NAME OF THE HOSPITAL:_____

72) Femorodistal Bypass With Vein Graft

1. Name of the Procedure: Femorodistal Bypass With Vein Graft

2. Select the Indication

a. Claudication: Yes/No

b. Distal limb gangrene: Yes/No

c. Absent distal pulse: Yes/No

d. Smoking: Yes/No

e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

(Upload CT angiography and/or Doppler study)

3. Treatment –

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

Treating Doctor Signature with Stamp

_____