NAME OF THE HOSPITAL: _____

1). Craniotomy And Evacuation Of Hematoma Subdural: S10I1.1

1. Name of the Procedure: Craniotomy And Evacuation Of Hematoma Subdural

2. Indication: Subdural haematoma with mass effect

3. Does the patient presented with RTA/Railway accident/any other accident with head injury with severe headache, drowsiness, convulsion: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Scan brain, CBC, RFT, LFT, ECG, Chest X ray, Coagulation Profile: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is there evidence of
   a. Seizure Disorder: Yes/No
   b. Weakness: Yes/No

For Eligibility for Craniotomy And Evacuation Of Hematoma Subdural 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: _____

2). Craniotomy And Evacuation Of Hematoma Extradural: S10I1.2

1. Name of the Procedure: Craniotomy And Evacuation Of Hematoma Extradural

2. Indication: Altered sensorium, may or may not hemiparesis, headache, vomiting

3. Does the patient presented with RTA/Railway accident/any other accident with severe headache, vomiting, nausea, convulsion generalized or focal, hemiparesis, altered sensorium: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Scan brain, ECG, Coagulation Profile: Yes/No (Upload reports)

For Eligibility for Craniotomy And Evacuation Of Hematoma Extradural the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

3). Evacuation Of Brain Abscess - Burr Hole: S10I1.3

1. Name of the Procedure: Evacuation Of Brain Abscess - Burr Hole

2. Indication: Severe headache/ Persistant vomiting/ Cause of infection & Septicemia

3. Does the patient presented with fever, headache, vomiting, convulsion, drowsiness, coma, hemiparesis, confusion: Yes/No

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

For Eligibility for Evacuation Of Brain Abscess - Burr Hole 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: _____

4). Excision Of Lobe (Frontal, Temporal, Cerebellum Etc.): S10I1.4

1. Name of the Procedure: Excision Of Lobe (Frontal, Temporal, Cerebellum Etc.)

2. Indication: Traumatic brain injuries/ All types of accidents

3. Does the patient presented with unconsciousness, altered sensorium: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Scan/ MRI brain, CBC, RFT, LFT, ECG, Chest X ray, Coagulation Profile: Yes/No (Upload reports)

For Eligibility for Excision Of Lobe (Frontal, Temporal, Cerebellum Etc.) 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: _____

5). Endoscopy Procedures: S10I1.5

1. Name of the Procedure: Endoscopy Procedures

2. Indication: Pituitary microadenoma/ CSF rhinorrhoea/ Pituitary tumors

3. Does the patient presented with headcahe/ vomiting /blurring of vision, drowsiness, unconsciousness, headache, convulsion, CSF rhinorrhoea: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI brain, CSF, Endocrine hormonal levels, Coagulation Profile, Relevant biochemical investigations: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is there evidence of
   a. Meningitis: Yes/No
   b. Septicemia: Yes/No

For Eligibility for Endoscopy Procedures 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: _____

6). De-Compressive Craniotomy (Non Traumatic): S10I1.6

1. Name of the Procedure: De-Compressive Craniotomy (Non Traumatic)

2. Indication: Tumors/ Cysts/ Subarachnoid Hemorrhage/ Subdural Hematoma/ Arteriovenous Malformation/ Brain Abscesses/ Craniosynostosis/ Cerebral Thrombosis/ Cerebral Venous Thrombosis/ Cortical Sinus Thrombosis

3. Does the patient presented with headache, vomiting, altered sensorium, convulsion, hemiparesis, fever, unconsciousness: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Bilateral orbital invasion in non-blind patients: Yes/No
   b. Lack of brain retraction: Yes/No
   c. Internal Carotid artery by aggressive malignancies: Yes/No

For Eligibility for De-Compressive Craniotomy (Non Traumatic) 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.

