



Surgical Privileges Form:

Clinical Privileges Request

"Neurosurgery"

Applicant's Name:

Scope of Practice:

License No. (If Any):

Facility:

Date:

Place of Work:

Privileges	For applicant use		For committee use		
	Request	Signature	Recommen- -ded	Not Recommended	Signature

CATEGORY I: Advanced Privileges

A. Cranial Procedures

1. Surgery for deep and complex skull base tumors					
2. Surgery for cerebral aneurysm or Arterio Venous Malformation and other vascular lesions					
3. Posterior fossa-microvascular decompression procedures					
4. Trans sphenoidal surgery for sellar / para /supra sellar lesions and Repair of Cerebro spinal fluid leak					
5. Robot assisted surgery for brain biopsy and resection					
6. Cranial endoscopic procedures including 3rd ventriculostomy and others					
7. Insertion of depth electrodes/subdural mats/electrodes for epilepsy					



8. Ablative surgery for epilepsy					
9. Stereotactic deep brain stimulation					
10. Stereotactic radiosurgery					

B. Spinal Procedures / Surgeries

1. Endoscopic Minimally invasive Surgery Cordotomy, rhizotomy and spinal cord stimulators for the relief of pain					
2. Selective blocks for pain medicine, stellate ganglion blocks					
3. Surgery on the sympathetic nervous system					
4. Percutaneous nucleoplasty for disc disease					

C. Surgery for Congenital Anomalies

1. Surgery for craniosynostosis					
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D. Endovascular Procedures

1. Transarterial and transvenous catheterization of the arteries and veins of the Central Nervous System, skull, face, neck, and spine.					
2. Embolization of arterial and venous vascular lesions of the central nervous system and the vessels supplying the structures of the Central Nervous System, skull, face, neck, and spine with embolic agents including but not limited to coils, glue, and particles.					
3. Intracranial arterial stent placement.					
4. Spinal angiography					



5. Intra-arterial and intra-venous injection of thrombolytic agents for clot lysis therapy in vessels supplying or draining the Central Nervous System or its related bony and soft tissue structures.					
6. Intra-arterial and intra-venous injection of non-thrombolytic agents for diagnostic testing and treatment of disease in vessels supplying or draining the CNS or its related bony and soft tissue structures.					

CATEGORY IV: Additional Privileges:

Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- 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.
- Granting privileges under supervision is no longer permitted

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.



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Applicant's signature (Stamp if any)

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Date

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

.....
Date

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

.....
2) Name

.....
Date