DELINEATION OF CLINICAL PRIVILEGES - OPTOMETRY

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.

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

Diagnosis and Management of:

Requested	Approved		Requested	Approved	
		a. Refractive error problems			(c) Inflammation
		b. Binocularity problems			(d) Glaucoma
		c. Accommodative problems			(e) Pain
		d. Low-vision problems			(4) Prescribing of oral medications used in the practice of optometry to treat:
		e. Developmental and perceptual problems			(a) Allergies
		f. Contact lens problems			(b) Infections
		g. Diseases and disorders of the visual system, the eye and associated structures			(c) Inflammation
		(1) Ordering of laboratory tests used in the practice of optometry			(d) Glaucoma
		(2) Ordering of diagnostic imaging tests used in the practice of optometry			(e) Pain
		(3) Prescribing of topical medications used in the practice of optometry to treat:			(5) Refill of expired ophthalmic prescriptions
		(a) Allergies			
		(b) Infections			

Procedures:

Requested	Approved	
		a. Intermediate or comprehensive medical examination and evaluation of the eye and adnexa with initiation of diagnostic and treatment program, new and established patient
		b. Intermediate or comprehensive medical examination and evaluation of the eye and adnexa with continuation of diagnostic and treatment program, new and established patient
		c. Determination of refractive state
		d. Gonioscopy
		e. Sensorimotor examination with multiple measurements of ocular deviation
		f. Orthoptic and/or pleoptic training
		g. Fitting of contact lens for treatment of disease
		h. Visual field examination with interpretation and report
		i. Serial tonometry
		j. Scanning computerized ophthalmic diagnostic imaging with interpretation and report
		k. Ophthalmoscopy, extended, with interpretation and report
		l. Ocular photography (fundus, external and anterior segment) with interpretation and report
		m. Prescription of optical and physical characteristics of and fitting of contact lenses, including aphakia
		n. Evaluation for prescription of low vision aids/devices

Procedures: *(Continued)*		
Requested	Approved	
		o. Removal of foreign body from cornea or conjunctiva, superficial or embedded
		p. Scraping of corneal epithelium, diagnostic
		q. Removal of corneal epithelium
		r. Closure of lacrimal punctum by plug
		s. Dilation, probing and irrigation of the lacrimal punctum, canaliculi, and sac
		t. Ophthalmic ultrasound, A and B scan
		u. Electrodiagnostic testing, (EOG or ERG) with interpretation and report
		v. Pachymetry
		w. Correction of trichiasis (Epilation by forceps only)

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)*