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

_____