DELINEATION OF CLINICAL PRIVILEGES - OPHTHALMOLOGY

(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

Requested	Approved		Requested	Approved	
		General Ophthalmology			Pediatric Ophthalmology

PROCEDURES

EYELID			CONJUNCTIVA		
Requested	Approved		Requested	Approved	
		a. Laceration, partial thickness			a. Repair of lacerations
		b. Laceration, full thickness *(single or multiple)*			b. Removal of tumors
		c. Canalicular lacerations			c. Excision and repair of pterygium
		d. Total eyelid reconstruction -			d. Conjunctival transplantation
		(1) Upper eyelid			e. Conjunctival mucous membrane grafting
		(2) Lower eyelid			f. Cryotherapy
		e. Partial eyelid reconstruction -			g. Lysis of symblepharon
		(1) Upper eyelid			h. Fornix reconstruction
		(2) Lower eyelid			
		f. Canthus reconstruction - medial or lateral			
		g. Skin grafts to eyelids, upper or lower	**CORNEA**		
		h. Eyelash grafts	Requested	Approved	
		i. Eyebrow grafts			a. Lamellar keratoplasty
		j. Excision of eyelid tumors			b. Penetrating keratoplasty
		k. Eyelid incision and drainage *(I&D)*			c. Repair of lacerations
		l. Scar revision - eyelid, brows			d. Tumor excision
		m. Correction of blepharospasm			e. Removal of foreign body
		n. Correction of congenital eyelid deformities			f. Conjunctival flaps
		o. Dermabrasion			g. Cauterization procedures
		p. Repair of -			h. Relaxing incisions
		(1) Blepharochalasis			i. Astigmatism reduction procedures
		(2) Dermatochalasis, upper or lower lid			j. Keratoprosthesis
		(3) Epicanthus			k. Periosteal grafts
		(4) Telecanthus			l. Patch grafts
		(5) Ectropion, entropion			
		(6) Eyelid malposition	**LENS**		
		(7) Eyelid retraction	Requested	Approved	
		(8) Brow ptosis			a. Extracapsular cataract extraction
					b. Intracapsular cataract extraction
					c. Phaco-emulsification of cataract

LENS *(Continued)* Requested	Approved	
		d. Discission of lens capsule
		e. Capsulotomy
		f. Capsulectomy - partial or complete
		g. Intraocular lens -
		(1) Insertion
		(2) Removal
		(3) Repositioning
		h. Lensectomy using vitreous cutting device
		i. Phako-fragmentation
		j. Surgical capsulectomy

IRIS Requested	Approved	
		a. Extracapsular cataract extraction
		b. Intracapsular cataract extraction
		c. Phaco-emulsification of cataract
		d. Discission of lens capsule
		e. Capsulotomy
		f. Iridoplasty
		g. Laser iridotomy

GLAUCOMA Requested	Approved	
		a. Corneoscleral trephination
		b. Trabeculectomy
		c. Trabeculotomy
		d. Goniotomy
		e. Aspiration of anterior chamber
		f. Posterior sclerectomy
		g. Posterior sclerotomy
		h. Laser trabeculoplasty

SCLERA Requested	Approved	
		a. Suturing of sclera incisions, lacerations, and ruptures
		b. Scleral dissection and resection
		c. Scleral implant
		d. Scleral exoplant
		e. Diathermy of sclera
		f. Cryopexy of sclera
		g. Scleral graft

OCULAR MUSCLES Requested	Approved	
		a. Resection of ocular muscle, fixed
		b. Resection of ocular muscle, adjustable
		c. Resection of ocular muscle
		d. Myectomy of ocular muscle
		e. Myotomy of ocular muscle
		f. Tenectomy of ocular muscle
		g. Tenotomy of ocular muscle
		h. Tucking of ocular muscle
		i. Posterior fixation suture of ocular muscle
		j. Transplantation of ocular muscle

ORBIT Requested	Approved	
		a. Optic nerve decompression
		b. Orbitotomy -
		(1) Lateral
		(2) Anterior
		(3) Medial
		(4) Inferior
		c. Repair of -
		(1) Orbital floor fractures
		(2) Orbital wall fractures
		(3) Orbital rim fractures
		(4) Trimalar fractures
		(5) Orbital deformities
		(6) Exenteration deformity with bone /muscle/dermis-fat grafts
		d. Fine needle aspiration biopsy *(orbit)*
		e. Removal of foreign body *(orbit)*
		f. Antral/ethmoid decompression
		g. Exenteration, with or without skin grafts
		h. Orbital volume augmentation

