HEALTHSOUTH®

Delineation of Privileges - ***Pain Management***

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES:	**Requested**	**Not Requested**	**Approved**	**Denied**
REGIONAL BLOCKS				
▪ Cervical nerves block				
▪ Upper extremities blocks				
▪ Lower extremities blocks				
▪ Bier blocks				
▪ Paravertebral blocks				
▪ Intercostal blocks				
SYMPATHETIC BLOCKS				
▪ Stellate ganglion block				
▪ Paravertebral lumbar				
▪ Sympathetic blocks				
Epidural steroid injection				
Indwelling epidural catheter/morphine pump				
Facet injections				
Other: Implantable pumps & spinal cord stimulators				

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **Pain Management** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

_____ _____

Physician Date

APPROVAL:

Comments:

_____

_____

_____

_____

_____ _____

Medical Director/President, Medical Staff Date