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NAME OF THE HOSPITAL: _____

7). Intra-Cerebral Hematoma Evacuation: S10I1.7

1. Name of the Procedure: Intra-Cerebral Hematoma Evacuation

2. Indication: Intra-Cerebral bleed

3. Does the patient presented with headache/ vomiting, hemiparesis, altered sensorium, convulsion, unconsciousness: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of vegetative unstable stage: Yes/No

For Eligibility for Intra-Cerebral Hematoma Evacuation the answer to questions 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: _____

8). Endoscopic Third Ventriculostomy: S10I1.8

1. Name of the Procedure: Endoscopic Third Ventriculostomy

2. Indication: Hydrocephalous/ Normal Pressure Hydrocephalus (NPH)

3. Does the patient presented with headache, vomiting, increased skull circumference (in pediatrics), sunset sign, altered sensorium: Yes/No

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

For Eligibility for Endoscopic Third Ventriculostomy 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: _____

9). Temporal Lobectomy: S10I10.1

1. Name of the Procedure: Temporal Lobectomy

2. Indication: Recurrent, unprovoked epileptic seizures which originates from temporal lobe may be due to brain injury/ Encephalitis/ Meningitis/ Post brain tumour excision

3. Does the patient presented with simple & complex partial seizures, generalized tonic clonic convulsion: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Scan/ MRI brain, Multiple EEG, Psychologic assessment: Yes/No (Upload reports)

   For Eligibility for Temporal Lobectomy the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

10). Lesionectomy Type 1: S10I10.2

1. Name of the Procedure: Lesionectomy Type 1

2. Indication: Movement Disorders/ Involuntary movements

3. Does the patient presented with simple & complex partial seizures, generalized tonic clonic convulsion: Yes/No

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

   For Eligibility for Lesionectomy Type 1 the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

11). Lesionectomy Type 2: S10I10.3

1. Name of the Procedure: Lesionectomy Type 2

2. Indication: Localized lesion in brain causing seizures/ Seizures that cant be managed with epilepsy treatment/ Lesions that may have to be removed to prevent further complications of human behavior & personality disorders

3. Does the patient presented with generalized tonic clonic convulsion, focal seizures, violent behavior, schizophrenia, personality disorders: Yes/No

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

   For Eligibility for Lesionectomy Type 2 the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

12). Temporal Lobectomy Plus Depth Electrodes: S10I10.4

1. Name of the Procedure: Temporal Lobectomy Plus Depth Electrodes

2. Indication: Recurrent, unprovoked epileptic seizure

3. Does the patient presented with simple & complex partial seizures, generalized tonic clonic convulsion: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT Scan/ MRI brain, multiple EEG, Psychologic assessment: Yes/No (Upload reports)

For Eligibility for Temporal Lobectomy Plus Depth Electrodes the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

13). Radiofrequency Ablation: S10I11.1

1. Name of the Procedure: Radiofrequency Ablation

2. Indication: Trigeminal Neuralgia

3. Does the patient presented with intense facial pain affecting day to day activity & can be triggered by common activities such as eating, talking, shaving, brushing, chewing: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done – MRI Brain, MRI Angio to see artery in C.P angle: Yes/No (Upload reports)

   For Eligibility for Radiofrequency Ablation the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

14). Micro Vascular Decompression: S10I11.2

1. Name of the Procedure: Micro Vascular Decompression

2. Indication: Trigeminal Neuralgia

3. Does the patient presented with severe episodes of intense facial pain & hemifacial spasm: Yes/No

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

For Eligibility for Micro Vascular Decompression the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

15). Embolization: S10I12.1

1. Name of the Procedure: Embolization

2. Indication: Management of aneurysms

3. Does the patient presented with severe headache, vomiting, sudden loss of consciousness, acute hydrocephalous: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Above 65 years with poor clinical status or co-morbid conditions: Yes/No
   b. Aneurysm more than 10mm in diameter: Yes/No
   c. Aneurysm neck greater than or equal to 4mm: Yes/No

For Eligibility for Embolization 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.

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NAME OF THE HOSPITAL: _____

16). Cost Of Each Coil: S10I12.2

1. Name of the Procedure: Cost Of Each Coil

2. Indication: Management of aneurysms

3. Does the patient presented with fainting or sudden loss of consciousness, seizure, vomiting, blurred vision, changes in speech, severe headache: Yes/No

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

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

   For Eligibility for Cost Of Each Coil the answer to question 5 must be NO

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NAME OF THE HOSPITAL: _____

17). Parasagittal Tumour: S10I2.1

1. Name of the Procedure: Parasagittal Tumour

2. Indication: Parasagittal Tumours

3. Does the patient presented with seizures, headache, muscle weakness, confusion, changes in personality, visual disorders, hearing loss: Yes/No

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

   For Eligibility for Parasagittal Tumour the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

18). Ventriculoatrial Shunt: S10I2.10

1. Name of the Procedure: Ventriculoatrial Shunt

2. Indication: Brain Tumor/ Hydrocephalous/ Arnold Chiari malformation

3. Does the patient presented with headache, convulsion, vomiting, altered sensorium, hemiparesis: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Meningitis: Yes/No
   b. Ischemic Heart Disease: Yes/No
   c. Septicemia: Yes/No

For Eligibility for Ventriculoatrial Shunt 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.

