**SCOTLAND MEMORIAL HOSPITAL**
**Clinical Privileges Delineation Form**
**Specialty: Diagnostic Imaging**

Physician Name: ____________________

## I. *General Privileges*

By virtue of being granted any level of clinical privileges, a physician is automatically granted the following privileges:

> Performing physical examinations and ordering and interpreting of other diagnostic studies that are normally considered part of the practice of diagnostic imaging, including, but not limited to, laboratory and electrocardiographic studies.
>
> Prescribing and administering medications normally considered part of the practice of diagnostic imaging.
>
> Requesting consultations and technical procedures to be performed by other physicians and qualified consultants/technicians.
>
> At the time of a clinical emergency, the provision of whatever care the physician believes to be indicated to prevent loss of life or serious injury to a patient.

## II. *Specific Privileges: Clinical*

Physicians granted clinical privileges in Diagnostic Imaging must demonstrate knowledge and skills usually achieved only through training sufficient to attain eligibility for Board certification in Diagnostic Imaging, or equivalent experience (NOTE: if sufficient training is not documented, specific experience must be outlined in writing).

| Procedure | Requested | Approved | Not Approved/ Approved with Restrictions | Procedure | Requested | Approved | Not Approved/ Approved with Restrictions |
|---|---|---|---|---|---|---|---|
| **General Diagnostic Radiology** | | | | Special Procedures with C.T., Fluoroscopic, Ultrasonic or C-Arm Guidance | | | |
| Gen. Plain Film Diagn. | | | | Arteriography, Aorta | | | |
| Computer. Tomography | | | | Arteriography, Extremity | | | |
| Contrast Studies: Barium | | | | Venography, Other | | | |
| Contrast Studies: Water Soluble Media | | | | **Diagnostic Nuclear Medicine** | | | |
| Other Media | | | | Endocrine | | | |
| Magnetic Resonance Imaging | | | | Hematopoietic, Reticuloendothelial & Lymphatic-incl. Spleen | | | |
| Bronchography | | | | Gastrointestinal - incl. Liver | | | |
| Cystography | | | | Musculoskeletal | | | |
| Lymphography | | | | Cardiovascular | | | |
| Arthrography | | | | Respiratory (Lung) | | | |
| Mammography | | | | CNS | | | |
| Myelography | | | | Genitourinary | | | |
| Sialography | | | | **Other** | | | |
| Salpingography | | | | Percutaneous Biopsy | | | |
| **Ultrasonography** | | | | Liver Biopsy | | | |
| Pelvic (incl. obstetrical) | | | | Lung Nodule Biopsy | | | |
| Head and Neck | | | | Tumor Biopsy | | | |
| Chest, Abdomen and Retroperitonium | | | | Enlarged Lymph Node Biopsy | | | |

I hereby request the clinical privileges listed above.

Applicant Signature_______________________________________ Date: _____ / _____ / _____

**DEPARTMENT CHAIRMAN APPROVAL**

**NOTE:** Any request indicated as "Not Approved / Approved with Restrictions" must be explained here, including listing any restrictions:

_______________________________________________________________________________________________
_______________________________________________________________________________________________
____________________________________________________________________________________

______________________________________________________ Date _____ / _____ / _____
Chairman, Department of Radiology