

EVALUATION OF CLINICAL PRIVILEGES - ORTHOPAEDICS

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	PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Amputation, major			
	b. Arthrocentesis			
	c. Arthroscopy, diagnostic and surgical			
	d. Arthrodesis			
	e. Arthroplasty			
	f. Arthrotomy			
	g. Bone graft procedures			
	h. Bone and muscle transposition to restore function or form of extremities			
	i. Excision of:			
	(1) Bursae, calcium deposits, soft tissue tumors of extremity			
	(2) Herniated nucleus pulposus			
	(3) Degenerated intervertebral disc			
	(4) Bone tumors			
	j. Flaps, local and distant microvascular free			
	k. Fractures and dislocations, open and closed reduction of major injuries, including skeletal traction, and internal and external fixation			
	l. Fusion of spine:			
	(1) Anterior, posterior cervical			
	(2) Anterior, posterior thoracic			
	(3) Anterior, posterior lumbar			
	m. Grafts, split thickness skin			
	n. Grafts, full thickness and pedicle			
	o. Laminectomy			
	(1) Cervical			
	(2) Thoracic			
	(3) Lumbar			
	p. Manipulation of deformities of musculo-skeletal system			
	q. Osteotomy			
	r. Osteomyelitis and septic arthritis, drainage of			
	s. Prosthetic replacement of bones and joints			
	t. Release and/or excision of muscles, tendons, fascia, ligaments and nerves			
	u. Reimplantation of severed digits using microvascular technique			
	v. Scoliosis and kyphosis, surgical correction with or without posterior instrumentation			
	w. Scoliosis and lordosis, surgical correction with or without anterior instrumentation			

CODE	PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	x. Skeletal defects:			
	(1) Intercalary reconstruction of segmental defects			
	(2) Reconstruction using synthetic or metal materials			
	y. Tendon grafts with or without preliminary silastic tendon prosthesis			
	z. Tendon repair, transfer, lengthening or shortening			
	aa. Ligament repair and reconstruction - hand, knee, ankles, shoulders, and elbows			
	ab. Nerve:			
	(1) Transplantation			
	(2) Grafts			
	(3) Repair			
	ac. Open and closed cervical, thoracic, and lumbar discectomy/disc injection or ablation			
	ad. Use of cement, i.e., methyl methacrylate, with or without prosthetic use			
	ae. Anesthesia, low and regional blocks			
	af. Lumbar puncture			
	ag. Myelography			

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

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE (YYYYMMDD)
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