**Surgicore**

of Jersey City LLC

DELINEATION OF PRIVILEGES: ***PAIN MANAGEMENT***

I am requesting Pain Management privileges for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Requested | Not Requested | Granted | Denied | Procedure |
| 🞏 | 🞏 | 🞏 | 🞏 | Brachial plexus, intercostals, peripheral nerve, selective nerve root, and sympathetic nerve blocks |
| 🞏 | 🞏 | 🞏 | 🞏 | Lumbar Epidural Steroid Injections (LESI) |
| 🞏 | 🞏 | 🞏 | 🞏 | Cervical Epidural Steroid Injections (CESI) and Thoracic Epidural Steroid Injections (TESI) |
| 🞏 | 🞏 | 🞏 | 🞏 | Facet joint injections, Sacroiliac joint injections, Trigger Point injections and Medial Branch Blocks |
| 🞏 | 🞏 | 🞏 | 🞏 | Platelet Rich Plasma (PRP) injections |
| 🞏 | 🞏 | 🞏 | 🞏 | Discography / Discogram |
| 🞏 | 🞏 | 🞏 | 🞏 | Epidurolysis / Neurolysis / Cryolysis |
| 🞏 | 🞏 | 🞏 | 🞏 | Joint and bursal sac injection |
| 🞏 | 🞏 | 🞏 | 🞏 | Sympathectomy techniques |
| 🞏 | 🞏 | 🞏 | 🞏 | Peripheral Nerve Stimulator use including but not limited to P-Stim Application |
| 🞏 | 🞏 | 🞏 | 🞏 | Administration of local anesthesia with or without oral sedation. This requires ability to manage local anesthetic or sedation overdose, including airway management and resuscitation [ ACLS Required ] |
| 🞏 | 🞏 | 🞏 | 🞏 | Management of therapies, side effects and complications of pharmacologic agents used in Pain Mgt. |
| 🞏 | 🞏 | 🞏 | 🞏 | Operation, interpretation and reporting of X-ray and C-arm imaging |

*SPECIAL PROCEDURES / TECHNIQUES:* To be eligible to apply for a special procedure listed below, you must demonstrate successful completion of an approved, recognized course, OR provide documentation of competence in performing that procedure (i.e. provide ten (10) operative reports for that same procedure), OR provide current Delineation of Privileges from a Hospital to perform that same procedure.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Requested | Not Requested | Granted | Denied | Procedure |
| 🞏 | 🞏 | 🞏 | 🞏 | Percutaneous Lumbar Discectomy |
| 🞏 | 🞏 | 🞏 | 🞏 | Endoscopic Rhizotomy |
| 🞏 | 🞏 | 🞏 | 🞏 | Radiofrequency Denervation |
| 🞏 | 🞏 | 🞏 | 🞏 | Spinal Cord Stimulator Trials |
| 🞏 | 🞏 | 🞏 | 🞏 | Implantation of Dorsal Column Stimulator and Pulse Generator |
| 🞏 | 🞏 | 🞏 | 🞏 | Other: 1. |
| 🞏 | 🞏 | 🞏 | 🞏 |  2. |
| 🞏 | 🞏 | 🞏 | 🞏 |  3. |

I agree to admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of my privileges, use all skills normally learned during medical school and residency, and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

I will practice within the bounds of my training and competence and will not attempt to treat cases which are not in my scope of practice. I understand that any newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. I will become familiar with the capabilities and limitations of this Facility.

I understand that in making this request I am bound by the applicable Bylaws and/or Policies & Procedures of Surgicore of Jersey City LLC, and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry our requested procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Applicant’s Name Printed Applicant’s Signature

Above privileges, as requested, are recommended to the Board of Directors for formal approval to work at the center.

Granted \_\_\_\_\_\_\_\_\_ Deferred \_\_\_\_\_\_\_\_ Medical Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Granted \_\_\_\_\_\_\_\_\_ Deferred \_\_\_\_\_\_\_\_ Administrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_