

# CASE SUMMARY INDEX FORM 111 - 2012

Place your name on the top of every page and sign at the bottom of each page. Sign and date the attestation form Attachment A

Last Name \_\_\_\_\_, First \_\_\_\_\_

A list of forty-eight (48) cases (no more than 48) are due by **January 14, 2012** and are to be submitted **TYPED OR PRINTED CLEARLY**. Provide **3 COPIES, SINGLE SIDED AND STAPLED**. List cases in each of the 17 categories (A-Q). Asterisked categories A, B, and C are mandatory. See "Type of Cases" in the booklet entitled "Exam Information and Requirements for 2012" on our website. Avoid repeating a minimum of 3 cases in each of a minimum of 14 categories, plus an additional 6 cases so that 48 cases are submitted in all. It is imperative that the 48 case submissions reflect a level of sophistication and relevance to the subject area under which they are listed. Reviewers will expect the cases to reflect the comprehensive evaluation of the stated diagnosis. **It is forbidden to use the same patient for more than one diagnosis**. If there are duplicated patient initials, indicate with a **middle initial or a different number after the initials**. For example: TAM and TRM, or TM1 and TM2. Remember to sign your name on the bottom of page two.

CATEGORY / CASE #	PRIMARY DIAGNOSIS	PATIENT'S	# VISITS INITIALS	Consul-tation	Imaging Studies	Lab Reports
<b>A. BIOMECHANICS, PATHOMECHANICS*</b>						
Sample	Plantarflexed First Ray	MB	16	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. DIABETES, ENDOCRINE, METABOLIC*</b>						
4	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. PODIATRIC MEDICINE*</b>						
7	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. GENERAL MEDICINE</b>						
10	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. GERIATRICS</b>						
13	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. INFECTIOUS DISEASE</b>						
16	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. GENERAL ORTHOPEDICS</b>						
19	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_

Last Name \_\_\_\_\_, First \_\_\_\_\_

CATEGORY / CASE # * MANDATORY CATEGORIES	PRIMARY DIAGNOSIS	PATIENT'S	# VISITS INITIALS	Consul- -tation	Imaging Studies	Lab Reports
<b>H. NEUROLOGIC DISEASE</b>						
22	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. PEDORTHICS</b>						
25	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. PERIPHERAL VASCULAR DISEASE</b>						
28	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. PODIATRIC DERMATOLOGY</b>						
31	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. PODIATRIC RADIOLOGY</b>						
34	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>M. PODOPEDIATRICS</b>						
37	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>N. REHABILITATION, PHYSIOTHERAPY</b>						
40	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>O. RHEUMATOLOGY</b>						
43	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_

Last Name \_\_\_\_\_, First \_\_\_\_\_

CATEGORY / CASE #	PRIMARY DIAGNOSIS	PATIENT'S	# VISITS INITIALS	Consul- -tation	Imaging Studies	Lab Reports
P. SPORTS MEDICINE, TRAUMA						
46	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. WOUND CARE						
49	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUPPLEMENTAL CASES (IF NEEDED)						
Category	S1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category	S2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category	S3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category	S4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category	S5	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category	S6	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above index is representative of patients who have been under my care for whom I can supply ABPOPPM's Case Review Committee complete documentation.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Attachment A

### Attestation Statement for Signature For Form 111

I attest that all patients submitted in this Form are or were my patients, under my direct supervision and responsibility, and that no patients have been entered more than once (any duplicate initials represent different patients). I understand and agree that if ABPOPPM discovers a breach of these rules, it will be grounds for barring me from the certification or re-certification process.

Signature \_\_\_\_\_

Date \_\_\_\_\_