

# AMERICAN BOARD OF FOOT AND ANKLE SURGERY

## Information and Requirements For Board Certification



**American Board of Foot and Ankle Surgery®**

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**This document contains information specific to the 2018 examinations only**

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Americans with Disabilities Act. In compliance with the *Americans With Disabilities Act*, the American Board of Foot and Ankle Surgery® will make reasonable accommodations for individuals with disabilities provided the candidate submits a written request and all required documentation no later than thirty (30) days prior to the date(s) of the examination. Candidates will find additional information including how to apply on the ABFAS website.

## The Board Certification Process

After attaining Board Qualified status, you can begin the Board Certification process. Board Certification must be achieved within 7 years of Board Qualification.

### What does it mean to be Board Certified?

#### *Board Certification in Foot Surgery*

Board certification in Foot Surgery indicates that you have demonstrated a cognitive knowledge of foot surgery, including the diagnosis of general medical problems and surgical management of pathologic foot conditions, deformities, and/or trauma, and related structures that affect the foot and ankle.

#### *Board Certification in Reconstructive Rearfoot/Ankle (RRA) Surgery*

Board certification in RRA Surgery indicates that you have demonstrated a cognitive knowledge of foot and ankle surgery, including the diagnosis of general medical problems and surgical management of pathologic foot and ankle conditions, deformities, and/or trauma, and related structures that affect the foot, ankle, and leg. **Board Certification in Foot Surgery is a prerequisite for Board Certification in RRA.**

### Board Certification is a Two-Part Process

There are two parts to the Board Certification process: (1) Case Review and (2) the Computer-based Patient Simulation Board Certification (CBPS) Examination. The Case Review process has four components: (1) PLS case logging, (2) completion of diverse procedures, (3) facility documentation, and (4) case documentation and review.

### Summary of Changes

Those holding ABFAS Board Qualification status are eligible to take the Part II CBPS exam any time after becoming board qualified. They cannot register for Case Review until they have met the procedure diversity requirements (listed below).

### Case Review

#### *Documentation*

##### **1. Podiatry Logging Service (PLS) Case Logging**

Log all post-residency procedures performed in accredited facilities for which you were the surgeon of record, into the [Podiatry Logging Service \(PLS\) for Surgery](#). ABFAS will request complete documentation for the required number of foot and RRA surgery cases from the PLS log. All surgical procedures must be logged into PLS to obtain ABFAS certification. Procedures you performed during residency are not acceptable for logging in PLS or for case submission. You may log cases performed while in a fellowship program provided you were surgeon of record.

ABFAS recommends that you enter into PLS all post-residency surgical procedures that you performed in accredited facilities. The PLS system will inform you when you have met the quantity and diversity requirements, but you must continue logging all cases until you complete the case review application process.

If you are certified in Foot Surgery and seeking only RRA certification, you may log only post-residency RRA procedures performed.

The PLS system will inform you when you have met the quantity and diversity requirements. ABFAS will lock

cases selected for case review (see below), however please continue logging procedures on PLS until you became board certified. If you do not pass case review, ABFAS will need to select different cases when you reapply. It is therefore necessary that you continue to log all required cases until you pass case review.

### PLS Checklist

- Ensure that cases are logged with the correct procedure code in PLS.  
*Note: Failure to correctly log procedure type is a common error.*
- Ensure that you are listed as Surgeon (not Co-surgeon, Assistant Surgeon, or any other designation) on all operative reports and all chart materials for every procedure on the list.
- Ensure that you are listed as the surgeon of record (not co-surgeon) in the intraoperative anesthesia record or circulating nurse notes.
- List every procedure performed and documented in the operative report.

## 2. Required Procedures

Candidates must log a minimum of 65 cases in PLS for eligibility to submit cases for review for Foot Surgery certification and/or Reconstructive Rearfoot/Ankle Surgery (RRA) certification (see [Appendix C](#)). For Foot Surgery certification, a minimum of 30 cases must include surgery from the First Ray, Other Osseous and Reconstructive Rearfoot/Ankle categories listed in [Appendix A](#). For RRA Surgery certification, a minimum of 30 RRA cases must be logged. Additionally, the RRA cases must include a minimum of 12 procedures from [Appendix B](#). Candidates repeating the Case Review portion of the examination must ensure they have an adequate volume of cases to meet the requirement. Cases selected for Case Review in previous years will not be used for Case Review in subsequent years.

- RRA procedures consisting of diagnostic operative arthroscopy, subtalar joint arthroereisis, foreign body/hardware removal, or ostectomy **are not counted** toward the required 30 total.
- Open management of fractures must include some type of internal or external fixation.
- Unproven or experimental procedures **are not counted** toward the required 65 total.
- Removal of internal or external fixation devices or implants **is not counted**.
- Extracorporeal shock wave therapy (ESWT) procedures and application of biological dressings **are not acceptable**.

### Required Cases for Access to Board Certification

<b>FOOT SURGERY CERTIFICATION</b>	65
First Ray, Other Osseous, RRA Cases <sup>a</sup>	30 <sup>b,c</sup>
<b>RRA SURGERY CERTIFICATION</b>	30 <sup>d,e</sup>
RRA - Elective Osseous	10 <sup>e</sup>
RRA - Nonelective Osseous	2 <sup>e</sup>

a. See [Appendix A](#) for more details.

b. Of these 30 cases, 27 (90 percent) must have been performed in an accredited healthcare facility.

- c. List procedures involving only the hallux as digital procedures.
- d. All 30 cases must have been performed in an accredited healthcare facility.
- e. See [Appendix B](#) for more details.

The procedures within each major category must demonstrate the candidate's range of surgical experience. Inappropriate use or overuse of one procedure type (e.g., chevron bunionectomy) may result in failing scores.

Important to know: **Follow all instructions carefully to optimize your chances of successfully passing Case Review.**

#### Mislogging

Mislogging is one of the major reasons why candidates fail case review. Pay close attention to ensure each case is logged accurately. Below is a list of common logging errors that resulted in candidates failing case review:

- 1) A Lisfranc fracture ORIF or arthrodesis is not considered a rearfoot procedure. A Lisfranc fracture ORIF should be logged as 4.13 (Open management of tarsometatarsal fracture/dislocation) and a Lisfranc joint arthrodesis is logged as 4.15 (tarsometatarsal fusion). Please note: "Midfoot" joint(s) refers to any joint proximal to, and not including, tarsometatarsal/Lisfranc joint.
- 2) A Lapidus bunionectomy is a first ray procedure and should only be logged as 2.1.6 (bunionectomy with first metatarsocuneiform fusion) or 2.2.5 (joint salvage with first metatarsocuneiform fusion) or 2.3.3 (metatarsocuneiform fusion, other than for hallux valgus or hallux limitus)
- 3) A Haglund's deformity where the posterior heel exostosis is shaved (without detaching and reattaching a major portion of the Achilles tendon) should be logged as 4.1 (partial ostectomy). Such cases are never used for case review. If logged incorrectly, and the case is pulled for review, a failing score will occur
- 4) Plastic surgery does not include simple wound debridement and synthetic/biological graft application. A synthetic/biological graft application and/or simple double elliptical lesion excision does not meet the criteria for case review and if submitted will result in a failing score.
- 5) A Kidner procedure should be logged either as 5.1.6 (ligament or tendon augmentation/supplementation/restoration) or 3.1 (excision of ossicle). Removal of any ossicle such as os peroneum, os navicularis, os trigonum should only be logged as 3.1. Do not take the risk and log incorrectly as a simple ossicle removal with/without tendon debridement is not a qualified procedure for case review and will result in a failing score.
- 6.) If a joint salvage procedure with cheilectomy only is logged as a joint salvage procedure with distal metatarsal osteotomy, the candidate will receive a low or failing score for that case.
- 7.) Open management of fracture or metatarsophalangeal joint (MTPJ) dislocation cases must include internal or external fixation.

### 3. Documentation of Facility, Procedures, and Hospital Privileges

#### ***Facility Verification Letter***

This is advance notice of a new requirement that will start in September 2018. ABFAS will require you to confirm the accreditation status of the facility(ies) in which you performed your cases. ABFAS will notify you of additional details in early 2018.

Accredited healthcare facilities include facilities accredited by The Joint Commission, Joint Commission International, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Osteopathic Association (AOA), or the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF).

### ***Hospital/Surgery Center Audit***

ABFAS will select one of the facilities in which you performed surgery to ensure that you have logged all procedures that you performed at that facility into PLS. On December 12, 2017, ABFAS will email you detailed instructions on obtaining and submitting the notarized facility letter to verify the list of procedures that you performed at that facility for a given period. **You will have until January 5, 2018 to upload the letter into PLS.**

### ***Verification of Surgical Privileges***

ABFAS requires official documentation of surgical privileges consistent with the area of certification desired (Foot Surgery and/or RRA). Please submit proof via email at [privileges@abfas.org](mailto:privileges@abfas.org), or fax to 415.553.7801. Do NOT upload proof of surgical privileges into PLS.

## **4. Case Documentation & Case Review**

ABFAS will randomly select 13 Foot Surgery and/or 13 RRA cases from your PLS log for detailed documentation of the case. By January 22, 2018, ABFAS will notify you via email that the list of selected cases is available on your PLS site. You will then submit complete documentation, including all images, to ABFAS for review no later than March 9, 2018.

After you submit all required documentation (detailed instructions below), a team of case reviewers (ABFAS board certified foot and ankle surgeons) will evaluate all aspects of the surgical procedures that you submitted. This includes evaluation of preoperative clinical assessment, preoperative radiographic assessment and post-operative care as well as performance of the procedures(s) including technical skills assessment, and outcomes analysis.

### ***Case Documentation Instructions***

ABFAS evaluates and scores all procedures based on materials provided by candidates. Provision of incomplete documentation is a common error that may result in a lower score. All documents must be legible. All typed/handwritten materials must be submitted in PDF format.

#### ***1. Podiatric History and Physical (H&P)***

- This is the record of your initial assessment (not that of another physician) when the patient first presented for the condition leading to the surgical procedure performed. Include all pertinent supportive medical assessments generated by another physician. If the records are handwritten, please submit H&P records electronically as both (1) scanned copies of all handwritten material; and (2) typed copies of all handwritten materials. Please convert typed copies to PDF format. Alternatively, you can submit copies of electronic medical records.

#### ***2. Operative Report (OP Report)***

- Submit a copy of the typed operative report upon which you are listed as Surgeon (not Co-Surgeon, Assistant Surgeon, or any other designation). Procedures listing more than one surgeon of record are not acceptable. **Common error: Another physician listed as surgeon or co-surgeon.**

### 3. Progress Notes

- Submit typed progress notes from the time of first presentation for the condition leading to the procedure(s) performed through final outcome. If a patient undergoes multiple procedures on separate dates, all progress notes must be presented, including any notes related to complications, prior surgery, or surgical revisions.
- For procedures involving hospital admissions of greater than 24 hours, include:
  - Typed copies of progress notes from the first 3 inpatient days
  - Copies of all inpatient progress notes (including those of consultants)
  - Typed versions of all outpatient follow-up visit progress notes through final outcome
- Submit progress note records electronically converted to PDF format and in chronological order from oldest to most recent.
- If you performed a surgery on a patient that you saw at a required free clinic/resident clinic/emergency facility, but were unable to follow the patient postoperatively, please address the reason for the inability for follow-up in the progress notes.

