

Albuquerque Surgery Center
1720 Wyoming NE
Albuquerque, NM 87112

Delineation of Privileges - *Orthopedics*

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.				
ACL reconstruction				
Amputation finger/toe				
Arthrodesis				
Arthroscopy <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow				
Arthroplasty				
Arthrotomy				
Bone grafts				
Bunionectomy				
Bursectomy				
Carpal tunnel release				
Cast application				
Closed reduction				
De Quervain's release				
Excision bony lesion				
Ganglionectomy				
Hammertoe repair				
Hardware removal				
I & D abscess				
Joint and tendon prosthesis				
Ligament repair				
Manipulation of joint				
Meniscectomy				
Neuroma excision				
Open reduction				
ORIF – extremity				
Osteotomy				
Peripheral nerve surgery				
Skin graft and flaps				
Synovectomy				
Tendon repair				
Tenolysis				
Trigger finger release				
Tumor excision				
Interpret x-rays				
Hand Surgery				
Surgery of muscle, tendon, and fascia of hand				
Transplantation of muscle and/or tendon of hand				
Plastic operation on hand with tissue graft or prosthetic implant				

ORTHOPAEDICS

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Do you anticipate giving local anesthesia? Yes No

Do you anticipate administering your own anesthesia? Yes* No

Do you administer anesthesia at any other local facilities? Yes No

(*If yes, please complete Anesthesia Privileges for non-anesthesiologists.)

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **Orthopaedics** 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:	

_____	_____
Medical Director/President, Medical Staff	Date