

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN AHP - PERFUSIONIST

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 DIRECT SUPERVISION (a)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist attending physicians and physician extenders in appropriate procedural requirements (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate autotransfusion devices (1,2,3,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate heart-lung machines (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate laser for TMR Procedure (Need course certificate) (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate Rapid Infusion Device (1,2)

R G C N PRIVILEGES WITH SUPERVISION (b)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Add blood or blood components to the extra-corporeal circuit as determined to be necessary under the auspices of the surgeon in charge (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Add medications and anesthetic agents to the extra-corporeal circuit as determined to be necessary under the auspices of the surgeon in charge with direction from an anesthesiologist and/or anesthesiologist (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Make sure all supplies are available for service requested (1,2,3,4,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate ancillary circulatory support equipment (1,2,3)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate cardiovascular and cardiopulmonary monitoring equipment (1,2,3)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate Intra-Aortic balloon pumps (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform a complete chart review in preparation for service required (1,2,3,4,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prepare all equipment for use according to department policy and manufacturer's specifications (1,2,3,4,5,6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Set up/preparation of ventricular assist device (Proof of training required) (1)

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R G C N PRIVILEGES WITH SUPERVISION (b)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transport patients with cardiopulmonary support devices when required (1,2,3,4)
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R G C N PRIVILEGES WITH SUPERVISING PHYSICIAN IN ATTENDANCE (c)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heated Intraperitoneal Chemotherapy (HIPEC) (1,2)* (Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiation of Ancillary Cardiac Support Devices (1,2,3,4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiation of Cardiopulmonary Bypass (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiation of Intra-Aortic Balloon Insertions (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiation of Rapid Infusion (1,2,3)

LEHIGH VALLEY HEALTH NETWORK
CEDAR CREST & I-78 PO BOX 689
ALLENTOWN, PA 18105-1556
CLINICAL PRIVILEGES IN AHP - PERFUSIONIST

Name _____

Qualifications:

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

SITES OF PRIVILEGES

- 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

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 - PERFUSIONIST

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

