NAME OF THE HOSPITAL: _____

1). Inferior Vena Cava Stenting Single Stent: M15W1.1

1. Name of the Procedure: Inferior Vena Cava Stenting Single Stent

2. Indications: Select indication which is applicable
   Complete IVC Membrane/ Partial IVC Membrane or narrowing

3. Does the patient presented with abdominal distention, jaundice or deranged liver function, lower limb swelling, dilated abdominal wall veins: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), creatinine, USG/ CT scan/ DSA IVC Gram: Yes/No (Upload reports)

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

For Eligibility for Inferior Vena Cava Stenting Single Stent 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). Gastrointestinal Visceral Arterial Embolization In Upper And Lower Gastrointestinal Bleeding With Microcatheter: M15W1.10

1. Name of the Procedure: Gastrointestinal Visceral Arterial Embolization In Upper And Lower Gastrointestinal Bleeding With Microcatheter

2. Indications: Select indication which is applicable
   Hematemesis or Malena causing drop in Hb by 2gms in 24 hrs/Hematemesis or Malena causing tachycardia or hypotension/Intermittent GI bleed causing anemia/Visceral arteries pseudoaneurysm/Visceral arteries AV Fistula

3. Does the patient presented with hematemesis, malena, drop in Hb > 1gm: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Hb, Coagulation profile (PT INR, Platelet Count), creatinine, GI endoscopy : Yes/No (Upload reports)

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

For Eligibility for Gastrointestinal Visceral Arterial Embolization In Upper And Lower Gastrointestinal Bleeding With Microcatheter 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: _____

3). Bronchial Artery Embolization In Hemoptysis Using PVA And Micro Catheter: M15W1.11

1. Name of the Procedure: Bronchial Artery Embolization In Hemoptysis Using PVA And Micro Catheter

2. Indications: Select indication which is applicable
   Hemoptysis > 300 ml in 24 hrs/Requiring blood transfusion/Hemoptysis causing drop in Hb by 2 gms in 24 hrs/Chronic Hemoptysis causing anemia (Hb < 10 gms %)

3. Does the patient presented with hemoptysis, hypotension, tachycardia, cough: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), Creatinine, Xray/CT chest showing pulmonary infiltration,bronchiectasis or cavitatory changes: Yes/No (Upload reports)

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

For Eligibility for Bronchial Artery Embolization In Hemoptysis Using PVA And Micro Catheter 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: _____

4). Radiofrequency Tumor Ablation Therapy: M15W1.12

1. Name of the Procedure: Radiofrequency Tumor Ablation Therapy

2. Indication: Select indication which is applicable

Liver: HCC/ Metastasis
Bone: Osteoid Osteoma/ Painful Lytic bone/ Metastases/ Osteoblastoma/ Chondroblastoma/ Giant Cell Tumor/ Painful Myeloma
Lung: NSCL/ pulmonary metastases
Kidney: Small Renal Cell Carcinoma < 4 cms limited to kidney/ RCC, poor surgical candidate/ RCC in solitary kidney/ Bilateral RCC/ RCC with genetic predisposition to multiple tumor

3. Does the patient presented with symptoms related to liver malingnancy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), Sr creatinine, Sr electrolytes, CT/MRI, PET Scan (optional): Yes/No (Upload reports)

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

    a. Tumor> 5 cms: Yes/No
    b. More than 3 Mets: Yes/No
    c. Severe Coagulopathy: Yes/No
    d. Child Pugh class C: Yes/No
    e. Tumor < 1cm from main bile duct: Yes/No

For Eligibility for Radiofrequency Tumor Ablation Therapy the answer to questions 5a, 5b, 5c, 5d, 5e 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: _____

