

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

15). Embolization: S10I12.1

1. Name of the Procedure: Embolization
2. Indication: Management of aneurysms
3. Does the patient presented with severe headache, vomiting, sudden loss of consciousness, acute hydrocephalous: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - MRI, Angiogram: Yes/No (Upload reports)
5. If the answer to question 4 is Yes then is there evidence of
  - a. Above 65 years with poor clinical status or co-morbid conditions: Yes/No
  - b. Aneurysm more than 10mm in diameter: Yes/No
  - c. Aneurysm neck greater than or equal to 4mm: Yes/No

For Eligibility for Embolization the answer to questions 5a, 5b & 5c must be NO

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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