DELINEATION OF CLINICAL PRIVILEGES - NEPHROLOGY

(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.

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

Category I.

Uncomplicated illnesses or problems, that have low risk to the patient. Non-specialists with little or no residency training but with experience in the care of these conditions.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.

Major illnesses, injuries, conditions or procedures, but with no substantial threat to life. Significant graduate training in the specialty related to the conditions, or considerable experience in the care of the conditions.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.

Major illnesses, conditions, or procedures that carry substantial risk to life. Extensive training and experience to include completion of a certified Nephrology training program and board eligibility.

Requested	Approved	
		Category III clinical privileges

Category IV. Includes Categories I, II, and III.

Unusually complex or critical diagnosis or treatment with serious threat to life. Board certification in Nephrology.

Requested	Approved	
		Category IV clinical privileges

Common General Internal Medicine Outpatient Procedures:

The following general internal medicine procedures fall within the scope of practice of the nephrologist practicing in ambulatory settings.

Requested	Approved	Biopsy or other tissue sampling	Requested	Approved	Special testing with interpretation
		a. Arterial puncture			a. Electrocardiogram (EKG)
		b. Arthrocentesis & injection			b. Expiratory spirometry
		c. Flexible sigmoidoscopy			
		d. Sigmoidoscopic biopsy			**Other**
		e. Punch skin biopsy			a. Nasogastric (N/G) tube placement
					b. Foley catheter placement

Additional Procedures:

In addition to the above outpatient procedures, the nephrologist who rotates as an Attending on the inpatient service or who provides subspecialty care will perform and/or supervise additional general internal medicine procedures.

Requested	Approved	Biopsy or other tissue sampling	Requested	Approved	Central Venous Lines
		a. Bone marrow biopsy & aspiration at posterior iliac crest			a. Femoral vein puncture and cannulation
		b. Abdominal paracentesis			b. Internal jugular vein puncture and cannulation
		c. Lumbar puncture			c. Subclavian vein puncture and cannulation
		d. Thoracentesis			

Additional Procedures: *(Continued)*

Requested	Approved	Common Nephrology Procedures	Requested	Approved	
		a. Arterial puncture and cannulation			g. Percutaneous native kidney biopsy
		b. Hemodialysis			h. Percutaneous transplant kidney biopsy
		c. Hemofiltration/hemoperfusion			
		d. Peritoneal dialysis			
		e. Therapeutic plasma exchange (plasmapheresis)			**Special testing with interpretation**
		f. Continuous renal replacement therapy (CRRT).			a. Urinalysis

Emergency Procedures: Emergency procedures such as pericardiocentesis, arterial and central venous lines, transvenous pacemaker insertion, and endotracheal intubation may be performed by any physician if he/she is the most skilled practitioner present in a catastrophic situation. Such procedures will not normally be considered as part of the "elective" privileges of a nephrologist.

Requested	Approved		Requested	Approved	
		a. Emergency procedures			

Critical Care Procedures: With the appropriate training and experience, the nephrologist may be privileged to perform the following procedures:

Requested	Approved		Requested	Approved	
		a. Pulmonary artery catheter placement and interpretation			c. Ventilator management
		b. Elective cardioversion			

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 - NEPHROLOGY

(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
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	Category IV clinical privileges			
	Common General Internal Medicine Outpatient Procedures:			
	Biopsy or other tissue sampling			
	a. Arterial puncture			
	b. Arthrocentesis & injection			
	c. Flexible sigmoidoscopy			
	d. Sigmoidoscopic biopsy			
	e. Punch skin biopsy			
	Special testing with interpretation			
	a. Electrocardiogram (EKG)			
	b. Expiratory spirometry			
	Other			
	a. Nasogastric (N/G) tube placement			
	b. Foley catheter placement			
	Additional Procedures			
	Biopsy or other tissue sampling			
	a. Bone marrow biopsy & aspiration at posterior iliac crest			
	b. Abdominal paracentesis			
	c. Lumbar puncture			
	d. Thoracentesis			
	Central Venous Lines			
	a. Femoral vein puncture and cannulation			
	b. Internal jugular vein puncture and cannulation			
	c. Subclavian vein puncture and cannulation			

CODE	Common Nephrology Procedures	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Arterial puncture and cannulation			
	b. Hemodialysis			
	c. Hemofiltration/hemoperfusion			
	d. Peritoneal dialysis			
	e. Therapeutic plasma exchange (plasmapheresis)			
	f. Continuous renal replacement therapy (CRRT).			
	g. Percutaneous native kidney biopsy			
	h. Percutaneous transplant kidney biopsy			
	Special testing with interpretation			
	a. Urinalysis			
	Emergency Procedures			
	a. Emergency procedures			
	Critical Care Procedures			
	a. Pulmonary artery catheter placement and interpretation			
	b. Elective cardioversion			
	c. Ventilator management			

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

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