NAME OF THE HOSPITAL: _____

1. **Caesarean hysterectomy with bladder repair: Atonic postpartum hemorrhage: S4C1.1**

    1. Name of the Procedure: Caesarean hysterectomy with bladder repair
    2. Select the Indication from the drop down of various indications provided under this head:

Atonic post partum hemorrhage
Traumatic PPH: Rupture uterus/extensive cervical or vaginal lacerations with broad ligament hematoma/ruptured corneal ectopic pregnancy.
Morbidly adherent placenta
Puerperal sepsis
Complete placenta previa

    3. Does the patient have atonic PPH: Yes/No
    4. If the answer to question 3 is yes,
        a. Did the patient receive uterotonic agents like oxytocin, methergin, 15 methyl PGF2α or PGE1 analogues: Yes/No
        b. Other methods like bimanualuterine compression, uterine packing, systemic devascularisation of uterus, B-Linch sutures etc. done: Yes/No
    5. If the answer to question 4a AND 4b is yes, then is the atonic PPH controlled with this measures: Yes/No

For eligibility for Caesarean hysterectomy with bladder repair in a case of Atonic PPH the answer to question 5 must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

2. Caesarean hysterectomy with bladder repair: Traumatic PPH: S4C1.1

1. Name of the Procedure: Caesarean hysterectomy with bladder repair
2. Select the Indication from the drop down of various indications provided under this head:

Atonic post partum hemorrhage
Traumatic PPH: Rupture uterus/extensive cervical or vaginal lacerations with broad ligament hematoma/ruptured corneal ectopic pregnancy
Morbidly adherent placenta
Puerperal sepsis
Complete placenta previa

3. Does the patient have traumatic PPH which is confirmed by examination or USG or culdocentesis: Yes/No (Upload reports)
4. If the answer to question 3 is yes, is the conservation of uterus possible by suturing the uterine rent or cervical or vaginal laceration or evacuating the broad ligament hematoma: Yes/No

For eligibility for Caesarean hysterectomy with bladder repair in a case of Traumatic PPH the answer to question 4 must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

3. Caesarean hysterectomy with bladder repair: Morbidly adherent placenta: S4C1.1

1. Name of the Procedure: Caesarean hysterectomy with bladder repair
2. Select the Indication from the drop down of various indications provided under this head:

Atonic post partum hemorrhage
Traumatic PPH: Rupture uterus/extensive cervical or vaginal lacerations with broad ligament hematoma/ruptured corneal ectopic pregnancy.
Morbidly adherent placenta
Puerperal sepsis
Complete placenta previa

3. Is the morbidly adherent placenta diagnosed in the ante partum period by doing an USG/MRI : Yes/No (Upload Report)
4. If the answer to question 3 is yes, then the patient is to be posted for an elective LSCS at or beyond 37 weeks with preoperative intervention radiology reference taken for uterine artery embolization. Is the bleeding controlled by the above mentioned methods: Yes/No
5. If answer to question 3 is No, and if it is diagnosed intrapartum, post delivery or during LSCS, leave placenta in-situ and give uterotonic agents to control bleeding? Is the bleeding controlled by these methods: Yes/No

For eligibility for Caesarean Hysterectomy with bladder repair the answer to question 4 OR 5 should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

4. Caesarean hysterectomy with bladder repair: Puerperal Sepsis: S4C1.1

1. Name of the Procedure: Caesarean hysterectomy with bladder repair
2. Select the Indication from the drop down of various indications provided under this head:

Atonic post partum hemorrhage
Traumatic PPH: Rupture uterus/extensive cervical or vaginal lacerations with broad ligament hematoma/ruptured corneal ectopic pregnancy.
Morbidly adherent placenta
Puerperal sepsis
Complete placenta previa

3. Is the puerperal sepsis diagnosed by relevant clinical symptoms and signs: Yes/No
4. If the answer to question 3 is yes, then has conservative treatment in form of general care and parenteral broad spectrum antibiotics given and is the patient responding: Yes/No
5. If the answer to question 4 is No is there evidence of multiple abscesses, gangrenous uterus or gas gangrene infection on USG/MRI: Yes/No (Upload USG/MRI report)

