Huntington Hospital

Delineation Of Privileges

Neurosurgery

Provider Name:

Privilege	Requested	Deferred	Approved

NEUROSURGERY PRIVILEGES:

Criteria - New Applicants or Current Staff Members: Board Certification or current participation in examination process leading to certification by the American Board of Neurosurgery.
Criteria - Current Staff Members Only: Successful completion of an ACGME or AOA approved training program OR demonstration of acceptable practice in the privileges being requested for a minimum of five (5) years.
Proctoring Requirements: A minimum of eight (8) cases in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:

Admit patients	___	___	___
Consultation **ONLY** Privileges	___	___	___
Surgical Assist **ONLY**	___	___	___
Sedation analgesia ***Criteria:*** Requires successful completion of the Sedation Assessment Test. ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course.	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___
Restraint and Seclusion ***Criteria:*** Requires successful completion of the Restraint and Seculsion Assessment Test.	___	___	___

CATEGORY 1 - NEUROSURGERY PRIVILEGES: ___ ___ ___
Includes the management and coordination of care, treatment and services, including: Medical history and physical examination, consultations and prescribing medications in accordance with the DEA certificate.
(* Denotes including but not limited to)

CRANIAL/SKULL BASE:

Scalp/skull procedures	___	___	___

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Neurosurgery

Provider Name:

Privilege	Requested	Deferred	Approved
Stereotactic/percutaneous procedures (*ablation, biopsy, stimulator, depth electrodes, image guidance)	___	___	___
Burr holes	___	___	___
Craniotomy/craniectomy (*tumor, trauma, clot, vascular, transphenoidal procedures)	___	___	___
CSF diversion (*ventriculostomy, ventriculoperitoneal shunt)	___	___	___
SKIN/MUSCLE:			
Repair, incision & drainage, biopsy	___	___	___
VASCULAR:			
Extracranial cervical vascular procedures (*carotid and veterbral artery, exposure, ligation, repair, endartectomy)	___	___	___
Harvesting vein or artery grafts	___	___	___
SPINE (Cervical, Thoracic, Lumbar, and Sacral):			
Traction/halo vest	___	___	___
Percutaneous procedures (*lumbar puncture, cerebrospinal fluid drainage, therapeutic injection, bone biopsy)	___	___	___
Vertebroplasty/Kyphoplasty	___	___	___
Laminectomy	___	___	___
Discectomy	___	___	___
Vertebrectomy	___	___	___
Fusion	___	___	___
Instrumentation	___	___	___

Provider Name:

Privilege	Requested	Deferred	Approved
Dura, spinal cord, and spinal nerve root procedures	___	___	___
Pain pumps, neurostimulators, bone growth stimulators	___	___	___
PERIPHERAL NERVE:			
Repair (*harvesting, grafting)	___	___	___
Injection	___	___	___
Biopsy	___	___	___
Decompression (*median nerve, ulnar nerve)	___	___	___
Tumor excision	___	___	___
Stimulator (*vagal nerve stimulator)	___	___	___

CATEGORY 2 - ADVANCED NEURO-ENDOVASCULAR PRIVILEGES:

Criteria: Applicants must have completed an ACGME approved residency program in Neurosurgery; AND either a two-year ACGME approved fellowship program in Interventional Neuro-Endovascular training OR equivalent training and experience. Fellowship training must include at least six (6) months of cognitive neuroscience training AND experience in performance of the procedures listed below on the privilege sheet.
Proctoring Requirements: Proctoring is required for a minimum of ten (10) cases as the primary surgeon. Must be proctored by a member of the HH Medical Staff with privileges in Neuroendovascular surgery.
Competency Requirements: The practitioner must have performed at least ten (10) neuroendovascular procedures per year. The cases may have been performed at another facility and the ten (10) cases may include any one of the procedures listed below on the privilege sheet.

CATEGORY 2 - ADVANCED NEURO-ENDOVASCULAR PRIVILEGES:

Carotid artery balloon test occlusion	___	___	___
Endovascular therapy of aneurysms	___	___	___
External carotid artery (ECA) embolization	___	___	___
Cerebral arteriovenous malformations (AVMS)	___	___	___

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Neurosurgery

Provider Name:

Privilege	Requested	Deferred	Approved
Head, neck, and brain tumor embolization	___	___	___
Intra-arterial thrombolysis and mechanical thrombectomy	___	___	___
Mechanical and pharmacologic Rx of vasospasm	___	___	___
Arteriovenous fistula (AVF) of the central nervous system (CNS)	___	___	___
Brachiocephalic angiography and stenting	___	___	___

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: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____

Revised: 10/25/2012; 02/08/2013; 05/23/2013; 10/30/2014