

LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN AHP - PA - NEUROLOGY

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, and LVHN Children's Surgery Center - 6 months - 18 Years)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adults: 13 - 65 Years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Geriatrics: Over 65 years

R G C N PRIVILEGES WITH SUPERVISION (b)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accept lab information from laboratory (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Admit/discharge patients on consultation with supervising physician (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Answers pages from floors in regards to specific patient (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist in filling out request forms signed by supervising physician (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Botox Injections for Chronic Migraine Treatment and Conducting/documenting face to face assessments according to policies (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dictate discharge summaries which will be reviewed and countersigned by the supervising physician, provide discharge management instructions, and distribute prescriptions as needed (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for medications as directed and countersigned by the supervising physician (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for other diagnostic studies appropriate to the diseases seen as directed and countersigned by the supervising physician (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for routine blood tests as directed and countersigned by the supervising physician and interpret their results (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for routine x-rays as directed and countersigned by the supervising physician and interpret their results (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders to include diet and activity levels as directed and countersigned by the supervising physician (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate appropriate evaluation and emergency management for emergency situations (cardiac arrest, respiratory distress, hemorrhage) (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inject appropriate vaccines and medications including antibiotics, antimigraine medications, antiemetics, corticosteroids, anxiolytic agents, and analgesics (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obtain a comprehensive health history, including an evaluation of physiological function, emotional and social well-being, development and maturation, and activities of daily living (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Order and/or administer blood and blood products (as set forth in written agreement) (1,2,3,4)

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R G C N PRIVILEGES WITH SUPERVISION (b)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Order restraints and seclusion and conduct/document face to face assessments according to policies* (*Must satisfy certain credentialing criteria to be approved) (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform and document patient education as appropriate (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform history and physical examination of specific patients, interpretation and evaluation of data, and formulation of treatment protocols in conjunction with supervising physician (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform patient hospital rounds and write progress notes countersigned by supervising physician (1,2,3) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Place intravenous lines when indicated (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prepare patient/family for discharge (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pronouncement of death (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Provide and document patient instructions as needed (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Provide and document patient teaching as deemed necessary (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Remove and/or apply dressings to observe the status of surgical incisions or wounds (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Remove sutures at appropriate time or when requested by the attending physician (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Review and document in Medical Record (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Triage patient telephone calls and advise, where appropriate, in the treatment of applicable diseases (1,2,3,4) |

R G C N PRIVILEGES WITH SUPERVISING PHYSICIAN IN ATTENDANCE (c)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assist with code blue situations (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assist with EMG/NCV (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assist with other neurodiagnostic procedures including lumbar puncture (1,2,3,4) |

R G C N PRESCRIPTIVE PRIVILEGES - Controlled Substances

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 2 (1,2,3,4) |
|--------------------------|--------------------------|--------------------------|--------------------------|----------------------|

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- | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 2N (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 3 (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 3N (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 4 (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 5 (1,2,3,4) |

R G C N PRESCRIPTIVE PRIVILEGES - Non-Controlled Substances

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescriptive Privileges (1,2,3,4) (See list of exclusions, if any) |
|--------------------------|--------------------------|--------------------------|--------------------------|--|

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN AHP - PA - NEUROLOGY

Name _____

Qualifications:

Will function in joint collaboration with the physician or physician group with which she/he is associated.

All verbal and telephone orders must be signed by the Physician Assistant within seven (7) days. All orders must be countersigned by the Supervising Medical Staff member within ten (10) days for the following:

1. For the first twelve (12) months the Physician Assistant is practicing post-graduation and initial licensure.
2. For the first twelve (12) months the Physician Assistant is practicing in a new specialty.
3. For the first six (6) months the Physician Assistant is practicing in the same specialty, but is located in a new practice area.

All written/electronic orders must be countersigned by the Supervising Physician within ten (10) days.

SITES OF PRIVILEGE

- 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

DEFINITIONS OF SUPERVISION

(a) DIRECT SUPERVISION - The physical presence of the supervising physician on the premises so that the supervising physician is immediately available to the allied health professional when needed.

(b) SUPERVISION - The control and personal direction exercised by the supervising physician over the medical services provided by an allied health professional. Constant physical presence of the supervising physician is not required so long as the supervising physician and the allied health professional are, or can easily be, in contact with each other by radio, telephone or telecommunications. Supervision requires the availability of the supervising physician to the allied health professional.

(c) SUPERVISING PHYSICIAN IN ATTENDANCE - Physical presence of supervising physician in room.

* ATTENTION SUPERVISING PHYSICIAN: Your signature, title and date are required on the first line of the signature page of this document.

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA AHP - PA - NEUROLOGY

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)	_____ Signature	_____/_____/_____ Date
Title	_____ Signature	_____/_____/_____ Date
Title	_____ Signature	_____/_____/_____ Date
Title	_____ Signature	_____/_____/_____ Date
Title	_____ Signature	_____/_____/_____ Date

