

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 only to the Spring 2024 examinations

As of November 2023

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Nondiscrimination Policy. In accordance with applicable federal laws, the American Board of Foot and Ankle Surgery® does not discriminate in any of its policies, procedures, or practices based on race, color, national origin, sex, sexual orientation, age, or disability.

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. You must achieve Board Certification within seven (7) years of becoming Board Qualified.

What Does It Mean to be Board Certified?

Board Certification in Foot Surgery

Board Certification in Foot Surgery indicates that you have demonstrated cognitive knowledge and skills 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 cognitive knowledge and skills 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 Surgery.***

The Board Certification Process

As of September 2020, candidates seeking ABFAS certification must follow the new certification process.

The new Board Certification process requires Board Qualified candidates to pass the Case Review Examination in addition to having an active, unrestricted medical license, and current hospital/surgery center surgical privileges. Candidates must become certified in foot surgery before becoming certified in RRA surgery, although candidates can apply for both Case Review exams in the same year or apply for RRA Case Review prior to Foot Case Review.

Please note, Board Qualified candidates who passed the 8-case Computer-based Patient Simulation (CBPS) exam to become Board Qualified must pass the 12-case NEW CBPS exam (or have passed the Part II CBPS examination) in addition to Case Review to become Board Certified. The former 8-case CBPS examination is not the psychometric equivalent of the NEW CBPS examination, which is the current requirement for Board Qualification. Please see the [ABFAS Board Qualification](#) document for additional information on the NEW CBPS examination.

	Former ABFAS Board Qualification and Certification Examinations Requirements	Board Qualification and Certification Examination Requirements as of September 2020
In-training Examinations (September)	PGY 1 & 2 take same examinations <ul style="list-style-type: none"> • Foot Surgery Didactic – 90 Items • Foot Surgery CBPS – 8 Cases PGY 3 (& PGY 4 where applicable) in PMSR/RRA programs <ul style="list-style-type: none"> • Foot & RRA Didactic – 90 Items • Foot & RRA CBPS – 4 Foot/4 RRA 	PGY 1 & 2 (and PGY 3 in 4-year programs) take same examinations <ul style="list-style-type: none"> • Foot Surgery Didactic – 80 Items • Foot Surgery CBPS – 8 Cases • RRA Surgery Didactic – 80 Items • RRA Surgery CBPS – 8 Cases Final-year Residents take In-training Exams that are the equivalent of the new Board Qualification Examination Series (see below)
Part I Board Qualification	<ul style="list-style-type: none"> • Foot Surgery Didactic – 80 Items • Foot Surgery CBPS – 8 Cases • RRA Surgery Didactic – 80 Items • RRA Surgery CBPS – 8 Cases 	<ul style="list-style-type: none"> • Foot Surgery Didactic – 80 Items • Foot Surgery CBPS – 12 Cases • RRA Surgery Didactic – 80 Items • RRA Surgery CBPS – 12 Cases Candidates will be able to apply their passing Final-year ITE scores for qualification purposes upon payment of a qualification fee.
Part II Board Certification	<ul style="list-style-type: none"> • Foot Surgery CBPS – 12 Cases • Foot Surgery Case Review • RRA Surgery CBPS – 16 Cases • RRA Surgery Case Review 	Board Qualified prior to September 2020: <ul style="list-style-type: none"> • NEW Foot Surgery CBPS – 12 cases • Foot Surgery Case Review • NEW RRA Surgery CBPS – 12 Cases • RRA Surgery Case Review Board Qualified September 2020 or after: <ul style="list-style-type: none"> • Foot Surgery Case Review • RRA Surgery Case Review

Registration for Case Review

Register

To get started, log into the [ABFAS website](#) with your ABFAS username and password. If you have forgotten your username or password, you will find assistance on the [login page](#).

After you have logged into your profile, click on **“Examinations”** on the top toolbar. Next, click **“Register for an Exam”** on the left-hand toolbar. Follow the steps to select and pay for your exam. You will then be registered for your exam.

For additional registration instructions [click here](#).

Summary of Case Review Changes for 2024

Changes to Surgeon of Record Timeframes and Document Clarification

ABFAS recognizes that many documentation errors on Surgeon of Record may be the result of uploading an incorrect document. Please remember that the purpose of the Surgeon of Record check is to have third party documentation that the candidate is the surgeon of record (not co-surgeon). ABFAS therefore requires that you upload the Intraoperative Anesthesia Record or Circulating Nurse’s Notes. Do not upload the pre-op anesthesia evaluation, post-operative information obtained in the post anesthesia care unit (PACU/recovery room, or anesthesia consultation notes.

New this year, ABFAS will review all candidates uploaded documents regarding Surgeon of Record prior to full review of candidates’ cases. ABFAS will contact those candidates with incorrect documents and allow them to upload their correct documents within two days of notification.


Changes to Appeal Process

Appeal candidates whose Case Review comments show that there is a missing document, e.g., images, or incorrect document upload e.g., images from different patient, will be able to upload the correct documents as part of the appeal process.

Importance of Case Review Checklist

When you are ready to upload your case documentation, this will be the first screen that will appear. Please note that if your facility does not have equipment for weightbearing images, there is a process to address this in the checklist. You will need to upload a notarized letter from the facility to address the lack of equipment. The information below the checklist screenshot outlines weightbearing image requirements.

Case Documentation Checklist - Case 1

1. Are you the Surgeon of Record? *	<input type="radio"/> Yes <input type="radio"/> No
2. Are all required imaging studies present? * - Best <u>two</u> preoperative and final postoperative views must be WEIGHTBEARING for all elective foot and ankle surgery. (Immediate postoperative best two views may be non-weight bearing). - Best <u>two</u> NON-WEIGHTBEARING preoperative, immediate postoperative, and final postoperative views may be submitted for trauma cases and infection cases.	<input type="radio"/> Yes <input type="radio"/> No
3. Date of the pre-operative assessment done by you or reviewed by you that includes the rationale/indications for all procedures performed in the case. *	Save
Select date 	
4. Is there complete clinical documentation present to evaluate the case? This should include typed progress notes from the time of the patient's first presentation to the final outcome. *	<input type="radio"/> Yes <input type="radio"/> No
5. Did the patient follow up per your recommendations? *	<input type="radio"/> Yes <input type="radio"/> No
6. Did the patient follow your postoperative care instructions? *	<input type="radio"/> Yes <input type="radio"/> No
7. What is your objective assessment of the final outcome regarding your preoperative goals? *	Save
<input type="text"/>	
8. Explain any missing materials (write N/A if not applicable). *	Save
<input type="text"/>	

Weight-bearing X-Rays

If your facility does not have access to weight-bearing x-ray machines, please answer no to Question 2 in the checklist and upload a notarized letter from your facility attesting to the lack of a weight-bearing x-ray machine for that case. The following procedures require weight-bearing x-rays.

