

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN HEMATOLOGY-MEDICAL ONCOLOGY

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

☐ ☐ ☐ ☐ Geriatrics: Over 65 Years

R G C N GENERAL PRIVILEGES

☐ ☐ ☐ ☐ Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,5,6,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Consultation Privileges (1,2,3,5,6,7,8,10,13,19,20)

☐ ☐ ☐ ☐ History and Physical (1,2,3,5,6,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Prescribing Privileges (1,2,3,5,6,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Certifying of Medical Marijuana (1,2,3,5,6,7,8,9,10,11,13,19,20) (*Must satisfy certian credentialing criteria to be approved)

R G C N GENERAL PROCEDURES

☐ ☐ ☐ ☐ Administration of Cellular Immunotherapy (1,2,3,7,8,10,11,13)

☐ ☐ ☐ ☐ Bone marrow interpretation (1,2,3,7,8,13,19,20)

☐ ☐ ☐ ☐ Iliac bone marrow aspiration/biopsy (1,2,3,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Lumbar puncture (1,2,3,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Sternal bone marrow aspiration (1,2,3,7,8,10,13,19,20)

R G C N SPECIAL NON-CORE PRIVILEGES OR PROCEDURES

☐ ☐ ☐ ☐ Access permanent indwelling venous catheter - (1,2,3,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Advanced PCA (1,2,3,7,8,10,13,19,20)

☐ ☐ ☐ ☐ Apheresis (1,2,3,7,8,10,13,19,20)

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R	G	C	N	SPECIAL NON-CORE PRIVILEGES OR PROCEDURES
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Authorize and co-sign chemotherapy orders (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone marrow/peripheral blood stem cell harvesting and transplant (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exchange transfusion (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fine needle aspiration of tissue (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infusion of chemotherapy venous catheter (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intrathecal administration of chemotherapy (1,2,3,7,8,10,13,19,20)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Write chemotherapy orders (1,2,3,7,8,10,13,19,20)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN HEMATOLOGY-MEDICAL ONCOLOGY

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
- 19 - LVH-Carbon
- 20 - LVH-Dickson City

LEHIGH VALLEY HEALTH NETWORK
CLINICAL AREA HEMATOLOGY-MEDICAL ONCOLOGY

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:

_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date