

**LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
 DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF PSYCHIATRY
 NURSE PRACTITIONER**

NAME OF APPLICANT _____ DATE _____

Initial Appointment and/or Additional Privileges Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair/Chief/Supervising Physician or Designee: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Follow department guidelines and standardized procedures, policies and protocols found in the Advance Practice Nursing Policy and Procedures Manual. Core Privileges: Basic privileges in Psychiatry include: - Institute treatment essential for the life of the patient (i.e. ACLS), - Transfer patients to observation areas, - Obtain a history, - Perform a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Obtain informed consent for procedures, - Perform and/or assist in the performance of diagnostic studies within the scope of specialty services, - Perform and/or assist in the performance of therapeutic procedures within the scope of specialty services, - Monitor patients throughout procedure and during recovery period, - Determine assessment and interval for follow up, - Conduct patient and family education, - Manage and provide consultations, - Document patient interactions, - Document care rendered in medical record, and - Complete discharge summaries of patients. for the following ages:			

M = LAC+USC Medical Center
 E = El Monte Comprehensive Health Center
 H = Hudson Comprehensive Health Center
 R = Roybal Comprehensive Health Center

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Children from 3 to 13 years of age			
				Adolescents from 13-17 years of age			
				Adults (ages 18 and older)			
				Furnishing of written orders for medications and medical devices.			
				1. TREATMENT			
				Psychotherapy			
				Psychotropic Medication			
				2. Complete LPS commitment paperwork, including medication capacity hearings, and present findings at the probable cause hearings and medication capacity hearings.			

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Revised: 3/2012

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PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient’s life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

 APPLICANT’S SIGNATURE

 DATE

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Department Chair/Chief/Supervising Physician or Designee:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#: _____
 Condition/Modification/Explanation: _____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#: _____
 Explanation for NOT recommending based on
 COMPETENCY: _____

If supplemental documentation provided, check here:

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_____ SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE	_____ DATE
_____ SIGNATURE OF THE SUPERVISING PHYSICIAN	_____ DATE

APPROVED BY INTERDISCIPLINARY PRACTICE COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

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