

# SURGICAL CARE AFFILIATES

## Delineation of Privileges - Urology

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 requesting.

<b>PRIVILEGES:</b>	<b>Requested</b>	<b>Approved</b>	<b>Denied</b>
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.			
Circumcision			
Penile prosthesis implantation or removal			
Excision penile lesion (with or without laser)			
Hypospadias repair			
Excision of penile plaque			
Repair and plastic operation on penis			
Inguinal hernia repair when incidental to orchiopexy			
Hernia repair associated with cord or testicular surgery			
Surgery of testicle, epididymis or vas deferens			
Vasectomy			
Vasectomy reversal			
Cystourethroscopy			
Cystourethroscopy with retrograde x-ray			
Cystotomy for excision bladder diversion (supra-pubic)			
Cystourethroscopy with urethrotomy female or male			
Cystourethroscopy removal of foreign body or stents			
Insertion of stents			
Cystourethroscopy with dilation of urethra			
Cystourethroscopy with biopsy			
Cystourethroscopy with fulguration of bladder tumor			
Transurethral resection of bladder neck (supra-pubic)			
Lithotripsy			
Ultrasound biopsy of prostate			
Reconstructive surgery of urinary and genital tract			
<b>Laser</b>			
ND YAG			
Holmium			
<b>Imaging</b>			
Provide imaging services (radiographic, fluoroscopic, ultrasonic, or other imaging services)			
Interpret and authenticate imaging results			
<b>Anesthesia</b>			
Local Anesthesia			
Moderate Sedation (only request if you intend to administer – must complete attached form and be ACLS certified)			

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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## Delineation of Privileges - **Urology**

Name: \_\_\_\_\_

Your initials as used in Medical Records \_\_\_\_\_

Your signature as used in Medical Records \_\_\_\_\_

I, \_\_\_\_\_, hereby request privileges in the specialty of **Urology** 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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## Delineation of Privileges - Urology

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:

- 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 SaO<sub>2</sub>.  
 Included in residency training and have maintained competency; **or**  
 I have used EKG and SaO<sub>2</sub> 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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