NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

1). Orchidopexy Bilateral: Torsion of testis (one/both) (S9H2.1)-A

1. Name of the Procedure: **Orchidopexy Bilateral**

2. Select the Indication from the drop down of various indications provided under this head:

Torsion of testis (one/both)
Subclinical torsion

3. Does the patient have
   a. Acute onset of Pain/Swelling: Yes/No
      AND/OR
   b. Gangrenous Testis: Yes/No

4. If the answer to either question 3a AND/OR 3b is Yes then is the patient having evidence of infarction/ absent flow on USG of scrotum with Doppler: Yes/No (Upload USG with Doppler film)

5. If the answer to question 4 is Yes then is the patient having evidence of
   a. Epididymo-orchitis: Yes/No

   b. Infective states of testis: Yes/No

   c. Maligancy of testis: Yes/No

For eligibility for Bilateral Orchidopexy, the answer to 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: _____

PATIENT NAME: _____

2). Orchidopexy Bilateral: Subclinical torsion (S9H2.1)-B

1. Name of the Procedure: **Orchidopexy Bilateral**

2. Select the Indication from the drop down of various indications provided under this head:

Torsion of testis (one/both)
Subclinical torsion

3. Does the patient have episodic pain in testis relieved after some time: Yes/No

4. If the answer to question 3 is Yes then is the patient having evidence of infarction/ absent flow on USG of scrotum with Doppler: Yes/No (Upload USG with Doppler film)

5. If the answer to question 4 is Yes OR No then is the patient having evidence of:

   a. Epididymo-orchitis: Yes/No

   b. Infective states of testis: Yes/No

   c. Maligancy of testis: Yes/No

   For eligibility for Bilateral Orchidopexy, the answer to 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: _____

PATIENT NAME: _____

3). Torsion Testis (one/both) (S9H2.2)

1. Name of the Procedure: **Torsion Testis**

2. Indication: Torsion Testis

3. Does the patient have
   a. Acute onset of Pain/Swelling: Yes/No
      AND/OR
   b. Gangrenous Testis: Yes/No

4. If the answer to either question 3a AND/OR 3b is Yes then is the patient having evidence of infarction/ absent flow on USG of scrotum with Doppler: Yes/No (Upload USG with Doppler film)

5. If the answer to question 4 is Yes then is the patient having evidence of:

   a. Epididymo-orchitis: Yes/No

   b. Infective states of testis: Yes/No

   c. Maligancy of testis: Yes/No

   For eligibility for torsion testis, the answer to 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: _____

PATIENT NAME: _____

4). Chordee Correction: As a part of hypospadius surgery first stage (S9H2.3)-A

1. Name of the Procedure: **Chordee Correction**

2. Select the Indication from the drop down of various indications provided under this head:

As a part of hypospadius surgery first stage
Primary curvature of penis – long
Chordee without hypospadius

3. Does the patient have
   a. Hypospadius: Yes/No
      AND/OR
   b. Curvature of penis causing pain/preventing coitus: Yes/No

4. If the answer to question 3a AND/OR 3b is Yes then is the child/adult having evidence of Hypospadius with curvature of penis documented on clinical photograph AND clinical Evaluation for Chordee: Yes/No (Upload Clinical Photograph)

   For eligibility for Cordee Correction, 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: _____

PATIENT NAME: _____

5). Chordee Correction: Primary curvature of penis – long (S9H2.3)-B

1. Name of the Procedure: **Chordee Correction**

2. Select the Indication from the drop down of various indications provided under this head:

As a part of hypospadius surgery first stage
Primary curvature of penis – long
Chordee without hypospadius

3. Does the child/adult without hypospadius has Curvature of penis causing pain/preventing coitus: Yes/No

4. If the answer to question 3 is Yes then is the child/adult without Hypospadius has evidence of curvature of penis documented on clinical photograph AND clinical Evaluation for Chordee: Yes/No (Upload Clinical Photograph)

For eligibility for Cordee Correction, the answer to 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: _____

PATIENT NAME: _____

6). Chordee Correction: Chordee without hypospadius (S9H2.3)-C

1. Name of the Procedure: **Chordee Correction**

2. Select the Indication from the drop down of various indications provided under this head:

As a part of hypospadius surgery first stage
Primary curvature of penis – long/required
Chordee without hypospadius

3. Does the child/adult without hypospadius has Curvature of penis causing pain/preventing coitus: Yes/No

4. If the answer to question 3 is Yes then is the child/adult without Hypospadius has evidence of curvature of penis documented on clinical photograph AND clinical Evaluation for Chordee: Yes/No (Upload Clinical Photograph)

For eligibility for Cordee Correction, the answer to 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: _____

PATIENT NAME: _____

7). PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT): Non healing ulcer of penis causing deformity of glans/distal shaft of penis (S9H2.4)-A

1. Name of the Procedure: **PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT)**

2. Select the Indication from the drop down of various indications provided under this head:

Non healing ulcer of penis causing deformity of glans/distal shaft of penis
Verrucous Ca of penis involving glans/distal shaft of penis
Multiple warts
Traumatic wound on distal shaft of penis/glans

3. Does the patient have
   a. Pain/deformity/non healing ulcer with bleeding / discharge from penis: Yes/No AND/OR
   b. Difficulty in coitus because of ulcer/deformity: Yes/No

4. If the answer to question 3a AND/OR 3b is Yes, then is there evidence of Non healing ulcer of penis causing deformity of glans/ distal shaft of penis documented on clinical photograph: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes is there evidence of malignancy confirmed by Wedge Biopsy of penis: Yes/No (Attach Biopsy Report)

For eligibility for partial amputation of penis, the answer to question 5 must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

8). PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT): Verrucous Ca of penis involving glans/distal shaft of penis (S9H2.4)-B

1. Name of the Procedure: **PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT)**

2. Select the Indication from the drop down of various indications provided under this head:

Non healing ulcer of penis causing deformity of glans/distal shaft of penis
Verrucous Ca of penis involving glans/distal shaft of penis
Multiple warts
Traumatic wound on distal shaft of penis/glans

3. Does the patient have
   a. Pain/deformity/non healing ulcer with bleeding/growth/discharge from penis: Yes/No
      AND
   b. Difficulty in coitus because of ulcer/growth: Yes/No

4. If the answer to question 3a AND 3b is Yes, then is there evidence of Non healing ulcer with bleeding/growth/deformity/discharge from penis documented on clinical photograph: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes is there evidence of
   a. Malignancy confirmed by Wedge Biopsy of penis: Yes/No (Attach Biopsy Report)

   b. Cancer penis involving the entire shaft of penis: Yes/No

For eligibility for partial amputation of penis, the answer to question 5a can be Yes/No

AND 5b must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

9). PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT): Multiple warts (S9H2.4)-C

1. Name of the Procedure: **PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT)**

2. Select the Indication from the drop down of various indications provided under this head:

Non healing ulcer of penis causing deformity of glans/distal shaft of penis
Verrucous Ca of penis involving glans/distal shaft of penis
Multiple warts
Traumatic wound on distal shaft of penis/glans

3. Does the patient have
   a. Pain/deformity/ multiple non healing ulcer with bleeding / discharge from penis: Yes/No
      AND
   b. Difficulty in coitus because of ulcer/deformity: Yes/No

4. If the answer to question 3a AND 3b is Yes then is there evidence of Pain/ deformity/ multiple non healing ulcer with bleeding/ discharge from penis documented on clinical photograph: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes is there evidence of malignancy confirmed by Wedge Biopsy of penis: Yes/No (Attach Biopsy Report)

For eligibility for partial amputation of penis, 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: _____

PATIENT NAME: _____

10). PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT): Traumatic wound on distal shaft of penis/glans (S9H2.4)-D

1. Name of the Procedure: **PARTIAL AMPUTATION OF PENIS (NON- MALIGNANT)**

2. Select the Indication from the drop down of various indications provided under this head:

Non healing ulcer of penis causing deformity of glans/distal shaft of penis
Verrucous Ca of penis involving glans/distal shaft of penis
Multiple warts
Traumatic wound on distal shaft of penis/glans

3. Does the patient have active wound on penis with history of trauma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Pain/wound with bleeding from penis documented on clinical photograph: Yes/No (Upload Clinical Photograph)

   For eligibility for partial amputation of penis, the answer to question 4 must be Yes.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

11). Total Amputation Of Penis (Malignant): Penile tumors whose size or location (proximal penile shaft) would not allow excision with an adequate surgical margin & preservation of remnant sufficient for upright voiding (S9H2.5)

1. Name of the Procedure: **Total Amputation of Penis (Malignant)**

2. Indication: Penile tumors whose size or location (proximal penile shaft) would not allow excision with an adequate surgical margin & preservation of remnant sufficient for upright voiding

3. Does the patient have growth involving penile shaft causing pain/deformity/bleeding with no stump available for upright voiding: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then is there evidence of malignancy documented on wedge biopsy from penile growth: Yes/No (Upload Wedge biopsy report)

5. Evidence of Lymph node involvement on USG/CT Scan: Yes/No (Upload USG/CT scan film) – (If clinically LN not palpable)

6. If the answer to question 4 & question 5 is Yes is there evidence of 3 cms or more normal penile stump where in partial amputation can give adequate shaft length: Yes/No

For eligibility for total amputation of penis, the answer to question 6 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: _____

PATIENT NAME: _____

12). OPEN PYELOLITHOTOMY: Removal of stone, > 2cm large in size (S9H3.1)

1. Name of the Procedure: **OPEN PYELOLITHOTOMY**

2. Indication: Removal of pelvic stone, > 2cm large in size

3. Does the patient have
   a. Pain/fever/ hematuria: Yes/No
      OR
   b. Incidental diagnosis of stone on X-ray for backache: Yes/No

4. If the answer to either question 3a OR 3b is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr.Creatinine is normal: Yes/No (Upload IVP film)
      OR
   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)
      (If Serum Creatinine is raised proceed for X-Ray KUB OR Plain CT scan)

5. If the answer to question 4a OR 4b is Yes is there evidence of
   a. Calyceal stone on IVP/CT: Yes/No
      If Yes- no permission should be given for OPEN PLYELOLITHOTOMY surgery

   b. Non- functioning on IVP/CT: Yes/No
      If Yes no permission should be given for surgery, proceed for DTPA/PCN to see for renal function. (if PCN is inserted: monitor output if output >500ml proceed for pyelolithotomy, if output less than 100ml no permission for pyelolithotomy proceed for nephrectomy / DTPA shows more than 22% function: proceed for open pyelotilthotomy & if DTPA shows 0-10% function: proceed for nephrectomy)

   c. Facility for PCNL available: Yes/No

For eligibility for Open Pyelolithotomy, the answer to all questions 5a AND 5b AND 5c must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

