NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

14. Amputations - Hind Quarter And Hemipelvectomy: S5D2.3

1. Name of the Procedure: Amputations - Hind Quarter And Hemipelvectomy

2. Indication: Bony tumors of hip bone, Ischium, Pubis & Ilium/ Head of femur

3. Does the patient presented with pain, tenderness, restriction of movements, large mass in pelvis: Yes/No

4. If the answer to question 3 is Yes then is there evidence of carcinoma - CT Scan Abdomen/pelvis, Metastatic work-up, X ray, relevant hematological investigations: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Metastatic Disease: Yes/No
   b. Surgically unfit: Yes/No
   c. Locally advanced tumors involving bilateral: Yes/No

For Eligibility for Amputations - Hind Quarter And Hemipelvectomy the answer to questions 5a, 5b & 5c must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

_____