LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN ANESTHESIOLOGY - PAIN MEDICINE (PHYSIATRIST)

Initial ☐ **Renewed** ☐

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

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

R	G	C	N	POPULATION
☐	☐	☐	☐	Pediatric: Birth - 25 Years (LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year)
☐	☐	☐	☐	Adults: 13 - 65 Years (Unless otherwise noted with ***)
☐	☐	☐	☐	Geriatrics: Over 65 Years (Unless otherwise noted with ***)

R	G	C	N	GENERAL PRIVILEGES
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	History and Physical (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,5,6,7,8,10,11,13)

R	G	C	N	REGIONAL
☐	☐	☐	☐	Epidural/Caudal (including continuous techniques) (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Peripheral Nerve Block (including continuous techniques) (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Epidural Steroid Administration (1,2,3,5,6,7,8,10,13)

R	G	C	N	CONSULTATIVE SERVICES
☐	☐	☐	☐	Management of Patients in Critical Care Units (1,2,7,13)
☐	☐	☐	☐	Resuscitation (1,2,3,5,6,7,8,10,11,13)

R	G	C	N	PAIN MEDICINE PROCEDURES
☐	☐	☐	☐	Diagnostic and Therapeutic Nerve Blocks - Chronic Pain Therapy (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Diskograms with Interpretation (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Implantation of Intrathecal Catheters and Drug Infusion Pumps (1,2,3,5,6,7,8,10,13)

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CLINICAL PRIVILEGES IN ANESTHESIOLOGY - PAIN MEDICINE (PHYSIATRIST)

Initial ☐ **Renewed** ☐

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

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

R	G	C	N	PAIN MEDICINE PROCEDURES
☐	☐	☐	☐	Implantation of Spinal Cord Stimulation Electrode(s) and Pulse Generator (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Insertion of Temporary Spinal Cord Stimulation Electrodes (1,2,3,5,6,7,8,10,13)
☐	☐	☐	☐	Intradiscal Electro Thermal Therapy* (IDET) (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Intrathecal Drug Trials (1,2,3,5,6,7,8,13)
☐	☐	☐	☐	Minimally Invasive Lumbar Decompression (MILD)* (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Nucleoplasty* (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Percutaneous Vertebroplasty/Kyphoplasty* (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Radiofrequency Rhizotomy (1,2,3,5,6,7,8,10,13)

R	G	C	N	OTHER
☐	☐	☐	☐	Electromyography (1,2,3,5,6,7,8,13)
☐	☐	☐	☐	Fluoroscopy privileges* (1,2,3,5,6,7,8,10,11,13) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN ANESTHESIOLOGY - PAIN MEDICINE (PHYSIATRIST)

Name_____

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA ANESTHESIOLOGY - PAIN MEDICINE (PHYSIATRIST)

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