

NAME OF THE HOSPITAL: _____

80) Vertebral Angioplasty

1. Name of the Procedure: Vertebral Angioplasty

3. Select the indication:

a. Neurological symptoms: Yes/No

If yes – mention specific –

(Upload angioplasty and/or OSA)

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp
