NAME OF THE HOSPITAL: _____ 5).

Cerebral Malaria (Falciparum) requiring Ventilatory support and treatment with Blood and Platelet Transfusion, IV antibiotics, IV fluids, Mefloquine, IV quinine or IV artesunate, Paracetamol: M16Q1.5

1. Name of the Procedure: Cerebral Malaria (Falciparum) requiring Ventilatory support and treatment with Blood and Platelet Transfusion, IV antibiotics, IV fluids, Mefloquine, IV quinine or IV artesunate, Paracetamol

2. Indication: Cerebral Malaria

3. Does the patient presented with Fever with altered mentation (No neck stiffness): Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of Peripheral blood smear positive for Malarial parasite OR Positive malaria antigen test for P. falciparum: Yes/No (Upload test reports)

5. If the answer to question 4 is Yes is there evidence of

   a. Oxygen saturation less than 90% on pulse oxymetry: Yes/No (Upload report)

   b. CSFAnalysis done: Yes/No (Upload report)-Optional

For Eligibility for Cerebral Malaria (Falciparum) requiring Ventilatory support the answer to question 5a must be Yes

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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