

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 Vena 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
