

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

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
