

NAME: _____

DATE: _____

SIERRA VISTA HOSPITAL
800 East Ninth Street
Truth or Consequences, New Mexico 87901

DELINEATION OF RADIOLOGICAL PRIVILEGES

I am qualified for and request the following privileges:

RADIOLOGICAL PRIVILEGES:

- _____ Mammography
- _____ Fluoroscopy
- _____ Diagnostic Radiology
- _____ Diagnostic Ultrasonography
- _____ Computerized Tomography

INTERPRETATIVE PROCEDURES:

* Plain film diagnostic radiology

- _____ Head and neck
- _____ Chest
- _____ Spine and pelvic
- _____ Upper extremities
- _____ Lower extremities
- _____ Abdomen
- _____ Gastrointestinal tract
- _____ Urinary tract

* Computerized tomography

- _____ Head
- _____ Facial bones
- _____ Paranasal sinuses
- _____ Neck
- _____ Chest
- _____ Abdomen
- _____ Pelvis
- _____ Extremity

* Diagnostic Ultrasonography

- _____ Obstetrical
- _____ Abdominal
- _____ Pelvic
- _____ Scotal
- _____ Renal
- _____ Vascular
- _____ Extremities
- _____ Breast

* Flouroscopy

- _____ Barium swallow
- _____ Esophagram
- _____ Upper GI series
- _____ Small bowel series
- _____ Barium enema
- _____ T-tube cholangiogram
- _____ Arthrography
 - _____ Wrist
 - _____ Shoulder
 - _____ Hip
 - _____ Knee

Chief of Staff

Date

Chairman of the Board

Date

Administrator

Date