13). OPEN NEPHROLITHOTOMY: Removal of larger stones & staghorn calculi (S9H3.2)

1. Name of the Procedure: **OPEN NEPHROLITHOTOMY**

2. Indication: Removal of larger stones & staghorn calculi

3. Does the patient have
   a. Pain/fever/ hematuria/CRF: Yes/No
      OR
   b. Incidental diagnosis of stone: Yes/No

4. If the answer to either question 3a OR 3b is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr.Creatinine is normal: Yes/No (Upload IVP film)
      OR
   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)
      (If serum creatinine is raised then CT Plain/USG KUB to find out the problem in opposite kidney)

   c. EC Scan to document renal function: Yes/No (Optional)

5. If the answer to question (4a OR 4b) AND/OR 4c is Yes is there evidence of

   a. Smaller stone that can be approached by PCNL: Yes/No
   b. If non-functioning on EC scan: Yes/No

   For eligibility for Open Nephrolithotomy, the answer to questions 5a AND/OR 5b must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

14). OPEN CYSTOLITHOTOMY: Removal of large bladder stone (S9H3.3)

1. Name of the Procedure: **OPEN CYSTOLITHOTOMY**

2. Indication: Removal of large bladder stone

3. Does the patient have evidence of
   a. Pain/ hematuria/ difficulty in passing urine/ retention of urine: Yes/No
   OR
   b. Incidental finding of Bladder Stone: Yes/No

4. If the answer to either question 3a OR 3b is Yes then is there evidence of
   a. Stone demonstrated on X-Ray KUB: Yes/No (Upload X-Ray film)

   OR

   b. Stone demonstrated on USG KUB: Yes/No (Upload USG film)

   c. Calibration of urethra normal by 14 F Foley's: Yes/No

5. If the answer to question (4a OR 4b) and 4c is Yes is there evidence of

   a. Small stone that can be approached endoscopically: Yes/No

   b. BPH with small bladder stone where simultaneous TURP is being done: Yes/No

   For eligibility for Open Cystolithotomy, the answer to both questions 5a AND 5b should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

15). LAPROSCOPIC PYELOLITHOTOMY: Patients with unusual anatomy (pelvic kidney) (S9H3.4)-A

1. Name of the Procedure: **LAPROSCOPIC PYELOLITHOTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Patients with unusual anatomy (pelvic kidney)
Stone size > 2cm

3. Does the patient have evidence of Pain/fever/hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr.Creatinine is normal: Yes/No (Upload IVP film)

   OR

   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)

   (If serum creatinine is raised USG KUB/CT Plain to find out problem in opposite kidney)

   For eligibility for Laproscopic pyelolithotomy, the answer to questions 4a OR 4b should be Yes.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

16). LAPROSCOPIC PYELOLITHOTOMY: Stone size > 2cm (S9H3.4)-B

1. Name of the Procedure: **LAPROSCOPIC PYELOLITHOTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Patients with unusual anatomy (pelvic kidney)
Stone size > 2cm

3. Does the patient have evidence of Pain/fever/hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr.Creatinine is normal: Yes/No (Upload IVP film)
   OR
   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)

   c. USG KUB – Optional, if facility for IVP/CT not available

5. If the answer to question 4a OR 4b is Yes is there evidence of small pelvic calculi or calyceal calculi amenable to PCNL: Yes/No

   For eligibility for Laproscopic pyelolithotomy, 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: _____

PATIENT NAME: _____

17). CYSTOLITHOTRIPSY: Stone (vesical calculus) ≤ 4 cm (S9H4.1)-A

1. Name of the Procedure: **CYSTOLITHOTRIPSY**

2. Select the Indication from the drop down of various indications provided under this head:

Stone (vesical calculus) ≤ 4 cm
Multiple small bladder calculi

3. Does the patient have evidence of Pain/ hematuria/ difficulty in passing urine: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on X-Ray KUB: Yes/No (Upload X-Ray film)

   OR

   b. Stone demonstrated on USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Calculus ≥ 4cm: Yes/No

   b. Associated pathology like bladder diverticulum: Yes/No

   c. Complex urethral anatomy/stricture: Yes/No

   d. Coagulopathy: Yes/No

   For eligibility for Cystolithotripsy, the answer to all questions 5a, 5b, 5c & 5d 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: _____

PATIENT NAME: _____

18). CYSTOLITHOTRIPSY: Multiple small bladder calculi (S9H4.1)-B

1. Name of the Procedure: **CYSTOLITHOTRIPSY**

2. Select the Indication from the drop down of various indications provided under this head:

Stone (vesical calculus) ≤ 4 cm
Multiple small bladder calculi

3. Does the patient have history of Pain/ fever/ hematuria/ difficulty in passing urine: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Multiple calculi demonstrated on X-Ray KUB: Yes/No (Upload IVP X-Ray film)

   OR

   b. Multiple calculi demonstrated on USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Calculus ≥ 4cm: Yes/No

   b. Associated pathology like bladder diverticulum: Yes/No

   c. Complex urethral anatomy/stricture: Yes/No

   d. Coagulopathy: Yes/No

   For eligibility for Cystolithotripsy, the answer to all questions 5a, 5b, 5c, 5d 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: _____

PATIENT NAME: _____

19). PCNL: Renal Stone removal more than 2 cm (S9H4.2)-A

1. Name of the Procedure: **PCNL**

2. Select the Indication from the drop down of various indications provided under this head:

Renal Stone removal approximately 2cm or more than 2 cm
Stone removal in special condition like Calyceal diverticulum, Horse shoe kidney, Pelvic kidney (laproscopic assisted), Morbidly obese patient

3. Does the patient have history of Pain/fever/hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr. Creatinine is normal: Yes/No (Upload IVP film)
   OR
   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)

   If serum creatinine is raised USG KUB AND/OR Plain CT to find out status of opposite kidney and put DJ Stent/PCN on both sides, see if serum creatinine comes down, if serum creatinine does not decrease, evaluate for CKD and get informed consent and proceed for surgery.

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Simultaneous PUJ obstruction which needs to be addressed: Yes/No

   b. Infundibular stenosis with calyceal calculi which can be addressed simultaneously by open surgery for stone removal: Yes/No

   c. Small stones amenable for ESWL (relative contraindication): Yes/No

   For eligibility for PCNL, the answer to all questions 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: _____

PATIENT NAME: _____

20). PCNL: Stone removal in special condition like Calyceal diverticulum, Horse shoe kidney, Pelvic kidney (laproscopic assisted), morbidly obese patient (S9H4.2)-B

1. Name of the Procedure: **PCNL**

2. Select the Indication from the drop down of various indications provided under this head:

Renal Stone removal approximately 2cm or more than 2 cm
Stone removal in special condition like Calyceal diverticulum, Horse shoe kidney, Pelvic kidney (laproscopic assisted), Morbidly obese patient

3. Does the patient have history of Pain/ fever/ hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr. Creatinine is normal: Yes/No (Upload IVP film)

   OR

   b. Stone demonstrated on CT Scan Abdomen & Pelvis pre/post contrast provided Sr.Creatinine is normal: Yes/No (Upload CT-Scan film)

   If serum creatinine is raised USG KUB AND/OR Plain CT to find out status of opposite kidney and put DJ Stent/PCN on both sides, see if serum creat comes down, if serum creat does not decrease, evaluate for CKD and get informed consent and proceed for surgery.

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Simultaneous PUJ obstruction which needs to be addressed: Yes/No

   b. Infundibular stenosis with calyceal calculi which can be addressed simultaneously by open surgery for stone removal: Yes/No

   c. Small stones amenable for ESWL (relative contraindication): Yes/No

For eligibility for PCNL, the answer to all questions 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: _____

PATIENT NAME: _____

21). ESWL: RENAL CACULUS UP TO 2 CM (S9H4.3)-A

1. Name of the Procedure: **ESWL**

2. Select the Indication from the drop down of various indications provided under this head:

RENAL CACULUS UP TO 2 CM
UPPER URETERIC CALCULUS

3. Does the patient have history of Pain/ fever/ hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of raised serum Creatinine levels: Yes/No (Upload Sr. Creat Report)

5. If answer to question 4 is No, then is there evidence of Stone <2cm demonstrated on IVP with normal renal anatomy: Yes/No (Upload IVP film)

6. If answer to question 4 is Yes then do USG KUB AND X-Ray KUB and if facility for PCN/DJ Stenting is available then do PCN/DJ stenting of both kidneys.
   a. Serum Creat reduced to normal with PCN/DJ Stenting and stone less than 2 cm: Yes/No

   b. If Serum Creat still raised evaluate for CKD-No ESWL

7. If the answer to questions 5 OR 6a is Yes, then is there evidence of
   a. Pregnancy in female patient: Yes/No
   b. Altered coagulation profile: Yes/No

   For eligibility for ESWL, the answer to questions 7a & 7b must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

22). ESWL: UPPER URETERIC CALCULUS (S9H4.3)-B

1. Name of the Procedure: **ESWL**

2. Select the Indication from the drop down of various indications provided under this head:

RENAL CACULUS UP TO 2 CM
UPPER URETERIC CALCULUS

3. Does the patient have history of Pain/ fever/ hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr. Creatinine is normal: Yes/No (Upload IVP film)

   OR

   b. Stone demonstrated on X-Ray KUB: Yes/No (Upload X-Ray film)

   c. Sr. Creatinine within normal range: Yes/No (Upload Sr. Creatinine Report)

   d. USG KUB – Optional

5. If the answer to questions (4a OR 4b) AND 4C is Yes is there evidence of
   a. Pregnancy in female patient: Yes/No
   b. Altered coagulation profile: Yes/No

   For eligibility for ESWL, the answer to questions 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: _____

PATIENT NAME: _____

23). URSL: Ureteric calculi (size > 6mm & trial of medical expulsion therapy for 2 weeks has failed) (S9H4.4)

1. Name of the Procedure: **URSL**

2. Indication: Ureteric calculi (size > 6mm & trial of medical expulsion therapy for 2 weeks has failed).

3. Does the patient have history of Pain/ Fever/ Hematuria: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on IVP provided Sr. Creatinine is normal: Yes/No (Upload IVP film)
   OR
   b. CT KUB Plain demonstrating ureteric calculus: Yes/No (Upload CT Scan film)
   [If Serum Creat is raised X-Ray KUB]

5. If the answer to questions 4a OR 4b is Yes is there evidence of concomitant upper tract abnormalities eg. Ureteral stricture, PUJ obstruction along with upper ureteric calculi that require surgical repair: Yes/No

