LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN PSYCHIATRY

Initial ☐ **Renewed** ☐

Name_____ **Effective from** ___/___/___ **to** ___/___/___

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

R	G	C	N	POPULATION
☐	☐	☐	☐	Pediatric: Birth - 25 Years (LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year)
☐	☐	☐	☐	Pediatric: Birth - 25 Years (CONSULTATION ONLY for ages Birth - 12 Years)
☐	☐	☐	☐	Adults: 13 - 65 Years
☐	☐	☐	☐	Geriatrics: Over 65 Years

R	G	C	N	GENERAL PRIVILEGES
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,10,11)
☐	☐	☐	☐	Attending Privileges (2,10,11)
☐	☐	☐	☐	Consultation Privileges (1,2,3,4,5,6,7,8,10,11,13)
☐	☐	☐	☐	History and Physical (1,2,3,4,5,6,7,8,10,11,13)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,4,5,6,7,8,10,11,13)

R	G	C	N	SPECIALIZED TREATMENT
☐	☐	☐	☐	Biofeedback (1,2,3,10,11,13)
☐	☐	☐	☐	Electro-Convulsive Therapy (ECT)* (1,2,3,10,11) (*Applicant must satisfy certain credentialing criteria to be approved for this privilege.)

R	G	C	N	OTHER SPECIALIZED TREATMENT
☐	☐	☐	☐	Hypnosis (1,2,3,10,11,13)
☐	☐	☐	☐	Psychopharmacology (1,2,3,5,7,8,10,11,13)
☐	☐	☐	☐	Psychotherapy (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Transcranial Magnetic Stimulation (TMS)* (1,2,3,10,11) (*Applicant must satisfy certain credentialing criteria to be approved for this privilege.)

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R	G	C	N	AREAS OF SPECIAL COMPETENCE
☐	☐	☐	☐	Child Psychiatry (1,2,3,7,10,11,13)
☐	☐	☐	☐	Adolescent Psychiatry (1,2,3,7,10,11,13)
☐	☐	☐	☐	Consultation-Liaison Psychiatry (1,2,3,7,10,11,13)
☐	☐	☐	☐	Forensic Psychiatry (1,2,3,7,10,11,13)
☐	☐	☐	☐	Geriatric Psychiatry (1,2,3,7,10,11,13)
☐	☐	☐	☐	Addiction Psychiatry (1,2,3,7,10,11,13)

R	G	C	N	OTHER AREAS OF SPECIAL COMPETENCE
☐	☐	☐	☐	Dissociative Disorders (1,2,3,7,10,11,13)
☐	☐	☐	☐	Mental Retardation (1,2,3,7,10,11,13)
☐	☐	☐	☐	Pain Management (1,2,3,7,10,11,13)
☐	☐	☐	☐	Psycho Oncology (1,2,3,7,10,11,13)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN PSYCHIATRY

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 PSYCHIATRY

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