



Bone And Joint Multispecialty Hospital
9-A-30, Rajiv Gandhi Auditorium Road RC Viyas Colony
Bhilwara, Rajasthan 311001

**INFORMED
CONSENT FOR
BLOOD
TRANSFUSION**

Patient Name:-	UHID No:-	IPD No:-	Age/Sex:-
Consultant Name:-	Dep't:-	Ward/Room:-	Diagnosis:-

रक्त चढ़ाये जाने सम्बन्धी विशेष सहमति पत्र

मुझे यह स्पष्ट रूप से सूचित कर दिया गया है कि मुझे/मेरे रोगी (नाम)आईपीडी संख्या का उपचार करने वाले चिकित्सककी राय में मुझे/रोगी को रक्त अथवा रक्त घटक मेरे/मेरे रोगी के स्वास्थ्य की स्थिति में सुधार के लिए चढ़ाया जा रहा है।

It has been clearly communicated to me that my / my patient(Name) _____ IPD NO _____ Opinion of the treating physician (Name) _____ are being offered blood / blood component to me /blood products / the patient to improve the health status of my / my patient.

भारत सरकार के द्वारा नियंत्रक द्वारा निर्धारित मार्गदर्शकों के आधार पर रक्त घटक चढ़ाये जाने (ट्रांसफ्यूजन) से पूर्व भतिभांति जाँच लिए गये हैं। रक्त अथवा रक्त घटक को अधिक सुरक्षित बनाये रखने हेतु किसी अन्य जाँच के लिए अथवा तकनीकी तथा अतिरिक्त जाँच सम्बन्धी खर्च के लिए मैं अपनी सहमति देता हूँ। फिर भी मुझे ज्ञात है कि इससे मुझे/मेरे रोगी को संक्रियत हैपेटाइटिस, एकायर्ड इम्यूनो डेफिशिएंसी सिंड्रोम (एडस) होने की सम्भावना भी हो सकती है अथवा अन्य दूसरी बीमारियाँ, रक्त प्रतिक्रिया, एलर्जी प्रतिक्रिया भी हो सकती है।

Based on the guidelines prescribed by the Controller of Drugs, Government of India, blood transfusions have been done prior to transfusion. I give my consent for any other test or for technical and additional testing related expenses to keep the blood or blood component safer. Even then I know that it may cause me / my patient to have infected hepatitis, acquired immunodeficiency syndrome (AIDS) or other diseases, blood reaction, allergic reaction.

मैं आश्वस्त हूँ कि रक्त चढ़ाये जाने से होने वाले इस तरह के संक्रमण का उपचार भी किया जा सकता है। यह कुछ मामलों में हो खतरनाक हो सकता है।

I am convinced that such transfusion caused by blood transfusion can also be treated. It can be dangerous in some cases.

मुझे रक्त चढ़ाये जाने से पूर्व इससे सम्बन्धित प्रश्न पूछने का पूरा अवसर दिया गया है तथा मैं अपनी संतुष्टि के लिए इससे सम्बन्धित समस्त प्रश्नों के उत्तर जान लिए हैं।

I have been given full opportunity to ask questions related to it before blood transfusions and I have found the answers to all the questions related to it to my satisfaction.

Patient/रोगी का नाम

Signature/हस्ताक्षर

Date/दिनांक

Declaration by Treating Doctor/चिकित्स द्वारा घोषणा

मैंने रोगी/उसके जिम्मेदार सहयोगी को प्रक्रिया एवं उससे जुड़े संभावित खतरों, लाभों एवं वैकल्पिक व्यवस्थाओं (यहाँ तक कि उपचार नहीं लिय जाने सम्बन्धी विकल्प) के बारे में स्पष्ट रूप से समझा दिया है। मैंने इस प्रक्रिया से जुड़ी रोगी की सभी शंकाओं को भलीभांति समझा दिया है।

I have clearly explained to the patient / his / her responsible aide about the process and the possible dangers associated with it, benefits and alternative arrangements (even options related to non-treatment). I have fully understood all the doubts of the patient associated with this process.

Doctor/फिजिशियन का नाम

Signature/हस्ताक्षर

Date/दिनांक

रक्त एवं रक्त उत्पाद चढ़ाये जाने के प्रति असहमति का अधिकार / Right to disagree about blood and blood products being offered:

रक्त घटक नहीं चढ़ाये जाने से होने वाले समस्त संभावित खतरों एवं समस्याओं के बारे में पूरी जानकारी रखते हुए मैं रक्त अथवा रक्त घटक चढ़ाये जाने के लिए सहमत नहीं हूँ। इस कारण से हुए संभावित खतरों, समस्याओं के लिए मैं स्वयं जिम्मेदार हूँ।

Having full knowledge about all the possible dangers and problems due to non-delivery of blood component, I do not agree to offer blood or blood component. For this reason I am myself responsible for the potential dangers and problems.

PatientName/रोगी का नाम
Attendant Name/जिम्मेदार
सम्बन्धी का नाम

Signature/हस्ताक्षर
Date/दिनांक

Signature witness /हस्ताक्षर साक्षी
Date/दिनांक



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**Post- Anesthesia
Monitor
Assessment
Sheet**

Wherever options are provided, please (✓) mark against the correct information. This form is to be filled in by the Anaesthesiologist/ Nurse. Date _____

1. Patient Profile

Name _____ UHID No. _____ IPD No. _____ Age/Sex _____

Consultant Incharge _____ Department _____ Date of Admission _____

2. Patient Transfer Details (to be filled in by the Nurse)

Diagnosis _____

Procedure Done _____

3. Post-Operative Handover Details (to be filled in by the Nurse)

HANDED OVER BY

Time _____ hrs./min. Name _____ (Signature) _____

HANDED OVER TO

Time _____ hrs./min. Name _____ (Signature) _____

TIME PATIENT WAS SHIFTED TO FLOOR / ICU

Time _____ hrs./min. Name _____ (Signature) _____

4. Nursing Notes (to be filled in by the Nurse)

URGENT INVESTIGATIONS (if any)

Time _____ hrs./min. Name _____

Time of sending sample _____ Report _____



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**Post- Anesthesia
Monitor
Assessment
Sheet**

(CONTINUED FROM PREVIOUS PAGE)

Parameters	Time (1/2 hr.)											
Alert / awake / asleep												
Heart Rate												
Blood Pressure												
Respiration												
O ₂ saturation (with or without O ₂)												
Pain scoring (facial 0 to 10)												
Nausea / emesis												
IV fluids												
Urine output												
Post operative drainage												
1.												
2.												
Irrigation												
In situ CVP/ART/epidural/IV line												

