LAKEWOOD REGIONAL MEDICAL CENTER
DEPARTMENT OF RADIOLOGY
PRIVILEGE/PROCEDURE CONTROL CARD

PHYSICIAN NAME_________________________________SPECIALTY_______________

In order to be granted privileges in Radiology, physicians must have satisfied the criteria to be a candidate for the American Board of Radiology or be certified.

RADIOLOGY PRIVILEGES

Req	Granted	
___	___	Admission of Patients to Hospital
___	___	General Radiology (including GI, GU, T-tube, film interpretation, cystography, Etc.)
___	___	Coronary arteriogram interpretation
___	___	Mammography
___	___	Ultrasound (including doppler, endovaginal, endorectal, esophageal)
___	___	CT Scan (brain, spine, body, extremities, other)
___	___	Nuclear Medicine
___	___	MRI
___	___	Arteriography, Seldinger, Trans-lumbar
___	___	Cerebral
___	___	Spinal
___	___	Visceral
___	___	Peripheral
___	___	Pulmonary
___	___	DSA
___	___	Venography
___	___	Peripheral
___	___	IVC, SVC, Selected
___	___	Moderate Sedation (See MS Policy)

INTERVENTIONAL

Req	Granted	
___	___	Percutaneous needle biopsy
___	___	Percutaneous image-guided cryoablation
___	___	Percutaneous thermal ablation ablation
___	___	Bone Biopsy
___	___	Percutaneous drainage procedures
___	___	Abscess
___	___	Renal (external, internal & stent)
___	___	Biliary (external, internal & stent)
___	___	Gastrostomy
___	___	Cystostomy
___	___	Vascular Stent Placement **
___	___	Vertebroplasty/Kyphoplasty with/without Epidural **

** (To request these privileges, MD must meet the qualifications as outlined per protocol)

Req	Granted	
___	___	Stone Removal
___	___	Kidney
___	___	Biliary
___	___	Intravascular FB retrieval
___	___	Percutaneous IVC filter Placement
___	___	Percutaneous Transluminal angioplasty
___	___	Peripheral
___	___	Renal
___	___	Other
___	___	Dilation of stricture, esophageal, GI, GU
___	___	Arterial infusions, including Streptokinase, Chemotherapy
___	___	Arterial Embolizations
___	___	Chymopapain Therapy
___	___	Fallopian Tube Dilation
___	___	Retrograde Urethrography
___	___	Other
___	___	Bronchography, Laryngography
___	___	Sialography
___	___	Percutaneous Transhepatic Cholangiogram
___	___	Hysterosalpingography
___	___	Hysterosalpingography
___	___	Myelography
___	___	Cyst puncture
___	___	Lymphangiography
___	___	Arthrography
___	___	Pneumoperitoneum
___	___	Dacryocystography

TELERADIOLOGY

Req	Granted	
___	___	Preliminary Readings

Signature of Physician____Date______________________

APPROVALS

DEPARTMENT CHAIR____Date_______________________

MEDICAL EXECUTIVE COMMITTEE____Date_______________________

GOVERNING BOARD____Date_______________________

LAKEWOOD REGIONAL MEDICAL CENTER
DEPARTMENT OF RADIOLOGY
PRIVILEGE/PROCEDURE CONTROL CARD

PHYSICIAN NAME______________________________________DATE_________

In order to be granted privileges in Radiology, physicians must have satisfied the criteria to be a candidate for the American Board of Radiology or be certified.

PRIVILEGES – RADIATION ONCOLOGY

Req Granted

___ ___ Admitting Privileges
___ ___ History & Physical Privileges
___ ___ Radiation Oncology Consults

___ ___ Radiology Supervisor's Permit (Must have current permit on file)

___ ___ Other ____________________________

___ ___ Other ____________________________

Signature of Physician____Date_______________________

APPROVALS

DEPARTMENT CHAIR____Date________________________

MEDICAL EXECUTIVE
COMMITTEE____Date________________________

GOVERNING BOARD____Date________________________