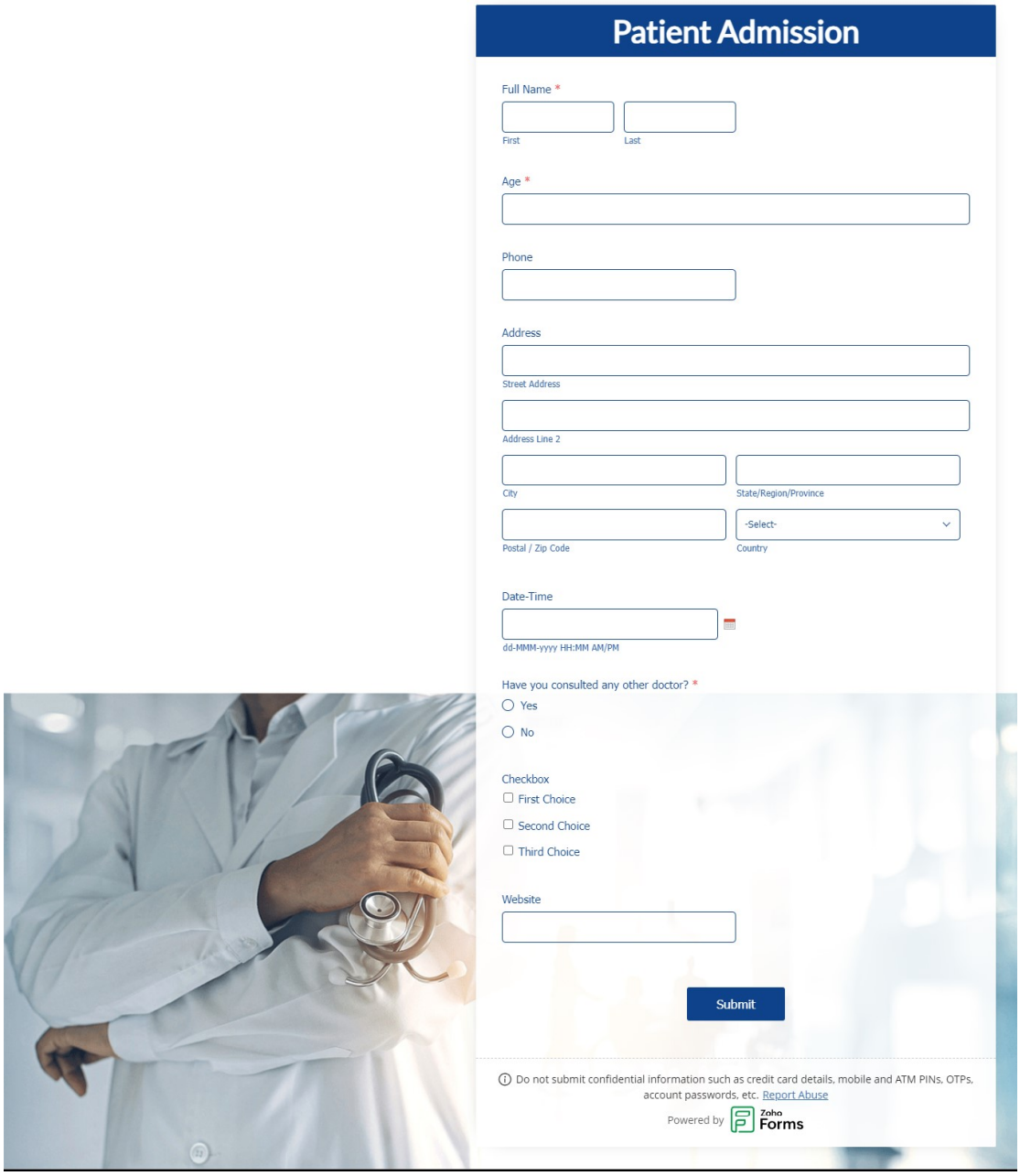
Patient Admission
Full Name *
First
Last
Age *
Phone
Address
Street Address
Address Line 2
City
State/Region/Province
Postal / Zip Code
-Select-
Country
Date-Time
dd-MMM-yyyy HH:MM AM/PM
Have you consulted any other doctor? *
Yes
No
Checkbox
First Choice
Second Choice
Third Choice
Website
Submit
Do not submit confidential information such as credit card details, mobile and ATM PINs, OTPs, account passwords, etc. Report Abuse
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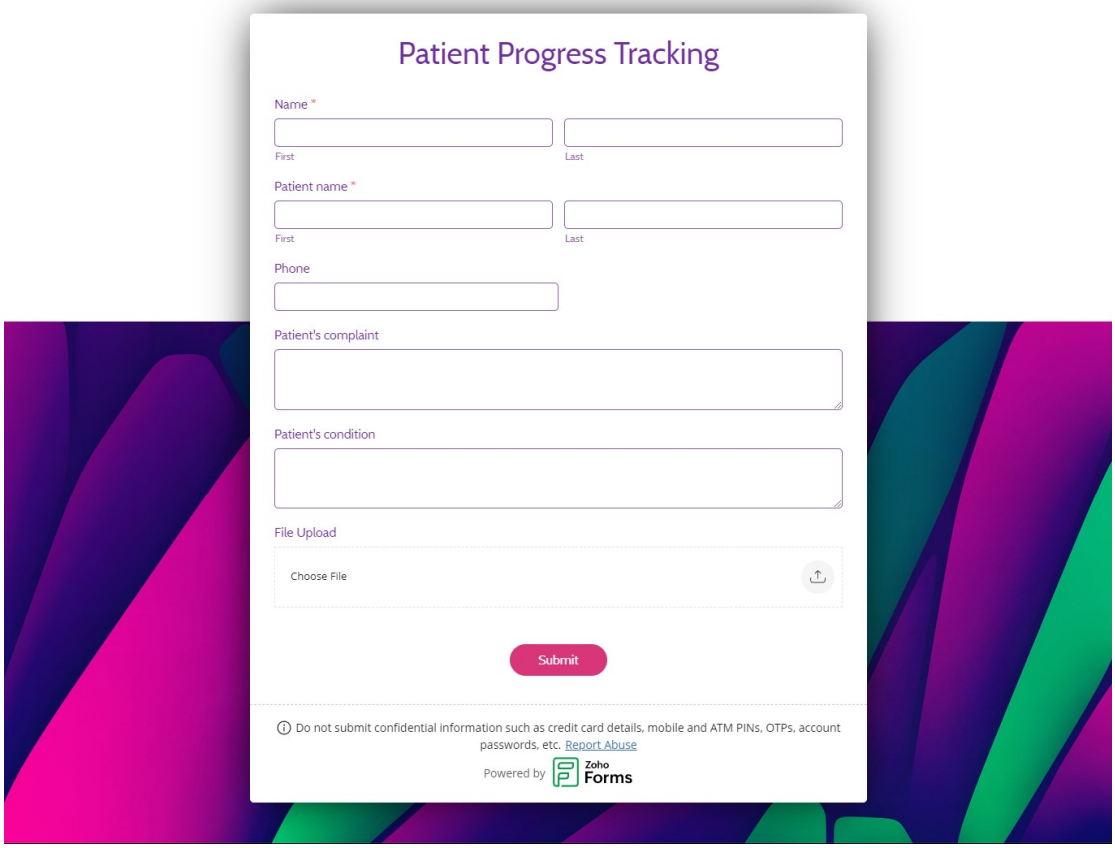