5). Radiofrequency Tumor Ablation Therapy: M15W1.12

1. Name of the Procedure: Radiofrequency Tumor Ablation Therapy

2. Indication: Select indication which is applicable

Liver: HCC/ Metastasis
Bone: Osteoid Osteoma/ Painful Lytic bone/ Metastases/ Osteoblastoma/ Chondroblastoma/ Giant Cell Tumor/ Painful Myeloma
Lung: NSCL/ pulmonary metastases
Kidney: Small Renal Cell Carcinoma < 4 cms limited to kidney/ RCC, poor surgical candidate/ RCC in solitary kidney/ Bilateral RCC/ RCC with genetic predisposition to multiple tumor

3. Does the patient presented with symptoms related to bone malignancy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), Sr creatinine, Sr electrolytes, CT/MRI, PET Scan (optional): Yes/No (Upload reports)

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

    a. Coagulopathy: Yes/No
    b. Active infection: Yes/No

For Eligibility for Radiofrequency Tumor Ablation Therapy 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.

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

6). Radiofrequency Tumor Ablation Therapy: M15W1.12

1. Name of the Procedure: Radiofrequency Tumor Ablation Therapy

2. Indication: Select indication which is applicable

Liver: HCC/ Metastasis
Bone: Osteoid Osteoma/ Painful Lytic bone/ Metastases/ Osteoblastoma/ Chondroblastoma/ Giant Cell Tumor/ Painful Myeloma
Lung: NSCL/ pulmonary metastases
Kidney: Small Renal Cell Carcinoma < 4 cms limited to kidney/ RCC, poor surgical candidate/ RCC in solitary kidney/ Bilateral RCC/ RCC with genetic predisposition to multiple tumor

3. Does the patient presented with symptoms related to lung malignancy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), Sr creatinine, Sr electrolytes, CT/MRI, PET Scan (optional): Yes/No (Upload reports)

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

    a. Tumor > 3.5 cms: Yes/No
    b. Coagulopathy: Yes/No
    c. Pts with ECOG status > 2: Yes/No

For Eligibility for Radiofrequency Tumor Ablation Therapy the answer to questions 5a, 5b & 5c 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: _____

7). Radiofrequency Tumor Ablation Therapy: M15W1.12

1. Name of the Procedure: Radiofrequency Tumor Ablation Therapy

2. Indication: Select indication which is applicable

Liver: HCC/ Metastasis
Bone: Osteoid Osteoma/ Painful Lytic bone/ Metastases/ Osteoblastoma/ Chondroblastoma/ Giant Cell Tumor/ Painful Myeloma
Lung: NSCL/ pulmonary metastases
Kidney: Small Renal Cell Carcinoma < 4 cms limited to kidney/ RCC, poor surgical candidate/ RCC in solitary kidney/ Bilateral RCC/ RCC with genetic predisposition to multiple tumor

3. Does the patient presented with symptoms related to kidney malignancy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile (PT INR, Platelet Count), Sr creatinine, Sr electrolytes, CT/MRI, PET Scan (optional): Yes/No (Upload reports)

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

    a. Presence of distant metastases: Yes/No
    b. Tumor > 5 cms or tumor in hilum or central collecting system: Yes/No

For Eligibility for Radiofrequency Tumor Ablation Therapy 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.

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

8). Embolization Of Postoperative And Post Traumatic Bleeding: M15W1.13

1. Name of the Procedure: Embolization Of Postoperative And Post Traumatic Bleeding

2. Indications: Select indication which is applicable
   Post operative Bleeding/ Post Traumatic Bleeding causing Hemodynamic instability/ Post Traumatic Bleeding causing Drop in Hb by 2 gm in 24 hrs/ Post Traumatic Bleeding causing Pseudoneurysm or arteriovenous fistula

3. Does the patient presented with bleeding, hypotension, tachycardia: Yes/No (Upload clinical photograph in external bleeding)

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation Profile (PT INR, Platelet Count), Creatinine, CT scan: Yes/No (Upload reports)

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

For Eligibility for Embolization Of Post operative And Post Traumatic Bleeding 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: _____

