

Albuquerque Surgery Center  
1720 Wyoming NE  
Albuquerque, NM 87112

***Delineation of Practice Prerogatives – Surgical Assist***

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

PRACTICE PREROGATIVES:	Requested	Not Requested	Approved	Denied	Independent	MD/DO Present
Assist in management of acute medical emergencies						
Assist sponsoring physician in Operating Room						
Assist surgeon by holding retractors and/or holding limb						
Assist with patient positioning.						
Cleanse and dress wounds						
Complete all necessary counts as per facility policy						
Decontamination and sterilization of instrumentation per facility policy and procedures						
Initiate verbal orders of sponsoring physician (to be countersigned by sponsoring physician within twenty-four hours.)						
Observe frequency of vital signs and clinical observations						
Order routine studies, diagnostic test and procedures per verbal order (to be countersigned by sponsoring physician within twenty-four hours)						
Remove sutures						
Set up sterile field in surgery following facility policy						
Suture minor wounds and lacerations (in presence of sponsoring physician)						
Troubleshoot equipment/appliances						
Assist with movement of patient to stretcher/bed						
Opening of sterile supplies						
Surgical scrub – gowning/gloving						
Surgical draping of patient						
Visualization of surgical site – sponging, retraction, suction, cauterization, clamping						
Suture tying, cutting						
Application surgical dressing						
Other: please specify						

Your initials as used in Medical Records - \_\_\_\_\_.

Your signature as used in Medical Records - \_\_\_\_\_.

I, \_\_\_\_\_, hereby request practice prerogatives in the Allied Health specialty of **Surgical Assist** as indicated. I understand that practice prerogatives requested may differ from those approved. I further understand that this request does not preclude me from requesting additional practice prerogatives in the future.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sponsoring Physician Signature

\_\_\_\_\_  
Date

APPROVAL:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Medical Director

\_\_\_\_\_  
Date