Surgical Privileges Form: Urology (Core Privileges)

Clinical Privileges Request

Applicant's Name: …… Scope of Practice: ……

License No. (If Any): …… Facility: ……

Date: ……

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommen -ded*	*Not Recommended*	*Signature*

Category I: General Procedures

Kidney					
1- Simple nephrectomy					
2- Surgery for renal cysts and abscesses					
3- Pyeloplasty					
4- Management of renal injuries					
5- Nephrostomy & renal biopsy (Open)					
6- Nephropexy					
Ureter					
1- Ureterolithotomy					
2- Excision of ureteric segment and end to end anastomosis					
3- Ureteric reimplantation					

4- Ureterocalycostomy					
5- Extended psoas hitch					
Bladder					
1- Repair of traumatic bladder injuries					
2- Diverticulectomy					
Prostate					
1- Simple retropubic prostatectomy					
2- Transvesical prostatectomy					
Penis					
1- Circumcision					
2- Meatotomy					
3- Meatoplasty					
Testicle and scrotum					
1- Testicular biopsy					
2- Operations for hydrocele					
3- Orchidopexy					
4- Radical orchidectomy					
5- Orchidectomy					
6- Epididymectomy					
7- Excision of spermatocele					
8- Excision of epididymal cyst					
9- Vasectomy					

10- Surgery for scrotal skin infection					

Category II: Endoscopic Procedures

1. Urethroscopy					
2. Urethral dilitation					
3. Optical urethrotomy					
4. C ystoscopy					
5. Bladder biopsy					
6. TUR-BT					
7. TUR-P					
8. Ureterorenoscopy					
9. Ureterotomy					
10. Endopyelotomy					
11. Percutaneous nephrolithotomy					
12. Use of laser in endoscopic procedures					

Category II: Special Urologic Procedures

1- Percutaneous suprapubic catheter insertion						
2- ESWL						
3- Insertion of nephrostomy tubes						
4- Ultrasound of the urinary tract						

Note:

- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the recognized policies and rules.

…….. ……
Applicant's signature (Stamp if any) Date

1. …….. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

…….. ……
Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……
1) Name Date

…….. ……
2) Name Date