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NAME OF THE HOSPITAL: _____

19). Excision Of Brain Abscess: S10I2.11

1. Name of the Procedure: Excision Of Brain Abscess

2. Indication: Brain Abscess causing persistant vomiting, headache, convulsion

3. Does the patient presented with fever, severe headache, convulsion, drowsiness, comatous state, hemiparesis, confusion: 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 there evidence of
   a. Meningitis: Yes/No
   b. Compromised immune system: Yes/No
   c. On immunosuppresant drugs: Yes/No

For Eligibility for Excision Of Brain Abscess the answer to questions 5a, 5b & 5c must be NO

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NAME OF THE HOSPITAL: _____

20). Aneurysm Clipping: S10I2.12

1. Name of the Procedure: Aneurysm Clipping

2. Indication: Management of Unruptured aneurysm/ Ruptured aneurysm

3. Does the patient presented with persistant headache, vomiting, dizziness, eye pain, diplopia, blurred vision, seizures: Yes/No

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

   For Eligibility for Aneurysm Clipping the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

21). External Ventricular Drainage (EVD): S10I2.13

1. Name of the Procedure: External Ventricular Drainage (EVD)

2. Indication: Hydrocephalous/ Hemorrhage/ Tumor/ Meningitis/ Traumatic Brain Injury

3. Does the patient presented with vomiting, altered sensorium, drowsiness, seizure, generalized tonic clonic convulsions, headcahe: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. On anticoagulation therapy: Yes/No
   b. Scalp infection: Yes/No
   c. Brain Abscess: Yes/No

For Eligibility for External Ventricular Drainage (EVD) 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.

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NAME OF THE HOSPITAL: _____

22). Basal Brain Tumour: S10I2.2

1. Name of the Procedure: Basal Brain Tumour

2. Indication: Basal Brain Tumour

3. Does the patient presented with progressive disturbances of mental status & consciousness, akinesia, tremors, convulsion, hemiparesis, visual disturbances: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. On anticoagulation therapy: Yes/No
   b. Septicemia: Yes/No
   c. Meningitis: Yes/No

For Eligibility for Basal Brain Tumour 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.

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NAME OF THE HOSPITAL: _____

23). Brain Stem Tumour: S10I2.3

1. Name of the Procedure: Brain Stem Tumour

2. Indication: Progressive neurological defects/ Subacute Hemmorrhage/ Malformations with mass effect/ Persistant symptoms

3. Does the patient presented with lack of facial controls, double vision, headache, visual disturbances, vomiting, weakness, fatigue, seizures, imbalance while walking: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. On immunosuppresant drugs: Yes/No
   b. Elderly persons: Yes/No
   c. Immunocompromised state: Yes/No

For Eligibility for Brain Stem Tumour 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.

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NAME OF THE HOSPITAL: _____

24). C P Angle Tumour: S10I2.4

1. Name of the Procedure: C P Angle Tumour

2. Indication: C P Angle Tumour

3. Does the patient presented with severe headache, vomiting, giddiness, hearing loss, hemiparesis, visual disturbances, imbalance: Yes/No

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

   For Eligibility for C P Angle Tumour 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: _____

25). Meningoencephalocele: S10I2.5

1. Name of the Procedure: Meningoencephalocele

2. Indication: Meningoencephalocele

3. Does the patient presented with headache, giddiness, severe vomiting: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Multiple synostoses: Yes/No
   b. Facial dysmorphia: Yes/No
   c. Syndactyly: Yes/No
   d. CSF leak: Yes/No
   e. Meningitis: Yes/No

For Eligibility for Meningoencephalocele 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.

