

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN ANESTHESIOLOGY - PAIN MEDICINE
(ANESTHESIOLOGIST)

Initial ☐

Renewed ☐

Name _____

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 (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"/> | Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,5,6,7,8,10,11,13,14,15,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History and Physical (1,2,3,5,6,7,8,10,11,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescribing Privileges (1,2,3,5,6,7,8,10,11,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Certifying of Medical Marijuana (1,2,3,5,6,7,8,9,10,11,13,14,15,17,19,20) (*Must satisfy certain credentialing criteria to be approved) |

R G C N MANAGEMENT ANESTHESIOLOGY

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-operative Management of Anesthetic Complications (1,2,3,5,6,7,10,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pre-operative Evaluation of Patients (1,2,3,5,6,7,10,13,14,15,17,19,20) |

R G C N ANESTHETIC TECHNIQUES

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inhalation Anesthesia (1,2,3,5,6,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intravenous Anesthesia (1,2,3,5,6,7,10,13) |

R G C N REGIONAL

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epidural/Caudal (including continuous techniques) (1,2,3,5,6,7,10,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Nerve Block (including continuous techniques) (1,2,3,5,6,7,10,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Subarachnoid Block (including continuous techniques) (1,2,3,5,6,7,10,13,14,15,17,19,20) |

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R G C N REGIONAL

☐ ☐ ☐ ☐ Epidural Steroid Administration (1,2,3,5,6,7,10,13,14,15,17,19,20)

R G C N CONSULTATIVE SERVICES

☐ ☐ ☐ ☐ Management of Patients in Critical Care Units (1,2,7,10,13,20)

☐ ☐ ☐ ☐ Resuscitation (1,2,3,5,6,7,8,10,11,13,14,15,17,19,20)

R G C N PAIN MEDICINE PROCEDURES

☐ ☐ ☐ ☐ Botulinum toxin use for neurologic conditions* (1,2,3,9) (*Must satisfy certain credentialing criteria to be approved)

☐ ☐ ☐ ☐ Diagnostic and Therapeutic Nerve Blocks - Chronic Pain Therapy (1,2,3,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Diskograms with Interpretation (1,2,3,4,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Dorsal Root Ganglion Stimulation Therapy* (1,2,3,5,6,7,10,13,14,15,17,19,20) (Must provide DRG Certification)

☐ ☐ ☐ ☐ Implantation of Intrathecal Catheters and Drug Infusion Pumps (1,2,3,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Implantation of Spinal Cord Stimulation Electrode(s) and Pulse Generator (1,2,3,4,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Insertion of Temporary Spinal Cord Stimulation Electrodes (1,2,3,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Intradiscal Electro Thermal Therapy* (IDET) (1,2,3,5,6,7,10,13,14,15,17,19,20) (*Must satisfy certain credentialing criteria to be approved)

☐ ☐ ☐ ☐ Intrathecal Drug Trials (1,2,3,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Minimally Invasive Lumbar Decompression (MILD)* (1,2,3,5,6,10,13,14,15,17,19,20) (*Must satisfy certain credentialing criteria to be approved)

☐ ☐ ☐ ☐ Nucleoplasty* (1,2,3,5,6,10,13,14,15,17,19,20) (*Must satisfy certain credentialing criteria to be approved)

☐ ☐ ☐ ☐ Percutaneous Vertebroplasty/Kyphoplasty* (1,2,3,5,6,10,13,14,15,17,19,20) (*Must satisfy certain credentialing criteria to be approved)

☐ ☐ ☐ ☐ Placement of Reservoir Pumps subcutaneously for drug delivery (1,2,3,5,6,7,10,13,14,15,17,19,20)

☐ ☐ ☐ ☐ Radiofrequency Rhizotomy (1,2,3,5,6,7,10,13,14,15,17,19,20)

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R G C N PAIN MEDICINE PROCEDURES

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Superior Vertiflex* (*must complete Superior Physician Bioskills training and provide certificate from Boston Scientific) (1,2,3,5,6,7,10,13,14,15,17,19,20) |
|--------------------------|--------------------------|--------------------------|--------------------------|--|

R G C N OTHER

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Electromyography (1,2,3,5,6,13,14,15,17,19,20) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fluoroscopy privileges* (1,2,3,5,6,7,8,10,13,14,15,17,19,20) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moderate Sedation - Pediatric (birth - 25 years)*** (1,2,3,5,6,7,8,9,10,11,13,14,15,17,19,20)(Applicant must satisfy certain credentialing criteria to be approved for this privilege.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moderate Sedation - Adult (13 years or older)*** (1,2,3,5,6,7,8,9,10,11,13,14,15,17,19,20) (Applicant 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 ANESTHESIOLOGY - PAIN MEDICINE (ANESTHESIOLOGIST)

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 - Bethehelem
- 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 ANESTHESIOLOGY - PAIN MEDICINE (ANESTHESIOLOGIST)

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:

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