NAME OF THE HOSPITAL:_____

73) Peripheral Angioplasty

1. Name of the Procedure: Peripheral Angioplasty

2. Select the Indication

   a. Claudication: Yes/No

   b. Distal limb gangrene: Yes/No

   c. Absent distal pulse: Yes/No

   d. Smoking: Yes/No

   e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

      (Upload CT angiography and/or Doppler study)

3. Treatment –

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

Treating Doctor Signature with Stamp

_____