For eligibility for Caesarean hysterectomy with bladder repair in a case of Puerperal sepsis the answer to question 5 must be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

5. Caesarean hysterectomy with bladder repair: Complete placenta previa: S4C1.1

1. Name of the Procedure: Caesarean hysterectomy with bladder repair
2. Select the Indication from the drop down of various indications provided under this head:

Atonic post partum hemorrhage
Traumatic PPH: Rupture uterus/extensive cervical or vaginal lacerations with broad ligament hematoma/ruptured corneal ectopic pregnancy.
Morbidly adherent placenta
Puerperal sepsis
Complete placenta previa

3. Is the complete placenta previa diagnosed in the ante partum period by doing a USG pelvis: Yes/No(Upload USG report)
4. If the answer to question 3 is yes, then the patient is to be posted for an elective LSCS at or beyond 37 weeks with preoperative intervention radiology reference taken for uterine artery embolisation. Is the bleeding controlled by the above mentioned methods: Yes/No
5. If answer to question 3 is No, and if it is diagnosed intrapartum with severe bleeding p/v or incidental finding during LSCS, give uterotonic agents or bimanual uterine massage to control bleeding during LSCS. Is the bleeding controlled by these methods: Yes/No

For eligibility for Caesarean Hysterectomy with bladder repair the answer to question 4 OR 5 should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

6. Rupture Uterus: Trauma to the abdomen: S4C1.2

1. Name of the Procedure: Rupture Uterus
2. Indication: Rupture uterus due to abdominal trauma
3. Does the patient have rupture uterus which is confirmed by relevant signs, symptoms and clinical examination: Yes/No
4. If answer to question 3 is Yes, whether findings confirmed by doing USG/ Culdocentesis/ Abdominal tapping: Yes/No (Upload reports)

For eligibility for Rupture Uterus, the answer to question 4 may be Yes/No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

7. Eclampsia with complication requiring Ventilatory support: S4C1.3

1. Name of the Procedure: Eclampsia with complication requiring Ventilatory support
2. Indication: Eclampsia with complication
3. Is there any evidence of other causes of convulsions:
    a. Epilepsy: Yes/No
    b. Encephalitis/ meningitis: Yes/No
    c. Intracranial tumors: Yes/No
    d. Puerperal cerebral thrombosis: Yes/No
    e. Electrolyte imbalance/ hypoglycemia: Yes/No
    f. Drug reactions: Yes/No
4. If answer to questions 3a AND 3b AND 3c AND 3d AND 3e AND 3f is No, whether patient is a known case of Pre-eclampsia with convulsions: Yes/No
5. If the answer to question 4 is yes, then is there evidence of Eclampsia with complications confirmed through investigations like CBC with platelets, PT, APTT, Fibrinogen, FDP, LFT, RFT, Coagulation profile, U albumin, Fundoscopy and ABG: Yes/No (Upload reports)

For eligibility for Eclampsia with complication requiring Ventilatory support the answer to question 5 should be Yes with evidence of Respiratory distress on ABG analysis

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

8. Abruptio Placenta with Coagulation Defect – DIC: S4C1.4

1. Name of the Procedure: Abruptio Placenta with Coagulation Defect - DIC
2. Indication: Abruptio placenta with DIC
3. Does the patient have symptoms of abruption?
    a. Hemodynamically not stable: Yes/No
    b. Intense abdominal pain with severe bleeding p/v: Yes/No
    c. Uterus feels tonically contracted: Yes/No
    d. FHR abnormalities-fetal distress/absent FHR: Yes/No
4. If answer to questions 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes is there evidence of retro- placental clot demonstrated on USG: Yes/No (Upload USG report)
5. If the answer to question 4 is yes, then is there evidence of DIC confirmed through investigations like CBC with platelets, PT, APTT, Fibrinogen, FDP, LFT/ RFT: Yes/No (Upload reports)

For eligibility for Abruptio Placenta with Coagulation defect-DIC the answer to question 5 must be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

9. LAVH: S4C2.1

1. Name of the Procedure: Laparoscopically Assisted Vaginal Hysterectomy (LAVH)

2. Indication:

Dysfunctional Uterine Bleeding
Fibroid uterus
Adenomyosis/Endometriosis
Chronic Cervicitis

