

NAME OF THE HOSPITAL: _____

39). Peritoneal Shunt: S10I3.9

1. Name of the Procedure: Peritoneal Shunt
2. Indication: Hydrocephalus or other related disease
3. Does the patient presented with vomiting, ataxia, incontinence of urine, drowsiness, altered sensorium: Yes/No
4. If the answer to question 3 is Yes then are the following tests being done - CT/ MRI brain, CSF Analysis: Yes/No (Upload reports)
For Eligibility for Peritoneal Shunt 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
