NAME OF THE HOSPITAL: ____

PATIENT NAME: ____

2). COPD (Infective Exacerbations) up to 14 days stay with Ventilator support: M3Q1.2

1. Name of the Procedure:
   COPD (Infective Exacerbations) up to 14 days stay with Ventilator support

2. Indication: COPD (Infective Exacerbations)

3. Does the patient a known case of COPD (Breathlessness, cough, expectoration) presents with increased symptoms and/or fever, with/without systemic manifestations: Yes/No

4. If the answer to question 3 is Yes, then is the patient having evidence of:

   a). Arterial blood gas assessment documenting SaO2<90%: Yes/No (Upload ABG Report)

   b). Total Leucocyte count > 10,000/cumm: Yes/No (Upload CBC Report)

   c). X-ray chest done: Yes/No (Upload X-Ray film)
   (CT Scan optional in case of doubt/complication suspected)

   d). Spirometry done: Yes/No (Upload Spirometry report)-(optional)

   e). ECG and/or 2D-ECHO done to r/o cardiac abnormalities: Yes/No (Upload ECG and/or 2D- ECHO report)

For eligibility for COPD (Infective Exacerbations) up to 14 days stay, the answers to 4a AND 4b AND 4c AND 4e 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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