

Lady of the Sea General Hospital		
Radiology		
Practitioner Name:		
Please indicate in the "Requested" section, those privileges which you are requesting.		
Requested	Recommen	Approved
Delineation of Privileges		
DIAGNOSTIC (ROUTINE) IMAGING		
		Arthrography
		Bronchography
		Computerized Tomography, Head and Neck
		Contrast Studies, Barium
		Contrast Studies, Other
		Contrast Studies, Water Soluble Media
		Cystography
		Dacryocystography
		General Plain Film Diagnosis
		Lymphography
		Mammography
		Myelography
		Salpingography
		Sialography
		Other:
ULTRASOUND IMAGING		
		Abdomen and Retroperitoneum
		Cardiovascular
		Doppler studies all organs, extremities, excluding cardiac
		Neck
		Pelvic (including Obstetrical)
		Testicles
		Thyroid
		Other:
NUCLEAR MEDICINE		
		Cardiovascular
		CNS
		Endocrine (including Thyroid)
		Gastrointestinal (including Liver)
		Genitourinary

I am qualified and competent to perform those privileges as requested in my application.

Signature: _____ Date: _____

Lady of the Sea General Hospital		
Radiology		
Practitioner Name:		
Please indicate in the "Requested" section, those privileges which you are requesting.		
Requested	Recommen	Approved
Delineation of Privileges		
		Hematopoietic
		Lymphatic (including Spleen)
		Musculoskeletal
		Other:
		Respiratory (Lung)
		Reticuloendothelial
		Therapeutic
SPECIAL PROCEDURES		
		Arteriography
		Arthrography
		CT guided biopsy, drainage of lung & solid organ
		Intraoperative Ultra Sound
		Lymphangiography
		Paracentesis
		Picc line / Central line access
		Pneumonoperitoneum
		Thoracentesis
		Ultra Sound and mammographic placement for wire localization
		Ultra Sound guided biopsy, drainage, foreign body localization
		Venography
		Other:
TELERADIOLOGY INTERPRETATIONS		
		CT
		Ultrasound Exams
		Nuclear Medicine Exams
		X-ray
		Other:
OTHER		
		Magnetic Resonance Imaging

I am qualified and competent to perform those privileges as requested in my application.

Signature: _____ Date: _____

Lady of the Sea General Hospital		
Radiology		
Practitioner Name:		
Please indicate in the "Requested" section, those privileges which you are requesting.		
Requested	Recommen	Approved
Delineation of Privileges		
<input type="checkbox"/>	<input type="checkbox"/>	Magnetic Resonance Angiography
<input type="checkbox"/>	<input type="checkbox"/>	Contrast Studies including Gadolinium
<input type="checkbox"/>	<input type="checkbox"/>	Magnetic Resonance Arthrography

I am qualified and competent to perform those privileges as requested in my application.

Signature: _____ Date: _____