

LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN ACUPUNCTURIST

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 (Fairgrounds Surgical Center, 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 (Unless otherwise noted with ***) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Geriatrics: Over 65 Years (Unless otherwise noted with ***) |

R G C N GENERAL PRIVILEGES

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History and Physical (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform Consultations (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Evaluation and Treatment of New Patients (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform Follow-up Visits on Established Patients (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Use of Traditional and Modern Therapeutic Styles of Acupuncture (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Traction (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kinetic Activity (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Therapeutic Evaluation (1,2,3,4) |

R G C N THERAPEUTIC MODALITIES

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acupressure (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cupping (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Education of Tai Chi and Chi Gong (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Electric and Low-Level Laser Stimulation (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food and Nutritional Counseling (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Guasha (1,2,3,4) |

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R G C N THERAPEUTIC MODALITIES

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Herbal and Homeopathic Practices (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot and Cold Therapy (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lifestyle Modifications (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Massage Therapy (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moxibustion (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Myofascial Release (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuromuscular Massage (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteopathic Manipulation (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform Therapeutic Exercises (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scar Deactivation (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trigger Point Injection (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tui na Massage (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Forms of Energy Healing (1,2,3,4) |

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN ACUPUNCTURIST

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 ACUPUNCTURIST

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:

SUPERVISING PHYSICIAN (AHPs ONLY)

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

