Huntington Hospital

Delineation Of Privileges

Perfusion Assistant

Provider Name:

Privilege	Requested	Deferred	Approved

JOB DESCRIPTION:

The Perfusionist is responsible to the chair fo the Department of Cardiothoracic Surgery under the direct supervision of the supervising physician and/or Perfusionist. The Perfusionist Assistant is responsible for the surgical patient while under the auspices of his/her specialty. The responsibility encompasses the knowledgeable operation of various therapeutic and operational modalities with the application of the appropriate physiological principles of such modalities.

QUALIFICATIONS:

1. One (1) year medical field experience preferred
2. Current BLS certification from the American Heart Association

Assist the Perfusionist/supervising physician in providing support, treatment, measurement, and/or supplementation for the following procedures: ___ ___ ___

- Routine and emergent extracorporeal bypass
- Percutaneous extracorporeal support
- Ventricular assistance and/or bridge to transplantation initiation and/or monitoring
- Extracorporeal membrane oxygenation
- Patient monitoring

Provide complete clinical services, including: ___ ___ ___

- Intra-aortic (IAB) counterpulsation
- Blood salvaging, auttransfusion, and platelet gel therapy
- Organ procurement

Act as a resource person for medical personnel, and/or allied health personnel ___ ___ ___

Provide documentation of procedures and point of care of testing devices ___ ___ ___

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privileges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

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Signature of AHP: _____ Date:_____

Signature of Supervising Physician: _____ Date:_____

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:

I have reviewed the requested practice privileges and supportive documentation for the above names applicant and recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: _____YES _____ NO

Exceptions/Limitations (Please Specify):

_____

Privileges Effective _____ to _____

APPROVALS:

Interdisciplinary Practice Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Date: _____