9). Inferior Vena Cava Filter Placement: M15W1.14

1. Name of the Procedure: Inferior Vena Cava Filter Placement

2. Indications: Select indication which is applicable
   In documented DVT & PE cases:
   Contraindication to anticoagulation/ Failure of anticoagulation/ Complication of anticoagulation

3. Does the patient presented with breathlessness with reduced O2 saturation, hemoptysis, associated lower limb swelling, CCF: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- creatinine, Color Doppler (Deep Vein Thrombosis)/ CT Scan (Pulmonary Embolism): Yes/No (Upload reports)

For Eligibility for Inferior Vena Cava Filter Placement 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: _____

10). Biliary Drainage Procedures - External Drainage And Stent Placement - Single Metallic Stent: M15W1.15

1. Name of the Procedure: Biliary Drainage Procedures - External Drainage And Stent Placement - Single Metallic Stent

2. Indications: Select indication which is applicable
   Decompress Obstructed Biliary System/ Dilate Biliary Strictures/ Remove bile stones when ERCP fails or is contraindicated/ Divert bile from bile duct leak and stent bile duct defect/ Treatment of acute biliary sepsis/ Malignant Obstructive Jaundice

3. Does the patient presented with fever, jaundice, pruritis, sepsis, post operative or post traumatic biliary output from surgical drain: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Coagulation profile (PT INR, platelet count), Creatinine, CT/ MRI/ USG/ ERCP: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Ascites: Yes/No
   b. Uncorrectable Coagulopathy: Yes/No

For Eligibility for Biliary Drainage Procedures - External Drainage And Stent Placement - Single Metallic Stent the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

11). Nephrostomy Tube And Nephroureteral Stent Placement: M15W1.16

1. Name of the Procedure: Nephrostomy Tube And Nephroureteral Stent Placement

2. Indications: Select indication which is applicable
   Urinary tract obstruction caused by intrinsic or extrinsic ureteral obstruction related to stones, malignancies or iatrogenic causes/ Pyonephrosis or infected hydronephrosis/ Urinary Leakage or fistulas/ Removal of selected renal or ureteral calculi/ Ureteral stent placement when the retrograde approach is unsuccessful or not feasible/ To deliver medications or chemotherapy into the collecting system, as for treatment of fungus balls, bacillus Calmette Guerin vaccine instillation for upper tract transitional cell carcinomas, or chemolysis for dissolution of renal or ureteral calculi/ Foreign body retrieval; eg, fractured or proximally migrated ureteral stents/ Urinary diversion for hemorrhagic cystitis

3. Does the patient presented with oliguria or anuria, fever: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Coagulation profile (PT INR, platelet count), Serum creatinine, USG/CT: Yes/No (Upload reports)

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

For Eligibility for Nephrostomy Tube And Nephroureteral Stent Placement 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). Uterine Artery Embolization In Severe Menorrhagia Secondary To PPH, Uterine Fibroids And AVM: M15W1.17

1. Name of the Procedure: Uterine Artery Embolization In Severe Menorrhagia Secondary To PPH, Uterine Fibroids And AVM

2. Indications: Select indication which is applicable
   Post partum hemorrhage/ Uterine Fibroids/ Uterine AVM/Adenomyosis

3. Does the patient presented with menorrhagia/dysmenorrhoea/obstructive systems such as hydronephrosis, hypotension/shock, anemia: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Viable Pregnancy: Yes/No
   b. Adenexal malignancy: Yes/No
   c. Pelvic Inflammatory Disease: Yes/No

For Eligibility for Uterine Artery Embolization In Severe Menorrhagia Secondary To PPH, Uterine Fibroids And AVM the answer to question 5a, 5b & 5c must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

