NAME OF THE HOSPITAL: _____

24). C P Angle Tumour: S10I2.4

1. Name of the Procedure: C P Angle Tumour

2. Indication: C P Angle Tumour

3. Does the patient presented with severe headache, vomiting, giddiness, hearing loss, hemiparesis, visual disturbances, imbalance: 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 C P Angle 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

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