LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN HOSPITAL MEDICINE

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) (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Consultation Privileges (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	GENERAL PROCEDURES
☐	☐	☐	☐	Arterial Puncture (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Arthrocentesis (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Central Venous Pressure (CVP) Monitoring (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Emergency Defibrillation (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Lumbar Puncture (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Paracentesis - Abdominal (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Paracentesis - Thoracic (1,2,7,10,11,13)
☐	☐	☐	☐	Repair of simple lacerations (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Sigmoidoscopy - Flexible (1,2,7,8,13)
☐	☐	☐	☐	Skin Tag Excision (1,2,3,5,6,7,8,10,11,13)

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R	G	C	N	**CORTICOSTEROID INJECTIONS**
☐	☐	☐	☐	Carpal Tunnel (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Joint (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Morton's neuroma (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Plantar fascia (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Trigger finger (1,2,3,5,6,7,8,10,11,13)

R	G	C	N	**HOSPITAL MEDICINE**
☐	☐	☐	☐	Diagnosis and treatment of medical or surgical conditions (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Diagnosis and treatment of psychobehavioral disorders (1,2,3,5,6,7,8,10,11,13)

R	G	C	N	**Point of Care Ultrasound (POCUS)(*Must satisfy criteria)**
☐	☐	☐	☐	Abdominal Aorta* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Cardiac Echocardiography (ECHO) Expanded* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Cardiac Echocardiography (ECHO) Limited* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Focused Abdominal Sonography for Trauma/Extended (FAST Exam-Trauma)* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Gallbladder* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Gastrointestinal-SBO/Appendicitis* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Lung* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Musculoskeletal* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Ocular* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Pelvic (Female)* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)

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R	G	C	N	**Point of Care Ultrasound (POCUS)(*Must satisfy criteria)**
☐	☐	☐	☐	Procedural Guidance* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Renal* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Soft Tissue* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)
☐	☐	☐	☐	Vascular-Deep Vein Thrombosis (DVT)/Inferior Vena Cava (IVC)* (1,2,3,5,6,7,8,9,10,11,13,14,15,16)

R	G	C	N	**OTHER**
☐	☐	☐	☐	Arterial Cannulation (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Cardioversion (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Continuous-assisted Ventilation - Limited (1,2,7,10,11,13)
☐	☐	☐	☐	Intubation - Emergency (1,2,3,5,6,7,8,10,11,13)
☐	☐	☐	☐	Pericardiocentesis - Emergency (1,2,3,5,6,7,10,11,13)
☐	☐	☐	☐	Swan-Ganz Insertion (1,2,7,10,11,13)
☐	☐	☐	☐	Temporary Pacemaker Insertion (1,2,3,5,6,7,10,11,13)
☐	☐	☐	☐	Thoracentesis (1,2,3,5,6,7,10,11,13)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN HOSPITAL MEDICINE

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

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA HOSPITAL MEDICINE

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