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NAME OF THE HOSPITAL: _____

26). Meningomylocele: S10I2.6

1. Name of the Procedure: Meningomylocele

2. Indication: Meningomylocele

3. Does the patient presented with exposed spinal cord, orthopedic deformities, hydrocephalous, chiari II malformations: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI brain + whole spine, relevant heamatological investigations: Yes/No (Upload reports)

   For Eligibility for Meningomylocele 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: _____

27). C.S.F. Rhinorrhoea: S10I2.7

1. Name of the Procedure: C.S.F. Rhinorrhoea

2. Indication: Nasal CSF leak

3. Does the patient presented with CSF leak from nose, headache, fever, neck stiffness: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of Pyogenic Meningitis: Yes/No

For Eligibility for C.S.F. Rhinorrhoea 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: _____

28). Cranioplasty: S10I2.8

1. Name of the Procedure: Cranioplasty

2. Indication: Defect in skull bones – post injury or post craniotomy

3. Does the patient presented with skull defect, headache: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Hydrocephalus: Yes/No
   b. Infection: Yes/No

   For Eligibility for Cranioplasty 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: _____

29). Meningocele Excision: S10I2.9

1. Name of the Procedure: Meningocele Excision

2. Indication: Meningocele

3. Does the patient presented with lump in back, paraparesis, severe headache, severe vomiting, stiffness of neck, giddiness, bladder bowel syndrome: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI brain/spine, relevant heamatological investigations: Yes/No (Upload reports)

   For Eligibility for Meningocele Excision the answer to questions 4 must be YES

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NAME OF THE HOSPITAL: _____

30). Other Procedures: S10I3.1

1. Name of the Procedure: Other Procedures (Excision Of Brain Tumours)

2. Indication: Brain Tumour causing increased intracranial pressure, vomiting, convulsion

3. Does the patient presented with headache, giddiness, generalized tonic clonic convulsions, neurological deficit/ altered sensorium/ diplopia: Yes/No

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

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

For Eligibility for Other Procedures (Excision Of Brain Tumours) 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: _____

31). Atrial Shunt: S10I3.10

1. Name of the Procedure: Atrial Shunt

2. Indication: Brain Tumor/ Hydrocephalous/ Arnold Chiari malformation

3. Does the patient presented with headache, convulsion, vomiting, altered sensorium, hemiparesis: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Meningitis: Yes/No
   b. Ischemic Heart Disease: Yes/No
   c. Septicemia: Yes/No

For Eligibility for Atrial Shunt 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.

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NAME OF THE HOSPITAL: _____

32). Excision Of Brain Tumours Subtentorial: S10I3.2

1. Name of the Procedure: Excision Of Brain Tumours Subtentorial
2. Indication: Brain Tumours Subtentorial
3. Does the patient presented with severe ataxia, headache, giddiness, convulsion: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - CT brain: Yes/No (Upload reports)

For Eligibility for Excision Of Brain Tumours Subtentorial 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: _____

33). Ventriculolateral / Ventriculoperitoneal Shunt: S10I3.3

1. Name of the Procedure: Ventriculolateral / Ventriculoperitoneal Shunt

2. Indication: Hydrocephalus

3. Does the patient presented with dementia, incontinence of urine, imbalance while walking: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI brain, CSF examination, relevant heamatological investigations: Yes/No (Upload reports)

For Eligibility for Ventriculolateral / Ventriculoperitoneal Shunt 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: _____

34). Twist Drill Craniotomy: S10I3.4

1. Name of the Procedure: Twist Drill Craniotomy

2. Indication: To drain chronic subdural hematoma

3. Does the patient presented with gradually increasing headache, fluctuating level of consciousness, irritability, dizziness, disorientation, vomiting, slurred speech, ataxia: Yes/No

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

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

   For Eligibility for Twist Drill Craniotomy the answer to question 5 must be NO

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NAME OF THE HOSPITAL: _____

35). Subdural Tapping: S10I3.5

1. Name of the Procedure: Twist Drill Craniotomy

2. Indication: Acute or chronic subdural hematoma

3. Does the patient presented with gradually increasing headache, fluctuating level of consciousness, irritability, dizziness, disorientation, vomiting, slurred speech, ataxia: Yes/No

