

EVALUATION OF CLINICAL PRIVILEGES - THORACIC SURGERY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. PERIOD OF EVALUATION <i>(YYYYMMDD)</i> FROM _____ TO _____
4. DEPARTMENT/SERVICE	5. FACILITY <i>(Name and Address: City/State/ZIP Code)</i>	

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	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
ENDOSCOPY				
	a. Bronchoscopy (flexible, rigid)			
	b. Esopgagoscopy (flexible, rigid)			
	c. Laryngoscopy (direct, indirect)			
	d. Mediastinoscopy (direct, video assisted)			
	e. Thoracoscopy (direct, video assisted)			
	f. Esophagogastroduodenoscopy (EGD)			
	g. Colonoscopy			
	h. Sigmoidoscopy			
MINOR PROCEDURES				
	a. Thoracentesis			
	b. Tube thoracotomy			
	c. Pleural biopsy (closed, open)			
	d. Lymph node biopsy			
	e. Tracheotomy			
	f. Needle biopsy - lung			
	g. Insertion of esophageal bypass tube			
	h. Drainage of lung abscess			
	i. Esophageal dilatation			
LUNGS				
	a. Thoracotomy			
	b. Pleurectomy/ pleurodesis			
	c. Wedge resection			
	d. Segmental resection			
	e. Lobectomy			
	f. Pneumonectomy			
	g. Reduction pneumoplasty			
	h. Decortication			
CHEST WALL				
	a. Resection of tumor			
	b. Thoracoplasty			
	c. Resection of first rib - thoracic outlet syndrome			
	d. Resection of rib(s) - tumor			
	e. Resection of rib and drainage - Eloesser flap			

CODE	CHEST WALL <i>(Continued)</i>	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	f. Repair of chest wall deformity (pectus excavatum, carinatum)			
	g. Open reduction, internal fixation of sternal fracture			
	h. Sternal debridement and rewiring			
	i. Sternal resection (partial or complete, with primary or secondary closure, with or without pectoralis muscle advancement)			
TRACHEA				
	a. Repair trachea/ bronchus - trauma			
	b. Repair tracheoesophageal fistula			
	c. Resection for tumor			
MEDIASTINUM				
	a. Cervical mediastinotomy			
	b. Anterior mediastinostomy			
	c. Thymectomy			
	d. Excision of mediastinal tumors			
	e. Pericardial window			
ESOPHAGUS				
	a. Repair of esophageal trauma/ perforation			
	b. Ligation of varices			
	c. Esophageal anti-reflux procedures (intra/extra-thoracic)			
	d. Esophagostomy			
	e. Esophageal diverticulectomy (intra/extra-thoracic)			
	f. Esophagectomy			
	g. Esophagogastrostomy			
	h. Esophageal bypass or replacement (colon/small intestine)			
DIAPHRAGM				
	a. Repair esophageal and paraesophageal hiatal hernia (intra/ extra-thoracic)			
	b. Plication/ resection/ repair diaphragmatic hernias/ rupture/ tumor			
	c. Insertion of diaphragmatic pacer			
LASER PRIVILEGES				
	a. Restoration of airway patency			
	b. Treatment of pulmonary tumor			
	c. Other <i>(Specify)</i>			
SECTION II - COMMENTS <i>(Explain any rating that is "Unacceptable".)</i>				
NAME AND TITLE OF EVALUATOR		SIGNATURE		DATE (YYYYMMDD)