3. Does the patient presented with abnormal Uterine bleeding: Yes/No

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

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

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

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

10. LAVH: S4C2.1

1. Name of the Procedure: Laparoscopically Assisted Vaginal Hysterectomy (LAVH)

2. Indication:

Dysfunctional Uterine Bleeding
Fibroid uterus
Adenomyosis/Endometriosis
Chronic Cervicitis

3. Does the patient presented with Lump in pelvis/ abdomen/ vagina or menorrhagia: Yes/No

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

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

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

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

11. LAVH: S4C2.1

1. Name of the Procedure: Laparoscopically Assisted Vaginal Hysterectomy (LAVH)

2. Indication:

Dysfunctional Uterine Bleeding
Fibroid uterus
Adenomyosis/Endometriosis
Chronic Cervicitis

3. Does the patient presented with abnormal Uterine bleeding, Dysmenorrhea: Yes/No

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

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

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

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

12). LAVH: S4C2.1

1. Name of the Procedure: Laparoscopically Assisted Vaginal Hysterectomy (LAVH)

2. Indication:

Dysfunctional Uterine Bleeding
Fibroid uterus
Adenomyosis/Endometriosis
Chronic Cervicitis

3. Does the patient presented with abnormal Uterine bleeding, Dysmenorrhea: Yes/No

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

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

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

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

13. Laproscopic Cystectomy: S4C2.10

1. Name of the Procedure: Laproscopic Cystectomy
2. Indication: Benign ovarian tumors like endometriotic cyst, dermoid cyst, serous cyst adenoma, mucinous cyst adenoma/ Paraovarian cyst
3. Does the patient have symptoms suggestive of Ovarian/ Paraovarian cyst with positive clinical examination findings: Yes/No
4. If answer to questions 3 is Yes is there evidence of the cyst/ tumors demonstrated on USG: Yes/No (Upload USG report)
5. If the answer to question 4 is yes, then whether malignancy has been ruled out in suspicious lesions by doing CT scan pelvis, Tumor markers: Yes/No (Upload reports) - Optional

For eligibility for Laproscopic Cystectomy the answer to question 4 must be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

14. Laproscopic Ectopic Resection: Unruptured Ectopic Pregnancy: S4C2.11

1. Name of the Procedure: Laproscopic Ectopic Resection
2. Select the Indication from the drop down of various indications provided under this head

Unruptured ectopic pregnancy
Ruptured ectopic pregnancy

3. Is there evidence of ectopic pregnancy confirmed by clinical examination and USG: Yes/No (Upload USG Report)
4. If answer to questions 3 is yesthen whether patient is eligible for medical treatment with Injection Methotrexate judged through following parameters:
   a. Adnexal mass ≤ 3.5 cm in size on USG: Yes/ No
   b. Cardiac activity is absent: Yes/ No
   c. B-HCG values < 1500 mIU/ml: Yes/ No (Upload report)

For eligibility for Laproscopic Ectopic Resection in Unruptured ectopic pregnancy the answer to question 4a, 4B AND 4c must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

15. Laproscopic Ectopic Resection: Ruptured Ectopic Pregnancy: S4C2.11

1. Name of the Procedure: Laproscopic Ectopic Resection
2. Select the Indication from the drop down of various indications provided under this head

Unruptured ectopic pregnancy
Ruptured ectopic pregnancy

3. Is there evidence of ruptured ectopic pregnancy confirmed by clinical examination and USG: Yes/No (Upload USG Report)
4. If the answer to questions 3 is yes then whether patient is hemodynamically stable: Yes/No

For eligibility for Laproscopic Ectopic Resection in case of ruptured ectopic pregnancy the answers to question 4 must be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

16. Laparoscopic Ovarian Drilling: S4C2.12

1. Name of the Procedure: Laparoscopic Ovarian Drilling

2. Indication: PCOD

3. Does the patient presented with Irregular menses (oligomenorrhea), pain in abdomen, excessive weight gain: Yes/No

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

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

For Eligibility for Laparoscopic Ovarian Drilling the answer to question 5 must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

