NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

70). Renal Cyst Excision: Symptomatic Renal Cyst (S9H7.8)

1. Name of the Procedure: Renal Cyst Excision

2. Indication: Symptomatic Renal Cyst

3. Does the patient have evidence of Pain/Infection/Hemorrhage/Rupture: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. Renal Cyst on USG: Yes/No (Upload USG Report)

   b. CT KUB (plain + contrast) documenting Renal Cyst in kidney: Yes/No
   (Upload CT Scan film)

5. If the answer to questions 4a AND 4b is Yes is there evidence of
   a. Malignancy: Yes/No
   b. Non-functioning kidney: Yes/No

   For eligibility for Renal Cyst Excision procedure, the answer to questions 5a AND 5b should be No.

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

Treating Doctor Signature with Stamp

_____