NAME OF THE HOSPITAL: ____

6. Scleral Buckle for Retinal Detachment: S3B11.1

1. Name of the Procedure: Scleral Buckle for Retinal Detachment

2. Indication: Retinal Detachment

3. Does the patient presented with shadow or curtain that affected any part of the vision: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the B-Scan done: Yes/No (Upload B-scan report)

6. If the answer to question 5 is Yes is there evidence of:
   a. Media opacity obscuring visualization like vitreous hemorrhage, vitreous debris: Yes/No
   b. Advanced proliferative vitreo retinopathy: Yes/No
   c. Posterior tears: Yes/No
   d. Giant Retinal tear: Yes/No

For eligibility for Scleral Buckle for Retinal Detachment, the answers to questions 6a AND 6b AND 6c AND 6d should 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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