LACRIMAL SYSTEM Requested	Approved	
		a. Biopsy lacrimal gland
		b. Excision of lacrimal gland tumors
		c. Dacryocystotomy
		d. Dacryocystectomy
		e. Conjunctival dacryocystorhinostomy
		f. Canalicular dacryocystorhinostomy
		g. Probing of lacrimal system
		h. Intubation of lacrimal collecting system
		i. Correction of punctal malposition
		j. Repair of lacrimal trauma
		k. Repair of lacrimal fistula
		l. Turbinate fracture

LACRIMAL SYSTEM *(Continued)* Requested	Approved	
		m. Dacryoadenectomy

RETINA Requested	Approved	
		a. Cryopexy of retinal holes
		b. Diathermy of retinal holes
		c. Intraocular laser photocoagulation
		d. Slit lamp laser photocoagulation
		e. Retinal membrane peeling
		f. Retinal suturing

CHOROID Requested	Approved	
		a. Cryopexy of choroid
		b. Diathermy of choroid
		c. Subretinal fluid drainage
		d. Intraocular gas injection
		e. Intraocular medication injections

VITREOUS Requested	Approved	
		a. Closed vitrectomy
		b. Open sky vitrectomy
		c. Aspiration of vitreous
		d. Intraocular medication injections

EYEBALL Requested	Approved	
		a. Removal of intra-foreign bodies
		b. Examination under anesthesia
		c. Enucleation, with or without implant
		d. Evisceration, with or without implant, with or without preservation of cornea

SOCKET RECONSTRUCTION Requested	Approved	
		a. Repair of extruding, extruded implant
		b. Scleral, facial patch grafting
		c. Dermis-fat grafting
		d. Socket augmentation for correction of enophthalmos
		e. Fornix reconstruction
		f. Repair eyelid structure weakness
		g. Mucous membrane grafting
		h. Repair of contracted sockets
		i. Socket expansion to correct congenital deformities

OTHER Requested	Approved	
		a. Cyclo-photocoagulation
		b. Indirect laser photocoagulation

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 - OPHTHALMOLOGY

(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	CLINICAL PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	General Ophthalmology			
	Pediatric Ophthalmology			
	PROCEDURE/SKILL			
	EYELID			
	a. Laceration, partial thickness			
	b. Laceration, full thickness *(single or multiple)*			
	c. Canalicular lacerations			
	d. Total eyelid reconstruction -			
	(1) Upper eyelid			
	(2) Lower eyelid			
	e. Partial eyelid reconstruction -			
	(1) Upper eyelid			
	(2) Lower eyelid			
	f. Canthus reconstruction - medial or lateral			
	g. Skin grafts to eyelids, upper or lower			
	h. Eyelash grafts			
	i. Eyebrow grafts			
	j. Excision of eyelid tumors			
	k. Eyelid incision and drainage *(I&D)*			
	l. Scar revision - eyelid, brows			
	m. Correction of blepharospasm			
	n. Correction of congenital eyelid deformities			
	o. Dermabrasion			
	p. Repair of -			
	(1) Blepharochalasis			
	(2) Dermatochalasis, upper or lower lid			
	(3) Epicanthus			
	(4) Telecanthus			
	(5) Ectropion, entropion			
	(6) Eyelid malposition			
	(7) Eyelid retraction			
	(8) Brow ptosis			

CODE	PROCEDURE/SKILL (*Continued*)	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	CONJUNCTIVA			
	a. Repair of lacerations			
	b. Removal of tumors			
	c. Excision and repair of pterygium			
	d. Conjunctival transplantation			
	e. Conjunctival mucous membrane grafting			
	f. Cryotherapy			
	g. Lysis of symblepharon			
	h. Fornix reconstruction			
	CORNEA			
	a. Lamellar keratoplasty			
	b. Penetrating keratoplasty			
	c. Repair of lacerations			
	d. Tumor excision			
	e. Removal of foreign body			
	f. Conjunctival flaps			
	g. Cauterization procedures			
	h. Relaxing incisions			
	i. Astigmatism reduction procedures			
	j. Keratoprosthesis			
	k. Periosteal grafts			
	l. Patch grafts			
	LENS			
	a. Extracapsular cataract extraction			
	b. Intracapsular cataract extraction			
	c. Phaco-emulsification of cataract			
	d. Discission of lens capsule			
	e. Capsulotomy			
	f. Capsulectomy - partial or complete			
	g. Intraocular lens -			
	(1) Insertion			
	(2) Removal			
	(3) Repositioning			
	h. Lensectomy using vitreous cutting device			
	i. Phako-fragmentation			
	j. Surgical capsulectomy			
	IRIS			
	a. Extracapsular cataract extraction			
	b. Intracapsular cataract extraction			
	c. Phaco-emulsification of cataract			
	d. Discission of lens capsule			
	e. Capsulotomy			