For eligibility for URSL, the answer to question 5 must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

24). NEPHROSTOMY: Pyonephrosis (S9H4.5)-A

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/ Fever with chills/ Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creatinine Report)

   OR

   b. Pyonephrosis demonstrated on USG KUB: Yes/No (Upload USG film)

   OR

   c. Pyonephrosis demonstrated on CT KUB: Yes/No (Upload CT film)

5. If the answer either questions 4a OR 4b OR 4c is Yes is there evidence of
   a. Malignancy of kidney: Yes/No
   b. Bleeding disorders: Yes/No

   For eligibility for Nephrostomy, the answer to questions 5a & 5b must be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

25). NEPHROSTOMY: Impacted ureteric calculus/PUJ calculus (S9H4.5)-B

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/ Fever/ Impending Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creat Report)

   b. Ureteric calculus/PUJ calculus demonstrated on X-Ray KUB: Yes/No

   c. Pyonephrosis along with ureteric calculus/PUJ calculus demonstrated on USG KUB: Yes/No (Upload USG film)

   d. Pyonephrosis along with ureteric calculus/PUJ calculus demonstrated on CT KUB: Yes/No (Upload CT film) --Optional

5. If the answer to all questions 4a AND 4b AND 4c is Yes is there evidence of bleeding disorder: Yes/No

   For eligibility for Nephrostomy, 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: _____

PATIENT NAME: _____

26). NEPHROSTOMY: Tight PUJ Obstruction (S9H4.5)-C

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/ Fever/ Impending Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creat Report)

   b. Pyonephrosis demonstrated on USG KUB: Yes/No (Upload USG film)

   c. Pyonephrosis demonstrated on CT KUB: Yes/No (Upload CT film) --Optional

5. If the answer to questions 4a AND 4b is Yes is there evidence of bleeding disorder: Yes/No

   For eligibility for Nephrostomy, 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: _____

PATIENT NAME: _____

27). DJ Stent (One side): Obstructive uropathy: (S9H4.6)-A

1. Name of the Procedure: **DJ Stent (One side)**

2. Select the Indication from the drop down of various indications provided under this head:

Obstructive Uropathy
Urine leak post surgery (PCNL)

3. Does the patient have history of Pain/ Fever/ Impending Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creat Report)

   b. Any ROD demonstrated on X-Ray KUB: Yes/No (Upload X-Ray film)

   c. Obstructive uropathy demonstrated on USG KUB: Yes/No (Upload USG film)

   d. Obstructive Uropathy demonstrated on CT KUB Plain: Yes/No (Upload CT film) – Optional

   For eligibility for DJ Stent, the answers to question 4a AND 4b AND 4c 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: _____

PATIENT NAME: _____

28). DJ Stent (One side): Urine leak post surgery (PCNL): (S9H4.6)-B

1. Name of the Procedure: **DJ Stent (One side)**

2. Select the Indication from the drop down of various indications provided under this head:

Obstructive Uropathy
Urine leak post surgery (PCNL)

3. Does the patient have history of urine leak from operative site/ fever: Yes/No

4. If the answer to question 3 is Yes then are the following investigations done:
   a. Post surgery X-Ray KUB: Yes/No (Upload X-Ray film)

   b. Post surgery USG KUB: Yes/No (Upload USG film)--Optional

   For eligibility for DJ Stent, the answer to question 4a should 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: _____

PATIENT NAME: _____

29). Urethroplasty for Stricture Urethra Double Stage Stage-1: BXO/ dense stricture not permitting 8fr catheter/ scope to enter its lumen: (S9H5.2)-A

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Stage-1**

2. Select the Indication from the drop down of various indications provided under this head:

BXO/ dense stricture not permitting 8fr catheter/ scope to enter its lumen
Presence of multiple fistula with stricture

3. Does the patient have evidence of
   a. Poor urine stream: Yes/No
   AND/OR
   b. History of recurrent infection: Yes/No

4. If the answer to questions 3a AND/OR 3b is Yes then is there evidence of BXO/dense stricture on MCU/RGU: Yes/No (Upload MCU/RGU film)
   (Optional Investigations USG abdomen and pelvis, Urine flow rate)

5. If the answer to question 4 is Yes is there evidence of
   a. Soft short stricture: Yes/No

   b. Stricture in posterior urethra: Yes/No

   c. Female patient: Yes/No

   For eligibility for Urethroplasty for Stricture Urethra Double Stage Stage-1, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

30). Urethroplasty for Stricture Urethra Double Stage Stage-1: Presence of multiple fistula with stricture: (S9H5.2)-B

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Stage-1**

2. Select the Indication from the drop down of various indications provided under this head:

BXO/ dense stricture not permitting 8fr catheter/ scope to enter its lumen
Presence of multiple fistula with stricture

3. Does the patient have evidence of
   a. Poor urine stream: Yes/No
   b. History of recurrent infection: Yes/No
   c. Urine leak: Yes/No

4. If the answer to questions 3a AND 3b AND 3c is Yes then is there evidence of

   a. Multiple fistula with stricture on MCU/RGU: Yes/No

   b. clinical photograph demonstrating fistula: Yes/No (Upload clinical photograph) (Optional Investigations USG abdomen and pelvis)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Soft short stricture: Yes/No

   b. Stricture in posterior urethra: Yes/No

   c. Female patient: Yes/No

   For eligibility for Urethroplasty for Stricture Urethra Double Stage Stage-1, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

31). Urethroplasty for Stricture Urethra Double Stage Stage-2: After 3 months of 1st stage Urethroplasty: (S9H5.3)

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Stage-2**

2. Indication: After 3 months of 1st stage Urethroplasty

3. Does the patient have undergone stage-1 Urethroplasty: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU/RGU: Yes/No (Upload MCU/RGU report)

   b. Calibration of proximal meatus being done: Yes/No
   (Clinical photo optional)

5. If the answer to all questions 4a AND 4b is Yes is there evidence of

   a. Unhealthy urethral plate: Yes/No

   b. Proximal meatal stenosis: Yes/No

   For eligibility for Urethroplasty for Stricture Urethra Double Stage Stage-2, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

32). Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure: Complex Fistula: (S9H5.4)-A

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure**

2. Select the Indication from the drop down of various indications provided under this head:

Complex fistula
Redo-surgery
Associated recto-urethral fistula

3. Does the patient have evidence of
   a. Poor urine stream: Yes/No
   b. Urine leak due to associated fistula: Yes/No

4. If the answer to questions 3a AND 3b is Yes, then is there evidence of
   a. Stricture urethra with complex fistula on MCU/RGU: Yes/No (Upload MCU/RGU report)
   b. Stricture urethra with complex fistula on CT- Pelvis + Cystogram: Yes/No (Upload CT Cystogram film)--Optional

5. If the answer to question 4a is Yes is there evidence of
   a. Simple soft stricture of urethra: Yes/No
   b. Presence of severe infection: Yes/No
   c. Malignancy: Yes/No
   d. Duration less than 6 mths after previous open surgery: Yes/No

   For eligibility for Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure, the answers to all questions 5a, 5b, 5c & 5d should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

33). Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure: Redo-Surgery: (S9H5.4)-B

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure**

2. Select the Indication from the drop down of various indications provided under this head:

Complex fistula
Redo-surgery
Associated recto-urethral fistula

3. Does the patient have evidence of
   a. Poor urine stream: Yes/No
   b. Retention with SPC in situ: Yes/No

4. If the answer to questions 3a AND 3b is Yes, then is there evidence of
   a. stricture on recent MCU/RGU: Yes/No (Upload MCU/RGU film)

   b. Previous discharge summary AND/OR previous MCU+RGU: Yes/No (Upload discharge summary/MCU+RGU film)
   (CT-Pelvis + Cystogram Optional)

5. If the answer to question 4a AND 4b is Yes is there evidence of
   a. Simple soft stricture of urethra: Yes/No
   b. Presence of severe infection: Yes/No
   c. Malignancy: Yes/No
   d. Duration less than 6 mths after previous open surgery: Yes/No

   For eligibility for Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure, the answers to all questions 5a, 5b, 5c & 5d should 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: _____

PATIENT NAME: _____

34). Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure: Associated recto-urethral fistula: (S9H5.4)-C

1. Name of the Procedure: **Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure**

2. Select the Indication from the drop down of various indications provided under this head:

Complex fistula
Redo-surgery
Associated recto-urethral fistula

3. Does the patient have evidence of
   a. Poor urine stream: Yes/No

   b. Urine leak per rectum: Yes/No

   c. Fecaluria/ Pneumaturia: Yes/No

4. If the answer to all questions 3a AND 3b AND 3c is Yes, then is there evidence of

   a. Stricture urethra with recto-urethral fistula demonstrated on MCU/RGU: Yes/No (Upload MCU/RGU film)

   b. Preoperative SPC and colostomy is mandatory: Yes/No (Upload clinical photograph)

   c. Stricture urethra with recto-urethral fistula demonstrated on CT- Pelvis: Yes/No (Upload CT-Pelvis film)- Optional

   d. Colonoscopy-- Optional

5. If the answer to question 4a AND 4B is Yes is there evidence of
   a. Simple soft stricture of urethra: Yes/No

   b. Presence of severe infection: Yes/No

   c. Malignancy: Yes/No

   d. Duration less than 6 mths after previous open surgery: Yes/No

For eligibility for Urethroplasty for Stricture Urethra Double Stage Reconstruction procedure, the answers to all questions 5a, 5b, 5c & 5d should 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: _____

PATIENT NAME: _____

35). Hypospadius Adult Double Stage stage-1: Penile curvature with abnormal (proximal) meatal opening: (S9H5.6)

1. Name of the Procedure: **Hypospadius Adult Double Stage stage-1**

2. Indication: Penile curvature with abnormal(proximal) meatal opening

3. Does the patient have evidence of
   a. Physical deformity: Yes/No
      AND/OR
   b. Painful coitus: Yes/No
      AND/OR
   c. Difficulty in voiding: Yes/No

4. If the answer to all questions 3a AND/OR 3b AND/OR 3c is Yes, then is there evidence of Penile curvature with abnormal(proximal) meatal opening: Yes/No (Upload clinical photograph)

5. If the answer to question 4 is Yes is there evidence of Distal Hypospadias: Yes/No

   For eligibility for Hypospadius adult double stage stage-1 procedure, the answer to question 5 should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

36). Hypospadius Adult Double Stage stage-2: Patient undergoing stage-1 Hypospadius Repair: (S9H5.7)

