

**SIMPLE FILLABLE AND
PRINTABLE RECEIPT TEMPLATE**

INVOICE

Company Name
123 Main Street
Hamilton, OH 44416
(321) 456 7890
Email Address

DATE OF INVOICE

INVOICE NO.

DATE DUE

AMOUNT

CUSTOMER NAME
ATTN: Name / Department
Company Name
123 Main Street
Hamilton, OH 44416
(321) 456-7890
Email Address

DESCRIPTION

AMOUNT

TOTAL

Please make check payable to Your Company Name.

THANK YOU

For questions concerning this invoice, please contact
Name, (321) 456 7890, Email Address

www.yourwebaddress.com



Case Report

A fracture of OS trigonum: a rare case report

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ABSTRACT

Fractures of os trigonum is an extremely rare event. It is one of the accessory ossicles of the foot found in about 7 % of the population. Very few cases have been reported in the literature about a fracture of the ostrigonum. We present a case of fracture of ostrigonum with associated fracture of the fibula and a large lacerated wound in the leg, in a young man sustained due to road traffic accident. The initial radiological examination with Xray ankle showed a doubtful fracture of posterior process of talus but was not clear. The diagnosis was clinched by CT scan of the ankle with 2mm cuts, which showed clearly a fracture of the os trigonum. It was treated by flap cover for the wound and plaster immobilisation for the fracture. So, any doubtful fracture near the posterior process of talus should be fully assessed radiologically with a CT scan to guide in the treatment.

Keywords: OS trigonum, Talus, Posterior process, Fracture

INTRODUCTION

OS trigonum is one of the accessory ossicles of the foot due to failure of fusion of a secondary center with the main bone of talus.⁶ Fracture of this bone is extremely rare event. To the best of our knowledge very few cases-less than ten, have been reported in the literature.^{1,3}

CASE REPORT

A 30-year-old man presented to our emergency department with history of road traffic accident-he was a two-wheeler driver hit by a speeding car and he was thrown out and landed on his right leg. His vitals were stable. He had a deep lacerated wound on the anteromedial aspect of his right leg (Figure 1) with swelling around his ankle.

All movements of ankle, particularly plantar flexion was extremely painful. X-rays revealed comminuted fracture of shaft of fibula at mid third distal third junction with a

fracture fragment at the posterior aspect of talus. (Figure 2-4).



Figure 1: Clinical pictures.

To clarify the nature of the fragment a CT scan was taken and axial, and sagittal cuts revealed a fracture of the ostrigonum-which is extremely rare (Figure 5-10). He was

Sex	Female	44 (21)
	Male	167 (77)
	Not indicated	5 (2)
Age	20-24 years	35 (16)
	25-29 years	68 (31)
	30-34 years	43 (20)
	35-39 years	25 (12)
	≥ 40 years	45 (21)
Number of years practicing as a clinician	≤ 3 years	76 (36)
	≥ 3-5 years	43 (20)
	≥ 5-10 years	45 (22)
	≥ 10-15 years	10 (5)
	≥ 15-20 years	10 (5)
	≥ 20 years	10 (5)
Professional title	Medical doctor	21 (10)
	Clinical officer	112 (51)
	Medical assistant	45 (21)
	Other	17 (8)
Country of training	Malawi	262 (94)
	Other	13 (6)
Institution	Central hospital	100 (46)
	District hospital	68 (31)

Application Form for Registration of Clinical Establishments

1. ESTABLISHMENT DETAILS

1. Name of the establishment: _____

2. Address: _____

Village/Town: _____ Block: _____

District: _____ State: _____ Pin code _____

Tel No (with STD code): _____ Mobile: _____ Fax : _____

Email ID : _____ Website (if any): _____

3. Month and Year of starting: _____

(From 4 to 11 mark all whichever are applicable)

4. Location:

Rural _____ Urban _____ Metro _____

Notified / inaccessible areas (including Hilly / tribal areas) _____

5. Ownership of Services

Government/Public Sector

Central government ☐ State government ☐ Local government (Municipality, Zilla parishad, etc)

Public Sector Undertaking ☐ Other ministries and departments (Railways, Police, etc.)