**Note: Preprinted or standardized operative reports with blank spaces filled in or using standardized language from a word processor or computer are not acceptable.**

### 4. Pathology Report (Path Report)

- Submit copies of any pathology report for soft-tissue lesions, infections, and other procedures for which a specimen was sent because abnormal pathology was present.

#### **ABFAS Policy for Potential Misrepresentation**

- Any incomplete, questionable, modified or falsified case materials submitted may be evaluated further by ABFAS.
- If case review uncovers any suspicion or evidence of falsified records, including altered labeling of medical imaging studies, if substantiated, this may result in, at minimum, forfeiture of the right to sit for the examination and all fees paid, and at maximum, your disqualification for Board Qualification or Certification.
- ABFAS may require that you help verify submitted documents.
- ABFAS reserves the right to pursue further investigation including, but not limited to, sending an ABFAS-appointed representative to the hospital/surgery center to further review documentation.
- Failure to comply with the process and/or discovery of falsified records will result in disqualification and such other action as ABFAS deems appropriate including revocation of Board Qualified status, disqualification for certification, and forfeiture of fees paid.

### 5. Laboratory Reports (Labs)/Diagnostic Reports

- Submit copies of any relevant report of preoperative tests ordered, including laboratory studies, MRI, nuclear medicine, electrodiagnostic studies, etc.

### 6. Intraoperative Anesthesia Record/Circulating Nurse's Notes

- Submit copies of the intraoperative anesthesia record or circulating nurse's notes from the facility listing the candidate as the surgeon of record (not the anesthesiology consultation notes).

**Appendix E provides examples of proper documentation**

## Image Submission Requirements

### General Requirements

The following general requirements apply to every image presented as part of complete case documentation. Noncompliance with image requirements and instructions may result in rejection of case documentation, with no opportunity to resubmit missing materials. Appendix D provides further information

#### 1. JPG Format

- Submit all images, regardless of original format, in JPG, JPEG or PNG format.

**ABFAS reserves the right to examine, on site, images stored on the imaging equipment hard drive to determine that submitted images have not been altered. If it is determined that images have been altered, you will forfeit, at minimum, the right to sit for the examination and all fees paid.**

#### 2. Image Clarity

- All images must be clearly readable.
- Ensure that the reviewer will be able to clearly identify all pathology, fixation, and bone healing within the image.

**Note: Unreadable images may lead to rejection of procedures and/or failing the case.**

#### 3. Three Views

- For MRIs and computerized tomographic (CT) images, submit individual images of a minimum of three views (see below) clearly demonstrating pathology or findings.

### Required Radiographic Images

- Select appropriate views for each procedure, listed below. Identify each image, and label each image with patient's name and date of imaging. "Best two views" must demonstrate appropriate surgical pathology and outcome.

	First Ray Surgery	Infection/ Other Osseous Foot Surgery	Foot and Ankle Trauma	RRA Surgery
<b>Preoperative images</b> <i>(weight-bearing not required for trauma)</i>	<b>Weight-bearing</b> AP, Lateral	Best two views	Best two views	<b>Weight-bearing</b> Best two views
<b>Initial postoperative images</b> <i>Within 1 week of surgery</i> <i>Demonstrate operative alignment and fixation, if used (intraoperative images acceptable)</i>	AP, Lateral	Best two views	Best two views	Best two views
<b>Final outcome images</b> <i>At least 4 weeks postoperative</i> <i>Demonstrate removal of provisional/ temporary hardware and radiographic osseous union of osteotomies, fusions, and fractures</i>	<b>Weight-bearing</b> AP, Lateral	Best two views	Best two views	<b>Weight-bearing</b> Best two views

When appropriate, an MRI may substitute for an x-ray.



### Common Errors

- Lack of preoperative weight-bearing radiographs where required.
- Lack of postoperative weight-bearing radiographs demonstrating reduction of deformity, bone healing, or consolidation.
- Final radiographs demonstrating provisional/temporary hardware.
- Failure to upload each image in the appropriate category represented by the image (preoperative, immediate postoperative, and final).

### Board Certification Examination

The Board Certification Computer-based Patient Simulation (CBPS) examination evaluates knowledge and skills in obtaining and interpreting clinical information as well as the ability to reason logically and to arrive at a diagnosis or treatment plan for a specific patient presentation.

#### 1. Register

To register for an ABFAS examination, log into the ABFAS website [www.ABFAS.org](http://www.ABFAS.org). Click “Register for an Exam” under exam quick links. If you are taking both the Foot Surgery and RRA Surgery CBPS examinations, you may sit for both examinations on the same day.

#### 2. Test Components

The CBPS Examination consists of 12 CBPS questions for the Foot Surgery CBPS and 16 for RRA Surgery CBPS. Similar to the Board Qualification CBPS Examination, the Board Certification CBPS Examination uses case scenarios to evaluate clinical reasoning skills, content knowledge, problem-solving ability, and clinical decision making, i.e., ability to reason logically and arrive at a diagnosis or treatment plan for a specific patient presentation. It measures the clinical knowledge, skills, and judgment associated with your ability to integrate academics with surgical experience.

The case questions cover diagnostic, intraoperative, and perioperative care of the podiatric surgical patient via clinical scenarios, problem-solving in a case-based format, surgical outcomes assessment, perioperative management, and decision-making. The examination represents commonly accepted standards of care (i.e., regionally and individually unbiased).

The examination questions encompass the diagnostic, intraoperative, and perioperative care of the presented patient. The intraoperative content of the Foot examination may include surgical procedures of the entire foot and ankle, except for RRA procedures.

The subject areas covered in the Foot Surgery and RRA Surgery examinations are shown in **Table 2**. The subject area subcategories are listed in **Table 3**.

#### 3. Instructions and Practice Examination

##### Instructions

Access the [CBPS Practice Exam](#) instructions

## Practice Exam

Access the CBPS practice exam. During the exam, do not press the [F5] key or the browser back button. This will log you out of the exam.

## 4. Testing Sites

ABFAS contracts with Pearson VUE to administer examinations. Pearson VUE offers 200 testing sites in the United States and abroad (see <http://www.pearsonvue.com/abps/>). ABFAS strongly encourages early registration to ensure availability of a convenient testing site.

## Failure to Appear

Candidates who fail to appear for their examination(s) without completing the formal withdrawal process forfeit all fees.

## 5. Scoring

### Test Results

ABFAS will email you a notification when your test results have been posted (log in to see your results) to your ABFAS profile page. If you fail an exam, you will be able to download a score report that provides an analysis of your performance. Copies of the test items are not available. If you pass only one component of the Board Certification exams, you will receive credit for that component but will not achieve Board Certification status. CBPS or Case Review credit is valid for 7 years or until your eligibility for ABFAS certification expires, whichever occurs first.

## 6. Appeals

ABFAS does not have an appeal process for its examinations. An independent psychometric consultant rescues and reviews all failed examinations. Candidates may write to [examconcerns@abfas.org](mailto:examconcerns@abfas.org) if they have questions about their exam score reports.

## 7. Confidentiality

ABFAS considers the status of an individual's participation in and the stage of completion of all Certification components, including an individual's certification status and certification history, to be public information. ABFAS reserves the right to publish and share public information in any and all public forums determined by ABFAS to be reasonable, including the posting of public information on the ABFAS website, sharing the public information with medical licensure boards, managed care organizations, third party payers, or others. While ABFAS generally regards all other information about individuals as private and confidential, there are times that ABFAS must release certain information to fulfill its responsibilities as a medical specialty board.

### Statute of Limitations

*If your Board Qualified status in Foot Surgery expires before your Board Qualified status in RRA Surgery, ABFAS will suspend your RRA status until you have successfully reestablished the required status in Foot Surgery (provided that your RRA status has not expired prior to the reestablishment of Foot Surgery status).*

*If you do not achieve Board Certification by the close of the seventh year after you achieve Board Qualification status, you will no longer be eligible for ABFAS certification, unless you finished a PMSR or PMSR/RRA residency program prior to 2014.*

ABFAS specifically regards the results of an individual's Qualification, Certification, or Recertification examination (score and whether the individual passed or failed) as private and confidential.

### **Diplomate Certificates**

After you meet all Board Certification requirements and pass the Board Certification examination, ABFAS will issue you a certificate confirming that you are a:

- Diplomate of the American Board of Foot and Ankle Surgery® with Certification in Foot Surgery  
and (if applicable)
  
- Diplomate of the American Board of Foot and Ankle Surgery® with Certification in Reconstructive Rearfoot/Ankle Surgery

### ***Period of Certification***

Initial certification is for a period of 10 years. Board Certified surgeons may promote their status on ABFAS letterhead, publications, and other advertisements following [ABFAS advertising guidelines](#).

## Calendar

A full calendar for all ABFAS examinations and deadlines is at [Exam Calendar](#). The dates that pertain to the Board Certification Examination and Case Documentation are repeated below for convenience.

Board Certification Examination (CBPS)	
	<b>Spring</b>
Registration opens	November 1, 2017
Registration closes	April 25, 2018
Last day to withdraw without penalty	May 2, 2018
Examination	May 9, 2018

Case Review	
Registration opens	November 1, 2017
Registration closes	December 8, 2017
ABFAS notifies candidates of hospital audit/surgical privileges needs	December 12, 2017
Deadline for ABFAS to receive hospital audit documentation	January 5, 2018
ABFAS notifies candidate of case selection	January 22, 2018
Deadline for candidate to upload all case documentation	March 9, 2018
Case Reviewers meet	April 12-14, 2018

## Examination Fees

You can find a full list of all ABFAS application, examination, and other fees at [Exam Fees](#). The fees that pertain to the Board Certification Examinations are also repeated below for your convenience.

Application Fee (NON-REFUNDABLE). Paid once per calendar year, regardless of number of exams.	\$225
Examination	
Board Certification Examination (CBPS)	\$425
Case Review	\$475
Withdrawal*	
On-time	0
Late fees	
One Part	\$150
Two Parts	\$250

\* Candidates who do not appear for an examination and have not withdrawn before the examination date will forfeit all fees paid.

## APPENDIX A

### Expanded List of Categories for Foot Certification Case Review

Procedures must be logged correctly on PLS by the candidate. Procedures are evaluated and scored based on the category under which it is categorized. For example, if a joint salvage procedure with cheilectomy only is logged as a joint salvage procedure with distal metatarsal osteotomy, the candidate will receive a low or failing score for that case. Open management of fracture or MTPJ dislocation cases must include internal or external fixation. Procedures are evaluated based on surgical decision-making, preoperative clinical assessment, preoperative radiographic assessment, technical skills assessment, and outcomes analysis.

Each category in *“italics”* has an allowable maximum of 2 of the 30 required cases.

Each category in “non-italics” has an allowable maximum of 15 of the 30 required cases.

