

SURGICAL CARE AFFILIATES

Delineation of Privileges - *Orthopaedics*

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.			
Hand / Upper Extremity			
Bursectomy			
Carpal tunnel release			
Carpal tunnel release, endoscopic			
De Quervain's release			
Trigger Finger release			
Surgery of the muscle, tendon, and fascia of hand			
Transplantation of muscle/tendon of hand			
Plastic operation of hand with tissue graft or prosthetic implant of hand			
Arthroscopy - <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist			
Repair - Open			
Shoulder			
Wrist			
Elbow			
Repair - Arthroscopy			
Shoulder			
Wrist			
Elbow			
Arthroscopy - removal of loose body - all joints			
Elbow tendon reconstruction			
Medial/Lateral Epicondylectomy			
Phalangectomy			
Anterior/Cervical Discectomy & Fusion			
Anterior/Cervical fusion			
Anterior/Posterior repair			
Condylectomy			
Distal Clavicular resection			
Capsular shrinkage			
Cervical Laminectomy			
Amputation of finger			
Excision bony lesions			
Ganglionectomy			
Legs and Feet / Lower Extremity			
Bunionectomy			
Arthrodesis			
Bone Spur removal			
Excision heel spur			

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Claw toe repair			
Knee arthrotomy with Genzyme Re-implantation			
Plantar Fascia Release			
Sesamoidectomy			
Subtalar fusion with iliac crest graft			
Tarsal tunnel release			
Anterior/posterior cruciate ligament reconstruction			
Arthroscopy with medial collateral ligament repair			
Lateral collateral ligament repair			
Hemiarthroplasty			
Lumbar Laminectomy			
Orthotripsy			
Tenotomies			
Tenolysis			
Arthroplasty			
Arthrotomy			
Bone Grafts			
Excision bony lesions			
Arthroscopy <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Hip			
Ganglionectomy			
Amputation of toe			
Hammertoe repair			
Ligament repair			
Meniscectomy			
Osteotomy			
Peripheral Nerve surgery			
Synovectomy			
Tarsal Tunnel repair - open			
Tarsal Tunnel repair - arthroscopy			
Miscellaneous			
Cast application			
Closed reduction			
Open reduction - ORIF			
Hardware removal			
I & D abscess			
Joint and Tendon Prosthesis			
Manipulation of joint			
Skin grafts and flaps			
Tumor Excision			
Extracorporeal shockwave therapy* (certificate required)			
Shoulder resurfacing			
Spine Surgery			
Anterior Cervical fusion			
Discectomy - Cervical, open			

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Discectomy - Lumbar, open			
Discectomy, Percutaneous			
Lumbar Laminectomy; Laminotomy			
Kyphoplasty* requires evidence of training			
Vertebroplasty* requires evidence of training			
Laser			
Holmium			
CO ₂			
Imaging			
Provide imaging service (radiographic, fluoroscopic, ultrasonic, or other services)			
Interpret and authenticate imaging results			
Anesthesia			
Local Anesthesia			
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 **Orthopaedics** 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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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:

- 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.
- 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.
- 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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