

NAME OF THE HOSPITAL: \_\_\_\_\_

30) Coarctation Of Aorta Repair Without Graft

1. Name of the Procedure: Coarctation Of Aorta Repair Without Graft

2. Select the Indication:

a. Claudication: Yes/No

b. Distal ischemic signs: Yes/No

Mention – Any specific

c. Focal aorta Coarctation with distal ischemic symptoms: Yes/No  
(Upload 2D echo/CT angiography)

3. Treatment –

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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