#### Hallux Valgus Surgery

##### ***2.1.3 bunionectomy with phalangeal osteotomy***

2.1.4 bunionectomy with distal first metatarsal osteotomy

2.1.5 bunionectomy with first metatarsal base or shaft osteotomy

2.1.6 bunionectomy with first metatarsocuneiform fusion

2.1.7 MTPJ fusion

2.1.8 MTPJ implant

#### Hallux Limitus Surgery

##### ***2.2.1 cheilectomy***

##### ***2.2.2 joint salvage with phalangeal osteotomy (Kessel- Bonney, enclavement)***

2.2.3 joint salvage with distal metatarsal osteotomy

2.2.4 joint salvage with first metatarsal shaft or base osteotomy

2.2.5 joint salvage with first metatarsocuneiform fusion

2.2.6 MTPJ fusion

2.2.7 MTPJ implant

#### Other First Ray Surgery

2.3.2 osteotomy (e.g., dorsiflexory)

2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)

##### ***2.3.4 amputation***

2.3.5 management of osseous tumor/neoplasm (with or without bone graft)

2.3.6 management of bone/joint infection (with or without bone graft)

2.3.7 open management of fracture or MTPJ dislocation with fixation

2.3.8 corticotomy with callus distraction

2.3.9 revision/repair of surgical outcome (e.g., nonunion, hallux varus)

#### Osseous Foot Surgery

##### ***4.5 lesser MTPJ implant***

##### ***4.6 central metatarsal osteotomy***

##### ***4.7 bunionectomy of the fifth metatarsal with osteotomy***

**4.8 open management of lesser metatarsal fracture(s)**

4.10 amputation (lesser ray, transmetatarsal amputation (TMA))

**4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)**

**4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)**

**4.13 open management of tarsometatarsal fracture/dislocation**

**4.14 multiple osteotomy management of metatarsus adductus**

4.15 tarsometatarsal fusion

**4.16 corticotomy/callus distraction of lesser metatarsal**

**Elective – Soft-tissue**

**5.1.1 plastic surgery techniques involving the midfoot, rearfoot or ankle**

**5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg**

**5.1.4 soft-tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)**

5.1.5 delayed repair of ligamentous structures

5.1.6 ligament or tendon augmentation/supplementation/restoration

**Elective - Osseous**

**5.2.2 detachment/reattachment of Achilles tendon with partial osteotomy**

5.2.4 midfoot, rearfoot, or ankle fusion

5.2.5 midfoot, rearfoot, or tibial osteotomy

5.2.6 coalition resection

**5.2.7 open management of talar dome pathology (with or without osteotomy)**

**5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement** **5.2.9 ankle implant**

**5.2.10 corticotomy or osteotomy with callus distraction/ correction of complex deformity of the midfoot, rearfoot, ankle, or tibia**

**Nonelective – Soft tissue**

**5.3.1 repair of acute tendon injury**

**5.3.2 repair of acute ligament injury**

**5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle**

**5.3.4 excision of soft-tissue tumor/mass of the foot (with reconstructive surgery)**

5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)

**Nonelective – Osseous**

5.4.1 open repair of adult midfoot fracture

5.4.2 open repair of adult rearfoot fracture

5.4.3 open repair of adult ankle fracture

5.4.4 open repair of pediatric rearfoot/ankle fracture or dislocation

**5.4.5 management of bone tumor/neoplasm (with or without bone graft)**

**5.4.6 management of bone/joint infection (with or without bone graft)**

5.4.7 amputation proximal to the tarsometatarsal joints

## APPENDIX B

RRA Surgery Certification requires logging a minimum of 30 RRA procedures. ABFAS requires a minimum of 12 procedures from the following list.

### RRA Elective Osseous (minimum 10)

- 5.2.4 midfoot, rearfoot, or ankle fusion
- 5.2.5 midfoot, rearfoot, or tibial osteotomy
- 5.2.9 ankle implant
- 5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia

### RRA Nonelective Osseous (minimum 2)

- 5.4.2 open repair of adult rearfoot fracture
- 5.4.3 open repair of adult ankle fracture
- 5.4.4 open repair of pediatric rearfoot/ankle fracture or dislocation
- 5.4.5 management of bone tumor/neoplasm (with or without bone graft)

Procedures must be logged correctly on PLS by the candidate. Procedures are evaluated and scored based on the category under which it is categorized. For example, if excision of a fracture fragment is logged as open reduction and internal fixation of a fracture, the candidate will receive a low or failing score for that case. Open management of fracture or dislocation cases must include internal or external fixation. Foot Surgery cases logged as Reconstructive Rearfoot/Ankle surgery cases will not be scored and no credit will be given for that case. Procedures are evaluated based on surgical decision-making, preoperative clinical assessment, preoperative radiographic assessment, technical skills assessment, and outcomes analysis.

## APPENDIX C

### Table of ABFAS Procedure Categories

#### 1. **Digital Surgery category (lesser digit or hallux)**

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- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>1.1 partial ostectomy</li> <li>1.2 phalangectomy</li> <li>1.3 arthroplasty (interphalangeal joint [IPJ])</li> <li>1.4 implant (IPJ)</li> <li>1.5 diaphysectomy</li> <li>1.6 phalangeal osteotomy</li> <li>1.7 fusion (IPJ)</li> </ul> | <ul style="list-style-type: none"> <li>1.8 amputation</li> <li>1.9 management of osseous tumor/neoplasm</li> <li>1.10 management of bone/joint infection</li> <li>1.11 open management of digital fracture/dislocation</li> <li>1.12 revision/repair of surgical outcome</li> <li>1.13 other osseous digital procedure not listed above</li> </ul> |
|--|--|

#### 2. **First Ray Surgery (30 procedures).**

##### **Hallux Valgus Surgery**

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- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>2.1.1 bunionectomy (partial ostectomy/Silver procedure)</li> <li>2.1.2 bunionectomy with capsulotendon balancing procedure</li> <li>2.1.3 bunionectomy with phalangeal osteotomy</li> <li>2.1.4 bunionectomy with distal first metatarsal osteotomy</li> </ul> | <ul style="list-style-type: none"> <li>2.1.5 bunionectomy with first metatarsal base or shaft osteotomy</li> <li>2.1.6 bunionectomy with first metatarsocuneiform fusion</li> <li>2.1.7 MTPJ fusion</li> <li>2.1.8 MTPJ implant</li> <li>2.1.9 MTPJ arthroplasty</li> </ul> |
|---|---|

##### **Hallux Limitus Surgery**

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- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>2.2.1 cheilectomy</li> <li>2.2.2 joint salvage with phalangeal osteotomy (Kessel- Bonney, enclavement)</li> <li>2.2.3 joint salvage with distal metatarsal osteotomy</li> <li>2.2.4 joint salvage with first metatarsal shaft or base osteotomy</li> </ul> | <ul style="list-style-type: none"> <li>2.2.5 joint salvage with first metatarsocuneiform fusion</li> <li>2.2.6 MTPJ fusion</li> <li>2.2.7 MTPJ implant</li> <li>2.2.8 MTPJ arthroplasty</li> </ul> |
|---|--|

##### **Other First Ray Surgery**

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- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>2.3.1 tendon transfer/lengthening/capsulotendon balancing procedure</li> <li>2.3.2 osteotomy (e.g., dorsiflexory)</li> <li>2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)</li> <li>2.3.4 amputation</li> <li>2.3.5 management of osseous tumor/neoplasm (with or without bone graft)</li> </ul> | <ul style="list-style-type: none"> <li>2.3.6 management of bone/joint infection (with or without bone graft)</li> <li>2.3.7 open management of fracture or MTPJ dislocation with fixation</li> <li>2.3.8 corticotomy with callus distraction</li> <li>2.3.9 revision/repair of surgical outcome (e.g., nonunion, hallux varus)</li> <li>2.3.10 other first ray procedure not listed above</li> </ul> |
|--|--|



### 3. **Other Soft-tissue Foot Surgery**

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- |     |   |      |   |
|-----|---|------|---|
| 3.1 | excision of ossicle/sesamoid  | 3.9  | plantar fasciectomy   |
| 3.2 | excision of neuroma   | 3.10 | excision of soft-tissue tumor/mass of the foot (without reconstructive surgery)   |
| 3.3 | removal of deep foreign body (excluding hardware removal)                                       | 3.11 | external neurolysis/decompression (including tarsal tunnel)   |
| 3.4 | plantar fasciotomy  | 3.12 | plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot) |
| 3.5 | lesser MTPJ capsulotendon balancing   | 3.13 | microscopic nerve/vascular repair (forefoot only)   |
| 3.6 | tendon repair, lengthening, or transfer involving the forefoot (including digital FDL transfer) | 3.14 | other soft-tissue procedures not listed above (limited to the foot).  |
| 3.7 | open management of dislocation (MTPJ/tarsometatarsal)   |      |   |
| 3.8 | incision and drainage/wide debridement of soft-tissue infection (including plantar space)       |      |   |

### 1. **Osseous Foot Surgery**

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- |      |   |      |  |
|------|---|------|--|
| 4.1  | partial ostectomy (metatarsocuneiform exostosis or exostectomy) | 4.11 | management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft) |
| 4.2  | lesser MTPJ arthroplasty  | 4.12 | management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)  |
| 4.3  | bunionectomy of the fifth metatarsal without osteotomy          | 4.13 | open management of tarsometatarsal fracture/dislocation  |
| 4.4  | metatarsal head resection (single or multiple)                  | 4.14 | multiple osteotomy management of metatarsus adductus   |
| 4.5  | lesser MTPJ implant   | 4.15 | tarsometatarsal fusion   |
| 4.6  | central metatarsal osteotomy                                    | 4.16 | corticotomy/callus distraction of lesser metatarsal  |
| 4.7  | bunionectomy of the fifth metatarsal with osteotomy             | 4.17 | revision/repair of surgical outcome in the forefoot  |
| 4.8  | open management of lesser metatarsal fracture(s)                | 4.18 | other osseous procedures not listed above (distal to the tarsometatarsal joint)                      |
| 4.9  | harvesting of bone graft distal to the ankle                    |      |  |
| 4.10 | amputation (lesser ray, transmetatarsal amputation (TMA))       |      |  |

**5. Reconstructive Rearfoot/Ankle Surgery (30 procedures)****Elective –Soft-tissue**

- |  |  |
|--|--|
| 5.1.1 plastic surgery techniques involving the midfoot, rearfoot or ankle                      | 5.1.5 delayed repair of ligamentous structures   |
| 5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg                           | 5.1.6 ligament or tendon augmentation/supplementation/restoration                        |
| 5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg                        | 5.1.7 open synovectomy of the rearfoot/ankle   |
| 5.1.4 soft-tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus) | 5.1.8 other elective reconstructive rearfoot /ankle soft-tissue surgery not listed above |

**Elective –Osseous**

- |   |  |
|---|--|
| 5.2.1 operative arthroscopy   | 5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement   |
| 5.2.2 detachment/reattachment of Achilles tendon with partial osteotomy   | 5.2.9 ankle implant  |
| 5.2.3 subtalar arthroereisis  | 5.2.10 corticotomy or osteotomy with callus distraction/ correction of complex deformity of the midfoot, rearfoot, ankle, or tibia |
| 5.2.4 midfoot, rearfoot, or ankle fusion                                  | 5.2.11 other elective reconstructive rearfoot /ankle osseous surgery not listed above  |
| 5.2.5 midfoot, rearfoot, or tibial osteotomy                              |  |
| 5.2.6 coalition resection   |  |
| 5.2.7 open management of talar dome pathology (with or without osteotomy) |  |

**Nonelective – Soft tissue**

- |  |  |
|--|--|
| 5.3.1 repair of acute tendon injury  | 5.3.5 excision of soft-tissue tumor/mass of the ankle (with or without reconstructive surgery) |
| 5.3.2 repair of acute ligament injury  | 5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)                          |
| 5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle         | 5.3.7 other nonelective reconstructive rearfoot /ankle soft-tissue surgery not listed above.   |
| 5.3.4 excision of soft-tissue tumor/mass of the foot (with reconstructive surgery) |  |

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**Nonelective – Osseous**

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- 5.4.1 open repair of adult midfoot fracture
- 5.4.2 open repair of adult rearfoot fracture
- 5.4.3 open repair of adult ankle fracture
- 5.4.4 open repair of pediatric rearfoot/ankle fracture or dislocation
- 5.4.5 management of bone tumor/neoplasm (with or without bone graft)
- 5.4.6 management of bone/joint infection (with or without bone graft)
- 5.4.7 amputation proximal to the tarsometatarsal joints
- 5.4.8 other nonelective reconstructive rearfoot/ankle osseous surgery not listed above

## Appendix D

### Uploading Images into PLS

One of the major areas of concern for candidates preparing their board certification case documentation is images. Indeed, unreadable or inappropriately uploaded images are frequently cited in the case review process. The following information can assist you in the preparation of suitable images for uploading with your case documentation.

