NAME OF THE HOSPITAL: ____

1). Branchial Cyst Excision: S1A1.1

1. Name of the Procedure: Branchial Cyst Excision
2. Indication: Branchial Cyst
3. Does the patient presented with swelling in lateral side of neck, discharge: Yes/No (Upload Clinical Photograph)
4. If the answer to question 3 is Yes then are the following tests being done - USG Neck/ FNAC/ X-ray Neck AP or Lateral: Yes/No (Upload reports)
5. If the answer to question 4 is Yes, then is the patient having evidence of Infected cyst: Yes/No

For Eligibility for Branchial Cyst Excision the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

2). Cystic Hygroma Excision-Extensive: S1A1.10

1. Name of the Procedure: Cystic Hygroma Excision-Extensive

2. Indication: Cystic Hygroma

3. Does the patient presented with swelling over head & neck/ swelling sometimes in axilla/ soft, painless & compressible mass/ transillumination positive: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG/CT Scan: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Infected cyst: Yes/No
   b. Premature infants with neuro vascular structure involvement: Yes/No

For Eligibility for Cystic Hygroma Excision-Extensive the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

3). Abbe Operation: S1A1.11

1. Name of the Procedure: Abbe Operation

2. Indication: Defect in lip between 1/3rd to 2/3rd the length of lip

3. Does the patient presented with defect in lip due to trauma or tumor: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - X ray skull AP or Lateral: Yes/No (Upload reports)

For Eligibility for Abbe Operation the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

4). Vermilionectomy: S1A1.12

1. Name of the Procedure: Vermilionectomy

2. Indication: Extensive precancerous leukoplakia/ Chronic Solar Cheilitis

3. Does the patient presented with leukoplakia over vermilion border, chronic inflammation, actinic cheilitis: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - Biopsy: Yes/No (Upload reports) - Report may be submitted at the time of claim

For Eligibility for Vermilionectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

5). Wedge Excision & Vermilionectomy Inv: S1A1.13

1. Name of the Procedure: Wedge Excision & Vermilionectomy Inv

2. Indication: Actinic cheilits with squamous cell carcinoma

3. Does the patient presented with whitish discolouration of the vermilion border with lip involvement: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - FNAC/ Biopsy suggestive of squamous cell carcinoma: Yes/No (Upload reports)

For Eligibility for Wedge Excision & Vermilionectomy Inv the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

6). Wedge Excision: S1A1.14

1. Name of the Procedure: Wedge Excision

2. Indication: Squamous cell carcinoma

3. Does the patient presented with swelling over lip: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - FNAC/ Biopsy suggestive of squamous cell carcinoma: Yes/No (Upload reports)

For Eligibility for Wedge Excision the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

7). Cystic Hygroma Excision-Major: S1A1.15

1. Name of the Procedure: Cystic Hygroma Excision-Major
2. Indication: Presence of cystic hygroma
3. Does the patient presented with swelling over head & neck, swelling sometimes in axilla, soft, painless & compressible mass, transillumination positive: Yes/No (Upload clinical photograph)
4. If the answer to question 3 is Yes then are the following tests being done - USG/CT Scan: Yes/No (Upload reports)
5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Infected cyst: Yes/No
   b. Premature infants with neuro vascular structure involvement: Yes/No

For Eligibility for Cystic Hygroma Excision-Major the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

8). Cystic Hygroma Excision-Minor: S1A1.16

1. Name of the Procedure: Cystic Hygroma Excision-Minor

2. Indication: Presence of Cystic Hygroma

3. Does the patient presented with swelling over head & neck, swelling sometimes in axilla, soft, painless & compressible mass, transillumination positive: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG/CT Scan: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Infected cyst: Yes/No
   b. Premature infants with neuro vascular structure involvement: Yes/No

For Eligibility for Cystic Hygroma Excision-Minor the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

9). Parathyroidectomy: S1A1.18

1. Name of the Procedure: Parathyroidectomy

2. Indication: Parathyroidadenoma/ Hyperparathyroidism

3. Does the patient presented with pain in bones, renal stones, nausea, vomiting, abdominal pain, myopathy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG Neck, Serum Calcium/ PTH levels/ 24 hr Urine Calcium: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of asymptomatic parathyroid adenoma without mass effect: Yes/No

For Eligibility for Parathyroidectomy the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

10). Excision Of Thyroglossal Cyst Fistula: S1A1.19

1. Name of the Procedure: Excision Of Thyroglossal Cyst Fistula
2. Indication: Fistula in thyroglossal cyst
3. Does the patient presented with discharge from thyroglossal cyst, swelling in midline of neck: Yes/No (Upload clinical photograph)
4. If the answer to question 3 is Yes then are the following tests being done - USG Neck/ X-ray neck AP or Lateral: Yes/No (Upload reports)