Employee State Insurance Corporation ☐ Autonomous organization under Government ☐

Non-Government / Private Sector

Individual Proprietorship ☐ Partnership ☐ Registered companies (registered under

central/provincial/state Act) ☐ Society/trust (Registered under central/provincial/state Act)

6. Name of the owner of Clinical Establishment: _____

Address: _____

Village/Town: _____ Block: _____ District: _____

State: _____ Pin code _____

Tel No (with STD code): _____ Mobile: _____ Fax : _____

Email ID: _____

7. Name, Designation and Qualification of person in-charge of the clinical establishment: _____

Qualification(s): _____

Registration Number: _____

Name of Central/State Council (with which registered): _____

Tel No (with STD code): _____ Fax: _____ Mobile: _____ E-mail ID: _____

8. Systems of Medicine offered: (please tick whichever is applicable)

☐ Allopathy ☐ Ayurveda ☐ Unani ☐ Siddha ☐ Homoeopathy ☐ Yoga ☐ Naturopathy ☐ Sowa-Rigpa

☐

☐

9. Type of establishment :(please tick whichever is applicable)

☐ (I). Clinic (Outpatient)

☐

• Single practitioner

(Consultation services only/with diagnostic services/with short stay facility)

- Poly clinic
(Consultation services only/with diagnostic services/with short stay facility)
- Dispensary
- Health Checkup Centre

(II). Day Care facility

Medical Surgical Medical SPA Wellness centers (where qualified medical professionals are available to supervise the services).

(III). Hospitals including Nursing Home (outpatient and inpatient):

- Hospital Level 1 a
- Hospital Level 1 b
- Hospital Level 2
- Hospital Level 3 (Non teaching)
- Hospital Level 4 (Teaching)

(IV). Dental Clinics and Dental Hospital:

a. Dental clinics

- Single practitioner
- Poly Clinics (dental)

b. Dental Hospitals (specialties as listed in the IDC Act.)

- Oral and maxillofacial surgery
- Oral medicine and radiology
- Orthodontics
- Conservative dentistry and Endodontics
- Periodontics
- Pedodontics and preventive dentistry
- Oral pathology and Microbiology
- Prosthodontics and crown bridge
- Public health dentistry

□ (V).Diagnostic Centre

□ A. Medical Diagnostic Laboratories:

□ Pathology □ Biochemistry Microbiology
Molecular Biology and Genetic Labs Virology

□ B. Diagnostic Imaging centers

i. **Radiology**

- General radiology
- Interventional radiology

ii. **Electromagnetic imaging**

- Magnetic Resonance Imaging (MRI),
- Positron Emission Tomography (PET) Scan

iii. **Ultrasound**

□ C. Miscellaneous

- ☐ Electro Cardio Graphy(ECG)
- ☐ Tread Mill Test
- ☐ Electro Encephalo Graphy(EEG)
- ☐ Mammography
- ☐ Echocardiography
- ☐ Electro MyoGraphy (EMG)
- ☐ Electrophysiological studies

D. Collection centers

For the clinical labs and diagnostic centres shall function under registered clinical establishment

Yes/No

if Yes, then No of Collection Centre:

(VI). Allied Health professions:

- Audiology
- Behavioral health (counseling, marriage and family therapy etc)
- Exercise physiology
- Nuclear medicine technology
- Medical Laboratory Scientist
- Dietetics
- Occupational therapy
- Optometry
- Orthoptics
- Orthotics and prosthetics
- Osteopathy
- Paramedic
- Podiatry
- Health Psychology/ Clinical Psychology
- Physiotherapy
- Radiation therapy
- Radiography / Medical imaging
- Respiratory Therapy
- Sonography
- Speech pathology