13). Intra-Arterial Thrombolysis For Acute Ischemic Limbs: M15W1.18

1. Name of the Procedure: Intra-Arterial Thrombolysis For Acute Ischemic Limbs

2. Indications: Select indication which is applicable
   Rutherford Category I: Viable Limb, No sensory or motor loss, audible arterial & venous Doppler signals/ Rutherford Category IIa: Threatened Marginal, Minimal sensory loss, no motor loss, arterial signals often inaudible, venous audible/ Rutherford Category IIb: Threatened Immediate, Rest pain and mild motor loss, arterial signals often inaudible, venous audible

3. Does the patient presented with pain & discolouration of limb, cold limb, gangrene: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- creatinine, Color Doppler /Peripheral Angiogram: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of sensory or motor loss of affected limb: Yes/No

For Eligibility for Intra-Arterial Thrombolysis For Acute Ischemic Limbs 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: _____

14). Permanent Tunnelled Catheter Placement As Substitute For AV Fistula In Long Term Dialysis: M15W1.19

1. Name of the Procedure: Permanent Tunnelled Catheter Placement As Substitute For AV Fistula In Long Term Dialysis

2. Indications: Select indication which is applicable
   Hemodialysis (Long-term)/ Failed arterio-venous fistula

3. Does the patient presented with Chronic kidney disease, failed or immature arterio-venous fistula: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Hb, creatinine, Coagulation profile (PT INR, platelet count), Color Doppler /Peripheral Angiogram: Yes/No (Upload reports)

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

For Eligibility for Permanent Tunnelled Catheter Placement As Substitute For AV Fistula In Long Term Dialysis 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: _____

15). Hepatic Vein Stenting In Budd - Chiari Syndrome Single Stent: M15W1.2

1. Name of the Procedure: Hepatic Vein Stenting In Budd - Chiari Syndrome Single Stent

2. Indications: Hepatic vein occlusion/ stenosis < 3cms

3. Does the patient presented with ascites, jaundice, liver cirrhosis, dilated abdominal veins: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Creatinine, Coagulation profile (PT INR, APTT, platelet count), Color Doppler/ CT/ MRI Liver: Yes/No (Upload reports)

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

For Eligibility for Hepatic Vein Stenting In Budd - Chiari Syndrome Single Stent 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: _____

16). Central Venous Stenting For Central Venous Occlusion (Brachiocephalic, Subclavian Vein And Sup Vena Cava) Single Metallic Stent: M15W1.20

1. Name of the Procedure: Central Venous Stenting For Central Venous Occlusion (Brachiocephalic, Subclavian Vein And Sup Vena Cava) Single Metallic Stent

2. Indications: Select indication which is applicable
   Subclavian vein occlusion or stenosis (>70%)/ Brachiocephalic vein occlusion or stenosis/ Superior Vana Cava occlusion or stenosis

3. Does the patient presented with dysfunctional AV fistula, upper limb swelling, facial puffiness: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Creatinine, Color Doppler/ CT venogram/ MRI venogram/ Conventional venogram: Yes/No (Upload reports)

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

For Eligibility for Central Venous Stenting For Central Venous Occlusion (Brachiocephalic, Subclavian Vein And Sup Vena Cava) Single Metallic Stent 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). Endovascular Intervention For Salvaging Hemodialysis AV Fistula: M15W1.21

1. Name of the Procedure: Endovascular Intervention For Salvaging Hemodialysis AV Fistula

2. Indications: Select indication which is applicable
   Stenosis > 50% of the lumen diameter in the dialysis graft or native fistula
   Thrombosed AV fistula or graft

3. Does the patient presented with swelling in the limb, Chronic Kidney Disease, fistula failure/absent thrill, failure of fistula to mature: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- Creatinine, Coagulation Profile (PT INR, Platelet Count), Color Doppler: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of Infected access site: Yes/No

For Eligibility for Endovascular Intervention For Salvaging Hemodialysis AV Fistula 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). Balloon Retrograde Transvenous Obliteration Of Bleeding Gastric Varices (BRTO): M15W1.21