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

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

   For Eligibility for Twist Drill Craniotomy the answer to question 5 must be NO

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NAME OF THE HOSPITAL: _____

36). Ventricular Tapping: S10I3.6

1. Name of the Procedure: Ventricular Tapping

2. Indication: Ventricular Tapping

3. Does the patient presented with severe headache, giddiness, seizure disorder, vomiting, drowsiness: Yes/No

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

   For Eligibility for Ventricular Tapping 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: _____

37). Abscess Tapping: S10I3.7

1. Name of the Procedure: Abscess Tapping

2. Indication: Excision of brain tumour with abscess

3. Does the patient presented with headache, giddiness, convulsion, severe vomiting, heaviness of head, fever: Yes/No

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

   For Eligibility for Abscess Tapping 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: _____

38). Vascular Malformations: S10I3.8

1. Name of the Procedure: Vascular Malformations

2. Indication: Seizures, Intra-cerebral haemorrhage

3. Does the patient presented with seizures, headache, neurological problems like learning disorders or ischemia, lack of oxygen affects muscle control, vision, speech: Yes/No

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

   For Eligibility for Vascular Malformations 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: _____

39). Peritoneal Shunt: S10I3.9

1. Name of the Procedure: Peritoneal Shunt

2. Indication: Hydrocephalus or other related disease

3. Does the patient presented with vomiting, ataxia, incontinence of urine, drowsiness, altered sensorium: Yes/No

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

   For Eligibility for Peritoneal Shunt 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: _____

40). Surgery On Cord Tumours: S10I5.1

1. Name of the Procedure: Surgery On Cord Tumours

2. Indication: Spinal Cord Tumour

3. Does the patient presented with severe backache, weakness or paralysis of upper limb, erectile dysfunction, loss of bladder & bowel control: Yes/No

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

   For Eligibility for Surgery On Cord Tumours 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: _____

41). Laminectomy: S10I5.10

1. Name of the Procedure: Laminectomy

2. Indication: Bulge with disc/ Canal stenosis

3. Does the patient presented with severe back with leg pain, unable to walk with numbness, tingling sensation: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI LS spine, relevant hematological investigations: Yes/No (Upload reports)

   For Eligibility for Laminectomy the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

42). Discectomy: S10I5.11

1. Name of the Procedure: Discectomy

2. Indication: Vertebral disc with canal stenosis

3. Does the patient presented with severe backache, unable to walk, numbness & weakness of both legs: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI LS spine, relevant hematological investigations: Yes/No (Upload reports)

For Eligibility for Discectomy the answer to questions 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: _____

43). Spinal Fusion Procedure: S10I5.12

1. Name of the Procedure: Spinal Fusion Procedure

2. Indication: To stabilize the neck & prevent damage to spinal cord/ To remove & reduce pressure on nerve root caused by tone fragments or ruptured IVD/ Spine disc herniation/ Spinal tumor/ Scoliosis/ Kyphosis/ Post rami syndrome/ Discogenic pain/ Spondylosis/ Spinal disc degenerative disease

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

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

   For Eligibility for Discectomy the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

44). Spinal Intramedullary Tumours: S10I5.2

1. Name of the Procedure: Spinal Intramedullary Tumours

2. Indication: Tumours

3. Does the patient presented with severe backache, weakness or paralysis, loss of bladder or bowel control: Yes/No

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

For Eligibility for Spinal Intramedullary Tumours the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

45). Spina Bifida Surgery Major: S10I5.3

1. Name of the Procedure: Spina Bifida Surgery Major

2. Indication: Neural tube defect/ Spina bifida/ Myelomeningocele

3. Does the patient presented with muscle weakness of legs, bowel & bladder problems, seizures, orthopedic problems: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of hemorrhagic disorders: Yes/No

   For Eligibility for Spina Bifida Surgery Major 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: _____

46). Spina Bifida Surgery Minor: S10I5.4

1. Name of the Procedure: Spina Bifida Surgery Minor

2. Indication: Spina Bifida

3. Does the patient presented with hairy patch, dimple, dark spot, swelling in the back at the site of the gap in spine, may associated with poor ability to walk, problems with bladder or bowel control, hydrocephalous: Yes/No

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

For Eligibility for Spina Bifida Surgery Minor 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: _____

