

**LAKWOOD REGIONAL MEDICAL CENTER
DEPARTMENT OF ANESTHESIOLOGY
PRIVILEGE/PROCEDURE CONTROL CARD**

PHYSICIAN NAME: _____ **SPECIALTY:** _____

I hereby request the following privileges from the Department of Anesthesiology:

Req Granted

- | | | |
|-------|-------|--|
| _____ | _____ | All ASA Classes for elective and emergency procedures for General Surgery, Orthopedic Surgery, Gynecology and Vascular Surgery, to include general anesthesia, spinal anesthesia and regional block. |
| _____ | _____ | Admission of Patients to Hospital |
| _____ | _____ | History and Physical Examination |

Anesthesia for major procedures in the following:

Observations/Proctoring: 3 varied, major cases must be observed by an eligible observer. One of the 3 cases observed may be observed by the applicant's associate. Whenever possible, observers must be varied as well. This is a minimum requirement and based upon the review of the cases observed, additional observations may be required.

- | | | |
|-------|-------|--|
| _____ | _____ | Intra-thoracic surgery |
| _____ | _____ | Intra-cranial surgery |
| _____ | _____ | Major vascular surgery |
| _____ | _____ | Pediatrics under 6 months and newborns |
| _____ | _____ | Intensive care management |
| _____ | _____ | Epidural Narcotics & Steroids |
| _____ | _____ | Hypothermia |
| _____ | _____ | Diagnostic and therapeutic nerve blocks |
| _____ | _____ | Cardiac anesthesia (See Protocol) |
| _____ | _____ | TEE (Transesophageal Echocardiogram) (See Protocol) |
| _____ | _____ | Other _____ |
| _____ | _____ | _____ |
| _____ | _____ | Swan Ganz catheters |
| _____ | _____ | Central Venous Pressure Lines |
| _____ | _____ | Arterial Lines |

ACLS Certification is required for all physicians requesting Anesthesia Privileges.

Pain Management-requires documentation of one year training in approved pain management fellowship or minimum one year documented, active participation in a multidisciplinary pain clinic or their equivalent. (ACLS is not required for Pain Management Privileges Only)

Req Granted

- | | | |
|-------|-------|--|
| _____ | _____ | Cervical epidurals |
| _____ | _____ | Tunnelled long term epidural catheters |
| _____ | _____ | Discograms (image) |
| _____ | _____ | Selective nerve root blocks (image) |
| _____ | _____ | Cryoneurolysis |
| _____ | _____ | Spinal stimulation** |
| _____ | _____ | Morphine pumps, port-a-caths** |
| _____ | _____ | Facet blocks (image) |
| _____ | _____ | Celiac plexus blocks (image) |
| _____ | _____ | Use of Fluoroscopy (requires special permit) |

**Requires observation by Active Staff member with privileges in procedure of a minimum of 1 each per requested procedure.

Signature of Applicant: _____

COMMENTS: _____

DEPARTMENT CHAIR _____ DATE _____

EXECUTIVE COMMITTEE _____ DATE _____

GOVERNING BOARD _____ DATE _____

(ANES PRIV.0210)