1. Name of the Procedure: Balloon Retrograde Transvenous Obliteration Of Bleeding Gastric Varices (BRTO)

2. Indications: Select indication which is applicable
   Actively bleeding gastric varices with gastro renal shunt (GRS)/ Refractory encephalopathy with gastro renal shunt (GRS)/ Poor candidates for TIPSS

3. Does the patient presented with hematemesis, malena, encephalopathy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Coagulation profile, serum creatinine, upper GI endoscopy, Triple phase CT/MRI: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of oesophageal variceal bleeding: Yes/No

For Eligibility for Balloon Retrograde Transvenous Obliteration Of Bleeding Gastric Varices (BRTO) 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: _____

19). Preoperative Portal Vein Embolization For Liver Tumors: M15W1.23

1. Name of the Procedure: Preoperative Portal Vein Embolization For Liver Tumors

2. Indications: Patients with major hepatic resection with FLR < 25-35%

3. Does the patient presented with weight loss, loss of apetite, hepatic malignancy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- USG/ CT/ Triple phase CT showing tumor volumetry depicting future liver remnant (FLR): Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Tumor invading portal vein: Yes/No
   b. Uncorrectable Coagulopathy: Yes/No

For Eligibility for Preoperative Portal Vein Embolization For Liver Tumors the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

20). Chemo Embolization For Liver Tumors Using Drug And PVA Or DC Beads: M15W1.24

1. Name of the Procedure: Chemo Embolization For Liver Tumors Using Drug And PVA Or DC Beads

2. Indications: Select indication which is applicable
   Liver dominant malignancies who are not candidates for surgical resection/ Hepatocellular carcinoma with absent extra hepatic disease and normal portal vein/ Hepatic Metastasis

3. Does the patient presented with weight loss, loss of apetite: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. 50% involvement of liver by tumor: Yes/No
   b. Contraindications to chemotherapy: Yes/No
   c. Hepatic Encephalopathy: Yes/No
   d. Patients performance status more than 2: Yes/No

For Eligibility for Chemo Embolization For Liver Tumors Using Drug And PVA Or DC Beads the answer to question 5a, 5b, 5c & 5d 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: _____

21). Percutaneous Vertebro Plasty/ Cementoplasty (For Each Level) Post Procedure Evidence Of Clinical Photograph And Radiographic Image: M15W1.25

1. Name of the Procedure: Percutaneous Vertebro Plasty/ Cementoplasty (For Each Level) Post Procedure Evidence Of Clinical Photograph And Radiographic Image

2. Indications: Select indication which is applicable
   Osteoporosis/ Primary tumors/ Metastasis (osteolytic)/ Painful aggressive hemangioma alone or in conjunction with alcohol ablation/ Trauma

3. Does the patient presented with backache, neuro deficits: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Breach in the posterior cortex of the vertebral body: Yes/No
   b. Epidural extension: Yes/No
   c. Vertebra plana: Yes/No
   d. Uncorrectable coagulopathy: Yes/No

For Eligibility for Percutaneous Vertebro Plasty/ Cementoplasty (For Each Level) Post Procedure Evidence Of Clinical Photograph And Radiographic Image the answer to question 5a, 5b, 5c & 5d 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: _____

22). Trans Jugular Intrahepatic Portosystemic Shunt (TIPSS): M15W1.26

1. Name of the Procedure: Trans Jugular Intrahepatic Portosystemic Shunt (TIPSS)

2. Indications: Select indication which is applicable
   Budd-Chiari Syndrome/ Refractory Ascites/ Prevention of variceal bleeding/ Portal hypertensive gastropathy/ Bleeding gastric varices/ Refractory hepatic hydrothorax/ Hepatorenal Syndrome/ Hepatopulmonary Syndrome/ Veno-occlusive disease

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

4. If the answer to question 3 is Yes then are the following tests being done- Creatinine, Liver function test, PT INR, Upper GI endoscopy, Calculated MELD score, USG, MRI/ Color Doppler: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Rapid progressive liver failure: Yes/No
   b. Uncontrolled encephalopathy: Yes/No
   c. Heart failure: Yes/No
   d. Calculated MELD score > 24: Yes/No

