NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

12. Amputations – Forequarter: S5D2.2

1. Name of the Procedure: Fore-quarter amputation

2. Select the Indication from the drop down of various indications provided under this head:

Malignant tumor stage 1 & 2
Traumatic Injury

3. Does the patient have
   a. Swelling: Yes/No
      AND
   b. Pain: Yes/No

4. If the answer to either 3a AND/OR 3b is Yes then is the patient having evidence of malignancy on biopsy: Yes/No (Attach biopsy report)

5. If the answer to 4 is Yes then is the patient having evidence of Metastasis on CT Chest/Bone Scan: Yes/No (Upload CT chest/Bone scan film)
   For eligibility for Fore-quarter amputation, 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

_____

NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

13. Amputations – Forequarter: S5D2.2

1. Name of the Procedure: Fore-quarter amputation

2. Select the Indication from the drop down of various indications provided under this head:

Malignant tumor stage 1 & 2
Traumatic Injury

3. Does the patient have mangled extremity: Yes/No (Upload photograph of extremity)

4. If the answer to question 3 is Yes then is the patient having evidence of Reconstructable limb: Yes/No

For eligibility for Fore-quarter amputation, 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

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