47). Excision Of Cervical Intervertebral Discs: S10I5.5

1. Name of the Procedure: Excision Of Cervical Intervertebral Discs

2. Indication: Tumor/ Infection/ Vertebral fracture

3. Does the patient presented severe cervical pain, tingling, numbness, weakness of upper limb: Yes/No

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

For Eligibility for Excision Of Cervical Intervertebral Discs 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: _____

48). Posterior Cervical Discectomy: S10I5.6

1. Name of the Procedure: Posterior Cervical Discectomy

2. Indication: Cerival spine disc

3. Does the patient presented with severe cervical radiating pain, giddiness, numbness & weakness of hand: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI cervical spine, relevant hematological investigations: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is there evidence of
   a. Weakness of upper limb: Yes/No
   b. Wrist drop: Yes/No

For Eligibility for Posterior Cervical Discectomy 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: _____

49). Anterior Cervical Discectomy: S10I5.7

1. Name of the Procedure: Anterior Cervical Discectomy

2. Indication: Cervical spine disc with bulge

3. Does the patient presented with severe cervical radiating pain, giddiness, numbness & weakness of hand: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI cervical spine, relevant hematological investigations: Yes/No (Upload reports)

For Eligibility for Anterior Cervical Discectomy the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

50). Anterior Cervical Spine Surgery With Fusion: S10I5.8

1. Name of the Procedure: Anterior Cervical Spine Surgery With Fusion

2. Indication: Surgery has been done to remove herniation or degenerative disc in cervical area

3. Does the patient presented with severe cervical radiating pain, tingling, numbness & weakness of both upper limbs: Yes/No

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

For Eligibility for Anterior Cervical Spine Surgery With Fusion the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

51). Anterolateral Decompression: S10I5.9

1. Name of the Procedure: Anterolateral Decompression

2. Indication: Traumatic injury leading to severe pain & neurological deficit/ Cord compression/ Monoparesis/ Paraparesis

3. Does the patient presented with severe pain/ tingling & numbness in lower limb, monoparesis, paraparesis: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI Cervical spine, X ray cervical spine: Yes/No (Upload reports)

For Eligibility for Anterolateral Decompression the answer to question 4 must be YES

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NAME OF THE HOSPITAL: _____

52). Stereotactic Procedures - Post Procedure Evidence Of Clinical Photograph: S10I6.1

1. Name of the Procedure: Stereotactic Procedures - Post Procedure Evidence Of Clinical Photograph

2. Indication: Minimally invasive form of surgical intervention to locate small targets inside the body & perform action on them such as ablation/ biopsy/ lesion/ injection/ stimulation/ implantation/ radiosurgery

3. Does the patient presented with brain tumor lesions, seizures involment disorders: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - X ray, CT tomography/ MRI: Yes/No (Upload reports & clinical photograph)

For Eligibility for Stereotactic Procedures - Post Procedure Evidence Of Clinical Photograph 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: _____

53). Trans Sphenoidal Surgery: S10I6.2

1. Name of the Procedure: Trans Sphenoidal Surgery

2. Indication: Tumors of pituitary gland/ Sellar region tumors/ Tumors of sphenoid sinus/ Pituitary adenoma/ Craniopharyngioma/ Rathke's cleft cyst/ Chordoma

3. Does the patient presented with visual defect, endocrine defect: Yes/No

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

   For Eligibility for Trans Sphenoidal Surgery 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: _____

54). Trans Oral Surgery: S10I6.3

1. Name of the Procedure: Trans Oral Surgery
2. Indication: Basilar Invagination
3. Does the patient presented with neurodeficit: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - CT/ MRI brain/ cervical spine, X ray: Yes/No (Upload reports)
5. If the answer to question 4 is Yes then is there evidence of Oral Malignancy: Yes/No

For Eligibility for Trans Oral Surgery 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: _____

55). Combined Trans Oral Surgery And CV Junction Fusion: S10I6.4

1. Name of the Procedure: Combined Trans Oral Surgery And CV Junction Fusion

2. Indication: Management of congenital atlanoto-axial dislocation

3. Does the patient presented with pyramidal sign (weakness & spasticity), stigmata of craniovertebral junction, restricted neck movements, torticollis: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Active naso-oral bleeding: Yes/No
   b. Oral Ca: Yes/No

For Eligibility for Combined Trans Oral Surgery And CV Junction Fusion 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: _____