5. Before Shifting Recovering Notes (Doctor's)

|
|
|

6. Report of Investigation before Shifting to the Ward (if any) (Nurses)

|
|
|

SHIFTING [] Ward [] Critical Care Unit

7. Transfer Notes (To be filled in by the Nurse)

[] Awake [] Drowsy [] Asleep [] Pain free [] Comfortable

Pulse | _____ BPI | _____ SPO₂ | _____ Respiratory rate | _____

OTHER NOTES

|
|

ANAESTHESIOLOGISTS

Date & Time _____

Name & Signature _____



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**Post - Anesthesia
Recovering
Assessment
sheet**

1. Patient Profile

Patient Name : _____ Age _____ Sex _____

UHID No. : _____ IP No. _____ Date of Admission : _____

Consultant Incharge : _____ Department _____

	CRITERIA	POINT VALUE
OXYGENATION	• SpO2 > 92% on Room Air	2
	• SpO2 > 90% on Oxygen	1
	• SpO2 < 90% on Oxgen	0
RESPIRATION	• Breathes deeply and coughs freely	2
	• Dyspneic, shallow or limited breathing	1
	• apnea	0
CIRCULATION	• Blood pressure 20mm Hg of normal	2
	• Blood pressure 20-50mm Hg of normal	1
	• Blood pressure more than 0mm Hg of normal	0
CONSCIOUSNESS	• Fully awake	2
	• Arousable on calling	1
	• Not responsible	0
ACTIVITY	• Moves all extremities	2
	• Moves two extremities	1
	• No movement	0

Total Score

NOTE : Ideally, The Patient should be Discharged When The Total Score is 10 But A minimum 9 of is Required.

Signature (Duty Nurse)

Date & Time

Signature (SR/Consultant)

Regd. No.



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Anesthesia Monitoring Form
(To be filled by doctor)

PATIENT NAMEUHIDAGESEX

CONSULTANT NAMEIPD NO.WARD

DiagnosisTime startedTime finished

Proposed operationDate of operationTime of operation

Anesthesia : General / Spinal / Epidural / Local

History related to anesthesia

Pre-Op. Assessment : DM PULSE

Tooth & Airway HT BP

CVS IHD HB%

Resp ASTHAMA BL.SUGAR

Metabolic Disorder KOCH'S X-RAY

Any other previous History

Pre Medication

: Atropine / Pyrolate / Midazolam / Reglan / Fentanyl / tramadol

Immediate pre.Op.

: Pulse BP.....mm/hg PaO₂% HB.....%

Position

Spinal / Epidural

: Xylocaine% sensocaine

Induction

: Thiopentone/ Propofol/ Ketamine

Maintance

: O₂ / N₂O/ N₂O / Air Fluothane / Isoflurane / sevoflurane

Relaxant

Post operative : pulse BPmm /hg PaO₂

Conscious / extubated BDTDOS

DRUGS USED DURING SURGERY

ANAESTHESIA : DR. NAME

SIGNATURE



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**WHO SURGICAL
SAFETY CHECK
LIST**

Before induction of Anaesthesia

Before Skin incision

Before Patient leaves operating room

SIGN IN :

Please mention the time

- Patient Has Confirmed
 - Identity
 - Site
 - Procedure
 - Consent

Site Marked Not Applicable

Anaesthesia Machine & Medication Check Done

Pulse Oximeter On Patient And Functioning

Does Patient Have A :

Known Allergy?

- No
- Yes

Difficult Airway/aspiration Risk?

- No
 - Yes, And Equipment/assistance Available
- Risk Of > 500ml Blood Loss
(7ml/kg In Children)?
- No
 - Yes, And Adequate Intravenous Access And Fluids Planned

Patient Name :

IP No.....UHID No.....Age/Sex.....

Procedure

Diagnosis

TIME OUT :

Please mention the time

- Confirm All Team Members Have Introduced Themselves By Name And Role
- Surgeon, Anaesthesia Professional And Nurse Verbally Confirm
 - Patient Name
 - Site of incision
 - Procedure

Anticipated Critical Events

Surgeon Reviews:

- What Are The Critical or Unexpected Steps?
- Operation Duration?
- Anticipated Blood Loss?

Anesthesia Team Reviews :

- Are There Any Patient-specific Concerns?

Nursing Team Reviews :

- Has Sterility (including Indicator Results) Been Confirmed?
- Are There Equipment Issues Or Any Concerns?

Has Antibiotic Prophylaxis Been Given Within The Last 60 Minutes?

- Yes
- Not Application

Is Essential Imaging Displayed?

- Yes
- Not Application

SIGN OUT :

Please mention the time

Nurse Verbally Conforms With The Team:

- The Name Of The Procedure Recorded
 - That Instrument, Sponge And Needle Counts Are Correct (or Not Applicable)
 - How The Specimen Is Labelled (including Patient Name)
 - Whether There Are Any Equipment Problems To Be Addressed
 - Surgeon, Anaesthesia Professional And Nurse Review The Key Concerns For Recovery And Managements Of This Patient
- Name Of The Surgeon :-
- Regd. No. :-
- Name Of The Anesthetist :-
- Regd. No. :-
- Name Of The Nurse :-
- Date :-



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Pre-operative Assessment Sheet
(To be filled by Doctor/Nurse)

1. Patient Profile/ रोगी प्रोफाइल

Patient Name _____ Age/Sex _____

Father/Husband/Guardian Name _____ Tel. No. _____

UHID No. _____ IPD No. _____ Date of Admission _____

Consultant Incharge _____ Department _____

Diagnosis _____

Surgery _____

PARTICULARS	TICK ONE (x/✓) OF THE FOLLOWING		REMARKS
History Sheet	FILLED <input type="checkbox"/>	NOT FILLED <input type="checkbox"/>	
Plan of Care	FILLED <input type="checkbox"/>	NOT FILLED <input type="checkbox"/>	
Pre Operative Instruction	WRITTEN <input type="checkbox"/>	NOT WRITTEN <input type="checkbox"/>	
Surgery & Anaesthesia Consent Form	TAKEN <input type="checkbox"/>	NOT TAKEN <input type="checkbox"/>	
High Risk Consent Form	TAKEN <input type="checkbox"/>	NOT TAKEN <input type="checkbox"/>	
Radiological Investigation	ATTACHED <input type="checkbox"/>	NOT ATTACHED <input type="checkbox"/>	
Laboratory Investigation	ATTACHED <input type="checkbox"/>	NOT ATTACHED <input type="checkbox"/>	
Blood Donation Done	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Blood Arranged	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
PAC Fitness	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Financial Clearance From IPD Billing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
All Viral Marker Done (HIV-I&II, HBsAg, HCV)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Other			
Remarks			

