Union West Surgery Center

PRIVILEGE REQUEST: Oral and Maxillofacial Surgery

Provider Printed Name: _____

Provider Signature: _____

Date: _____

PROCEDURE	REQUESTED	APPROVED
DENTOALVEOLAR:		
EXCISION OF TUMORS/CYSTS OF THE MOUTH		
EXPOSURE OF IMPACTED TEETH WITH/WITHOUT PLACEMENT OF ORTHODONTIC APPLICANCE		
EXTRACTION OF TEETH (ERUPTED/IMPACTED)		
INCISIONAL/EXCISIONAL BIOPSY OF SOFT TISSUE/OSSEOUS		
INTRAORAL INCISION AND DRAINAGE OF INFECTION		
INTERPRETATION OF X-RAYS		
LINGUAL/LABIAL FRENECTOMY		
ORTHOGNATHIC SURGERY:		
GENLOPLASTY WITH/WITHOUT GRAFT		
RESTORATIVE DENTISTRY:		
DENTAL EXAMINATION		
PREPARATION OF TEETH FOR CROWNS, BRIDGES, DENTURE ABUTMENTS		
PREPROSTHETIC SURGERY:		
EXCISION OF MUCOSAL GRAFTS		
EXCISION OF SPLIT THICKNESS AND DERMAL SKIN GRAFTS		
MAXILLOFACIAL TRAUMA:		
CLOSED/OPEN REDUCTION OF FACIAL FRACTURES INCLUDING:		
MANDIBULAR FRACTURES		
MAXILLARY FRACTURE		
TEMPOROMANDIBULAR JOINT (TMJ) ARTHROCENTESIS		
TEMPOROMANDIBULAR JOINT (TMJ) ARTHROSCOPY		
OTHER PROCEDURES:		
ANESTHESIA – LOCAL		
ANESTHESIA – TOPICAL		
CONSCIOUS SEDATION		
EMERGENCY TRACHEOSTOMY		
EXCISION OF FOREIGN BODIES OF MOUTH/JAWS		
HISTORY AND PHYSICAL		
INTERPRETATION OF X-RAYS		
LIGATION OF VESSELS FOR UNCONTROLLABLE ORAL BLEEDING		
SUPERVISION OF NON-PHYSICIAN PERSONNEL		

Medical Executive Committee - Approved By:	Approval Date:
Board of Managers — Approved By:	Approval Date: