NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

1. Bone Grafting: S5D1.1

1. Name of the Procedure: Bone Grafting

2. Indication: Atrophic Non-Union

3. Does the patient have
   a. Painless Abnormal Mobility: Yes/No
      AND
   b. Deformity: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of Atrophic Non-Union on X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having evidence of infected fracture: Yes/No

   For eligibility for Bone Grafting, the answer to 5 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

2. Excision and other operation for fracture scaphoid: FIXATION: S5D1.2

1. Name of the Procedure: Fixation

2. Indication:

Displaced fresh fracture
Non-Union
Wrist Arthritis

3. Does the patient has evidence of displaced fresh fracture of scaphoid bone on X-Ray: Yes/No (Upload X-Ray film)

4. If the answer to question 3 is Yes then is the patient having evidence of un-displaced fresh fracture on X-Ray: Yes/No

For eligibility for Fixation of Scaphoid fracture, the answer to 4 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

3. Excision and other operation for fracture scaphoid: FIXATION + Bone Grafting: S5D1.2

1. Name of the Procedure: FIXATION + Bone Grafting

2. Indication:

Displaced fresh fracture
Non-Union
Wrist Arthritis

3. Does the patient has evidence of Non-Union of scaphoid bone fracture on X-Ray: Yes/No (Upload X-Ray film)

4. If the answer to question 3 is Yes then is the patient having evidence of fresh fracture on X-Ray: Yes/No

For eligibility for FIXATION + Bone Grafting of Scaphoid fracture, the answer to 4 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

4. Excision and other operation for fracture scaphoid: EXCISION: S5D1.2

1. Name of the Procedure: EXCISION

2. Indication: Wrist Arthritis

Displaced fresh fracture
Non-Union
Wrist Arthritis

3. Does the patient has evidence of wrist arthritis on X-Ray: Yes/No (Upload X-Ray film)

4. If the answer to question 3 is Yes then is the patient having evidence of no wrist joint changes on X-Ray: Yes/No

   For eligibility for Excision of scaphoid bone, the answer to 4 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

5. Open Reduction & Internal Fixation Of Fingers & Toes: S5D1.3

1. Name of the Procedure: Open Reduction & Internal Fixation Of Fingers & Toes

2. Indication: Fresh fractures of toes and fingers

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Swelling: Yes/No
      AND
   c. Crepitus: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of deformity on examination: Yes/No

5. If the answer to question 4 is Yes then is the patient having evidence of fracture on X-Ray: Yes/No

6. If the answer to question 5 is Yes then is the patient having evidence of undisplaced fracture: Yes/No

   For eligibility for ORIF of fingers and toes, the answer to 6 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

6. Reduction Of Compound Fractures & External Fixation: Compound fracture Grade 2A onwards: S5D1.4

1. Name of the Procedure: Reduction Of Compound Fractures & External Fixation

2. Indication: Compound fracture Grade 2A onwards

3. Does the patient have
   a. Open Fracture: Yes/No
      AND
   b. Wound: Yes/No
      AND
   c. Crepitus: Yes/No
      AND
   d. Pain: Yes/No

4. If the answer to all 3a AND 3b AND 3c AND 3d is Yes then is the patient having evidence of Compound fracture on X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having evidence of closed fracture, mangled extremity: Yes/No

   For eligibility for reduction of compound fracture and external fixator, the answer to 5 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

7. ILLIZAROV RING FIXATOR: Infected Non-Union: S5D1.5

1. Name of the Procedure: ILLIZAROV RING FIXATOR

2. Select the Indication from the drop down of various indications provided under this head:

Infected Non-Union
Non-Union with deformity

3. Does the patient have
   a. Infected Fracture: Yes/No
      AND/OR
   b. Painless abnormal mobility at fracture site: Yes/No

4. If the answer to either 3a AND/OR 3b is Yes then is the patient having evidence of Infection on culture, Haemogram: Yes/No (Upload Culture, Haemogram report)

For eligibility for Ilizarov Ring Fixator Application, the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

8. ILLIZAROV RING FIXATOR: Infected Non-Union: S5D1.5

1. Name of the Procedure: ILLIZAROV RING FIXATOR

2. Select the Indication from the drop down of various indications provided under this head:

Infected Non-Union
Non-Union with deformity

3. Does the patient have
   a. Deformity: Yes/No
      AND
   b. Shortening: Yes/No
      AND
   c. Abnormal Mobility: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of Non-Union with deformity on X-Ray: Yes/No (Upload X-Ray film)

For eligibility for Ilizarov Ring Fixator Application, the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

9. Neglected CTEV-JESS FIXATOR: Neglected CTEV: S5D1.6

1. Name of the Procedure: Neglected CTEV-JESS FIXATOR

2. Indication: Neglected CTEV

3. Does the patient have
   a. Recurrence of CTEV: Yes/No
      AND/OR
   b. Relapse of CTEV: Yes/No
      AND
   c. More than 2 years of age: Yes/No

4. If the answer to questions 3a AND/OR 3b AND 3c is Yes then is the patient having evidence of Deformity on examination: Yes/No

5. If the answer to question 4 is Yes then is there evidence of deformity on X-Ray: Yes/No (Upload X-Ray film)

6. If the answer to question 5 is Yes then is the patient having
   a. Age less than 2 years: Yes/No
   b. Correctable Deformity: Yes/No

For eligibility for Neglected CTEV-JESS FIXATOR, the answer to question 6a AND 6b must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

10. Open Reduction Of Dislocations - Deep: S5D2.1

1. Name of the Procedure: Open Reduction Of Dislocations

2. Select the Indication from the drop down of various indications provided under this head:

Old neglected dislocation
Recurrent dislocation

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Swelling: Yes/No
      AND
   c. Deformity: Yes/No
      AND
   d. Loss of ROM: Yes/No

4. If the answer to all 3a AND 3b AND 3c AND 3d is Yes then is the patient having evidence of Dislocation on X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to 4 is Yes then is the patient having evidence of fresh dislocation: Yes/No

For eligibility for Open Reduction Of Dislocations, the answer to question 5 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

11. Open Reduction Of Dislocations – Deep: S5D2.1

1. Name of the Procedure: Open Reduction Of Dislocations

2. Select the Indication from the drop down of various indications provided under this head:

Old neglected dislocation
Recurrent dislocation

3. Does the patient have
   a. Recurrent history of dislocation: Yes/No
      AND
   b. Instability of joint: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of ligament injuries on MRI: Yes/No (Upload MRI film)

5. If the answer to 4 is Yes then is the patient having evidence of fresh dislocation: Yes/No

   For eligibility for OR for dislocation, the answer to 5 must be NO

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

12. Amputations – Forequarter: S5D2.2

1. Name of the Procedure: Fore-quarter amputation

2. Select the Indication from the drop down of various indications provided under this head:

Malignant tumor stage 1 & 2
Traumatic Injury

3. Does the patient have
   a. Swelling: Yes/No
      AND
   b. Pain: Yes/No

4. If the answer to either 3a AND/OR 3b is Yes then is the patient having evidence of malignancy on biopsy: Yes/No (Attach biopsy report)

5. If the answer to 4 is Yes then is the patient having evidence of Metastasis on CT Chest/Bone Scan: Yes/No (Upload CT chest/Bone scan film)

   For eligibility for Fore-quarter amputation, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

13. Amputations – Forequarter: S5D2.2

1. Name of the Procedure: Fore-quarter amputation

2. Select the Indication from the drop down of various indications provided under this head:

Malignant tumor stage 1 & 2
Traumatic Injury

3. Does the patient have mangled extremity: Yes/No (Upload photograph of extremity)

4. If the answer to question 3 is Yes then is the patient having evidence of Reconstructable limb: Yes/No

For eligibility for Fore-quarter amputation, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

14. Amputations - Hind Quarter And Hemipelvectomy: S5D2.3

1. Name of the Procedure: Amputations - Hind Quarter And Hemipelvectomy

2. Indication: Bony tumors of hip bone, Ischium, Pubis & Ilium/ Head of femur

3. Does the patient presented with pain, tenderness, restriction of movements, large mass in pelvis: Yes/No

4. If the answer to question 3 is Yes then is there evidence of carcinoma - CT Scan Abdomen/pelvis, Metastatic work-up, X ray, relevant hematological investigations: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Metastatic Disease: Yes/No
   b. Surgically unfit: Yes/No
   c. Locally advanced tumors involving bilateral: Yes/No

For Eligibility for Amputations - Hind Quarter And Hemipelvectomy the answer to questions 5a, 5b & 5c must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

15. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

2. Select the Indication from the drop down of various indications provided under this head:

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No
      AND/OR
   c. Decreased Range of Movement: Yes/No
      AND/OR
   d. Crepitus: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes then is the patient having reduction of joint space in X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

16. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

2. Select the Indication from the drop down of various indications provided under this head:

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No
      AND/OR
   c. Constitutional Symptoms: Yes/No
      AND/OR
   d. Raised WBC: Yes/No (Attach report)

4. If the answer to either question 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes then is the patient having reduction of joint space in X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

17. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

2. Select the Indication from the drop down of various indications provided under this head:

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. History of dislocation: Yes/No
      AND/OR
   c. Muscular Weakness: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c is Yes then is the patient having evidence of dislocation on MRI: Yes/No (Upload MRI film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

18. Arthroscopy - Diagnostic: S5D2.5

1. Name of the Procedure: Diagnostic Arthroscopy

2. Select the Indication from the drop down of various indications provided under this head:

Partial ACL tear
Synovial Biopsy
Cartilage Defects
Assessment of tracking of patella

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No
      AND/OR
   c. Instability in knee: Yes/No

4. If the answer to all questions 3a AND 3b AND 3c is Yes then is there evidence of Partial ACL tear on MRI: Yes/No (Upload MRI film)

5. If the answer to question 4 is yes, then is the patient having evidence of local infection of knee: Yes/No

For eligibility for Diagnostic Arthroscopy (to assess the strength of remaining ACL) the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

19. Arthroscopy - Diagnostic: S5D2.5

1. Name of the Procedure: Diagnostic Arthroscopy

2. Select the Indication from the drop down of various indications provided under this head:

Partial ACL tear
Synovial Biopsy
Cartilage Defects
Assessment of tracking of patella

3. Does the patient have
   a. Joint Swelling: Yes/No
      AND/OR
   b. Pain: Yes/No
      AND/OR
   c. Redness: Yes/No

4. If the answer to all questions 3a AND 3b AND 3c is Yes then is the patient having evidence of positive joint aspiration: Yes/No (Attach joint aspiration report)

5. If the answer to question 4 is Yes then is the patient having evidence of local infection of knee: Yes/No

   For eligibility for Diagnostic Arthroscopy, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

20. Arthroscopy - Diagnostic: S5D2.5

1. Name of the Procedure: Diagnostic Arthroscopy

2. Select the Indication from the drop down of various indications provided under this head:

Partial ACL tear
Synovial Biopsy
Cartilage Defects
Assessment of tracking of patella

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No

4. If the answer to questions 3a AND 3b is Yes then is there evidence of Cartilage defect on MRI: Yes/No (Upload MRI report)

5. If the answer to question 4 is Yes then is the patient having evidence of local infection of knee: Yes/No

For eligibility for Diagnostic Arthroscopy (to assess the cartilage defect), the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

21. Arthroscopy - Diagnostic: S5D2.5

1. Name of the Procedure: Diagnostic Arthroscopy

2. Select the Indication from the drop down of various indications provided under this head:

Partial ACL tear
Synovial Biopsy
Cartilage Defects
Assessment of tracking of patella

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Swelling: Yes/No
      AND
   c. Difficulty in knee flexion: Yes/No

4. If the answer to all questions 3a AND 3b AND 3c is Yes then is maltracking of patella ascertained clinically and by X-rays: Yes/No (Upload X-ray report)

5. If the answer to question 4 is yes then is the patient having evidence of local infection of knee: Yes/No

   For eligibility for Diagnostic Arthroscopy, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

22. Arthroscopy. Operative Meniscectomy: S5D2.6

1. Name of the Procedure: Arthroscopy. Operative Meniscectomy

2. Indication: Meniscus tear

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Swelling: Yes/No
      AND
   c. Locking: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of positive Macmurrays test: Yes/No

5. If the answer to question 4 is Yes then is the patient having evidence of meniscus tear on MRI: Yes/No (Upload MRI film)

6. If the answer to question 5 is Yes then is the patient having evidence of repairable meniscus tear on MRI: Yes/No

   For eligibility for Arthroscopic Meniscectomy, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

23. Arthroscopy - ACL Repair: S5D2.7

1. Name of the Procedure: Arthroscopy - ACL Repair

2. Indication: Instability of Knee

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Instability: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of positive Lachmanns test: Yes/No

5. If the answer to question 4 is Yes then is the patient having evidence of ACL tear on MRI: Yes/No (Upload MRI film)

6. If the answer to question 5 is Yes then is the patient having evidence of multi-ligament injury on MRI: Yes/No

   For eligibility for Arthroscopic ACL reconstruction, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

24. Avascular Necrosis Of Femoral Head (Core Decompression): S5D2.8

1. Name of the Procedure: Avascular Necrosis Of Femoral Head (Core Decompression)

2. Indication: AVASCULAR NECROSIS Stage 1 and 2

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Lurch: Yes/No
      AND
   c. Decreased Range of movement of hip: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of Avascular Necrosis on MRI/Bone Scan: Yes/No (Upload MRI/Bone scan film)

5. If the answer to question 4 is Yes then is the patient having evidence of
   a. Collapse of femoral head: Yes/No
   b. Arthritis: Yes/No

For eligibility for femoral head core decompression, the answer to 5a AND 5b must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

25. Soft Tissue Reconstruction Procedures For Joints/Osteotomy: S5D2.9

1. Name of the Procedure: Soft Tissue Reconstruction Procedures For Joints/Osteotomy

2. Select the Indication from the drop down of various indications provided under this head:

Instability at joint
Deformity/Muscle-Tendon-Fascia Contractures/Hypotonia/Spasticity/Nerve Palsy

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Loss of movement: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of ligament injuries and joint arthritic changes on MRI: Yes/No (Upload MRI film)

5. If the answer to question 4 is Yes then is the patient having evidence of stable non-arthritic joint: Yes/No

For eligibility for Soft Tissue Reconstruction Procedures For Joints/Osteotomy, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

26. Soft Tissue Reconstruction Procedures For Joints/Osteotomy: S5D2.9

1. Name of the Procedure: Soft Tissue Reconstruction Procedures For Joints/Osteotomy

2. Select the Indication from the drop down of various indications provided under this head:

Instability at joint
Deformity/Muscle-Tendon-Fascia Contractures/Hypotonia/Spasticity/Nerve Palsy

3. Does the patient have evidence of deformity of joint/ muscle-tendon-fascia contractures/ hypotonia/ spasticity/ nerve palsy: Yes/No

4. If the answer to question 3 is Yes then is the patient having evidence of any of the above on X-Ray/USG/MRI/EMG/NCV testing/Muscle Charting: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is the patient having evidence of arthritis/infection: Yes/No

For eligibility for Soft Tissue Reconstruction Procedures For Joints/Osteotomy, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

27. Anterolateral Clearance For Tuberculosis: S5D2.10

1. Name of the Procedure: Anterolateral Clearance For Tuberculosis

2. Select the Indication from the drop down of various indications provided under this head:

Increased neurodeficit despite AKT
Instability
Resistant TB

3. Does the patient have
   a. Neurodeficit: Yes/No
      AND
   b. Pain: Yes/No
      AND
   c. Abscess: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of no resolution of disease on MRI: Yes/No (Upload MRI film)

5. If the answer to question 5 is Yes then is the patient having evidence of stable neurodeficit on AKT: Yes/No

For eligibility for Antero-lateral Tb spine clearance, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

28. Anterolateral Clearance For Tuberculosis: S5D2.10

1. Name of the Procedure: Anterolateral Clearance For Tuberculosis

2. Select the Indication from the drop down of various indications provided under this head:

Increased neurodeficit despite AKT
Instability
Resistant TB

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Deformity: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of deformity on MRI: Yes/No (Upload MRI film)

5. If the answer to question 5 is Yes then is the patient having evidence of stable neurodeficit on AKT: Yes/No

For eligibility for Antero-lateral Tb spine clearance, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

29. Anterolateral Clearance For Tuberculosis: S5D2.10

1. Name of the Procedure: Anterolateral Clearance For Tuberculosis

2. Select the Indication from the drop down of various indications provided under this head:

Increased neurodeficit despite AKT
Instability
Resistant TB

3. Does the patient have no response to first line Anti-TB drugs: Yes/No

4. If the answer to question 3 is Yes then is the patient having evidence of disease on MRI: Yes/No (Upload MRI film)

5. If the answer to question 5 is Yes then is the patient having evidence of stable neurodeficit on AKT: Yes/No

For eligibility for Antero-lateral Tb spine clearance, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

30. Costo Transversectomy: S5D2.11

1. Name of the Procedures: Costo Transversectomy

2. Indication: Compression or Damage of spinal nerves due to Bone spur/ Tumor/ Infection/ Fracture/ Herniated Disc/ Kyphosis/ Deformity of spine

3. Does the patient presented with pain/ deformity/ weakness: Yes/No

4. If the answer to question 3 is Yes then is there evidence of compression on X ray, CT/ MRI: Yes/No (Upload reports)

For Eligibility for Costo Transversectomy the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

31. Spinal Ostectomy And Internal Fixations: S5D2.12

1. Name of the Procedure: Spinal Ostectomy And Internal Fixations

2. Select the Indication from the drop down of various indications provided under this head:

Spinal Deformity
Spinal Fracture

3. Does the patient have
   a. Deformity: Yes/No
      AND
   b. Pain: Yes/No

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of spinal deformity on X-Ray/CT Scan: Yes/No (Upload X-Ray/CT Scan film)

For eligibility for Spinal Ostectomy And Internal Fixations, the answer to 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

32. Spinal Ostectomy And Internal Fixations: S5D2.12

1. Name of the Procedure: Spinal Ostectomy And Internal Fixations

2. Select the Indication from the drop down of various indications provided under this head:

Spinal Deformity
Spinal Fracture

3. Does the patient have
   a. Pain: Yes/No
      AND
   b. Swelling: Yes/No
      AND
   c. Deformity: Yes/No
      AND
   d. Neurodeficit: Yes/No

4. If the answer to all 3a AND 3b AND 3c AND 3d is Yes then is the patient having evidence of spinal fracture on MRI: Yes/No (Upload MRI film)

5. If the answer to 4 is Yes then is the patient having evidence of stable fracture pattern: Yes/No

For eligibility for Spinal Ostectomy And Internal Fixations, the answer to 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

33. Nerve Repair With Grafting: S5D2.13

1. Name of the Procedure: Nerve Repair With Grafting

2. Indication: Nerve Injury

3. Does the patient have
   a. Less than 1 year old injury: Yes/No
      AND
   b. Neurodeficit: Yes/No
      AND
   c. Flexible joints: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of nerve injury on EMG/Nerve conduction study: Yes/No (Upload EMG/Nerve conduction study report)

5. If the answer to question 4 is Yes then is the patient having evidence of
   a. Neuropraxia: Yes/No
   b. Stiff joints: Yes/No

For eligibility for Nerve Repair With Grafting, the answer to 5a AND 5b must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

34. Neurolysis/Nerve Suture: S5D2.14

1. Name of the Procedure: Neurolysis/Nerve Suture

2. Indication: Neurotmesis, Axonotmesis

3. Does the patient have
   a. Loss of muscle power: Yes/No
      AND
   b. Loss of sensation: Yes/No
      AND
   c. Loss of function: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c is Yes then is the patient having evidence of neurolysis on EMG/Nerve Conduction Study: Yes/No (Upload Report)

5. If the answer to question 4 is Yes then is the nerve injury old: Yes/No

For eligibility for Nerve Repair With Grafting, the answer to 5a AND 5b must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

35. Operations For Brachial Plexus & Cervical Rib: S5D2.15

1. Name of the Procedures: Operations For Brachial Plexus

2. Indication: Shoulder trauma/ Tumor/ Infection/ any injury to brachial plexus

3. Does the patient presented with damage to C5-T1 root, cord or peripheral level: Yes/No

4. If the answer to question 3 is Yes then is there evidence of damage on CT/ MRI, EMG-NCV: Yes/No (Upload reports)

For Eligibility for Operations For Brachial Plexus & Cervical Rib the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

36. Operations For Brachial Plexus & Cervical Rib: S5D2.15

1. Name of the Procedures: Operations For Cervical Rib

2. Indication: Congenital/ Thoracic Outlet Syndrome (Neurological/Vascular)

3. Does the patient presented with neurological involvement to C5-T1 root, cord or peripheral level: Yes/No

4. If the answer to question 3 is Yes then is there evidence of neurological involvement on X ray/ CT/ MRI/ Doppler study: Yes/No (Upload reports)

For Eligibility for Operations For Brachial Plexus & Cervical Rib the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

37. Excision Of Bone Tumours. Deep With Re-Construction With Conventional Prosthesis: S5D6.1

1. Name of the Procedure: Excision Of Bone Tumours. Deep With Re-Construction With Conventional Prosthesis

2. Indication: Uni-compartmental malignancy

3. Does the patient have
   a. Pain, Swelling & Deformity: Yes/No
      AND
   b. Biopsy showing malignant tumor: Yes/No (Attach Biopsy Report)
      AND
   c. MRI showing uni- compartmental malignancy: Yes/No (Upload MRI report)

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of
   a. Metastasis on CT chest: Yes/No (Upload CT film)
   b. Metastasis on Bone Scan: Yes/No (Upload Bone scan film)

For eligibility for excision of tumor and reconstruction using conventional prosthesis, the answer to 4a AND 4b must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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