

# Chino Vascular & Surgery Center

## PRIVILEGE DELINEATION: VASCULAR SURGERY

NAME: \_\_\_\_\_

Please Print

Please indicate which privilege you are requesting by marking the appropriate box (es) and by signature at the end of this document. If you are requesting a privilege that falls under a specialty other than your original training, you will need to show evidence of training in the area and include it with the privilege list. Privileges will be granted on an individual basis, in accordance with the applicant's documented training, experience and current competence.

Applied for:

Approved:

### LOWER EXTREMITY INTERVENTIONS

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Angioplasty, iliac artery, unilateral, initial vessel                     | <input type="checkbox"/> |
| <input type="checkbox"/> Stent placement(s) iliac artery, unilateral, initial vessel               | <input type="checkbox"/> |
| <input type="checkbox"/> Angioplasty, femoral popliteal artery(s) unilateral                       | <input type="checkbox"/> |
| <input type="checkbox"/> Atherectomy, femoral popliteal artery(s) unilateral                       | <input type="checkbox"/> |
| <input type="checkbox"/> Stent placement(s) femoral, popliteal arteries unilateral                 | <input type="checkbox"/> |
| <input type="checkbox"/> Stent placement(s), atherectomy, femoral, popliteal arteries unilateral   | <input type="checkbox"/> |
| <input type="checkbox"/> Angioplasty, tibial, peroneal artery(s) unilateral, initial vessel        | <input type="checkbox"/> |
| <input type="checkbox"/> Atherectomy, tibial, peroneal artery(s) unilateral, initial vessel        | <input type="checkbox"/> |
| <input type="checkbox"/> Stent placement(s), tibial, peroneal arteries, unilateral, initial vessel | <input type="checkbox"/> |
| <input type="checkbox"/> Transluminal atherectomy, iliac artery each vessel                        | <input type="checkbox"/> |

### ANGIOPLASTY/STENTING IN OTHER VESSELS

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Transcatheter placement of intravascular stent(s) open or percutaneous for radiological S&I and angioplasty; initial artery | <input type="checkbox"/> |
| <input type="checkbox"/> Transcatheter placement of intravascular stent(s) open or percutaneous for radiological S&I and angioplasty; initial vein   | <input type="checkbox"/> |
| <input type="checkbox"/> Transluminal balloon angioplasty, open or percutaneous for radiological S&I initial artery                                  | <input type="checkbox"/> |
| <input type="checkbox"/> Transluminal balloon angioplasty, open or percutaneous for radiological S&I initial vein                                    | <input type="checkbox"/> |
| <input type="checkbox"/> Renal artery angioplasty and stenting   | <input type="checkbox"/> |

### DIALYSIS CIRCUIT IMAGING AND INTERVENTION

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including inferior or superior vena cava   | <input type="checkbox"/> |
| <input type="checkbox"/> With transluminal balloon angioplasty, peripheral dialysis segment  | <input type="checkbox"/> |
| <input type="checkbox"/> With transcatheter placement of intravascular stent(s), peripheral  | <input type="checkbox"/> |
| <input type="checkbox"/> Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including S&I, diagnostic angiography, fluoroscopic guidance, catheter placement(s) and intraprocedural pharmacological thrombolytic injection(s) | <input type="checkbox"/> |
| <input type="checkbox"/> With Balloon angioplasty  | <input type="checkbox"/> |
| <input type="checkbox"/> With intravascular stent  | <input type="checkbox"/> |

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Applied for:

Approved:

**THROMBOLYSIS MECHANICAL THROMBECTOMY**

- ( ) Transcatheter therapy, arterial infusion for thrombolysis, initial treatment ( )
- ( ) Transcatheter therapy, venous infusion for thrombolysis, initial treatment ( )
- ( ) Primary percutaneous transluminal mechanical thrombectomy, initial ( )
- ( ) Percutaneous transluminal mechanical thrombectomy, vein(s) ( )
- ( ) Percutaneous transluminal mechanical thrombectomy, vein(s) repeat treatment on subsequent day during course of thrombolytic therapy ( )

**OTHER SUPPORTIVE PROCEDURES**

- ( ) Transcatheter retrieval, percutaneous, of intravascular foreign body ( )
- ( ) Vein Ablation ( )
- ( ) Stab phlebectomy ( )
- ( ) Vein stripping ( )
- ( ) AV fistulas and grafts placement and revisions ( )
- ( ) Placement of tunneled dialysis catheters ( )
- ( ) embolization of veins, tumors and fibroids ( )
- ( ) IVC filter placement and removals ( )

- \* Procedure may require documentation of special training
- \*\* Requires application, credentialing and competency determination (written test)
- \*\*\* Requires special credentialing, proctoring and specific procedure rider on liability insurance.
- \*\*\*\* Requires specific pain management privilege request form

I certify that I am competent to exercise the above clinical privileges by virtue of my training and experience.

I have no physical or mental impairments, which would hinder my ability to exercise these privileges.

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED.

EXCEPTIONS / LIMITATIONS: NONE SPECIFY

Signature of Medical Director \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Governing Body Director \_\_\_\_\_

PRIVILEGES EFFECTIVE FROM: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO: \_\_\_\_/\_\_\_\_/\_\_\_\_