NAME OF THE HOSPITAL:____

46) Diaphragmatic Eventeration

1. Name of the Procedure: Diaphragmatic Eventeration

2. Select the Indication:

   a. Congenital DE: Yes/No

   b. Acquired DE: Yes/No

      (Upload X Ray and/or CT and/or USG)

3. Treatment –

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

____