

NON-CORE PRIVILEGE FORM: OROFACIAL PAIN PRIVILEGE REQUEST

Applicant's Name:

License No. :

Scope of Practice:

	Privileges	For applicant use		For committee use		
		Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1	Provide accurate diagnosis of the most common intraoral and orofacial pain conditions, be able to recognize the more complex orofacial pain conditions, and initiate referrals to appropriate experts in managing such patients.					
2	Perform extensive temporomandibular joint, masticatory, and cervical muscle examination, evaluation of dental occlusion.					
3	Diagnostic and treatment procedures including <ol style="list-style-type: none"> 1. Craniofacial nerve blocks. 2. Intramuscular trigger point injections in the masticatory, head, and neck muscles. 3. Cognitive-behavioral management strategies. 					
4	Pharmacotherapy management including topical and systemic analgesics, muscle relaxants, anxiolytics, anticonvulsants, antidepressants					
5	Performing some of physiotherapy modalities including Manual manipulation, Ultrasound therapy, TENS, Therapeutic exercises.					



6	Fabrication of oral occlusal appliances.					
7	Selective occlusal therapy					
8	Botox injection therapy for headaches and muscle pain conditions.					

Committee Decision:

Evaluation type:

- By Interview (virtual / personal)
 By documents only
 Or both

Other comments:

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Clinical privileging committee members:

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

Committee members:

Name: Date:

Signature: Stamp:

Name: Date:

Signature: Stamp:

Name: Date:

Signature: Stamp:

Medical director of the facility:

Name: Date:

Signature: Stamp: