NAME OF THE HOSPITAL: _____

1) Failed device closure for ASD and/or VSD. Emergency retrieval of device with defect closure under cardiopulmonary bypass

1. Name of the Procedure: Failed device closure for ASD and/or VSD. Emergency retrieval of device with defect closure under cardiopulmonary bypass
2. Select the indications:

Failed device closure for ASD
Failed device closure for VSD

3. Does the patient has significant Left to right shunt: Yes /No
4. Significant pulmonary vascular disease : Yes/No
   (Upload 2 D echo & Catheterization Report if possible)
5. Whether pericardial or artificial patch used for closure.
   (Intra operative photo of patch)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

2) Mitral Valve Replacement (With Valve): S7F6.4 1.

1. Name of the Procedure: Mitral Valve Replacement Surgery
2. Select the Indication from the drop down of various indications provided under this head:

Mitral Stenosis
Mitral Regurgitation

3. Does the patient have severe mitral stenosis (mitral valve area < 1cm2): Yes/No (Upload ECHO report
4. Does the patient have Severe mitral regurgitation: Yes/No (Upload ECHO report)
5. If answer to question 4 is Yes, Does the patient have either of the following
    a. Exertional Symptoms (class II-IV): Yes/No
    b. LV end systolic dimension > 45 mm: Yes/No
    c. LVEF
6. Does the patient have significant aortic valve disease: Yes/No (Upload ECHO report)

    For eligibility for MVR, the answer to 6 must be NO

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

3) Truncus Arteriosus surgery

1. Name of the Procedure: Truncus Arteriosus surgery

2. Select the Indication:

   Cyanosis: Yes/No – Type **I, II, II, IV** truncus arteruisus – Mention the type
   (Upload 2 D echo report)

3. Surgery :

   a. Using conduit with or

   b. Without valve & artificial path
      (Upload sticker for graft conduit)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

4) Surgery for HOCM (Hypertrophic obstructive cardiomyopathy)

1. Name of the Procedure: Surgery for HOCM (Hypertrophic obstructive cardiomyopathy)
2. Select the Indication:

   DOE – Grade : Yes/No

   SAM – Present : Yes/No

   LVOT – Gradient at rut > 30mmhg : Yes/No
   (Upload 2 D echo report)
3. Surgical treatment – Septal Myectomy

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

5) Thyomectomy

1. Name of the Procedure: Thyomectomy
2. Select the Indication:
    a. Benign thymic mass:Yes/No
    b. Malignant thymic mass:Yes/No
    c. Symptomatic patient of myasthenia: Yes/No

    (Upload HRCT Chest or MRI)
3. Surgery – Thyomectomy
    (Post operative HP report)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

5) Pulmonary Valve Replacement

1. Name of the Procedure: Pulmonary Valve Replacement

2. Select the Indication:

   Cyanosis:Yes/No

   Isolated pulmonary valve stenosis:Yes/No

3. Symptomatic or asymptomatic patient with RV dilation / RV failure / arrthythmias, exercise intolerance: Yes/No
   any of the above. (Upload 2 D echo report or cath study if possible)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

7) Pulmonary AV Malformation

4. Name of the Procedure: Pulmonary AV Malformation
5. Select the Indication:
    a. DOE:Yes/No
    b. Fatigue:Yes/No
    c. Cyanosis:Yes/No
    d. Orthodeoxia:Yes/No
6. Haemoptysis with / without symptoms:Yes/No
7. Haemothorax with / without symptoms:Yes/No
   (Upload 2 D echo report or CT angiography reports with plates)
8. Surgery – Lobectomy/Segmentectomy/pneumonectomy
   Mention surgery –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

8)Surgery for Arterial Aneurysm Renal Artery

1. Name of the Procedure: Surgery for Arterial Aneurysm Renal Artery
2. Select the Indication:

   Pressure symptoms :Yes/No

   Hypertension:Yes/No

   Pain in abdomen:Yes/No

   Aneurusm of Unilateral artery:Yes/No

   Aneurusm of Bilateral artery:Yes/No
   (Upload color doppler or CT angiography)
3. Surgery:

   Unilateral repair with/without graft

   Bilateral repair with/without graft

   Orthodeoxia

   (For bilateral disease repair package should be more as 2 grafts repaired & surgery also supra major)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

9) Blalock–Thomas–Taussig (BT) Shunt (inclusives of grafts)

1. Name of the Procedure: Blalock–Thomas–Taussig (BT) Shunt (inclusives of grafts)
2. Select the Indication:

   Cyanosis at rest: Yes/No

   Cyanosis on Crying: Yes/No

   a. Tetralogy of fallot: Yes/No

   b. Tricuspid atresia: Yes/No

   c. Ebstein's anomaly: Yes/No

   d. Hypoplastic left heart syndrome: Yes/No

   e. Pulmonary atresia: Yes/No

   f. Inadequate pulmonary arteries: Yes/No

   g. Complex congenital cyanotic heart disease: Yes/No
3. Surgery: BT shunt with/without graft (2 D echo and/or cath study)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