17. Laproscopic Myomectomy: S4C2.13

1. Name of the Procedure: Laparoscopic Myomectomy
2. Indication: Uterine Myoma
3. Does the patient presented with symptoms suggestive of Uterine myoma such as pain, Menorrhagia/ Infertility/ Abortions/ Degeneration: Yes/No
4. If the answer to questions 3 is yes then is there evidence of single intramural or subserosal fibroid ≤ 15 cms or three or fewer fibroids of ≤ 5 cms: Yes/No (Upload USG report)
5. If the answer to question 4 is Yes is there evidence of asymptomatic fibroids which are accidently detected and not causing tubal block: Yes/No

For eligibility for Laproscopic Myomectomy the answer to question 5 must be No.

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

18. Laproscopic Recanalization: S4C2.14

1. Name of the Procedure: Laparoscopic Recanalization
2. Indication: Reversal of tubal sterilization for want of child/ Mild tubal block due to various pathology (e.g. endometriosis, past pelvic surgery, Pelvic inflammatory disease)/ Tubal occlusion secondary to ectopic pregnancy treatment/ Salpingitis isthamica nodosa
3. Does the patient desire further pregnancy: Yes/No
4. Does the patient have history of previous tubal ligation done: Yes/No (Upload previous operative notes/ TL certificate/ HSG showing bilateral tubal block)
5. Is the answer to question 4 is No is there evidence of:
    a. Mid tubal block due to various pathology (eg: endometriosis, past pelvic surgery, pelvic inflammatory disease): Yes/No (Upload USG report)
    b. Tubal occlusion secondary to ectopic pregnancy treatment: Yes/No (Upload previous operative notes)
    c. Salphingitis isthamica nodosa: Yes/No (Upload HSG report)
6. If the answer to question 4 is Yes OR question (5a OR 5b OR 5c) is Yes is there evidence of
    a. Genital Tuberculosis: Yes/No
    b. Sclerotic tubes or dense adhesions: Yes/No
    c. Bilateral Fimbriectomy done: Yes/No

For Eligibility for Laproscopic Recanalization procedure the answer to questions 6a, 6b AND 6c should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

19. Laproscopic Sling Operation: S4C2.15

1. Name of the Procedure: Laparoscopic Sling Operation
2. Indication: Pelvic organ prolapse in patients desiring future pregnancy/ previous operation for Prolapsed failed
3. Does the patient desire further pregnancy: Yes/No
4. If the answer to question 3 is Yes is there evidence of:
    a. Pelvic Organ Prolapse: Yes/No (Upload USG and PAP smear report)
    b. Failed Cervicopexy: Yes/No (Upload previous operative notes, USG and PAP smear report)
5. Is the answer to either question 4a OR 4b is Yes is there evidence of:
    a. Pregnancy: Yes/No
    b. Less than 6 weeks post delivery or post abortion: Yes/No
    c. Suspected lower genital tract malignancy: Yes/No
    d. Short sigmoid mesocolon: Yes/No

For Eligibility for Laproscopic Sling Operation the answer to questions 5a, 5b, 5c AND 5d should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

20. Laproscopic Adhesiolysis: S4C2.16

1. Name of the Procedure: Laparoscopic Adhesiolysis
2. Indication: Chronic pelvic pain/ Infertility/ Endometriosis/ Intestinal obstruction/ Pelvic Inflammatory disease
3. Does the patient have symptoms suggestive of Chronic pelvic pain OR endometriosis with adhesions which are unresolved after medical line of management such as NSAID's, Neurolytic agents and hormonal agents (eg: GnRh analogues, OC pills, progesterone, danazol): Yes/No(Upload USG report and attach prescription of previous treatment)
4. Does the patient presented with infertility due to adhesions wherein other causes of infertility have been ruled out: Yes/No (Upload USG/HSG report)
5. Does the patient presented with Pelvic Inflammatory disease with adhesions and medical line of Management i.e antibiotics and NSAIDS being prescribed: Yes/No (Upload USG report and Attach prescription of previous treatment)
6. If the answer to either question 3 OR 4 OR 5 is Yes is there evidence of
    a. Peritonitis: Yes/No
    b. Massive abdominal distension: Yes/No
    c. Severe co-morbid factors affecting heart and lung: Yes/No
    d. Hemodynamic instability: Yes/No