(VII) AYUSH

Ayurveda

Ausadh Chikitsa Shalya Chikitsa Shodhan Chikitsa Rasayana
Pathya Vyavastha

Yoga

Ashtang Yoga

Unani

Matab Jarahat Ilaj-bit-Tadbeer Hifzan-e-Sehat

Siddha

Maruthuvam Sirappu Maruthuvam Varmam Thokknam & Yoga

Homoeopathy

General Homoeopathy

Naturopathy

External Therapies with natural modalities

Internal Therapies

II. TYPES OF SERVICE

- **TYPE**

□

General Practice Services

Single Specialty Services □

Multi Specialty Services (including Palliative care Centre, Trauma Centre, Maternity

Home - applicable for hospitals only)

Super Specialty Services □

- **SPECIALITY SPECIFIC**

Medical Specialties – for which candidates must possess recognized PG degree
(MD/Diploma/DNB or its equivalent degree)

- i. Anesthesiology
- ii. Aviation Medicine
- iii. Community Medicine
- iv. Dermatology, Venerology and Leprosy
- v. Family Medicine
- vi. General Medicine
- vii. Geriatrics
- viii. ImmunoHaematology and Blood Transfusion
- ix. Nuclear Medicine
- x. Paediatrics
- xi. Physical Medicine Rehabilitation
- xii. Psychiatry
- xiii. Radio-diagnosis
- xiv. Radio-therapy
- xv. Rheumatology
- xvi. Sports Medicine
- xvii. Tropical Medicine
- xviii. Tuberculosis & Respiratory Medicine or Pulmonary Medicine

Surgical specialties - for which candidates must possess, recognized PG degree
(MS/Diploma/DNB or its equivalent degree)

- i. Otorhinolaryngology
- ii. General Surgery
- iii. Ophthalmology
- iv. Orthopedics
- v. Obstetrics & Gynecology

Medical Super specialties –

- i. Cardiology
- ii. Clinical Hematology including Stem Cell Therapy
- iii. Clinical Pharmacology

- iv. Endocrinology
- v. Immunology
- vi. Medical Gastroenterology
- vii. Medical Genetics
- viii. Medical Oncology
- ix. Neonatology
- x. Nephrology
- xi. Neurology
- xii. Neuro-radiology

Surgical Super-specialities-

- i. Cardiovascular thoracic Surgery)
- ii. Urology
- iii. Neuro-Surgery
- iv. Paediatrics Surgery.
- v. Plastic & Reconstructive Surgery
- vi. Surgical Gastroenterology
- vii. Surgical Oncology
- viii. Endocrine Surgery
- ix. Gynecological Oncology
- x. Vascular Surgery

III INFRASTRUCTURE DETAILS

10. Area of the establishment (in sqft):

a) Total Area: _____ b) Constructed area: _____

11. Out Patient Department:

11.1 Total no. of OPD Clinics: _____

11.2 Specialty-wise distribution of OPD Clinic

S.No.	Specialty

12. In Patient Department:

12.1. Total number of beds: _____

12.2. Specialty-wise distribution of beds, please specify:

S.No.	Specialty	Beds

13. Biomedical waste Management

13.1 Method of treatment and/or disposal of Bio-medical waste

- ☐ Through Common Facility
 ☐ Onsite Facility
☐ Any other (please specify): _____

13.2. Whether authorization from Pollution Control Board/Pollution Control Committee obtained?

☐ Yes ☐ No ☐ Applied For ☐ Not Applicable

IV HUMAN RESOURCES

14. Total number of Staff (as on date of application):

No. of permanent staff: _____ No. of temporary staff: _____

Please furnish the following details:-

Category of staff	Name	Qualification	Registration No	Nature of service Temporary/ Permanent
Doctors				
Nursing staff				
Para-medical staff				
Pharmacists				
Administrative staff				
Others, please specify				

Separate annexure may be attached.

Support Staff

Category	Total no.	Remark

15. Payment options for Registration Fees:

☐ Online payment ☐ Demand Draft ☐ Bank Challan

Amount (in Rs): _____

Details: _____

Receipt No. _____

I,on behalf of myself and the company/society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the provisions made under the Clinical Establishment (Registration and Regulation) Act 2010.