For Eligibility for Excision Of Thyroglossal Cyst Fistula the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

11). Cervical Rib Excision: S1A1.2

1. Name of the Procedure: Cervical Rib Excision
2. Indication: Presence of neuro vascular symptoms due to cervical rib
3. Does the patient presented with vascular compression of subclavian vessels, tingling numbness: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - Chest X-ray, colour doppler: Yes/No (Upload reports)

For Eligibility for Cervical Rib Excision the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

12). Excision Of Lingual Thyroid: S1A1.20

1. Name of the Procedure: Excision Of Lingual Thyroid

2. Indication: Presence of lingual thyroid

3. Does the patient presented with dysphagia, dysphonia, upper airway obstruction: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then are the following tests being done - Thyroid function test, X-ray neck AP or Lateral & FNAC showing normal thyroid tissue at the base of tongue: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is it the only functional thyroid tissue in body: Yes/No

For Eligibility for Excision Of Lingual Thyroid the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

13). Removal Of Submandibular Salivary Gland: S1A1.3

1. Name of the Procedure: Removal Of Submandibular Salivary Gland

2. Indication: Recurrent sialoadenitis/ Sialorrhoea/ Benign Submandibular gland tumour

3. Does the patient presented with excessive salivation, pain in submandibular region: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG Neck with respect to submandibular gland/ CT Neck with contrast: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of submandibular gland swelling with FNAC suggestive of Carcinoma: Yes/No (Upload FNAC report)

For Eligibility for Removal Of Submandibular Salivary Gland the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

14). Parotid Duct Repair: S1A1.4

1. Name of the Procedure: Parotid Duct Repair
2. Indication: Parotid duct injury
3. Does the patient presented with pain in parotid region radiating to neck, palpable lump in parotid region, fever: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - Sialography: Yes/No (Upload reports)

For Eligibility for Parotid Duct Repair the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

15). Branchial Sinus Excision: S1A1.5

1. Name of the Procedure: Branchial Sinus Excision

2. Indication: Branchial Sinus

3. Does the patient presented with fever & clinically visible sinus: Yes/No – Also upload photograph

4. If the answer to question 3 is Yes then are the following tests being done - USG/CECT: Yes/No (Upload reports)

For Eligibility for Branchial sinus excision the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

16). Hemimandibulectomy: S1A1.6

1. Name of the Procedure: Hemimandibulectomy

2. Indication: Mandibular Carcinoma/ Mandibular trauma

3. Does the patient presented with swelling, pain: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - X-ray/ CT head: Yes/No (Upload reports)

For Eligibility for Hemimandibulectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

17). Segmental Mandible Excision: S1A1.7

1. Name of the Procedure: Segmental Mandible Excision
2. Indication: Mandibular tumour invading mandible/ Osteomyelitis of Mandible/ Severe Mandibular trauma
3. Does the patient presented with swelling, pain: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - X-ray/ CT head/ MRI: Yes/No (Upload reports)
5. If the answer to question 4 is Yes, then is the patient having evidence of uncorrected coagulopathy: Yes/No

For Eligibility for Segmental Mandible Excision the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

18). Carotid Body-Tumours Excision: S1A1.8

1. Name of the Procedure: Carotid Body - Tumours Excision
2. Indication: Carotid body – Tumour
3. Does the patient presented with painless pharyngeal mass, fever: Yes/No (Upload photograph)
4. If the answer to question 3 is Yes then are the following tests being done - USG neck/ ColourDoppler/ Carotid Angiogram/ MRI: Yes/No (Upload report)

For Eligibility for Carotid Body-Tumours Excision the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

19). Partial Glossectomy: S1A1.9

1. Name of the Procedure: Partial Glossectomy

2. Indication: Ca Tongue

3. Does the patient presented with growth over tongue, difficulty in chewing: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then is there evidence of Ca Tongue on biopsy: Yes/No (Upload Biopsy report)

For Eligibility for Partial Glossectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

20). Operation For Hydatid Cyst Liver: S1A10.1

1. Name of the Procedure: Operation For Hydatid Cyst Liver
2. Indication: Hydatid cysts in Liver
3. Does the patient presented with abdominal pain, vomiting, fever: Yes/No
4. If the answer to question 3 is Yes then is there evidence of Hydatid cyst documented through investigations like USG/ CT Scan: Yes/No (Upload reports)
5. If the answer to question 4 is Yes, then is the patient having evidence of multiple small hydatid cysts involving both lobes of liver: Yes/No

For Eligibility for Operation For Hydatid Cyst Liver the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

