Surgical Privileges Form:

Clinical Privileges Request

Neurosurgery (Core Privileges)

Applicant's Name: ……..……

Scope of Practice: …….

License No. (If Any): ……..……..

Facility: ……..

Date: ……

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	

CATEGORY I: Cranial Procedures (Core Privileges

1. Surgery for cranial trauma				
2. Surgery for convexity/superficial brain tumors				
3. Surgery for deep and complex skull base tumors				
4. Surgery for posterior fossa brain tumors				
5. Surgery for cerebral aneurysm or Arterio Venous Malformation and other vascular lesions				

A. Spinal Procedures / Surgeries

1. Epidural steroid injections for pain				
2. Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion				
3. Lumbar subarachnoid-peritoneal shunt				
4. Endoscopic Minimally invasive Surgery				
5. Cordotomy, rhizotomy and spinal cord stimulators for the relief of pain				
6. Radiofrequency ablation				

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7. Selective blocks for pain medicine, stellate ganglion blocks				

B. Peripheral Nerve Procedures

1. Peripheral nerve procedures, including decompressive procedures and reconstructive procedures on the peripheral nerves				
2. Nerve blocks				
3. Nerve biopsy				
4. Muscle biopsy				

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	

C. Other Procedures

1. Intra Cranial Pressure insertion				
2. Lumbar Drain				
3. External Ventricular Drain				
4. Lumbar puncture, cisternal puncture, ventricular tap, subdural tap				
5. Shunts: ventriculoperitoneal, ventriculoatrial, ventriculopleural, subdural peritoneal, lumbar subarachnoid/peritoneal (or other cavity)				

D. Surgery for Congenital Anomalies

1. Surgery for craniosynostosis				
2. Surgery for Chairi malformation				
3. Management of congenital anomalies, such as encephalocele, meningocele, myelomeningocele				

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E. Endovascular Procedures

1. Performing and interpreting diagnostic imaging studies related to the vasculature of the Central Nervous System, head, neck, and spine.				
2. Participating in short-term and long-term post procedure follow-up care, including neurointensive care				
3. Transarterial and transvenous catheterization of the arteries and veins of the Central Nervous System, skull, face, neck, and spine.				

CATEGORY IV: Additional Privileges:

Note: You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's policies and rules applicable generally and any applicable to the particular situation.
b) 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 recognized policies and rules.

…….. ……

Applicant's signature (Stamp if any) Date

…….. ……

1. Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

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Name of applicant: ----------

For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

…….. ……
Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……
1) Name Date

…….. ……
1) Name Date

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