

Scottish Audit of Intracranial Vascular Malformations (SAIVMs)

①

Please insert these essential identifying details for the patient you wish to notify.

**They must be
Scottish residents**

Forename	<input type="text"/>		
Surname	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>
	day	month	year
	... or affix the patient's identification label from your hospital		
Hospital No.	<input type="text"/>	X ray/Path No.	<input type="text"/>

②

Indicate the type(s) of IVM. They must be **first diagnosed**:
1/1/99 – 31/12/03
or after 1/1/06.

Specify type(s) of IVM	Indicate the quantity:
<input type="text"/>	<input type="text"/>
Date of first diagnosis (by imaging or biopsy)	
	day month year
	<input type="text"/> <input type="text"/> <input type="text"/>

③

Please tell us which consultant and GP look after this patient.

Consultant initials & surname	GP initials & surname
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Hospital name & address	Practice name & address
<input type="text"/>	<input type="text"/>

④

Now add your signature and today's date.

Signature	<input type="text"/>
Print your name	<input type="text"/>
Date	<input type="text"/> <input type="text"/> <input type="text"/>
	day month year

⑤

Please post or fax us this notification form...

SAIVMs Contact	TELEPHONE / FACSIMILE
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