- 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
- 2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis
- 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 metatarso-cuneiform fusion
- 2.2.6 MPJ fusion
- 2.2.7 MPJ implant

- 2.3.2 osteotomy (e.g., dorsiflexory)
- 2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
- 2.3.8 corticotomy with callus distraction
- 2.3.9 revision/repair of surgical outcome (e.g., nonunion, hallux varus)
- 5.2.4 midfoot, rearfoot, or ankle fusion
- 5.2.5 midfoot, rearfoot, or tibial osteotomy
- 5.2.6 coalition resection
- 5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
- 5.3.4 excision of soft tissue tumor/mass of the foot, ankle, or leg (with reconstructive surgery)
- 5.3.6 open repair of dislocation (proximal) to tarsometatarsal joints
- 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

Case Review

The Case Review process has four components: (1) PLS case logging, (2) completion of diverse procedures, (3) facility audit, and (4) case documentation and review.

Documentation

1. Podiatry Logging Service (PLS) Case Logging

Log all post-residency procedures for which you were the surgeon of record into the [Podiatry Logging Service \(PLS\) for Surgery](#). You must log all surgical procedures into PLS to qualify for ABFAS certification. Residency cases do not meet the surgeon of record requirement, therefore **DO NOT LOG RESIDENCY CASES**. You may log fellowship cases if you were surgeon of record. ABFAS will request complete documentation for 11 foot and 11 RRA surgery cases that are in your PLS logs. ABFAS performs a hospital/surgery center audit as part of determining your eligibility for Case Review.

Please remember to log into PLS **all post-residency surgical procedures that you performed as surgeon of record. If, however, you are already certified in Foot Surgery and seeking only RRA Surgery certification, you may log only post-residency RRA procedures.**

The PLS system will inform you when you have met the quantity and diversity requirements. If you click on the link at the top of the “Manage Case” page which states, “Do I meet the requirements?” it will generate a report that shows the number of cases in each qualifying category (see Case Requirements example below). In the report, the bottom of the table shows the minimum number of cases you need for Foot and for RRA case review eligibility. The center section addresses whether you have enough cases for ABFAS to select cases for the exam. If you have taken Case Review previously and were unsuccessful, ABFAS will not use previously reviewed cases again. Therefore, while you may meet the required minimum number of cases, you may not have enough cases to meet case selection criteria. This is why it’s important for you to continue logging all cases until you pass Case Review.

Case Requirements ✕

ABFAS has analyzed your cases according to the standards and requirements currently in effect. You will find the current version of the ABFAS Board Certification requirements here: [Board Certification Document](#).

The case requirements represent the **minimum** number of cases you need before you can register for case review. Please note, upon completion of your residency you should log all surgical cases where you are surgeon of record.

You meet the 2023 case requirements for **Foot Surgery**.

You do not meet the 2023 case requirements for **Reconstructive Rearfoot/Ankle Surgery**.

- You do not have enough cases with Reconstructive Rearfoot/Ankle Surgery procedures required by ABFAS.

Foot Category	Minimum	Count
Total Cases	65	117
Total Foot Category Cases	30	67

Procedures	Limit	Count
2.1.3 bunionectomy with phalangeal osteotomy.	2	1
2.1.4 bunionectomy with distal first metatarsal osteotomy.	15	7
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy.	15	3
2.1.6 bunionectomy with first metatarsocuneiform fusion.	15	1
2.1.7 MPJ fusion.	15	2
2.1.8 MPJ implant.	2	2
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement).	2	1
2.2.3 joint salvage with distal metatarsal osteotomy.	15	4
2.2.4 joint salvage with first metatarsal shaft or base osteotomy.	15	3
2.2.5 joint salvage with first metatarsocuneiform fusion.	15	1

Items per page:

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Reconstructive Rearfoot/Ankle Category	Minimum	Count
Total Cases	30	32
Total RRA Category cases	13	12

PLS Checklist

- Ensure that you log cases using the correct procedure code in PLS.
Note: Failure to correctly log procedure type is a common error. Mislogging is one of the major reasons candidates fail Case Review.
- Ensure that you are listed as the only 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's 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. (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, you must log a minimum of 30 RRA surgery cases. Additionally, the RRA cases must include a minimum of 13 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 requirements. 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, chondroplasty involving the bones of the hindfoot, or ostectomy **are not counted** toward the required 30 total.
- Open management of fractures must include some type of internal or external fixation.
- 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**.
- ABFAS **accepts** minimally invasive surgery procedures.

Required Cases for Case Review Eligibility

FOOT SURGERY CERTIFICATION	65
First Ray, Other Osseous, RRA Cases ^a	30 ^b
RRA SURGERY CERTIFICATION	30 ^c
RRA - Elective and Nonelective Osseous	13 ^c

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

- b. List procedures involving only the hallux as digital procedures.
- c. See [Appendix B](#) for more details.

The procedures within each major category must demonstrate the candidate's range of surgical experience.

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 you log each case accurately. Below is a list of common logging errors that resulted in candidates failing Case Review:

1. Lisfranc fracture ORIF or arthrodesis. Please note: "Midfoot" joint(s) refers to any joint proximal to, and **not including**, tarsometatarsal/Lisfranc joint.
 - a) A Lisfranc fracture repair or arthrodesis is **not considered a rearfoot procedure**. Log an ORIF as 4.13 (Open management of tarsometatarsal fracture/dislocation) and a Lisfranc joint arthrodesis (with or without ORIF) as a 4.15 (tarsometatarsal fusion).
 - b) The correct code for **isolated Lisfranc reduction with suture button fixation without any osseous fractures** is 3.7 (open management of dislocation) as the procedure focuses on soft tissue ligamentous repair of the Lisfranc injury).
 - c. If there is a **ligament injury as well as osseous fractures where you have performed an actual reduction of bone fracture/displacement/joint dislocation via an open incision**, the procedure code is 4.13.
- 2) A **Lapidus bunionectomy** is a **first-ray procedure** and log only 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) is a 4.1 (partial osteotomy). If removal of the bone spur includes detachment and reattachment of the Achilles, you must use 4.19.
- 4) **Plastic surgery** does not include wound debridement and synthetic/biological graft application. A synthetic/biological graft application and/or double elliptical lesion excision does not meet the criteria for Case Review.
- 5) A **Kidner procedure** correct code is either as 5.1.6 (tendon augmentation/supplementation/restoration) or 3.1 (excision of ossicle without tendon advancement). Do not log as both 5.1.6 and 3.1 as 5.1.6 includes the ossicle excision. Removal of any ossicle such as os peroneum, os trigonum, or os navicularis is only a 3.1.
- 6) Do not log a **cheilectomy** separately if done in conjunction with another 1st metatarsal procedure (osteotomy or TMTJ fusion). Only one 2.2 procedure can be logged at the same time.
 - 2.2.1 An isolated cheilectomy as a joint salvage procedure.
 - 2.2.3 A cheilectomy is done in combination with a distal metatarsal osteotomy.
 - 2.2.4 A cheilectomy is done in combination with a metatarsal shaft or base osteotomy
 - 2.2.5 A cheilectomy is done in conjunction with a first TMT joint fusion.