21). Portocaval Anastomosis: S1A10.2

1. Name of the Procedure: Portocaval Anastomosis

2. Indication: Bleeding Oesophageal varices

3. Does the patient presented with abdominal pain, bilious vomiting, haematamesis, malena: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then is there evidence of cirrhosis with bleeding oesophagialvarices documented through USG/ MRI and upper GI Endoscopy: Yes/No (Upload report)

For Eligibility for Portocaval Anastomosis the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

22). Cholecystectomy: S1A11.1

1. Name of the Procedure: Cholecystectomy

2. Indication: Calculousbilliary tract disease

3. Does the patient presented with abdominal pain, distention, vomiting, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ USG, LFT: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. End stage liver disease: Yes/No
   b. Acute Cholangitis: Yes/No

For Eligibility for Cholecystectomy the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

23). Lap.Cholecystectomy: S1A11.2

1. Name of the Procedure: Lap.Cholecystectomy

2. Indication: Calculous billiary tract disease

3. Does the patient presented with abdominal pain, vomiting, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ USG, LFT: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. End stage liver disease: Yes/No
   b. Acute Cholangitis: Yes/No
   c. Advance GB cancer: Yes/No

For Eligibility for Lap.Cholecystectomy the answer to question 5a, 5b & 5c must be No

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

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NAME OF THE HOSPITAL: ____

24). Cholecystectomy & Exploration CBD: S1A11.3

1. Name of the Procedure: Cholecystectomy & Exploration CBD

2. Indication: Gall stones/ Calulous billiary tract disease

3. Does the patient presented with abdominal pain, yellowish discoloration of skin and eyes, vomiting, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ USG, LFT: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. End stage liver disease: Yes/No
   b. Acute Cholangitis: Yes/No

For Eligibility for Cholecystectomy & Exploration CBD the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

25). Lap CholecystostomyWith Exploration CBD: S1A11.4

1. Name of the Procedure: Lap Cholecystostomy With Exploration CBD

2. Indication: Calculous billiary tract disease

3. Does the patient presented with abdominal pain, yellowish discoloration of skin and eyes, itching all over body, loss of appetite: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ USG, LFT: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Obstructive pulmonary disease: Yes/No
   b. Congestive heart failure: Yes/No
   c. GB cancer: Yes/No

For Eligibility for Lap Cholecystostomy With Exploration CBD the answer to question 5a, 5b & 5c must be No

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

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NAME OF THE HOSPITAL: ____

26). Cystojejunostomy: S1A11.5

1. Name of the Procedure: Cystojejunostomy

2. Indication: Pseudocyst of Pancreas

3. Does the patient presented with abdominal pain, abdominal distension, fever, vomiting: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Pseudocyst of Pancreas documented through investigations like CT/ USG, LFT: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of grossly infected psuedocyst: Yes/No

For Eligibility for Cystojejunostomy the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

27). Cystogastrostomy: S1A11.6

1. Name of the Procedure: Cystogastrostomy

2. Indication: Pseudocyst of pancreas

3. Does the patient presented with pain in epigastric region radiating to back, palpable lump in epigastric region, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ USG, LFT, Serum Amylase, Serum Lipase: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of Pseudocyst in the head of pancreas: Yes/No

For Eligibility for Cystogastrostomy the answer to question 5 must be No

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

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NAME OF THE HOSPITAL: ____

28). Repair Of CBD: S1A11.7

1. Name of the Procedure: Repair Of CBD

2. Indication: Common bile duct injuries

3. Does the patient presented with abdominal pain, abdominal distension, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT/ ERCP, LFT: Yes/No (Upload reports)

For Eligibility for Repair Of CBD the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

29). Operation Of Adrenal Glands, Bilateral For Tumour: S1A12.1

1. Name of the Procedure: Operation Of Adrenal Glands, Bilateral For Tumour

2. Indication: Adrenal tumors producing pressure symptoms,cusshing syndrome

3. Does the patient presented with abdominal pain, lump, bowel complaints, giddiness, weakness, weight Loss, palpitations, hormonal changes: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT/ MRI, Urine Test, Biochemical tests: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence
   a. Inoperable tumor: Yes/No
   b. Coagulation disorders: Yes/No

For Eligibility for Operation Of Adrenal Glands, Bilateral For Tumour the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

30). Operation On Adrenal Glands Unilateral For Tumour: S1A12.2

1. Name of the Procedure: Operation On Adrenal Glands Unilateral For Tumour

2. Indication: Tumor more than 6cm size/ Malignancy

3. Does the patient presented with weight loss, palpitations, giddiness, hormonal changes: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT/ MRI, Harmonal assay/ Urine test: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence
   a. Inoperable tumor: Yes/No
   b. Coagulation disorders: Yes/No

For Eligibility for Operation On Adrenal Glands Unilateral For Tumour the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

31). Splenectomy For Hypersplenism: S1A13.1

1. Name of the Procedure: Splenectomy For Hypersplenism

2. Indication: Thalasseaemia, ITP, Hereditory Spherocytosis, Myelofibrosis

3. Does the patient presented with left hypochondriac pain, easy bruising, fever, weakness: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - Peripheral smear, USG / CT: Yes/No (Upload reports)

For Eligibility for Splenectomy For Hypersplenism the answer to question 4 must be Yes.

