SCOTLAND MEMORIAL HOSPITAL
Privileges Delineation Form
Specialty: Tele-Neurology

PHYSICIAN: _____

TELE-NEUROLOGY CORE PRIVILGES			
	Requested	**Approved**	**Not Approved/ Approved with Restrictions**
Evaluation and treatment of patients great than 18 years of age presenting with emergency neurological illnesses including, but not limited to, acute stroke, stroke, and threatened stroke (TIE or Transient Ischemic Attack).	☐	☐	☐
Studies obtaining an orderly and detailed history from the patient, family and staff.	☐	☐	☐
Conducting a through and timely neurology examination with HIPAA-compliant, two-way radio, and HIPAA-compliant, two-way video-conferencing technology.	☐	☐	☐
Reviewing and personally interpreting relevant brain imaging studies.	☐	☐	☐
Reviewing and correlating the results of other relevant diagnostic tests with the patient's clinical history and examination to formulate a differential diagnosis and recommend an evaluation and management plan.	☐	☐	☐
Reviewing and personally interpreting non-invasive intracranial and extracranial vascular studies.	☐	☐	☐
Remote interpretation and reporting of other tests.	☐	☐	☐

Acknowledgement of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise.

In exercising any clinical privileges granted, I am constrained by Medical Staff policies and rules applicable generally and any applicable to the particular situation.

I request the clinical privileges listed above.

Applicant's Signature: _____ Date: _____/_____/_____

Department Chairman Comments

Any request indicated as "Questions Or Restrictions Recommended" must be explained here, including listing any restrictions.

I have reviewed this request for privileges and the applicant's qualifications and competency to exercise clinical privileges as noted above.

Department Chairman **Date**