1. Name of the Procedure: **Hypospadius Adult Double Stage stage-2**

2. Indication: Patient undergoing stage-1 Hypospadius repair

3. Does the patient has undergone stage-1 Hypospadius repair: Yes/No (Upload clinical photograph)

4. If the answer to questions 3 is Yes is there evidence of
   a. Unhealthy urethral plate: Yes/No

   b. Infection: Yes/No

   For eligibility for Hypospadius adult double stage stage-2 procedure, the answers to questions 4a & 4b should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

37). Anatrophic Pyelolithotomy For Staghorn Calculus: Complete Staghorn calculus (S9H10.1)

1. Name of the Procedure: **Anatrophic Pyelolithotomy for Staghorn calculus**

2. Indication: Complete Staghorn calculus

3. Does the patient have evidence of Pain/ Fever/ CRF : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG KUB showing evidence of Staghorn calculus: Yes/No (Upload USG film)

   b. IVP/CT Scan demonstrating Staghorn calculus provided Sr. Creatinine is normal: Yes/No (Upload IVP/CT film)

   c. X-ray KUB demonstrating Staghorn calculus: Yes/No (Upload X-Ray film)

5. If the answer to questions 4a AND 4b AND 4c is Yes is their evidence of
   a. Bleeding disorder: Yes/No

   b. Calyceal calculus: Yes/No

   c. Non functioning kidney: Yes/No

   d. PCNL facility Available: Yes/No

   For eligibility for Anatrophic Pyelolithotomy, the answer to questions 5a, 5b, 5c & 5d should 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: _____

PATIENT NAME: _____

38). Anderson Hynes Pyeloplasty: PUJ obstruction due to congenital or iatrogenic causes (S9H10.2)

1. Name of the Procedure: **Anderson Hynes Pyeloplasty**

2. Indication: PUJ obstruction due to congenital or iatrogenic causes

3. Does the patient have evidence of Pain/Fever/Impending renal failure : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG KUB showing evidence of hydronephrotic changes secondary to PUJ obstruction: Yes/No (Upload USG film)

   b. IVP/CT Scan demonstrating hydronephrotic changes secondary to PUJ obstruction provided Sr. reatinine is normal: Yes/No (Upload IVP film)

   c. DTPA scan showing evidence of functioning kidney and PUJ Obstruction: Yes/No (Upload DTPA Scan film)

5. If the answer to questions 4a AND 4b AND 4c is Yes is their evidence of
   a. Very small intrarenal pelvis: Yes/No

   b. Long segment ureteric narrowing: Yes/No

   For eligibility for Anderson Hynes Pyeloplasty, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

39). NEPHROSTOMY: Pyonephrosis: (S9H7.1)-A

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/ fever with chills/ Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of

a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creatinine Report)

OR

b. Pyonephrosis demonstrated on USG KUB: Yes/No (Upload USG film)

OR

c. Pyonephrosis demonstrated on CT KUB : Yes/No (Upload CT film)

5. If the answer either questions 4a OR 4b OR 4c is Yes is there evidence of
   a) Malignancy of kidney: Yes/No
   b) Bleeding disorders: Yes/No

For eligibility for Nephrostomy, the answer to questions 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: _____

PATIENT NAME: _____

40). NEPHROSTOMY: Impacted ureteric calculus/PUJ calculus: (S9H7.1)-B

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/fever/Impending Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creat Report)

   b. Ureteric calculus/PUJ calculus demonstrated on X-Ray KUB: Yes/No

   c. Pyonephrosis along with ureteric calculus/PUJ calculus demonstrated on USG KUB: Yes/No (Upload USG film)

   d. Pyonephrosis along with ureteric calculus/PUJ calculus demonstrated on CT KUB: Yes/No (Upload CT film) --Optional

5. If the answer to all questions 4a AND 4b AND 4c is Yes is there evidence of bleeding disorder: Yes/No

   For eligibility for Nephrostomy, 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: _____

PATIENT NAME: _____

41). NEPHROSTOMY: Tight PUJ Obstruction: (S9H7.1)-C

1. Name of the Procedure: **NEPHROSTOMY**

2. Select the Indication from the drop down of various indications provided under this head:

Pyonephrosis
Impacted ureteric calculus/PUJ calculus
Tight PUJ obstruction

3. Does the patient have history of Pain/fever/Impending Renal failure: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Raised serum Creatinine suggesting deranged renal function: Yes/No (Upload Sr. Creatinine Report)

   b. Pyonephrosis demonstrated on USG KUB: Yes/No (Upload USG film)

   c. Pyonephrosis demonstrated on CT KUB: Yes/No (Upload CT film) --Optional

5. If the answer to questions 4a AND 4b is Yes is there evidence of bleeding disorder: Yes/No

   For eligibility for Nephrostomy, 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: _____

PATIENT NAME: _____

42). Nephrectomy Pyonephrosis/Xgp: Non-functioning kidney secondary to pyonephrosis/Xgp: (S9H7.2)

1. Name of the Procedure: **Nephrectomy Pyonephrosis/Xgp**

2. Indication: Non-functioning kidney secondary to pyonephrosis/Xgp

3. Does the patient have evidence of Pain/ Fever/ Sepsis/ Renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Non-functioning kidney on IVP/CT (plain + contrast) provided Serum Creatinine is normal: Yes/No (Upload IVP/CT films)
   (CT Plain if Serum Creatinine elevated)

   b. USG KUB documenting Pyonephrosis/Xgp(Stone): Yes/No (Upload USG film)

   c. CBC suggestive of increased WBC counts: Yes/No (Upload CBC report)

   d. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report) - If facility available

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of Functioning kidney: Yes/No

   For eligibility for Nephrectomy procedure, the answers to questions 5 should 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: _____

PATIENT NAME: _____

43). Simple Nephrectomy: Non-functioning kidney (S9H7.3)-A

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have evidence of Pain/ Fever/ Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Non-functioning kidney on IVP/CT (plain with contrast) provided Serum Creatinine is normal: Yes/No (Upload IVP/CT films)
   (CT Plain if Serum Creatinine elevated)

   b. USG-KUB: Yes/No (Upload USG film)

   c. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Renal Malignancy: Yes/No

   c. Unstable patient: Yes/No

For eligibility for Simple Nephrectomy procedure, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

44). Simple Nephrectomy: Donar Nephrectomy for Renal Transplant (S9H7.3)-B

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Subject is an donar for renal transplant: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Normal Serum Creatinine: Yes/No (Upload Sr. Cr Report)

   b. Normal findings on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Normal findings on CT renal angiogram: Yes/No (Upload CT renal angiogram report)

   d. Clearance from hospital authorization committee obtained: Yes/No (Upload hospital authorization committee report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Renal Malignancy: Yes/No

   c. Unstable patient: Yes/No

For eligibility for Simple Nephrectomy procedure, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

45). Simple Nephrectomy: Reno-vascular hypertension (S9H7.3)-C

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient has uncontrolled HTN not relieved on medication: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of

   a. Serum creatinine levels done: Yes/No (Upload Sr. Creat Report)

   b. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. CT renal angiogram showing renal vessel abnormality: Yes/No (Upload CT renal angiogram film)

   d. Renal damage demonstrated on duplex ultrasonography: Yes/No (Upload duplex ultrasonography film)

   (Conventional Contrast Arteriography optional)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

46). Simple Nephrectomy: Renal trauma (Grade IV or V) (S9H7.3)-D

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ life threatening hemorrhage/ hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. CECT with renal angiogram demonstrating grade IV or V renal trauma: Yes/No (Upload CT film)- CT plain if Sr Creatinine is raised

   b. Renal damage demonstrated on duplex ultrasonography: Yes/No (Upload duplex ultrasonography film)

5. If the answer to questions 4a AND 4b is Yes is there evidence of Sepsis: Yes/No

   For eligibility for Simple Nephrectomy procedure, the answers to questions 5 should 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: _____

PATIENT NAME: _____

47). Simple Nephrectomy: Polycystic kidney (S9H7.3)-E

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ hypertension/ CRF and occasional hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Sr. Creat report)

   b. CT KUB (Plain with contrast) demonstrating more than 3 cysts in both kidneys: Yes/No (Upload CT film) - CT plain if Sr Creatinine is raised

   c. More than 3 cysts demonstrated in each kidney on USG: Yes/No (Upload USG film)

   d. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

48). Simple Nephrectomy: Ischemic nephropathy (S9H7.3)-F

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/hypertension/impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Sr. Creat report)

   b. Ischemic renal damage demonstrated on Duplex Utrasonography: Yes/No (Upload ultrasonography report)

   c. CT KUB (Plain with contrast) [if Sr Creatinine is normal] demonstrating renal parenchymal damage/reduced function: Yes/No (Upload CT film)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

   For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

49). Simple Nephrectomy: Reflux Nephropathy (S9H7.3)-G

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ fever/ infection/ renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Reflux Nephropathy demonstrated on MCU: Yes/No (Upload MCU film)

   b. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Serum Creatinine levels: Yes/No (Upload Sr. Creat report)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No
   b. Unstable patient: Yes/No

   For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

50). Simple Nephrectomy: Renal arterio-venous fistula (S9H7.3)-H

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ profuse hematuria/ hypertension not responding to conservative management: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Sr. Creat report)

   b. CECT with renal angiogram demonstrating renal A-V fistula: Yes/No
   (Upload CT film)
   (Optional investigations - MRI & Conventional Contrast arteriography)

5. Profuse hematuria not responding to Angio-embolization: Yes/No

6. If the answer to questions (4a AND 4b) AND 5 is Yes is there evidence of Sepsis: Yes/No

For eligibility for Simple Nephrectomy procedure, the answer to question 6 should 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: _____

PATIENT NAME: _____

51). Simple Nephrectomy: Renal tuberculosis (S9H7.3)-I

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ fever/ dysuria/ hematuria/ impending renal failure/ HTN : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Renal parenchymal destruction/non-functioning kidney demonstrated on IVP provided Sr. Creat is normal: Yes/No (Upload IVP film)

   OR

   b. CT KUB (Plain or Plain with contrast) demonstrating renal parenchymal destruction/ non-functioning kidney: Yes/No (Upload CT film)

   c. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   d. Urine-AFB/TB-PCR done: Yes/No (Upload urine-AFB/TB-CR report)
   (**Patient should have completed 4-6 wks of AKT**)

5. If the answer to questions (4a OR 4b) AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

b. Unstable patient: Yes/No

For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

52). Simple Nephrectomy: Chronic Pyelonephritis (S9H7.3)-J

1. Name of the Procedure: **Simple Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Non-functioning kidney
Donar nephrectomy for renal transplant
Reno-vascular hypertension
Renal trauma(Grade IV or V)
Polycystic kidney
Ischemic nephropathy
Reflux nephropathy
Renal arterio-venous fistula
Renal tuberculosis
Chronic Pyelonephritis

3. Does the patient have pain/ infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No(Upload Serum. Creat Report)

   b. If Non-Functioning kidney demonstrated on IVP/CT or DTPA or EC Scan: Yes/No
   (Upload IVP/CT film OR DTPA or EC Scan report)
   (Optional investigation – MRI)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Sepsis: Yes/No
   b. Unstable patient: Yes/No

   For eligibility for Simple Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

53). Laproscopic Nephrectomy simple: Chronic Hydronephrosis (S9H7.4)-A

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/ fever/ infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Hydronephrosis Grade III with reduced renal function demonstrated on IVP provided Serum Creatinine is normal: Yes/No (Upload IVP film).

   OR

   b. CT KUB (Plain or Plain with contrast) demonstrating Grade III Hydronephrosis with renal parenchymal damage: Yes/No (Upload CT film)

   c. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   d. Renal damage demonstrated on ultrasonography: Yes/No (Upload ultrasonography film)- Optional

5. If the answer to questions (4a OR 4b) AND 4c is Yes is there evidence of

   a. Sepsis: Yes/No

   b. Renal malignancy: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

54). Laproscopic Nephrectomy simple: Chronic pyelonephritis (S9H7.4)-B

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/ infection/ CRF: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Elevated Serum Creatinine levels suggesting renal damage: Yes/No(Upload Serum. Creat Report)

   b. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Renal damage demonstrated on ultrasonography: Yes/No (Upload ultrasonography report)

   d. CT KUB (Plain or Plain with contrast) demonstrating renal damage: Yes/No (Upload CT film)
   (Optional investigation – MRI)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

   For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

55). Laproscopic Nephrectomy simple: Renal Tuberculosis (S9H7.4)-C

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/ fever/ dysuria/ hematuria/ impending renal failure/ HTN : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Renal damage demonstrated on IVP provided Sr. Creat is normal: Yes/No (Upload IVP film)

      OR

   b. CT KUB (Plain or Plain with contrast) demonstrating renal damage: Yes/No (Upload CT film)

   c. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   d. Renal damage demonstrated on ultrasonography: Yes/No (Upload ultrasonography report)

   e. Renal tuberculosis confirmed by Urine-AFB/TB-PCR: Yes/No (Upload urine-AFB/TB-PCR report)- Should have completed 4-6 wks of AKT

5. If the answer to questions (4a OR 4b) AND 4c AND 4d AND 4e is Yes is there evidence of

a. Sepsis: Yes/No

b. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

56). Laproscopic Nephrectomy simple: Reflux Nephropathy (S9H7.4)-D

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/fever/infection/renal failure : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Reflux Nephropathy demonstrated on MCU: Yes/No (Upload MCU film)

   b. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Serum Creatinine levels: Yes/No (Upload Sr. Creat report)

   d. Renal damage demonstrated on ultrasonography: Yes/No (Upload ultrasonography report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

57). Laproscopic Nephrectomy simple: Ischemic Nephropathy (S9H7.4)-E

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/ hypertension/ impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Sr. Creat report)

   b. Ischemic renal damage demonstrated on Ultrasonography: Yes/No (Upload ultrasonography report)

   c. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   d. CT KUB (Plain with contrast) demonstrating ischemic nephropathy: Yes/No (Upload CT film) -- CT plain if Sr Creatinine is raised -- Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

   For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

58). Laproscopic Nephrectomy simple: Polycystic Kidney (S9H7.4)-F

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have pain/ hypertension/ CRF and occasional hematuria : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Sr. Creat report)

   b. CT KUB (Plain with contrast) demonstrating polycystic kidney disease: Yes/No (Upload CT film) - CT plain if Sr Creatinine is raised

   c. Polycystic kidney disease demonstrated on USG: Yes/No (Upload USG film)

   d. Renal damage demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

59). Laproscopic Nephrectomy simple: Reno-vascular hypertension (S9H7.4)-G

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient has uncontrolled HTN not relieved on medication : Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum creatinine levels done: Yes/No (Upload Sr. Creat Report)

   b. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. CT renal angiogram showing renal vessel abnormality: Yes/No (Upload CT renal angiogram film)

   d. Renal damage demonstrated on duplex ultrasonography: Yes/No (Upload duplex ultrasonography film)

   (Conventional Contrast Arteriography optional)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a & 5b should 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: _____

PATIENT NAME: _____

60). Laproscopic Nephrectomy simple: Donar nephrectomy for renal transplant (S9H7.4)-H

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Subject is an donar for renal transplant: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Normal Serum Creatinine: Yes/No (Upload Sr. Cr Report)

   b. Normal findings on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Normal findings on CT renal angiogram: Yes/No (Upload CT renal angiogram report)

   (Conventional Contrast Arteriography optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Renal Malignancy: Yes/No

   c. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

61). Laproscopic Nephrectomy simple: Non-functioning kidney (S9H7.4)-I

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have evidence of Pain/ Fever/ Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of

   a. Non-functioning kidney on IVP/CT (plain with contrast) provided Serum Creatinine is normal: Yes/No (Upload IVP/CT films)
   (CT Plain if Serum Creatinine elevated)

   b. USG-KUB: Yes/No (Upload USG film)

   c. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of

   a. Sepsis: Yes/No

   b. Renal Malignancy: Yes/No

   c. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

62). Laproscopic Nephrectomy simple: Pain (S9H7.4)-J

1. Name of the Procedure: **Laproscopic Nephrectomy Simple**

2. Select the Indication from the drop down of various indications provided under this head:

Chronic Hydronephrosis
Chronic pyelonephritis
Renal tuberculosis
Reflux nephropathy
Ischemic nephropathy
Polycystic kidney
Reno-vascular hypertension
Donar nephrectomy for renal transplant
Non-functioning kidney
Pain

3. Does the patient have evidence of Pain/Fever/Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Non-functioning kidney on IVP/CT (plain with contrast) provided Serum Creatinine is normal: Yes/No (Upload IVP/CT films)
   (CT Plain if Serum Creatinine elevated)

   b. Non-functioning kidney demonstrated on DTPA/EC Scan: Yes/No (Upload DTPA/EC Scan report)

   c. Obtain informed consent that patient is undergoing ablative surgery for pain and non-urological causes of pain(eg. Chronic backache, Neuralgia) has been ruled out: Yes/No (Upload informed consent)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Sepsis: Yes/No

   b. Renal Malignancy: Yes/No

   c. Unstable patient: Yes/No

For eligibility for Laproscopic Nephrectomy procedure, the answers to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

63). Laproscopic Nephrectomy Radical: T2 or Larger Tumours (S9H7.5)

1. Name of the Procedure: **Laproscopic Nephrectomy Radical**

2. Indication: T2 or larger tumours

3. Does the patient have evidence of Pain/ Lump/ Hematuria/ Loss of wt/ Backache: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Evidence of tumour on CT/MRI Scan Abdomen + Pelvis (Upload CT/MRI film)

   b. X-Ray chest not suggestive of metastasis: Yes/No (Upload X-ray film)

   c. LFT levels within Normal limits: Yes/No (Upload LFT Report)

   d. Serum Calcium done: Yes/No (Upload Sr. Calcium report)

   e. Serum Alkaline Phosphatase within normal limits: Yes/No (Upload serum alkaline phosphatase Report)
   (HRCT, Bone Scan Optional)

5. If the answer to all questions 4a AND 4b AND 4c AND 4d AND 4e is Yes is there evidence of
   a. IVC Thrombosis: Yes/No

   b. Metastatic disease: Yes/No

   For eligibility for Laproscopic Nephrectomy Radical procedure, the answers to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

64). Laproscopic Partial Nephrectomy: Irreversible damage to a portion of kidney by trauma (S9H7.6)-A

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/ Hematuria/ Hypotension: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of

a) Irreversible damage to a portion of kidney demonstrated by CECT with renal angiography: Yes/No (Upload CT film)

b) USG KUB documenting renal damage: Yes/No (Upload USG film)

c) Serum Creatinine report: Yes/No (Upload Serum Creat Report)
(MR-Angiography optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of Trauma involving renal pedicle: Yes/No

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to question 5 should 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: _____

PATIENT NAME: _____

65). Laproscopic Partial Nephrectomy: Segmental parenchymal damage caused by reno-vascular hypertension (S9H7.6)-B

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/Hypertension/Impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Segmental parenchymal damage to kidney demonstrated by CECT with renal angiography: Yes/No (Upload CT film)

   b. Duplex Ultrasonography documenting renal damage: Yes/No (Upload Duplex Ultrasound film)

   c. Serum Creatinine report: Yes/No (Upload Sr. Creat report)
   (MR-Angiography optional, Serum Creat should be normal for contrast CT)

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to questions 4a AND 4b AND 4c should 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: _____

PATIENT NAME: _____

66). Laproscopic Partial Nephrectomy: Synchronous bilateral tumors (S9H7.6)-C

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/ Hematuria/ loss of weight: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine report: Yes/No (Upload Sr. Creat report)

   b. Synchronous bilateral tumors of kidney showing contrast enhancement demonstrated on CECT abdomen+pelvis: Yes/No (Upload CT film)

      [Remaining renal parenchyma atleast 25% should be free of tumour]

   c. X-Ray Chest not suggestive of metastasis: Yes/No (Upload X-Ray film)

      (USG KUB, MR-Angiography & Bone Scan optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Tumor involving renal hilum/IVC Thrombosis: Yes/No
   b. Multiple tumors/secondary renal metastasis: Yes/No
   c. Lymph node metastasis: Yes/No

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

67). Laproscopic Partial Nephrectomy: Tumor in solitary kidney (S9H7.6)-D

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/ hematuria/ loss of weight/ bone pain: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine report: Yes/No (Upload Sr. Creat report)

   b. Tumor in solitary kidney showing contrast enhancement demonstrated on CECT abdomen+pelvis: Yes/No (Upload CT film)
   [Remaining renal parenchyma atleast 25% should be free of tumour]

   c. X-Ray Chest not suggestive of metastasis: Yes/No (Upload X-Ray film)
   (USG KUB, MR-Angiography optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Tumor involving renal hilum/IVC Thrombosis: Yes/No
   b. Multiple tumors/secondary metastasis: Yes/No
   c. Lymph node metastasis: Yes/No

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

68). Laproscopic Partial Nephrectomy: Benign Tumor > 4 cms or severe pain (S9H7.6)-E