For Eligibility for Trans Jugular Intrahepatic Portosystemic Shunt (TIPSS) the answer to question 5a, 5b, 5c & 5d 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: _____

23). Embolization Of Pulmonary AV Malformation Post Procedure Evidence Of Clinical Photograph And Radiographic Image: M15W1.27

1. Name of the Procedure: Embolization Of Pulmonary AV Malformation Post Procedure Evidence Of Clinical Photograph And Radiographic Image

2. Indications: Select indication which is applicable
   Embolization Of Pulmonary AV Malformations/ Embolization Of Pulmonary pseudoaneurysms

3. Does the patient presented with arterial hypoxemia, paradoxical embolization, hemoptysis, hemothorax: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, CT/ pulmonary angio: Yes/No (Upload reports)

For Eligibility for Embolization Of Pulmonary AV Malformation Post Procedure Evidence Of Clinical Photograph And Radiographic Image 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: _____

24). Preoperative Prophylactic Tumor Embolization: M15W1.28

1. Name of the Procedure: Preoperative Prophylactic Tumor Embolization

2. Indications: Moderate or highly hypervascular tumor

3. Does the patient presented with weight loss, loss of apetite: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Fever: Yes/No
   b. Sepsis: Yes/No

For Eligibility for Preoperative Prophylactic Tumor Embolization the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

25). Embolization Of AV Malformation Of Brain Per Sitting With Onyx: M15W1.29

1. Name of the Procedure: Embolization Of AV Malformation Of Brain Per Sitting With Onyx

2. Indications: Select indication which is applicable
   Ruptured AV malformation/ Unruptured AV malformation with intractable epilepsy/ Unruptured AV malformation with progressive neurodeficit/ Unruptured AV malformation with intractable headache/ Unruptured AV malformation with exclusive deep venous drainage/ Unruptured AV malformation with intranidal aneurysm/ Unruptured AV malformation with intranidal AVF

3. Does the patient presented with epilepsy, severe headache, vomiting, loss of consciousness, neuro deficits: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, CT, MRI: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Unfavorable anatomy: Yes/No
   b. Renal insufficiency: Yes/No
   c. Contrast allergy: Yes/No
   d. Uncorrectable coagulopathy: Yes/No

For Eligibility for Embolization Of AV Malformation Of Brain Per Sitting With Onyx the answer to question 5a, 5b, 5c & 5d 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: _____

26). Acute Stroke Thrombolysis With rTPA: M15W1.3

1. Name of the Procedure: Acute Stroke Thrombolysis With rTPA

2. Indications: Select indication which is applicable
   Ischemic stroke with major vessel occlusion without large infarction on imaging/ Patient presents within window period (6-8 hours for anterior cerebral circulation & upto 24 hours for posterior cerebral circulation)/ Significant non improving neurodeficit

3. Does the patient presented with hemiparesis, aphasia, dyarthria, loss of consciousness, cranial nerve palsy: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Renal insufficiency: Yes/No
   b. Contrast allergy: Yes/No
   c. Uncorrectable coagulopathy: Yes/No

For Eligibility for Acute Stroke Thrombolysis With rTPA the answer to question 5a, 5b & 5c must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

27). Carotid Stenting Single Stent With Protection Device: M15W1.30

1. Name of the Procedure: Carotid Stenting Single Stent With Protection Device

2. Indications: Select indication which is applicable
   Symptomatic moderate to severe carotid artery disease (diameter of the lumen of the internal carotid artery is reduced by more than 70% as documented by non invasive imaging or more than 50% as documented by catheter angiography)/ Asymptomatic high grade stenosis (>70%) with contralateral ICA occlusion

3. Does the patient presented with hemiparesis, aphasia, dyarthria, loss of consciousness, cranial nerve palsy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, PT INR, Creatinine, MRI/ CT- Angiogram, Doppler: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Thrombus at site of disease: Yes/No
   b. Chronic total occlusion: Yes/No