Name and Signature of Doctor on Duty : _____

Date : _____



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Operative and Post-Operative Notes
(To be filled by Doctor)

Name of Patient _____ Age/Sex _____

UHID No. _____ IPD No. _____ Date of Admission _____

Room/Ward No. _____ Consultant _____

Department : _____

Date of Surgery _____ Start Time _____ End Time _____

Pre Operative Diagnosis _____ Surgeon _____

Post Operative Diagnosis _____ Anaesthetist _____

Name of Procedure _____ Scrub Nurse _____

Type of Anesthesia _____ Assistants _____

Operative Steps _____



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Operative and Post-Operative Notes
(To be filled by Doctor)

Post Operative Vitals :

Specimens :

Estimated Blood Loss :

Fluids Given :

Drains & Position :

Condition of Patient at end of Surgery : Stable Fair Critical

Post Operative Orders :

Disposition : ICU / Recovery Room / Patient Room

Name & Signature of the Surgeon

Regd. No. _____



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**Pre Anesthesia
Checkup Form**
(To be filled by Doctor)

Name of Patient _____ Age/Sex _____

UHID No. _____ IPD No. _____ Date of Admission _____

Consultant _____

Provisional Diagnosis _____ Procedure Planned _____

Consultant Incharge _____ Department _____

Anesthesia Planned _____ Surgeon _____

PREOPERATIVE HISTORY **No / Yes** **Details / Comments / List Current Medication / Herbs :**

Allergies : To Medication / dressing / food (List) ?			
Are you under any medical / herbal treatment now ?			
Any steroids (prednisone / cortisone) in past 6 months?			
Any aspirin / warfarin / anti-platelet drugs in last 2 weeks?			
Do you smoke ? (cig. per day for years)			
Do you regularly consume alcohol ?			
Any past serious illness / hospitalisation ?			
Any recent change in health status ?			
Cardiac / Pulmonary System			
1. Effort Tolerance for Level Ground =			
2. Effort Tolerance for Stairs =			
3. Shortness of breath at rest or on lying flat			
4. Asthma / bronchitis / COPD / OSA			
5. High blood pressure			
6. Heart Attack / disease			
7. Chest pain exertion or at night			
8. Irregular heart beats			
9. Rheumatic fever / heart murmur			
Homeopathic System			
8. DVT / blood clot in the legs or lungs			
9. Bleeding tendency / easy bruising			
10. Anaemia / blood disease / Blood Transfusion			
Endocrine System			
11. Diabetes			
12. Thyroid Disease			
Gastrointestinal / Genitourinary System			
13. Indigestion / heartburn / reflux / hiatus hernia			
14. Jaundice / liver disease / hepatitis			
15. Kidney disease / renal dialysis			
16. (Female) Are you pregnant ? LMP			
17. Psychiatric illness			
18. Stroke / TIA			
19. Epilepsy or other fits / faints			
20. Muscle disease or weakness			
21. Arthritis / joint disease / numbness in fingers of			
any other medical problems not included above ? (Describable)			

Have you ever had an operation ? (List with dates)	Dates	No Yes
		GA / RA / LA
		GA / RA / LA



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**Pre Anesthesia
Checkup Form**
(To be filled by Doctor)

SUMMARY (List of Problems)

A
N
E
S
T
H
E
S
I
A

	NO	YES	
Normal Airway (if No, tick or describe abnormality)			1
Mouth Opening < 2 Fingers			
Thyromental Distance < 3 Fingures			2
Limited Neck Movement			
			3

Mallampati Gr. I II III IV

CVS

Resp

Neuro / Spine

Other

Anesthetic Plan and Risk Discussed with Patient

ASA : I II III IV V E

INSTRUCTION FOR USUAL MEDICATION / PREOPERATIVE PREPARATION

HR	BP	Sat	%
Wt kg	HT cm	BMI	

Any teeth missing or loose ? Any crowns or bridges ? NO YES

	Right	Left	Top	Full	Partial
Missing	Loose				
Crown	Bridge		Bottom	Full	Partial

INVESTIGATIONS

Hematology	Biochemistry	Other Blood Tests
HB _____	Bl. Sugar ^F _{PP} _____	S. Bil _____
TLC _____	Urea _____	SGOT _____
PLT _____	Cr _____	SGPT _____
PT _____	Na _____	Alk. Phos. _____
INR _____	K+ _____	T. Protein _____
APTT _____	Cl _____	Albumin _____
BT _____	HIV _____	TSH _____
CT _____	HBSAg _____	Blood Gr. _____
	HCV _____	

ECG

C. X RAY

CT SCAN

ECHO/ Stress Echo/DSE

Urine R & M :

Urine C & S :

Other Investigations

Re-Evaluation :

a) Anesthesia Plan :-

b) Vitals :-

c) Is Patient Fit For Surgery :-

Name

(Signature)

Date



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Informed Consent for Anesthesia
(To be filled by Doctor)

Name of Patient _____ Age/Sex _____

Room/Ward No. _____ UHID No. _____ IPD No. _____ DOA _____

Consultant _____

Proposed Surgery/ चिकित्सा :

1. I _____ authorize Dr. _____ and who so ever he/she may designate to administer anaesthesia SA GA LA to me.

मैं अथोहस्ताक्षरी डॉ.

उनके द्वारा नियुक्त को निश्चेतन करने की अनुमति देता हूँ/देती हूँ।

2. I state that I am not having any medical problem ()

मुझे किसी प्रकार का कोई रोग नहीं है। ()

3. I state that I am having following medical problem.

() Hypertension () Diabetes () Heart Disease () Kidney Failure
() Hypothyroidism () Bronchial Asthma () Jaundice () Thyrotoxicosis
() Steroid Therapy () Allergy to drugs () Bleeding Disorders () Epilepsy
() Complication of previous anaesthesia () Other (specify) _____

मैं निम्नलिखित रोगों/दशाओं के इतिवृत्त की घोषणा करता हूँ / करती हूँ।

() उच्च रक्तचाप () मधुमेह () हृदय रोग () किडनी विफल
() हाइपोथायराडिज्म () अस्थमा () पीलिया () थाइरोटोक्सीकोसिस
() स्टीरायड चिकित्सा () दवाइयों से एलर्जी () रक्तरसाव विकार () ऐपीलेप्सी
() पूर्व एन्सथीसिया संबंधी जटिलताएं () यदि कोई और जटिलता

4. I have been explained adequately in language that there may be unforeseen complications of anaesthesia procedure like :-

* Reaction to anaesthetic drugs which may lead to long term morbidity or even mortality.

