NAME OF THE HOSPITAL: _____

5. Chronic Renal Failure (CRF) - 5 Days Stay for Initial treatment and Dialysis and supportive therapy: M8T2.5

1. Name of the Procedure: Chronic Renal Failure (CRF) - 5 Days Stay for Initial treatment and Dialysis and supportive therapy

2. Does the patient has history of more than 3 months: Yes/No

3. If the answer to question 2 is yes, does the patient has raised Urea ad Creatinine levels: Yes/No (Upload Urea and Creatinine Report)

4. If the answer to question 3 is yes then is the patient having following evidence on USG Abdomen and KUB:

   a) Small size Kidney (Less than 9cms): Yes/No

   AND/OR

   b) Enlarged Kidney with multiple cysts/obstruction: Yes/No

   AND/OR

   c) Normal size kidneys in case of long standing diabetes/hypertension: Yes/No

5. If the answer to question 4a/4b/4c is Yes then is there evidence of Hemoglobin less than 10gms/dl: Yes/No (Upload Hb Report)

6. If the answer to question 5 is yes, check iron status of patient by performing serum iron studies: Yes/No- Optional

7. If the answer to question 5 is Yes OR No does the patient have symptoms of nausea/vomiting/difficulty in breathing/drowsiness/acidotic breathing/flaps: Yes/No

8. If the answer to question 7 is No, does this patient has raised serum urea and creatinine with eGFR< 10 ml/min: Yes/No

If answer to question 7 OR 8 is yes, patient warrants initiation of hemodialysis

(Patient usually requires dialysis when serum creatinine is more than 6 mg/dl AND/OR eGFR< 10 ml/min. However, if patient has above mentioned symptoms, an early dialysis can be initiated)

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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