I undertake that I shall inform the District Registering Authority of any changes in the particulars given above.

I shall comply with the minimum standards prescribed under Clinical Establishment Act for the services provided by us and also all other conditions of registration as stipulated under the aforesaid Act and Rule there-under.

Place:

Date:

Signature of the Authorized Signatory

Office Seal

Id: 328520

Test, Hunter

Sex: MALE

Visit Date: 12/12/2025

DOB: 01/01/2000

PCP:



Patient: Hunter Test (01/01/2000 - 25y), Male
Address: Sw Iowa Dr Tualatin, OR 97062
Phone: (302) 394-0930
Seen On: 12/12/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Abdominal pain, 10 Panel Rapid Drug Test
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

Social History

No social history entered

Family History

No family history entered

Review of Systems

System: Gastrointestinal



Patient: Hunter Test (01/01/2000 - 25y), Male
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Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Patient Reports: Abdominal pain

System: Allergic/Immunologic

Patient Reports: Itchy skin

Patient Denies: Itchy eyes

System: Skin

Patient Reports: Bruising

Patient Denies: Bite

All non-documented systems have been reviewed and are considered negative

Exam

Respiratory (Normal)

Normal: Patient did not cough during exam.

Musculoskeletal (Abnormal)

Abnormal: Antalgic gait on the left side observed. Antalgic gait on the right side observed.

Orders & Procedures

Status: Completed

Procedure: 10 PANEL HAIR DRUG TEST

Category: Procedure

Lab Requests:

ANA SCREEN, IFA, W/REFL TITER AND PATTERN

Assessment/Plan

No assessment plan entered

Explanation:



Patient: Hunter Test (01/01/2000 - 25y), Male
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Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Treatment:

External Orders:

Order File: Hunter Test Order to TestingLab Facility 12/12/2025.pdf

Result: ANA SCREEN, IFA, W/REFL TITER AND PATTERN

Prescription

Signature

Addendums

Order Form

12/06/2023

DoseSpotClinic
N Washington Ave
Green Brook, NJ 08812

NPI:

Phone: (860) 944-9421 Fax: (860) 995-9416

Stewart Slater Male 01/02/2000
(860) 955-9531

Scott Dr
Hillsborough, NJ 08844

Primary Insurance

Subscriber Name

Insurance Address

Insured Name

Address

Priority:

ICD10 Code

MR MUSCULOSKELETAL

- ☐ Shoulder
☐ Elbow ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R
☐ Hip ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Lower Leg ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ MR Arthrography Specify joint:

MR BODY

- ☐ Abdomen ☐ Pelvis
☐ MRCP ☐ Liver
☐ Kidney

MR NEURO

- ☐ Brain
☐ IAC's/Orbits
☐ Pituitary
☐ Soft Tissue Neck
☐ Brachial Plexus ☐ L ☐ R
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ w/3D Myelogram
☐ Sacrum/Coccyx
☐ WEIGHT BEARING MRI

MR SPECIAL

- ☐ Breast
☐ Cardiac
☐ Enterography (MRE)
☐ Prostate
☐ TMJ
☐ Urogram
(Abd/Pel w/w/o with 3D recon)

MRA

- ☐ Brain ☐ Carotid
☐ Abdomen ☐ Kidney
☐ Runoff (Abd, Pel, Bilat legs)
☐ MRV Specify area of interest:

☐ MR OTHER Specify area of interest:**CT NEURO**

- ☐ Brain ☐ Sinus
☐ Facial Bones
☐ IAC's/Temporal Bone
☐ Orbits ☐ Soft Tissue Neck
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine

CT MUSCULOSKELETAL ☐

Extremity (Specify area of interest)
☐ w/3D Recon.