- 7) **Open management of fracture or metatarsophalangeal joint (MTPJ) dislocation** cases must include internal or external fixation.
- 8) In cases where a **subchondroplasty** procedure is performed as part of another procedure, only the index procedure must be logged. For example, a talar dome or distal tibial subchondroplasty may only be logged as:
5.2.7 open management of talar dome lesion (with or without osteotomy), or
5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
- If subchondroplasty is performed in isolation, use of one of the following subcategories:
1.13 other osseous digital procedure not listed above
2.3.10 other first ray procedure not listed above
4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)
5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above
- 9) Log **treatment of a dislocating peroneal tendon** (including fibular groove deepening) as 5.16 (tendon augmentation/supplementation/restoration), not as an osteotomy.
- 10) Log isolated **syndesmotic ankle repair** as 5.3.2, (repair of acute ligament injury). This category cannot be combined with 5.4.3 (open repair of adult ankle fracture) or 5.4.4 (open repair of pediatric rearfoot/ankle fractures or dislocations).
- 11) Log **5th metatarsal bunionectomy without osteotomy** as a 4.3 (bunionectomy of the fifth metatarsal without osteotomy). If a fifth metatarsal osteotomy with osseous realignment is performed, then the correct code is 4.7 (bunionectomy of the fifth metatarsal with osteotomy).
- 12) Do not log treatment of **insufficiency fractures** with curettage and/or injection of biologics as ORIF fracture. The correct code is 4.18 (other osseous procedures not listed) or 5.2.11 (other elective reconstructive rearfoot/ankle osseous surgery not listed above), based on the location of the surgical site (forefoot vs rearfoot).
- 13) Please ensure you are using **4.3 bunionectomy of the fifth metatarsal without osteotomy** correctly.

3. Documentation of Facility, Procedures, and Hospital/Surgery Center Privileges

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, 2023, ABFAS will email you detailed instructions on obtaining and submitting a case list and facility attestation letter to verify the list of procedures that you performed at that facility for a given period. **You will have until January 5, 2024, to upload the facility attestation letter and case list into PLS.** See [Appendix F](#) for a sample of a case list and attestation letter.

4. Case Documentation & Case Review

ABFAS will randomly select 11 Foot Surgery and/or 11 RRA Surgery cases from your PLS log for detailed documentation of the case. On January 19, 2024, ABFAS will notify you via email that the list of selected cases is

available on your PLS site. You will then upload complete documentation, including all images, into PLS for review. ABFAS does not allow paper submissions.

After you upload 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. Providing incomplete documentation is a common error that may result in a lower score. A few important things to remember:

- All documents must be legible.
- Submit all typed/handwritten materials in PDF format.
- **Please highlight your name where listed as surgeon and also highlight the surgery date.** Taking these steps will help the reviewers during the surgeon of record check and also help you as you pull together your documentation so that you have the correct files.
- **If for some reason the facility does not have all of the records for the case, please contact ABFAS prior to the deadline for submittal of cases.**
- Please ensure the documents do not have any redactions.
- When you download the documents from an electronic medical records system, please ensure you include your name and the patient's name/ID in each of the files.

1. Pre-operative Assessment

- ABFAS is looking for your pre-operative clinical and radiographic workup/assessment of the specific condition leading to the surgical procedure.** If the records are handwritten, please submit electronically as both (1) scanned copies of all handwritten material; and (2) typed copies of all your handwritten materials. Please convert typed copies to PDF format.

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 following the procedure through final outcome. Include all pertinent supportive medical assessments generated by another physician. If a patient undergoes multiple procedures on separate dates, present all progress notes, including any notes related to complications, prior surgery, or surgical revisions. **Please note, evidence of addenda after the date of case selection will lead to case rejection.**
- 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 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 and in the checklist.
- If a patient is lost to follow-up, please provide documentation to support that the patient did not show up or cancelled their last follow-up appointment with your office. If you are using an EMR system, please generate an appointment report and submit this along with your progress notes as evidence to support that the patient was lost to follow-up.

4. Consultation

- Submit separate consultative reports such as vascular, neurological, oncology, etc.

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. 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.

7. Intraoperative Anesthesia Record/Circulating Nurse's Notes

- Submit complete copies of the intraoperative anesthesia record (not the anesthesiology consultation notes) or the intraoperative circulating nurse's notes from the facility listing you as the surgeon of record. This document provides ABFAS with the **PRIMARY** source of verification that you were the surgeon of record.

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.*

[Appendix G](#) provides examples of proper documentation.

Image Submission Requirements

General Requirements

The following general requirements apply to every image you upload 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.

Weight-bearing X-Rays

If your facility does not have access to weight-bearing x-ray machines, please answer no to Question 1 in the [checklist](#) and upload a notarized letter from your facility attesting to the lack of a weight-bearing x-ray machine for that case.

1. Image 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 storage device 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, and at maximum, your ability to qualify for Board Certification.

2. Image Clarity

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

Note: Unreadable images may negatively impact your score.

3. Three Views

- For MRIs and computerized tomographic (CT) images, submit individual images of the best three views (see below for radiographs/plain films) 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. Provide axial calcaneal and lateral views for osseous procedures of the calcaneus (fracture ORIF, osteotomies), either in initial or final outcome images. Axial calcaneal views are not required for subtalar or triple arthrodesis. You may submit up to ten (10) images per category. Radiographs that best show final healing are most helpful for review. When appropriate, an MRI or CT may supplement the x-ray for pre-operative images. For RRA surgery cases, CT may substitute for plain film x-rays if they show pathology.

	First Ray Surgery	Infection/ Other Osseous Foot Surgery	Foot and RRA Trauma	RRA Surgery
Preoperative images <i>(weight-bearing not required for trauma)</i>	Weight-bearing AP, Lateral	Best two views	Minimal Best two views	Weight-bearing Best two views
Initial postoperative images <i>Demonstrate operative alignment and fixation, if used. Intraoperative images are acceptable.</i>	AP, Lateral	Best two views	Minimal Best two views	Best two views
Final outcome images <i>Latest final postoperative images. Images from last visit.</i> <i>Demonstrate removal of provisional/ temporary hardware and radiographic osseous union of osteotomies, fusions, and fractures</i>	Weight-bearing AP, Lateral	Best two views	Minimal Best two views of correction	Weight-bearing Best two views

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).

Resources

The following is available on the ABFAS website Case Review Overview for Candidates web page. You must log in prior to access the presentations.

- Podcast “Case Review Preparation and PLS Logging”
- Webinar: An introduction to ABFAS Case Review: What Candidates Need to Know About Uploading Case Documentation (2023)
- Webinar: Case Review Overview for Candidates (2021)

Examination Results

ABFAS will email you a notification after posting your exam results (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. If you took the NEW CBPS exam for board certification purposes, copies of the exam 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. Case Review credit is valid for 7 years or until your eligibility for ABFAS certification expires, whichever occurs first.

