

NAME OF THE HOSPITAL: _____

1). Cleft Lip: S12M1.1

1. Name of the Procedure: Cleft Lip
2. Indication: Congenital cleft of the lip either unilateral or bilateral for functional correction/ Secondary deformity of corrected cleft lip for aesthetic or functional correction
3. Has the patient presented with split lip which may be either complete or incomplete and unilateral or bilateral/ deformities of the lip or nose due to earlier operated cleft lip - any time after birth: Yes/No
4. If the answer to question 3 is Yes then is there evidence of cleft lip or cleft lip secondary deformity on clinical photograph: Yes/No (Upload clinical photograph)

For Eligibility for Cleft Lip 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: _____

2). Ptosis: S12M1.10

1. Name of the Procedure: Ptosis
2. Indication: Congenital ptosis either unilateral or bilateral for aesthetic or functional correction/ Secondary deformity of ptosis due to any other reason for aesthetic or functional correction
3. Has the patient presented with drooping of eyelid either congenital or acquired or recurrent drooping due to earlier operated ptosis - any time after birth: Yes/No
4. If the answer to question 3 is Yes then then is there evidence of ptosis on clinical photograph: Yes/No (Upload clinical photograph)

For Eligibility for Ptosis 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: _____

3). Tumour Of Mandible And Maxilla: S12M1.11

1. Name of the Procedure: Tumour Of Mandible And Maxilla
2. Indication: Benign or malignant tumor of the mandible or maxilla for removal of tumor and reconstruction
3. Has the patient presented with any or some or all of these - Solid Mass/ Ulcerative lesion in the mucosa, oral cavity, outside on face, swelling of mandible or maxilla, trismus, bleeding from lesion: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done- Biopsy/ CT/ MRI/ HPE/ X ray, clinical photograph: Yes/No (Upload reports & clinical photograph)

For Eligibility for Tumour Of Mandible And Maxilla 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: _____

4). Vaginal Atresia: S12M1.12

1. Name of the Procedure: Vaginal Atresia
2. Indication: Absence of vaginal cavity or vaginal introitus for functional correction - presenting anytime after birth
3. Has the patient presented with absent vaginal cavity/ single cloacal opening: Yes/No
4. If the answer to question 3 is Yes is there evidence of vaginal atresia on Ultra sound of pelvis/ Hormone studies/ detailed clinical examination notes with sketch: Yes/No (Upload reports)

For Eligibility for Vaginal Atresia 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: _____

5). Vascular Malformations: S12M1.13

1. Name of the Procedure: Vascular Malformations
2. Indication: Swelling of vascular origin - presenting anytime after birth
3. Has the patient presented with pain, swelling, ulceration, bleeding, palpable thrill, functional impairment due to the presence of the malformation/ anomaly, repeated bouts of infection, oozing: Yes/No
4. If the answer to question 3 is Yes then is there evidence of vascular malformation on X ray, CT/MRI, Angiogram and clinical photograph: Yes/No (Upload reports and clinical photographs)

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.

Treating Doctor Signature with Stamp

NAME OF THE HOSPITAL: _____

6). Corrective Surgery For Congenital Deformity Of Hand (Per Hand): S12M1.14

1. Name of the Procedure: Corrective Surgery For Congenital Deformity Of Hand (Per Hand)
2. Indication: Any congenital deformity of upper limb because of which patient has a functional or aesthetic issue
3. Has the patient presented with syndactyly, polydactyly, acrosyndactyly, symbrachydactyly, amniotic bands, absent/ small thumb, radial or ulnar club hand, poland's syndrome, horizontal shortening of limb etc: Yes/No
4. If the answer to question 3 is Yes then is there evidence of congenital deformity of hand on X ray/ CT and clinical photograph: Yes/No (Upload reports and clinical photograph)

For Eligibility for Corrective Surgery For Congenital Deformity Of Hand (Per Hand) 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: _____

7). Corrective Surgery For Craniosynostosis: S12M1.15

1. Name of the Procedure: Corrective Surgery For Craniosynostosis
2. Indication: Deformed shape of the cranium due to any cranial sutures closing early
3. Has the patient presented with cranial deformity which needs aesthetic or functional correction: Yes/No
4. If the answer to question 3 is Yes then is there evidence of Craniosynostosis on CT/MRI/ 3D CT, clinical photograph: Yes/No (Upload reports & clinical photograph)

