

LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN AHP - NP - PAIN MEDICINE

Initial Renewed

Name _____

Effective from ___/___/___ to ___/___/___

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 - (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"/>	Epidural catheter removal (1,2,5,14,15)
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R G C N PRIVILEGES WITH SUPERVISION (b)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Answers pages from floors in regards to specific patient (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apply simple dressings and change same as indicated (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for medications appropriate to the disease entities he/she diagnoses and treats according to established protocol or at direction of physician (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for other diagnostic studies appropriate to the diseases seen (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for routine blood tests and interpret their results (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders for routine x-rays and interpret their results (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate and take orders to include diet and activity levels according to established protocol or at direction of physician (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initiate appropriate evaluation and emergency management for emergency situations (cardiac arrest, respiratory distress, hemorrhage) (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inject appropriate vaccines and medications including antibiotics, antimigraine medications, antiemetics, corticosteroids, anxiolytic agents, and analgesics (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obtain a comprehensive health history, including an evaluation of physiological function, emotional and social well-being, development and maturation, and activities of daily living (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Order blood and blood products (1,2,3,5,6,14,15)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Order restraints and seclusion and conduct/document face-to-face assessments according to policies.* (1,2,3,5,6,14,15) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform and document patient education as appropriate (1,2,3,5,6,14,15)

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R G C N PRIVILEGES WITH SUPERVISION (b)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform history and physical examination of specific patients, interpretation and evaluation of data, and formulation of treatment protocols in conjunction with supervising physician (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform patient hospital rounds and write progress notes (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perform venipuncture (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Place intravenous lines when indicated (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-op visit to see patient following surgery and notify physician regarding status (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pre-op visit to see patient evening prior to surgery to answer questions (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Provide and document patient instructions as needed (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Provide and document patient teaching as deemed necessary (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Review and document in Medical Records (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Triage patient telephone calls and advise, where appropriate, in the treatment of applicable diseases (1,2,3,5,6,14,15) |

R G C N PRESCRIPTIVE PRIVILEGES - Controlled Substances

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 2 (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 2N (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 3 (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 3N (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 4 (1,2,3,5,6,14,15) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Schedule 5 (1,2,3,5,6,14,15) |

R G C N PRESCRIPTIVE PRIVILEGES - Non-Controlled Substances

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescriptive Privileges (1,2,3,5,6,14,15) (See list of approved drug categories below) |
|--------------------------|--------------------------|--------------------------|--------------------------|--|

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN AHP - NP - PAIN MEDICINE

Name _____

Qualifications:

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

All verbal and telephone orders must be signed within seven (7) days.

SITES OF PRIVILEGE

- 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

DEFINITIONS 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 - NP - PAIN 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