

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