Appeals

A candidate who fails the 2024 Case Review examination may request a one-time appeal of the result if they provide an objective basis to overturn one or more of the findings. There is no retroactive appeal of prior Case Review examinations. The Case Review Appeal policy defines the procedures for this limited appeal. Please note, surgeon of record issues are not subject to appeal.

Procedure to Initiate an Appeal Request

A candidate who desires to appeal may not communicate with ABFAS about their Case Review results or the appeal process other than under the terms of this policy.

A candidate may request an appeal of a specific or multiple Case Review finding(s) no later than 14 calendar days (2 weeks) after ABFAS publishes the Case Review results on the candidate's profile page and notifies the candidate (usually by email) that the results are available (the "Case Review Results Release Date"). A request for appeal must be submitted by completing all fields in ABFAS' online Case Review Appeal Request form. The form asks for, among other information, case number, procedure category, evaluation area, and the specific case(s) and initial reviewer(s)'s findings (available from the candidate's score report) about which the candidate has chosen to request an appeal and the objective reason(s) why the candidate is appealing the findings for each case.

Appeal Initial Review

An ABFAS representative, usually the ABFAS Credentials Associate Director, will review the candidate's online submission and contact the candidate to discuss the candidate's questions and basis for appeal during a single phone call to occur no later than 35 calendar days (5 weeks) after the Case Review Results Release Date.

Procedure to Request an Appeal

If the candidate determines after the phone call with the ABFAS representative to continue to pursue an appeal, the candidate must no later than 63 calendar days (9 weeks) after the Case Review Results Release Date submit a letter to ABFAS explaining the candidate's basis for appeal of each case and reviewer's findings being appealed.

If after the phone call with the ABFAS representative, the candidate determines to continue to pursue an appeal, the candidate must, no later than 63 calendar days (9 weeks) after the Case Review Results Release Date, submit Final Comments via the online submission portal, explaining the candidate's basis for appeal of each case and reviewer's findings being appealed. Neither the candidate's Initial nor Final Comments may include, and ABFAS will not consider, any additional documentation not originally submitted as part of the Case Review submission, unless ABFAS requests the appellant to upload the documentation.

After submitting the Final Comments, candidates can either click "Continue to Payment" to initiate the payment process, or they can return to the "Home Page" if they need to submit final appeals for the other Case Review exams (if applicable).

The online appeals form allows for online payment of the appeals fee via credit card. If a candidate prefers to pay by check please mail the check, via trackable delivery such as FedEx, UPS, or USPS with tracking to the American Board of Foot and Ankle Surgery, Attn: Case Review Appeals, 445 Fillmore Street, San Francisco, CA 94117. Please make the valid check payable to the American Board of Foot and Ankle Surgery in the amount of \$4,000. If the candidate is appealing findings in the Foot Surgery and RRA Surgery exams, the cost is \$8,000.

ABFAS will not consider appeals that fail to strictly comply with this policy.

ABFAS Procedure for Review Panel

No later than 84 calendar days (12 weeks) after the Case Review Results Release Date, ABFAS will convene a Review Panel of three ABFAS Diplomates who participated in the most recent Case Review examination but did not score the candidate's appealed Case Review submission(s). The Review Panel's members will remain confidential, and each member is prohibited from having any other communication with the candidate that is in any way related to the appeal. The appealing candidate may not initiate any other communication with Review Panel members related to the appeal and may not be present for the Review Panel's review of the candidate's submission.

Upon review of the candidate's written submission, the Review Panel will determine whether to leave the result unchanged or to revise one or more of the appealed findings. If the Review Panel decides to revise one or more findings, the revised finding(s) will be provided to an independent psychometrician to re-score the candidate's Case Review using the same scoring methodology previously applied. If the re-scored Case Review meets or exceeds the minimum passing score, the candidate will pass Case Review and receive a refund of the appeal fee.

No later than 10 calendar days after either a decision not to revise any finding or completion of the re-score, ABFAS will send a letter to the candidate by overnight, trackable delivery communicating the result of the appeal. The Review Panel's decision is final. By submitting a request for appeal, the candidate accepts the outcome and acknowledges that there is no further obligation by ABFAS.

Step	Deadline: Calendar Days (Weeks) After Case Review Results Release Date
Submit Appeal Form	14 days (2 weeks)
ABFAS Representative Calls Appellant	35 days (5 weeks)
ABFAS Receives Appellant Letter	63 days (9 weeks)
Review Panel Convenes	84 days (12 weeks)
ABFAS Responds to All Appellants	112 days (16 weeks)

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.

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

Additional Requirements

Verification of Surgical Privileges

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

Active, Unrestricted License to Practice

ABFAS requires that that you maintain a valid, unrestricted, podiatric license in the US or Canada. Candidates must report any change in licensing status to ABFAS. Submit license documentation or notification of change in licensing status via email to licenses@abfas.org or by fax to 415.553.7801

Diplomate Certificates

After you meet all Board Certification requirements and pass the Board Certification examination, ABFAS will issue you one (1) complimentary framed 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. During that time period, ABFAS Diplomates participate in the LEAD program. Newly certified Diplomates start participating in LEAD the first January following their initial

certification date.

ABFAS Diplomates may promote their status on ABFAS letterhead, publications, and other advertisements following [ABFAS advertising guidelines](#). ABFAS provides a [toolkit](#) for promoting your certification on its website. **All ABFAS Diplomates may use the D.ABFAS suffix as part of their signature.**

Statute of Limitations

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 PM&S-36, PMSR or PMSR/RRA residency program prior to 2014 and requalify.

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).

Calendar

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

November 1, 2023 – Case Review registration opens.

December 8, 2023 – Case Review registration closes.

December 12, 2023 – ABFAS sends candidates instructions for hospital/surgical center audit.

January 5, 2024 – Deadline for hospital/surgical center audit documentation.

January 19, 2024 – The list of your procedures selected for Case Review is available on the PLS website.

March 15, 2024 – Deadline for candidate submission of complete electronic case documentation. You must submit by 11:59 pm Pacific Time on March 15, 2024.

April 11-13, 2024 – Case Reviewers meet. Candidates do not attend case review.

Examination Fees

Case Review Examination Fee	
Application Fee (NON-REFUNDABLE). Paid once per calendar year, regardless of number of exams, based on the year the exam takes place.	\$225
Case Review Examination	\$475

Case Review Refund Policy

Circumstance	Refund
Candidate requests to withdraw prior to the facility audit date.	Exam fee(s)
Candidate fails facility audit and is therefore unable to continue the Case Review process. ABFAS generates withdrawal and exam fee refund.	Exam fee(s)
Candidate requests to withdraw post facility audit date.	Exam fee(s)
Candidate does not upload required Case Review documentation by due date.	None

APPENDIX A

Expanded List of Categories for Foot Certification Case Review

Please ensure that you correctly log procedures into PLS. Case reviewers evaluate procedures based on the category you have assigned. For example, if a joint salvage procedure with cheilectomy only is logged as a joint salvage procedure with distal metatarsal osteotomy, you 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, perioperative ancillary laboratory 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

2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis

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

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 lesser metatarsal 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 primary or secondary repair of ligamentous structures

5.1.6 tendon augmentation/supplementation/restoration

Elective – Osseous

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 lesion (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, ankle, or leg (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

5.4.9 application of multiplanar external fixation midfoot, rearfoot, and ankle (does not include mini or mono rails)

APPENDIX B

RRA Surgery Certification requires logging a minimum of 30 RRA procedures. Of this 30, ABFAS requires logging a minimum of 13 procedures from the following list.

