NAME OF THE HOSPITAL: _____

23). Brain Stem Tumour: S10I2.3

1. Name of the Procedure: Brain Stem Tumour

2. Indication: Progressive neurological defects/ Subacute Hemmorrhage/ Malformations with mass effect/ Persistant symptoms

3. Does the patient presented with lack of facial controls, double vision, headache, visual disturbances, vomiting, weakness, fatigue, seizures, imbalance while walking: 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. On immunosuppresant drugs: Yes/No
   b. Elderly persons: Yes/No
   c. Immunocompromised state: Yes/No

For Eligibility for Brain Stem Tumour 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

_____