

**Magna Health Systems**  
**PRIVILEGE REQUEST FORM**  
**GASTROENTEROLOGY**

I am applying for the following privileges of which I am also currently credentialed at \_\_\_\_\_ an Illinois Hospital

Privileges requested for Magna Surgical Center

<b>Requested</b>	<b>Granted</b>	<b>Procedure</b>
_____	_____	<b>Special Studies, Invasive</b>
_____	_____	Other respiratory tract intubation
_____	_____	Esophageal tamponade (Blakemore/Sengstaken)
_____	_____	Insertion naso-gastric tube
_____	_____	Bronchial lavage
_____	_____	Inject chemotherapy agent
_____	_____	<b>Biopsy Procedure, Endoscopic</b>
_____	_____	Bronchus (brushing)
_____	_____	Lymph node
_____	_____	Bone marrow
_____	_____	Small Intestine
_____	_____	Rectum
_____	_____	Pancreas
_____	_____	Skin
_____	_____	<b>Biopsy Procedure, Excisional</b>
_____	_____	Thyroid (open)
_____	_____	Lung
_____	_____	Pleura
_____	_____	Pericardium
_____	_____	Lymph Node
_____	_____	Bone marrow
_____	_____	Small Intestine
_____	_____	Rectum
_____	_____	Liver
_____	_____	Pancreas
_____	_____	Abdominal wall
_____	_____	Peritoneum
_____	_____	Kidney
_____	_____	Soft tissue
_____	_____	Skin

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_____	_____	<b>Biopsy Procedure, Percutaneous</b>
_____	_____	Thyroid
_____	_____	Lung
_____	_____	Mediastinum (closed)
_____	_____	Pericardium
_____	_____	Lymph node
_____	_____	Bone marrow
_____	_____	Spleen
_____	_____	Rectum
_____	_____	Liver
_____	_____	Pancreas
_____	_____	Abdominal wall
_____	_____	Kidney
_____	_____	Soft tissue
_____	_____	Skin
_____	_____	<b>Endoscopy Procedures</b>
_____	_____	Laryngoscopy
_____	_____	Bronchoscopy flexible
_____	_____	Bronchoscopy with biopsy
_____	_____	Mediastinoscopy with biopsy
_____	_____	Esophagoscopy with biopsy
_____	_____	Gastrosocopy with biopsy
_____	_____	Duodenoscopy with biopsy
_____	_____	Sigmoidoscopy flexible
_____	_____	Colonoscopy with biopsy
_____	_____	Polypectomy of large intestine
_____	_____	Rigid Procto/sigmoidoscopy
_____	_____	Proctosigmoidoscopy with biopsy
_____	_____	E.R.C.P.
_____	_____	Peritoneoscopy with biopsy
_____	_____	<b>Special Study, Non-invasive</b>
_____	_____	Esophageal dilation
_____	_____	<b>Other (Please Specify):</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Practitioner's Signature

Print Name

Date

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Medical Director Approval, Magna Surgical Center

Date

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Governing Body Approval

Date