NAME OF THE HOSPITAL: _____

24. Cystocele, Rectocele & Perineorraphy: S4C2.4

1. Name of the Procedure: Cystocele, Rectocele & Perineorraphy
2. Indication: Cystocoele, Rectocoele, Vaginal Laxity
3. Does the patient presented with Cystocoele, Rectocoele, Vaginal Laxity with or without difficulty in passing urine and stools/ Stress Urinary Incontinence: Yes/No
4. If the answer to question 3 is Yes is there evidence of
    a. Anterior or posterior compartment defect (cystocoele, rectocoele): Yes/No
    b. Stress Urinary Incontinence: Yes/No
5. If the answer to either question 4a OR 4b is Yes whether USG and PAP smear has been done: Yes/No (Upload USG and PAP smear report)

For Eligibility for Cystocele, Rectocele & Perineorraphy the answer to question 5 should 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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