56). C.V. Junction Fusion: S10I6.5

1. Name of the Procedure: C.V. Junction Fusion

2. Indication: Surgical treatment for occipito cervical instability/ Atlanto-axial instability with inability to fixate C1, C2 or both

3. Does the patient presented with severe neck pain: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Severe osteoporosis: Yes/No
   b. Destruction of bone surfaces: Yes/No

For Eligibility for C.V. Junction Fusion 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: _____

57). Anterior Discectomy & Bone Grafting: S10I8.1

1. Name of the Procedure: Anterior Discectomy & Bone Grafting

2. Indication: Surgical procedure for patient suffering from pain & neurological deficits/ Unresponsive to conservative management/ Cervical arthrodesis

3. Does the patient presented with severe cervical pain: Yes/No

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

For Eligibility for Anterior Discectomy & Bone Grafting 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: _____

58). Discectomy With Implants: S10I8.2

1. Name of the Procedure: Discectomy With Implants

2. Indication: Disc herniation not responding to conservative management

3. Does the patient presented with pain, weakness & numbness in both lower limb: Yes/No

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

   For Eligibility for Discectomy With Implants 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: _____

59). Corpectomy For Spinal Fixation: S10I8.3

1. Name of the Procedure: Corpectomy For Spinal Fixation

2. Indication: Spinal fracture/ Spinal tumor/ Infection causing compression of spinal cord & nerves

3. Does the patient presented with pain, tingling, numbness & weakness in lower or upper limbs: Yes/No

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

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

For Eligibility for Corpectomy For Spinal Fixation the answer to question 5 must be NO

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NAME OF THE HOSPITAL: _____

60). Spinal Fixation Rods And Plates, Artificial Discs: S10I8.4

1. Name of the Procedure: Corpectomy For Spinal Fixation

2. Indication: Degenrative disc disease/ Spondylolisthesis/ Scoliosis or other spinal deformities/ Trauma to spine/ Spinal tumors

3. Does the patient presented with severe pain, tingling, numbness or weakness in extremity, Bladder or bowel involvement: Yes/No

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

5. If the answer to question 4 is Yes then is there evidence of
   a. Brittle bone: Yes/No
   b. Vitamin D deficiency: Yes/No
   c. Unstable support: Yes/No
   d. Coagulopathies: Yes/No

For Eligibility for Corpectomy For Spinal Fixation the answer to 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: _____

61). Syringomyelia: S10I8.5

1. Name of the Procedure: Syringomyelia

2. Indication: Syringomyelia

3. Does the patient presented with chronic severe pain, tingling sensation, numbness, paralysis/paresis, vocal cord paralysis: Yes/No

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

   For Eligibility for Syringomyelia 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: _____

62). Repair Of Brachial Plexus Injury: S10I9.1

1. Name of the Procedure: Repair Of Brachial Plexus Injury

2. Indication: Brachial Plexus Injury with soft tissue injury

3. Does the patient presented with paraparesis of upper limb with flexor & extensor muscle weakness: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI, relevant hematological investigations, EMG & Nerve Conduction studies: Yes/No (Upload reports)

For Eligibility for Repair Of Brachial Plexus Injury 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: _____

63). Decompression/Excision Of Optic Nerve Lesions: S10I9.4

1. Name of the Procedure: Decompression/Excision Of Optic Nerve Lesions

2. Indication: Traumatic eye hematoma/ Loss of vision with orbital bone fracture

3. Does the patient presented with head injury with eye hematoma, optic nerve injury, orbital bone fracture: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - MRI brain with orbit, relevant hematological investigations: Yes/No (Upload reports)

For Eligibility for Decompression/Excision Of Optic Nerve Lesions 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: _____

64). Peripheral Nerve Injury Repair: S10I9.5

1. Name of the Procedure: Peripheral Nerve Injury Repair

2. Indication: Peripheral Nerve Injury due to infection or trauma

3. Does the patient presented with signs & symptoms depending on the nerve: Yes/No

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

   For Eligibility for Peripheral Nerve Injury Repair 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: _____

65). Proptosis: S10I9.6

1. Name of the Procedure: Proptosis
2. Indication: Proptosis
3. Does the patient presented with neurodeficit: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - MRI brain with orbit: Yes/No (Upload reports)

   For Eligibility for Proptosis 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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