



CIBOLA GENERAL HOSPITAL

1016 ROOSEVELT • GRANTS, NM 87020 • (505) 287-4446 • FAX (505) 287-5309

RADIOLOGY CLINICAL PRIVILEGES REQUEST FORM DIAGNOSTIC RADIOLOGY

Name: _____
(please print)

Group I General Roentgenology

- _____ (a) Chest
- _____ (b) Gastrointestinal
- _____ (c) Genitourinary
- _____ (d) Pediatric
- _____ (e) Musculoskeletal
- _____ (f) Head and Neck
- _____ (g) Mammography
- _____ (h) Venography (peripheral)

Group II Ultrasonography _____

Group III Special Procedures

- _____ (a) Visceral Angiography
- _____ (b) Peripheral Angiography
- _____ (c) Interventional Radiology
 - _____ (1) Biopsy procedures
 - _____ (2) Therapeutic procedures
- _____ (d) Myelography
- _____ (e) Arthrography

GROUP IV Computerized Axial Tomography _____

GROUP V Magnetic Resonance Imaging _____

IMPORTANT NOTATION:

As indicated above, certain specialized invasive examinations will require approval on a procedure by procedure basis. These examinations have been listed below. Kindly

check off the column next to the name of the procedure for which you would like to have clinical privileges in Radiology granted to you:

- _____ Biopsies:
- _____ Abdominal masses
 - _____ Articular and periarticular tissues
 - _____ Bones
 - _____ Breast masses
 - _____ Miscellaneous lymph nodes
 - _____ Miscellaneous soft tissue masses
 - _____ Pleural, pulmonary or mediastinal masses
 - _____ Retroperitoneal viscera
 - _____ Solid abdominal and pelvic viscera
- _____ Angioplasties
- _____ Calculus, foreign body & catheter/guide wire retrieval
- _____ Hysterosalpinography
- _____ Interventional Angiography:
- _____ Pharmacological chemotherapy, transcatheter
 - _____ Pharmacological therapeutic hemostasis, transcatheter
 - _____ Transcatheter blood sampling for assay
 - _____ Transcatheter pressure gradient determination
 - _____ Tumor embolization and/or infarction
- _____ Transjugular heptobiliary biopsy and contrast injection
- _____ Percutaneous abscess drainage
- _____ Percutaneous biliary drainage
- _____ Percutaneous intestinal or biliary bypass
- _____ Percutaneous nephrostomy for diagnosis and drainage therapy
- _____ Percutaneous transhepatic cholangiography

_____ Applicant Signature

_____ Date

Appointment Recommended Appointment Not Recommended Appointment Deferred

_____ Date

_____ Chairman, Executive Committee

Appointed

Disapproved

Deferred

_____ Date

_____ Chairman, Board of Directors



HEALTH STATEMENT

Do you presently have a physical or mental health condition which would affect or is likely to affect your ability to perform professional or medical staff duties as a physician/allied health professional?:

_____ Yes _____ No

If yes, please explain: _____

During the last two years, have you been hospitalized or received any other type of institutional care for a health problem?:

_____ Yes _____ No

Significant finding: _____

Signature

Date

*******IMPORTANT – MUST BE SIGNED BY VERIFYING PHYSICIAN*******

I affirm to the best of my knowledge that the above mentioned physician has no physical or psychological impairments that would impede his/her ability to perform quality health care services.

(Signature of verifying physician)

Date: _____