DELINEATION OF CLINICAL PRIVILEGES - ANESTHESIA

(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	
		a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures.
		b. The support of life functions under the stress of anesthetic and surgical manipulation.
		c. The clinical management of the patient who is unconscious from whatever cause.
		d. The management of problems in pain relief.
		e. The management of problems in cardiac and respiratory resuscitation.
		f. The application of specific methods of respiratory therapy.
		g. The clinical management of various fluid, electrolyte, and metabolic disturbances.

TYPE ANESTHESIA

Requested	Approved		Requested	Approved	
		a. General			(5) Axillary Block
		b. Regional			(6) Intravenous *(Bier-Block)*
		(1) Spinal			(7) Other *(Specify)*
		(2) Epidural			c. Monitored Anesthesia Care (MAC)
		(3) Caudal			
		(4) Nerve Block			

SPECIAL PROCEDURES

Requested	Approved		Requested	Approved	
		a. Arterial Pressure Lines			e. Hypothermia
		b. Central Venous Pressure Lines			
		c. Pulmonary Artery Catheter			
		d. Arterial/Venous Puncture			

Classification of physical status (P) and anesthesia risk as devised by the American Society of Anesthesiologists (ASA):

P 1 - Normal, healthy patient.
P 2 - Patient with mild systemic disease.
P 3 - Patient with severe systemic disease.
P 4 - Patient with severe systemic disease that is a constant threat to life.
P 5 - Morbid patient who is not expected to survive for 24 hours without the operation.
P 6 - A declared brain-dead patient whose organs are being removed for donor purposes.
E - A patient for whom an emergency operation is required.

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 - ANESTHESIA

(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	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures.			
	b. The support of life functions under the stress of anesthetic and surgical manipulation.			
	c. The clinical management of the patient who is unconscious from whatever cause.			
	d. The management of problems in pain relief.			
	e. The management of problems in cardiac and respiratory resuscitation.			
	f. The application of specific methods of respiratory therapy.			
	g. The clinical management of various fluid, electrolyte, and metabolic disturbances.			
	a. General			
	b. Regional			
	(1) Spinal			
	(2) Epidural			
	(3) Caudal			
	(4) Nerve Block			
	(5) Axillary Block			
	(6) Intravenous *(Bier-Block)*			
	(7) Other *(Specify)*			
	c. Monitored Anesthesia Care (MAC)			
	a. Arterial Pressure Lines			
	b. Central Venous Pressure Lines			
	c. Pulmonary Artery Catheter			
	d. Arterial/Venous Puncture			
	e. Hypothermia			

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

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