NAME OF THE HOSPITAL: _____

18). Ventriculoatrial Shunt: S10I2.10

1. Name of the Procedure: Ventriculoatrial Shunt

2. Indication: Brain Tumor/ Hydrocephalous/ Arnold Chiari malformation

3. Does the patient presented with headache, convulsion, vomiting, altered sensorium, hemiparesis: Yes/No

4. If the answer to question 3 is Yes then are the following tests being done - CT/ MRI brain: Yes/No (Upload reports)

5. If the answer to question 4 is Yes then is there evidence of
   a. Meningitis: Yes/No
   b. Ischemic Heart Disease: Yes/No
   c. Septicemia: Yes/No

For Eligibility for Ventriculoatrial Shunt 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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