

DELINEATION OF CLINICAL PRIVILEGES - PULMONARY DISEASE

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. FACILITY
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INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Clinical privileges in this specialty include the diagnosis, evaluation, prevention, and treatment of diseases in adult and adolescent patients as in internal medicine, with special expertise in the areas of pulmonary disease. The following list of diagnostic and therapeutic modalities exemplifies the various areas of the subspecialty, but is neither inclusive nor exclusive.

NOTE: This document is to be used in conjunction with DA Form 5440-3, Delineation of Clinical Privileges - Internal Medicine.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested <i>(Justification attached)</i>	2 - Modification required <i>(Justification noted)</i>
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Requested	Approved		Requested	Approved	
		a. Tube thoracostomy			o. Pericardiocentesis
		b. Diagnostic bronchoscopy			p. Thoracentesis
		c. Interventional bronchoscopy			q. Arthrocentesis
		d. Bronchial brushing			r. Bone marrow aspiration
		e. Bronchial lavage			s. Bone marrow biopsy
		f. Bronchograms			t. Arterial puncture and cannulation
		g. Diagnostic and interventional laryngoscopy			u. Central venous puncture <i>(including subclavian, internal jugular, and femoral sites)</i>
		h. Transthoracic needle lung aspiration and biopsy			v. Pulmonary artery catheterization
		i. Pleural biopsy <i>(closed)</i>			w. Endotracheal intubation
		j. Transtracheal aspiration			x. Respirator management
		k. Percutaneous tracheostomy			y. Elective cardioversion
		l. Bronchoprovocation challenge			z. Cardiac pacemaker insertion
		m. Interpretation of:			aa. Spinal tap
		(1) Pulmonary function testing			ab. Administration of conscious sedation
		(2) Cardiopulmonary exercise testing			ac. Whole lung lavage under general anesthesia
		(3) Electrocardiograms			
		(4) Polysomnograms			
		n. Paracentesis			

LASER PRIVILEGES

Requests for laser privileges may require attendance at a formal laser training program(s), supporting documentation of training, experience, etc., acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibility for laser therapy. The necessary documentation in support of this request is attached.

Requested	Approved		Requested	Approved	
		a. YAG laser ablation via bronchoscopy			
		b. Photodynamic laser therapy			

COMMENTS

SIGNATURE OF PROVIDER

DATE (YYYYMMDD)

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested

Approval with Modifications *(Specify below)*

Disapproval *(Specify below)*

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*

SIGNATURE

DATE (YYYYMMDD)

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested

Approval with Modifications *(Specify below)*

Disapproval *(Specify below)*

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*

SIGNATURE

DATE (YYYYMMDD)