RRA Elective Osseous

- 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

- 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

Please ensure that you correctly log procedures into PLS. Case reviewers evaluate procedures based on the category you have assigned. Open management of fracture dislocation cases must include internal or external fixation. Procedures are evaluated based on surgical decision-making, preoperative clinical assessment, preoperative radiographic assessment, perioperative ancillary laboratory assessment, technical skills assessment, and outcomes analysis.

APPENDIX C

Table of ABFAS Procedure Categories

1. Digital Surgery category (lesser digit or hallux)

1.1	partial ostectomy/exostectomy	1.8	amputation
1.2	phalangectomy	1.9	management of osseous tumor/neoplasm
1.3	arthroplasty (interphalangeal joint [IPJ])	1.10	management of bone/joint infection
1.4	implant (IPJ), silastic implant or spacer	1.11	open management of digital fracture/dislocation
1.5	diaphysectomy	1.12	revision/repair of surgical outcome
1.6	phalangeal osteotomy	1.13	other osseous digital procedure not listed above
1.7	fusion (IPJ)		

2. First Ray Surgery (30 procedures). Procedures isolated to the hallux should be logged as digital procedures.

Hallux Valgus Surgery

2.1.1	bunionectomy (partial ostectomy/Silver procedure) with or without capsulotendon balancing procedure	2.1.5	bunionectomy with first metatarsal base or shaft osteotomy
2.1.3	bunionectomy with phalangeal osteotomy	2.1.6	bunionectomy with first metatarsocuneiform fusion
2.1.4	bunionectomy with distal first metatarsal osteotomy	2.1.7	MPJ fusion
		2.1.8	MPJ implant
		2.1.9	MPJ arthroplasty
		2.1.10	bunionectomy with double correction with osteotomy and/or arthrodesis

Hallux Limitus Surgery

2.2.1	cheilectomy	2.2.5	joint salvage with first metatarsocuneiform fusion
2.2.2	joint salvage with phalangeal osteotomy (Kessel- Bonney, enclavement)	2.2.6	MPJ fusion
2.2.3	joint salvage with distal metatarsal osteotomy	2.2.7	MPJ implant
2.2.4	joint salvage with first metatarsal shaft or base osteotomy	2.2.8	MPJ arthroplasty

Other First Ray Surgery

2.3.1	tendon transfer/lengthening	2.3.6	management of bone/joint infection (with or without bone graft)
2.3.2	osteotomy (e.g., dorsiflexory)	2.3.7	open management of fracture or MPJ dislocation with fixation
2.3.3	metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)	2.3.8	corticotomy with callus distraction
2.3.4	amputation	2.3.10	other first ray procedure not listed above
2.3.5	management of osseous tumor/neoplasm (with or without bone graft)		

3. Other Soft-tissue Foot Surgery

- | | |
|--|--|
| <ul style="list-style-type: none"> 3.1 excision of ossicle/sesamoid 3.2 excision of neuroma 3.3 removal of deep foreign body (excluding hardware removal) 3.4 plantar fasciotomy 3.5 lesser MTPJ capsulotendon balancing 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital FDL transfer) 3.7 open management of dislocation (MPJ/tarsometatarsal) 3.8 incision and drainage/wide debridement of soft-tissue infection includes foot, ankle, and leg 3.9 plantar fasciectomy/plantar fibroma resection | <ul style="list-style-type: none"> 3.10 excision of soft-tissue tumor/mass of the foot (without reconstructive surgery) includes foot, ankle, and leg 3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot) 3.13 microscopic nerve/vascular repair (forefoot only) 3.14 other soft-tissue procedures not listed above (limited to the foot). 3.16 external neurolysis/decompression (including tarsal tunnel) 3.17 decompression of compartment syndrome (includes foot or leg) |
|--|--|

4. Osseous Foot Surgery

- | | |
|---|--|
| <ul style="list-style-type: none"> 4.1 partial ostectomy includes foot, ankle, and leg 4.2 lesser MPJ arthroplasty 4.3 bunionectomy of the fifth metatarsal without osteotomy 4.4 metatarsal head resection (single or multiple) 4.5 lesser MPJ implant 4.6 central metatarsal osteotomy 4.7 bunionectomy of the fifth metatarsal with osteotomy 4.8 open management of lesser metatarsal fracture(s) 4.9 harvesting of bone graft includes foot, ankle, and leg 4.10 amputation (lesser ray, transmetatarsal amputation (TMA)) 4.11 management of bone/joint infection distal to the tarsometatarsal joints | <ul style="list-style-type: none"> (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 4.17 revision/repair of surgical outcome in the forefoot 4.18 other osseous procedures not listed above (distal to the tarsometatarsal joint) 4.19 detachment/reattachment of Achilles tendon with partial ostectomy |
|---|--|

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 primary or secondary repair of ligamentous structures |
| 5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg | 5.1.6 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) | 5.1.9 other elective reconstructive rearfoot/ankle soft-tissue surgery not listed above |

Elective –Osseous

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

Nonelective – Soft tissue

- | | |
|---|--|
| 5.3.1 repair of acute tendon injury | 5.3.6 open repair of dislocation (proximal to tarsometatarsal joints) |
| 5.3.2 repair of acute ligament injury | 5.3.7 other nonelective reconstructive rearfoot /ankle soft-tissue surgery not listed above. |
| 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, ankle, or leg (with reconstructive surgery) | |

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
- 5.4.8 other nonelective reconstructive rearfoot/ankle osseous surgery not listed above
- 5.4.9 application of multiplanar external fixation midfoot, rearfoot, and ankle (does not include mini or mono rails)

6.0 Other Podiatric Procedures

Appendix D

ABFAS SPRING 2024 EXAMINATIONS Which Exams Do I Need to Take? Board Certification

FOOT SURGERY BOARD CERTIFICATION EXAMS

CANDIDATE HAS PASSED PART I FOOT DIDACTIC	CANDIDATE HAS PASSED PART I FOOT CBPS (Spring 2020 or earlier)	CANDIDATE HAS PASSED PART II FOOT CBPS, FY ITE FOOT CBPS or NEW FOOT CBPS	EXAM REQUIREMENTS IN PURSUIT OF BOARD CERTIFICATION
YES	YES	YES	If meet case volume and diversity requirements, register for 2024 Foot Case Review; registration opens November 1, 2023
YES	YES	NO	NEW FOOT CBPS* and Foot Case Review (<i>see note above</i>)
YES	NO	NO	NEW FOOT CBPS* and Foot Case Review** (<i>see note above. Must be Board Qualified in Foot Surgery to register for Foot Case Review.</i>)