☐ CT Arthrography (Specific Joint)**CT BODY**

- ☐ Chest ☐ Abdomen ☐ Pelvis
☐ Urogram (Abd/Pel w/w/o with 3D recon)
☐ Cardiac Calcium Score
☐ Low Dose Lung Screen

VASCULAR CT ANGIOGRAPHY

- (All with IV contrast--no oral contrast)
☐ CTA Brain ☐ CTA Carotids
☐ CTA Chest (Pulmonary Embolus Protocol)
☐ CTA Aorta (Chest, Abd, Pel)
☐ CTA Coronary Arteries
☐ CTA Venous Structure
☐ CT OTHER (Specify area of interest)

X-RAY/FLUOROSCOPY

- ☐ Chest ☐ Abdomen
☐ Pelvis ☐ Cervical Spine
☐ Thoracic Spine ☐ Flex
☐ Lumbar Spine ☐ Ext.
☐ Scoliosis/AP & LAT (T+L Spine)
☐ Pelvis Hip ☐ RT ☐ LT
☐ Upper Extremity Indicate Site:
_____ ☐ RT ☐ LT
☐ Lower Extremity Indicate Site:
_____ ☐ RT ☐ LT
☐ Upper GI-W/Air per Rad*
☐ Ba Enema-W/Air per Rad*
☐ Esophagram*
☐ Small Bowel Study*
☐ Other

NUCLEAR MEDICINE Provide comparison films

- ☐ DaTscan
☐ Bone Scan Whole Body
☐ Bone Scan 3 Phase of:

☐ Bone Scan Limited of:

- ☐ Hepatobiliary Scan (HIDA)
☐ With EF ☐ W/O EF
☐ Thyroid Scan & Uptake*
☐ Liver/Spleen Scan
☐ Parathyroid Scan with SPECT
☐ Muga Resting
☐ Gastric Emptying Scan* Single Phase Only
☐ Renogram* ☐ Lasix ☐ No Lasix
☐ Renogram* With Captopril
☐ Lung Scan ☐ Vent/LPerf ☐ Quantilation
☐ Other _____

WOMEN'S IMAGING

- ☐ 3D Mammogram - Screening
☐ 3D Mammogram - Diagnostic
w/ CAD and Breast US if questionable mammo ☐ L ☐ R ☐ B
☐ Breast US - Screening ☐ L ☐ R ☐ B
☐ Breast US - Diagnostic ☐ L ☐ R ☐ B
☐ DEXA scan ☐ L ☐ R ☐ B
☐ Stereotactic Biopsy ☐ L ☐ R ☐ B
☐ Needle Localization ☐ L ☐ R ☐ B
☐ US biopsy ☐ L ☐ R ☐ B
☐ Cyst Aspiration ☐ L ☐ R ☐ B
☐ MR Biopsy ☐ L ☐ R ☐ B

PET

- ☐ PET/Skull Base to Thigh*
☐ PET / Whole Body*
☐ PET/Brain Amyvid Alzheimers
☐ PET/Brain* ☐ PET/Bone Scan

ULTRASOUND

- ☐ Abdomen
☐ Pelvis w/ Transvaginal
☐ Aorta
☐ Retroperitoneum
☐ Scrotum
☐ Thyroid

VASCULAR ULTRASOUND

- ☐ Arterial ☐ Venous
☐ Upper Ext.
☐ Lower Ext.
☐ L ☐ R ☐ BILAT
☐ ABI
☐ Insufficiency
☐ Carotid
☐ Renal Doppler
☐ US OTHER (Specify area of interest)



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Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

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Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered

Immunization

No immunizations entered

Surgical History

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Medical Condition

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Preventative Med Notes

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Social History

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Family History

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Review of Systems

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Provider:

Patient Reports: Abdominal pain

System: Allergic/Immunologic

Patient Reports: Itchy skin

Patient Denies: Itchy eyes

System: Skin

Patient Reports: Bruising

Patient Denies: Bite

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Normal: Patient did not cough during exam.

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Abnormal: Antalgic gait on the left side observed. Antalgic gait on the right side observed.

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Procedure: 10 PANEL HAIR DRUG TEST

Category: Procedure

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