#### Hard Copy Images (including MRI and CT)

- Use a light box to photograph the image.
- Capture the entire image; do not crop or zoom in. Include patient identifying information if possible.
- Pictures can be taken with a digital camera or good mobile phone camera. **Do not scan the x-ray.**
- Check the picture carefully. It should be as clear as the original. If it is not, retake until satisfied (a few attempts with different exposures may be necessary).
- Save the pictures to your computer. The preferred format for saving is “jpg”. If you do not have that option, you may save it as “jpeg” or “png”.

#### Digital Images

- Download the image from your system to your computer or a flash drive. Save it in “jpg” format. If “jpg” is not an available option, then save it in “jpeg” or “png” format.
- **Do not take a picture of the image from a monitor or computer screen.**

#### General Upload instructions

- Follow ABFAS instructions carefully.
- Be sure **all** images are labeled with the patient name and date taken **on the image**. If your EMR deletes this information or it is unreadable on your picture, place a text box in the image and type in the patient name and date the image was taken.
- How do I place a text box?
  - o To do this in Microsoft Paint: Click Open With from the menu bar, hit the text button “A” to insert a text box. Save.
  - o To do this in Preview on a Mac: Go to the View menu, select “Show Edit Toolbar” then select the text tool to insert a text box. Save.
- Be sure all uploaded images are of the correct patient and procedure.
- Be sure to upload images into the correct section on PLS (pre-op/immediate post-op/final)
- First ray and RRA cases are to include weight-bearing pre-op and weight-bearing final images.
- Trauma cases are not required to have weight-bearing pre-op images.

Appendix E

Sample of Case Documentation to Upload into PLS

Appendix E provides samples of case documentation. Institutions use different types of records, so your institution's reports may differ from these. ABFAS is providing samples to provide guidance as to the types of required reports.

The reports are samples. The contents of these reports are not examples of expectations of a high or low scored case. It is to provide enough information so that you understand the document types.

The samples are in order of the categories you will see when uploading your documents into PLS:

- Pre-op H&P
- Op Report
- Pre-op Documentation
- Post-op Documentation
- Consultations
- Labs
- Pathology Report
- Anesthesia Record/Circular's Notes

# Pre-Op H&P

Progress Note, Podiatry  
\* Final Report \*

Example of Pre-op H&P. Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [REDACTED]  
Result status: Auth (Verified)  
Result title: SU377-LE  
Performed by: [REDACTED]  
Verified by: [REDACTED]  
Encounter info: [REDACTED]  
Contributor system: [REDACTED]

**\* Final Report \***

DOC01455 (Verified)

CHIEF COMPLAINT/REASON FOR VISIT  
Left foot fractures.

HISTORY OF PRESENT ILLNESS

[REDACTED] is a [REDACTED] who presents to my clinic today with complaints of left foot fractures. He sustained this injury on [REDACTED]. Patient notes that he was out when he stepped off a curb wrong rolling his foot. He does note that he was drinking at the time. He wore a friend's boot and crutches until he was seen on [REDACTED] where radiographs revealed displaced 3rd and 4th metatarsal fractures as well as essentially nondisplaced 2nd metatarsal fracture. He does note today that he has been ambulating on the extremity in the boot. His pain has improved to some extent.

SYSTEMS REVIEW

Denies calf pain, shortness of breath, or chest pain.

ALLERGIES

Acetaminophen and aspirin.

MEDICATIONS

Reviewed per EMR.

PAST MEDICAL/SURGICAL HISTORY

PAST MEDICAL HISTORY: Depression. Generalized anxiety. ADHD.  
PAST SURGICAL HISTORY: None.

FAMILY HISTORY

Denies.

SOCIAL HISTORY

Patient is single. He does not currently use tobacco products is a former smoker, noting that he quit about 4 months ago. He consumes on an average 6 drinks per day and typically over 30 drinks per week.

PHYSICAL EXAMINATION

Printed by: [REDACTED]  
Printed on: [REDACTED]



VITAL SIGNS:

PHYSICAL EXAMINATION

GENERAL: Patient alert, oriented, and in no apparent distress.

VASCULAR: Dorsalis pedis and posterior tibial pulses are palpable at 2/4. Capillary refill is within normal limits to all digits of the left foot. Pedal hair growth is present to the digits. No areas of necrosis noted.

DERMATOLOGIC: Skin of normal texture and turgor without signs of atrophy or open lesions. No erythema or edema noted. Toenails appear healthy without signs of discoloration or thickening.

NEUROLOGIC: Gross sensation is intact to all digits on the left foot without signs of peripheral neuropathy.

MUSCULOSKELETAL: There is edema to the left forefoot, midfoot with palpatory tenderness over the 2nd, 3rd, and 4th metatarsal midshaft fractures. There is no sign of fracture blistering or compartment syndrome. His foot compartments are soft and supple. There is no Lisfranc tenderness. Active and passive dorsiflexion and plantar flexion are intact to the level of the ankle as well as to all digits. There is no skin tenting. The skin lines are present. Remainder of forefoot, midfoot, rearfoot, and ankle is nontender to palpation. Ankle joint range of motion is smooth and largely within normal limits. Calf is soft and nontender.

DIAGNOSTICS

Three views of the left foot and ankle exhibit displaced 3rd and 4th metatarsal midshaft fractures as well as essentially nondisplaced 2nd metatarsal midshaft fracture. There is lateral translation and some degree of shortening appreciated to the 3rd and 4th metatarsal fractures. Lisfranc complex is well aligned. No other overt fractures are appreciated.

IMPRESSION/REPORT/PLAN

1. Displaced left 3rd and 4th metatarsal diaphyseal fractures.
2. Nondisplaced 2nd metatarsal diaphyseal fracture secondary to injury.

PLAN: I did review imaging and discussed findings with [REDACTED] today. At times, fractures can be treated conservatively without surgical intervention and at other times require surgical intervention. While his fractures could potentially heal in the current position, they are not in ideal alignment and are also at higher risk for delayed or nonunion, subsequent structural deformities of the foot. As a result, I would recommend surgical open reduction internal fixation of the 3rd and 4th metatarsal fractures. I discussed with them what this would entail. Patient would need to be nonweightbearing for up to 6 weeks postoperatively and with another month of protected weightbearing in a boot after that. We discussed all risks and potential complications of surgery which include but are not limited to superficial or deep infection, bone infection, nonunion, delayed union, or malunion, hardware complications, wound healing complications, temporary or permanent numbness, painful or unsightly scarring, ongoing pain despite surgical intervention, need for repeat surgical intervention, injury to adjacent structures, blood clot formation, pulmonary embolus that could be life-threatening, or complications with anesthesia that could be life-threatening. I did perform a DVT risk assessment today. Patient has no personal or familial history of thrombosis. He will be nonweightbearing postoperatively. We will have him take aspirin 81 mg 2 times a day postoperatively and perform range-of-motion exercises 5 times a day reps of 20 through all major joints. I did discuss signs and symptoms of blood clot formation or pulmonary embolus and what to do if he experiences these. We also discussed time off work. He will plan to be off work for 3 weeks at then strictly seated nonweightbearing work after that. I dispensed a short boot for him today. I also put an order for a Roll-A-Bout scooter as well. We will plan to move forward with surgical intervention on [REDACTED]. This can be performed under monitored anesthesia care in the out-patient surgical setting. Patient will obtain a preoperative history and physical prior to that time. All questions are answered per his satisfaction. Absolutely no guarantees were given or implied in regard to surgical intervention.

# Op Report



Example of Op Report: Your Institution's Report May Look Different

Patient Name	[REDACTED]	Account No.	[REDACTED]
Document No.	[REDACTED]	Medical Record No.	[REDACTED]
Physician	[REDACTED]	Patient Location	[REDACTED]
Report Type	Operative Report		
Date of Birth	[REDACTED]		

DATE OF PROCEDURE: [REDACTED]

SURGEON: [REDACTED]

ASSISTANT: [REDACTED]

PREOPERATIVE DIAGNOSES: Left foot fourth and fifth metatarsal open fracture, left foot laceration.

POSTOPERATIVE DIAGNOSES: Left foot fourth and fifth metatarsal open fracture, left foot laceration.

PROCEDURE: Open reduction and internal fixation of left fourth and fifth metatarsal repair of laceration both to the left foot.

PATHOLOGY: None.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Less than 50 milliliters.

COMPLICATIONS: None.

INTRAOPERATIVE FINDINGS: Comminuted fracture to the left fifth metatarsal complete extraarticular displaced and a displaced fracture of the fourth metatarsal extraarticular complete as well as laceration to left foot.

INDICATIONS FOR A PROCEDURE: This is a [REDACTED] who was seen in the [REDACTED] for a left fourth and fifth metatarsal open fracture and laceration. The patient states she was trimming a tree at 1:40 this afternoon, when the patient sustained an injury to her left foot after a branch fell on her foot. The patient immediately came to the emergency room where she was found to have an open fourth and fifth metatarsal fracture. The laceration was also noted to have gross contamination from the environment. The patient was also noted to have significant bleeding at the time of the injury as well as decreased sensation to her fourth and fifth digits. The patient was taken to the OR within the 8-hour mark post-injury. The expected pre, peri and postoperative risks, benefits and potential complications were reviewed. Informed consent was signed freely and the operation took place as follows.

PROCEDURE IN DETAIL: The patient was brought to the operating room, placed in the operating table in supine position. After general endotracheal tube anesthesia, the foot was then

OPERATIVE REPORT



Example of Op Report: Your Institution's Report May Look Different

Patient Name		Account No.	
Document No.		Medical Record No.	
Physician		Patient Location	
Report Type	Operative Report		
Date of Birth			

prepped and draped using aseptic technique. Tourniquet was placed above the left calf, but was not used during the operation. Attention was then directed to the open laceration on the left foot where the laceration was then irrigated extensively and all gross contamination was removed. After irrigating with copious amounts of sterile saline, soft tissue structures were then inspected. The extensor tendons to the lesser digits of both the longus and brevis were found to be intact and of normal working condition. It was noted that 2 cutaneous nerves were found in the operation, the more medial nerve was intact; however, it was significantly injured and devoid of soft tissue coverings. There also was a lateral nerve was found in the laceration. This nerve was severed during the injury. All handling of the soft tissue was done using atraumatic technique with extensive care taken to the distal flap to preserve as much soft tissue and blood supply as possibly be obtained to the flap. Normal healthy bleeding tissue was also experienced throughout the flap. Upon inspection, the area was then again flushed with copious amounts of sterile saline. Intraoperative fluoroscopy was used to confirm fractures to both the fourth and fifth metatarsal.

