NAME OF THE HOSPITAL: _____

17). Parasagittal Tumour: S10I2.1

1. Name of the Procedure: Parasagittal Tumour

2. Indication: Parasagittal Tumours

3. Does the patient presented with seizures, headache, muscle weakness, confusion, changes in personality, visual disorders, hearing loss: 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)
   For Eligibility for Parasagittal Tumour 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

_____