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/ Hematuria/ lump: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Benign tumor demonstrated by CECT abdomen+pelvis: Yes/No (Upload CT film)

   b. Serum Creatinine report: Yes/No (Upload Sr. Creat report)

   c. X-Ray Chest not suggestive of metastasis: Yes/No (Upload X-Ray film)
   (MR-Angiography optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Tumor involving renal hilum/IVC Thrombosis: Yes/No
   b. Multiple tumors: Yes/No
   c. Lymph node metastasis: Yes/No

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

69). Laproscopic Partial Nephrectomy: T1 Tumor (S9H7.6)-F

1. Name of the Procedure: **Laproscopic Partial Nephrectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Irreversible damage to a portion of kidney by trauma
Segmental parenchymal damage caused by renovascular hypertension
Synchronous bilateral tumors
Tumor in solitary kidney
Benign tumor > 4 cms or severe pain
T1 tumor

3. Does the patient have evidence of Pain/ Hematuria/ loss of wt: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine report: Yes/No (Upload Sr. Creat report)

   b. T1 tumor showing contrast enhancement demonstrated on CECT abdomen+pelvis: Yes/No (Upload CT film)
   [Remaining renal parenchyma atleast 25% should be free of tumour]

   c. X-Ray Chest not suggestive of metastasis: Yes/No (Upload X-Ray film)
   (USG Abdomen and Pelvis, MR-Angiography optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Tumor involving renal hilum/IVC Thrombosis: Yes/No
   b. Multiple tumors: Yes/No
   c. Lymph node metastasis: Yes/No

   For eligibility for Laproscopic Partial Nephrectomy procedure, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

70). Renal Cyst Excision: Symptomatic Renal Cyst (S9H7.8)

1. Name of the Procedure: **Renal Cyst Excision**

2. Indication: Symptomatic Renal Cyst

3. Does the patient have evidence of Pain/Infection/Hemorrhage/Rupture: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Renal Cyst on USG: Yes/No (Upload USG Report)

   b. CT KUB (plain + contrast) documenting Renal Cyst in kidney: Yes/No
   (Upload CT Scan film)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Malignancy: Yes/No
   b. Non-functioning kidney: Yes/No

   For eligibility for Renal Cyst Excision procedure, the answer to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

71). Endoscope Removal Of Stone In Bladder (S9H7.9)-A

1. Name of the Procedure: **Endoscope Removal Of Stone In Bladder**

2. Select the Indication from the drop down of various indications provided under this head:

Stone (vesical calculus) ≤ 4 cm
Multiple small bladder calculi

3. Does the patient have evidence of Pain/ hematuria/ difficulty in passing urine: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a. Stone demonstrated on X-Ray KUB: Yes/No (Upload X-Ray film)

      OR

   b. Stone demonstrated on USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Calculus ≥ 4cm: Yes/No

   b. Associated pathology like bladder diverticulum: Yes/No

   c. Complex urethral anatomy/stricture: Yes/No

   d. Coagulopathy: Yes/No

   For eligibility for Endoscope Removal Of Stone In Bladder, the answer to all questions 5a, 5b, 5c & 5d 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: _____

PATIENT NAME: _____

72). Endoscope Removal Of Stone In Bladder (S9H4.1)-B

1. Name of the Procedure: **Endoscope Removal Of Stone In Bladder**

2. Select the Indication from the drop down of various indications provided under this head:

Stone (vesical calculus) ≤ 4 cm
Multiple small bladder calculi

3. Does the patient have history of Pain/ fever/ hematuria/ difficulty in passing urine: Yes/No

4. If the answer to question 3 is Yes then is there evidence of
   a) Multiple calculi demonstrated on X-Ray KUB: Yes/No (Upload IVP X-Ray film)

   OR

   b) Multiple calculi demonstrated on USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Calculus ≥ 4cm: Yes/No
   b. Associated pathology like bladder diverticulum: Yes/No
   c. Complex urethral anatomy/stricture: Yes/No
   d. Coagulopathy: Yes/No

   For eligibility for Endoscope Removal Of Stone In Bladder, the answer to all questions 5a, 5b, 5c, 5d 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: _____

PATIENT NAME: _____

73). Vesico-Vaginal Fistula Repair: Presence of VVF: (S9H8.1)

1. Name of the Procedure: **Vesico-Vaginal Fistula Repair**

2. Indication: Presence of VVF

3. Does the patient have evidence of Urine leak/ Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. VVF on MCU: Yes/No (Upload MCU film))

   b. Cysto-urethroscopy documenting VVF: Yes/No (Upload Cysto-urethroscopy findings)

   c. USG to demonstrate normal Upper tract: Yes/No (Upload USG film)

   (If upper tract abnormality detected on USG, then IVP to look for ureteric involvement) (CT Scan Optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Untreatable Malignancy: Yes/No

   b. Gross infection: Yes/No

   c. Poor general condition of patient: Yes/No

   For eligibility for Vesico-vaginal fistula repair, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

74). Epispadiasis Correction: Presence of Epispadiasis (S9H8.2)

1. Name of the Procedure: **Epispadiasis Correction**

2. Indication: Presence of Epispadiasis

3. Does the patient have evidence of Deformity/ Difficulty in coitus/ Urine dribble: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Presence of Epispadiasis documented on clinical photo: Yes/No (Upload Clinical Photograph)

   b. X-ray PBH documenting the extent of pubic defect: Yes/No (Upload X-Ray film)

   c. USG for assessment of bladder and upper tracts: Yes/No (Upload USG film)
   (Optional Investigations: CT Scan Abdomen & Pelvis, Bladder Plate Biopsy)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Infection at local site: Yes/No
   b. Poor general condition of patient: Yes/No

For eligibility for epispadius correction, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

75). Closure of Urethral Fistula: Post traumatic/post surgical fistula (S9H8.3)

1. Name of the Procedure: **Closure of Urethral Fistula**

2. Indication: Post traumatic/post surgical fistula

3. Does the patient have evidence of Urine leak/ Infection/ Difficulty in passing urine: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Urethral fistula demonstrated on MCU+RGU: Yes/No (Upload MCU+RGU film)

   b. USG KUB Done: Yes/No (Upload USG film)
   (Biopsy of fistula in specific cases, UFR as an optional investigation)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Infection: Yes/No
   b. Distal Obstruction: Yes/No

   For eligibility for Closure of Urethral fistula, the answer to questions 5a & 5b should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

76). Optical Urethrotomy: Small short stricture less than 1 cm (S9H8.4)

1. Name of the Procedure: **Optical Urethrotomy**

2. Indication: Small short stricture less than 1 cm

3. Does the patient have evidence of poor urine stream/Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of Small short stricture demonstrated on MCU+RGU: Yes/No (Upload MCU+RGU film)

   (Optional investigations: USG Abdomen and pelvis & UFR)

5. If the answer to question 4 is Yes is there evidence of
   a. Long Stricture: Yes/No

   b. Presence of fistula: Yes/No

   c. Complete dense Stricture: Yes/No

   d. Presence of diverticulum, infection: Yes/No

   e. H/O previous VIU more than 2-3 times: Yes/No

For eligibility for Optical Urethrotomy, the answer to questions 5a, 5b, 5c, 5d & 5e should 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: _____

PATIENT NAME: _____

77). Perineal Urethrostomy: Retention with distal urethral stricture (S9H8.5)-A

1. Name of the Procedure: **Perineal Urethrostomy**

2. Select the Indication from the drop down of various indications provided under this head:

Retention with distal urethral stricture (elderly patients)
Ca bladder with distal urethral stricture with AUR
Completely scarred penile & distal bulbar urethra

3. Does the patient have evidence of difficulty in passing urine/ pain/ infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU+RGU demonstrating distal urethral stricture: Yes/No (Upload MCU+RGU film)

   b. USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Perineal Infection: Yes/No

   b. Stricture in posterior urethra: Yes/No

   For eligibility for Perineal Urethrostomy, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

78). Perineal Urethrostomy: Ca bladder with distal urethral stricture with AUR (S9H8.5)-B

1. Name of the Procedure: **Perineal Urethrostomy**

2. Select the Indication from the drop down of various indications provided under this head:

Retention with distal urethral stricture (elderly patients)
Ca bladder with distal urethral stricture with AUR
Completely scarred penile & distal bulbar urethra

3. Does the patient have evidence of painful retention/ hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU+RGU demonstrating distal urethral stricture: Yes/No (Upload MCU+RGU film)

   b. USG abdomen and pelvis showing evidence of bladder growth: Yes/No (Upload USG film)

   c. CECT abdomen+pelvis showing evidence of Bladder growth: Yes/No (Upload CT film)

   d. X-Ray chest done: Yes/No (Upload X-RAY film)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Perineal Infection: Yes/No

   b. Stricture in Posterior urethra: Yes/No

   c. Ca Bladder with metastasis or very moribund patient: Yes/No
   (If yes do not proceed for surgery)

   For eligibility for Perineal Urethrostomy, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

79). Perineal Urethrostomy: Completely scarred penile & distal bulbar urethra (S9H8.5)-C

1. Name of the Procedure: **Perineal Urethrostomy**

2. Select the Indication from the drop down of various indications provided under this head:

Retention with distal urethral stricture (elderly patients)
Ca bladder with distal urethral stricture with AUR
Completely scarred penile & distal bulbar urethra

3. Does the patient have evidence of difficulty in passing urine/ pain/ infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU+RGU demonstrating completely scarred penile & distal bulbar urethra: Yes/No (Upload MCU+RGU film)

   b. USG KUB: Yes/No (Upload USG film)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Perineal Infection: Yes/No

   b. Stricture in posterior urethra: Yes/No

   For eligibility for Perineal Urethrostomy, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

80). Ureteric Reimplantation: Vesico - Ureteric Reflux (S9H8.6)-A

1. Name of the Procedure: **Ureteric Reimplantation**

2. Select the Indication from the drop down of various indications provided under this head:

Vesico-Ureteric Reflux
Lower ureteric stricture

3. Does the patient have evidence of pain/ infection/ impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Vesico-ureteric reflux on MCU: Yes/No (Upload biopsy report)

   b. USG abdomen and pelvis showing dilatation of pelvi-calyceal system: Yes/No (Upload USG film)

   c. DTPA showing presence of renal scarring: Yes/No (Upload DTPA report)-Optional (Optional investigation: UDS)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Unstable and small capacity bladder: Yes/No

   b. Poor general condition of patient: Yes/No

   For eligibility for Ureteric Reimplantation, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

