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

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