Providence Hospital
of North Houston

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

_____ _____
Print Name Date

Privilege Request Form –Pain Management

SECTION I – GENERAL REQUIREMENTS PAIN MANAGEMENT

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 residency or fellowship training program or an AOA-approved training program.

- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency 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 or 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.

- Subspecialty qualification in Pain Management by the American Board of Anesthesiology or certified by the American Board of Pain Management is preferred.

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- Interview by the Medical Director and/or Chief of Staff when requested.

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REAPPOINTMENT MAINTENANCE OF PRIVILEGE

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

SECTION II – PRIVILEGES REQUESTED

Procedures	Requested	Granted	Denied
Admit Patients			
Perform History & Physical			
Provide consultation to determine need for surgical intervention			
Evaluation and diagnosis of medical conditions to determine need for surgical intervention with regard to appropriate consultation when prudence and good medical care so requires.			
Evaluation and diagnosis of acute and chronic pain syndromes			

Procedure	# procedures in last 12 months	Requested	Granted	Granted w conditions	Denied
Management of acute and chronic pain syndromes using short term pharmaceutical and therapeutic procedures limited to :					
SPINAL					
• Diagnostic					
• Therapeutic					
• Continuous					
EPIDURAL					
• Continuous					
• One shot					
• Caudal					
• thoracic					

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• Lumbar tanslaminar epidural steroid injections					
• Epidural blood patches					

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NERVE BLOCKS					
• Stellate ganglion					
• Paravertebral lumbar					
• Axillary					
Moderate sedation					
Trigger Point Injections					
The management of acute and chronic pain syndromes using of a broad range of therapeutic modalities, including					
Psycho logic pharmacotherapy					
Cryotherapy					
Neurolysis					
Plexus blockade					
Neuraxial blockade					
Neuroablations					
Paravertebral sympathetic blocks					
Joint Injections					
Placement of implantable neuroaugmentative infusion pumps					
Placement of neuro					
Intradiscal electrothermal therapy					

I have been approved for these procedures at the following hospitals/ambulatory surgery centers:

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SECTION III - ACKNOWLEDGE 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 as requested.

I understand that:

1. 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.
2. 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.
3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe 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 SIGNATURE **DATE**

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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**