NAME OF THE HOSPITAL: _____

13) Thrombendarterectomy

1. Name of the Procedure: Thrombendarterectomy

2. Select the Indication:

a. Claudication:Yes/No

b. Distal gangrene:Yes/No

c. Chronic limb ischaemia:Yes/No

d. Acute on chronic limb ischaemia:Yes/No
(Upload color Doppler or angiography)

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

Treating Doctor Signature with Stamp

_____