Medical Standards & Research Pre-approval Form

This is a pre-requisite form provided upon request for the **"Brain Death Diagnosis Confirmation".**

Kindly fill in all the requested information given below. This is a mandatory step to proceed further. Failure to provide information relevant to approval will delay the processing of the applicant's request. The provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Member's Name: _____
  ☐ New ☐ Established
- Member Card #: _____
- Policy: _____
- Age: _____
- Gender: ☐ Female ☐ Male
- Date (dd-mm-yyyy): / /

PROVIDER INFORMATION

- Provider's Name: _____
- Ordering Clinician (ID # & Name): _____
- Performing Provider Name: _____
- Performing Clinician Specialty (ID # & Name): _____
- Referring Physician (ID # & Name): _____

GENERAL PHYSICAL EXAMINATION

- Temperature: .....
- Heart rate: .....
- Blood pressure: .....
- SO2%: .....

SYSTEMIC EXAMINATION

- Respiratory system (tick one): On Room Air ☐ Oxygen/BiPAP ☐ On MV ☐
- CVS- On cardiac support: Yes ☐ No ☐
- GIT- Feeding status: Oral ☐ NG tube ☐ PEG ☐ TPN ☐
- CNS- GSC (tick one): Mild (13-15) ☐ Moderate (9-12) ☐ Severe (6-8) ☐ 3-5 ☐

IF GCS IS BETWEEN 3-5 THEN PLEASE COMPLETE BELOW NEUROLOGICAL ASSESSMENT

- **Pupillary reflex**: Do the pupils react to light? Test for direct consensual response on both sides. Yes ☐ No ☐
- **Corneal reflex**: Is there any eyelid movement when each cornea is touched in turn? Touching the sclera is not sufficient. The use of sterile gauze is recommended. Yes ☐ No ☐
- **Motor response**: Is there any motor response within the cranial nerve or somatic distribution when supraorbital pressure is applied? Repeat both sides. Somatic reflex limb and trunk movements (spinal reflexes) may need to be differentiated. Yes ☐ No ☐
- **Gag reflex**: Does the gag reflex present? Stimulate the posterior pharynx bilaterally. Use a tongue depressor or firm suction catheter (e.g. Yankauer sucker). A laryngoscope may assist. Yes ☐ No ☐
- **Cough reflex**: Is the cough reflex present? Pass a suction catheter down the trachea to the carina. Yes ☐ No ☐

SERVICE REQUESTED

- Principal/ Primary Diagnosis: _____
- ICD-10: _____
- Requested Procedural Code & Description (CPT): _____

Is the member age is more than 18 years?

No ☐

Yes ☐

- ≥ 6 hours have passed since the initial insult: Yes ☐ No ☐
- All preconditions have been met? Yes ☐ No ☐
- All confounders have been excluded: Yes ☐ No ☐
- Coma diagnosis is confirmed by absence of brainstem reflexes: Yes ☐ No ☐

- Apnea test performed: Yes ☐ No ☐

  If the answer is yes, comment on test result:
  .....
  .....

- Ancillary test to confirm the diagnosis:
  EEG: Yes ☐ No ☐
  CT Angiogram (CTA): Yes ☐ No ☐

  Absence of brain circulation by any of (Cerebral angiogram, Nuclear medicine cerebral blood flow study, Transcranial Doppler, CT cerebral angiogram): Yes ☐ No ☐

- Second examination performed: Yes ☐ No ☐

If the member age is less than 18 years?

- All preconditions have been met: Yes ☐ No ☐
- All confounders have been excluded: Yes ☐ No ☐
- Coma diagnosis is confirmed by absence of brainstem reflexes: Yes ☐ No ☐
- Additional reflexes tested (Suckling and rooting reflex) in neonates: Yes ☐ No ☐
- First apnea test performed: Yes ☐ No ☐
- Second apnea test performed: Yes ☐ No ☐
- Is ancillary test required to confirm the diagnosis: Yes ☐ No ☐
  (if yes, what test was performed)
  EEG: Yes ☐ No ☐
  CT Angiogram (CTA): Yes ☐ No ☐

Additional information

- Any additional test performed: Yes ☐ No ☐
  If the answer is yes, comment on test result:
  .....
  .....
- Second opinion obtained: Yes ☐ No ☐
- Any admission to acute care in previous month
  (if yes, attach discharge summery): Yes ☐ No ☐
- Physician Signature 1 .....
- Physician Signature 2 .....
- Physician Signature 3 .....

- Physician Comments:
  .....
  .....
  .....

Indication for coverage

1: Is the patient pregnant? Yes ☐ No ☐

If yes, then what is the gestational week

1-13 ☐

14- 26 ☐

27 -39 ☐

>40 ☐

2: Is the patient a potential/confirmed organ donor?

Yes ☐ No ☐

Please specify the organ to be donated:

Justification and Documentation of Patient transplant status for patients on life support greater than one week (Please attach): .....
.....

3: Is there any court order justifying continuation of mechanical ventilation and life support?

Yes ☐ No ☐