Surgical Privileges Form: Ophthalmology

Clinical Privileges Request

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

License No. (If Any): …… Facility: ……

Date: ……

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	

CATEGORY I: OPHTHALMOLOGY PROCEEDURES (Anterior Segment Section)

1. Cataract operation				
a. Phacoem ulsification+ IOL				
b. ECCC+IOL				
c. Irrigation & Aspiration± Ant.vitrectomy±IOL				
2. 2nd Implantation				
a. Ant.IOL				
b. Post.IOL				
3. Keratoplasty				
a. Pentrating keratoplasty				
b. Lamellar keratoplasty				
4. Glaucoma				
a. Trabeculectomy + Mytomycin C				
b. Trabeculectomy				

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c. Deep sclerectomy				
d. Goniotomy				
e. Trabeculotomy				
5. Cyclo-cryopexy				
6. Cyclophotocoagulation				
7. Iris Surgery				
a. Iridectomy				
b. Iris Lesion Excision				
8. YAG Laser Capsulotomy				
9. Laser Iridectomy				
10. Superficial Keratectomy				
11 .Conjunctival lesion excision biopsy				
12. Examination under anesthesia				
13. Eye trauma repair				

CATEGORY II: OPHTHALMOLOGY PROCEEDURES (Posterior Segment Section)

1. Scleral buckling for retinal detachment				
2. Pars plana vitrectomy for				
a. Diabetic vitreous he or tractional retinal detachment				
b. Macular hole surgery with internal limiting membrane removal				
c. Proliferate vitreo retinopathy with or without anterior retinectomy				

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d. Endophthalmitis				
e. Removal of sub retinal hemorrhage				
f. Removal of intra-ocular foreign body				
g. Removal of dropped nucleus or IOL				
3. Pars plana Lensectomy				
4. Anterior vitrectomy				
5. Intravitreal injection of:				
a. Antibiotic				
b. Triamicnolon/Avastin/Lucentis				
c. Expansile gases(pneumatic retinopathy)				
6. Silicon oil injection or intravitreal injection of gases				
7.Silicon oil removal				
8. Cryopexy				
9. Indirect Laser				
10.Cyclo-Photocoagulation				
11.Argon Laser				
a. Panretinal laser photocoagulation				
b. Focal laser photocoagulation				
c. Grid Laser				
12.Phaco or ECCE + PPV				
13.Phaco + silicon oil removal				
14.Phaco + IV injection				
15.EUA for pediatric retina				
16.Eye trauma repair				

CATEORGY III: OCULOPLASTIC PROCEDURES

1.Everting sutures,horizontal lid shortening				
a. For Entropion & Triciasis lower lid				

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b. For Ectropion of upper lid				
2. Tarsal fracture				
3. Tarsorraphy – for facial pulsy				
4. Levator resection for ptosis				
5. Brow suspention for ptosis				
6. Eyelid tumor excision				
7. DCR+ intubation for dacryocystitis				
8. Dermoid and lipodermoid excision				
9. Enucleation and implant				
10.Evisceration and implant				
11 .Blepharoplasty				
12.Eye trauma repair				
13.Probing and intubation				
14.Pterygium and Autograft				
15.Chalazion I & C				

CATEGORY IV: PEDIATRIC OPHTHALMIC SURGICAL

1. Strabismus				
a. Horizontal muscle recession+ resection				
b. horizontal muscle tendons transposition				
c. Vertical muscles adjustable suture, recession and resection				
d. Vertical muscle recession, resection and faden sutures				
e. Oblique muscles myectomy, recession and transposition				
2. Congenital and traumatic cataract				
a. Lensectomy and anterior vitrectomy				

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b. Phaco emulsification & primary IOL implant				
c. Secondary IOL implant				
d. Secondary IOL implant with scleral fixation				
3. Congenital glucoma				
a. Goniotomy				
b. Trabeculoctomy with & without mitomycin C				
4. Oculoplatic				
a. Probing of nasolacrimal				
b. Probing and intubation of nasolacrimal duct				
c. Dermoid cyst excision (limbal, angular)				
d. Congential lid and anterior segment tumors excision				
5. Anterior segment				
a. Iris surgery (iridectomies, congential iris tumor excision)				
b. Pupiloplasty (congentia anterior papillary membrane reminants and adhesions, post traumatic pupil reconstruction)				
6. Examination under anesthesia				
7. Eye trauma repair				

CATEGORY V: Additional Privileges (not included above)

1.				
2.				
3.				
4.				

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5.				
6.				

Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- 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.

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

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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

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