DEPARTMENT OF BEHAVIORAL WELLNESS

PSYCHIATRIC HEALTH FACILITY (PHF)

REQUEST FOR PRIVILEGES, DELINEATION AND CRITERIA
GENERAL MEDICAL SERVICES

PHYSICIAN'S NAME: _____

PRIVILEGES REQUESTED	CRITERIA
1. **MEDICAL CARE:** Perform physical examinations, order tests, diagnose and treat general medical conditions. REQUESTED ( ) YES ( ) NO	a. Board eligible/certified in Primary Care Specialty b. Current privileges, training or peer reviewed experience in the evaluation and treatment of general medical conditions.
2. **PHARMACOLOGY:** Prescribe medications and treatment to clients according to Medical Staff guidelines and PHF policies & procedures. REQUESTED ( ) YES ( ) NO	c. Board eligible/certified in Primary Care Specialty d. Current privileges, training or peer reviewed experience in the evaluation and pharmacologic treatment of clients with co-occurring medical and psychiatric conditions.
3. **OBSTETRICS & GYNECOLOGY:** Examine & treat gynecological problems of minor to moderate complexity (e.g. vaginitis; vaginal bleeding), and monitor uncomplicated pregnancy and/or STD infections. REQUESTED ( ) YES ( ) NO	a. Board eligible/certified in Primary Care Specialty b. Current privileges, training or peer reviewed experience in treating clients with gynecological problems of minor to moderate complexity or uncomplicated pregnancy and/or STD infections.
4. **MINOR SURGERY:** Examine and treat minor surgical problems/conditions (e.g. removal of small cysts, small biopsies, management of abscesses, hemorrhoids, ingrown toenails, repair small lacerations in non-vital areas, etc.). REQUESTED ( ) YES ( ) NO	a. Board eligible/certified in Primary Care Specialty b. Current privileges, training or peer reviewed experience in the treatment of minor surgical condition(s).
5. **MEDICAL CONSULTATION:** Perform medical consultation on clients when requested by other physicians. REQUESTED ( ) YES ( ) NO	a. Board eligible/certified in Primary Care Specialty b. Current privileges, training or peer reviewed experience in specific aspects of primary care medicine.

SIGNATURE OF PHYSICIAN REQUESTING PRIVILEGES:

_____ **Date:** _____

RECOMMENDATIONS TO THE GOVERNING BODY AND ACTION:

POSITION/TITLE	ACTION	SIGNATURE AND DATE
Manager, Behavioral Wellness Quality Care Management Division	( ) Approve ( ) Approve with Provisions ( ) Defer ( ) Disapprove	
Chair, Behavioral Wellness PHF Medical Practice Committee	( ) Approve ( ) Approve with Provisions ( ) Defer ( ) Disapprove	

PHF, Governing Body	( ) Approve ( ) Approve with Provisions ( ) Defer ( ) Disapprove	