10) Glenn Shunt (without cardiopulmonary bypass)

1. Name of the Procedure: Glenn Shunt (without cardiopulmonary bypass)
2. Select the Indication:

   Cyanosis: Yes/No

   Hypoplastic left heart syndrome: Yes/No

   Tricuspid atresia: Yes/No

   Double outlet right ventricle: Yes/No

   Complex cyanotic heart disease: Yes/No
   (2 D echo and/or cath study)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

11) Thromboembolectomy (pre-auth not required, usually done as emergency)

1. Name of the Procedure: Thromboembolectomy (pre-auth not required, usually done as emergency)
2. Select the Indication:

   Pain: Yes/No

   Burning: Yes/No

   Dark discoloration: Yes/No

   Gangrene: Yes/No

   Non healing artery ulcer: Yes/No

3. Peripheral artery thromboembolism mention the affected artery/arteries.
   (Upload Doppler report and/or CT angiography)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

12) Thoracocentesis

1. Name of the Procedure: Thoracocentesis
   a. DOE: Yes/No
   b. Palpitation: Yes/No
   c. Chest pain: Yes/No

2. Select the Indication: Pleural effusion: Yes/No
   a. Benign: Yes/No
   b. Malignant: Yes/No
   c. Traumatic (Haemothorax): Yes/No
   d. Infective: Yes/No
   e. Idiopathic: Yes/No
   (Upload X Ray Chest or CT Chest)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

13) Thrombendarterectomy

1. Name of the Procedure: Thrombendarterectomy
2. Select the Indication:
    a. Claudication:Yes/No
    b. Distal gangrene:Yes/No
    c. Chronic limb ischaemia:Yes/No
    d. Acute on chronic limb ischaemia:Yes/No
    (Upload color Doppler or angiography)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

14) Encysted Empyema/Pleural Effusion - Tubercular

1. Name of the Procedure: Encysted Empyema/Pleural Effusion - Tubercular
2. Select the Indication:
    a. Breathlessness:Yes/No
    b. Cough:Yes/No
    c. Chest pain:Yes/No
    d. Active tuberculosis and/or past history:Yes/No
    e. Pleural effusion Yes/No
    f. Empyma:Yes/No
3. Surgery –

    (Upload HRCT Chest)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

15) Pericardiocentesis

1. Name of the Procedure: Pericardiocentesis
2. Select the Indication: Symtomatic pericardial effusion
    a. DOE – Present: Yes/No
    b. Haemodynamaically unstable: Yes/No
    c. iatrogenic pericardial effusion: Yes/No
    d. Pericardial tamponade: Yes/No
    e. Traumatic pericardial effusion: Yes/No
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

16) Annulus Aortic Ectasia With Valved Conduits

1. Name of the Procedure: Annulus Aortic Ectasia With Valved Conduits
2. Select the Indication:
    a. Dyspnoea / fatigue: Yes/No
    b. Chest pain Yes/No
    c. Ascending aorta more than or equal to 5 cm: Yes/No
    d. Marfan syndrome with dilated aorta with AR: Yes/No
    e. Severe AR – in infective etiology: Yes/No
    f. Traumatic rupture: Yes/No
    g. Degenerative aortic disease with AR with bicuspid aortic valve: Yes/No
    (Upload 2D echo, angiogram)

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) A V Fistula At Wrist

1. Name of the Procedure: A V Fistula At Wrist
2. Select the Indication:
    a. Patient of CRF requiring: Yes/No
    b. Frequent dialysis: Yes/No
    (Upload doppler study)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

18) Surgery Without Graft For Arterial Injuries, Venous Injuries

1. Name of the Procedure: Surgery Without Graft For Arterial Injuries, Venous Injuries

    a. Traumatic rupture of arteries/veins: Yes/No

    b. Iatrogenic rupture of arteries/veins: Yes/No
    (Upload doppler studies/CT angiography)

3. Intra – operative photographs of ruptured vessel in case of iatrogenic injury: Yes/No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

19) Thoracic Vascular Injuries - Payable maximum upto 1.5 lacs.

1. Name of the Procedure: Thoracic Vascular Injuries
2. Select the Indication:
    a. Major/minor vessel injury into the thorax: Yes/No
    b. Major haemodinamically instability/shock in case of thoracic vascular injury: Yes/No
    c. Iatrogenic injury: Yes/No

    Payable max upto 1.5 lacs in cases of major conduits/graft required.

    (Upload doppler and/or CT angiography and/or 2 D echo)

and in case of iatrogenic trauma and/or emergency exploration of traumatic injury intra – op photographs.

Stickers of conduits/grafts.

