

**LEHIGH VALLEY HEALTH NETWORK**  
**CLINICAL PRIVILEGES IN PULMONARY/CRITICAL CARE MEDICINE**

Initial  Renewed   
 Effective from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

**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) (1,2,3,5,6,7,8,9,10,11,13)

Consultation Privileges (1,2,3,5,6,7,8,9,10,11,13)

History and Physical (1,2,3,5,6,7,8,9,10,11,13)

Prescribing Privileges (1,2,3,5,6,7,8,9,10,11,13)

**R G C N GENERAL PROCEDURES**

Arterial Cannulation (1,2,3,5,6,7,8,9,10,11)

Arterial Puncture (1,2,3,5,6,7,8,9,10,11)

Arthrocentesis (1,2,7,8)

Cardioversion (1,2,3,5,6,7,8,9,10,11)

Central Venous Pressure (CVP) Monitoring (1,2,3,5,6,7,8,9,10,11)

Continuous-assisted ventilation - unlimited/limited (1,2,3,5,6,7,8,9,10,11)

Emergency Defibrillation (1,2,3,5,6,7,8,9,10,11)

Intubation (1,2,3,5,6,7,8,9,10,11)

Lumbar Puncture (1,2,3,5,6,7,8,9,10,11)

Paracentesis (1,2,7,8,10,11)

Percutaneous Insertion of Dialysis Devices (1,2,7,8,10)

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**R G C N GENERAL PROCEDURES**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pericardiocentesis - Emergency (1,2,3,5,6,7,8,9,10,11) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swan-Ganz Insertion (1,2,7,8,10,11)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Temporary Pacemaker Insertion (1,2,3,5,6,7,8,9,10,11)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracentesis (1,2,3,5,6,7,8,9,10,11)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tube Thoracostomy (1,2,3,5,6,7,8,9,10,11)              |

**R G C N PULMONARY PRIVILEGES**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy - Bronchus (1,2,7,10,11)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy - Lung (fiberoptic, transbroncheal) (1,2,7,10,11)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy - Lung (needle percutaneous) (1,2,7,10,11)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy - Pleura (1,2,7,10,11)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brachytherapy (1,2)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchial Lavage and/or Brushing (1,2,3,5,6,7,9,10,11)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchoscopy - Autofluorescence* (1,2) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchoscopy - Flexible (1,2,3,5,6,7,9,10,11)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchoscopy - Navigational* (1,2,7) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchoscopy - Rigid* (1,2,3,5,6,9) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Electrocautery/Argon Plasma Coagulation for endobronchial tumor ablation* (1,2) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endobronchial Laser Ablation* (1,2) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endobronchial Ultrasound* (1,2) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endobronchial Valve Placement and Removal* (1,2) (*Must satisfy certain credentialing criteria to be approved)                                |

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**R G C N PULMONARY PRIVILEGES**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpretation of Methacholine Challenge Testing (1,2,7,8,10,11,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpretation of Polysomnography (1,2,3,7,8,10,11,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpretation of Pulmonary Function Testing (1,2,3,5,6,7,8,9,10,11,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpretation of Pulmonary Stress Testing (1,2,7,8,10,11,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Photodynamic Therapy* (1,2) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trachea Laser Therapy - Respiratory Tract* (1,2) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheal and Bronchial Stents/Balloon Tracheo/Bronchoplasty* (1,2) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transtacheal Needle Aspiration of Lymph Nodes/Masses (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transtacheal Oxygen Catheter Insertion* (1,2) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tunneled Pleural Catheter (1,2)

**R G C N OTHER**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchial Thermoplasty* (1,2) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroscopy privileges* (1,2,3,5,6,7,8,9,10,11) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moderate Sedation - Adult* (13 years or older)*** (1,2,3,5,6,7,8,10,11) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treadmill Stress Test* (1,2,7,8) (*Must satisfy certain credentialing criteria to be approved)

# LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

## CLINICAL PRIVILEGES IN PULMONARY/CRITICAL CARE 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 PULMONARY/CRITICAL CARE 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