* Injure to teeth / lips / intra Oral Structures like Buccal Mucosa / Larynx / Epiglottis.

* Backache (in case of spinal / Epidural Anaesthesia)

* Delayed recovery / poor recovery.

मुझे मेरी भाषा में एन्सथीसिया संबंधी जटिलताओं के संबंध में प्रश्न पुछने का अवसर दिया गया है और मैं सभी उत्तरों से आश्वस्त हूँ :-

- संवेदनाहारी दवाओं की प्रतिक्रिया जो लम्बे समय तक प्रभावित करें।
- दाँतों / होंठों / मुँह / तालू में घाव
- कमर का दर्द (स्पाइनल / एपीड्यूल एन्सथीसिया)
- देर से ठीक होना / आंशिक ठीक होना



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Informed Consent for Anesthesia
(To be filled by Doctor)

5. I understand that in even of unexpected complication, I authorize anaesthesia team to take appropriate steps in treatment. I further state that in the even of unexpected complications, my family members will not hold members of anaesthesia term in particular or in addendum person allyliable for person action.
मैं समझता हूँ कि अप्रत्याशित जटिलताओं की स्थिति में मैं एन्सथीसिया विशेषज्ञ को उपयुक्त कदम उठाने के लिए अधीकृत करता हूँ।
इन अप्रत्याशित जटिलताओं कि परीस्थिति मैं या मेरे परिवार के सदस्य एन्सथीसिया दल के किसी भी सदस्य पर कोई व्यक्तिगत कार्यवाही नहीं करेंगे।
6. I give my permission for placing appropriate mechanisms for post operative pain management.
मैं एन्सथीसिया विशेषज्ञ को ऑपरेशन से हुए दर्द से निवारण की व्यवस्था की व्यवस्था करने की अनुमति देता हूँ / देती हूँ।
7. I have been given an opportunity to ask any question and seek second opinions, I have understood all implication of above consent and further submit that all applicable information was filled in any inapplicable paragraph as stricken off before I signed that consent / put my thumb impression.
मुझे कोई भी प्रश्न पुछने का पूरा अवसर दिया गया है और मुझे द्वितीय का विकल्प भी दिया गया है। मैं पूर्ण सन्तुष्टि के बाद ही हस्ताक्षर / अंगूठा चिन्ह लगा रहा हूँ / रही हूँ।

	Name	Address	Sign.	Date
Patient / मरीज				
Witness / गवाह				
Doctor / डॉक्टर				



Bone And Joint Multispecialty Hospital
9-A-30, Rajiv Gandhi Auditorium Road RC Viyas Colony
Bhilwara, Rajasthan 311001

**Informed Surgery
consent**
(To be filled by Doctor)

1. Patient Profile/ रोगी प्रोफाईल

Name _____ Age/Sex _____

Father/Husband/Guardian Name _____ Tel. No. _____

E-mail ID _____ Consultant Incharge _____

UHID No. _____ IPD No. _____ Room No. _____ Bed No. _____

Procedure Name : _____

Authorisation for medical treatment or diagnostic/therapeutic procedure/ Surgery
चिकित्सा उपचार के लिए प्राधिकार/अथवा जाँच/चिकित्सीय प्रक्रियाओं के लिए प्राधिकार

2. Instructions/ निर्देश

1. The physician or his designee doctors are responsible for obtaining the informed consent.
1. इस फार्म को करवाने की जिम्मेदारी चिकित्सक या उसके द्वारा नियुक्त किए गए चिकित्सक की है।
2. This consent form should be signed by: The patient if an adult (18 year or older); parent/guardian if the patient is a minor; the spouse or adult children or parents or adult brothers or sister (in this order of priority), if the patients lacks the ability to make an informed decision.
2. यह सहमति फार्म निम्नलिखित व्यक्तियों द्वारा भरा जाना चाहिए, रोगी यदि व्यस्क (18 वर्ष या उससे बड़ा है), अभिभावक/संरक्षक यदि होगी नाबालिंग है, पति या पत्नी, या व्यस्क बच्चों या माता-पिता या भाई-बहर आदि (प्राथमिकता के इस क्रम में), यदि रोगी कोई भी निर्णय लेने में असमर्थ हैं।

3. Consent (To be filled in by the Consultant and Patient/Attendant*)/ सहमति (डॉक्टर और रोगी/रोगी के सम्बंधी द्वारा भरा जाएगा)

1. I, hereby authorise the Hospital and those it may designate as staff to perform the following medical treatment/surgical operation, and diagnostic/therapeutic procedures.
1. मैं, हॉस्पिटल एवं उसके द्वारा नियुक्त कर्मचारियों को निम्न स्वास्थ्य संबंधी चिकित्सा/शल्य चिकित्सा एवं निदान/चिकित्सकीय प्रक्रियाओं के लिए अनुमति देता/देती हूँ।

Upon Mr./Mrs./Ms./Mast. _____

2. I have been advised of the following benefits and reasons for the procedure (s) as indicated by the clinical observations and/or diagnostics performed. I recognise that the practice of medicine is as much an art as a science and, acknowledge that no guarantee has been or can be made regarding the likelihood of success or outcome.
2. मुझे इलाज पद्धति के कारण, इससे होने वाले निम्नलिखित फायदे और संभावित नुकसान की जानकारी प्रदान की गई है। मैं स्वीकार करता/करती हूँ कि दवा का अभ्यास जिस प्रकार विज्ञान है उसी प्रकार की कला भी है। इसलिए इस बात से सहमति भी रखता/रखती हूँ की इलाज की सफलता और परिणाम की कार्रवानी नहीं होती।

3. I have been advised that major risks involved in the above procedure (s) are :

3. मुझे इलाज पद्धति के कारण, इससे होने वाले संभावित नुकसान की जानकारी प्रदान की गई है।

