SURGICAL CARE AFFILIATES

Delineation of Privileges - *Oral and Maxillofacial Surgery*

Name: ________________

Please indicate by a check in the requested column those privileges which 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.			
Oral and maxillofacial procedures			
Extraction of teeth-routine			
Impressions of dental and facial structures			
Prosthesis fabrication			
Incisional and excisional biopsy, hard and soft tissues			
Nasogastric tube placement			
Repair, intra and extraoral lacerations			
Biopsy of maxillary sinus lesion			
Submandibular glands (salivary gland) dissection			
Mandibular/maxillary fractures			
Orbital fractures (rim, septum, tubercle)			
TMJ disorders - Diagnosis and Treatment			
Manipulation			
Maxillofacial fractures - closed reduction			
Dentoalveolar			
Tooth/Teeth			
Mandible			
Maxilla			
LeFort I			
Insertion extraoral pins and devices			
TMJ – temporomandibular joint surgery			
Oral and Maxillofacial Infections			
Intraoral incision and drainage			
Foreign body removal			
Sequestrectomy			
Nerve			
Steroid injection			
Alcohol injection			
Treatment of trigeminal neuralgia			
Airway Management			
Tracheostomy (Emergency)			
Laryngoscopy			
Imaging			
Provide imaging services (radiographic, fluoroscopic, ultrasonic, or other imaging services)			
Interpret and authenticate imaging results			
Anesthesia			
Local Anesthesia			

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.

Name: ___________________

Moderate Sedation (only request if you intend to administer – must complete attached form and be ACLS certified)			

Your initials as used in Medical Records ____

Your signature as used in Medical Records ____

I, _____________________, hereby request privileges in the specialty of **Oral and Maxillofacial 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:

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____ ____________________
Medical Director Date

Moderate Sedation (Non-anesthesiologist)

Please note: Moderate Sedation will only be <u>approved</u> 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

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.

Name: ________________

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 SaO_2.
   - ❑ Included in residency training and have maintained competency; **or**
   - ❑ I have used EKG and SaO_2 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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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.