Albuquerque Surgery Center
1720 Wyoming NE
Albuquerque, NM 87112

Delineation of Privileges - ***Ophthalmology***

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES:	Requested	Not Requested	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.				
Anterior chamber irrigation				
Blepharoptosis surgery				
Blepharotomy – hordeolum				
Cataract surgery, excluding phacoemulsification				
Chalazion surgery				
Conjunctival biopsy				
Corneal curettage				
Corneal Transplant				
Cyclocryotherapy				
Cyclodialysis				
Dacryocystorhinostomy				
Ectropion/entropion repair				
Enucleation and evisceration				
Epilation of eyelashes				
Excision of ciliary body lesions				
Excision of iris lesions				
Exenteration surgery				
Glaucoma filtering procedures				
Goniotomy				
I & D lacrimal sac abscess				
Intraocular lens implantation				
Iridectomy/iridotomy				
Keratoplasty				
Keratoprosthesis surgery				
Lacrimal duct probing				
Major plastic repair				
Phacoemulsification procedures				
Pterygium surgery				
Punctum and canalicular surgery				
Removal of intraocular and intraorbital foreign bodies				
Removal of superficial foreign body				
Repair of extensive lacerations of lids, conjunctivae, cornea, globe				
Repair of minor lacerations of lids, conjunctivae				
Retinal detachment surgery				
Strabismus surgery				
Subconjunctival and retrobulbar injections				
Tarsorrhaphy				
Trabeculectomy/trabeculotomy				

*include documentation of continuing education/training.

Your initials as used in Medical Records ____

Your signature as used in Medical Records ______________________________________

I, ____________________, hereby request privileges in the specialty of **Ophthalmology** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

____ ____________________
Physician Date

APPROVAL:

Comments:

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Medical Director/President, Medical Staff Date