DELINEATION OF CLINICAL PRIVILEGES - CRITICAL CARE MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Critical care medicine is a specialty that involves skills applicable to general internal medicine and its subspecialties, or general surgery. In addition, it requires special expertise in the evaluation, examination, diagnosis of and treatment of critically ill patients of all ages with a variety of intensive care disorders to include medical, surgical, and pediatric. The diagnostic and therapeutic modalities of this specialty may include all those listed on DA Form 5440-3 or DA Form 5440-13, as well as the following procedures. This list is neither inclusive nor exclusive.

NOTE: This document is to be used in conjunction with DA Form 5440-3, Delineation of Clinical Privileges - Internal Medicine, or DA Form 5440-13, Delineation of Clinical Privileges - General Surgery.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Requested	Approved		Requested	Approved	
		a. Pediatric intensive care disorders			r. Lumbar cerebrospinal fluid examination
		b. Treatment of respiratory failure			s. Percutaneous placement of peritoneal dialysis catheter
		c. Thoracentesis			t. Peritoneal lavage and dialysis
		d. Paracentesis			u. Continuous hemofiltration dialysis
		e. Pericardiocentesis			v. Cardioversion including defibrillation
		f. Arthrocentesis			w. Transvenous pacemaker insertion
		g. Tube thoracostomy			x. Balloon tamponade of bleeding esophageal and gastric varices
		h. Flexible tube broncoscopy			y. Administration of moderate sedation
		i. Transtracheal needle aspiration			z. Supervision and application of respiratory therapy; gas humidification; positive pressure ventilation; postural drainage and percussion
		j. Intubation - Oral and nasotracheal			aa. Other *(Specify)*
		k. Percutaneous tracheostomy			
		l. Ventilator management to include rapid frequency			
		m. Central venous line placement			
		n. Swan-Ganz catheterization			
		o. Arterial line placement			
		p. Venous cutdown			
		q. Intracranial pressure monitoring			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*