DELINEATION OF CLINICAL PRIVILEGES - CRITICAL CARE MEDICINE

(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: Critical care medicine is a specialty that involves skills applicable to general internal medicine and its subspecialties, or general surgery. In addition, it requires special expertise in the evaluation, examination, diagnosis of and treatment of critically ill patients of all ages with a variety of intensive care disorders to include medical, surgical, and pediatric. The diagnostic and therapeutic modalities of this specialty may include all those listed on DA Form 5440-3 or DA Form 5440-13, as well as the following procedures. This list 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, or DA Form

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		Requested	Approved	
		a. Pediatric intensive care disorders			q. Lumbar cerebrospinal fluid examination
		b. Treatment of respiratory failure			r. Percutaneous placement of peritoneal dialysis catheter
		c. Thoracentesis			s. Peritoneal lavage and dialysis
		d. Paracentesis			t. Continuous hemofiltration dialysis
		e. Pericardiocentesis			u. Cardioversion including defibrillation
		f. Arthrocentesis			v. Transvenous pacemaker insertion
		g. Tube thoracostomy			w. Balloon tamponade of bleeding esophageal and gastric varices
		h. Flexible tube broncoscopy			x. Administration of conscious sedation
		i. Transtracheal needle aspiration			y. Supervision and application of respiratory therapy; gas humidification; positive pressure ventilation; postural drainage and percussion
		j. Intubation - Oral and nasotracheal			z. Other *(Specify)*
		k. Percutaneous tracheostomy			
		l. Ventilator management to include rapid frequency			
		m. Central monitoring line placement			
		n. Arterial line placement			
		o. Venous cutdown			
		p. Intracranial pressure monitoring			

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 - CRITICAL CARE MEDICINE

(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	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Pediatric intensive care disorders			
	b. Treatment of respiratory failure			
	c. Thoracentesis			
	d. Paracentesis			
	e. Pericardiocentesis			
	f. Arthrocentesis			
	g. Tube thoracostomy			
	h. Flexible tube broncoscopy			
	i. Transtracheal needle aspiration			
	j. Intubation - Oral and nasotracheal			
	k. Percutaneous tracheostomy			
	l. Ventilator management to include rapid frequency			
	m. Central monitoring line placement			
	n. Arterial line placement			
	o. Venous cutdown			
	p. Intracranial pressure monitoring			
	q. Lumbar cerebrospinal fluid examination			
	r. Percutaneous placement of peritoneal dialysis catheter			
	s. Peritoneal lavage and dialysis			
	t. Continuous hemofiltration dialysis			
	u. Cardioversion including defibrillation			
	v. Transvenous pacemaker insertion			
	w. Balloon tamponade of bleeding esophageal and gastric varices			
	x. Administration of conscious sedation			
	y. Supervision and application of respiratory therapy; gas humidification; positive pressure ventilation; postural drainage and percussion			
	z. Other *(Specify)*			

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

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