

NAME OF THE HOSPITAL: \_\_\_\_\_

13). Radiofrequency Ablation: S10I11.1

1. Name of the Procedure: Radiofrequency Ablation

2. Indication: Trigeminal Neuralgia

3. Does the patient presented with intense facial pain affecting day to day activity & can be triggered by common activities such as eating, talking, shaving, brushing, chewing:  
Yes/No

4. If the answer to question 3 is Yes then are the following tests being done – MRI Brain, MRI Angio to see artery in C.P angle: Yes/No (Upload reports)  
For Eligibility for Radiofrequency Ablation the answer to question 4 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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