

NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

24. Avascular Necrosis Of Femoral Head (Core Decompression): S5D2.8

1. Name of the Procedure: Avascular Necrosis Of Femoral Head (Core Decompression)

2. Indication: AVASCULAR NECROSIS Stage 1 and 2

3. Does the patient have

a. Pain: Yes/No

AND

b. Lurch: Yes/No

AND

c. Decreased Range of movement of hip: Yes/No

4. If the answer to all 3a AND 3b AND 3c is Yes then is the patient having evidence of Avascular Necrosis on MRI/Bone Scan: Yes/No (Upload MRI/Bone scan film)

5. If the answer to question 4 is Yes then is the patient having evidence of

a. Collapse of femoral head: Yes/No

b. Arthritis: Yes/No

For eligibility for femoral head core decompression, the answer to 5a AND 5b must be No

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

Treating Doctor Signature with Stamp