4. I have been advised of the following existing alternatives, treatment and prognosis if the procedure (s) is not done listed as follows :
4. मुझे इलाज पद्धति के नहीं होने पर अन्य विकल्प सुझाव व प्रक्रिया की जानकारी प्रदान कर दी गई है।

5. I authorise Dr. _____ and such assistants and associates as may be selected by him/her to perform any part of the above procedure (s) upon myself/the patient. I have been advised and agree that any member of this team may perform any part of my procedure (s) according to his / her stage or training and ability, if in the opinion of the above named physician, the experience and capability of the assistant surgeon justifies such as decision.
5. मैं अधिकत करता/करती हूँ कि डॉ. व ऐसे सहयोगी और उनके द्वारा नियुक्त सहायकता को कि वे मेरा/मेरे मरीज का उपयुक्त इलाज करें। मुझे दिए गए सुझाव के अनुसार मैं इस बात की सहमति देता/देती हूँ कि नियुक्त किए गए सदस्य उपचार विधि में अपनी गुणवत्ता, कौशल और प्रशिक्षण स्तर के अनुसार कार्यवाही करें, जो सहयोगी सर्जन की क्षमता और अनुभव के आधार पर अगर उपयुक्त चिकित्सक की राय में पुष्टि करता/करती हूँ।

* If patient is a minor or physically/mentally incompetent/* यदि रोगी अवयस्क या शारीरिक/मानसिक All disputes are subject to the District Courts only / सभी विवाद केवल जिला न्यायालय के अधिकार क्षेत्र में ही रहेंगे।



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**Informed Surgery
consent**
(To be filled by Doctor)

(Continued from previous page)

6. It has been explained to me that during the course of the operation / procedure, unforeseen conditions may be revealed which may necessitate surgical or other emergency procedure in addition to or different from, those contemplated at the time of the initial diagnosis. Also risk such as blood infection, heart failure, change in blood pressure, anaesthetics/ allergic, reactions, paralysis etc. may arise necessitating attention. Therefore, I further consent and authorise the rendering of such additional surgical and other care and treatment as my physician or his designee reasonably believes necessary, should one or more of these and / or other unforeseeable events occur.

मुझे विस्तार से बता दिया गया है कि ऑपरेशन की कार्य प्रणाली के दौरान आकर्षित रूप से हालत बिगड़ने पर आवश्यक शल्य चिकित्सा या दूसरे आवश्यक आपातकालीन तरीके अथवा प्राथमिक विदान के समय विवारित तरीकों से अलग प्रक्रिया की आवश्यकता पड़ सकती है और इस संक्रमण, दिल का दौरा, उक्तचाप, विश्वेतन / एलजी संक्रमण, लकवा तथा अन्य रोगों का खतरा हो सकता है। मैं अपने चिकित्सक और उनके सहयोगी को ऐसी स्थिति में उद्यत उपचार की सहमति और अधिकृत प्रदान करता/करती हूँ।

7. I consent to the photographing or video filming of the procedure(s) for the purpose of advancing medical education, or its publishing in scientific journals, provided my/the patient's identity is not revealed by the images or description in the accompanying text. In an effort to further medical science and education, I consent to be admittance of qualified observers to the operation room, as may be authorised by the hospital and its regulatory laws and agencies.

मैं अपने शरीर के किसी भाग की होने वाली शल्य चिकित्सा की तस्वीरें या वीडियो फ़िल्म बनाने की मंजूरी देता / देती हूँ जिसका प्रयोग चिकित्सा, अनुसंधान या शिक्षा से जुड़ा हो परन्तु उसमें मेरी पहचान न बतायी जाए या उसके साथ मेरा कोई विवरण नहीं दिया जाए। चिकित्सा शिक्षा के प्रयोजन के लिए मैं शल्य चिकित्सा के कमरे में पर्यवेक्षकों का प्रवेश के लिए अनुमति देता/देती हूँ। मैं स्टीकार करता/करती हूँ कि मुझे किसी प्रकार के परिणाम का आश्वासन या वादा नहीं किया जाये है।

8. I further give my consent to the release of professional and/ or other information from the medical records as deemed necessary in accordance with the rules and policies of the hospital. I give consent for procedure related photography.

मैं समस्त जानकारी, मेडिकल रिकार्ड, दस्तावेज जो अस्पताल के नियम अधिनियम के अनुसार जल्दी हैं को प्रदान करने की सहमति प्रदान करता/करती हूँ। मैं सहमति देता हूँ कि मेरी इलाज प्रक्रिया के दौरान फोटोग्राफी करने की शल्य चिकित्सा सुधार के लिए।

9. I further give my consent to carry out histopathological examination of any body part/organ after the surgery.

मैं अपने शरीर के किसी भी अंग की शल्य चिकित्सा के दौरान या बाद में की जाने वाली हिस्टोपैथोलॉजी जांच की अनुमति प्रदान करता हूँ।

10. [] I am [] I am not suffering from any known allergies/ drugs/ reactions. If allergic, please provide details.

मैं किसी एलजी / दवा की प्रतिक्रिया से पीड़ित [] नहीं हूँ, [] नहीं हूँ। अगर एलजिक हो तो कृपया उसका विवरण दें।

11. I declare that I am not suffering from hypertension / diabetes / bleedings disorders / heart disease or _____

मैं धोखित करता / करती हूँ कि मैं उच्च रक्तचाप / मधुमेह / खून प्रवाह की गड़बड़ी / हृदय रोग या से पीड़ित नहीं हूँ।

12. [] I am [] I am not pregnant

[] मैं गर्भवती हूँ, [] नहीं हूँ

If pregnant, please state by how many weeks _____

अगर गर्भवती है तो कृपया बताएं कितने सप्ताह से हैं _____

PATIENT/ATTENDANT /रोगी/सम्बंधी

I acknowledge that I had an opportunity to discuss this procedure, as stated above, with my physician or his/her designee, I certify that the statement made in this consent form have been read over and explained to me in a language I easily understand. I have fully understood the implication of the consent, and further submit that the statements therein referred to were filled in, and any inapplicable paragraphs stricken off, before I signed/applied my thumb impression.

