TEXAS SPINE & JOINT HOSPITAL
RADIOLOGY CLINICAL PRIVILEGES

NAME: _____

☐ Initial appointment
☐ Reappointment

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

QUALIFICATIONS FOR DIAGNOSTIC RADIOLOGY

To be eligible to apply for core privileges in diagnostic radiology, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in diagnostic radiology.

CORE PRIVILEGES

DIAGNOSTIC RADIOLOGY CORE PRIVILEGES

☐ **Requested** Perform general diagnostic radiology to diagnose and treat diseases of patients of all ages. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

REQUESTED	PRIVILEGE	APPROVED	DENIED
	Fluoroscopy		
	Interpretation of Diagnostic Radiographs		
	Ultrasound Procedures-Diagnostic **Abdominal** **Pelvic** **Cardiac (Echocardiography)**		
	Computed Tomography-Diagnostic **Neurological (Including Sprine)** **Thorax** **Abdomen & Pelvis,** **Skeletal & Extremities**		
	Magnetic Resonance Imaging		
	Arthrography		
	Needle Biopsy-Percutaneous **CT Control** **Ultrasound Control** **Fluoroscopic Control**		

REQUESTED	PRIVILEGE	APPROVED	DENIED
	Neurological Lumbar Puncture w/Fluoroscopy C1-2 Puncture with Fluoroscopy Myelography Discography Ventriculography		
	Jugular Venography		
	Renal Venography		
	Adrenal Venography		
	Aotography Arch Thoracic Abdominal		
	Cerebral Angiography		
	Selectrive Carotid and Verteb ral Catherization		
	Selective Visceral Catheterization		
	Spinal Angiography		
	Extremity Angiography		
	Intra-arterial Embolic Procedures		
	Hepatic Percutaneous Transhepatic Cholanglogram Percutaneous Biliary Drainage Percutaneous Nephrostomy Tract and Retrieval of Urinary Calculi Percutaneous Cyst Puncture Percutaneous Needle Biopsy with CT or Ultrasound		
REQUESTED	**PRIVILEGE**	**APPROVED**	**DENIED**
	Percutaneous Drainage of Abscess and Fluid Collections Fluoroscopic Control Ultrasound Control CT Control		
	Angiography Pulmonary Coronary Intracardiac Cavography		
	Conscious Sedation (Required Current ACLS)		
	Line Placement Central Mid-Line Picc		

Acknowledgement of Practitioner

I am qualified to perform the privileges I have requested based on my licensure, education, training, experience and current competence. I certify that I am able to perform the privileges I have requested.

_____ _____

Practitioner's Signature **Date**