Huntington Hospital

Delineation Of Privileges

Comprehensive Pain Management Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

COMPREHENSIVE PAIN MANAGEMENT PRIVILEGES - CATEGORY 1

Criteria: Applicants must meet one of the following:
A) Board Certified in Pain Management by either the American Board of Anesthesia; the American Board of Psychiatry & Neurology; or the American Board of Physical Medicine and Rehabilitation.
- OR -
B) Successful completion of a twelve (12) month ACGME approved program in Pain Management.
Proctoring Requirements: A minimum of six (6) cases, in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:

Admit	___	___	___
Consultation Only Privileges	___	___	___

CATEGORY I PRIVILEGES: ___ ___ ___
Includes the management and coordination of care, treatment and services; including: medical history and physical examinations, consultations and prescribing medication in accordance with DEA certificate.

Peripheral Nerve Blocks	___	___	___
Epidural and subarachnoid injections	___	___	___
Joint and bursal sac injections	___	___	___
Cryotherapeutic techniques	___	___	___
Epidural, subarachnoid, or peripheral neurolysis	___	___	___
Electrical stimulation techniques	___	___	___
Implanted epidural and intrathecal catheters, ports, and infusion pumps	___	___	___
Accupuncture and acupressure	___	___	___
Behavioral modification	___	___	___
Physical therapy	___	___	___

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Hypnosis, stress management and relaxation techniques	___	___	___
Trigeminal ganglioinectomy	___	___	___
Peripheral neurectomy and neurolysis	___	___	___
Sympathectomy techniques	___	___	___
Prevention, recognition, and management of local anesthetic overdose, including airway management and resuscitation	___	___	___

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section Chair: _____ Date: _____

Department Chair: _____ Date: _____

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Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____