

**MOUNTAIN STATES HEALTH ALLIANCE
INDIAN PATH MEDICAL CENTER**

CLINICAL PRIVILEGES REQUEST FORM

IPMC - Urology

NAME: _____

	Requested	Not Requested	Granted
Nephrotomy and nephrostomy	_____	_____	_____
Pyelotomy and pyelostomy	_____	_____	_____
Diagnostic procedures on kidneys	_____	_____	_____
Local excision or destruction of lesion or tissue of kidney	_____	_____	_____
Partial nephrectomy	_____	_____	_____
Complete nephrectomy	_____	_____	_____
Transplant of kidney	_____	_____	_____
Nephropexy	_____	_____	_____
Other repair of kidney (Suture of laceration of kidneys, closure of nephrostomy and pyelostomy)	_____	_____	_____
Other operations on kidney (Decapsulation of kidney, Replacement of nephrostomy tube)	_____	_____	_____
Transurethral removal of obstruction from ureter and renal pelvis	_____	_____	_____
Diagnostic Procedures on Ureter	_____	_____	_____
Ureteral meatotomy	_____	_____	_____
Ureterotomy	_____	_____	_____
Cutaneous uretero-ileostomy	_____	_____	_____
Other external urinary diversion (Anastomosis of ureter to skin, revision of ureterostomy stoma)	_____	_____	_____
Other anastomosis or bypass of ureter (Urinary diversion to intestine, revision of ureterointestinal anastomosis)	_____	_____	_____
Repair of ureter	_____	_____	_____
Other operations on ureter (Dilation of ureteral meatus, ligation of ureter)	_____	_____	_____
Transurethral clearance of bladder	_____	_____	_____
Cystotomy	_____	_____	_____
Cystostomy	_____	_____	_____
Diagnostic procedures on bladder	_____	_____	_____
Transurethral excision or destruction of bladder tissue	_____	_____	_____
Other excision or destruction of bladder tissue (Excision of urachial sinus of bladder, suprapubic excision of bladder lesion)	_____	_____	_____
Partial cystectomy	_____	_____	_____
Total cystectomy	_____	_____	_____
Other repair of urinary bladder (Suture of laceration of bladder, Closure of cystostomy)	_____	_____	_____
Other operations on bladder (Spinicterotomy of bladder, Dilation of bladder neck)	_____	_____	_____
Urethrotomy	_____	_____	_____
Urethral meatotomy	_____	_____	_____
Diagnostic procedures on urethra	_____	_____	_____
Excision or destruction of urethral tissue or lesion	_____	_____	_____
Repair of urethra	_____	_____	_____
Release of urethral stricture	_____	_____	_____
Dilation of urethra	_____	_____	_____
Other operations on urethra and periurethral tissue (Incision of periurethral tissue, excision of periurethral tissue)	_____	_____	_____

NAME: _____

	Requested	Not Requested	Granted
Dissection of retroperitoneal tissue	_____	_____	_____
Incision of perivesical tissue	_____	_____	_____
Plication of urethrovesical junction	_____	_____	_____
Suprapubic sling operation	_____	_____	_____
Retropubic urethral suspension	_____	_____	_____
Paraurethral suspension	_____	_____	_____
Other repair of urinary stress incontinence (levator muscle operation, anterior urethropexy)	_____	_____	_____
Ureteral catheterization	_____	_____	_____
Other operations on urinary tract (replacement of cystostomy tube, Ultrasonic fragmentation of urinary stones)	_____	_____	_____
Incision of Prostate	_____	_____	_____
Diagnostic Procedures on Prostate and Seminal Vesicles	_____	_____	_____
Transurethral Prostatectomy	_____	_____	_____
Suprapubic Prostatectomy	_____	_____	_____
Retropubic Prostatectomy	_____	_____	_____
Radical Prostatectomy	_____	_____	_____
Other Prostatectomy (Local Excision of Lesion of Prostate, Perineal Prostatectomy)	_____	_____	_____
Operations on seminal vesicles	_____	_____	_____
Incision or excision of periprostatic tissue	_____	_____	_____
Other operations on prostate (percutaneous aspiration of prostate, Injection into prostate)	_____	_____	_____
Incision and drainage of scrotum and tunical vaginalis	_____	_____	_____
Diagnostic Procedures on Scrotum and Tunica Vaginalis	_____	_____	_____
Excision of hydrocele	_____	_____	_____
Excision or destruction of lesion or tissue of scrotum	_____	_____	_____
Repair of scrotum and tunica vaginalis	_____	_____	_____
Other operations on scrotum and tunica vaginalis (percutaneous aspiration of tunica vaginalis, excision of lesion of tunica vaginalis other than hydrocele)	_____	_____	_____
Incision testis	_____	_____	_____
Diagnostic procedures on testes	_____	_____	_____
Excision or destruction of testicular lesion	_____	_____	_____
Unilateral orchiectomy	_____	_____	_____
Bilateral orchiectomy	_____	_____	_____
Orchiopexy	_____	_____	_____
Repair of testes	_____	_____	_____
Insertion of testicular prosthesis	_____	_____	_____
Other operations on testes (Aspiration of testes, injection of therapeutic substance into testis)	_____	_____	_____
Diagnostic procedures on spermatic cord, epididymis, and vas deferens	_____	_____	_____
Excision of varicocele and Hydrocele of spermatic cord	_____	_____	_____
Excision of cyst or epididymis	_____	_____	_____
Excision of other lesion or tissue of spermatic cord and epididymis	_____	_____	_____
Epididymectomy	_____	_____	_____
Repair of spermatic cord and epididymis	_____	_____	_____
Vasotomy	_____	_____	_____
Vasectomy and ligation of vas deferens	_____	_____	_____
Repair of vas deferens and epididymis	_____	_____	_____
Other operations on spermatic cord, epididymis, and vas deferens (Aspiration of spermatocele, epididymotomy)	_____	_____	_____
Circumcision	_____	_____	_____
Diagnostic procedures on the penis	_____	_____	_____

NAME: _____

	Requested	Not Requested	Granted
Local excision of destruction of lesion of penis	_____	_____	_____
Amputation of penis	_____	_____	_____
Repair and plastic operation on penis	_____	_____	_____
Operations for sex transformation	_____	_____	_____
Other operations on male genital organs (Dorsal or lateral slit of prepuce, Incision of penis)	_____	_____	_____
Other (specify): _____	_____	_____	_____

OTHER:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Signature: _____ Date: _____

DEPARTMENT CHAIR REVIEW:

I HEREBY CERTIFY THAT I HAVE REVIEWED EACH COGNITIVE AND PROCEDURAL PRIVILEGE REQUEST AS SUPPORTED BY DOCUMENTATION OF TRAINING/EXPERIENCE AND CLINICAL COMPETENCE AND FEEL THE APPLICANT IS QUALIFIED TO PERFORM PRIVILEGES AS DESIGNATED ABOVE.

SIGNATURE: _____ DATE: _____
 (DEPARTMENT CHAIR)

APPROVED

DATE

CREDENTIALS COMMITTEE: _____

MEDICAL EXECUTIVE COMMITTEE: _____

COMMUNITY BOARD: _____

MSHA BOARD OF DIRECTORS: _____