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

20) Surgery With Vein Graft

1. Name of the Procedure: Surgery With Vein Graft
2. Select the Indication:
    a. Severe blood loss: Yes/No
    b. Shock: Yes/No
    c. Traumatic vein injury: Yes/No
    d. Iatrogenic vein injury: Yes/No
    e. Segmental vein loss: Yes/No
    (Upload doppler report and/or photograph of injured vein)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

21) Minor Vascular Injury Repair - Vessels In Foot – Payable maximum upto 80,000

1. Name of the Procedure: Minor Vascular Injury Repair - Vessels In Foot
2. Select the Indication:
    a. Blood loss: Yes/No
    b. Shock: Yes/No
    c. Vascular trauma: Yes/No
    d. Iatrogenic injury: Yes/No
    e. Blunt trauma to vessel and bleeding: Yes/No
    f. Trauma causing thrombosis of artery: Yes/No
    (Upload doppler report/CT angiography and/or photograph of iatrogenic)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

22) Arterial Embolectomy

1. Name of the Procedure: Arterial Embolectomy
2. Select the Indication:
    a. Limb pain/claudication/burnigng: Yes/No
    b. Distal gangrene: Yes/No
    c. Dark discoloration: Yes/No
    d. Acute limb ischaemia: Yes/No
    e. Acute on chronic limb ischaemia: Yes/No
    f. Arterial thrombo embolism due to cardiac pathology: Yes/No
    g. Arterial thrombo embolism due to thorax: Yes/No
    (Upload doppler report and/or CT angiography)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

23) A V Fistula At Elbow

1. Name of the Procedure: A V Fistula At Elbow
2. Select the Indication:
    a. Patient of CRF on chronic dialysis with: Yes/No
    b. Thrombosed or low caliber veins or arteries of wrist or failed fistula at wrist: Yes/No (Upload doppler study)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

24) Surgery-PDA

1. Name of the Procedure: Surgery-PDA

2. Select the Indication:
   a. Recurrent respiratory tract infection: Yes/No
   b. Murmur present: Yes/No
   c. PDA with shunting of blood: Yes/No
   (Upload 2D echo report and/or cath study)

3. Tretment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

25) Systemic Pulmonary Shunts With Graft

1. Name of the Procedure: Systemic Pulmonary Shunts With Graft

2. Select the Indication:
   a. Cyanosis: Yes/No

   b. Murmur: Yes/No

   c. Cyanotic congenital heart disease:Yes/No

   d. Severe pulmonary artery stenosis: Yes/No

   e. Pulmonary artery atresia: Yes/No
      (Upload 2D echo report and/or cath studies)
      (Upload sticker of graft)

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

26) Systemic Pulmonary Shunts Without Graft

1. Name of the Procedure: Systemic Pulmonary Shunts Without Graft
2. Select the Indication:
   a. Cyanosis: Yes/No
   b. Murmur: Yes/No
   c. Cyanotic congenital heart disease:Yes/No
   d. Severe pulmonary artery stenosis: Yes/No
   e. Pulmonary artery atresia: Yes/No

   (Upload 2D echo report and/or cath studies)
   (Upload sticker of graft)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

27) Closed Mitral Valvotomy

1. Name of the Procedure: Closed Mitral Valvotomy

2. Select the Indication:
   a. DOE:Yes/No
   b. Palpitation:Yes/No
   c. Auscultation OS/MDM:Yes/No
   d. Severe mitral stenosis with severe DOE:Yes/No
      (Upload 2D echo report)

3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

28) Minor Vascular Injury Repair- Tibial Vessels In Leg - Payable maximum upto

1. Name of the Procedure: Minor Vascular Injury Repair- Tibial Vessels In Leg
2. Select the Indication:
    a. Blood loss:Yes/No
    b. Shock:Yes/No
    c. Limb ischaemia:Yes/No
    d. Vascular trauma: Yes/No
    e. Iatrogenic injury: Yes/No
    f. Blunt trauma to vessel and bleeding: Yes/No
    g. Trauma causing thrombosis of artery: Yes/No
    (Upload doppler report/CT angiography and/or photograph of iatrogenic)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

29) Peripheral Embolectomy Without Graft

1. Name of the Procedure: Peripheral Embolectomy Without Graft
2. Select the Indication:
    a. Pain: Yes/No
    b. Burning: Yes/No
    c. Dark discoloration: Yes/No
    d. Gangrene: Yes/No
    e. Acute limb ischaemia: Yes/No
    f. Acute on chronic limb ischaemia: Yes/No
    g. Arterial thrombo embolism due to cardiac pathology: Yes/No
    h. Arterial thrombo embolism due to thorax: Yes/No

    (Upload doppler report and/or CT angiography)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

30) Coarctation Of Aorta Repair Without Graft

1. Name of the Procedure: Coarctation Of Aorta Repair Without Graft
2. Select the Indication:
    a. Claudication: Yes/No
    b. Distal ischemic signs: Yes/No

        Mention – Any specific

    c. Focal aorta Coarctation with distal ischemic symptoms: Yes/No
    (Upload 2D echo/CT angiography)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

31) CABG On Pump Without IABP

1. Name of the Procedure: CABG On Pump Without IABP
2. Select the Indication from the drop down of various indications provided under this head:

Chronic Stable Angina
Acute Coronary Syndrome Unstable Angina
Acute Coronary Syndrome
Non-ST Elevation MI

3. Does the patient have Angina class III-IV: Yes/No
4. If answer to 3 is NO, does the patient have a moderately or strongly positive stress test: Yes/No (Attach Stress Test Report)
5. If the answer to either question 3 OR question 4 is yes,
    a. Does the patient have >50% diameter stenosis of the left main coronary artery: Yes/No (Upload Angiogram) AND/OR
    b. Does the patient have significant(>70%) two or three-vessel coronary disease: Yes/No (Upload Angiogram)
6. If the answer to either question 5a OR 5b is Yes then is the patient receiving aspirin and statin AND at least 2 of the following classes of drugs: long acting nitrates, betablockers, calcium channel blockers: Yes/No (Attach Prescription)
7. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

32) Pericardectomy

1. Name of the Procedure: Percardectomy
2. Select the Indication:
    a. Chest pain: Yes/No
    b. DOE: Yes/No
    c. Palpitation: Yes/No
    d. Constrictive pericarditis: Yes/No
    e. Pericarditis due to bacterial/viral infection: Yes/No
    f. Autoimmune disease: Yes/No
    g. Chest radiation: Yes/No
    h. Reaction to certain medications: Yes/No
    i. Complication of previous cardiac surgery: Yes/No
    j. Idiopathic: Yes/No
    (Upload 2D echo and/or HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

33) Coarctation Of Aorta Repair With Graft

1. Name of the Procedure: Coarctation Of Aorta Repair With Graft
2. Select the Indication:
    a. Claudication: Yes/No
    b. Distal ischaemia signs: : Yes/No
    c. Coarctation Of Aorta involving large segmental coarctation or multiple site coarctation: Yes/No (Upload 2D echo/Aortograme)
3. Post op sticker of graft
4. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

34) Coronary Bypass Surgery Off Pump With IABP

1. Name of the Procedure: Coronary Bypass Surgery Off Pump With IABP
2. Select the Indication from the drop down of various indications provided under this head:

Chronic Stable Angina
Acute Coronary Syndrome Unstable Angina
Acute Coronary Syndrome
Non-ST Elevation MI

3. Does the patient have Angina class III-IV: Yes/No
4. If answer to 3 is NO, does the patient have a moderately or strongly positive stress test: Yes/No

   (Attach Stress Test Report)
5. If the answer to either question 3 OR question 4 is yes,

   c. Does the patient have >50% diameter stenosis of the left main coronary artery: Yes/No

   (Upload Angiogram) AND/OR

   d. Does the patient have significant(>70%) two or three-vessel coronary disease: Yes/No

   (Upload Angiogram)
6. If the answer to either question 5a OR 5b is Yes then is the patient receiving aspirin and statin

   AND at least 2 of the following classes of drugs: long acting nitrates, betablockers, calcium

   channel blockers: Yes/No (Attach Prescription)

   Ejection Succession less than 30%
7. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

35) Aorto Billac - Bifemoral Bypass With Synthetic Graft

1. Name of the Procedure: Aorto Billac - Bifemoral Bypass With Synthetic Graft
2. Select the Indication:
    a. Claudicaition: Yes/No
    b. Gangrene: Yes/No
    c. Sings of ischaemia: Yes/No
    d. Atherosclerotic occlusive disease involving abdominal and on iliac arteries: Yes/No
    e. Aortic aneurysm involving the iliac arteries: Yes/No
    f. Severe claudication despite medical management: Yes/No
    g. Critical limb ischaemia/impotence: Yes/No
    h. Trauma: Yes/No
    i. Acute or chronic occlusions: Yes/No
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

36) Ross procedure - Intracardiac repair of complex congenital heart diseases With Special Conduits

1. Name of the Procedure: Ross procedure - Intracardiac repair of complex congenital heart diseases With Special Conduits
2. Select the Indication:
    a. Fatigue: Yes/No
    b. Chest pain: Yes/No
    c. Syncope: Yes/No
    d. Congenital aortic stenosis/bicuspid aortic valve: Yes/No
    e. Complex congenital disease: Yes/No
    f. Manfan syndrome with AR and dilated aorta: Yes/No

    (Upload 2D echo and/or Cath study)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

37) Bronchial Injuries Due To Foreign Body Repair Surgery

1. Name of the Procedure: Bronchial Injuries Due To Foreign Body Repair Surgery
2. Select the Indication:
    a. Cough: Yes/No
    b. Haemoptysis: Yes/No
    c. Oxygen saturation: Yes/No
    d. Traumatic/iatrogenic bronchial injury due to foreign body or due to trauma while its retrieval procedure: Yes/No
    e. X Ray chest or HRCT: Yes/No
    f. Photographs showing injury segment/part: Yes/No
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