81). Ureteric Reimplantation: Lower ureteric stricture (S9H8.6)-B

1. Name of the Procedure: **Ureteric Reimplantation**

2. Select the Indication from the drop down of various indications provided under this head:

Vesico-Ureteric Reflux
Lower ureteric stricture

3. Does the patient have evidence of pain/ fever/ impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Lower ureteric stricture demonstrated on IVP/CT Scan Plain+contrast provided Sr Creat is normal: Yes/No (Upload IVP/CT film)

   b. USG abdomen and pelvis showing dilatation of pelvi-calyceal system: Yes/No (Upload USG film)

   (Optional investigation: Urine AFB, UDS)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Unstable and small capacity bladder: Yes/No

   b. Poor general condition of patient: Yes/No

   For eligibility for Ureteric Reimplantation, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

82). Ileal Conduit Formation: Small contracted bladder with contraindication to bladder augmentation (S9H8.7)-A

1. Name of the Procedure: **Ileal Conduit Formation**

2. Select the Indication from the drop down of various indications provided under this head:

Small contracted bladder with contraindication to bladder augmentation
Ca bladder high grade undergoing cystectomy

3. Does the patient have evidence of frequency/ pain/ dysuria/ hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of

   a. USG documenting small contracted bladder: Yes/No (Upload USG film)

   b. MCU demonstrating small contracted bladder: Yes/No (Upload MCU film)

   c. Chest X-Ray done: Yes/No (Upload Chest X-Ray film)

   d. CT Scan ABDOMEN+PELVIS -- Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Intestinal pathology such as TB and Cronhs disease: Yes/No
   b. Poor general condition of patient: Yes/No
   c. Distant metastasis: Yes/No

   For eligibility for Ileal Conduit Formation, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

83). Ileal Conduit Formation: Ca bladder high grade undergoing cystectomy (S9H8.7)-B

1. Name of the Procedure: **Ileal Conduit Formation**

2. Select the Indication from the drop down of various indications provided under this head:

Small contracted bladder with contraindication to bladder augmentation
Ca bladder high grade undergoing cystectomy

3. Does the patient have evidence of hematuria/ weight loss/ dysuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Biopsy proven malignancy: Yes/No (Upload Biopsy Report)

   b. CT Scan abdomen + pelvis demonstrating bladder growth: Yes/No (Upload CT Scan film)

   c. LFT & X-Ray not showing evidence of metastasis: Yes/No (Upload LFT & X-Ray chest report)
   (Optional Investigation: Bone Scan)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Intestinal pathology such as TB and Cronhs disease: Yes/No

   b. Poor general condition of patient: Yes/No

   c. Distant metastasis: Yes/No

   For eligibility for Ileal Conduit Formation, the answer to questions 5a, 5b & 5c should 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: _____

PATIENT NAME: _____

84). Ureterocele (S9H8.8)

1. Name of the Procedure: **Ureterocele (Incision)**

2. Indication: Ureterocele

3. Does the patient have evidence of Pain/ UTI/ Stone/ Impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Ureterocele demonstrated on IVP provided Serum Creatinine is normal: Yes/No (Upload IVP film)

   b. Ureterocele demonstrated on USG abdomen and pelvis: Yes/No (Upload USG film)

   (Optional investigations: CT Scan Abdomen)

5. If the answer to questions 4a AND 4b is Yes is there evidence of active UTI: Yes/No

For eligibility for Ureterocele Incision, 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: _____

PATIENT NAME: _____

85). Transurethral Resection of Prostate: Prostate Cancer (Channel TURP) (S9H8.9)-A

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of LUTS/ poor urine stream/ hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Elevated Sr. PSA suggestive of prostate cancer: Yes/No (Upload Serum PSA Report)

   b. USG suggestive of prostate enlargement: Yes/No (Upload USG film)

   c. Prostate Biopsy suggestive of malignancy: Yes/No (Upload Biopsy report)

   d. Serum Creatinine done: Yes/No (Upload Serum Creat Report)
   (Urine flow rate optional)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5 should 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: _____

PATIENT NAME: _____

86). Transurethral Resection of Prostate: Hematuria due to large Prostate (S9H8.9)-B

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of LUTS with hematuria: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   b. USG suggestive of large Prostate: Yes/No (Upload USG film)

   c. Serum Creatinine done: Yes/No (Upload Serum Creat Report)

   d. UFR suggestive of bladder outflow obstruction: Yes/No (Upload UFR report)--Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Very large Prostate: Yes/No
   b. Active Infection/sepsis: Yes/No
   c. Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

87). Transurethral Resection of Prostate: Recurrent UTI due to BPH (S9H8.9)-C

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of LUTS/ FEVER/ PAIN: Yes/No

4. If the answer to question 3 is Yes, then:-
   a. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   b. USG suggestive of BPH: Yes/No (Upload USG film)

   c. Urine C/S done: Yes/No (Upload Urine C/S report)

   d. Serum Creatinine done: Yes/No (Upload Serum Creat Report)

   e. UFR suggestive of bladder outflow obstruction: Yes/No (Upload UFR report)-Optional

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Very large Prostate: Yes/No
   b. septic syndrome: Yes/No
   c. Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

88). Transurethral Resection of Prostate: Damage to upper tract due to BPH (S9H8.9)-D

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of LUTS with impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum Creatinine done: Yes/No (Upload Serum Creat Report)
   (If serum Creat remains raised after 2 wks of catheter i.e nadir serum creat > 2 mg% then proceed for TURP)

   b. USG suggestive of BPH and upper tract damage: Yes/No (Upload USG film)

   c. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   d. UFR suggestive of bladder outflow obstruction: Yes/No (Upload UFR report)-Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Very large Prostate: Yes/No
   b. septic syndrome: Yes/No
   c. Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

89). Transurethral Resection of Prostate: BPH patient not happy on alpha blocker (S9H8.9)-E

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of LUTS: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   b. USG showing evidence of BPH: Yes/No (Upload USG film)

   c. Medical bills showing purchase of alpha-blockers for last 2 months: Yes/No (Upload Medical bills)

   d. Serum Creatinine done: Yes/No (Upload Serum Creat Report)
   (UDS, UFR optional)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Very large Prostate: Yes/No
   b. septic syndrome: Yes/No
   c. Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

90). Transurethral Resection of Prostate: Failed catheter free trial twice (S9H8.9)-F

1. Name of the Procedure: **Transurethral Resection of Prostate**

2. Select the Indication from the drop down of various indications provided under this head:

Prostate cancer(Channel TURP)
Hematuria due to large prostate
Recurrent UTI due to BPH
Damage to upper tract due to BPH
BPH patient not happy on alpha blocker
Failed catheter free trial twice

3. Does the patient have evidence of retention with per urethral catheter: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   b. USG showing evidence of BPH: Yes/No (Upload USG film)

   c. Serum Creatinine done: Yes/No (Upload Serum Creat Report)

   (UDS optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Very large Prostate: Yes/No
   b. Septic syndrome: Yes/No
   c. Poor general condition of patient: Yes/No

   For eligibility for TURP, the answer to questions 5a & 5b & 5c should 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: _____

PATIENT NAME: _____

91). Open Prostatectomy: Patient unfit for TURP due to difficulty in giving position (S9H9.2)- A

1. Name of the Procedure: **Open Prostatectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Patient unfit for TURP due to difficulty in giving position
Large prostate gland (benign) > 100ml

3. Does the patient have evidence of LUTS/ retention: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG KUB showing evidence of BPH with PVR: Yes/No (Upload USG film)

   b. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   c. Serum Creatinine done: Yes/No (Upload Serum Creat Report)

   b. UFR suggestive of bladder outflow obstruction: Yes/No (Upload UFR report)-Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Urinary Bladder malignancy: Yes/No
   b. Bleeding disorder: Yes/No

   For eligibility for Open Prostatectomy, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

92). Open Prostatectomy: Large prostate gland (benign) > 100ml (S9H9.2)-B

1. Name of the Procedure: **Open Prostatectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Patient unfit for TURP due to difficulty in giving position
Large prostate gland (benign) > 100ml

3. Does the patient have evidence of LUTS/ retention: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG KUB showing evidence of Large prostate gland > 100ml with PVR: Yes/No (Upload USG film)

   b. Serum PSA within normal range: Yes/No (Upload Serum PSA Report)

   c. Serum Creatinine done: Yes/No (Upload Serum Creat Report)

   d. UFR suggestive of bladder outflow obstruction: Yes/No (Upload UFR report)-Optional

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Urinary Bladder malignancy: Yes/No
   b. Bleeding disorder: Yes/No

   For eligibility for Open Prostatectomy, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

93). Caecocystoplasty: Clam cystoplasty in Neurogenic bladder (S9H9.3)-A

1. Name of the Procedure: **Caecocystoplasty**

2. Select the Indication from the drop down of various indications provided under this head:

Clam cystoplasty in Neurogenic bladder
Bladder augmentation in small capacity bladder due to TB, Post radiotherapy or any other cause

3. Does the patient have evidence of frequency/ infection/ incomplete evacuation/ impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Bladder assessment in MCU: Yes/No (Upload MCU film)

   b. CT Scan abdomen + pelvis not suggestive of malignancy of caecum and inflammatory bowel disease: Yes/No (Upload CT Scan film)

   c. Cystoscopy done: Yes/No (Upload Cystoscopy photo/video)

   d. Urodynamic pressure flow study being done for evaluation of bladder: Yes/No (Upload Urodynamic pressure flow study report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Inflammatory bowel disease: Yes/No
   b. Malignancy of Caecum: Yes/No

   For eligibility for Caecocystoplasty, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

94). Caecocystoplasty: Bladder augmentation in small capacity bladder due to TB, Post radiotherapy or any other cause (S9H9.3)-B

1. Name of the Procedure: **Caecocystoplasty**

2. Select the Indication from the drop down of various indications provided under this head:

Clam cystoplasty in Neurogenic bladder
Bladder augmentation in small capacity bladder due to TB, Post radiotherapy or any other cause

3. Does the patient have evidence of Frequency/ dysuria/ hematuria/ infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Small capacity bladder in MCU: Yes/No (Upload MCU film)

   b. CT Scan abdomen + pelvis not suggestive of malignancy of caecum and inflammatory bowel disease: Yes/No (Upload CT Scan film)

   c. Cystoscopy: Yes/No (Upload Cystoscopy photo/video)

   d. Urodynamic pressure flow study being done for evaluation of bladder: Yes/No (Upload Urodynamic pressure flow study report)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Inflammatory bowel disease: Yes/No
   b. Malignancy of Caecum: Yes/No

   For eligibility for Caecocystoplasty, the answer to questions 5a & 5b should 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: _____

PATIENT NAME: _____

95). Total Cystectomy: Tuberculosis of bladder (Thimble bladder) (S9H9.4)-A

1. Name of the Procedure: **Total Cystectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Tuberculosis of Bladder (Thimble bladder)
Exostrophy with metaplasia
Carcinoma Bladder

3. Does the patient have evidence of frequency/ urgency/ dysuria/ pain: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU demonstrating reduced bladder capacity less than 100ml: Yes/No (Upload MCU film)

   b. Urine AFB done: Yes/No (Upload Urine AFB report)

   c. CECT abdomen+pelvis and or IVP: Yes/No (Upload CT/IVP film)

   d. X-Ray Chest done: Yes/No (Upload X-Ray film)
   (Patient should have completed 4 -6 weeks of AKT prior to surgery)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of Active tuberculosis: Yes/No

   For eligibility for Total Cystectomy, the answer to questions 5 should be No.