For Eligibility for Carotid Stenting Single Stent With Protection Device the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

28). Intracranial Arterial And Venous Stenting: M15W1.31

1. Name of the Procedure: Intracranial Arterial And Venous Stenting

2. Indications: Failed optimum medical management (control hypertension, diabetes, de addiction, statins, anti platelets) with recurrent TIAS/ strokes in cases of moderate to severe (> 70%) stenosis

3. Does the patient presented with hemiparesis, aphasia, dyarthria, loss of consciousness, cranial nerve palsy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, PT INR, Creatinine, MRI/ CT- Angiogram: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Renal insufficiency: Yes/No
   b. Contrast allergy: Yes/No
   c. Uncorrectable coagulopathy: Yes/No

For Eligibility for Intracranial Arterial And Venous Stenting the answer to question 5a, 5b & 5c must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

29). Peripheral Stent Graft For Peripheral Aneurysms And AV Fistulae: M15W1.32

1. Name of the Procedure: Peripheral Stent Graft For Peripheral Aneurysms And AV Fistulae

2. Indications: Select indication which is applicable
   Peripheral artery pseudoaneurysm/ Peripheral artery arteriovenous fistula

3. Does the patient presented with swelling in the limbs, warmness: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, CT/ Doppler/ Digital Subtraction Angiography: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Fever: Yes/No
   b. Sepsis: Yes/No

For Eligibility for Peripheral Stent Graft For Peripheral Aneurysms And AV Fistulae the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

30). Embolization Of Caratico-Cavernous Fistula: M15W1.33

1. Name of the Procedure: Embolization Of Caratico-Cavernous Fistula

2. Indications: All symptomatic cases

3. Does the patient presented with pulsatile proptosis, cranial nerve palsy, loss of consciousness, headache, vomiting, neurodeficit: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, clinical photograph of affected eye, CT/ MRI: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Renal insufficiency: Yes/No
   b. Contrast allergy: Yes/No
   c. Uncorrectable coagulopathy: Yes/No

For Eligibility for Embolization Of Caratico-Cavernous Fistula the answer to question 5a, 5b & 5c must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

31). Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting: M15W1.34

1. Name of the Procedure: Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting

2. Indications: Select indication which is applicable
   Bleeding/ Pre operative/ Cosmetic/ Neurodeficit

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

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, CT/ MRI: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Infection at local site: Yes/No
   b. Renal insufficiency: Yes/No
   c. Contrast Allergy: Yes/No
   d. Uncorrectable coagulopathy: Yes/No

For Eligibility for Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting the answer to question 5a, 5b, 5c & 5d 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: _____

32). Renal Artery Embolization With Multiple Coils And Microcatheter: M15W1.4

1. Name of the Procedure: Renal Artery Embolization With Multiple Coils And Microcatheter

2. Indications: Select indication which is applicable
   Renal artery pseudoaneurysm/ Renal arterio-venous fistula/ Renal arterio-venous malformation/ Benign or malignant hypervascular tumors

3. Does the patient presented with hematuria/ retroperitoneal hematoma/ hypotension/ tachycardia/ abdominal pain: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, USG, CT-Angiogram/ MRI/ DSA Angiogram: Yes/No (Upload reports)

For Eligibility for Renal Artery Embolization With Multiple Coils And Microcatheter 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: _____

33). Cortical Venous Sinus Thrombolysis: M15W1.5

1. Name of the Procedure: Cortical Venous Sinus Thrombolysis

2. Indications: Select indication which is applicable
   Major venous sinus thrombosis without large hematoma/ Altered Sensorium (GC scale < 10)/ Refractory to anticoagulation with progressive disease