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

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NAME OF THE HOSPITAL: ____

32). Splenorenal Anastomosis: S1A13.2

1. Name of the Procedure: Splenorenal Anastomosis
2. Indications: Portal hypertension/ Aortic aneurysm/ Renal artery obstruction/ Renal artery injury/ Renal artery aneurysm/ Anomalous renal artery/ Aortic thrombosis
3. Does the patient presented with weakness, hematemesis, abdominal lump, decreased urine output: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - LFT, USG/ MRI, Upper GI endoscopy: Yes/No (Upload reports)

For Eligibility for Splenorenal Anastomosis the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

33). Warren Shunt: S1A13.3

1. Name of the Procedure: Warren Shunt
2. Indication: Portal hypertension
3. Does the patient presented with hematemesis, abdominal pain: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - USG/ MRI, Upper GI endoscopy: Yes/No (Upload reports)

For Eligibility for Warren Shunt the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

34). Mal-Rotation & Volvulus Of The Midgut: S1A14.1

1. Name of the Procedure: Mal-Rotation & Volvulus Of The Midgut
2. Indications: Midgut volvulus
3. Does the patient presented with abdominal pain, bilious vomiting: Yes/No
4. If the answer to question 3 is Yes then is there evidence of Mal-rotation & Volvulus of the midgut on X-RAY abdomen, USG/ CT: Yes/No (Upload reports)

For Eligibility for Mal-Rotation & Volvulus Of The Midgut the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

35). Operation For Volvulus Of Large Bowel: S1A14.2

1. Name of the Procedure: Operation For Volvulus Of Large Bowel

2. Indications: Sigmoid volvulus

3. Does the patient presented with abdominal pain, distention, vomiting, constipation: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Volvulus of large bowel on X-RAY abdomen, CT: Yes/No (Upload reports)

For Eligibility for Operation For Volvulus Of Large Bowel the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

36). Operation Of The Duplication Of The Intestines: S1A14.3

1. Name of the Procedure: Operation Of The Duplication Of The Intestines

2. Indications:

Duplication cyst of large intestine
Duplication cyst of rectum

3. Does the patient presented with lump, obstruction, intussuception, GI bleed: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG abdomen/ CT abdomen - cystic or tubular lesion arising from intestine: Yes/No (Upload reports)

For Eligibility for Operation of the Duplication of the Intestines the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

37). Operation Of The Duplication Of The Intestines: S1A14.3

1. Name of the Procedure: Operation Of The Duplication Of The Intestines

2. Indications:

Duplication cyst of large intestine
Duplication cyst of rectum

3. Does the patient presented with constipation, pelvic mass: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT pelvis - cystic mass arising from rectum: Yes/No (Upload reports)

For Eligibility for Operation of the Duplication of the Intestines the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

38). Left Hemi Colectomy: S1A14.4

1. Name of the Procedure: Left Hemi Colectomy

2. Indications: Carcinoma of descending colon or sigmoid colon

3. Does the patient presented with altered bowel habits, hematochezia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of carcinoma on Barium/ USG/ CT, Endoscopy, Biopsy: Yes/No (Upload reports)

For Eligibility for Left Hemi Colectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

39). Right Hemi Colectomy: S1A14.5

1. Name of the Procedure: Right Hemi Colectomy

2. Indications: Carcinoma caecum or ascending colon, ileocaecal tuberculosis

3. Does the patient presented with abdominal pain, malena, lethargy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of carcinoma on Barium/ USG/ CT, Endoscopy, Biopsy: Yes/No (Upload reports)

For Eligibility for Right Hemi Colectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

40). Total Colectomy: S1A14.6

1. Name of the Procedure: Total Colectomy

2. Indications: Ulcerative colitis

3. Does the patient presented with abdominal pain, passage of red blood per rectum, fever, weight loss: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Ulcerative colitis on USG/ CT, Endoscopy: Yes/No (Upload reports)

For Eligibility for Total Colectomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

