

FORT BAYARD MEDICAL CENTER
DELINEATION OF CLINICAL PRIVILEGES
PSYCHIATRIST SERVICES

NAME

DATE

TITLE

SIGNATURE

By checking an item below you are requesting the privilege of practicing the item without supervision and stating that you are qualified to do so.

PROCEDURES

- _____ Routine primary care procedures such as, suturing of skin lacerations, care of minor wounds, insertion of nasogastric tubes, drawing of venous and arterial blood samples, and applying simple casts and splints
- _____ Emergency medical procedures as needed including cardiorespiratory resuscitation (Basic CPR)
- _____ Biofeedback

PROCEDURES: (Perform and Interpret relative to age of population served; i.e., adulthood through geriatric age groups)

- _____ Diagnostic Evaluation
- _____ Psychological Testing
- _____ Cognitive Testing
- _____ Mental Status Evaluation
- _____ Individual Psychotherapy
- _____ Group Psychotherapy
- _____ Family Medical Psychotherapy
- _____ Participation in Team Conference Meetings
- _____ Behavior Therapy Interventions
- _____ Staff Support Groups
- _____ Psychiatric History
- _____ Psychiatric Evaluation
- _____ Psychiatric Diagnosis
- _____ Mental Competency Evaluations and Testimony
- _____ Other: (Describe) _____
- _____

TREATMENT

- _____ Evaluation and treatment of connective tissue disorders
- _____ Evaluation and treatment of acute and chronic neuromusculoskeletal pain syndromes
- _____ Treatment of metabolic disorder as related to musculoskeletal problems in the course of rehabilitation
- _____ Treatment of endocrinological disorders as related to musculoskeletal problems or as needed in the course of rehabilitation
- _____ Management of degenerative, metabolic hereditary, traumatic, and miscellaneous types of bone and joint disease
- _____ Evaluation and treatment of degenerative problems of the nervous system, vascular problems, infectious problems when related to the rehabilitation of patients, carcinomatous problems, treatment of congenital problems
- _____ Treatment of diseases and conditions of any body system when related to neuromusculoskeletal complaints or an overall rehabilitation program
- _____ Treatment of contractures of soft tissues and joints
- _____ Prescription of Physical Therapy and Occupational Therapy
- _____ Prescription of orthotic and prosthetic devices
- _____ Treatment of pressure ulcers
- _____ Treatment of neurogenic bladder and bowel dysfunction
- _____ Management of routine medical problems of patients with chronic psychiatric illness and/or dementia
- _____ Treatment of psychiatric disorders
- _____ Evaluation of therapy for and treatment of psychiatric disorders
- _____ Monitoring effects of psychoactive medications
- _____ Prescription of Clinical Psychology services

CHEMICAL DEPENDENCY TREATMENT

- _____ Evaluation and treatment including detoxification of patients with alcohol, opioid, cocaine, benzodiazepine and other drugs
 - _____ Diagnosis and treatment of co-occurring disorders
 - _____ Counseling
 - _____ Education of staff
 - _____ Other: (Describe)
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I hereby request the privileges identified above. Furthermore, I am physically and mentally capable to perform the requested privileges.

Signature

Date

FBMC CREDENTIALING COMMITTEE RECOMMENDATION:

The members of the FBMC Credentialing Committee have reviewed and investigated this application and hereby recommend that this application be:

_____ Accepted for appointment/reappointment of staff membership and/or continuation of current privileges.

_____ Accepted for reappointment of staff membership and modification of privileges as outlined on privilege delineation forms.

_____ Rejected or accepted with restrictions for the following reasons:

FBMC Medical Director: _____ Date: _____

Comments:

ACTION BY GOVERNING BOARD:

_____ Concur with FBMC Credentialing Committee recommendation

_____ Other action (describe): _____