Next, using 0.062-inch Kirschner wire, the wire was retrograded through the fourth metatarsal head and plantarly exiting the foot proximal to the proximal phalanx. This wire was then retrograded back through the metatarsal shaft and excellent alignment and compression was noted across the fracture site. The same procedure was then done for the fifth metatarsal, taking care to include the comminution in both distal fragments. After adequate reduction of both the fourth and fifth metatarsals using 0.0-inch Kirschner wire, the wires were then bent and cut. The area was then again flushed with copious amounts of sterile saline. At the time of the final irrigation, it was noted that 5 liters of normal saline were used in total for the irrigation. It was also noted at this time that all gross contamination was removed off from the laceration and considering the decrease infection, it also was decided to primarily close the laceration. This was achieved using combination of simple and horizontal mattress of 4-0 nylon sutures. Again, care was taken to use atraumatic technique and to preserve the distal flap as much as possible. Upon completion of the closure, the laceration was then covered with Betadine soaked moistened Owen silk, 4 x 4 gauze and Kerlix. It was noted at this time that the digits were pink and warm to the touch and the laceration margins were viable. Next, a well-padded posterior splint was then applied to the left lower extremity. The patient tolerated the procedure well without complications, was extubated successfully and left the operating room with vital signs stable and vascular status intact to the operative foot. The patient will be admitted for continued IV antibiotic, pain control and will be seen tomorrow morning during rounds.

Dictated by:

OPERATIVE REPORT

# Pre-Op Documentation

Progress Note, Podiatry  
\* Final Report \*

Example of Pre-op Report: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [REDACTED]  
Result status: Auth (Verified)  
Result title: [REDACTED]  
Performed by: [REDACTED]  
Verified by: [REDACTED]  
Encounter info: [REDACTED]  
Contributor system: [REDACTED]

### \* Final Report \*

[REDACTED]

**CHIEF COMPLAINT/REASON FOR VISIT**  
Left foot fractures.

**HISTORY OF PRESENT ILLNESS**

[REDACTED] is a [REDACTED] who presents to my clinic today with complaints of left foot fractures. He sustained this injury on 08/20/2016. Patient notes that he was out when he stepped off a curb wrong rolling his foot. He does note that he was drinking at the time. He wore a friend's boot and crutches until he was seen on [REDACTED] where radiographs revealed displaced 3rd and 4th metatarsal fractures as well as essentially nondisplaced 2nd metatarsal fracture. He does note today that he has been ambulating on the extremity in the boot. His pain has improved to some extent.

**SYSTEMS REVIEW**

Denies calf pain, shortness of breath, or chest pain.

**ALLERGIES**

Acetaminophen and aspirin.

**MEDICATIONS**

Reviewed per EMR.

**PAST MEDICAL/SURGICAL HISTORY**

PAST MEDICAL HISTORY: Depression. Generalized anxiety. ADHD.

PAST SURGICAL HISTORY: None.

**FAMILY HISTORY**

Denies.

**SOCIAL HISTORY**

Patient is single. He does not currently use tobacco products is a former smoker, noting that he quit about 4 months ago. He consumes on an average 6 drinks per day and typically over 30 drinks per week.

**PHYSICAL EXAMINATION**

Printed by: [REDACTED]  
Printed on: [REDACTED]

VITAL SIGNS:

PHYSICAL EXAMINATION

GENERAL: Patient alert, oriented, and in no apparent distress.

VASCULAR: Dorsalis pedis and posterior tibial pulses are palpable at 2/4. Capillary refill is within normal limits to all digits of the left foot. Pedal hair growth is present to the digits. No areas of necrosis noted.

DERMATOLOGIC: Skin of normal texture and turgor without signs of atrophy or open lesions. No erythema or edema noted. Toenails appear healthy without signs of discoloration or thickening.

NEUROLOGIC: Gross sensation is intact to all digits on the left foot without signs of peripheral neuropathy.

MUSCULOSKELETAL: There is edema to the left forefoot, midfoot with palpatory tenderness over the 2nd, 3rd, and 4th metatarsal midshaft fractures. There is no sign of fracture blistering or compartment syndrome. His foot compartments are soft and supple. There is no Lisfranc tenderness. Active and passive dorsiflexion and plantar flexion are intact to the level of the ankle as well as to all digits. There is no skin tenting. The skin lines are present. Remainder of forefoot, midfoot, rearfoot, and ankle is nontender to palpation. Ankle joint range of motion is smooth and largely within normal limits. Calf is soft and nontender.

DIAGNOSTICS

Three views of the left foot and ankle exhibit displaced 3rd and 4th metatarsal midshaft fractures as well as essentially nondisplaced 2nd metatarsal midshaft fracture. There is lateral translation and some degree of shortening appreciated to the 3rd and 4th metatarsal fractures. Lisfranc complex is well aligned. No other overt fractures are appreciated.

IMPRESSION/REPORT/PLAN

1. Displaced left 3rd and 4th metatarsal diaphyseal fractures.
2. Nondisplaced 2nd metatarsal diaphyseal fracture secondary to injury.

PLAN: I did review imaging and discussed findings with [REDACTED] today. At times, fractures can be treated conservatively without surgical intervention and at other times require surgical intervention. While his fractures could potentially heal in the current position, they are not in ideal alignment and are also at higher risk for delayed or nonunion, subsequent structural deformities of the foot. As a result, I would recommend surgical open reduction internal fixation of the 3rd and 4th metatarsal fractures. I discussed with them what this would entail. Patient would need to be nonweightbearing for up to 6 weeks postoperatively and with another month of protected weightbearing in a boot after that. We discussed all risks and potential complications of surgery which include but are not limited to superficial or deep infection, bone infection, nonunion, delayed union, or malunion, hardware complications, wound healing complications, temporary or permanent numbness, painful or unsightly scarring, ongoing pain despite surgical intervention, need for repeat surgical intervention, injury to adjacent structures, blood clot formation, pulmonary embolus that could be life-threatening, or complications with anesthesia that could be life-threatening. I did perform a DVT risk assessment today. Patient has no personal or familial history of thrombosis. He will be nonweightbearing postoperatively. We will have him take aspirin 81 mg 2 times a day postoperatively and perform range-of-motion exercises 5 times a day reps of 20 through all major joints. I did discuss signs and symptoms of blood clot formation or pulmonary embolus and what to do if he experiences these. We also discussed time off work. He will plan to be off work for 3 weeks at then strictly seated nonweightbearing work after that. I dispensed a short boot for him today. I also put an order for a Roll-A-Bout scooter as well. We will plan to move forward with surgical intervention on [REDACTED]. This can be performed under monitored anesthesia care in the out-patient surgical setting. Patient will obtain a preoperative history and physical prior to that time. All questions are answered per his satisfaction. Absolutely no guarantees were given or implied in regard to surgical intervention.

[REDACTED]

Progress Note, Podiatry  
\* Final Report \*



Example of Pre-op Report: Your Institution's Report May Look Different

Signature Line



Completed Action List:





# Post-Op Documentation

Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [Redacted]  
Result status: Auth (Verified)  
Result title: S0377-LE  
Performed by: [Redacted]  
Verified by: [Redacted]  
Encounter info: [Redacted]  
Contributor system: [Redacted]

**\* Final Report \***

DOC01455 (Verified)

[Redacted] is here today for followup of open reduction internal fixation of left 3rd and 4th metatarsal fractures. Second metatarsal fracture was treated nonoperatively. He notes that his pain is well controlled at this point. He denies any falls or other issues. I had recommended a Roll-A-Bout, but he has refused this and is using crutches. He denies any other issues.

**SYSTEMS REVIEW**

Denies nausea, vomiting, fever, chills, calf pain, shortness of breath, or chest pain.

**PHYSICAL EXAMINATION**

The incision site to the left forefoot is well coated and nearly healed at this point. Sutures are intact. There is no sign of peri-incisional erythema, fluctuance, crepitus, hematoma or dehiscence. There is no peri-incisional paresthesias nor dysesthesias. Calf is soft and nontender. The 2nd, 3rd and 4th metatarsal fractures are clinically stable.

**DIAGNOSTICS**

Three views of the left foot exhibit no change in position as compared to previously. There is a reasonable reduction of the 3rd metatarsal fracture and anatomical alignment of the 4th metatarsal fracture. The 2nd remains nondisplaced. No hardware complications.

**IMPRESSION/REPORT/PLAN**

One week status post left 3rd and 4th metatarsal fracture open reduction internal fixation, 2nd metatarsal fracture treated conservatively.

PLAN: Derreck is progressing as anticipated at this point. I discussed with him the importance of staying strictly nonweightbearing on this extremity due to the comminuted nature of these fractures. If weightbearing earlier than instructed, this places him at much higher risk for complications, including nonunion hardware issues and need for repeat surgery. I do have some concerns that he will ambulate sooner than he is supposed to. He is to complete 6 weeks of nonweightbearing. I also strongly encouraged that he obtain a Roll-A-Bout scooter, but he is not interested in that at this time. He will continue to use the crutches. I will plan to see him back in 1 week for anticipated suture removal. He will contact me sooner with any acute issues. All questions answered.

Printed by:  
Printed on:



Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different



Signature Line

Electronically Signed By:



On:



Completed Action List:



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Printed on:



Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [Redacted]  
Result status: Auth (Verified)  
Result title: S0377-LE  
Performed by: [Redacted]  
Verified by: [Redacted]  
Encounter info: [Redacted]  
Contributor system: [Redacted]

**\* Final Report \***

DOC01455 (Verified)

[Redacted] is here today for followup of left 3rd and 4th metatarsal fracture open reduction internal fixation. He is currently 2 weeks out from surgery and is doing well. He denies putting weight on the foot for the most part. He has not had any falls or other issues. He never did pick up the Roll-A-Bout and has just been using crutches. He denies any constitutional symptoms.

**SYSTEMS REVIEW**

Denies nausea, vomiting, fever, chills, calf pain, shortness of breath, or chest pain.

**PHYSICAL EXAMINATION**

The incision site to the left dorsal forefoot is well coated and healed today. Sutures were removed uneventfully. There is no peri-incisional erythema, fluctuance, crepitus, or signs of dehiscence. The 3rd and 4th metatarsal fractures are noted to be clinically stable as is the 2nd metatarsal fracture. The metatarsal parabola appears well aligned. Mild edema consistent with typical postoperative course.

**IMPRESSION/REPORT/PLAN**

Two-and-half weeks' status post left 3rd and 4th metatarsal fracture open reduction internal fixation, 2nd metatarsal fracture treated conservatively.

