

SURGICAL CARE AFFILIATES

Delineation of Privileges - *Plastic 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			
BREAST			
Augmentation mammoplasty			
Reduction mammoplasty			
Mastopexy			
Mastectomy – partial or complete			
Incision and drainage of abscess			
Excision of cyst or tumor			
Insertion of tissue expanders			
Biopsy of breast			
Excision of Gynecomastia			
EYE			
Blepharoplasty			
Transconjunctival biopsy of eyelid			
Excision of lesion			
FACIAL			
Nasal fractures, simple			
Nasal fractures, open reduction			
Maxillary – mandibular fractures			
Rhinoplasty			
Rhytidectomy			
Laser facial resurfacing			
Microdermabrasion			
MOHS repair			
Botox injections			
Tattooing			
Brow lift			
Chin augmentation			
Cheiloplasty			
HEAD AND NECK			
Cleft lip repair			
Cleft palate repair			
Excision of lesion			
Otoplasty			
SKIN & SUBCUTANEOUS TISSUE			
Biopsy			
Burn treatment – debridement			
Scar revision			

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PRIVILEGES:	Requested	Approved	Denied
Liposuction			
Skin graft			
Suture repair			
Laceration repair			
HAND			
Carpal tunnel procedures			
DeQuervain's release			
Suture – muscle, tendon, fascia			
Transplantation of muscle, tendon			
Plastic repair with tissue graft or prosthetic implant			
Reimplantation of extremities			
Peripheral nerve repair			
GENERAL			
Penile implant			
Hypospadias repair			
Gender re-assignment			
Tissue expanders and implants			
Laser			
CO ₂			
Erbium			
Imaging			
Provide imaging services (radiographic, fluoroscopic, ultrasonic, or other imaging 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 **Plastic 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

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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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