Lakeview Surgery Center

DELINEATION OF PRIVILEGES FOR - <u>GENERAL / PEDIATRIC / ORAL MAXILLOFACIAL DENTISTRY</u>

<u>General Dentistry</u> privileges-the following minimum threshold criteria must be met:

1. Licensed by the State of Iowa as D.D.S. or D.M.D.

Provide diagnostic, preventive, and therapeutic oral health care, inclusive of cleaning, fillings and simple extractions to patients of all ages to correct or treat various routine conditions of the oral cavity.

Requesting For:	Requested	Granted	
	□	□	Preventative Care for the teeth
	□	□	Simple surgical extractions
	□	□	Restorations / Fillings to the teeth
	□	□	Administration of local anesthesia
	□	□	Operation and interpretation of X-rays imaging
	□	□	Supervision of Allied Health Practitioner/Residents/Students

<u>Pediatric Dentistry</u> privileges-the following minimum threshold criteria must be met:

1. Licensed by the State of Iowa as D.D.S. or D.M.D., **And**
2. Completion of an accredited ADA residency in pediatric dentistry

Restore, consult, work up, and provide diagnostic, preventive, and therapeutic oral health care of children from birth through adolescence to correct or treat various routine conditions of the oral cavity. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate mental, physical or emotional problems.

Requesting For:	Requested	Granted	
	□	□	Preventative Care for the teeth
	□	□	Simple surgical extractions
	□	□	Restorations / Fillings to the teeth
	□	□	Administration of local anesthesia
	□	□	Operation and interpretation of X-rays imaging
	□	□	Simple Frenotomy
	□	□	Supervision of Allied Health Practitioner/Residents/Students

<u>Oral Maxillofacial</u> privileges-the following minimum threshold criteria must be met:

1. Licensed by the State of Iowa as D.D.S. or D.M.D., **And**
2. Completion of an accredited ADA residency in oral and maxillofacial

The ability to work up, and perform surgical procedures on patients of all ages presented with illnesses, injuries, and disorders of both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Inclusive of preventive, reconstructive or emergency care for the teeth, mouth, jaws and facial structure.

Requesting For:	Requested	Granted	
	□	□	Preventative / Reconstructive care for the teeth, mouth, jaws or facial structures
	□	□	Exploration / Debridement / Excision / Biopsy / Drainage / Repair oral cavity lesions
	□	□	Mandible bone grafting
	□	□	Implant placement and removal
	□	□	Administration of local anesthesia
	□	□	Operation and interpretation of X-rays imaging
	□	□	Supervision of Allied Health Practitioner/Residents/Students

You are granted privileges to admit patients, perform histories and dental clinical examinations, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during dental school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility. **Patients having dental surgery must have a History & Physical by a physician no more than 30 days prior to the day of surgery. If this H&P does not support the need for surgery, you will be required to complete a dental plan to document the need for surgery.**
You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request and have provided supportive documentation. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

Date : _____ Physician Signature : _____ Printed Name: _____

Privileges:

Granted _____ Deferred _____ MEC Signature: _____ Date: _____

Granted _____ Deferred _____ GB Signature: _____ Date: _____

Modifications: _____