LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN DENTAL MEDICINE

Initial ☐ **Renewed** ☐

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

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

R	G	C	N	POPULATION
☐	☐	☐	☐	Infants: Birth - 1 Year (Fairgrounds Surgical Center and LVHN Children's Surgery Center - 6 months - 1 Year) (Unless otherwise noted with ***)
☐	☐	☐	☐	Children: 2 - 12 Years (Unless otherwise noted with ***)
☐	☐	☐	☐	Adolescents: 13 - 25 Years (Unless otherwise noted with ***)
☐	☐	☐	☐	Adults: 18 - 65 Years (Unless otherwise noted with ***)
☐	☐	☐	☐	Adults: 18 - 65 Years (with underlying medical or handicapping conditions)
☐	☐	☐	☐	Geriatrics: Over 65 Years (Unless otherwise noted with ***)

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

R	G	C	N	ANESTHESIA
☐	☐	☐	☐	Facial Pain Management (1,2,3,4,9,10,12)
☐	☐	☐	☐	Local Infiltration and Block Anesthesia (1,2,3,4,7,9,10,12)
☐	☐	☐	☐	Regional Blocks (1,2,3,4,9,10,12)
☐	☐	☐	☐	Anxiolytic Agents** (1,2,3,4,9) (**Copy of appropriate anesthesia permit required)
☐	☐	☐	☐	Nitrous Oxide/Oxygen Analgesia** (1,2,3,4,7,9,10,12) (**Copy of appropriate anesthesia permit required)

R	G	C	N	DIAGNOSTIC
☐	☐	☐	☐	Examination (1,2,3,4,7,9,10,12)

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R	G	C	N	**DIAGNOSTIC**
☐	☐	☐	☐	Radiographs - Intra and Extra Oral (1,2,3,4,7,9,10,12)

R	G	C	N	**PREVENTIVE DENTISTRY**
☐	☐	☐	☐	Fluoride Treatment (1,2,3,4,7,9)
☐	☐	☐	☐	Prophylaxis (1,2,3,4,7,9)
☐	☐	☐	☐	Space Maintenance (1,2,3,4,7,9)

R	G	C	N	**RESTORATIVE DENTISTRY**
☐	☐	☐	☐	Maxillo-facial Prosthetics (1,2,3,4,7,9)
☐	☐	☐	☐	Prosthodontic Procedures - Fixed (1,2,3,4,7,9)
☐	☐	☐	☐	Prosthodontic Procedures - Removable (1,2,3,4,7,9)
☐	☐	☐	☐	Prosthodontic Procedures for Endosteal Implants (1,2,3,4,7,9)
☐	☐	☐	☐	Single Tooth Intra and Extra Coronal Restorative Procedures (1,2,3,4,7,9)

R	G	C	N	**EMERGENCY PROCEDURES**
☐	☐	☐	☐	Transplantation of Teeth (1,2,3,4,7,9)
☐	☐	☐	☐	Treatment of Avulsed and/or Partially Avulsed Teeth (1,2,3,4,7,9)

R	G	C	N	**ENDODONTICS**
☐	☐	☐	☐	Non-surgical Procedures (1,2,3,4,7,9)
☐	☐	☐	☐	Periapical Surgery Procedures (1,2,3,4,9)

R	G	C	N	**ORTHODONTICS**
☐	☐	☐	☐	Limited Orthodontic Treatment (1,2,3,4,7,9)
☐	☐	☐	☐	Comprehensive Orthodontic Treatment (1,2,3,4,7,9)
☐	☐	☐	☐	Interceptive Orthodontic Treatment (1,2,3,4,7,9)

R	G	C	N	**PERIODONTICS**
☐	☐	☐	☐	Non-surgical Procedures (1,2,3,4,7,9)

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R	G	C	N	PERIODONTICS
☐	☐	☐	☐	Crown Lengthening (1,2,3,4,9)
☐	☐	☐	☐	Gingival Curettage (1,2,3,4,7,9)
☐	☐	☐	☐	Gingivectomy (1,2,3,4,9)
☐	☐	☐	☐	Gingivoplasty (1,2,3,4,9)
☐	☐	☐	☐	Graft Extraction Sockets/Sites (1,2,3,4,9)
☐	☐	☐	☐	Grafts - Bone Replacement (1,2,3,4,9)
☐	☐	☐	☐	Guided Tissue Regeneration (1,2,3,4,9)
☐	☐	☐	☐	Mucogingival Procedures (1,2,3,4,9)
☐	☐	☐	☐	Osseous Surgery (1,2,3,4,9)

R	G	C	N	ORAL SURGERY
☐	☐	☐	☐	Alveolectomy (1,2,3,4,9)
☐	☐	☐	☐	Alveolus Fracture (1,2,3,4,9)
☐	☐	☐	☐	Biopsy of the Mouth - Incisional and Excisional up to or <5 cm (1,2,3,4,9,10,12)
☐	☐	☐	☐	Extraction of Erupted Teeth with Forceps and/or Elevators without Flap Elevation (1,2,3,4,7,9,10,12)
☐	☐	☐	☐	Intra Oral Incision and Drainage (1,2,3,4,9,10,12)
☐	☐	☐	☐	Placement of Endosteal Implants (1,2,3,4,9,10,12)
☐	☐	☐	☐	Repair of Minor Lacerations <5 cm (1,2,3,4,9,10,12)
☐	☐	☐	☐	Repair of Lacerations >5 cm (1,2,3,4,9,10,12)
☐	☐	☐	☐	Surgical Removal of Erupted Teeth and Residual Roots (1,2,3,4,7,9,10,12)
☐	☐	☐	☐	Surgical Removal of Impacted Teeth (1,2,3,4,9,10,12)
☐	☐	☐	☐	Wound Care and Management - Soft Tissue (1,2,3,4,9)

R	G	C	N	TEMPERO-MANDIBULAR DYSFUNCTION & OCCLUSION TREATMENT
☐	☐	☐	☐	Limited Equilibration (1,2,3,4,7,9)
☐	☐	☐	☐	Full Equilibration (1,2,3,4,7,9)
☐	☐	☐	☐	Nightguard Fabrication and Management (1,2,3,4,7,9)

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R	G	C	N	TEMPERO-MANDIBULAR DYSFUNCTION & OCCLUSION TREATMENT
☐	☐	☐	☐	Splint Fabrication and Management (1,2,3,4,7,9)
☐	☐	☐	☐	Non-surgical Tempero-Mandibular Dysfunction Treatment and Orofacial Pain Management (1,2,3,4,7,9)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN DENTAL MEDICINE

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 DENTAL MEDICINE

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