**PLAN:** I discussed findings with [Redacted]. He is progressing as anticipated at this point. Sutures were removed uneventfully. He is to remain nonweightbearing. We discussed deep vein thrombosis prophylaxis measures and what to do if he experiences these symptoms. I also did encourage him to obtain a Roll-A-Bout to make nonweightbearing more feasible longer-term for him. He is hesitant about this, but I did once again put an order in case he would like to pick this up. He does feel as though he is ready to return back to work in a nonweightbearing fashion as he does note that they have seated nonweightbearing work for him to do. Thus, I did write a note indicating that he could return to work on 09/26/2016 in a strictly nonweightbearing fashion with seated-work only.

I will plan to see patient back in 1 month with repeat radiographs or they will contact me sooner with any acute issues. All questions are answered. Radiographs can be weightbearing at the next appointment.

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Progress Note, Podiatry  
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Signature Line



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Printed on:



Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [Redacted]  
Result status: Auth (Verified)  
Result title: S0377-LE  
Performed by: [Redacted]  
Verified by: [Redacted]  
Encounter info: [Redacted]  
Contributor system: [Redacted]

**\* Final Report \***

**DOC01455 (Verified)**

**HISTORY OF PRESENT ILLNESS**

[Redacted] is here today for followup of his left thumb 3rd and 4th metatarsal fracture open reduction internal fixation as well as a 2nd metatarsal fracture treated conservatively. He does note that he has been doing well. While he can have some sensations of tightness in his foot, he denies any pain at this time. He did inadvertently stepped down hard on the foot one time, otherwise denies any falls and notes that he has been compliant with nonweightbearing with a Roll-A-Bout. Denies any new issues.

**SYSTEMS REVIEW**

Complete 10-point review of systems was reviewed and is negative other than that discussed in HPI. Denies calf pain, shortness of breath, or chest pain.

**PHYSICAL EXAMINATION**

The incision site to the left foot is well coapted and healed today. There is a small superficial eschar that was left intact with no signs of underlying wound, drainage, fluctuance, crepitus or erythema. There is appreciable palpatory tenderness over the 3rd or 4th metatarsal fracture sites, which are noted to be clinically stable. The 2nd metatarsal fracture does exhibit some mild palpatory tenderness, but was also noted to be clinically stable. The metatarsal parabola distally appears to be in satisfactory alignment. No digital deformity. Mild edema is consistent with typical postoperative course. Calf is soft and nontender.

**DIAGNOSTICS**

Radiographs three views of the left foot exhibit progressive interval healing at the 2nd through 4th metatarsal fracture sites. On the oblique view there is clear callus formation occurring at the 3rd metatarsal fracture site. No hardware complications or change in position as compared to previously.

**IMPRESSION/REPORT/PLAN**

Six weeks status post left 3rd and 4th metatarsal fracture open reduction internal fixation, 2nd metatarsal fracture treated conservatively.

PLAN: I discussed findings with [Redacted] and we did review his imaging. At this time, I would like to have him minimally touchdown weightbearing with crutches only for short distances. Otherwise, he will continue to stay off of the foot. In a few weeks he can begin to do some light protected weightbearing for short distances in the boot if it is pain-free for him to do so. Reinforced icing and elevation. He should certainly not be doing any ambulation out of the boot or he has been

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Progress Note, Podiatry

\* Final Report \*

Example of Post-op Documentation: Your Institution's Report May Look Different

aggressive or longer distance activity in the boot. I did provide him with a note today indicating that he can continue with seated work for the next month where he is unable to accommodate, so he has been off work. All questions are answered per his satisfaction. I will plan to see him back in 1 month with repeat radiographs or he will contact me sooner with any acute issues.

Signature Line

Completed Action List:

Printed by:  
Printed on:

Page 2 of 2  
(End of Report)

Progress Note, Podiatry

\* Final Report \*

Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry

Result date:

Result status:

Auth (Verified)

Result title:

S0377-J F

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Verified by:

Encounter info:

Contributor system:

### \* Final Report \*

DOC01455 (Verified)

is here today for followup of left 3rd and 4th metatarsal fracture open reduction and internal fixation. He is currently about 10 weeks out from surgery. He has been back to work for a few weeks essentially doing largely seated work with some ambulation for very short distances in the boot. This has been going well for him. He denies tobacco use but does relate daily cannabis use. He does have some tenderness over the area that he points to as the 2nd metatarsal but no tenderness over the surgical site.

#### SYSTEMS REVIEW

Denies calf pain, shortness of breath or chest pain.

#### PHYSICAL EXAMINATION

The incision site to the left foot is well coated and healed today with appropriate postsurgical scarring. There are no signs of dehiscence or drainage. I am unable to elicit any palpatory tenderness over the 3rd or 4th metatarsal fractures nor other corresponding metatarsal heads, and these areas are noted to be clinically stable. There is some degree of low-grade tenderness over the midshaft of the 2nd metatarsal corresponding with the fracture site. This is also noted to be clinically stable. There is some mild tenderness sub 2nd metatarsophalangeal joint, low-grade edema consistent with typical postoperative course at this stage and continues to improve. No erythema. No peri-incisional paresthesias nor dysesthesias. Calf is soft and nontender.

#### DIAGNOSTICS

Three views the left foot exhibit further interval healing to the left 2nd, 3rd and 4th metatarsal fractures with interval callus formation and further obscuring to the fracture lines. There has been no interval hardware loosening or complication. There remains some mild angular deformity to the distal fragment of the 3rd metatarsal that is unchanged in alignment as compared to previously.

#### IMPRESSION/REPORT/PLAN

Ten weeks status post left 3rd and 4th metatarsal fracture open reduction and internal fixation, 2nd metatarsal fracture treated conservatively.

PLAN: I discussed imaging and findings with today. He does continue to progress forward. We discussed cannabis smoking cessation. For the time being, patient is to remain in boot. He is weightbearing in the boot. We will continue with current restrictions at work consisting of mainly seated work with ambulation for short distances, no heavy lifting above 15 pounds. These restrictions have been going well for him. He is to continue to avoid any excessive or

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Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

exacerbating activities with this extremity. I will plan to see him back in 1 month with repeat radiographs or he will contact me sooner with any acute issues. All questions are answered.



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Electronically Signed By:



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Printed on:



Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry  
Result date: [Redacted]  
Result status: Auth (Verified)  
Result title: S0377 LE  
Performed by: [Redacted]  
Verified by: [Redacted]  
Encounter info: [Redacted]  
Contributor system: [Redacted]

**\* Final Report \***

DOC01455 (Verified)

**CHIEF COMPLAINT/REASON FOR VISIT**

[Redacted] is here today for followup of left 3rd and 4th metatarsal fracture open reduction internal fixation. He is currently nearly 4 months out from surgery. He does continue to ambulate in the boot and has been doing largely seated work. This has been going well for him. He has tried to get out of the boot and walk barefoot a little bit to "test the foot" as he describes it. He denies any pain in the foot at this time when ambulatory in the boot.

**SYSTEMS REVIEW**

Denies calf pain, shortness of breath, or chest pain.

**PHYSICAL EXAMINATION**

The incision site to the left foot is well coapted and healed today with appropriate postsurgical scarring and no peri-incisional paresthesias nor dysesthesias. There is some mild persistent palpatory tenderness over the 2nd metatarsal fracture site as well as the right 3rd and 4th metatarsal heads and to a lesser extent over the 3rd and 4th metatarsal fracture sites. Overall this is improved as compared to previously. Very mild edema consistent with typical postoperative course at this stage. No palpably prominent hardware. Calf is soft and nontender.

**DIAGNOSTICS**

Three views of left foot exhibit interval healing to the 2nd and 4th metatarsal fracture sites. There also does appear to be some degree of increased callus formation to the 3rd metatarsal fracture site more medially, although there is persistent fracture line appreciated. No acute loosening of hardware or interval hardware complications.

**IMPRESSION/REPORT/PLAN**

Four months status post left 3rd and 4th metatarsal fracture open reduction internal fixation, 2nd metatarsal fracture treated conservatively.

PLAN: I discussed findings with [Redacted] today. We did review his imaging. He does continue to show signs of healing. The 3rd metatarsal fracture site is relatively slow to heal but does continue to progress forward. We will plan to keep him in the boot at this time and not change his work restrictions. I will plan to see him back in 1 month with repeat radiographs weightbearing of the foot. He is to abstain from any weightbearing out of the boot at this point.

Printed by: [Redacted]  
Printed on: [Redacted]

Progress Note, Podiatry  
\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different



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On:



Completed Action List:



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Printed on:



Progress Note, Podiatry

\* Final Report \*

Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry

Result date:

Result status:

Auth (Verified)

Result title:

S0377-LE

Performed by:

Verified by:

Encounter info:

Contributor system:

### \* Final Report \*

DOC01455 (Verified)

is here today for followup of left 3rd and 4th metatarsal fracture open reduction internal fixation and 2nd metatarsal fracture treated conservatively. He is nearly 5 months out from surgery. He does continue to wear the boot and is doing mainly seated sedentary work at his job. He does relate "pushing the envelop" and doing more activity up on the foot than has been instructed. He denies any tobacco use or new issues. He experiences no pain in the boot whatsoever.

#### SYSTEMS REVIEW

Denies calf pain, shortness of breath or chest pain.

#### PHYSICAL EXAMINATION

The incision site to the dorsal left forefoot is well healed today with appropriate postsurgical scaring and no peri-incisional paresthesias nor dysesthesias. There is no palpably prominent hardware. There is some mild palpatory tenderness over the midshaft of the 2nd metatarsal extending into the second metatarsal, neck region. Otherwise, I am unable to elicit any palpatory tenderness whatsoever to the forefoot or midfoot today. In particular, there is absolutely no palpatory tenderness over the 3rd or 4th metatarsal fracture sites, which are both noted to be clinically stable. The metatarsal distally appears to be clinically well aligned. There is no metatarsal head or interspace pain. Digits are noted to be in satisfactory rectus alignment. Continue to decrease edema as compared to previously. Calf is soft and nontender.

#### DIAGNOSTICS

Radiographs: Three views of the left foot exhibit near complete healing to the 2nd metatarsal and 4th metatarsal midshaft fractures as any discrete obvious linear lucency is not well visualized at this point. This is consistent with near complete fracture healing. The 3rd metatarsal comminuted midshaft fracture remains readily visualized today with no overt interval callus formation as compared to previous radiographs on . There is no sign of hardware failure or obvious loosening of hardware as compared to previous radiographs.

#### IMPRESSION/REPORT/PLAN

1. Five months status post left 3rd and 4th metatarsal fracture open reduction and internal fixation, 2nd metatarsal fracture treated conservatively.
2. Delayed healing, left 3rd metatarsal midshaft fracture.

