NAME OF THE HOSPITAL: ____

PATIENT NAME: ____

1). Acute severe asthma with acute respiratory failure with up to 10 days stay: M3Q1.1

1. Name of the Procedure:

   Acute severe asthma with acute respiratory failure with up to 10 days stay

2. Indication: Acute severe asthma with acute respiratory failure
3. Does the patient have
   a. Presence of asthma: Yes/No

      AND

   b. Severe Breathlessness(Respiratory rate>30/min): Yes/No

4. If the answer to questions 3a AND 3b is Yes then is the patient having evidence of:

   a). $SaO_2<90\%$, $PaO_2<60$mmHg with/without $PaCO_2\geq40$mmHg on Arterial blood gas assessment: Yes/No (Upload ABG Report)

   b). Low Peak Expiratory Flow rate (< 100Liters/min): Yes/No (Upload PEF Report)-Optional

   c). Biochemical Investigations i.e. Serum electrolytes, urea, creatinine, LFT and Blood Sugar done: Yes/No (Upload Reports)

5. If the answer to questions 4a AND 4c is Yes, then is the patient having evidence of:

   a. Pneumothorax /other abnormalities detected on X-Ray Chest: Yes/No (Upload X-ray Chest film)

   b. Chest CT being done for doubtful infiltrates on X-Ray / differential diagnosis from other conditions: Yes/No (Upload CT film) ---- Optional Investigation

   For eligibility for acute severe asthma with acute respiratory failure with up to 10 days stay, the answer to either 5a OR 5b can 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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