NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

3). Torsion Testis (one/both) (S9H2.2)

1. Name of the Procedure: Torsion Testis

2. Indication: Torsion Testis

3. Does the patient have
   a. Acute onset of Pain/Swelling: Yes/No

      AND/OR

   b. Gangrenous Testis: Yes/No

4. If the answer to either question 3a AND/OR 3b is Yes then is the patient having evidence of infarction/ absent flow on USG of scrotum with Doppler: Yes/No (Upload USG with Doppler film)

5. If the answer to question 4 is Yes then is the patient having evidence of:

   a. Epididymo-orchitis: Yes/No

   b. Infective states of testis: Yes/No

   c. Maligancy of testis: Yes/No

For eligibility for torsion testis, the answer to 5a, 5b & 5c must be No

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

Treating Doctor Signature with Stamp

_____