NAME OF THE HOSPITAL: _____

1). Thrombocytopenia With Bleeding Diathesis: M16Q1.1

1. Name of the Procedure: Thrombocytopenia With Bleeding Diathesis

2. Indication: Thrombocytopenia With Bleeding Diathesis

3. Does the patient presented with Petechiae/purpura/ecchymosis/epistaxis/gingival and conjunctival haemorrhages/gastrointestinal, genitourinary or intracranial bleeding in severe thrombocytopenia or platelet count < 10000/ml: Yes/No

4. If the answer to question 3 is Yes then is there evidence of thrombocytopenia documented through investigations like CBC (platelet count), PT INR, BT, CT: Yes/No (Upload reports)

For Eligibility for Thrombocytopenia With Bleeding Diathesis the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

2). Haemophilia treatment with IV FFP, Factor VIII /Cryoprecipitate: M16Q1.2

1. Name of the Procedure: Haemophilia treatment with IV FFP, Factor VIII /Cryoprecipitate
2. Indication: Haemophilia
3. Does the patient presented with bleeding in the joints/muscles: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done VON WILLE BRANDS / FACTOR VIII ASSAY, PT INR: Yes/No (Upload reports) (VON WILLE BRANDS / FACTOR VIII ASSAY)- Old or New report

For Eligibility for Haemophilia treatment with IV FFP, Factor VIII /Cryoprecipitate the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

3). Other Coagulation Disorders with Von willebrand Factor: treatment with IV FFP, Factor VIII /Cryoprecipitate: M16Q1.3

1. Name of the Procedure: Other Coagulation Disorders with Von willebrand Factor: treatment with IV FFP, Factor VIII /Cryoprecipitate

2. Indication: Other Coagulation Disorders with Von willebrand Factor

3. Does the patient presented with Bleeding symptoms involve mucous membranes commonly epistaxis/oral bleeding/menorrhagia/gastrointestinal bleeding: Yes/No

4. If the answer to question 3 is Yes then is there evidence of coagulation disorder documented through investigations like VON WILLEBRANDS FACTOR & PT INR: Yes/No (Upload reports)

For Eligibility for Other Coagulation Disorders with Von willebrand Factor: treatment with IV FFP, Factor VIII /Cryoprecipitate the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

4). Chelation Therapy For Thalassemia: M16Q1.4

1. Name of the Procedure: Chelation Therapy For Thalassemia

2. Indication: Chelation Therapy For Thalassemia

3. Does the patient with history of multiple regular blood transfusions for thalassemia presented with chronic fatigue/ joint pain/ abdominal pain/ breathelessness/ jaundice/ skin color changes: Yes/No

4. If the answer to question 3 is Yes then whether thalassemia with iron overload confirmed through investigations like Haemogram, Hb Electrophoresis, Serum Ferritin: Yes/No (Upload reports)

For Eligibility for Chelation Therapy For Thalassemia the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

5). Cerebral Malaria (Falciparum) requiring Ventilatory support and treatment with Blood and Platelet Transfusion, IV antibiotics, IV fluids, Mefloquine, IV quinine or IV artesunate, Paracetamol: M16Q1.5

1. Name of the Procedure: Cerebral Malaria (Falciparum) requiring Ventilatory support and treatment with Blood and Platelet Transfusion, IV antibiotics, IV fluids, Mefloquine, IV quinine or IV artesunate, Paracetamol

2. Indication: Cerebral Malaria

3. Does the patient presented with Fever with altered mentation (No neck stiffness): Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of Peripheral blood smear positive for Malarial parasite OR Positive malaria antigen test for P. falciparum: Yes/No (Upload test reports)

5. If the answer to question 4 is Yes is there evidence of

   a. Oxygen saturation less than 90% on pulse oxymetry: Yes/No (Upload report)

   b. CSFAnalysis done: Yes/No (Upload report)-Optional

For Eligibility for Cerebral Malaria (Falciparum) requiring Ventilatory support the answer to question 5a 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: _____

6). Tb Meningitis: M16Q1.6

1. Name of the Procedure: Tb Meningitis

2. Indication: Tb Meningitis

3. Does the patient presented with Fever with altered mentation with Neck stiffness: Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of
   a. Increased proteins, Decreased Sugars, Increased lymphocytes/Polymorphonuclear picture on CSF examination: Yes/No (Upload CSF report)
   OR
   b. CT/MRI suggestive of basal exudates with evidence of Tb elsewhere: Yes/No (Upload CT/MRI report)

For Eligibility for Tb Meningitisthe answer to either question 4a OR 4b must be Yes

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NAME OF THE HOSPITAL: _____

7). Snake Bite Requiring Ventilator Support: M16Q1.7

1. Name of the Procedure: Snake Bite Requiring Ventilator Support

2. Indication: Snake Bite

3. Does the patient presented with Snake bite with respiratory paralysis(cobra bite)/abdominal pain(krait bite): Yes/No

4. If the answer to question 3 is Yes is there evidence of 5 D's(Dyspnea / Dysarthria / Diplopia / Dysphonia / Dysphagia) with 2 P's(Ptosis / Cranial nerve palsies): Yes/No

5. If the answer to question 4 is Yes, then is the patient having evidence of Oxygen saturation less than 90% demonstrated on Pulse Oxymetry OR Respiratory rate <5 or >30: Yes/No (Upload Pulse Oxymetry report)

For Eligibility for Snake Bite Requiring Ventilator Supportthe answer to question 5 must be Yes

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NAME OF THE HOSPITAL: _____

8). Scorpion sting requiring Ventilator Support: M16Q1.8

1. Name of the Procedure: Scorpion sting requiring Ventilator Support

2. Indication: Scorpion sting

3. Does the patient presented with Scorpion sting with hypertension, tachycardia and/or priapism(Male patient): Yes/No

4. If the answer to question 3 is Yes is there evidence of Pulmonary edema on X-ray chest: Yes/No (Upload X-Ray chest report)

5. If the answer to question 4 is Yes, then is the patient having evidence of Oxygen saturation less than 90% demonstrated on Pulse Oxymetry: Yes/No (Upload Pulse Oxymetry report)

For Eligibility for Scorpion sting Requiring Ventilator Supportthe answer to question 5 must be Yes

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NAME OF THE HOSPITAL: _____

9). Metabolic coma requiring Ventilator Support: M16Q1.9

1. Name of the Procedure: Metabolic coma requiring Ventilator Support

2. Indication: Metabolic coma

3. Does the patient presented with Coma with no localization in CNS examination/Dolls eye normal/Plantars either extensor or flexor without any neck stiffness: Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of Metabolic coma demonstrated through investigations like Blood Sugar/LFT/RFT/Serum Electrolytes and ABG : Yes/No (Upload Reports)

5. If the answer to question 4 is Yes is there evidence of Respiratory failure documented by Oxygen saturation less than 90% on Pulse Oxymetry OR ABG showing PaO2<70: Yes/No(Upload Reports)

For Eligibility for Metabolic coma requiring Ventilator Supportthe answer to question 5 must be Yes

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

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