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PLAN: I discussed findings with [REDACTED] today. It is important he not push his activity level as he describes he has done, as this can place him at higher risk of hardware failure and need for revisional surgery. While the 2nd and 4th metatarsal fractures continue to consolidate in and appear to be essentially nearly healed at this point, there have not been obvious signs of callus formation or further healing to the 3rd metatarsal fracture site over the last month. We discussed treatment options. I would recommend that he remain in the short boot or postop shoe at this point. I did not want him ambulating out of it at this point. He would actually prefer the boot as opposed to the postop shoe at this point and will continue with boot. We also discussed that in the setting of delayed healing, we can consider an external bone stimulator to help facilitate the bone healing process. I would not anticipate a bone stimulator to be covered by insurance at this point, which would require an out-of-pocket cost for the patient if we were to pursue that at this time. Patient is not interested in that at this time. We will continue with work restrictions to consist of protected weightbearing in the open-toed boot with no lifting greater than 20 pounds. No pushing or pulling maneuvers. Patient is instructed to inform my clinic if he is struggling with work duties or having any issues with these restrictions. Once again, he is to abstain from any weightbearing out of boot at this point or any aggressive or exacerbating activities even in the boot, both of which could place him at higher risk of hardware failure, ongoing delayed union or nonunion which could require revisional surgery. If we fail to continue to see progression of healing at the 3rd metatarsal fracture site, we will consider external bone stimulator options once this has the potential to be covered from an insurance standpoint. We discussed other potential barriers to bone healing. I discussed taking a vitamin D3 supplement on a daily basis. We could also further evaluate with vitamin D lab work today but patient would like to wait on that. Patient will contact me with any issues prior to being seen back in 1 month with repeat weightbearing radiographs of the left foot at that time.

Signature Line

Completed Action List:

Progress Note, Podiatry

\* Final Report \*



Example of Post-op Documentation: Your Institution's Report May Look Different

Result type: Progress Note, Podiatry

Result date: [Redacted]

Result status: Auth (Verified)

Result title: S0377-LE

Performed by: [Redacted]

Verified by: [Redacted]

Encounter info: [Redacted]

Contributor system: [Redacted]

**\* Final Report \***

**DOC01455 (Verified)**

[Redacted] is here today for followup of a left 3rd and 4th metatarsal fracture open reduction, internal fixation and 2nd metatarsal fracture treated conservatively. He is currently 6 months out from surgery. He does continue with postop shoe immobilization and has been tolerating this well. He denies any overt pain to the foot at this point. He continues to wear the boot while at work and has been tolerating this well. He denies tobacco use. No new concerns or issues from the patient's standpoint at this point.

**SYSTEMS REVIEW**

Denies calf pain, shortness of breath, or chest pain.

**PHYSICAL EXAMINATION**

The incision site to the dorsal left foot is well coated and healed today with appropriate postsurgical scarring. There are no appreciable peri-incisional paresthesias nor dysesthesias. There is no appreciable palpatory tenderness over the 3rd and 4th metatarsal fracture sites which are noted to be clinically stable. There is no palpably prominent hardware appreciated. There is some mild palpatory tenderness over the midshaft of the 2nd metatarsal. There is also some mild tenderness sub 2nd and 3rd metatarsophalangeal joints although, I do not appreciate palpable deformity at the level of the metatarsophalangeal joints. No intermetatarsal space tenderness appreciated. Very low-grade edema that is near to baseline at this point. The digits are in satisfactory alignment. The calf is soft and nontender.

**DIAGNOSTICS**

**RADIOGRAPHS:** Three views of the left foot exhibit no overt sign of obvious linear lucency to the 2nd or 4th metatarsal fracture sites, consistent with healed fractures at this point. There is some callus formation at the 3rd metatarsal midshaft fracture site with no signs of interval hardware loosening or failure as compared to previous radiographs. There may be some increased callous formation as compared to previous radiographs on the oblique view although variation in angulation of radiograph as compared to previous oblique view could account for this difference. Complete osseous union across the third metatarsal fracture site has not yet been achieved, consistent with delayed healing.

**IMPRESSION/REPORT/PLAN**

1. Six months, status post left 3rd and 4th metatarsal fracture open reduction and internal fixation, 2nd metatarsal fracture treated conservatively.
2. Delayed healing, left 3rd metatarsal midshaft fracture.

Printed by: [Redacted]  
Printed on: [Redacted]



Example of Post-op Documentation: Your Institution's Report May Look Different

PLAN: I discussed findings with [redacted] today. There is delayed healing of the 3rd metatarsal fracture although, this area is not really clinically tender for the patient. The hardware is noted to be clinically intact, and the fracture site is noted to be clinically stable. I discussed with [redacted] that at times we can consider further imaging such as a CT to evaluate extent of healing, but he would like to wait on that at this time. At this point, as there has been some progression of third metatarsal fracture healing over the last three months, I would not anticipate an external bone stimulator to be covered by insurance. We discussed out-of-pocket costs that can be associated with an external bone stimulator if not covered by insurance, and the patient does not wish to pursue that at this time, although there is potential this could be necessary at some point in the future. We did discuss working restrictions which have been going well for the patient. We will plan for work restrictions to consist of lifting no more than 25 pounds at work with no heavy pushing or pulling maneuvers. Work note was provided indicating these restrictions. He will continue with the postoperative shoe. He will continue to monitor his progress and contact us if he is struggling with his work restrictions. We also discussed continuing to take a vitamin D3 supplement on a daily basis. We will continue to closely follow this. I would like to see the patient back in 1 month with repeat weightbearing radiographs prior, or he will contact us sooner with any acute issues. All questions were answered per his satisfaction.



Signature Line



Completed Action List:



# Consultations



**PROGRESS RECORD**

Date	Time	RECORD: Adequate admission note, progress of case, complications, change in diagnosis, condition on discharge, instructions to patient
		<p>In staff HLP C. Thompson</p> <p>HPI: It is a 40 y/o F in no past medical history presents with a                      acute laceration on her (L) foot. States significant amount of bleeding                      that was noted in tonight. Taken to OR for <sup>open</sup> <del>closed</del> fracture                      of 4th/5th lateral. air packed in wound. pain is controlled post                      surgical.</p> <p>PMH: none                      PSYH: none                      MEDS: none                      All: normal                      PE: 124/79, 94, 95, 16, 98% O<sub>2</sub>                      GI: A/G, NAD                      CV: S, S, 3/11/17                      PMH: LGA 10/12/14                      All: S, N/A                      Ext: casts on (L) foot &amp; splint</p> <p>Plan: (1) (L) 4th &amp; 5th lateral fracture sp repair                      - pain control Polarity follow, Gent/2osyn, JVC                      (2) Hypertension - J HCLAC                      (3) Leukocytosis - 1 unit RBC to 5                      (4) Glutathione eumyosin                      (5) + DVT - PA start low dose when clear by polarity                      (6) H. pylori (Dati Admin)</p>
		<p>EM: F-CAB.                      S: ext, ext, ext, ext</p> <p>139   104   9   141   170   171                      3.8   22   0.82   375</p> <p>X-R Foot: frac. (L) 4th &amp; 5th lateral</p>
		<p>Internal Medicine Residency Staff Service                      I have personally seen and examined the patient. I discussed the                      case with the resident and reviewed their documentation.                      I <input checked="" type="checkbox"/> agree with/amended (circle one) the resident's documentation.                      Critical/Key: [Redacted]</p> <p>Attending Printed Name: [Redacted]                      Attending Signature: [Redacted]</p>

P. Thompson  
 Dr. Thompson  
 P. Thompson  
 Dr. Thompson  
 P. Thompson  
 Dr. Thompson



Dr. Thompson  
 PA

# Labs

Example of Labs: Your Institution's Report May Look Different

Flowsheet Print Request

Patient: [REDACTED]

Printed by: [REDACTED]

MRN: [REDACTED]

Date Range: [REDACTED]

Event Date	Event	Result	Ref. Range	Status
[REDACTED]	Hgb	15.6 g/dL	(13.5 - 17.5)	
	Hct	45.2 %	(38.8 - 50.0)	
	WBC	7.3 x10(9)/L	(3.5 - 10.5)	
	RBC	4.96 x10(12)/L	(4.32 - 5.72)	
	MCV	91.1 fL	(81.2 - 95.1)	
	RDW	13.4 %	(11.8 - 15.6)	
	Platelet	271 x10(9)/L	(150 - 450)	
	Neutro Absolute	4.01 10(9)/L	(1.70 - 7.00)	
	Lymph Absolute	2.36 x10(9)/L	(0.90 - 2.90)	
	Mono Absolute	0.69 x10(9)/L	(0.30 - 0.90)	
	Eos Absolute	0.18 x10(9)/L	(0.05 - 0.50)	
	Baso Absolute	0.05 x10(9)/L	(0.00 - 0.30)	
	Differential?	Auto		
	Sodium Lvl	140 mmol/L	(135 - 145)	
	Potassium Lvl	^ 4.1 mmol/L	(3.5 - 5.1)	
	Chloride	^ 101 mmol/L	(98 - 107)	
	CO2	^ 24 mmol/L	(22 - 29)	
	AGAP	15 mmol/L	(10 - 20)	
	Alkaline Phosphatase	^ L 40 unit/L	(45 - 115)	
	Glucose Lvl	81 mg/dL	(70 - 139)	
	Creatinine	^ 1.07 mg/dL	(0.80 - 1.30)	
	EGFR (MDRD)	^ >60 mL/min/1.73m2	(>=60 - )	
	EGFR African American (MDRD)	^ >60 mL/min/1.73m2	(>=60 - )	
	BUN	^ 19 mg/dL	(8 - 24)	
	Calcium Lvl	^ 9.3 mg/dL	(8.6 - 10.3)	
	Protein Total	^ 7.3 gm/dL	(6.3 - 7.9)	
	Albumin Lvl	^ 4.5 g/dL	(3.5 - 5.0)	
	AST	17 unit/L	(8 - 48)	
	ALT	^ 11 U/L	(7 - 55)	
	Bili Total	^ 0.4 mg/dL	( - <=1.2)	
[REDACTED]	Hgb	14.8 g/dL	(13.5 - 17.5)	
	Hct	43.6 %	(38.8 - 50.0)	
	WBC	8.4 x10(9)/L	(3.5 - 10.5)	
	RBC	4.65 x10(12)/L	(4.32 - 5.72)	
	MCV	93.8 fL	(81.2 - 95.1)	
	RDW	13.3 %	(11.8 - 15.6)	
	Platelet	247 x10(9)/L	(150 - 450)	
	Neutro Absolute	5.38 10(9)/L	(1.70 - 7.00)	
	Lymph Absolute	2.20 x10(9)/L	(0.90 - 2.90)	
	Mono Absolute	0.65 x10(9)/L	(0.30 - 0.90)	
	Eos Absolute	0.10 x10(9)/L	(0.05 - 0.50)	
	Baso Absolute	0.05 x10(9)/L	(0.00 - 0.30)	
	Differential?	Auto		
	D-Dimer	^ <0.28 mcg/mL FEU	( - <=0.50)	
	Sodium Lvl	141 mmol/L	(135 - 145)	
	Potassium Lvl	^ 4.1 mmol/L	(3.5 - 5.1)	
	Chloride	^ 103 mmol/L	(98 - 107)	
	CO2	^ 26 mmol/L	(22 - 29)	
	AGAP	13 mmol/L	(10 - 20)	

# Example of Labs: Your Institution's Report May Look Different

## Flowsheet Print Request

Patient: [REDACTED]

