

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