RRA SURGERY BOARD CERTIFICATION EXAMS (*Board Certification in Foot Surgery is a prerequisite for Board Certification in RRA Surgery*)

CANDIDATE HAS PASSED PART I RRA DIDACTIC	CANDIDATE HAS PASSED PART I RRA CBPS (Spring 2020 or earlier)	CANDIDATE HAS PASSED PART II RRA CBPS, FY ITE RRA CBPS, or NEW RRA CBPS	EXAM REQUIREMENTS IN PURSUIT OF BOARD CERTIFICATION
YES	YES	YES	If meet case volume and diversity requirements, register for 2024 RRA Case Review; registration opens November 1, 2023.
YES	YES	NO	NEW RRA CBPS** and RRA Case Review (<i>see note above</i>)
YES	NO	NO	NEW RRA CBPS** and RRA Case Review (<i>see note above. Must be Board Qualified in RRA Surgery to register for RRA Case Review.</i>)

- * **The NEW Foot Surgery CBPS:** *This examination supersedes Part I Foot CBPS and is required for board certification. If you previously passed Part I Foot Surgery CBPS, you must also pass the NEW Foot Surgery CBPS examination. If you did not previously pass the Part II Foot Surgery CBPS. Passage of the NEW Foot Surgery CBPS fulfills the Part II Foot Surgery CBPS examination requirement for board certification purposes.*

- ** **The NEW RRA Surgery CBPS:** *This examination supersedes Part I RRA CBPS and is required for board certification. If you previously passed Part I RRA Surgery CBPS, you must also pass the NEW RRA Surgery CBPS examination if you did not previously pass the Part II RRA Surgery CBPS. Passage of the NEW RRA Surgery CBPS fulfills the Part II RRA Surgery CBPS examination requirement for board certification purposes.*

- NOTES:**
1. **Passed exam scores are valid for seven (7) years. If the failed section is not passed at the end of seven (7) years, the candidate must retake ALL sections in that exam series in order to fulfill those exam requirements.**
 2. **Candidates are limited to seven (7) years to achieve Board Certified status after becoming Board Qualified.**

APPENDIX E

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’s 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’s name and date the image was taken.
- How do I place a text box?
 - To do this in Microsoft Paint: Click “Open With” from the menu bar, hit the text button “A” to insert a text box. Save.
 - 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 F**Sample: Case Review Facility Audit Case List****ABFAS Hospital and Surgery Center****Date Range: December 1, 2018 – March 20, 2019**

DPM: Jane Doe

Date of Procedure	Procedure name	Surgeon
December 1, 2018	First MPJ implant	Dr. Board
December 3, 2018	Partial Phalangectomy	Dr. Board
December 8, 2018	Tailor's bunionectomy	Dr. Board
December 17, 2018	First MPJ implant	Dr. Board
January 4, 2019	Austin bunionectomy	Dr. Board
January 6, 2019	Austin bunionectomy	Dr. Board
January 9, 2019	Partial Phalangectomy	Dr. Board
January 18, 2019	Tailor's bunionectomy	Dr. Board
February 15, 2019	Austin bunionectomy	Dr. Board
February 18, 2019	Partial Phalangectomy	Dr. Board
February 21, 2019	Austin bunionectomy	Dr. Board
March 2, 2019	Austin bunionectomy	Dr. Board
March 5, 2019	Partial Phalangectomy	Dr. Board
March 9, 2019	Partial Phalangectomy	Dr. Board
March 13, 2019	First MPJ implant	Dr. Board
March 20, 2019	Tailor's bunionectomy	Dr. Board

- Please note: This is the minimum information ABFAS requires in both details and format. If the facility includes the patient's name or medical number, that is fine. ABFAS does not accept CPT codes in place of procedure names.

Sample: Facility Audit Attestation Letter

Letterhead

Main Street, Anytown USA

Date: January 30, 2020

Re: Jane Abfas, DPM

To Whom It May Concern,

Please find attached a list of surgical cases performed at Letterhead by Dr. Jane Abfas between 05/19/2019 to 07/12/2019. I attest that this is an accurate and complete list for the above stated time period.

Sincerely,



Director

-

APPENDIX G

Sample of Case Documentation That You Upload into PLS

Appendix G 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 in PLS:

- Pre-operative Assessment
- Op Report
- Progress Notes
- Intraoperative Anesthesia/Circulator RN Record
- Consultations
- Labs
- Pathology Report

Please do NOT redact your documents! The samples show redactions as they are from real cases. Do not redact the documents that you upload!

The following page shows the screenshot of what you will see when you upload. The sample documentation shows these categories and examples of the types of documentation you would include in your upload for each of the categories.



Upload Cases

Test Candidate ▾


- Logs ▾
- Case Documentation ▲
- Upload Cases
- View Facility Case List
- Reports ▾
- Contact Us

Foot
RRA
Summary








01 Test Patient 1	▾
02 Test Patient 2	▾
03 Test Patient 3	▾
04 Test Patient 4	▾
05 Test Patient 5	▾
06 Test Patient 6	▾
07 Test Patient 7	▾
08 Test Patient 8	▾
09 Test Patient 9	▾
10 Test Patient 10	▾
11 Test Patient 11	▾

Date 06/05/2023	Facility Test Facility	Name Test Patient 1	Gender Male	Birth Year 1984
Procedure 4.13 open management of tarsometatarsal fracture/dislocation.				Location Right

Images


 Upload

Checklist
Instructions

<p style="margin-bottom: 5px;">Pre-operative Assessment</p> <div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>	<p style="margin-bottom: 5px;">OP Report</p> <div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>	<p style="margin-bottom: 5px;">Progress Notes</p> <div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>
<p style="margin-bottom: 5px;">Intraop Anes/Circ RN Record</p> <div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>		
<p style="margin-bottom: 5px;">Consultations</p> <input type="checkbox"/> Not applicable	<p style="margin-bottom: 5px;">Labs</p> <input type="checkbox"/> Not applicable	<p style="margin-bottom: 5px;">Path Report</p> <input type="checkbox"/> Not applicable
<div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>	<div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>	<div style="border: 1px solid #ccc; padding: 10px; text-align: center; width: 100px; margin: 0 auto;">  Upload </div>

Pre-operative Assessment

ABFAS is looking for your pre-operative clinical and radiographic assessment of the specific condition requiring/leading to the surgical procedure.



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

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:
Printed on:



VITAL SIGNS: [REDACTED]

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
Document No.
Physician
Report Type
Date of Birth

Operative Report

Account No.
Medical Record No.
Patient Location

DATE OF PROCEDURE:

SURGEON:

ASSISTANT:

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

Progress Notes

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: [Redacted] 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.

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Printed on: [Redacted]

Progress Note, Podiatry
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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
* Final Report *



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Result date: [Redacted]
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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 *

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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:

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(End of Report)

Progress Note, Podiatry

* Final Report *

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Result type: Progress Note, Podiatry

Result date:

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S0377-J.F.

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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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(Continued)

Progress Note, Podiatry
* Final Report *



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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.



