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

_____