CODE	PROCEDURE/SKILL *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	IRIS *(Continued)*			
	f. Iridoplasty			
	g. Laser iridotomy			
	GLAUCOMA			
	a. Corneoscleral trephination			
	b. Trabeculectomy			
	c. Trabeculotomy			
	d. Goniotomy			
	e. Aspiration of anterior chamber			
	f. Posterior sclerectomy			
	g. Posterior sclerotomy			
	h. Laser trabeculoplasty			
	SCLERA			
	a. Suturing of sclera incisions, lacerations, and ruptures			
	b. Scleral dissection and resection			
	c. Scleral implant			
	d. Scleral exoplant			
	e. Diathermy of sclera			
	f. Cryopexy of sclera			
	g. Scleral graft			
	OCULAR MUSCLES			
	a. Resection of ocular muscle, fixed			
	b. Resection of ocular muscle, adjustable			
	c. Resection of ocular muscle			
	d. Myectomy of ocular muscle			
	e. Myotomy of ocular muscle			
	f. Tenectomy of ocular muscle			
	g. Tenotomy of ocular muscle			
	h. Tucking of ocular muscle			
	i. Posterior fixation suture of ocular muscle			
	j. Transplantation of ocular muscle			
	ORBIT			
	a. Optic nerve decompression			
	b. Orbitotomy -			
	(1) Lateral			
	(2) Anterior			
	(3) Medial			
	(4) Inferior			
	c. Repair of -			
	(1) Orbital floor fractures			
	(2) Orbital wall fractures			

CODE	PROCEDURE/SKILL *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	ORBIT *(Continued)*			
	(3) Orbital rim fractures			
	(4) Trimalar fractures			
	(5) Orbital deformities			
	(6) Exenteration deformity with bone/muscle/dermis-fat grafts			
	d. Fine needle aspiration biopsy *(orbit)*			
	e. Removal of foreign body *(orbit)*			
	f. Antral/ethmoid decompression			
	g. Exenteration, with or without skin grafts			
	h. Orbital volume augmentation			
	LACRIMAL SYSTEM			
	a. Biopsy lacrimal gland			
	b. Excision of lacrimal gland tumors			
	c. Dacryocystotomy			
	d. Dacryocystectomy			
	e. Conjunctival dacryocystorhinostomy			
	f. Canalicular dacryocystorhinostomy			
	g. Probing of lacrimal system			
	h. Intubation of lacrimal collecting system			
	i. Correction of punctal malposition			
	j. Repair of lacrimal trauma			
	k. Repair of lacrimal fistula			
	l. Turbinate fracture			
	m. Dacryoadenectomy			
	RETINA			
	a. Cryopexy of retinal holes			
	b. Diathermy of retinal holes			
	c. Intraocular laser photocoagulation			
	d. Slit lamp laser photocoagulation			
	e. Retinal membrane peeling			
	f. Retinal suturing			
	CHOROID			
	a. Cryopexy of choroid			
	b. Diathermy of choroid			
	c. Subretinal fluid drainage			
	d. Intraocular gas injection			
	e. Intraocular medication injections			
	VITREOUS			
	a. Closed vitrectomy			
	b. Open sky vitrectomy			
	c. Aspiration of vitreous			

CODE	PROCEDURE/SKILL *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	VITREOUS *(Continued)*			
	d. Intraocular medication injections			
	EYEBALL			
	a. Removal of intra-foreign bodies			
	b. Examination under anesthesia			
	c. Enucleation, with or without implant			
	d. Evisceration, with or without implant, with or without preservation of cornea			
	SOCKET RECONSTRUCTION			
	a. Repair of extruding, extruded implant			
	b. Scleral, facial patch grafting			
	c. Dermis-fat grafting			
	d. Socket augmentation for correction of enophthalmos			
	e. Fornix reconstruction			
	f. Repair eyelid structure weakness			
	g. Mucous membrane grafting			
	h. Repair of contracted sockets			
	i. Socket expansion to correct congenital deformities			
	OTHER			
	a. Cyclo-photocoagulation			
	b. Indirect laser photocoagulation			

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

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