

**LEHIGH VALLEY HEALTH NETWORK**  
**CLINICAL PRIVILEGES IN AHP - GENETIC COUNSELOR**

Name \_\_\_\_\_

Initial  Renewed   
 Effective from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**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 (Fairgrounds Surgical Center, LVHN Surgery Center-Tilghman, and LVHN Children's Surgery Center - 6 months - 18 Years) |
| <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 PRIVILEGES WITH SUPERVISION (b)**

|                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Cancer patients (1)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Cardiology patients (1)                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Neurology patients (1)                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Obstetrics and Gynecology patients (1) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Pediatric patients (1)                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform genetic counseling for Surgery patients (1)                   |

# LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

## CLINICAL PRIVILEGES IN AHP - GENETIC COUNSELOR

Name \_\_\_\_\_

### Qualifications:

Will function in joint collaboration with the physician or physician group with which she/he is associated.

### SITES OF PRIVILEGE

- 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

### DEFINITIONS OF SUPERVISION

(a) DIRECT SUPERVISION - The physical presence of the supervising physician on the premises so that the supervising physician is immediately available to the allied health professional when needed.

(b) SUPERVISION - The control and personal direction exercised by the supervising physician over the medical services provided by an allied health professional. Constant physical presence of the supervising physician is not required so long as the supervising physician and the allied health professional are, or can easily be, in contact with each other by radio, telephone or telecommunications. Supervision requires the availability of the supervising physician to the allied health professional.

(c) SUPERVISING PHYSICIAN IN ATTENDANCE - Physical presence of supervising physician in room.

\* ATTENTION SUPERVISING PHYSICIAN: Your signature, title and date are required on the first line of the signature page of this document.

# LEHIGH VALLEY HEALTH NETWORK

## CLINICAL AREA AHP - GENETIC COUNSELOR

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 |
|-------------------------|--------------------------|
|                         |                          |
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|                         |                          |
|                         |                          |
|                         |                          |

Explanation:

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### SUPERVISING PHYSICIAN (AHPs ONLY)

|       |                 |                     |
|-------|-----------------|---------------------|
| Title | Signature _____ | Date ____/____/____ |
| Title | Signature _____ | Date ____/____/____ |
| Title | Signature _____ | Date ____/____/____ |
| Title | Signature _____ | Date ____/____/____ |
| Title | Signature _____ | Date ____/____/____ |