For Eligibility for Laproscopic Adhesiolysis the answers to questions 6a, 6b, 6c AND 6d should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

21. Vaginal Hysterectomy: S4C2.17

1. Name of the Procedure: Vaginal Hysterectomy
2. Indication: Abnormal uterine bleeding/ Uterine leiomyomata/ Pelvic organ prolapse/ Pelvic pain or infection (e.g.endometriosis, adenomyosis, pelvic inflammatory diseases)/ Malignant and premalignant disease
3. Does the patient presented with abnormal uterine bleeding not responding to medical line of Management (e.g. tranexemic acid, mefenemic acid, hormonal treatment – OC pills, progesterone's, etc) AND Dilation and Curettage: Yes/No (Attach prescription AND D & C report)
4. Does the patient presented with uterine leiomyomata documented on USG/ CT: Yes/No (Upload USG/ CT report)
5. Does the patient presented with Pelvic organ prolapse: Yes/No (Upload USG and PAP smear Report)
6. Does the patient presented with Pelvic pain or infection (e.g.Endometriosis, Adenomyosis, Pelvic inflammatory diseases) not responded to medical line of management such as antibiotics, NSAID's, Neurolytic agents, and hormonal management (e.g. GnRh analogues, oc pills, progesterone, danazol) and other causes of pain ruled out: Yes/No (Upload USG, Attach Prescription)
7. Does the patient has evidence of malignant and pre-malignant disease and invasive cancer ruled out by doing examination under anesthesia, cystoscopy, x-ray, CT scan/ MRI been done: Yes/No (Upload reports)
8. If the answer to either question 3 OR 4 OR 5 OR 6 OR 7 is Yes is there evidence of

   a. Ovarian tumour: Yes/No

   b. Possible other intra abdominal disease: Yes/No

For Eligibility for Vaginal Hysterectomy the answers to questions 8a AND 8b should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

22. Vaginal Hysterectomy with pelvic floor repair: S4C2.2

1. Name of the Procedure: Vaginal Hysterectomy with pelvic floor repair
2. Indication: Pelvic organ prolapse/ Prolapse of uterus with or without cystocele, rectocele and enterocele
3. Does the patient presented with prolapse uterus with or without associated bladder and bowel complaints: Yes/No
4. If the answer to question 3 is Yes is there evidence of Pelvic organ prolapse/ Prolapse of uterus with or without cystocele, rectocele and enterocele documented through clinical examination and USG: Yes/No (Upload USG report)
5. If the answer to question 4 is Yes is there evidence of malignancy confirmed through PAP smear and endometrial sampling histopathology: Yes/No (Upload PAP smear and endometrial sampling histopathology report)
6. If the answer to question 5 is No is there evidence of

    a. Pregnancy: Yes/No

    b. Advanced cancers: Yes/No

    c. Ovarian tumours: Yes/No

    d. Possible other intra-abdominal disease: Yes/No

For Eligibility for Vaginal Hysterectomy with pelvic floor repair the answers to questions 6a, 6b, 6c AND 6d should be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

23. Vaginal Hysterectomy with Mesh Repair: S4C2.3

1. Name of the Procedure: Vaginal Hysterectomy with Mesh repair
2. Indication: Utero-vaginal descent with completed family and above 35 years of age
3. Does the patient presented with Utero-vaginal descent with completed family and above 35 years of age with or without Difficulty in passing urine and stools/ genital prolapses/ stress urinary incontinence/ menorrhagia/ DUB/ Pre or invasive Gynac cancers: Yes/No
4. If the answer to question 3 is Yes is there evidence of
    a. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    b. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b is Yes is there evidence of failed previous treatment modalities like abdominal sling surgery and physiotherapy: Yes/No (Upload Previous operative notes)
6. If the answer to question 5 is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Vaginal Hysterectomy with Mesh repair the answer to question 6 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

24. Cystocele, Rectocele & Perineorraphy: S4C2.4

1. Name of the Procedure: Cystocele, Rectocele & Perineorraphy
2. Indication: Cystocoele, Rectocoele, Vaginal Laxity
3. Does the patient presented with Cystocoele, Rectocoele, Vaginal Laxity with or without difficulty in passing urine and stools/ Stress Urinary Incontinence: Yes/No
4. If the answer to question 3 is Yes is there evidence of
    a. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    b. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Cystocele, Rectocele & Perineorraphy the answer to question 5 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

