NAME OF THE HOSPITAL: _____

PATIENT NAME: _____

73). Vesico-Vaginal Fistula Repair: Presence of VVF: (S9H8.1)

1. Name of the Procedure: Vesico-Vaginal Fistula Repair

2. Indication: Presence of VVF

3. Does the patient have evidence of Urine leak/ Infection: Yes/No

4. If the answer to question 3 is Yes, then is there evidence of
   a. VVF on MCU: Yes/No (Upload MCU film))

   b. Cysto-urethroscopy documenting VVF: Yes/No (Upload Cysto-urethroscopy findings)

   c. USG to demonstrate normal Upper tract: Yes/No (Upload USG film)

   (If upper tract abnormality detected on USG, then IVP to look for ureteric involvement)
   (CT Scan Optional)

5. If the answer to questions 4a AND 4b AND 4c is Yes is there evidence of
   a. Untreatable Malignancy: Yes/No

   b. Gross infection: Yes/No

   c. Poor general condition of patient: Yes/No

   For eligibility for Vesico-vaginal fistula repair, the answer to questions 5a, 5b & 5c should be No.

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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