Signature Line
Electronically Signed By:



Completed Action List:



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Progress Note, Podiatry

* Final Report *

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

Result type: Progress Note, Podiatry

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S0377 LE

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Encounter info:

Contributor system:

* Final Report *

DOC01455 (Verified)

CHIEF COMPLAINT/REASON FOR VISIT

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 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.

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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:

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Result title:

S0377-LE

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* 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.

[REDACTED]

Signature Line

[REDACTED]

Completed Action List:

[REDACTED]

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

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Encounter info:

Contributor system:

* Final Report *

DOC01455 (Verified)

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:

Printed on:



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:



Appointment History - Select Patient:

Visit	Appt Date	Appt Time	Column	Status/ Action	User	Reason/ Appt Type	Change Date	Change Time
+	09/18/2018	11:00 AM		MOVED		SX/PO	09/11/2018	11:46 AM
+	09/11/2018	11:15 AM		COMPLETE		SX/PO	09/11/2018	11:45 AM
+	09/06/2018	09:30 AM		CANCELLED		PT IN HOSPITAL	09/06/2018	08:19 AM
	09/03/2018	09:00 AM		MADE		SURGERY	09/03/2018	04:24 PM
	09/02/2018	08:00 AM		MADE		HOSPITAL CONSULT	09/03/2018	04:22 PM
	09/01/2018	08:00 AM		MADE		HOSPITAL CONSULT	09/03/2018	04:21 PM
+	08/08/2018	04:30 PM		NOSHOW		NO SHOW	08/08/2018	05:29 PM
+	08/01/2018	01:45 PM		COMPLETE		FU	08/01/2018	03:10 PM
+	07/27/2018	04:30 PM		COMPLETE		FU	07/27/2018	05:18 PM
	06/29/2018	11:45 AM		MADE		FU	06/22/2018	11:09 AM
	06/25/2018	12:00 PM		MADE		HOSPITAL CONSULT	06/25/2018	08:19 AM
+	06/22/2018	10:15 AM		COMPLETE		FU	06/22/2018	11:09 AM
	06/18/2018	08:30 AM		MADE		HOSPITAL CONSULT	06/19/2018	08:16 AM
	06/17/2018	08:00 AM		MADE		HOSPITAL CONSULT	06/17/2018	07:49 PM
	06/16/2018	08:00 AM		MADE		HOSPITAL CONSULT	06/17/2018	07:48 PM
	06/15/2018	04:15 PM		MADE		HOSPITAL CONSULT	06/17/2018	07:46 PM
+	06/15/2018	10:45 AM		CANCELLED		GOING INTO HOSPITAL	06/15/2018	08:17 AM
+	06/08/2018	11:00 AM		COMPLETE		FU	06/08/2018	12:21 PM
	05/30/2018	07:45 AM		MADE		HOSPITAL CONSULT	05/29/2018	02:02 PM
	05/29/2018	07:15 AM		MADE		HOSPITAL CONSULT	05/29/2018	01:57 PM
	05/28/2018	07:00 AM		MADE		HOSPITAL CONSULT	05/29/2018	01:55 PM
	05/27/2018	08:00 AM		MADE		HOSPITAL CONSULT	05/29/2018	01:54 PM
	05/26/2018	08:00 AM		MADE		HOSPITAL CONSULT	05/29/2018	10:04 AM
+	05/10/2018	10:15 AM		NOSHOW		DR RESCHEDULE	05/10/2018	05:17 PM
	04/26/2018	10:30 AM		MADE		FU	05/21/2018	02:29 PM

Audit Log Appt Scheduler Moves: 3 Cancels: 2 No Shows: 2

Consultations

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:

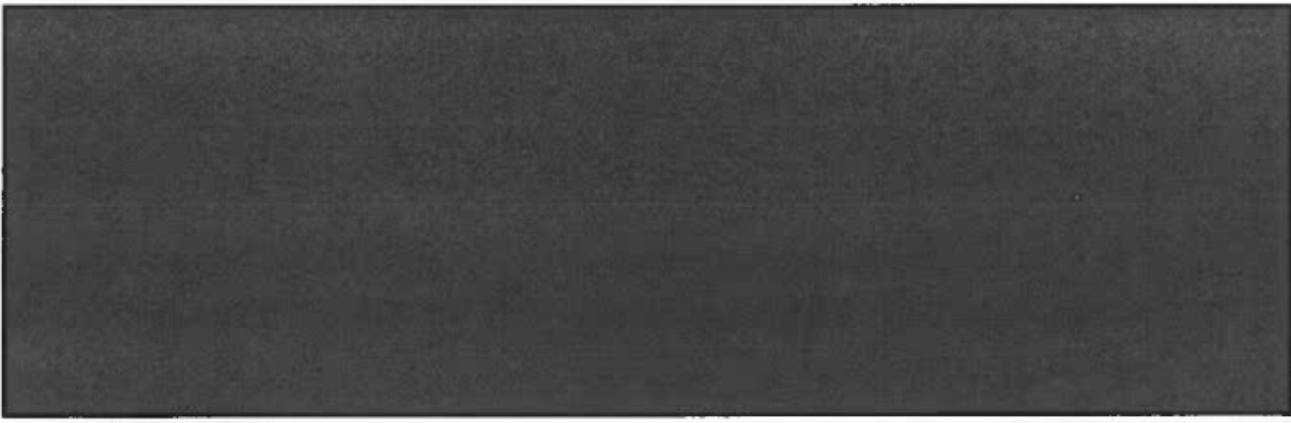
Printed by:

MRN:

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



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

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

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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)



Intraop Anes/Circ RN Record

These are the documents used for
independent documentation of Surgeon of
Record

ANESTHESIA RECORD

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

She [redacted]

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

IV Sedation for eye block note start/stop below

Anesthesia Stop [redacted] Anesthesia Stop [redacted]

Surgeon [redacted] Anesthesiologist [redacted] CRNA [redacted]

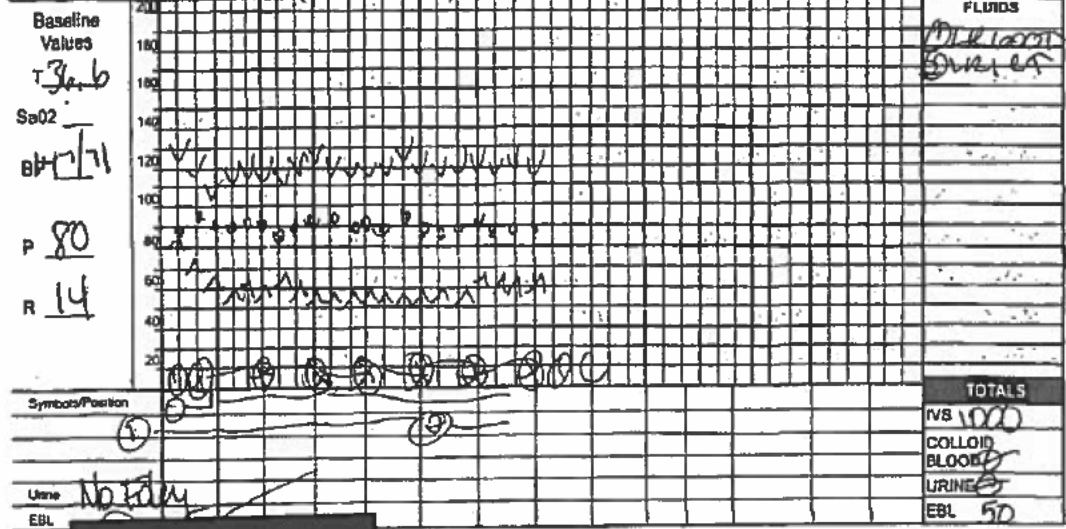
Diagnosis Open prostatectomy (1) 4th & 5th metastatic nodes