मैं समस्त जानकारी, मेडिकल रिकार्ड, दस्तावेज जो अस्पताल के नियम अधिनियम के अनुसार जल्दी हैं को प्रदान करने की सहमति प्रदान करता/करती हूँ। मैं प्रमाणित करता/करती हूँ कि सहमति फार्म में दिए गए कथन मुझे एक आसान भाषा में पढ़ाए तथा समझाए गए हैं। मैं पूरी तरह से सहमति फार्म के परिणाम को समझता / समझती हूँ और यह भी बयान करता / करती हूँ कि इक्स स्थानों को मेरे/सम्बंधी द्वारा भर दिया गया है और जो कथन मुझ पर लागू नहीं होते हैं, उन्हें मेरे हस्ताक्षर/अंगूठे के निशान लगाने से पूर्ण कांट दिया गया है।

Name of the Patient/ Gaurdin/ Relative

रोगी/अभिभावक / रिश्तेदार का नाम

Name & Signature of the Witness 1 :

गवाह का नाम व हस्ताक्षर

| _____

| _____

Relationship with patient

रोगी से सम्बन्ध

Name & Signature of the Witness 2 :

गवाह का नाम व हस्ताक्षर

| _____

| _____

(Signature / Thumb Impression)

हस्ताक्षर/अंगूठे का निशान

Date

दिनांक

Name & Signature of Doctor

Regd. No.

चिकित्सक का नाम व हस्ताक्षर



Bone And Joint Multispecialty Hospital

**9-A-30, Rajiv Gandhi Auditorium Road RC Viyas Colony
Bhilwara, Rajasthan 311001**

NURSING MONITORING SHEET



Bone And Joint Multispecialty Hospital
9-A-30, Rajiv Gandhi Auditorium Road RC Viyas Colony
Bhilwara, Rajasthan 311001

Repeat Assessment sheet
(To be filled by Doctor)

Name of Patient _____ UHID No. _____ IPD No. _____ Age/Sex _____

Consultant Name _____ Diagnosis _____

Ward/Room _____ Department _____ Date _____

Physical Examination

Time	BP	Pulse	Temp	Respiration	Spo2	CVS	Remarks

Systemic examination and Treatment:-

Name of Consultant: Dr.

Date & Time



Bone And Joint Multispecialty Hospital

**9-A-30, Rajiv Gandhi Auditorium Road RC Viyas Colony
Bhilwara, Rajasthan 311001**

PRE OPERATIVE ORDER

Patient Name:-

UHID No:-

IPD No:-

Age/Sex:-

Consultant Name:-

Dep't:-

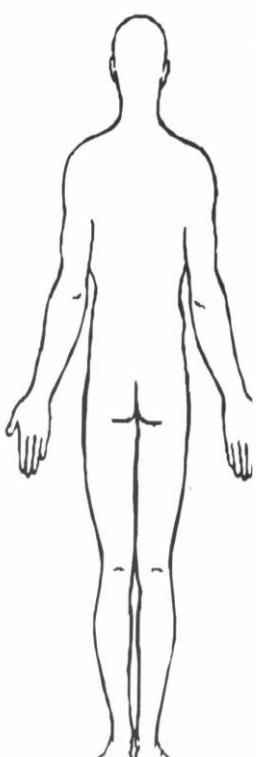
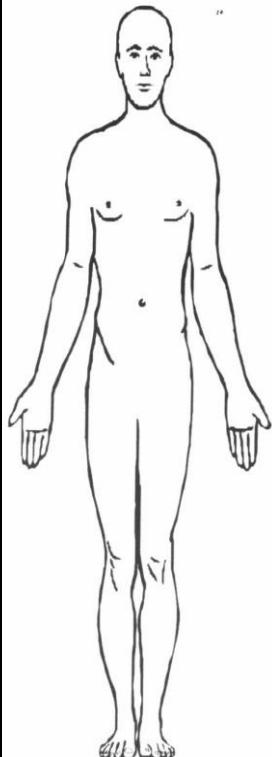
Ward/Room:-

Diagnosis:-

1. Take written consent for risk of surgery and Anaesthesia.
 2. N.B.M. after.....am/pm on date.....
 3. Bath and Shower at.....am/pm.....Yes/No.
 4. Enema: Simple/Glycerine/Practoclyss at.....am/pm.....Yes/No.
 5. Remove Dentures, Ornamentals & Nail Polish, Spectacles & Contact Lances.
 6. Skin Preparation, shaving (Part of the body as shown in the diagram) & saving wash.
 7. Transfer the patient to O.T. with case paper & Investing reports atam/pm.
 8. Special order or pre-Ope Medications.....

Anterior

Posterior



Name & Signature of Nurse

(.....)

Date & Time:-

Name & Signature of Surgeon

(.....)

Date & Time:-



Bone And Joint Multispecialty Hospital
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**POST OPERATIVE
ORDER**

Patient Name:-

UHID No:-

IPD No:-

Age/Sex:-

Consultant Name:-

Dep't:-

Ward/Room:-

Diagnosis:-

1. N. B. M. till.....am/pm. Liquids after.....am/pm(if no vomiting)
2. Raise Head end by 30°/45°
3. Nasogastric tube rules suction.....hrly/continuous
4. Vitals. Pulse.....hrly till.....am/pm Temp.....hrly/till.....am/pm
B.P.....hrly till.....am/pm Resp.....hrly/till.....am/pm
5. Record Intake & output chart: Yes/No
6. Allow the patient to sit up/stand after.....am/pm
7. Drugs:
 1. IV Fluids a) DNS
 b)R.L.
 - 2.
 - 3.
 - 4.
 - 5.
 - 6.
 - 7.

Dr. Name & Signature:

Date & Time



PATIENT REGISTRATION FORM

Patient's name		Date of registration	
Gender	Male/female	Date of Birth	
Guardian (In case of minor or patient)		Relationship	
Address		Mobile No:	
		Landline No:	
		Email ID	
Occupation			
Health Insurance available	Yes/No	Name of insurer	
Referring doctor			
FOR EMERGENCY SITUATION			
Name of person to be contacted		Relationship	
Contact No-1		Contact No.-2	
My statement that all information provided above is correct. I understand the information is being collected to register me and enable me to access the services of this hospital.			
मेरा कथन है कि ऊपर दी गई सभी जानकारी सही है। मैं समझता हूं कि मुझे पंजीकृत करने और मुझे इस अस्पताल की सेवाओं तक पहुंचने में सक्षम बनाने के लिए जानकारी एकत्र की जा रही है।			
Signature of patient		Date/Time	



Bone And Joint Multispecialty Hospital
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NURSING NOTES

Note:- Each entry be with Signature, date & Time



Bone And Joint Multispecialty Hospital
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NURSING INTIAL ASSESSMENT