25. Pelvic Floor Reconstruction with Mesh: S4C2.5

1. Name of the Procedure: Pelvic Floor Reconstruction with Mesh
2. Indication: Cystocoele, Rectocoele, Vaginal Laxity
3. Does the patient presented with Cystocoele, Rectocoele, Vaginal Laxity with or without Difficulty in passing urine and stools/ Stress Urinary Incontinence: Yes/No
4. If the answer to question 3 is Yes is there evidence of
    a. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    b. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b is Yes is there evidence of previous failed surgery i.e. Cystocele, Rectocele repair & Perineorraphy for the same indication: Yes/No (Upload previous operative notes)
6. If the answer to question 5 is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Pelvic Floor Reconstruction with Meshthe answer to question 6 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

26. Mc Indo-S Repair For Vaginal Atresia: S4C2.6

1. Name of the Procedure: Mc Indo-S Repair For Vaginal Atresia
2. Indication: Mayer Rokitansky Kustner Hauser Syndrome/ Androgen Insensitivity Syndrome/ Other mullerian anomalies/ Traumatic vaginal atresia
3. Does the patient presented with Vaginal Atresia confirmed on clinical examination: Yes/No
4. If the answer to question 3 is Yes is there evidence of failed non-surgical treatment modality like serial dilatation for the above indication: Yes/No
5. If the answer to question 4 is Yes whether USG has been done: Yes/No (Upload USG report)

For Eligibility for Mc Indo-S Repair For Vaginal Atresiathe answer to question 5 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

27. Slings with Mesh Repair For Prolapse: S4C2.7

1. Name of the Procedure: Slings with Mesh Repair For Prolapse
2. Indication: Utero vaginal descent and desirous of further pregnancy/ Utero vaginal descent and wants to retain her uterus
3. Does the patient presented with complains of Utero vaginal descent and desirous of further Pregnancy or wants to retain her uterus: Yes/No
4. If the answer to question 3 is Yes is there evidence of
    a. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    b. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b is Yes is there evidence of previous failed surgery i.e. Abdominal sling surgery/ failed physiotherapy intervention for the same indication: Yes/No (Upload previous operative notes)
6. If the answer to question 5 is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Slings with Mesh Repair For Prolapse the answer to question 6 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

28. Vault Prolapse Abdominal Repair: S4C2.8

1. Name of the Procedure: Vault Prolapse Abdominal Repair
2. Indication: Vault prolapse with or without Cystocoele, Rectocoele, Vaginal Laxity/ Difficulty in passing urine and stools/ Stress urinary incontinence
3. Does the patient presented with history of previous hysterectomy with complains related to vault prolapse with or without Difficulty in passing urine and stools/ Stress urinary incontinence: Yes/No (Attach previous operative notes)
4. If the answer to question 3 is Yes is there evidence of
    a. Apical defect (apical descent): Yes/No
    b. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    c. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b OR 4c is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Vault Prolapse Abdominal Repair the answer to question 5 should be Yes

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

29. Vault Prolapse Abdominal Repair with Mesh: S4C2.9

1. Name of the Procedure: Vault Prolapse Abdominal Repair with Mesh
2. Indication: Vault prolapse with or without Cystocoele, Rectocoele, Vaginal Laxity/ Difficulty in passing urine and stools/ Stress urinary incontinence
3. Does the patient presented with history of previous hysterectomy with complains related to vault prolapse with or without Difficulty in passing urine and stools/ Stress urinary incontinence: Yes/No (Attach previous operative notes)
4. If the answer to question 3 is Yes is there evidence of
    a. Apical defect (apical descent): Yes/No
    b. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    c. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b OR 4c is Yes is there evidence of previous failed Surgery i.e. Vault prolapse abdominal repair for the same indication: Yes/No (Upload previous Operative notes)
6. If the answer to question 5 is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Vault Prolapse Abdominal Repair with Mesh the answer to question 6 should be Yes

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

Treating Doctor Signature with Stamp

_____