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NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

96). Total Cystectomy: Exostrophy with metaplasia (S9H9.4)-B

1. Name of the Procedure: **Total Cystectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Tuberculosis of Bladder (Thimble bladder)
Exostrophy with metaplasia
Carcinoma Bladder

3. Does the patient have evidence of frequency/ urgency/ dysuria/ pain: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG KUB: Yes/No (Upload USG film)

   b. Bladder plate biopsy done: Yes/No (Upload Biopsy report)

   c. Exostrophy demonstrated on clinical photograph: Yes/No (Upload Clinical Photograph)
   (Optional Investigation: CECT)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of general contraindications for surgery: Yes/No

   For eligibility for Total Cystectomy, the answer to questions 5 should 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: _____

PATIENT NAME: _____

97). Total Cystectomy: Carcinoma Bladder (S9H9.4)-C

1. Name of the Procedure: **Total Cystectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Tuberculosis of Bladder (Thimble bladder)
Exostrophy with metaplasia
Carcinoma Bladder

3. Does the patient have evidence of Hematuria/ passing of tissue bits/ dysuria/ loss of weight: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. TUR Biopsy confirming carcinoma bladder: Yes/No (Upload TUR biopsy report)

   b. CECT abdomen+pelvis showing evidence of bladder growth: Yes/No (Upload X-Ray Chest film)

   c. Urine cytology done: Yes/No (Upload urine cytology report)

   d. X-Ray chest not suggestive of metastasis: Yes/No (Upload X-Ray film)

   e. USG KUB done: Yes/No (Upload USG film)-Optional

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of
   a. Benign Pathology: Yes/No
   b. Small bladder growth: Yes/No
   c. Amenable to TURBT: Yes/No

   For eligibility for Total Cystectomy, the answer to questions 5a AND 5b AND 5c should 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: _____

PATIENT NAME: _____

98). Diverticulectomy: Stone formation within the diverticulum (S9H9.5)-A

1. Name of the Procedure: **Diverticulectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Stone formation within the diverticulum
Diverticulum causing ureteral obstruction
Diverticulum causing ureteral reflux

3. Does the patient have evidence of Pain/ UTI/ LUTS: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG showing evidence of stone formation within the diverticulum: Yes/No (Upload USG film)
   OR
   b. CT abdomen and pelvis showing evidence of stone formation within the diverticulum: Yes/No (Upload CT Scan film)

   c. Cystoscopy confirming the exact location of the diverticulum: Yes/No (Upload Cystoscopy findings)-Optional
   (Other Optional investigation: UDS)

5. If the answer to questions 4a OR 4b is Yes is there evidence of
   a. Malignancy within diverticulum: Yes/No
   b. Primary cause not treated: Yes/No

   For eligibility for Diverticulectomy, the answer to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

99). Diverticulectomy: Diverticulum causing ureteral obstruction (S9H9.5)-B

1. Name of the Procedure: **Diverticulectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Stone formation within the diverticulum
Diverticulum causing ureteral obstruction
Diverticulum causing ureteral reflux

3. Does the patient have evidence of Pain/ Fever/ Obstructive Uropathy: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. IVP showing evidence of Diverticulum causing ureteral obstruction provided Serum Creatinine is normal: Yes/No (Upload IVP film)

   OR

   b. CT abdomen and pelvis showing evidence of diverticulum causing ureteral obstruction: Yes/No (Upload CT Scan film)

   c. Cystoscopy confirming the exact location of the diverticulum: Yes/No (Upload Cystoscopy findings)-Optional
   (Other Optional investigation: UDS, USG KUB)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Malignancy within diverticulum: Yes/No
   b. Primary cause not treated: Yes/No

   For eligibility for Diverticulectomy, the answer to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

100). Diverticulectomy: Diverticulum causing ureteral reflux (S9H9.5)-C

1. Name of the Procedure: **Diverticulectomy**

2. Select the Indication from the drop down of various indications provided under this head:

Stone formation within the diverticulum
Diverticulum causing ureteral obstruction
Diverticulum causing ureteral reflux

3. Does the patient have evidence of Pain/ LUTS/ Impending renal failure: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. MCU showing evidence of Diverticulum causing ureteral reflux: Yes/No (Upload IVP film)

   b. CT abdomen and pelvis/USG KUB showing evidence of diverticulum: Yes/No (Upload CT Scan/USG film)

   c. Cystoscopy confirming the exact location of the diverticulum: Yes/No (Upload Cystoscopy findings)-Optional
   (Other Optional investigation: UDS)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Malignancy within diverticulum: Yes/No

   b. Primary cause not treated: Yes/No

   For eligibility for Diverticulectomy, the answer to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

101). Incontinence Urine (Female): Incontinence (S9H9.6)-A

1. Name of the Procedure: **Surgery for Incontinence Urine (Female)**

2. Select the Indication from the drop down of various indications provided under this head:

Incontinence
Stress leakage of urine

3. Does the patient have evidence of Documented leakage causing social problems: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG abdomen and pelvis with pre and post void capacity of bladder rulling out large post void residue: Yes/No (Upload USG film)

   b. Frequency/ volume chart: Yes/No (Upload Frequency/volume chart report)

   c. No evidence of urethral diverticulum and large cystocele on clinical tests: Yes/No

   d. Boneys test done: Yes/No

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of

   a. Morbident patient who is bed ridden: Yes/No

   b. Terminal stages of malignancy: Yes/No

   For eligibility for Female urinary incontinence surgery, the answer to questions 5a AND 5b should 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: _____

PATIENT NAME: _____

102). Incontinence Urine (Female): Stress leakage of urine (S9H9.6)-B

1. Name of the Procedure: **Surgery for Incontinence Urine (Female)**

2. Select the Indication from the drop down of various indications provided under this head:

Incontinence
Stress leakage of urine

3. Does the patient have evidence of documented leakage causing social problems: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG abdomen and pelvis with pre and post void capacity of bladder rulling out large post void residue: Yes/No (Upload USG film)

   b. Frequency/volume chart done: Yes/No (Upload Frequency/volume chart report)

   c. Clinical test for urethral diverticulum/large cystocele done: Yes/No

   d. Boneys test suggestive of stress incontinence: Yes/No
   (UDS Optional)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is there evidence of Morbident patient who is bed ridden: Yes/No

   For eligibility for Female urinary incontinence surgery, the answer to questions 5 should 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: _____

PATIENT NAME: _____

103). Incontinence Urine (Male): Due to diseases of bladder like neurogenic bladder (S9H9.7)-A

1. Name of the Procedure: **Surgery for Incontinence Urine (Male)**

2. Select the Indication from the drop down of various indications provided under this head:

Due to diseases of bladder like neurogenic bladder
Incontinence following bladder or prostate surgery / urethral surgery
Continuous urinary leakage since birth

3. Does the patient have evidence of Leakage of urine not responding to medical line of treatment for a period of 6 months to 1 year/Social problem caused by leakage: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG abdomen and pelvis done: Yes/No (Upload USG film)

   b. Urodynamics pressure-flow study documenting neurogenic bladder: Yes/No (Upload Urodynamic pressure-flow study report)
   (In children with in-continence video UDS with EMG if facility available)

   c. Cystoscopy done: Yes/No (Upload Cystoscopy findings)
   (Optional investigations: MCU+RGU)

5. If the answer to questions 4a AND 4b AND 4c is Yes is the patient Terminally ill and Morbident : Yes/No

   For eligibility for Male urinary incontinence surgery, the answer to question 5 should 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: _____

PATIENT NAME: _____

104). Incontinence Urine (Male): Incontinence following bladder or prostate surgery/ urethral surgery (S9H9.7)-B

1. Name of the Procedure: **Surgery for Incontinence Urine (Male)**

2. Select the Indication from the drop down of various indications provided under this head:

Due to diseases of bladder like neurogenic bladder
Incontinence following bladder or prostate surgery / urethral surgery
Continuous urinary leakage since birth

3. Does the patient have evidence of Leakage of urine not responding to medical line of treatment for a period of 6 months to 1 year/ Social problem caused by leakage: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. USG abdomen and pelvis done: Yes/No (Upload USG film)

   b. Urodynamics pressure-flow study documenting incontinence: Yes/No (Upload Urodynamic pressure-flow study report)

   c. Cystoscopy done: Yes/No (Upload Cystoscopy findings)

   d. CT scan Abd & pelvis pre/post contrast if TB, Post RT, Post cancer surgery (Optional investigations: MCU+RGU)

5. If the answer to questions 4a AND 4b AND 4c is Yes is the patient Terminally ill and Morbident : Yes/No

   For eligibility for Male urinary incontinence surgery, the answer to question 5 should 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: _____

PATIENT NAME: _____

105). Incontinence Urine (Male): Continuous urinary leakage since birth (S9H9.7)-C

1. Name of the Procedure: **Surgery for Incontinence Urine (Male)**

2. Select the Indication from the drop down of various indications provided under this head:

Due to diseases of bladder like neurogenic bladder
Incontinence following bladder or prostate surgery / urethral surgery
Continuous urinary leakage since birth

3. Does the patient have Social problem caused by leakage: Yes/No

4. If the answer to question 3 is Yes, then:-
   a. USG abdomen and pelvis done: Yes/No (Upload USG film)

   b. IVP done (To demonstrate upper tract): Yes/No (Upload IVP film)

   c. Urodynamics pressure-flow study documenting incontinence: Yes/No (Upload Urodynamic pressure-flow study report)
   (In children with in-continence video UDS with EMG if facility available)

   d. Cystoscopy done: Yes/No (Upload Cystoscopy findings)
   (Optional investigations: MCU/RGU)

5. If the answer to questions 4a AND 4b AND 4c AND 4d is Yes is the patient Terminally ill and Morbident : Yes/No

   For eligibility for Male urinary incontinence surgery, the answer to question 5 should be No.

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

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