38) Vascular Injuries Repair With Prosthetic Graft

1. Name of the Procedure: Vascular Injuries Repair With Prosthetic Graft
2. Select the Indication:
    a. Bleeding: Yes/No
    b. Shock: Yes/No
    c. Sings of ischaemis: Yes/No
    d. Vascular trauma: Yes/No
    e. Iatrogenic injury: Yes/No
    f. Blunt trauma to vessel and bleeding: Yes/No
    g. Trauma causing thrombosis of artery: Yes/No
    (Upload sticker)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

39) Excision Of AV Malformation Small

1. Name of the Procedure: Excision Of AV Malformation Small
2. Select the Indication:
    a. A V malformation asymptomatic: Yes/No
    b. A V malformation with spontaneous bleeding or bleeding due to injury: Yes/No
    c. A V malformation failed to resolve by sclerotherapy: Yes/No
    (Upload USG/CT/MRI)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

40) Vascular Tumours

1. Name of the Procedure: Vascular Tumours
2. Select the Indication:
    a. Pressure symptoms: Yes/No
    b. Benign vascular tumour: Yes/No
    c. Malignant vascular tumour: Yes/No
    (Upload USG and/or MRI)
    (Post op HP)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

41) Surgery Without CPB

1. Name of the Procedure: Surgery Without CPB
2. Select the Indication:
    a. CAD multivessel disease: Yes/No
    b. Pericardial disease: Yes/No
    c. Pericardia temponade: Yes/No
    (Upload 2D echo and CT)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

42) Oesophageal Diverticula /Achlasia Cardia

1. Name of the Procedure: Oesophageal Diverticula /Achlasia Cardia
2. Select the Indication:
    a. Difficulty in swallowing: Yes/No
    b. Chest pain: Yes/No
    c. Burning: Yes/No
    d. Nausea: Yes/No
    e. Vomiting: Yes/No
    f. Oesophageal Diverticula disease causing dysphagia: Yes/No
    g. Achlasia Cardia: Yes/No
    (Upload Endoscopy report/oesphagogram/oesophagial manometry)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

43) Thoracotomy, Thoraco Abdominal Approach

1. Name of the Procedure: Thoracotomy, Thoraco Abdominal Approach
2. Select the Indication:
    a. Thoraco abdominal aortic aneurysm repair: Yes/No
    b. Descending aorta dissection: Yes/No
    c. Oesophagia malignancy: Yes/No
    d. Thoraco abdominal trauma involving major vessels: Yes/No
    (Upload Doppler and/or CT angiogram and/or USG and/or CT Chest and/or MRI)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

44) Tricuspid Valve Replacement

1. Name of the Procedure: Tricuspid Valve Replacement
2. Select the Indication:
    a. Generalised edema: Yes/No
    b. Ascites: Yes/No
    c. Dyspnoea: Yes/No
    d. Fatigue: Yes/No
    e. Severe tricuspid stenosis: Yes/No
    f. Primary or secondary symptomatic TR: Yes/No
    (Upload 2D echo)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

45) Diaphragmatic Hernia

1. Name of the Procedure: Diaphragmatic Hernia
2. Select the Indication:
    a. Severe respiratory distress in diagnosed DH: Yes/No

        (Upload X Ray and/or CT and/or USG)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

46) Diaphragmatic Eventeration

1. Name of the Procedure: Diaphragmatic Eventeration
2. Select the Indication:
    a. Congenital DE: Yes/No
    b. Acquired DE: Yes/No

    (Upload X Ray and/or CT and/or USG)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

47) Vascular Injury In Upper Limbs – Axillary,Branchial,Radial And Ulnar - Repair With Vein Graft - Payable maximum upto

1. Name of the Procedure: Vascular Injury In Upper Limbs – Axillary,Branchial,Radial And Ulnar - Repair With Vein Graft
2. Select the Indication:
    a. Bleeding: Yes/No
    b. Shock: Yes/No
    c. Signs of distal limb ischaemis: Yes/No
    d. Vascular trauma: Yes/No
    e. Iatrogenic injury: Yes/No
    f. Blunt trauma to vessel and bleeding: Yes/No
    g. Trauma causing thrombosis of artery: Yes/No
    (Upload doppler report/CT angiography and/or photograph of iatrogenic)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

48) Carotid Body Tumour Excision

1. Name of the Procedure: Carotid Body Tumour Excision
2. Select the Indication:
    a. Persistent swelling in the neck: Yes/No
    b. Pulsatile in nature: Yes/No
    c. Symptoms like hoarseness of voice: Yes/No
    d. Difficulty in swallowing: Yes/No
    (Upload USG and/or CT and/or MRI and/or DSA)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

49) Femoro-Femoral Bypass With Graft

1. Name of the Procedure: Femoro-Femoral Bypass With Graft
2. Select the Indication:
    a. Chronic obstructive atherosclerotic disease: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Sever claudication not responding to medical line of management: Yes/No
    (Upload Doppler study and/or CT angio)
    (Graft sticker)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

