytic therapy, catheter based, peripheral (1,2,7)

R G C N GENERAL PROCEDURES

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal wall hernia repair (1,2,3,4,5,6,7,8)
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation - above the knee, any level (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation - below the knee, any level (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation - toe, any level (1,2,4,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation - transmetatarsal (1,2,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation - trans-tarsal, with or without gastrocnemius tendon release (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arteriovenous fistula or bridge graft creation for dialysis (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholecystectomy (1,2,4,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploratory Laparotomy (1,2,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fasciotomy - lower extremity (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fasciotomy - upper extremity (1,2,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip disarticulation (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insertion of peritoneal dialysis catheter (1,2,3,5,6,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy (1,2,3,4,5,6,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nephrectomy (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteotomy, phalangeal or metatarsal (1,2,4,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral nerve biopsy (i.e., Sural nerve) (1,2,4,5,6,7,8)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resection of carotid body tumor (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Splenectomy (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sternotomy to treat conditions of the great vessels (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sympathectomy - cervical (1,2,7)

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R G C N GENERAL PROCEDURES

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sympathectomy - lumbar (1,2,7) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Temporal artery or other peripheral artery biopsy (1,2,3,4,5,6,7,8) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Treatment of thoracic outlet syndrome with accessory or first rib resection or claviclectomy (1,2,7) |

R G C N OTHER

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fluoroscopy privileges* (1,2,3,4,5,6,7,8) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laser privileges* (1,2,4,7,8) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moderate Sedation - Pediatric (birth - 25 years)*** (1,2,3,4,5,6,7,8) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moderate Sedation - Adult* (13 years or older)*** (1,2,3,4,5,6,7,8) (*Must satisfy certain credentialing criteria to be approved) |

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN VASCULAR AND ENDOVASCULAR 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)
- 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
- 13 - LVH-Hecktown Oaks
- 14 - LVH-Coordinated Health - Allentown
- 15 - LVH-Coordinated Health - Bethlehem
- 16 - LVHN Ambulatory Surgery Center of Lopatcong, Inc
- 17 - LVHN East Stroudsburg Ambulatory Surgery Center
- 18 - LVH-Pocono

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA VASCULAR AND ENDOVASCULAR 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