Patient Name:-	UHID No:-	IPD No:-	Age/Sex:-
Consultant Name:-	Dep't:-	Ward/Room:-	Diagnosis:-

- Height (ft) Weight (lbs)

Medical Data

- Chief Complaint
-
- Medical Diagnosis
-

Vital Signs

Temperature (C)	BP (mmHg)	Pulse Rate (bpm)	Respiratory Rate (bpm)
<input type="text" value="p[;vw"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Allergies

Food Environmental Medication No allergies are known

- Current Medications (Any meds including supplements)

- Medical Problems/Conditions

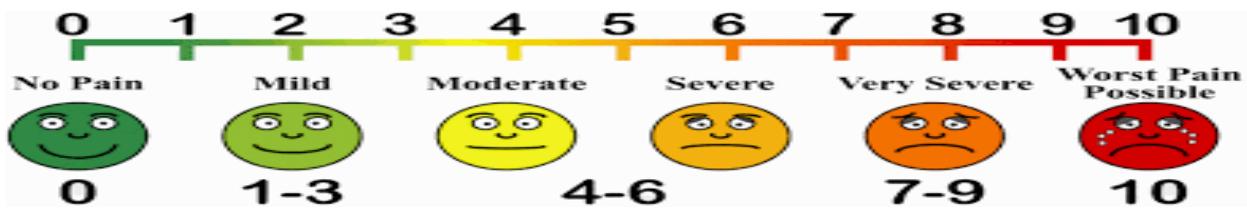
Past Medical History

Previous hospitalization (Provide the reason and treatment)

- Family History Illnesses

Asthma Cardio vascular Disease Diabetes Mellitus Hypertension Tuberculosis

PAIN SCALE STATUS :-



Review of Systems

SYSTEMIC EXAMINATION	Normal	Not Normal	Remarks
Sensory (Eyes, ears, nose, throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal (Mobility)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Rashes, irritation, pale)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurovascular (Pain, seizures, sensation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory (Skin, edema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory (Shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental (Dentures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial (Hallucinations, delusions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition (Diet, weight change, swallowing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination (Constipation, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NURSE NAME AND SIGNATURE

DATE AND TIME



Bone And Joint Multispecialty Hospital
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Bhilwara, Rajasthan 311001

**24-HRS. INTAKE &
OUTPUT CHART**

Patient Name:-

UHID No:-

IPD No:-

Age/Sex:-

Consultant Name:-

Dep't:-

Ward/Room:-

Diagnosis:-

FLUID

DRUGS

TIME	INTAKE IN MILI-LITRES		OUTPUT IN MILI-LITRES			
HOURS	INTRAVENOUS	ORAL	TOTAL INPUT	URINE	RYLES TUBE ASPIRATION	TOTAL OUTPUT
08						
09						
10						
11						
12						
01						
02						
Total						
03						
04						
05						
06						
07						
08						
Total						
09						
10						
11						
12						
01						
02						
03						
04						
05						
06						
07						
08						
Total						
TOTAL INPUT (ML)			TOTAL OUTPUT (ML)			
STOOL PASSED		TIME				

NURSE SIGNATURE: - MORNING : _____

EVENING : _____

NIGHT : _____



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**INFORMED
CONSENT FOR
BLOOD
TRANSFUSION**

Patient Name:-	UHID No:-	IPD No:-	Age/Sex:-
Consultant Name:-	Dep't:-	Ward/Room:-	Diagnosis:-

रक्त चढ़ाये जाने सम्बन्धी विशेष सहमति पत्र

मुझे यह स्पष्ट रूप से सूचित कर दिया गया है कि मुझे/मेरे रोगी (नाम)आईपीडी संख्या का उपचार करने वाले चिकित्सककी राय में मुझे/रोगी को रक्त अथवा रक्त घटक मेरे/मेरे रोगी के स्वास्थ्य की स्थिति में सुधार के लिए चढ़ाया जा रहा है।

It has been clearly communicated to me that my / my patient(Name) _____ IPD NO _____ Opinion of the treating physician (Name) _____ are being offered blood / blood component to me / the patient to improve the health status of my / my patient.

भारत सरकार के दवा नियंत्रक द्वारा निर्धारित मार्गदर्शकों के आधार पर रक्त घटक चढ़ाये जाने (ट्रांसफ्यूजन) से पूर्व भतिजाति जाँच लिए गये हैं। रक्त अथवा रक्त घटक को अधिक सुरक्षित बनाये रखने हेतु किसी अन्य जाँच के लिए अथवा तकनीकी तथा अतिरिक्त जाँच सम्बन्धी खर्च के लिए मैं अपनी सहमति देता हूँ। फिर भी मुझे जात है कि इससे मुझे/मेरे रोगी को संक्रियत हैपेटाइटिस एकायर्ड इम्यूनो डेफिशिएंसी सिंड्रोम (एडीस) होने की सम्भावना भी हो सकती है अथवा अन्य दूसरी बीमारियाँ, रक्त प्रतिक्रिया, एलर्जी प्रतिक्रिया भी हो सकती हैं।

Based on the guidelines prescribed by the Controller of Drugs, Government of India, blood transfusions have been done prior to transfusion. I give my consent for any other test or for technical and additional testing related expenses to keep the blood or blood component safer. Even then I know that it may cause me / my patient to have infected hepatitis, acquired immunodeficiency syndrome (AIDS) or other diseases, blood reaction, allergic reaction.

मैं आश्वस्त हूँ कि रक्त चढ़ाये जाने से होने वाले इस तरह के संक्रमण का उपचार भी किया जा सकता है। यह कुछ मामलों में हो खतरनाक हो सकता है।

I am convinced that such transfusion caused by blood transfusion can also be treated. It can be dangerous in some cases.

मुझे रक्त चढ़ाये जाने से पूर्व इससे सम्बंधित प्रश्न पूछने का पूरा अवसर दिया गया है तथा मैंने अपनी संतुष्टि के लिए इससे सम्बंधित समस्त प्रश्नों के उत्तर जान लिए हैं।

I have been given full opportunity to ask questions related to it before blood transfusions and I have found the answers to all the questions related to it to my satisfaction.

