DELINEATION OF CLINICAL PRIVILEGES - CARDIOVASCULAR 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:	large and the different	IFCTEDII. Footbooks and an analysis of the distribution of the dis					

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, <u>line through and initial</u> 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: Cardiovascular surgical privileges involve pre-operative preparation, surgical management, and post-operative care of patients with diseases or defects of the heart, its vascular and conduction systems, great and peripheral vessels, and the pericardium.

NOTE: This	document	is to be used in conjunction with DA Form 5440	0-13, Delinea	tion of Clini				
		PROVIDER CODES	SUPERVISOR CODES					
	-	etent to perform	1 - Approved as fully competent					
		n requested (Justification attached)	2 - Modification required (Justification noted)					
	•	n requested	3 - Supervision required					
		ted due to lack of expertise			red, insufficient expertise			
5 -	Not reques	ted due to lack of facility support/mission	5 -	Not approv	red, insufficient facility support/mission			
		SECTION I - CLIP	NICAL PRIVIL	EGES				
		MINOR PROCEDURES	REPAIR OF CONGENITAL DEFECTS IN CHILDREN (Continued)					
Requested	Approved		Requested	Approved				
		a. Subxyphoid window			f. Aortic vascular anomalies (coarctation, rings, aberrancies)			
		b. Cardioversion			3 1			
		c. Insertion of arterial (e.g., Swan-Ganz)	CARDI	AC REVASO	L CULARIZATION (w/CPB, OPCAB, MIDCAB)			
		catheter	Requested		The state of the s			
		d. Intra-aortic balloon pump insertion		Трргото	a. Coronary artery bypass			
VAL	VE SURGER	Y WITH CARDIOPULMONARY BYPASS			b. Coronary artery endarterectomy			
	Approved							
		a. Commissurotomy		CONDUCT	ION SYSTEM CARDIAC SURGERY			
		b. Valve replacement	Requested	Approved				
		c. Valve repair/ reconstruction			a. Pacemaker (transvenous, epicardial)			
		d. Homograft/ autograft replacement			b. AICD (transvenous, epicardial)			
			_		c. Maze procedure			
	REPAIR OF	CONGENITAL DEFECTS IN ADULTS			d. WPW/ accessory pathway division			
Requested	Approved				e. Ventricular aneurysmorrhaphy with ablation			
		a. Atrial septal defects (primum, secundum)						
		b. Ventricular septal defect	SURGERY OF THE GREAT AND PERIPHERAL VESSELS					
		c. Patent ductus arteriosus	Requested	Approved				
		d. Sinus venosus			Aortic replacement (ascending, descending)			
		e. Bicuspid aortic valve (commissurotomy, replacement)			b. Aortic arch replacement			
		f. Aortic vascular anomalies (coarctation,			c. Aortic root replacement			
		rings, aberrancies)			d. Thoracoabdominal aneurysmorrhaphy			
REPAIR OF CONGENITAL DEFECTS IN CHILDREN				e. Inominate/ carotid/ subclavian artery				
Requested	Approved				endarterectomy, repair, replacement, bypass			
		a. Atrial septal defects (primum, secundum)			f. Abdominal aortic/ iliac artery repair,			
		b. Ventricular septal defect			replacement, bypass			
		c. Patent ductus arteriosus			g. Femoral artery endarterectomy, repair,			
		d. Sinus venosus			replacement, bypass			
		e. Bicuspid aortic valve (commissurotomy, replacement)						

PULMONARY ARTERY SURGERY								PERICARDIUM					
Requeste	ed Ap	pprove					R	equested	Approved				
-				. Pulmona	ary embole	ectomy (acute)		-		a.	Pericardiectomy, perio	ardial win	dow
			b	. Pulmona	ary thromb	oendarterectomy							
			С	. Caval fil	ter placen	nent				RPO	REAL CIRCULATORY S	SUPPORT	
			d	. Vena ca	va repair/	interruption	R	equested	Approved				
											Cardiopulmonary bypa	ass (CPB)	
				CARDIOR	RHAPHY						Veno-veno bypass		
Requeste	ed Ap	pprove								c.	Left atrial to descendi	ng aorta o	r femoral
			а	. Excision	of tumor						artery bypass		
			b	. Repair o	f trauma						Hypothermic circulato		
			С	. Repair v	entricular	septal defect				e.	Insertion and manager assist devices (RVAD,		ntricular
			d	. Repair n	nyocardial	rupture				f.	Extracorporeal membr		nation
			е	. Repair n	nyocardial	pseudoaneurysm					(ECMO)		
										g.	Extracorporeal carbon removal (ECCOOR/ EC		(02)
				TRANS	PLANT						removal (ECCOOR/ EC	JUZK)	
Requeste	ed Ap	pprove											
			а	. Heart									
							4 OF D DDIV	W 5050					
Requests	for la	ser nr	riviled	ies may re	quire the		ASER PRIV		ogram(s) si	ınnı	orting documentation o	of training	and
experienc	ce, acl	knowl	edge	ment of re	ceipt of th	ne MTF laser policy	y and proce	edural guid	dance, and r	evie	ew and approval by app	propriate N	
personne	el with				lity for las	er therapy. The ne	ecessary d	ocumentat	tion in supp	ort (of this request is attacl	hed.	
			uest	ed	I								Approved
ARGON	ND:Y	/AG	CO2										1-1
						a. Transmyocard	lial revascu	ılarization					
				+	1	c. Other (Specify)							
COMME	NTS												
							SIGNATI	IRE OF PR	OVIDER			DATE (YY	YYMMDDI
							5.5.47.10	01 110	- · .DLI			2,(12/17	

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SECTION II - SUPERVISOR'S RECOMMENDATION								
Approval as requested	Approval with Modifica	ations (Specify below)	Disapproval (Specify below)					
COMMENTS								
DEPARTMENT/SERVICE CHIEF (Typ	ed name and title)	SIGNATURE		DATE (YYYYMMDD)				
	SECTION III - CREDENTIALS	COMMITTEE/FUNCTION REG	COMMENDATION					
Approval as requested	Approval with Modific		Disapproval (Specify below)					
COMMENTS	Approval with Mounte	ations (Specify below)	Disapproval (Specify below)					
COMMENTS								
COMMITTEE CHAIRPERSON (Name a	and rank)	SIGNATURE		DATE (YYYYMMDD)				
		1						

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