# LEHIGH VALLEY HEALTH NETWORK

## CLINICAL PRIVILEGES IN GASTROENTEROLOGY

**Initial** ☐ **Renewed** ☐

**Name**_____ **Effective from** ___/___/___ **to** ___/___/___

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

| R | G | C | N | **POPULATION** |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Adults: 13 - 65 Years (Exception: ERCP for patients 14 to 18 years of age, permissible with pediatric gastroenterologist referral) |
| ☐ | ☐ | ☐ | ☐ | Geriatrics: Over 65 Years |

| R | G | C | N | **GENERAL PRIVILEGES** |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,9,10,11,12) |
| ☐ | ☐ | ☐ | ☐ | 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 | **LOWER ENDOSCOPY** |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Anoscopy (1,2,3,4,7,8,10,12) |
| ☐ | ☐ | ☐ | ☐ | Bleeding Control, any method* (1,2,7,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Colonoscopy* (1,2,3,4,7,8,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Colonoscopy - Therapeutic including Polypectomy, biopsy* (1,2,4,7,8,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Dilation* (1,2,4,7,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Fecal Microbiota Transplant (1,2,3,4,7,8,10,12) |
| ☐ | ☐ | ☐ | ☐ | Foreign Body Removal (1,2,4,7,10,12) |
| ☐ | ☐ | ☐ | ☐ | Injection Therapy* (1,2,4,7,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Laser* (1,2,4,7) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Sigmoidoscopy (1,2,3,4,7,8,10,12) |
| ☐ | ☐ | ☐ | ☐ | Stent Placement* (1,2,10) (*Must satisfy certain credentialing criteria to be approved) |

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| R | G | C | N | UPPER ENDOSCOPY |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Band ligation of varies* (1,2,7,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Bleeding Control, any method* (1,2,7,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Dilation, any type* (1,2,4,7,8,9,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Double Balloon Endoscopy* (1,2) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Endoscopic Myotomy (POEM) and Endoscopic Submucosal Dissection (ESD)* (1,2,4,7,8,9,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Esophagogastroduodenoscopy (EGD)* (1,2,4,7,8,9,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Esophagogastroduodenoscopy (EGD) with Polypectomy, biopsy* (1,2,4,7,8,9,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Enteroscopy (1,2,10,12) |
| ☐ | ☐ | ☐ | ☐ | Endoscopic Retrograde Cholangiopancreatography (ERCP) - Therapeutic (spincterotomy, lithotripsy, removal of stones, biliary dilation)* (1,2,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Endoscopic Retrograde Cholangiopancreatography (ERCP) with stent placement, any type* (1,2,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Esophageal Mucosal Resection (EMR)* (1,2) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Foreign Body Removal (1,2,4,7,8,9,10,12) |
| ☐ | ☐ | ☐ | ☐ | Injection Therapy* (1,2,4,7,9,10,12) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Laser* (1,2,4,9) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Percutaneous Gastrostomy/Percutaneous Jejunostomy (PEG/PEJ) (1,2,4,7,9,10,12) |
| ☐ | ☐ | ☐ | ☐ | Sclerotherapy of esophagel/gastric varies* (1,2,7,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Stent Placement, any type* (1,2,10) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Transoral Incisionless Fundoplication* (1,2,3,4,7,8,10,11) (Must satisfy certain cedentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Wireless/Camera Endoscopy* (1,2,7) (*Must satisfy certain credentialing criteria to be approved) |

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## CLINICAL PRIVILEGES IN GASTROENTEROLOGY

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| R | G | C | N | PHYSIOLOGY STUDY |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Anal Rectal Motility (1) |
| ☐ | ☐ | ☐ | ☐ | Esophageal Motility Study (EMOT) /ph probe (1) |

| R | G | C | N | ENDOSCOPIC ULTRASOUND (EUS) |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Endoscopic Ultrasound - Esophagus, stomach, pancreas, duodenum (1) |
| ☐ | ☐ | ☐ | ☐ | Endoscopic Ultrasound - Rectal (1) |
| ☐ | ☐ | ☐ | ☐ | Endoscopic Ultrasound with therapeutic measures (aspiration, biopsy, injection, etc.) (1) |
| ☐ | ☐ | ☐ | ☐ | Extracorporeal shock wave lithotripsy (ESWL)* (1,2,10) (*Must satisfy certain credentialing criteria to be approved) |

| R | G | C | N | OTHER |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Emergency Defibrillation (1,2,3,4,5,6,7,8,9,10,11,12) |
| ☐ | ☐ | ☐ | ☐ | Liver Biopsy (1,7) |
| ☐ | ☐ | ☐ | ☐ | Paracentesis (1,7,10) |
| ☐ | ☐ | ☐ | ☐ | Fluoroscopy Privileges* (1,2,3,4,5,6,7,8,9,10,11,12) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved) |
| ☐ | ☐ | ☐ | ☐ | Moderate Sedation - Adult (13 years or older)*** (1,2,3,4,5,6,7,8,10,11,12) (Must satisfy certain credentialing criteria to be approved for this privilege.) |

# LEHIGH VALLEY HEALTH NETWORK

**CEDAR CREST & I-78 PO BOX 689**

**ALLENTOWN, PA 18105-1556**

## CLINICAL PRIVILEGES IN GASTROENTEROLOGY

**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-S East Norwegian
11-LVH-S South Jackson

# LEHIGH VALLEY HEALTH NETWORK

## CLINICAL AREA GASTROENTEROLOGY

**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 |