



ARTESIA GENERAL HOSPITAL

A FACILITY OF COMMUNITY HEALTH CORPORATION

NEUROLOGY

Life Threatening Emergencies: At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

Requested

Granted

| | | |
|-------|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____ | _____ | Diseases of the central nervous system, including the brainstem and spinal cord |
| _____ | _____ | Diseases of peripheral nerves, including traumatic, but not requiring surgical repair |
| _____ | _____ | Diseases of the neuromuscular junction, including toxic and metabolic conditions, but not requiring ventilatory support |
| _____ | _____ | Diseases of muscle, including dystrophies, inflammatory and metabolic myopathies, but not requiring ventilatory support |
| _____ | _____ | Diseases involving the cranial nerves, and/or the brainstem, but not requiring ventilatory or circulatory support, or parental alimentation |
| _____ | _____ | Hypertension |
| _____ | _____ | Arthritis |
| _____ | _____ | Diabetes mellitus without coma, including acidosis |
| _____ | _____ | Diseases of the central and/or peripheral nervous systems, myoneural junction and/or muscle-requiring ventilatory support and/or vascular assistance, with or without parenteral fluid/electrolyte/caloric maintenance |
| _____ | _____ | Cerebral or brainstem infarction, embolus or hemorrhage, with altered level of consciousness but without coma |
| _____ | _____ | Epilepsy, including cases difficult to control, but not including status epilepticus |
| _____ | _____ | Accelerated hypertension with encephalopathy, but without coma |
| _____ | _____ | Infectious diseases in patients with neurological impairment, including pulmonary, renal and blood stream infections, endocarditis, purulent and non-bacterial meningitis, encephalitis and focal supportive encephalitis (abscess), but without focal cerebral mass effect |
| _____ | _____ | Renal, pulmonary and cardiac insufficiency and decompensation in patients with neurological disease |
| _____ | _____ | Systemic and focal vasculitides with involvement of the central nervous systems or the somatic musculature |
| _____ | _____ | Coma from all causes, including toxic, metabolic, infectious, inflammatory, degenerative disease, that due to endocrinopathy, with or without increased intracranial pressure(due to focal mass or of a more generalized nature) |
| _____ | _____ | Status epilepticus |
| _____ | _____ | All diseases of the central and/or peripheral nervous systems, myoneural junctions and/or somatic musculature leading to the need for ventilatory and/or vascular life-support systems, including patients requiring parenteral alimentation, including hyperalimentation |
| _____ | _____ | Invasive monitoring procedures including central venous pressures, and intra-arterial pressure lines |
| _____ | _____ | Other: _____ |
| _____ | _____ | Other: _____ |

Signature of Requesting Provider

Date

Signature of Chief of Staff/Medical Executive Committee

Date

Signature of Chairman of the Board

Date



CONFIDENTIALITY STATEMENT

I, _____, understand that in performance of my duties at Artesia General Hospital, I am required to have access to and am involved in the processing of patient care data. I understand that I am obligated to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subject to legal action. I agree to comply with information security policies for Artesia General Hospital concerning the privacy and confidentiality consideration of patient care.

Signature

Date



MEDICAL STAFF SIGNATURE AUTHENTICATION FORM

Medicare regulation 482.24, authentication of signature, requires that the medical records department maintain a current list of authenticated signature, written initials, codes and stamps, when such are used for authorship.

Physician Name and Title (PRINTED)

Date

Physician Signature

Physician Initials

Approved Signature Stamps or Seals:

Original: Credential File
CC: Pharmacy, Medical Records



PHYSICIAN'S ACKNOWLEDGEMENT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to obtain a signed ***Physician's Acknowledgement Statement*** from any physician who is being granted admitting privileges at that Hospital.

Your signature acknowledges that you have received the following notice [42 CFR 41246 (b)]:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

Physician Name and Title (PRINTED)

Date

Physician Signature

UPIN/NPI #



BYLAWS ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have read and understood the Medical Staff Bylaws, Rules and Regulations of Artesia General Hospital.

Furthermore, I agree to abide by all such Bylaws, Rules and Regulations, Hospital Policies and Directives during the time I remain appointed to the Medical Staff or Allied Health Professional Staff of Artesia General Hospital.

Physician Name and Title (PRINTED)

Date

Physician Signature