41). Colostomy: S1A14.7

1. Name of the Procedure: Colostomy

2. Indications: Carcinoma colon/ Carcinoma Rectum/ Rectal perforation (traumatic)/ To facilitate operative management of High fistula in ano/ For incontinence/ Near totally obstructing rectal cancer prior to chemotherapy

3. Does the patient presented with Distension of abdomen/ Bleeding per rectum/ Perianal discharge in fistula in ano/ Stool incontinence: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT, Endoscopy: Yes/No (Upload reports)

For Eligibility for Colostomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

42). Colostomy Closure: S1A14.8

1. Name of the Procedure: Colostomy Closure

2. Indications: Colostomy for any indication

3. Does the patient presented with Mature stoma typically after colostomy has been established for two months: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - Barium study/ Distal loop cologram: Yes/No (Upload reports)

For Eligibility for Colostomy Closure the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

43). Hemithyroidectomy: S1A2.1

1. Name of the Procedure: Hemithyroidectomy

2. Indications: Follicular carcinoma of thyroid/ Follicular adenoma of thyroid

3. Does the patient presented with Swelling in the neck/ Features of hypo or hyperthyroidism: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - FNAC, Thyroid Function Tests, USG Neck, Thyroid Scan - (optional): Yes/No (Upload reports)

For Eligibility for Hemithyroidectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

44). Isthmectomy: S1A2.2

1. Name of the Procedure: Isthmectomy

2. Indications: In Undifferentiated (anaplastic) carcinoma for tracheal decompression and tissue for histology

3. Does the patient presented with swelling in the neck: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - FNAC, Thyroid Function Tests, USG Neck, Thyroid Scan - (optional): Yes/No (Upload reports)

   For Eligibility for Isthmectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

45). Partial Thyroidectomy: S1A2.3

1. Name of the Procedure: Partial Thyroidectomy

2. Indications: Goiter

3. Does the patient presented with swelling in the neck: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - FNAC, Thyroid Function Tests, USG Neck, Thyroid Scan - (optional): Yes/No (Upload reports)

For Eligibility for Partial Thyroidectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

46). Resection Enucleation: S1A2.4

1. Name of the Procedure: Resection Enucleation

2. Indications: Localized tumour/ lesion

3. Does the patient presented with symptoms of the localized tumour/ lesion: Yes/No

4. If the answer to question 3 is Yes then is there evidence of benign nature of tumour/ lesion documented through relevant investigations: Yes/No (Upload reports)

For Eligibility for Resection Enucleation the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

47). Subtotal Thyroidectomy: S1A2.5

1. Name of the Procedure: Subtotal Thyroidectomy
2. Indications: Colloid Goiter
3. Does the patient presented with swelling in the neck/ Features of hyper or hypo thyroidism: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - FNAC, Thyroid Function Tests, USG Neck: Yes/No (Upload reports)

For Eligibility for Subtotal Thyroidectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

48). Total Thyroidectomy: S1A2.6

1. Name of the Procedure: Total Thyroidectomy
2. Indications: Carcinoma Thyroid
3. Does the patient presented with Swelling in the neck/ Features of hyper or hypo thyroidism: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - FNAC, Thyroid Function Tests, USG: Yes/No (Upload reports)

For Eligibility for Total Thyroidectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

49). Simple Mastectomy (NM): S1A3.1

1. Name of the Procedure: Simple Mastectomy

2. Indications: Fungating Breast carcinomas/ Phylloid tumour

3. Does the patient presented with fungating growth, lump in breast: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - FNAC/ Biopsy/ Sonomamography/ MRI: Yes/No (Upload reports)

For Eligibility for Simple Mastectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

50). Epigastric Hernia Without Mesh: S1A4.1

1. Name of the Procedure: Epigastric Hernia Without Mesh

2. Indications: Epigastric hernia

3. Does the patient presented with midline swelling with or without cough impulse, pain over the swelling: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

For Eligibility for Epigastric Hernia Without Mesh the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

51). Epigastric Hernia With Mesh: S1A4.2

1. Name of the Procedure: Epigastric Hernia With Mesh

2. Indications: Epigastric hernia

3. Does the patient presented with midline swelling with or without cough impulse, pain over the swelling: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

For Eligibility for Epigastric Hernia With Mesh the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

52). Femoral Hernia: S1A4.3

1. Name of the Procedure: Femoral Hernia

2. Indications: Femoral Hernia

3. Does the patient presented with hernia below and lateral to pubic tubercle, obstructed femoral hernia with features of bowel obstruction: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - X ray Abdomen, USG/CT scan: Yes/No (Upload reports)

For Eligibility for Femoral Hernia the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