Patient/रोगी का नाम

Signature/हस्ताक्षर

Date/दिनांक

Declaration by Treating Doctor/चिकित्स द्वारा घोषणा

मैंने रोगी/उसके जिम्मेदार सहयोगी को प्रक्रिया एवं उससे जुड़े सम्बन्धित खतरों, लाभों एवं वैकल्पिक व्यवस्थाओं (यहाँ तक कि उपचार नहीं लिय जाने सम्बन्धी विकल्प) के बारे में स्पष्ट रूप से समझा दिया है। मैंने इस प्रक्रिया से जुड़ी रोगी की सभी शंकाओं को भलीभांति समझा दिया है।

I have clearly explained to the patient / his / her responsible aide about the process and the possible dangers associated with it, benefits and alternative arrangements (even options related to non-treatment). I have fully understood all the doubts of the patient associated with this process.

Doctor/फिजिशियन का नाम

Signature/हस्ताक्षर

Date/दिनांक

रक्त एवं रक्त उत्पाद चढ़ाये जाने के प्रति असहमति का अधिकार / Right to disagree about blood and blood products being offered:

रक्त घटक नहीं चढ़ाये जाने से होने वाले समस्त सम्बन्धित खतरों एवं समस्याओं के बारे में पूरी जानकारी रखते हुए मैं रक्त अथवा रक्त घटक चढ़ाये जाने के लिए सहमत नहीं हूँ। इस कारण से हुए सम्बन्धित खतरों, समस्याओं के लिए मैं स्वयं जिम्मेदार हूँ।

Having full knowledge about all the possible dangers and problems due to non-delivery of blood component, I do not agree to offer blood or blood component. For this reason I am myself responsible for the potential dangers and problems.

PatientName/रोगी का नाम

Signature witness /हस्ताक्षर साक्षी

Attendant Name/जिम्मेदार सम्बन्धी का नाम

Signature/हस्ताक्षर
Date/दिनांक

Date/दिनांक



Bone And Joint Multispecialty Hospital

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Bhilwara, Rajasthan 311001**

NURSING MEDICATION CHART

Patient Name:-

UHID No:-

IPD No:-

Age/Sex:-

Consultant Name:-

Dep't:-

Ward/Room:-

Diagnosis:-



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**DOCTOR'S
INITIAL
ASSESSMENT**

UHID No.....IPD No.....Ward/Room No.....Date & Time.....

Patient Name	Age/Sex	Height
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B.P.	PULSE	TEMP.	Weight
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Allergies

History of Present Illness

Past History

Personal History

Others



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**DOCTOR'S
INITIAL
ASSESSMENT**

Clinical Examination

Plan of Care

Date & Time:-

Doctor Name & Signature



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**DOCTOR'S
PROGRESS SHEET**

Patient Name:-	UHID No:-	IPD No:-	Age/Sex:-	Dep't:-.....
Consultant Name:-	Ward/Room:-	Diagnosis:-		
Clinical Finding & Treatment	Investigation Advise			

Date/Time

Doctor Name & Signature



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**Repeat
Assessment
sheet**
(To be filled by Doctor)

Name of Patient _____ UHID No. _____ IPD No. _____ Age/Sex _____

Consultant Name _____ Diagnosis _____

Ward/Room _____ Department _____ Date _____

Physical Examination

Time	BP	Pulse	Temp	Respiration	Spo2	CVS	Remarks

Systemic examination and Treatment:-

Name of Consultant: Dr.

Date & Time



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Post-Operative Patient Check List

Patient Name:-

UHID No:-

IPD No:-

Age/Sex:-

Consultant Name:-

Dep't:-

Ward/Room:-

Diagnosis:-

DOCUMENT CHECKLIST FOR PATIENT SHIFTING OUT OF OT

(TO BE FILLED BY OT TECHNICIAN)

S. NO.	ITEMS	CHECK BOX	
1.	RESPECTIVE WARD INFORMED FOR PATIENT TRANSFER FROM OT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	COMPLETED ANAESTHESIA NOTES ATTACHED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	COMPLETED OPERATION NOTES ATTACHED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	COMPLETED POST OPERATIVE INSTRUCTIONS ATTACHED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	CONSENT FOR SURGERY SIGNED BY PATIENT AND DOCTOR	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	CONSENT FOR ANAESTHESIA SIGNED BY PATIENT AND DOCTOR	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	HIGH RISK CONSENT (IF APPLICABLE) SIGNED BY PATIENT AND DOCTOR	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	COMPLETED BLOOD TRANSFUSION CONSENT FORM (IF APPLICABLE)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	ANY OTHER CONSENT (IF APPLICABLE)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10.	COMPLETED BIOPSY/ CULTURE FORM	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11.	IMPLANT STICKERS PASTED IN PATIENT'S FILE AND OT REGISTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12.	ALL PATIENT'S MEDICAL REPORTS ATTACHED IN PATIENT'S FILE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13.	CT/ MRI/ X-RAYS REPORTS ATTACHED IN PATIENT'S FILE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14.	BLOOD PRODUCTS RETURNED, IF NOT TRANSFUSED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
15.	MEDICINES & OTHER PRODUCTS RETURNED TO THE PATIENT, IF NOT USED	<input type="checkbox"/> YES	<input type="checkbox"/> NO

OT TECHNICIAN NAME & SIGNATURE



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**Pre-Operative
Patient Check List**

Patient Name:-	UHID No:-	IPD No:-	Age/Sex:-
Consultant Name:-	Dep't:-	Ward/Room:-	Diagnosis:-

No.	Check List	Yes	No
1.	Identification Tag		
2.	Information of Surgery to Patient		
3.	Part preparation done & checked by senior staff/ Nursing Supervisor		
4.	Blood Grouping/Cross Matching/ Arrangement of Blood		
5.	All investigation report including X-Ray/ CT Scan/ MRI/ Ultrasound etc. ready.		
6.	Patient instructed on deep breathing, coughing exercise		
7.	PAC Done		
8.	Consent Taken		
9.	Patient Fasting		
10.	Jewellery, Nail Polish, Dentures, eye Glass, Hearing Aid, Contact Lenses, Hair Pin, Ear-Pin, Rings etc. removed.		
11.	Hair Combed & tied.		
12.	Information about drug allergy		
13.	Bath & changed on to Hospital dress		
14.	Voided/ Catheterized		
15.	Enema given with Good result		
16.	Whether the patient is HbsAg / HIV+ve		
17.	N/G/ tube inserted & Place if ordered		
18.	Vital Signs checked & recorded		
19.	Pre Medication given on call to OT		
20.	Patient is handed over to OT nurse with records/ drug		

Time & Date

Name & sign of staff nurse