NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

23. Arthroscopy - ACL Repair: S5D2.7

1. Name of the Procedure: Arthroscopy - ACL Repair

2. Indication: Instability of Knee

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

4. If the answer to both 3a AND 3b is Yes then is the patient having evidence of positive Lachmanns test: Yes/No

5. If the answer to question 4 is Yes then is the patient having evidence of ACL tear on MRI: Yes/No (Upload MRI film)

6. If the answer to question 5 is Yes then is the patient having evidence of multi-ligament injury on MRI: Yes/No

   For eligibility for Arthroscopic ACL reconstruction, 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

_____