

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN AHP - PERFUSION ASSISTANT

Name _____

Initial Renewed
 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 (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"/>	Assist the staff perfusionist with the setup of Extracorporeal Oxygenation (ECMO) Extracorporeal Life Support (ELS). (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist with the daily setup and maintenance of the heart-lung machine (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maintain daily inventory of departmental supplies (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform cell saver management (1,2,3,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform heparin/anticoagulation monitoring and point of care blood analysis (1,2,3,4,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform intra-aortic balloon daily checks (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform record keeping/data documentation (1,2,3,4)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN AHP - PERFUSION ASSISTANT

Name _____

Qualifications:

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

SITES OF PRIVILEGES

9 - LVHN Children's Surgery Center

10 - LVH-Schuylkill East Norwegian

11 - LVH-Schuylkill South Jackson

12 - LVH-Schuylkill Surgery Center

DEFINITION 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 - PERFUSION ASSISTANT

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