50) Femoro Popliteal Bypass With Graft

1. Name of the Procedure: Femoro Popliteal Bypass With Graft
2. Select the Indication:
    a. Chronic obstructive atherosclerotic disease: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Sever claudication not responding to medical line of management: Yes/No
    (Upload Doppler study and/or CT angio)
    (Graft sticker)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

51) CABG With Aneurysmal Repair

1. Name of the Procedure: CABG With Aneurysmal Repair
2. Select the Indication:
    a. CAD multivessel disease with LV aneurysm: Yes/No
    b. CAD single and double vessel disease not stentable with LV aneurysm: Yes/No (Upload CAG with 2D echo)
3. Treatment –

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL:_____

52) Femoroileal Bypass With Graft

1. Name of the Procedure: Femoroileal Bypass With Graft
2. Select the Indication:
    a. Chronic obstructive atherosclerotic disease: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Sever claudication not responding to medical line of management: Yes/No

    (Upload Doppler study and/or CT angio)
    (Graft sticker)

4. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

53) Valve Repair With Prosthetic Ring

1. Name of the Procedure: Valve Repair With Prosthetic Ring
2. Select the Indication:
    a. DOE: Yes/No
    b. Palpitation Yes/No
    c. Chest pain Yes/No
    d. Severe MR: Yes/No
    e. Severe TR Primary: Yes/No
    f. Severe TR Primary Secondary to other pathology: Yes/No

    (Upload post op X Ray and 2D echo)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

54) CABG Off Pump Without IABP

1. Name of the Procedure: CABG Off Pump Without IABP
2. Select the Indication from the drop down of various indications provided under this head:

Chronic Stable Angina
Acute Coronary Syndrome Unstable Angina
Acute Coronary Syndrome
Non-ST Elevation MI

3. Does the patient have Angina class III-IV: Yes/No
4. If answer to 3 is NO, does the patient have a moderately or strongly positive stress test: Yes/No (Attach Stress Test Report)
5. If the answer to either question 3 OR question 4 is yes,
    a. Does the patient have >50% diameter stenosis of the left main coronary artery: Yes/No (Upload Angiogram) AND/OR
    b. Does the patient have significant(>70%) two or three-vessel coronary disease: Yes/No (Upload Angiogram)
6. If the answer to either question 5a OR 5b is Yes then is the patient receiving aspirin and statin AND at least 2 of the following classes of drugs: long acting nitrates, betablockers, calcium channel blockers: Yes/No (Attach Prescription)
7. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

55) Carotid Artery Bypass With Synthetic Graft

1. Name of the Procedure: Carotid Artery Bypass With Synthetic Graft
2. Select the Indication:
    a. Atherosclerotic carotid artery occlusion: Yes/No
    b. Causing neurological symptoms – stroke /TIA: Yes/No
    c. Carotid A injury - Traumatic: Yes/No
    - Iatrogenic: Yes/No

    (Upload doppler and/or CT angio and/or DSA and/or intra op photographs in case of injury)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

56) D V T - IVC Filter

1. Name of the Procedure: D V T - IVC Filter
2. Select the Indication:
    a. Severe limb edema: Yes/No
    b. Acute DVT: Yes/No
    c. Acute DVT with pulmonary embolism: Yes/No
    d. Recurrent PE: Yes/No
    e. DVT non responsive or contra indication to anti coagulation: Yes/No

    (Upload color doppler)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

57) Axillo Bifemoral Bypass With Synthetic Graft

1. Name of the Procedure: Axillo Bifemoral Bypass With Synthetic Graft
2. Select the Indication:
    a. Claudication: Yes/No
    b. Distal gangrene: Yes/No
    c. Impotence: Yes/No
    d. Atherosclerotic and/or thrombotic occlusion of distal aorta: Yes/No

    (Upload CT angiogram)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

58) Neck Vascular Injury - Carotid Vessels - Payable maximum upto

1. Name of the Procedure: Neck Vascular Injury - Carotid Vessels
2. Select the Indication:
    a. Bleeding from injured neck vessels: Yes/No
    b. Need of transfusion: Yes/No
    c. Giddiness: Yes/No
    d. TIA: Yes/No
    e. Loss of consciousness: Yes/No
    f. Iatrogenic trauma: Yes/No
    g. Need of graft: Yes/No

        (If graft : Yes – upload sticker)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

59) Abdominal Vascular Injuries - Aorta, Iliac Arteries, IVC, Iliac Veins - Payable maximum upto

1. Name of the Procedure: Abdominal Vascular Injuries - Aorta, Iliac Arteries, IVC, Iliac Veins
2. Select the Indication:
    a. Is patient in shock: Yes/No
    b. Blood loss: Yes/No
    c. Abdominal haemotoma: Yes/No
    d. Severe anemia: Yes/No
    e. Distal limb pulsations absent: Yes/No
    f. Intra abdominal vascular injury mention the injured vessel: Yes/No

    (Upload USG and/or CT abdomen and/or CT angiogram)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

