

SURGICAL CARE AFFILIATES
 Delineation of Privileges - **General Surgery**

Name: _____

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES:	Requested	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.			
ABDOMINAL WALL/THORAX/SKIN & SUBCUTANEOUS TISSUE			
Excision of mass – cutaneous/subcutaneous/muscle			
Biopsy/removal of lesions and/or cysts			
Graft – full and/or split thickness			
Incision and drainage of cysts, wounds, abscess			
Fasciotomy			
Suture Repair			
Biopsy/removal of lymph nodes			
Placement or removal of gastroscopy tube			
Repair of hernia – femoral or inguinal			
Repair of hernia – incisional, umbilical, ventral			
Thoracentesis			
Paracentesis			
Thyroidectomy			
Liver Biopsy			
Appendectomy, open			
BREAST			
Biopsy of breast			
Biopsy of breast with needle localization			
Sentinel node biopsy			
Chest wall mass excision			
Excision of cyst or lesion			
Incision and drainage of abscess			
Lumpectomy			
Mastectomy, complete and partial			
Gynecomastic excision			
Reduction mammoplasty			
Insertion or removal of tissue expander			
VASCULAR			
Insertion of pacemaker			
Insertion or removal of vascular catheter			
Creation of vascular AV fistula			
Insertion or removal of vascular graft			
Vein ligation and stripping			

Since this is an outpatient surgical center, the Medical Director and Administrator reserve the right to review any procedures scheduled as to their appropriateness in an outpatient setting.

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PRIVILEGES:	Requested	Approved	Denied
Multiple stab evulsions of secondary varicosities			
Temporal artery biopsy			
PICC line insertion			
COLORECTAL			
Repair of fissure or fistula			
Hemorrhoidectomy			
Sphincterotomy			
Pilonidal cystectomy			
Rectal biopsy			
Colorectal polypectomies			
ENDOSCOPY			
Appendectomy, laparoscopic			
Hernia repair, laparoscopic			
Cholecystectomy, laparoscopic			
Gastroscopy / Esophagoscopy			
Colonoscopy			
Endoscopic venous closure of greater saphenous vein			
Mediastinoscopy			
Laparoscopy - diagnostic			
MISCELLANEOUS			
Nail matrix ablation/nail removal			
Imaging			
Provide imaging services (radiographic, fluoroscopic, ultrasonic, or other imaging services)			
Interpret and authenticate imaging results			
Stereotactic Breast Biopsy*			
Laser			
CO ₂			
Anesthesia			
Local Anesthesia			
Moderate Sedation (only request if you intend to administer – must complete attached form and be ACLS certified)			

*include documentation of continuing education/training.

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Name: _____

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **General Surgery** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

Physician

Date

APPROVAL:

My recommendation in regard to clinical privileges and membership is based on review and evaluation of relevant verified education, training or experience, current licensure, current competence and the applicant's ability to exercise clinical privileges requested -

- Qualified to receive Medical Staff membership and clinical privileges as requested.
- Qualified to receive Medical Staff membership and clinical privileges with changes noted:

- Not qualified to receive Medical Staff membership and clinical privileges as requested:

Medical Director

Date

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Name: _____

Moderate Sedation (Non-anesthesiologist)

Please note: Moderate Sedation will only be approved if the Practitioner is ACLS certified.

1. Do you anticipate administering moderate sedation**? Yes* No
* If yes, complete request below. Otherwise, skip next section.

(Moderate Sedation – a medically controlled state of depressed consciousness that allows protective reflexes to be maintained. It allows the patient to be able to maintain a patent airway independently, and permits appropriate response by the patient to physical stimulation or verbal command. Indications for moderate sedation include, but are not limited to: joint manipulation, joint reduction, invasive procedures and diagnostic procedures.)

2. Do you administer moderate sedation at other facilities? Yes No
Name of local facility _____
Name _____ Phone _____
(Recommended contact at facility for verification of clinical privileges for sedation)

PRIVILEGES OF MODERATE SEDATION (NON-ANESTHESIOLOGIST)

Requirements:

1. Competency in airway management:
 ACLS Certification (please provide copy of current certification),
[ACLS expiration date: _____] **and**
 I certify that I have experience in intubation or resuscitation.
2. Familiar with the interpretation of appropriate monitors, including EKG and SaO₂.
 Included in residency training and have maintained competency; **or**
 I have used EKG and SaO₂ monitors in my practice and certify that I can adequately Interpret the critical information provided by these monitors.
3. Familiar with the actions, potency, side effects, dosages, and contraindications of drugs used in moderate sedation.
 Included in residency training and have maintained competency, **or**
 Training course certification, **or**
 I certify that I am familiar with the actions, potency, side effects, dosages, and contraindications of drugs used for moderate sedation.

I understand privileges granted for moderate sedation by non-anesthesiologists will require an immediate pre-induction anesthesia assessment of the patient the day of the procedure. Acknowledging the patient's right to be informed of risks, benefits and alternatives, I will also be expected to obtain informed consent for each patient that I provide sedation.

Initial Here

** The American Society of Anesthesiologists (ASA) has described sedation into four levels - minimal, moderate, deep, and anesthesia. Medicare assesses facilities based on this definition as well.

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