For Eligibility for Corrective Surgery For Craniosynostosis 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: _____

8). Cup And Bat Ears: S12M1.16

1. Name of the Procedure: Cup And Bat Ears
2. Indication: Deformity of ear for aesthetic correction
3. Has the patient presented with ear folded on the top/ ear choncha to mastoid angle increased: Yes/No
4. If the answer to question 3 is then is there evidence of cup and bat ears on clinical photograph: Yes/No (Upload clinical photographs at least two views showing the deformity from different angles)

For Eligibility for Cup And Bat Ears 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: _____

9). Flap Cover For Electrical Burns With Vitals Exposed: S12M1.17

1. Name of the Procedure: Flap Cover For Electrical Burns With Vitals Exposed
2. Indication: To cover vital structures of the body which have been exposed due to an electrical burn
3. Has the patient presented with gangrenous patches of skin over the upper or lower limb which when debrided will lead to exposure of tendons, bones, nerves or vessels/ already exposed tendons, bones, nerves or vessels in limbs/ exposed ribs, abdominal contents skull bones, facial bones: Yes/No
4. If the answer to question 3 is Yes then is there evidence of electrical burns with vitals exposed on clinical photograph: Yes/No (Upload clinical photographs)

For Eligibility for Flap Cover For Electrical Burns With Vitals Exposed 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). Reduction Surgery For Filarial Lymphedema: S12M1.18

1. Name of the Procedure: Reduction Surgery For Filarial Lymphedema
2. Indication: Functional reason/ Elephantiasis with severe skin changes and folds leading to repeated infections can be reduced – late stages (stages 5 to 7)/ Stage 3 to 6 - lymphatic microsurgery
3. Has the patient presented with Non-reversible lymphedema with shallow skin folds (Stage 3)/ Non-reversible lymphedema with skin protrusions (Stage 4)/ Non-reversible lymphedema with deep skin folds (Stage 5)/ Non-reversible lymphedema with mossy lesions (Stage 6)/ Non-reversible lymphedema and inability to perform daily activities (Stage 7): Yes/No
4. If the answer to question 3 is Yes then is there evidence of filarial lymphedema on clinical photograph: Yes/No (Upload clinical photographs)
5. If the answer to question 4 is Yes then is there evidence of:
 - a. Completely reversible lymphedema (Stage 1): Yes/No
 - b. Non-reversible lymphedema with normal skin (Stage 2): Yes/No

For Eligibility for Reduction Surgery For Filarial Lymphedema 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: _____

11). Hemifacial Atrophy: S12M1.19

1. Name of the Procedure: Hemifacial Atrophy
2. Indication: Aesthetic correction
3. Has the patient presented with progressive shrinkage and degeneration of tissues, usually on only one side of the face (hemifacial atrophy) but occasionally extending to other parts of the body: Yes/No
4. If the answer to question 3 is Yes then is there evidence of hemifacial atrophy on clinical photograph: Yes/No (Upload clinical photographs)

For Eligibility for Hemifacial Atrophy 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: _____

12). Cleft Palate: S12M1.2

1. Name of the Procedure: Cleft Palate
2. Indication: Functional correction
3. Has the patient presented with congenital cleft of the palate which may be complete or incomplete or submucous/ with or without cleft lip: Yes/No
4. If the answer to question 3 is Yes then is there evidence of cleft palate on clinical photograph: Yes/No (Upload clinical photograph)

For Eligibility for Cleft Palate 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: _____

13). Velo-Pharyngeal Incompetence: S12M1.3

1. Name of the Procedure: Velo-Pharyngeal Incompetence
2. Indication: Functional reason/ Secondary deformities of cleft palate causing speech deformity due to VPI/ VPI due to other deformities of maxilla and palate
3. Has the patient presented with unintelligible or unclear speech: Yes/No
4. If the answer to question 3 is Yes then is there evidence of VPI on nasopharyngoscopy report, speech therapists report, clinical photograph: Yes/No (Upload both reports and clinical photograph)

