LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN RADIATION ONCOLOGY

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)
☐	☐	☐	☐	Adults: 13 - 65 Years
☐	☐	☐	☐	Geriatrics: Over 65 Years

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

R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Arterial Puncture (1,2,7,8,13)
☐	☐	☐	☐	Indirect Fiberoptic Laryngoscopy (1,2,7,8,13)
☐	☐	☐	☐	Incision and Drainage of Abcess (1,2,7,8,13)
☐	☐	☐	☐	Paracentesis (1,2,7,8,13)
☐	☐	☐	☐	Skin Biopsy (1,2,7,8,13)
☐	☐	☐	☐	Thoracentesis (1,2,7,8,13)
☐	☐	☐	☐	Venipuncture (1,2,7,8,13)

R	G	C	N	SUPERVISE, USE AND OPERATE RADIATION THERAPY EQUIPMENT INCLUDING:
☐	☐	☐	☐	Linear Accelerators (1,2)

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R	G	C	N	**SUPERVISE, USE AND OPERATE RADIATION THERAPY EQUIPMENT INCLUDING:**
☐	☐	☐	☐	Treatment Simulators including CT Simulators (1,2)
☐	☐	☐	☐	High Dose Rate Brachytherapy Remote Afterloader (1,2)
☐	☐	☐	☐	Physics Equipment including Dosimetry and Treatment Planning Devices (1,2,7)

R	G	C	N	**SUPERVISE, USE AND OPERATE RADIOACTIVE ISOTOPES INCLUDING:**
☐	☐	☐	☐	Cesium-137 (1,2)
☐	☐	☐	☐	Cobalt-60 (1,2)
☐	☐	☐	☐	Gold AU-198 (1,2)
☐	☐	☐	☐	Iodine-125 (1,2,7)
☐	☐	☐	☐	Iodine-131(1,2)
☐	☐	☐	☐	Iridium-192 (1,2,7)
☐	☐	☐	☐	Phosphorus-32 (P-32) (1,2)
☐	☐	☐	☐	SR-90 (1,2,7)

R	G	C	N	**PLACEMENT OF:**
☐	☐	☐	☐	Foley Catheter (1,2,7,8,13)
☐	☐	☐	☐	Nasogastric Tubes (1,2,7,8,13)
☐	☐	☐	☐	Urinary Bladder Catheter (1,2,7,8,13)

R	G	C	N	**PROCEDURES REQUIRING UTILIZATION OF THE OPERATING ROOM**
☐	☐	☐	☐	Examination and biopsy of patient's affected area under anesthesia (1,2,7,13)

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R	G	C	N	PROCEDURES REQUIRING UTILIZATION OF THE OPERATING ROOM
☐	☐	☐	☐	Implantation of radioactive sources into various body cavities and tissues under local and general anesthesia (1,2,7,13)
☐	☐	☐	☐	Placement of catheters and other devices, to include insertion of gynecological applicators (1,2,7,13)

R	G	C	N	OTHER
☐	☐	☐	☐	Authorized User of Y90* (1) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Flexible ENT Scope (1,2)
☐	☐	☐	☐	Fluoroscopy privileges* (1,2,7,8,13) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Gamma Knife Radiosurgery* (1) (Applicant must satisfy certain credentialing criteria to be approved for this privilege) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	IV Contrast Administration (1,2,7,13)
☐	☐	☐	☐	Mammosite Catheter for Accelerated Partial Breast Irradiation* (1,2) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Prostate Brachytherapy* (1,2,7,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Stereotactic Radiosurgery (1,2)
☐	☐	☐	☐	Vascular Brachytherapy* (1,2) (*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 RADIATION ONCOLOGY

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 RADIATION ONCOLOGY

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