

Union West Surgery Center

PRIVILEGE REQUEST: Urology

Provider Printed Name: _____

Provider Signature: _____

Date: _____

PROCEDURE	REQUESTED	APPROVED
ANESTHESIA LOCAL		
ANESTHESIA REGIONAL		
ANESTHESIA TOPICAL		
CIRCUMCISION		
EPIDIDYMECTOMY UNILATERAL		
EPIDIDYMOVASOSTOMY		
EPIDIDYMOVASOSTOMY		
EXCISION LOCAL LESION TESTIS		
EXCISION OF SPEMATOCELE		
HISTORY AND PHYSICAL		
HYPOSPADIAS REPAIR		
INTERNAL SPERMATIC VEIN LIGATION		
INTERPRETATION OF X-RAYS		
MEATOTOMY		
ORCHIECTOMY		
ORCHIOPEXY WITH OR WITHOUT HERNIA REPAIR		
PENILE PROSTHESIS INSERTION/REMOVAL		
PLASTIC REPAIR OF URETHROCELE		
REPAIR TUNICA VAGINALIS HYDROCELE		
SPERMATOCELECTOMY		
SUPERVISION OF NON-PHYSICIAN PERSONNEL		
TESTICULAR BIOPSY		
TESTICULAR PROSTHEHSIS INSERTION		
VARICOCELECTOMY		
VASECTOMY		
VASOVASOSTOMY		

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