

SURGICAL CARE AFFILIATES

Delineation of Privileges - *Gynecology*

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.			
FEMALE EXTERNAL GENITAL ORGANS			
Bartholin gland, excision or marsupialization of cyst or abscess			
Vulvar or labial biopsy			
Hymenotomy			
Hymenectomy			
Simple vulvectomy			
Removal of condyloma			
PELVIC/ABDOMINAL PROCEDURES			
Diagnostic laparoscopy			
Tubal Ligation - laparoscopy			
Vaginal hysterectomy - laparoscopy			
Cystoscopy			
Pelviscopy			
Ovarian cystectomy			
Salpingostomy - pelviscopy			
Hysterosalpingogram			
LEEP - Loop electrosurgical excision procedure*			
Oophorectomy			
Salpingectomy			
Tubal re-anastomosis			
Removal of foreign body/intra-uterine device			
Endometrial ablation - electrosurgical*			
Thermachoice*			
Novasure*			
Essure*			
Hydrothermal ablation			
Hysteroscopy - vaginal			
Gamete intra-fallopian transfer (GIFT)*			
Cervical conization			
Cervical colposcopy			
Cervical biopsy			
Cervical cerclage			
Laser - cervical			
Laser - laparoscopic*			
Laser - intraabdominal*			

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
Perineoplasty			
Repair of cystocele/ rectocele			
Bladder suspension			
Vaginal hysterectomy			
D&C – Diagnostic			
D&C - Therapeutic			
Polypectomy			
Imaging			
Provide imaging services (radiographic, fluoroscopic, ultrasonic, or other imaging services)			
Interpret and authenticate imaging results			
Laser			
CO ₂			
ND:YAG			
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.

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **Gynecology** 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

<p>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 -</p> <p><input type="checkbox"/> Qualified to receive Medical Staff membership and clinical privileges as requested.</p> <p><input type="checkbox"/> Qualified to receive Medical Staff membership and clinical privileges with changes noted:</p> <p>_____</p> <p><input type="checkbox"/> Not qualified to receive Medical Staff membership and clinical privileges as requested:</p>

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_____	_____
Medical Director	Date

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.

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Name: _____

	Initial Here
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** 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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