Procedure ORIF 4th & 5th metastatic nodes

Outpatient Inpatient GA SP Epi Block MAC present for induction

<input type="checkbox"/> Identified <input type="checkbox"/> Chart Reviewed <input type="checkbox"/> Permit Signed <input checked="" type="checkbox"/> Band checked <input type="checkbox"/> Surgical Site verification <input type="checkbox"/> Machine check prior to use # _____ Pre-anesthetic State: <input type="checkbox"/> Awake <input type="checkbox"/> Calm <input type="checkbox"/> Sleepy <input type="checkbox"/> Agitated <input type="checkbox"/> Uncomfortable <input type="checkbox"/> Sedative ordered <input type="checkbox"/> Uncooperative <input type="checkbox"/> Unresponsive <input type="checkbox"/> Safety Belt on <input type="checkbox"/> Armboard Restraints <input type="checkbox"/> Arms Tucked <input checked="" type="checkbox"/> Pressure points checked and padded <input type="checkbox"/> Positioning roll <input type="checkbox"/> Eye Care: <input type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Taped <input type="checkbox"/> Padded <input type="checkbox"/> Goggles	<input checked="" type="checkbox"/> Continuous EKG <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Non-invasive B/P <input type="checkbox"/> Left <input type="checkbox"/> Right <input checked="" type="checkbox"/> Gas Analyzer <input type="checkbox"/> End Tidal CO2 <input type="checkbox"/> Airway Humidifier Sleigh <input type="checkbox"/> Precord. <input type="checkbox"/> Esoph <input type="checkbox"/> Nerve Stimulator <input type="checkbox"/> NG <input type="checkbox"/> OG <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Convection warmer <input type="checkbox"/> Foley <input type="checkbox"/> Upper body <input type="checkbox"/> Lower body <input type="checkbox"/> Hypotensive Technique <input type="checkbox"/> Hemodilution <input type="checkbox"/> Intraop Salvage <input type="checkbox"/> Endobronchial size _____ Fr	General: <input type="checkbox"/> Inhalation <input type="checkbox"/> Intravenous <input type="checkbox"/> LMA <input type="checkbox"/> Pre-Oxygenation <input type="checkbox"/> L.T.A. <input checked="" type="checkbox"/> Rapid Sequence <input type="checkbox"/> Cricoid Pressure Intubation: <input type="checkbox"/> ET size 7.0 <input type="checkbox"/> Agonist <input type="checkbox"/> Magill <input type="checkbox"/> R.A.E. <input type="checkbox"/> Laser <input type="checkbox"/> Cuffed <input type="checkbox"/> Uncuffed, leaks at _____ cm H2O <input type="checkbox"/> Magill <input type="checkbox"/> Direct <input type="checkbox"/> Fiber optic <input type="checkbox"/> Blind <input checked="" type="checkbox"/> Blade # 2 (Miller) mac <input checked="" type="checkbox"/> Secured @ 18 cm <input checked="" type="checkbox"/> ET CO2 present <input checked="" type="checkbox"/> SBSE <input type="checkbox"/> Atraumatic <input type="checkbox"/> Difficult <input checked="" type="checkbox"/> Attempts 0/1 <input type="checkbox"/> Orientation Unchanged Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal Oxygen: <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Tpiece <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> O2 mask <input type="checkbox"/> Arrived Intubated <input type="checkbox"/> NRB mask	<input type="checkbox"/> Time Out performed prior to block Regional: <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Aridie <input type="checkbox"/> Axillary <input type="checkbox"/> Paravertebral <input type="checkbox"/> Block <input type="checkbox"/> ITAP <input type="checkbox"/> Popliteal <input type="checkbox"/> Interspace Juc <input type="checkbox"/> Femoral <input type="checkbox"/> Other _____ <input type="checkbox"/> Right <input type="checkbox"/> Left _____ <input type="checkbox"/> US Guidance Image retained Local _____ Site _____ Needs _____ Level _____ Drug/Dose _____ Attempts X _____ Time _____ Signature _____
--	--	---	--

Monitoring Time Line	0	30	2:00	30	2:00	30	2:00	30	Totals
O ₂ Sat	100	100	100	100	100	100	100	100	100
FiO ₂ / PEEP	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5	1.0 / 5
SpO ₂ / PEEP	100 / 5	100 / 5	100 / 5	100 / 5	100 / 5	100 / 5	100 / 5	100 / 5	100 / 5
MAP	80	80	80	80	80	80	80	80	80
HR / RR / SpV / P _{av}	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5	80 / 12 / 98 / 5
Fentanyl	0	0	0	0	0	0	0	0	0
Midazolam	0	0	0	0	0	0	0	0	0
Propofol (mg)	0	0	0	0	0	0	0	0	0
Etomidate (mg)	0	0	0	0	0	0	0	0	0
ROXAPROLOL (mg)	0	0	0	0	0	0	0	0	0
ROXAPROLOL (SERVING)	0	0	0	0	0	0	0	0	0
EKG	50/2	50/2	50/2	50/2	50/2	50/2	50/2	50/2	50/2
% O ₂ inspired	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
O ₂ Saturation	100	100	100	100	100	100	100	100	100
End Tidal CO ₂	35	35	35	35	35	35	35	35	35
Temp. (skin/rect)	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5	36.5 / 37.5
CVP	5	5	5	5	5	5	5	5	5
Pa	80	80	80	80	80	80	80	80	80
PCWP	10	10	10	10	10	10	10	10	10
CO/CI	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5	4.5 / 1.5
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	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1



Preop Antibiotics Drug/Dose

Mic 2gm @ 1604

Ofloxacin 400mg

Started at: _____

Incision at: 1924

Remarks:

FLUIDS

DLR 1000

500ml

Reversal Agents

Neostigmine 5 mg

Glycopyrronium 1 mg

SYMBOLS

X ANESTHESIA

○ OPERATION

∇ SUP CLIFF INCIDENT

↓ ANTENAL LINE PRESSURE

S MEAN ANTENAL PRESSURE

● PULSE

○ SPONT. RESP.

∇ ASSISTED RESP.

⊕ CONTROLLED RESP.

⊕ ICH/HAEMORR.

TOTALS

IVS 1000

COLLOID BLOOD

URINE

EBL 50

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) papoose 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