3. Does the patient presented with convulsion, severe headache, vomiting, loss of consciousness, neuro deficits, cranial nerve palsy: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CT/ CT Angio/ MRI/ MR Angio, CBC, Creatinine, PT INR: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Large venous hemorrhagic venous infarction: Yes/No
   b. Renal insufficiency: Yes/No
   c. Contrast Allergy: Yes/No
   d. Uncorrectable coagulopathy: Yes/No

For Eligibility for Cortical Venous Sinus Thrombolysis the answer to question 5a, 5b, 5c & 5d 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: _____

34). Deep Venous Thrombolysis For DVT With IVC Filter: M15W1.6

1. Name of the Procedure: Deep Venous Thrombolysis For DVT With IVC Filter

2. Indications: Acute iliofemoral deep vein thrombosis less than 14 days

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

4. If the answer to question 3 is Yes then are the following tests being done- Color Doppler/ Clinical Photograph of affected limb: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Contraindications to thrombolytic therapy: Yes/No
   b. Patients > 70 years of age: Yes/No
   c. Moderate to severe renal dysfunction: Yes/No
   d. Pregnancy: Yes/No
   e. Severe liver dysfunction: Yes/No
   f. Severe uncontrolled hypertension: Yes/No

For Eligibility for Deep Venous Thrombolysis For DVT With IVC Filter the answer to question 5a, 5b, 5c, 5d, 5e & 5f 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: _____

35). Subclavian, Iliac, Superficial Femoral Artery Stenting Each With One Stent: M15W1.7

1. Name of the Procedure: Subclavian, Iliac, Superficial Femoral Artery Stenting Each With One Stent

2. Indications: Arterial Insufficiency of affected arterial territory

3. Does the patient presented with lifestyle limiting claudication, tingling, critical limb ischaemia, numbness of the affected upper limb, pre gangrenous changes & critical limb ischaemia of affected lower limb: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, Color Doppler/ Angiography: Yes/No (Upload reports)

For Eligibility for Subclavian, Iliac, Superficial Femoral Artery Stenting Each With One Stent 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: _____

36). Tibial Angioplasty In Critical Limb Ischemia: M15W1.8

1. Name of the Procedure: Tibial Angioplasty In Critical Limb Ischemia

2. Indications: Peripheral vascular insufficiency (Critical Limb Ischemia)

3. Does the patient presented with rest pain, ischemic ulceration, blackening of fingers: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done- CBC, Creatinine, PT INR, Angiogram/ Doppler: Yes/No (Upload reports)

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Vessels with acute ischemic symptoms: Yes/No
   b. Angiographic evidence of fresh thrombus: Yes/No

For Eligibility for Tibial Angioplasty In Critical Limb Ischemia the answer to question 5a & 5b must be No

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

Treating Doctor Signature with Stamp

_____

NAME OF THE HOSPITAL: _____

37). Mesenteric Artery Angioplasty & Stenting In Acute & Chronic Mesenteric Ischemia - Single Stent: M15W1.9

1. Name of the Procedure: Mesenteric Artery Angioplasty & Stenting In Acute & Chronic Mesenteric Ischemia - Single Stent

2. Indications: Select indication which is applicable
   Short segment occlusion (< 3cms)/ Short segment > 70% stenosis/ Short segment > 50% stenosis with systolic pressure gradient of 10 mm Hg

3. Does the patient presented with post prandial pain, nausea, weight loss, diarrhea, gasteroparesis, gastric ulceration: Yes/No

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Bowel Necrosis: Yes/No
   b. Extrinsic compression as a cause of stenosis (MALS) : Yes/No
   c. Presence of extensive diasease involving major secondary branches: Yes/No
   d. Angiographic evidence of intraluminal thrombus: Yes/No
   e. Cardiac source of emboli: Yes/No
   f. Coagulopathy: Yes/No

For Eligibility for Mesenteric Artery Angioplasty & Stenting In Acute & Chronic Mesenteric Ischemia - Single Stent the answer to question 5a, 5b, 5c, 5d, 5e & 5f must be No

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

Treating Doctor Signature with Stamp

_____