53). Hiatus Hernia Repair Abdominal: S1A4.4

1. Name of the Procedure: Hiatus Hernia Repair Abdominal

2. Indications: Paraesophageal Hiatus hernia

3. Does the patient presented with dysphagia, chest pain: Yes/No

4. If the answer to question 3 is Yes then is there evidence of hiatus hernia documented through investigations likeX ray chest/ USG, Upper GI endoscopy: Yes/No (Upload reports)

For Eligibility for Hiatus Hernia Repair Abdominal the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

54). Rare Hernias (Spigalion,Obuturator,Sciatic): S1A4.5

1. Name of the Procedure: Rare Hernias (Spigalion,Obuturator,Sciatic)

2. Indications: Spigelian hernia, obturator hernia, sciatic hernia

3. Does the patient presented with lump below umbilicus/ lump is Scarpas triangle/ lump in the lesser Sciatic foramina: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Abdomen & pelvis / USG abdomen: Yes/No (Upload reports)

For Eligibility for Rare Hernias (Spigalion,Obuturator,Sciatic) the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

55). Umbilical Hernia Without Mesh: S1A4.6

1. Name of the Procedure: Umbilical Hernia Without Mesh

2. Indication: Umbilical hernia small in size usually less than 2cm

3. Does the patient presented with umbilical swelling with or without cough impulse, pain over the swelling: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of Defect larger than 2cm: Yes/No

For Eligibility for Umbilical Hernia Without Mesh the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

56). Umbilical Hernia With Mesh: S1A4.7

1. Name of the Procedure: Umbilical Hernia With Mesh

2. Indication: Umbilical hernia with larger defect usually larger than 2 cm

3. Does the patient presented with swelling with or without cough impulse, pain over the swelling: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

For Eligibility for Umbilical Hernia With Mesh the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

57). Ventral and Scar Hernia Without Mesh: S1A4.8

1. Name of the Procedure: Ventral and Scar Hernia Without Mesh

2. Indication: Ventral and scar hernia with small defect and well approximation of the rectus sheath

3. Does the patient presented with localized swelling, increases steadily in size, vascular damage to skin: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of larger defect: Yes/No

For Eligibility for Ventral and Scar Hernia Without Mesh the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

58). Ventral and Scar Hernia With Mesh: S1A4.9

1. Name of the Procedure: Ventral and Scar Hernia With Mesh

2. Indication: Ventral hernia with large defects

3. Does the patient presented with localized swelling, increases steadily in size, vascular damage to skin: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of contaminated field such as in bowel injury: Yes/No

For Eligibility for Ventral and Scar Hernia With Mesh the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

59). Lap. Appendectomy: S1A5.1

1. Name of the Procedure: Lap. Appendectomy

2. Indication: Appendicitis

3. Does the patient presented with periumbilical colic, pain shifting to right iliac fossa, anorexia, nausea: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT: Yes/No (Upload report)

   For Eligibility for Lap. Appendectomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

60). Appendicular Perforation: S1A5.2

1. Name of the Procedure: Appendicular Perforation

2. Indication: Appendicular perforation

3. Does the patient presented with periumbilical colic, pain shifting to right iliac fossa, anorexia, nausea: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - X ray abdomen, USG: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of poor surgical candidate due to underlying comorbidity: Yes/No

For Eligibility for Appendicular Perforation the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

61). Highly Selective Vagotomy: S1A7.1

1. Name of the Procedure: Highly Selective Vagotomy

2. Indication: Duodenal ulcer

3. Does the patient presented with pain in epigastric region radiating to back, vomiting, bleeding: Yes/No

4. If the answer to question 3 is Yes then is there evidence of duodenal ulcer on endoscopy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of recurrent ulceration: Yes/No

For Eligibility for Highly Selective Vagotomy the answer to question 5 must be No.

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NAME OF THE HOSPITAL: ____

62). Gastrostomy Closure: S1A7.10

1. Name of the Procedure: Gastrostomy Closure

2. Indication: Gastric fistula

3. Does the patient presented with drainage of gastric contents from gastrocutaneous fistula with associated local skin edema and erythema: Yes/No

4. If the answer to question 3 is Yes then is there evidence of fistula on clinical photograph: Yes/No (Upload photograph)

5. If the answer to question 4 is Yes, then is the patient having evidence of poor surgical candidates due to their underlying comorbid conditions: Yes/No

For Eligibility for Gastrostomy Closure the answer to question 5 must be No
(Gastrostomy done for feeding purpose closes spontaneously does not require surgical closure)

