

UNION WEST SURGERY CENTER

PRIVILEGE REQUEST: Otolaryngology

Provider Printed Name: _____

Provider Signature: _____

Date: _____

PROCEDURE	REQUESTED	APPROVED
EAR:		
AURAL POLYPECTOMY		
BIOPSY EAR EXCISION EXOSTOSIS EXTERNAL CANAL		
EXCISION OF GLOMUS TUMOR MIDDLE EAR OR MASTOID		
EXCISION SOFT TISSUE LESION EXTERNAL CANAL		
FOREIGN BODY REMOVAL		
I&D ABSCESS OR HEMATOMA		
MASTOIDECTOMY SIMPLE		
MASTOIDECTOMY MODIFIED RADICAL		
MASTOIDECTOMY RADICAL		
MYRINGOPLASTY		
MYRINGOTOMY WITH OR WITHOUT TUBE		
PARTIAL OR TOTAL AURICULECTOMY WITH OR WITHOUT REPAIR		
REPAIR OVAL OR ROUND WINDOW FISTULA		
STEPEDECTOMY TYMPANOPLASTY		
TYMPANOTOMY		
NOSE:		
BIOPSY NASOPHARYNX		
EXCISION RHINOPHYMA		
EXCISION THORNWALDT'S BURSAE		
I&D NASAL OR SEPTAL ABSCESS OR HEMATOMA		
LATERAL RHINOTOMY		
POLYPECTOMY		
REMOVAL OF FOREIGN BODY RHINOPLASTY		
SEPTAL DERMATOPLASTY		
SMR OF TURBINATE		
SUBMUCOSUS RESECTION, SEPTOPLASTY BALLOON SINUPLASTY LASER EXCISION OF NASAL POLYPS		
SINUSES:		
ANTROTOMY		
ANTRUM LAVAGE		
CALDWELL-LUC		
FRONTOSPHEENOETHMOIDECTOMY		
SPHENOID SINUSOTOMY		
TREPINATION FRONTAL SINUS		
ENDOSCOPIC SINUS PRIVILEGES:		
ENDOSCOPIC ETHMOIDECTOMY		
ENDOSCOPIC MAXILLARY SINOSCOPY		

ENDOSCOPIC MAXILLARY SINUS EXPLORATION		
ENDOSCOPIC NASAL ENDOSCOPY		
ENDOSCOPIC NASAL POLYPECTOMY		
ENDOSCOPIC OSTEOMEATAL WINDOW		
ENDOSCOPIC SPENOIDOTOMY		
MOUTH, SALIVARY GLANDS:		
BIOPSY TONGUE, PALATE, GINGIVAE, FLOOR OF MOUTH, TONSIL		
EXCISION LESION OF LIP		
EXCISION SUBMAXILLARY TUMOR OR GLAND		
I&D PAROTID GLAND		
I&D PERITONSILLAR, PARA PHARYNGEAL ABSCESS		
I&D SUBLINGUAL, SUPRA-MYLOHYOID ABSCESS OR LUDWIG'S ANGINA		
I&D SUBMAXILLARY ABSCESS		
LIP SHAVE		
PAROTIDECTOMY, PARTIAL OR TOTAL WITH NERVE GRAFT		
SIALOLITHOTOMY PAROTID OR SUBMAXILLARY GLAND		
T&A		
LARYNX, TRACHEA, BRONCHI, ESOPHAGUS:		
ARYTENOIDECTOMY, ARYTENOIDOPEXY		
BRONCHOSCOPY, BIOPSY, FOREIGN BODY REMOVAL		
DIRECT LARYNGOSCOPY, BIOPSY, CORD STRIPPING, FOREIGN BODY REMOVAL		
ESOPHAGOSCOPY, BIOPSY, FOREIGN BODY REMOVAL, DILATATION		
TRACHEOSTOMY		
FRACTURES:		
REDUCTION MANDIBULAR FRACTURE		
REDUCTION MAXILLO-MALAR FRACTURE		
REDUCTION NASAL FRACTURE		
REDUCTION ORBITAL FLOOR FRACTURE		
NECK:		
BIOPSY SUPERFICIAL OR DEEP CERVICAL NODE		
I&D CERVICAL ABSCESS		
EXCISION THYROGLOSSAL DUCT CYST		
OTHER PROCEDURES:		
ANESTHESIA - LOCAL		
ANESTHESIA - REGIONAL		
ANESTHESIA - TOPICAL		
INTERPRETATION OF X-RAYS/SCANS		
SUPERVISION OF NON-PHYSICIAN PERSONNEL		

Medical Executive Committee -Approve By:	Approval Date:
Board of Manages- Approved By:	Approval Date: