MIDLAND MEMORIAL HOSPITAL
Delineation of Privileges
CHILD AND ADOLESCENT PSYCHIATRIC MEDICINE

Your home for healthcare

Physician Name: _____

Child and Adolescent Medicine Core Privileges

Qualifications

Minimum threshold criteria for requesting core privileges in child and adolescent psychiatric medicine:

- Basic education: MD or DO
- Successful completion of an ACGME or AOA-accredited residency in family medicine, pediatrics, or internal medicine, followed by successful completion of an accredited fellowship in child and adolescent psychiatric medicine.

AND

- Current certification or active participation in the examination process (with achievement of certification within 5 years) leading to certification in child and adolescent psychiatric medicine by the ABP or ABIM, or a Certificate of Added Qualifications in child and adolescent psychiatric medicine by the ABFM or in child and adolescent and young adult psychiatric medicine by the AOBP. *(*Members of the Staff prior to the adoption of Bylaws 10/2007 are considered grandfathered in and are encouraged but not required to achieve board certification)*

Required previous experience:

- Provision of clinical ambulatory or inpatient services, reflective of the scope of privileges requested, to 30 child and adolescent patients during the previous 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the prior 12 months.

References for New Applicants

A letter of reference should come from the director of the applicant's child and adolescent psychiatric medicine training program. Alternatively, a letter of reference regarding competence should come from the chief of child and adolescent psychiatric medicine at the institution where the applicant most recently practiced.

Reappointment

Reappointment should be based on unbiased, objective results of care according to the organization's existing quality improvement measures. Applicants must demonstrate that they have maintained competence by showing evidence that they have provided child and adolescent psychiatric medicine inpatient or consultative services for at least 50 patients in the past 24 months. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

Please check requested privileges.

<table>
<tr><td>Requested ❑</td><td>Approved ❑</td><td>Not Approved ❑</td><td rowspan="2">Core privileges include but are not limited to:
• History and physical examinations
• Provide care to patients in the intensive care setting in conformance with unit policies.
• Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
• Consultation with physicians in other fields regarding mental, behavioral, or emotional disorders, pharmacotherapy, psychotherapy (individual family or group), behavior modification, cognitive therapy.
• Treatment of psychiatric disorders in children and adolescents with severe physical illness, consultation to the courts, and emergency psychiatry</td></tr>
<tr><td colspan="3">Core Privileges: Admit, evaluate, diagnose, treat, and provide consultation to children and adolescents who suffer from developmental, mental, behavioral, addictive, or emotional disorders as well as the ordering of diagnostic laboratory tests and prescribing medications.</td></tr>
<tr><td>Requested ❑</td><td>Approved ❑</td><td>Not Approved ❑</td><td>Criteria</td></tr>
<tr><td colspan="3">Telepsychiatry or Telemedicine</td><td>Privileges include diagnosis and assessment; medication management; individual and group therapy; consultative services between psychiatrists, primary care physicians and other healthcare providers.</td></tr>
<tr><td>Requested ❑</td><td>Approved ❑</td><td>Not Approved ❑</td><td>Criteria</td></tr>
</table>

<table>
<tr><td colspan="3">Refer-and-follow privileges</td><td>Privileges include performing outpatient preadmission history and physical, ordering noninvasive outpatient diagnostic tests and services, visiting patients in the hospital, reviewing medical records, consulting with the attending physician, and observing diagnostic or surgical procedures with the approval of the attending physician or surgeon.</td></tr>
<tr><td>Requested ❑</td><td>Approved ❑</td><td>Not Approved ❑</td><td>Privilege/Criteria</td></tr>
<tr><td colspan="3" rowspan="2">Current Privileges: List any current privileges not listed above in core or non-core. These privileges will remain in effect until the end of the current appointment period and then will be moved up to the appropriate core/non-core section.

Please provide criteria and supporting documentation to medical staff office for any non-core privileges listed.</td><td>Core
❑ _____
❑ _____
❑ _____
❑ _____</td></tr>
<tr><td>Non-Core
❑ _____
❑ _____
❑ _____
❑ _____</td></tr>
</table>

To the applicant: If you wish to exclude any privileges, please strike through the privileges that you do not wish to request and then initial.

I understand that by making this request, I am bound by the applicable bylaws or policies of the hospital, and hereby stipulate that I meet the minimum threshold criteria for this request. I have requested **only** those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Midland Memorial Hospital. I also acknowledge that my professional malpractice insurance extends to all privileges I have requested and I understand that:

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

(b) Applicants have the burden of producing information deemed adequate by Midland Memorial Hospital for a proper evaluation of current competence, other qualifications and for resolving any doubts.

(c) I will request consultation if a patient needs service beyond my expertise.

_____ _____
Physician's Signature/Printed Name Date

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:
❑ Recommend all requested privileges
❑ Recommend privileges with the following conditions/modifications:
❑ Do not recommend the following requested privileges:

Privilege Condition/modification/explanation
Notes:

_____

_____

_____ _____
Department Chair/Chief Signature Date