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NAME OF THE HOSPITAL: ____

63). Duodenal Perforation: S1A7.2

1. Name of the Procedure: Duodenal Perforation

2. Indication: Duodenal perforation

3. Does the patient presented with pain in abdomen, nausea, vomiting, guarding and rigidity of abdomen on palpation: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG/ CT-abdomen, X-RAY: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Poor surgical candidate due to their underlying comorbid conditions: Yes/No
   b. Preoperative shock: Yes/No

For Eligibility for Duodenal Perforation the answer to question 5a & 5b must be No

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NAME OF THE HOSPITAL: ____

64). Selective Vagotomy Drainage: S1A7.3

1. Name of the Procedure: Selective Vagotomy Drainage

2. Indication: Duodenal ulceration/ Heineke – Mikuliczpyloro plasty done/ Gastrojejunostomy

3. Does the patient presented with pain in epigastric region radiating to back, vomiting, alternation in weight, bleeding: Yes/No

4. If the answer to question 3 is Yes then is there evidence of underlying pathology on endoscopy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of poor surgical candidates due to their underlying comorbid conditions: Yes/No

For Eligibility for Selective Vagotomy Drainage the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

65). Vagotomy Pyloroplasty: S1A7.4

1. Name of the Procedure: Vagotomy Pyloroplasty

2. Indication: Duodenal ulceration/ Heineke – Mikuliczpyloro plasty done

3. Does the patient presented with pain in epigastric region radiating to back, vomiting, alternation in weight, bleeding: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - endoscopy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of poor surgical candidate due to their underlying comorbid conditions: Yes/No

For Eligibility for Vagotomy Pyloroplasty the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

66). Gastrojejunostomy & Vagotomy: S1A7.5

1. Name of the Procedure: Gastrojejunostomy &Vagotomy

2. Indication: Duodenal ulceration

3. Does the patient presented with pain in epigastric region radiating to back, vomiting, alternation in weight, bleeding: Yes/No

4. If the answer to question 3 is Yes then is there evidence of duodenal ulceration on endoscopy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of poor surgical candidate due to their underlying comorbid conditions: Yes/No

For Eligibility for Gastrojejunostomy & Vagotomy the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

67). Operation For Bleeding Peptic Ulcer: S1A7.6

1. Name of the Procedure: Operation For Bleeding Peptic Ulcer

2. Indications: Gatric outlet obstruction/ Chronic duodenal or prepyloric ulcer with pyloric scarring/ Chronic gastric ulcer/ Suspicion of malignancy in gastric ulcer/ Resectable cancer of antro-pyloric region

3. Does the patient presented with pain in abdomen, vomiting, bloating, burping, weight loss, heart burn: Yes/No

4. If the answer to question 3 is Yes then is there evidence of underlying pathology on endoscopy: Yes/No (Upload report)

For Eligibility for Operation For Bleeding Peptic Ulcer the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

68). Partial/Subtotal Gastrectomy For Ulcer: S1A7.7

1. Name of the Procedure: Partial/ Subtotal Gastrectomy For Ulcer

2. Indications: Chronic antral ulcer/ Chronic pyloric ulcer with mass

3. Does the patient presented with vomiting, abdominal pain, hematemesis: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - Endoscopy/ Biopsy/ Barium meal: Yes/No (Upload report)

For Eligibility for Partial/Subtotal Gastrectomy for Ulcer the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

69). Pyloromyotomy: S1A7.8

1. Name of the Procedure: Pyloromyotomy

2. Indications: Hypertrophic pyloric stenosis/ pyloric stricture

3. Does the patient presented with non bilious vomiting, visible peristalsis: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG, Endoscopy: Yes/No (Upload report)

For Eligibility for Pyloromyotomy the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

70). Gastrostomy: S1A7.9

1. Name of the Procedure: Gastrostomy

2. Indications: Carcinoma esophagus with G-E junction obstruction, for feeding

3. Does the patient presented with weight loss, dysphagia, fatigue, weakness, muscle atrophy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG, Endoscopy/ Biopsy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence
   a. Planned gastric pull up procedure: Yes/No
   b. Severe comorbidity: Yes/No
   c. Distal G.I obstruction: Yes/No

For Eligibility for Gastrostomy the answer to question 5a, 5b & 5c must be No

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NAME OF THE HOSPITAL: ____

71). Intussusception: S1A8.1

1. Name of the Procedure: Intussusception
2. Indications: Intestinal Obstruction
3. Does the patient presented with abdominal pain, vomiting, bleeding per rectal: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - X-ray abdomen, USG/ CT abdomen: Yes/No (Upload report)

For Eligibility for Intussusception the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

72). Operation For Acute Intestinal Obstruction: S1A8.2

1. Name of the Procedure: Operation For Acute Intestinal Obstruction

2. Indications: Bowel obstruction due to mass,stricture,post infective thickening

3. Does the patient presented with abdominal pain, vomiting, abdominal distension, constipation: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - X-ray abdomen, USG/ CT abdomen: Yes/No (Upload report)

For Eligibility for Operation For Acute Intestinal Obstruction the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

73). Operation For Acute Intestinal Perforation: S1A8.3

1. Name of the Procedure: Operation For Acute Intestinal Perforation

2. Indications: Intestinal Perforation

3. Does the patient presented with abdominal pain, vomiting, abdominal distension, fever: Yes/No

4. If the answer to question 3 is Yes then is there evidence of acute intestinal perforation on X-ray abdomen, USG/ CT abdomen: Yes/No (Upload report)

For Eligibility for Operation For Acute Intestinal Perforation the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

74). Operation For Haemorrhage Of The Small Intestine: S1A8.4

1. Name of the Procedure: Operation For Haemorrhage Of The Small Intestine

2. Indication: Acute bleeding from angiodyspalsia and vascular malformations in small intestine

3. Does the patient presented with abdominal pain, vomiting, abdominal distension, hematemesis: Yes/No

4. If the answer to question 3 is Yes then is there evidence of haemorrhage of the small intestine on CT abdomen with contrast: Yes/No (Upload report)

For Eligibility for Operation For Haemorrhage Of The Small Intestine the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

75). Operations For Recurrent Intestinal Obstruction (Noble Plication Other): S1A8.5

1. Name of the Procedure: Operations For Recurrent Intestinal Obstruction (Noble Plication Other)

2. Indications: Recurrent small bowel obstruction with previous history of surgery

3. Does the patient presented with abdominal pain, vomiting, abdominal distension, constipation: Yes/No

4. If the answer to question 3 is Yes then is there evidence of intestinal obstruction on X ray abdomen, USG/CT abdomen: Yes/No (Upload report)

For Eligibility for Operations For Recurrent Intestinal Obstruction (Noble Plication Other) the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

76). Resection & Anastomosis Of Small Intestine: S1A8.6

1. Name of the Procedure: Resection & Anastomosis Of Small Intestine

2. Indications: Small bowel gangrene,perforation,mass,obstruction

3. Does the patient presented with abdominal pain, vomiting, abdominal distension: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - X ray abdomen, USG/CT abdomen: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of unhealthy friable bowel: Yes/No

For Eligibility for Resection & Anastomosis Of Small Intestine the answer to question 5 must be No

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NAME OF THE HOSPITAL: ____

77). Ileostomy: S1A8.7

1. Name of the Procedure: Ileostomy

2. Indications:
   i. DISTAL LARGE BOWEL TUMOR,PERFORATION,MASS OR TUMOR
   ii. ILEOCAECAL THICKENING
   iii. DISTAL BOWEL GANGRENE
   iv. IMA OCCLUSION
   v. ISCHAEMIC BOWEL OBSTRUCTION

3. Does the patient presented with abdominal pain, vomiting, abdominal distension: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG, CT abdomen: Yes/No (Upload report)

For Eligibility for Ileostomy the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

78). Ileostomy Closure: S1A8.8

1. Name of the Procedure: Ileostomy Closure

2. Indications: Post stoma formation

3. Does the patient presented with stoma in situ: Yes/No (Upload photograph)

4. If the answer to question 3 is Yes then are the following tests being done - USG, CT abdomen - optional: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Distal obstruction: Yes/No
   b. Severe comorbidity: Yes/No

   For Eligibility for Ileostomy Closure the answer to question 5a & 5b must be No

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

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NAME OF THE HOSPITAL: ____

79). Pull Through Abdominal Resection: S1A9.1

1. Name of the Procedure: Pull Through Abdominal Resection
2. Indications: Hirschprung disease
3. Does the patient presented with abdominal pain, vomiting, abdominal distension: Yes/No (Upload clinical photograph)
4. If the answer to question 3 is Yes then are the following tests being done - USG, CT abdomen-optional: Yes/No (Upload report)

For Eligibility for Pull Through Abdominal Resection the answer to question 4 must be Yes

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

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NAME OF THE HOSPITAL: ____

80). Anterior Resection: S1A9.2

1. Name of the Procedure: Anterior Resection

2. Indications: High rectal cancer, Low sigmoido-rectal cancer

3. Does the patient presented with abdominal pain, vomiting, palpable growth per rectum, bleeding per rectal: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - USG, Colonoscopy, Biopsy: Yes/No (Upload report)

5. If the answer to question 4 is Yes, then is the patient having evidence of distal rectal mucosa unhealthy or rectal vascularity compromised: Yes/No

For Eligibility for Anterior Resection the answer to question 5 must be No

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

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