DELINEATION OF CLINICAL PRIVILEGES - UROLOGY

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.

NOTE: This form is to be used as an attachment to DA Form 5440-13 (Delineation of Clinical Privileges - General Surgery).

PROVIDER CODES	SUPERVISOR 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/mission	5 - Not approved, insufficient facility support/mission

UROLOGICAL CANCER SURGERY

Requested	Approved		Requested	Approved	
		a. Radical/Partial Nephrectomy			f. Ileal Conduit
		b. Radical Cystectomy			g. Continent Diversion
		c. Radical/Simple Prostatectomy			h. Ultrasound-guided Prostate Biopsy
		d. Radical Orchiectomy			
		e. Exenterative Procedures			

INFERTILITY SURGERY

Requested	Approved		Requested	Approved	
		a. Vasectomy			d. Varicocelectomy
		b. Vasovasectomy			
		c. Vasoepididymostomy *(microscopic approach)*			

LAPAROSCOPIC SURGERY

Requested	Approved		Requested	Approved	
		a. Pelvic Lymphadenectomy			d. Diagnostic Laparoscopy
		b. Varicocelectomy			
		c. Nephrectomy			

STONE SURGERY

Requested	Approved		Requested	Approved	
		a. Uretero-Pyeloscopy			c. Extracorporeal Shock Wave Lithotripsy
		b. Open Lithotomy			

ENDOSCOPIC SURGERY

Requested	Approved		Requested	Approved	
		a. Transuretheral Resection of the Prostate			d. Cystoscopy
		b. Transuretheral Resection of the Bladder			e. Percutaneous Endoscopic Surgery
		c. Endoscopic Surgery of the Urethra			

SURGERY FOR IMPOTENCE

Requested	Approved		Requested	Approved	
		a. Placement of Penile Prosthesis			
		b. Penile Orthoplasty			

FEMALE UROLOGY

Requested	Approved		Requested	Approved	
		a. Bladder Neck Suspension			c. Major Reconstruction
		b. Bladder Sling			

PEDIATRIC UROLOGY					
Requested	Approved		Requested	Approved	
		a. Hypospadias Repair			d. Surgery for Congenital Anomalies
		b. Orchiopexy			
		c. Reconstructive Procedures of Genitalia, Bladder, Ureter, Kidney			

RECONSTRUCTIVE SURGERY					
Requested	Approved		Requested	Approved	
		a. Placement of Artificial Urinary Sphincter			d. Pyeloplasty
		b. Male Sling Surgery			
		c. Open Urethroplasty			

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)*