DELINEATION OF CLINICAL PRIVILEGES - NEUROLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Category I. Emergency care.

Uncomplicated illnesses or problems which have low risk to the patient such as recurrent headache or uncomplicated epilepsy or conditions with no available treatment such as completed ischemic stroke, progressive dementia in the elderly, and cerebral palsy.

Internists, pediatricians, family practitioners, and psychiatrists for whom neurology training has been included in their residency experience qualify for this level of privileges.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.

Major illnesses, injuries, conditions or procedures with little immediate risk to life, in a child or adult, such as multiple sclerosis, Parkinson's disease, and transient ischemic attacks. Management of crippling or like threatening disorders in settings where Category III and IV supervisor is available. Performance of EMG, EEG, evoked potentials, and other similar tests for which the applicant has had specific training.

One year of general postgraduate education and two years of specialty training in child or adult neurology is required.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.

Management of all conditions affecting the nervous system in adults, except those requiring neurosurgical intervention. Management of neurological conditions in children.

Completion of an accredited neurology residency is required.

Requested	Approved	
		Category III clinical privileges

Category IV (a). Includes Categories I, II, and III.

Child Neurology. Management of all neurologic conditions affecting children, except those requiring neurosurgical intervention. Individual patients display complexity exceeding that of category III patients.

Requested	Approved	
		Category IV (a) clinical privileges

Category IV (b). Includes Categories I, II, and III.

Neurology Subspecialties. Management of disorders or other problems reflecting additional subspecialty training and skill. Individual patients display complexity exceeding that of category III patients.

A post-residency Fellowship or other appropriate post-residency training is required for Category IV (a) or (b) privileges.

Requested	Approved	
		Category IV (b) clinical privileges

SUBSPECIALTY TRAINING *(Initial all that apply.)*

_____ Child Neurology _____ Neuro Pathology _____ Neuro Muscular _____ Neuro Physiology

_____ Neuro Behavioral _____ Neuro Ophthalmology _____ Neuro Rehabilitation

_____ Sleep Medicine _____ Epilepsy Surgical Evaluation (Epilepsy Monitoring)

Other: _____

SPECIAL PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Lumbar Puncture			l. Nerve Block, Peripheral
		b. Cisternal Tap			m. Muscle Biopsy, Needle
		c. Subdural Tap *(Infant)*			n. Muscle Biopsy, Open
		d. Electroencephalogram (EEG)			o. Chemodenervation
		e. Brain Stem Auditory Evoked Response			p. Ultrasound Examination of the Brain
		f. Visual Evoked Response			q. Ultrasound Examination of the Muscle
		g. Somatosensory Evoked Response			r. Ultrasound Examination of Spinal, Cervical and Intracranial Vasculature
		h. Electromyography/Nerve Conduction Velocity (EMG/NCV)			s. Carotid Duplex Ultrasonography
		i. Myelogram			t. Insertion of Sphenoidal EEG Electrodes
		j. Plasmapheresis			
		k. Nerve Biopsy			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*