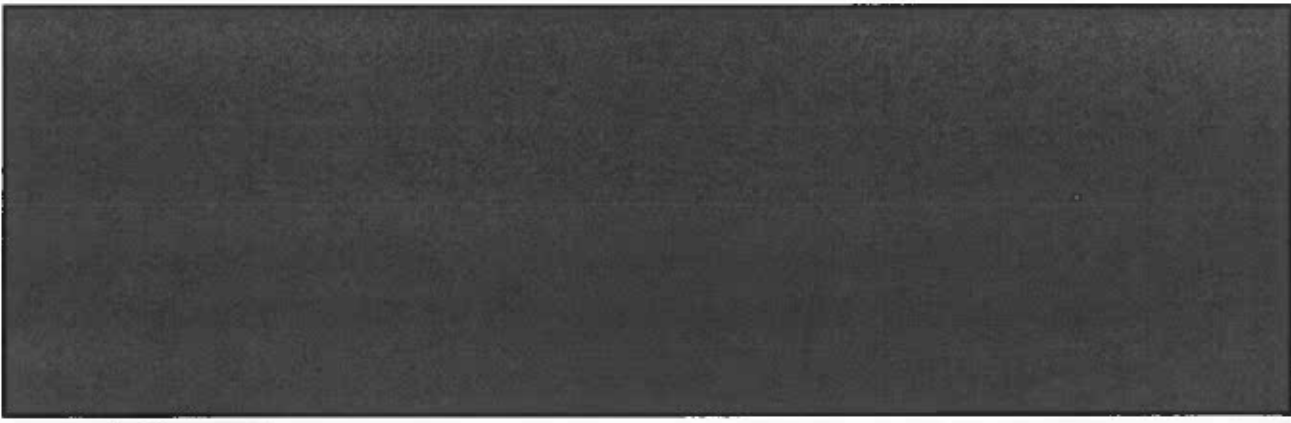
Printed by: [REDACTED]

MRN: [REDACTED]

Event Date	Event	Result	Ref. Range	Status
	Glucose Lvl	85 mg/dL	(70 - 139)	
	Creatinine	^ 1.10 mg/dL	(0.80 - 1.30)	
	EGFR (MDRD)	^ >60 mL/min/1.73m2	(>=60 - )	
	EGFR African American (MDRD)	^ >60 mL/min/1.73m2	(>=60 - )	
	BUN	^ 17 mg/dL	(8 - 24)	
	Calcium Lvl	^ 8.9 mg/dL	(8.6 - 10.3)	
	Troponin-T	<0.01 ng/mL	( - <=0.01)	

# Pathology Report

Example of Pathology Report: Your Institution's Report May Look Different



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Age/Sex: [redacted]  
DOB: [redacted]

Collection Date: [redacted]  
Date Received: [redacted]  
Report Date: [redacted]

**Tissue**  
bone, left foot

**Clinical Diagnosis**  
non-pressure chronic ulcer of left foot

**Final Diagnosis**

**Bone and soft tissue, left foot, excision:**  
**Reactive and degenerative changes and chronic inflammation.**

**Gross**

A. Part A is received in formalin labeled with the patient's name, medical record number, and "bone left foot", and consists of 4 2.5 x 1.5 x 1.5 cm fragments of bone and soft tissue consisting of phalangeal bones with overlying soft tissue. Representative sections are submitted as follows:

- Cassette 1 soft tissue
- Cassette 2 bone (after decalcification).

(CG/cg)



# Anesthesia Record/Circular's Notes

Please note – These records are a source of Surgeon of Record verification.  
Make sure you upload the correct report. Either report is acceptable.

### ANESTHESIA RECORD

PAGE OF 1 AGE 40 ASA 1 2 3 4 5 E

Site \_\_\_\_\_

Arterial Line	Radial	R L	Femoral	R L
CVP	IJ	R L	Subclavian	R L
Swan Ganz	IJ	R L	Subclavian	R L

IV Sedation for eye block note start/stop below

Anesthesia Stop \_\_\_\_\_

Surgeon \_\_\_\_\_ Anesthesiologist \_\_\_\_\_ CRNA \_\_\_\_\_

Diagnosis Open fracture of 4th & 5th metatarsals

Procedure ORIF 4th & 5th metatarsals

Modified  Chart Reviewed

Permit Signed  TO Band checked

Surgical Site verification

Machine check prior to use # \_\_\_\_\_

Pre-anesthetic Status:

Awake  Calm  Apprehensive

Sleepy  Sedative ordered

Uncomfortable  Unresponsive

Uncooperative  Armboard Restraints

Safety Belt on  Arms Tucked

Pressure points checked and padded

Positioning roll

Eye Care:  Ointment  Saline

Taped  Padded  Goggles

Continuous EKG  Pulse Oximeter

Non-invasive B/P  Left  Right

Gas Analyzer  End Tidal CO2

Airway Humidifier

Steth  Precord.  Esoph

Nerve Stimulator  NG  OG

Fluid Warmer  Convection warmer

Foley  Upper body  Lower body

Hypotensive Technique

Hemodilution  Intraop Salvage

Endobronchial size \_\_\_\_\_ Fr

General:  Inhalation  Intravenous

LMA  Pre-Oxygenation  LTA

Rapid Sequence  Cricoid Pressure

Intubation:  ET size 7.0

Agonist  Magill  R.A.E.  Laser

Cuffed  Uncuffed, leaks at \_\_\_\_\_ cm H2O

Magill  Direct  Fiber optic  Blind

Blade # 2 Miller mac  Secured @ 18cm

ET CO2 present  SBSE

Atraumatic  Difficult  Attempts 2

Orientation Unchanged

Airway:  Oral  Nasal

Oxygen:  Tracheotomy  Tpiece

Nasal Cannula  O2 mask

arrived Intubated  NRB mask

Time Out performed prior to block

Regional:  Spinal  Epidural  Arde

Axillary  Paravertebral  Block

ITAP  Popliteal  Interscal

Femoral  Other \_\_\_\_\_

Right  Left \_\_\_\_\_

US Guidance Image retained

Local \_\_\_\_\_ Site \_\_\_\_\_

Needle \_\_\_\_\_ Level \_\_\_\_\_

Drug/Dose \_\_\_\_\_

Attempts X \_\_\_\_\_ Time \_\_\_\_\_

Signature \_\_\_\_\_

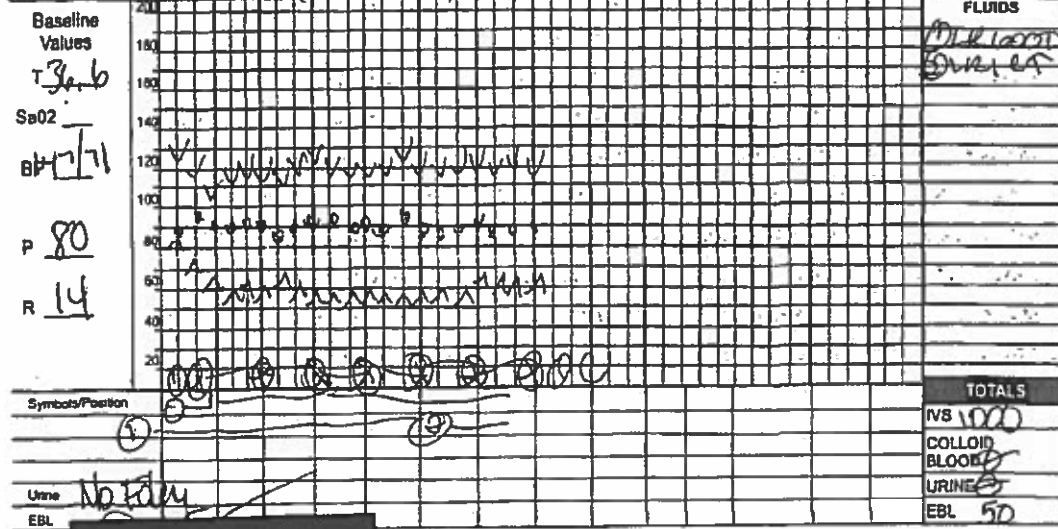
Monitoring Time Line	0	30	2:00	3:00	2:00	3:00	2:00	3:00	Totals
O2 l/min	6-2	1	1	1	1	1	1	1	10
FiO2	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21
Forane / Des / Bevo	1.8	2	1.8	1.8	1.8	1.8	1.8	1.8	15
SpO2	100	100	100	100	100	100	100	100	100
MAP	80	80	80	80	80	80	80	80	80
Mv / Roc / Cise / Pav	30	30	30	30	30	30	30	30	30
Fentanyl	3	0	0	0	0	0	0	0	3
Midazolam	8	0	0	0	0	0	0	0	8
Vecuronium	8	0	0	0	0	0	0	0	8
End	50	50	50	50	50	50	50	50	50
% O2 inspired	21	21	21	21	21	21	21	21	21
O2 Saturation	100	100	100	100	100	100	100	100	100
End Tidal CO2	40	40	40	40	40	40	40	40	40
Temp. (core)	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
CVP	10	10	10	10	10	10	10	10	10
Pa	80	80	80	80	80	80	80	80	80
PCWP	10	10	10	10	10	10	10	10	10
CO/CI	4	4	4	4	4	4	4	4	4
Tidal Volume	500	500	500	500	500	500	500	500	500
Resp. Rate	12	12	12	12	12	12	12	12	12
Peak Pressure	18	18	18	18	18	18	18	18	18
PEEP	5	5	5	5	5	5	5	5	5
TOF	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4

Preop Antibiotics  
Drug/Dose  
Micet 2gm @ 1604

Started at: \_\_\_\_\_

Incision at: 1924

Remarks:



FLUIDS	
<u>DLR 1000</u>	
<u>500ml</u>	
REVERSAL AGENTS	
Neostigmine	<u>5 mg</u>
Glycop/Atrropine	<u>1 mg</u>
SYMBOLS	
X ANESTHESIA	• PULSE
○ OPERATION	○ SPONT. RESP.
v BIPAP/CPAP	○ ASSISTED RESP.
∩ BIPAP/CPAP	○ CONTROLLED RESP.
∩ ARTERIAL LINE PRESSURE	∩ ICBN/ICU
S MEAN ARTERIAL PRESSURE	
TOTALS	
IVS	<u>1000</u>
COLLOID	<u>BLOODE</u>
URINE	<u>0</u>
EBL	<u>50</u>



Example of Circulating Nurse Report: Your Institution's Report May Look Different



**Nursing Intraop Record**

**Patient:**



**CC #:**

**MRN:**

**Acct #:**

**Sex:**

**DOB:**



**Patient Information**

**Admission Type:**

OP

**Visitors Waiting:**

Spouse

**Procedure Information**

**Procedure Date:**



**OR #:**

OR 18

**Sch Case Time:**

**Anesthesia Type**

General

**ASA:**

IE

**Case Type:**

Emergency

**Preop Diag:**

Fracture; Foot, left

**Postop Diag:**

Fracture; Foot, left

**Procedure:**

ORIF 4 TH AND 5 TH METATARSAL LEFT FOOT WITH PRIMARY CLOSURE AND SPLINT

Procedure(s)

Surgeon

I&D, Extremity: LEFT FOOT



Primary

Open Reduction Internal Fixation Toe

**Radiology Usage**

C-Arm-Mini

**Prep Location**

Left ; Foot

**Prep**

Betadine paint

**Position**

Safety strap on ; Supine ; Arm(s) papooseed to side(s)

Consent Status

Anesthesia consent; Completed - copy on chart

Blood consent; Completed - copy on chart

Operative consent; Completed - copy on chart; Signed, Correct, Verbally confirmed.

Verification



Patient verification -- ID Band; Name: Age: Verbally Confirmed; Allergy Band, if applicable; Date of Birth