60) Gastro Study Followed By Thoracotomy And Repairs For Oesophageal Injury For Corrosive Injuries/FB

1. Name of the Procedure: Gastro Study Followed By Thoracotomy And Repairs For Oesophageal Injury For Corrosive Injuries/FB
2. Select the Indication:
    a. Corrosive substance consumption: Yes/No
    b. Difficulty in swallowing: Yes/No
    c. Severe chest pain/burning: Yes/No
    d. Foreign body in Oesophagus: Yes/No

    (Upload USG and/or GI Scopy and/or Brain study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

61) Medium Size Arterial Aneurysms - Repair

1. Name of the Procedure: Medium Size Arterial Aneurysms - Repair
2. Select the Indication:
    a. Visible pulsatile swelling/limp: Yes/No
    b. Pain: Yes/No
    c. Impending rupture: Yes/No
    d. Intra aneurysamal thrombosis: Yes/No

    (Upload Doppler study/or CT angiography)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

62) Brachioradial Bypass With Synthetic Graft

1. Name of the Procedure: Brachioradial Bypass With Synthetic Graft
2. Select the Indication:
    a. Pain and/or burning in hands/fingers: Yes/No
    b. Bluish/blackish discoloration of fingers: Yes/No
    c. Gangrene of fingers: Yes/No
    d. Absent radial pulsation: Yes/No
    e. Absent ulnar pulsation: Yes/No

    (Upload Doppler study/or CT angiography)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

63) Carotid Embolectomy

1. Name of the Procedure: Carotid Embolectomy
2. Select the Indication:

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

64) Decortication

1. Name of the Procedure: Decortication
2. Select the Indication:
    a. Chronic cough: Yes/No
    b. Acute TB on – H/O Tuberculosis and/or on anti tubercular treatment: Yes/No
    c. Haemoptysis: Yes/No
    d. Intermittent fever: Yes/No
    e. DOE: Yes/No
    f. H/O intercostals drainage: Yes/No
    g. Chest pain: Yes/No
    h. H/O previous thoracotomy/thoracoscopic procedure: Yes/No

    (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

65) Lung Cyst

1. Name of the Procedure: Lung Cyst
2. Select the Indication:
    a. Chronic cough: Yes/No
    b. Haemoptysis: Yes/No
    c. Chest pain: Yes/No
    d. Fever: Yes/No
    e. H/O TB: Yes/No
    f. H/O Hydatid cyst anywhere else: Yes/No

    (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

66) SOL Mediastinum

1. Name of the Procedure: SOL Mediastinum
2. Select the Indication:
    a. Weight loss: Yes/No
    b. Loss of appetite: Yes/No
    c. H/O myesthesis gravis: Yes/No
    d. Chronic cough: Yes/No
    g. Haemoptysis: Yes/No
    h. Engorged neck veins: Yes/No
    i. Chest discomfort/pain: Yes/No

    (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

67) Lobectomy

1. Name of the Procedure: Lobectomy
2. Select the Indication:
    a. Chronic cough: Yes/No
    b. DOE: Yes/No
    c. Haemoptysis: Yes/No
    d. Chest pain/discomfort: Yes/No
    e. Pain H/O Koch's or active Koch's: Yes/No
    f. H/O Trauma – severe lung condition: Yes/No

    (Upload HRCT Chest and/or MRI)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

68) Pneumonectomy

1. Name of the Procedure: Pneumonectomy
2. Select the Indication:
    a. Cough: Yes/No
    b. DOE: Yes/No
    c. Haemoptysis: Yes/No
    d. Pain and/or active Koch's: Yes/No
    e. Traumatic lung injury: Yes/No
    f. Congenital lung disease: Yes/No
    g. Infective lung disease: Yes/No
    h. Multiple abscess/large abscess/heavy destruction: Yes/No

    (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

69) Thorocoplasty

1. Name of the Procedure: Thorocoplasty
2. Select the Indication:
    a. Severe cough: Yes/No
    b. Haemoptysis: Yes/No
    c. H/O previous pneumonectomy/lobectomy or any other surgical procedure mention: Yes/No
    d. Diabetes: Yes/No
    e. H/O Chemo/radiotheraphy: Yes/No
    f. H/O Smocking: Yes/No
    g. Spontaneous pneumothorax: Yes/No
    h. Associated malignancy: Yes/No

        If Yes – mention

        (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

70) Transpleural BPF Closure

1. Name of the Procedure: Transpleural BPF Closure
2. Select the Indication:
    i. Severe cough: Yes/No
    j. Haemoptysis: Yes/No
    k. H/O previous pneumonectomy/lobectomy or any other surgical procedure mention: Yes/No
    l. Diabetes: Yes/No
    m. H/O Chemo/radiotheraphy: Yes/No
    n. H/O Smocking: Yes/No
    o. Spontaneous pneumothorax: Yes/No
    p. Associated malignancy: Yes/No