For Eligibility for Velo-Pharyngeal Incompetence 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). Syndactyly Of Hand For Each Hand: S12M1.4

1. Name of the Procedure: Syndactyly Of Hand For Each Hand
2. Indication: Fingers stuck to each other since birth/ Functional reason
3. Has the patient presented with fingers stuck to each other since birth - complete or incomplete, simple, complex or complicated: Yes/No
4. If the answer to question 3 is Yes then is there evidence of syndactyly of hand on X ray and clinical photograph: Yes/No (Upload Xrays and clinical photographs)

For Eligibility for Syndactyly Of Hand For Each Hand 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: _____

15). Microtia/Anotia: S12M1.5

1. Name of the Procedure: Microtia/Anotia
2. Indication: Deformity of external ear since birth – Aesthetic reason
3. Has the patient presented with absence of some parts of the external ear or absence of complete external ear: Yes/No
4. If the answer to question 3 is Yes then is there evidence of microtia/anotia on clinical photograph: Yes/No (Upload clinical photograph)
5. If the answer to question 4 is Yes then is the child less than 6 years of age: Yes/No

For Eligibility for Microtia/Anotia 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). TM Joint Ankylosis: S12M1.6

1. Name of the Procedure: TM Joint Ankylosis
2. Indication: Unable to open the mouth – Functional reason
3. Has the patient presented with inability to open mouth completely or partially because of bony or fibrous union of the TM joint either unilaterally or bilaterally: Yes/No
4. If the answer to question 3 is Yes then is there evidence of TM joint ankylosis on OPG, CT Scan & clinical photograph: Yes/No (Upload reports & clinical photograph)

For Eligibility for TM Joint Ankylosis 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: _____

17). Hemifacial Microsomia: S12M1.7

1. Name of the Procedure: Hemifacial Microsomia
2. Indication: Aesthetic reason or functional reason
3. Has the patient presented with deformity of the face due to congenital cleft/ microtia/ anotia/ ear tags/ ramus and body of mandible smaller/ cleft of angle of mouth/ whole hemi lower face smaller on the affected side: Yes/No
4. If the answer to question 3 is Yes then is there evidence of hemifacial microsomia on CT/ MRI/ 3 DCT: Yes/No (Upload reports)

For Eligibility for Hemifacial Microsmia 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: _____

18). Leprosy Reconstructive Surgery: S12M1.8

1. Name of the Procedure: Leprosy Reconstructive Surgery
2. Indication: Functional or aesthetic correction of post leprosy deformities of face, upper limbs or lower limbs
3. Has the patient presented with Leonine faces, mega ear lobe, eyebrow loss, sagging face, nose deformities/ Face deformities due to facial nerve palsy/ Clawing of fingers, wrist drop or any other hand or upper limb deformity due to nerve affectation/ Lower limb deformity due to nerve affectation/ Finger deformities and injuries due to de-sensate hand/ Foot deformities and ulcers due to de-sensate sole: Yes/No
4. If the answer to question 3 is Yes then is there evidence of Leprosy deformities on clinical photograph: Yes/No (Upload clinical photographs)
5. If the answer to question 4 is Yes then is there evidence of active Leprosy: Yes/No

For Eligibility for Leprosy Reconstructive 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.

Treating Doctor Signature with Stamp

NAME OF THE HOSPITAL: _____

19). Nerve And Tendon Repair + Vascular Repair: S12M1.9

1. Name of the Procedure: Nerve And Tendon Repair + Vascular Repair
2. Indication: Functional reasons
3. Has the patient presented with loss of sensations on upper or lower limb with loss of movements with absent pulsations due to injury to nerves, tendons and arteries which may be either an acute injury case or an old injury with scar: Yes/No
4. If the answer to question 3 is Yes then is there evidence of any open injury on clinical photograph in an acute trauma case (and intraoperative photographs) OR in old delayed repair case evidence of old scar on photograph and evidence of nerve injury in nerve conduction study and evidence of vascular injury on Color Doppler or angiogram: Yes/No (Upload clinical photographs in acute injury cases and in old delayed case upload clinical photograph of scar and the reports of nerve and vascular injury)

For Eligibility for Nerve And Tendon Repair + Vascular 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.

Treating Doctor Signature with Stamp
