LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN RADIOLOGY-DIAGNOSTIC MEDICAL IMAGING

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) (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	History and Physical (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,5,6,7,8,10,11,13,19,20)

R	G	C	N	**CONVENTIONAL RADIOGRAPHY**
☐	☐	☐	☐	General diagnostic radiology (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Dual Energy X-ray Absorptiometry (DEXA) (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Fluoroscopy privileges* (1,2,3,5,6,7,8,10,11,13,19,20) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	General fluoroscopic procedures (esophagram, upper GI, small bowel series, barium enema, other general procedures) (1,2,3,5,6,7,8,10,11,13,19,20)

R	G	C	N	**CONVENTIONAL RADIOGRAPHY - Special Fluoroscopic Procedures**
☐	☐	☐	☐	Lumbar Puncture (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Myelography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Myelography - INTERPRETATION ONLY (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Arthrography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Arthrography - INTERPRETATION ONLY (1,2,3,5,6,7,8,10,11,13,19,20)

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R	G	C	N	**CONVENTIONAL RADIOGRAPHY - Special Fluoroscopic Procedures**
☐	☐	☐	☐	Hysterosalpingography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Hysterosalpingography - INTERPRETATION ONLY (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Sialography (1,2,3,,5,6,7,8,13,19,20)
☐	☐	☐	☐	Cholangiography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Fluoroscopic guided biopsy or drainage procedure (1,2,3,5,6,7,8,13,19,20)

R	G	C	N	**ULTRASOUND**
☐	☐	☐	☐	Breast (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	General diagnostic ultrasound (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Histotripsy* (1,2,3,5,6,7,8,10,11,13,19,20)(* Applicant must satisfy certain credentialing criteria to be approved for this privilege.)
☐	☐	☐	☐	Pediatric brain (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Pediatric hip (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Pediatric spine (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Ultrasound guided procedures (excluding breast) (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Ultrasound guided procedures (excluding breast) - GUIDANCE ONLY (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Ultrasound guided biopsy/aspiration of breast* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Vascular (1,2,3,5,6,7,8,10,11,13,19,20)

R	G	C	N	**COMPUTED TOMOGRAPHY**
☐	☐	☐	☐	Brain (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Orbits/facial bones (1,2,3,5,6,7,8,10,11,13,19,20)

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R	G	C	N	**COMPUTED TOMOGRAPHY**
☐	☐	☐	☐	Temporal bones (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Neck (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Spine (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Chest, abdomen and pelvis (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Musculoskeletal (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Dentascan (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Computed Tomography Angiography (CTA) of head (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Computed Tomography Angiography (CTA) of neck (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Computed Tomography Angiography (CTA) of chest, abdomen and pelvis (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Computed Tomography Angiography (CTA) of peripheral vessels (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Computed Tomography Angiography (CTA) of coronary arteries* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Computed Tomography (CT) guided procedures (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Computed Tomography (CT) guided procedures - INTERPRETATION ONLY (1,2,3,5,6,7,8,10,11,13,19,20)

R	G	C	N	**MAGNETIC RESONANCE IMAGING**
☐	☐	☐	☐	Brain (1,2,3,5,6,7,810,11,13,19,20)
☐	☐	☐	☐	Spine (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Neck (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Chest, abdomen and pelvis (1,2,3,5,6,7,8,13,19,20)
☐	☐	☐	☐	Musculoskeletal (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Cardiac* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)

LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN RADIOLOGY-DIAGNOSTIC MEDICAL IMAGING

Initial ☐ **Renewed** ☐

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R	G	C	N	**MAGNETIC RESONANCE IMAGING**
☐	☐	☐	☐	Breast* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Magnetic Resonance Angiography (MRA) of head (1,2,3,,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Magnetic Resonance Angiography (MRA) of neck (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Magnetic Resonance Angiography (MRA) of chest, abdomen and pelvis (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Magnetic Resonance Angiography (MRA) of peripheral vessels (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Magnetic Resonance (MR) guided procedures of breast* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Magnetic Resonance (MR) guided procedures, excluding breast (1,2,3,5,6,7,8,13,19,20)

