DELINEATION OF CLINICAL PRIVILEGES - VASCULAR SURGERY

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

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

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: Vascular surgery privileges involve preparation, surgical management, and post-operative care of patients of all age groups with diseases of, or trauma to, the peripheral vessels, including all arteries, veins, and lymphatics of the body, with the exceptions noted below.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
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	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Requested	Approved	
		a. Arterial Operations.
		(1) Aneurysmorraphy/endarterectomy/arterial bypass of all arteries with the exception of coronary and intracerebral vessels
		(2) Arteriovenous fistulae or shunt formation for renal dialysis
		(3) Amputations for severe vascular insufficiency
		(4) First rib/cervical rib resections for thoracic outlet syndrome
		(5) Sympathectomy for vascular insufficiency or spasm
		b. Endograft Placement.
		(1) Aortic or peripheral arteries for aneurysmal or occlusive disease
		c. Endovascular Operations.
		(1) Angioplasty and stenting of all arteries and veins with the exception of coronary and intracerebral vessels
		(2) Transfemoral and transbrachial arteriography with interpretation
		(3) Thrombolysis of all arteries and veins with the exception of coronary arteries and intracerebral vessels
		(4) Intraoperative arteriography
		(5) Angioscopy
		d. Portal Hypertension Operations.
		(1) Portacaval or mesocaval shunts, splenorenal shunts and others
		e. Venous Operations.
		(1) Vein stripping and avulsions, interruption of perforating veins including SEPS, treatments for spider veins including laser
		(2) Lymphangioplasty or lymphaticovenous shunts for lymphedema
		(3) Venography
		f. Non-invasive Vascular Laboratory Interpretations.
		g. Other. *(Specify)*

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 RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - VASCULAR SURGERY

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

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Arterial Operations.			
	(1) Aneurysmorraphy/endarterectomy/arterial bypass of all arteries with the exception of coronary and intracerebral vessels			
	(2) Arteriovenous fistulae or shunt formation for renal dialysis			
	(3) Amputations for severe vascular insufficiency			
	(4) First rib/cervical rib resections for thoracic outlet syndrome			
	(5) Sympathectomy for vascular insufficiency or spasm			
	b. Endograft Placement.			
	(1) Aortic or peripheral arteries for aneurysmal or occlusive disease			
	c. Endovascular Operations.			
	(1) Angioplasty and stenting of all arteries and veins with the exception of coronary and intracerebral vessels			
	(2) Transfemoral and transbrachial arteriography with interpretation			
	(3) Thrombolysis of all arteries and veins with the exception of coronary arteries and intracerebral vessels			
	(4) Intraoperative arteriography			
	(5) Angioscopy			
	d. Portal Hypertension Operations.			
	(1) Portacaval or mesocaval shunts, splenorenal shunts and others			
	e. Venous Operations.			
	(1) Vein stripping and avulsions, interruption of perforating veins including SEPS, treatments for spider veins including laser			
	(2) Lymphangioplasty or lymphaticovenous shunts for lymphedema			
	(3) Venography			
	f. Non-invasive Vascular Laboratory Interpretations.			
	g. Other. *(Specify)*			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*