        If Yes – mention

        (Upload HRCT Chest)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

71) Aorto-Aorto Bypass With Graft

1. Name of the Procedure: Aorto-Aorto Bypass With Graft
2. Select the Indication
    a. Claudication: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Impotence: Yes/No
    d. Absent pulse: Yes/No
    e. Smoking: Yes/No
    f. Chronic/acute on chronic atherosclerotic occlusive disease of aorta: Yes/No
    g. Idiopathic: Yes/No

    (Upload CT angiogram)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

72) Femorodistal Bypass With Vein Graft

1. Name of the Procedure: Femorodistal Bypass With Vein Graft
2. Select the Indication
    a. Claudication: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Absent distal pulse: Yes/No
    d. Smoking: Yes/No
    e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

    (Upload CT angiography and/or Doppler study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

73) Peripheral Angioplasty

1. Name of the Procedure: Peripheral Angioplasty
2. Select the Indication
    a. Claudication: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Absent distal pulse: Yes/No
    d. Smoking: Yes/No
    e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

    (Upload CT angiography and/or Doppler study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

74) Major Vascular Injury -In Lower Limbs-Repair – Payable maximum upto

1. Name of the Procedure: Major Vascular Injury -In Lower Limbs-
2. Select the Indication
    a. Claudication: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Absent distal pulse: Yes/No
    d. Smoking: Yes/No
    e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

    (Upload CT angiography and/or Doppler study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

75) Axillo Brachial Bypass Using With Synthetic Graft

1. Name of the Procedure: Axillo Brachial Bypass Using With Synthetic Graft
2. Select the Indication
    a. Claudication: Yes/No
    b. Distal limb gangrene: Yes/No
    c. Absent distal pulse: Yes/No
    d. Smoking: Yes/No
    e. Acute and/or acute on chronic and/or chronic atherosclerotic occlusive disease: Yes/No

    (Upload CT angiography and/or Doppler study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

76) Intrathoracic Aneurysm-Aneurysm Not Requiring Bypass (With Graft)

1. Name of the Procedure: Intrathoracic Aneurysm-Aneurysm Not Requiring Bypass (With Graft)
2. Select the Indication:
    a. Chest pain/Back pain/Joint Pain: Yes/No
    b. Palpitation: Yes/No
    c. Coughing/wheezing/shortness of breath: Yes/No
    d. Hoarseness of voice: Yes/No
    e. Difficulty in Swallowing: Yes/No
    f. Radiological image showing aneurysmally dilated aorta: Yes/No

    (Upload CT angiogram)
    (Upload Sticker)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

77) Open Pulmonary Valvotomy

1. Name of the Procedure: Open Pulmonary Valvotomy
2. Select the Indication
    a. Cyanosis: Yes/No
    b. Cyanosis on crying: Yes/No
    c. Shortness of breath: Yes/No
    d. Palpitation: Yes/No
    g. Failure to thrive: Yes/No
    h. Isolated pulmonary stenosis: Yes/No

    (Upload 2D echo and/or chath study)
3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL:_____

78) Medium Size Arterial Aneurysms With Synthetic Graft

1. Name of the Procedure: Medium Size Arterial Aneurysms With Synthetic Graft

2. Select the Indication

    a. Pain on affected area: Yes/No

    b. Pressure symptoms: Yes/No
    If yes – mention specific

    c. Pulsatile limp/swelling: Yes/No
    (Upload doppler study and/or CT angiography)

3. Treatment –

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

79) Excision of AV malformation large

1. Name of the Procedure: Excision of AV malformation large
2. Select the indication:
    a. Swelling/limp: Yes/No (If yes – mention site of swelling/limp)
    b. Characteristics:
        - Expansible: Yes/No
        - Compressible: Yes/No
        - Raised temperature: Yes/No
    c. Present symptoms: Yes/No
    If yes – mention
    d. Changes overlying skin: Yes/No

    (Upload CT and/or MRI angiography)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

80) Vertebral Angioplasty

1. Name of the Procedure: Vertebral Angioplasty

3. Select the indication:

    a. Neurological symptoms: Yes/No

        If yes – mention specific –

        (Upload angioplasty and/or OSA)

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

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

81) Surgery with CPB

1. Name of the Procedure: Surgery with CPB
2. Cardiac surgeries:
    a. Valvular heart disease: Yes/No
    b. Congenital heart disease: Yes/No
    c. Coronary arterial disease: Yes/No
    d. Aortic surgeries: Yes/No

        If yes – mention the specific disease

        (Upload 2 D echo and/or CAG and/or CT and/or cardiac MRI and/or Cath study)
3. Non cardiac surgeries:
    a. Major thoracic surgery: Yes/No
    If yes – mention specific surgery
    b. Neurosurgery for aneurysm and/or tumours: Yes/No
    If yes – mention specific surgery
    c. Abdominal surgery:
        - Renal malignancy: Yes/No
        - Liver malignancy: Yes/No
        - Transplantation: Yes/No

    If yes – mention specific surgery
4. Treatment –

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

Treating Doctor Signature with Stamp

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