SCOTLAND MEMORIAL HOSPITAL
Clinical Privilege Delineation Form
Specialty: *PEDIATRICS*

PHYSICIAN NAME:______________________________

I. ***General Privileges***

By virtue of being granted any level of clinical privileges, a physician is automatically granted the following privileges:

Performing physical examinations and ordering and interpreting of diagnostic studies that are normally considered part of the practice of Pediatrics, including, but not limited to, laboratory, diagnostic imaging, and electrocardiographic studies.

Prescribing and administering medications normally considered part of the practice of Pediatrics.

Requesting consultations and technical procedures to be performed by other physicians and qualified consultants/technicians.

At the time of a clinical emergency, the provision of whatever care the physician believes to be indicated to prevent loss of life or serious injury to a patient.

II. ***Specific Privileges: Clinical***

Three categories of clinical privileges may be granted for each clinical area listed on the following page. The category of privileges being requested, if any, must be indicated next to the specific clinical area being addressed.

Category 1: Uncomplicated illnesses or problems that present no serious threat to life, and which are expected to require only a short period of hospitalization. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

Category 2: Major illnesses, injuries, or conditions, but with no significant risk to life. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

Category 3: Major illnesses, injuries, or conditions that carry substantial threat to life. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

GENERAL MEDICAL PRIVILEGES: In the area marked "Level of Privileges Requested" **circle** the number indicating the level of privileges that you wish to be granted in each of the areas listed. **"LEVELS NOTED IN RED"**

Area	Level of Privileges Requested	Approved	Not Approved/ Approved with Restrictions	Area	Level of Privileges Requested	Approved	Not approved/ Approved with Restrictions
Allergy	**1 2 3**			Genitourinary Diseases	**1 2 3**		
Cardiac Diseases	**1 2 3**			Musculoskeletal Diseases	**1 2 3**		
Collagen Diseases	**1 2 3**			Neurologic Diseases	**1 2 3**		
Hematological Diseases	**1 2 3**			Pulmonary Diseases	**1 2 3**		
Hepatic Diseases	**1 2 3**			Renal Diseases	**1 2 3**		
Gastrointestinal Diseases	**1 2 3**			Metabolic/Endocrine Diseases	**1 2 3**		

NURSERY PRIVILEGES

Privilege	Requested	Approved	Not Approved/ Approved with Restrictions
Attend High-Risk Deliveries			
Attend Cesarean Section Deliveries			
Normal Care of Newborn Infants (birthweight $\geq$ 2,000 grams)			
Care of Newborn Infants (birthweight $\geq$ 2,000 grams) with Complications			
Care of Pre-Term or Low Birth Weight Infants without Potentially Life-Threatening Illness			
Care of Pre-Term or Low Birth Weight Infants with Potentially Life-Threatening Illness			

SURGICAL PROCEDURES

Procedure	Requested	Approved	Not Approved/ Approved with Restrictions	Procedure	Requested	Approved	Not Approved/ Approved with Restrictions
Local Anesthesia				Bladder Catheterization			
Digital Blocks				CVP Line Placement			
I&D of Abscess				Periph Arterial Cutdown			
Circumcision				Periph Venous Cutdown			
Meatotomy				Periph Arterial Puncture			
Spinal Tap				Periph Venous Puncture			
Subdural Tap				Intubation			
Thoracentesis				Myringotomy			
Paracentesis				Exchange Transfusion			
Pericardiocentesis				Umbilical Catheterization			

Anoscopy				Suture Minor Laceration			

OTHER

Procedure	Requested	Approved	Not Approved/ Approved with Restrictions	Procedure	Requested	Approved	Not Approved/ Approved with Restrictions
Transthorauc Echcardiology							
ECG Interpretation							
Holter Interpretation							

I hereby request clinical privileges as outlined above.

Signature: ____ Date: _____ /_____ /_____

DEPARTMENT CHAIRMAN APPROVAL

NOTE: Any request indicated as "Not Approved or Approved with Restrictions" must be explained here, including listing any restrictions.

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I have reviewed this application and recommend clinical privileges as indicated above.

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Chairman, Department of Pediatrics Date