NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

15. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

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

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No
      AND/OR
   c. Decreased Range of Movement: Yes/No
      AND/OR
   d. Crepitus: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes then is the patient having reduction of joint space in X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, 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: _____

16. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

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

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. Swelling: Yes/No
      AND/OR
   c. Constitutional Symptoms: Yes/No
      AND/OR
   d. Raised WBC: Yes/No (Attach report)

4. If the answer to either question 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes then is the patient having reduction of joint space in X-Ray: Yes/No (Upload X-Ray film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, 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: _____

17. Arthrodesis Of - Major Joints: S5D2.4

1. Name of the Procedure: ARTHRODESIS MAJOR JOINTS

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

Degenerative Arthritis
Infective Arthritis
Instability

3. Does the patient have
   a. Pain: Yes/No
      AND/OR
   b. History of dislocation: Yes/No
      AND/OR
   c. Muscular Weakness: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c is Yes then is the patient having evidence of dislocation on MRI: Yes/No (Upload MRI film)

5. If the answer to question 4 is Yes then is the patient having early, moderate Osteoarthritis: Yes/No

   For eligibility for Arthrodesis, 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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