NAME OF THE HOSPITAL: _____

31). Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting: M15W1.34

1. Name of the Procedure: Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting

2. Indications: Select indication which is applicable
   Bleeding/ Pre operative/ Cosmetic/ Neurodeficit

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

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

5. If the answer to question 4 is Yes, then is the patient having evidence of
   a. Infection at local site: Yes/No
   b. Renal insufficiency: Yes/No
   c. Contrast Allergy: Yes/No
   d. Uncorrectable coagulopathy: Yes/No

For Eligibility for Embolization Of AV Malformation Of Peripheral Extremity, Craniofascial And Visceral Per Sitting the answer to question 5a, 5b, 5c & 5d 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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