R	G	C	N	**NUCLEAR MEDICINE**
☐	☐	☐	☐	Diagnostic Nuclear Medicine (1,2,3,7,10,11,13,19,20)
☐	☐	☐	☐	Therapeutic Nuclear Medicine (1,2,3,7,10,11,13,19,20)
☐	☐	☐	☐	Sentinel Node Procedure (1,2,3,7,10,11,13,19,20)
☐	☐	☐	☐	Positron Emission Tomography/Computed Tomography (PET/CT)* (1,2,3,7,10,11,13, 19 20) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	**MAMMOGRAPHY**
☐	☐	☐	☐	Screening mammography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Diagnostic mammography (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Needle localization procedure of breast (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Stereotactic core biopsy of breast* (1,2,3,5,6,7,8,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Galactography (1,2,3,5,6,7,8,13,19,20)

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R	G	C	N	INTERVENTIONAL RADIOLOGY
☐	☐	☐	☐	Diagnostic angiography (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Diagnostic venography (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Carotid Angioplasty and Stenting* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Carotid Angioplasty and Stenting* - ONLY IN SETTING OF ACUTE STROKE THERAPY (1,2,3,7,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Renal and Iliac Angiography and Angioplasty and Stenting* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Other angioplasty and/or intravascular stent placement (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Vascular embolization (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Chemoembolization* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Percutaneous thrombolysis/thrombectomy for stroke therapy (1,2,3,7,13,19,20)
☐	☐	☐	☐	Percutaneous thrombolysis/thrombectomy (excluding stroke therapy) (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Regional drug infusion (excluding thrombolysis) (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Isolated limb infusion* (1,2,3,7,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Venous access procedure (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Vena Cava Filter Placement (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Percutaneous biopsy (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Percutaneous abscess drainage (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Percutaneous gastrotomy (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Endovenous Laser Treatment (1,2,3,7,13,19,20)
☐	☐	☐	☐	Non-vascular stricture dilation (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Retrieval of intravascular foreign body (1,2,3,7,10,13,19,20)

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R	G	C	N	**INTERVENTIONAL RADIOLOGY**
☐	☐	☐	☐	Fallopian tube catheterization (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Transjugular Intrahepatic Portosystemic Shunt (TIPS)* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Vertebroplasty* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Kyphoplasty* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Neurointerventional procedures (1,2,3,7,13,19,20)
☐	☐	☐	☐	Radiofrequency Ablation of Neoplasms* (1,2,3,7,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	**INTERVENTIONAL RADIOLOGY - Biliary**
☐	☐	☐	☐	Transhepatic cholangiography and biliary decompression (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Percutaneous cholecystostomy (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Retained bile duct stone removal (1,2,3,7,10,13,19,20)

R	G	C	N	**INTERVENTIONAL RADIOLOGY - Renal**
☐	☐	☐	☐	Percutaneous nephrostomy (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Tract dilation for stone removal (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Placement of ureteral stent (1,2,3,7,10,13,19,20)
☐	☐	☐	☐	Suprapubic cystostomy (1,2,3,7,10,13,19,20)

R	G	C	N	**OTHER**
☐	☐	☐	☐	Authorized User of Y90* (1) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Moderate Sedation - Pediatric (birth - 25 years)*** (1,2,3,5,6,7,8,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)

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R	G	C	N	OTHER
☐	☐	☐	☐	Moderate Sedation - Adult* (13 years or older)*** (1,2,3,5,6,7,8,10,13,19,20) (*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 RADIOLOGY-DIAGNOSTIC MEDICAL IMAGING

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
19 - LVH-Carbon
20 - LVH-Dickson City

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA RADIOLOGY-DIAGNOSTIC MEDICAL IMAGING

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:

_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date
_____	_____	_____/_____/_____
Title	Signature	Date