Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_________________________________ _______________________

Print Name Date

Privilege Request Form –Neurological Surgery

SECTION I – GENERAL REQUIREMENTS NEUROLOGICAL SURGERY

Requested Staff Category

______ Active _______ Courtesy _______ Consulting _______ Affiliate

Basic Education: MD or DO

INITIAL APPOINTMENT

Minimal formal training and experience

- Successful completion of an ACGME-accredited Neurological Surgery residency program or clinical fellowship training program or an AOA- approved training program in Neurological Surgery.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency referenced above, must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director of the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.
- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- Certification by the American Board of Neurological Surgery, American Osteopathic Board of Neurological Surgery is preferred.
- Interview by the Medical Director and/or Chief of Staff when requested.

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR

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- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

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SECTION II – PRIVILEGES REQUESTED

Core Procedures	**Requested**	**Granted**	**Denied**
Admit Patients			
Perform H & P			
Provide consultation to determine need for surgical intervention			
Order diagnostic studies & procedures			
Order medications			
Post-surgical evaluation and treatment			
Medical management of post-surgical patients using prudent and good medical judgment for appropriate consultation			

Surgical Procedures	**# of Procedures in last 12 months**	**Requested**	**Granted**	**Granted w Conditions**	**Denied**
Aneurysms, Intracranial					
Anterior cervical fusion, open/close					
Biopsy or incision, open/closed					
Burrholes					
Carotid and vertebral Angiograms, interpretation of					
Carotid Endarterectomy					
Central venous access – subclavian, jugular route					
Cerebrovascular disease, evaluation and management of					
Chiari malformation, repair of					
Cranial and spinal CT scans, interpretation of					
Cranial and spinal wounds, open/close including dural opening and repair					
Cranial reconstruction for congenital and acquired deformities					
Cranial vault expansion					
Craniectomy					
Cranioplasty					
Craniotomy					
CT guided biopsy					

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Surgical Procedures	# of Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
Detehering procedures, uncomplicated					
Diagnostic Angiography					
Diagnostic Cervicocerebral Angiography					
Diskectomy, open/close					
Electroencephalogram, interpretation of					
Electroencephalography (EEG)					
Electromyography (EMG)					
Endoscopic Carpal Tunnel					
Endoscopy, Intraventricular					
Extracranial carotid surgery					
Extracramial vascular disease, management of					
Functional mapping					
General Lumbar Puncture					
General lumbar puncture, children					
Intracranial encephalocele, repair of					
Intacranial hematoma, evacuate					
Intrathecal Baclofen Pump Implantation (ITB)					
Intraventricular puncture, children					
Jugular shunt placement or revision					
Laminectomy, cervical open/closed					
Laminectomy, lumbar open/close					
Laminectomy, thoracic open/closed					
Lobectomy, temporal					
Myelography					
Neoplasms, intracranial/spinal					
Nerve Biopsy					
Neurologic bladder control, management of					
Non-traumatic and traumatic lesions MRI, interpretation of					
Pleural shunt placement or revision					
Posterior fossa and supratentorial lesions, removal					
Radiographic studies of truma patients, interpretation of					
Radiosurgery					

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Surgical Procedures	# of Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
Rhizotomy					

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Surgical Procedure	**# of Procedures in last 12 months**	**Requested**	**Granted**	**Granted w Conditions**	**Denied**
Shunt tap					
Skeletal tongs, placement of					
Spinal Angiograms, interpretation of					
Spinal myelograms and postmyelogram CT scans, interpretation of					
Spinal or cranial neural tube defect, open/closed					
Spine disorder, management of					
Stereotactic biopsy					
Stereotaxic surgery					
Subarachnoid and subdural hemorrhage, management of					
Subdural puncture, children					
Sympathectomy for autonomic dystrophy					
Synostectomy, sagittal					
Transcranial Doppler Untrasonography n(TCD)					
Transohenoidal surgery					
Trauma and tumors of the nervous system, management of					
Traumatic brain injury, management of					
Ulnar transposition					
Vagas Nerve Stimulator implantation					
Ventriculoperitoneal shunt placement or revision					
Ventriculostomy					

SECTION III - ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records, and information are available that verify my qualifications and competency to practice urological surgery or any other special privileges I have requested and to perform the requested procedures.

I understand that

- In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

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- Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.
- The use of any other new, untried, or unproven procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner.

_______________________________________ _______________________________

PHYSICIAN SIGANTURE **DATE**

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____________________________________ ________________________

Print Name Date

SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

______ Approval of all requested privileges

______ Approval of the following privileges with conditions:
____

______ Denial of the following privileges:
____

____ ___________________________

Medical Director **Date**

Recommendation of the Medical Executive Committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

______ Approval of all requested privileges

______ Approval of the following privileges with conditions:
____

______ Denial of the following privileges:
____

____ ___________________________

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___________________________________ _______________________
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Chief of Staff **Date**

Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

______ granted all requested privileges

______ granted the following privileges with conditions:
____

_____ denied the following privileges:
____

_____________________________________ ___________________________
Chairman of the Board **Date**