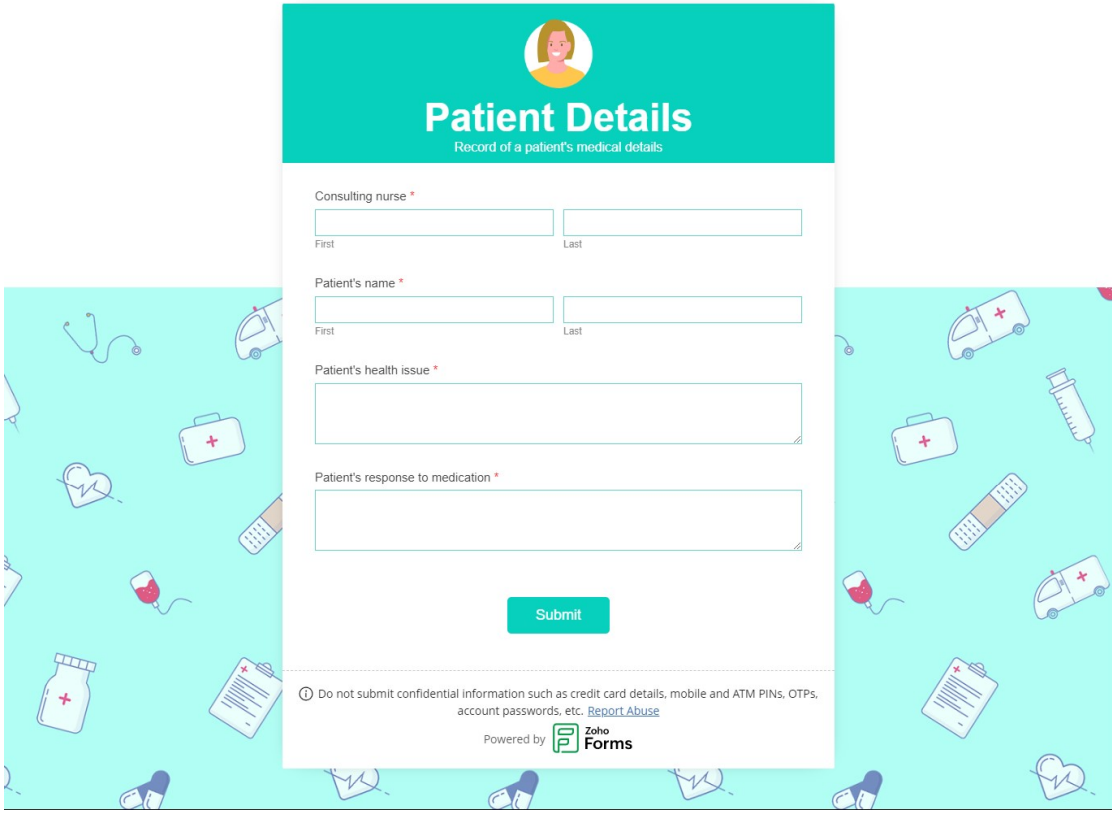
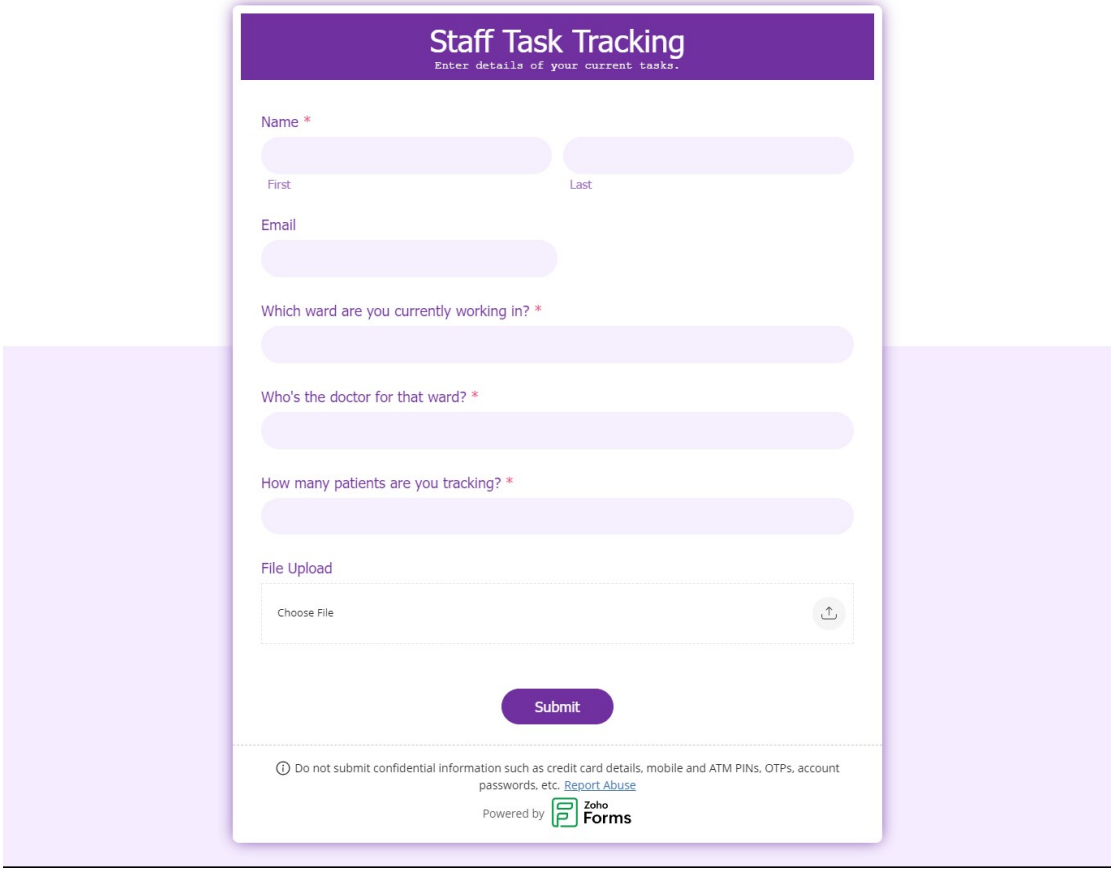

Patient Progress Tracking
Name *
First
Last
Patient name *
First
Last
Phone
Patient's complaint
Patient's condition
File Upload
Choose File
Submit
Do not submit confidential information such as credit card details, mobile and ATM PINs, OTPs, account passwords, etc. Report Abuse
Powered by Zoho Forms


Patient Details
Record of a patient's medical details
Consulting nurse *
First
Last
Patient's name *
First
Last
Patient's health issue *
Patient's response to medication *
Submit
Do not submit confidential information such as credit card details, mobile and ATM PINs, OTPs, account passwords, etc. Report Abuse
Powered by Zoho Forms


Staff Task Tracking
Enter details of your current tasks.
Name *
First
Last
Email
Which ward are you currently working in? *
Who's the doctor for that ward? *
How many patients are you tracking? *
File Upload
Choose File
Submit
Do not submit confidential information such as credit card details, mobile and ATM PINs, OTPs, account passwords, etc. Report Abuse
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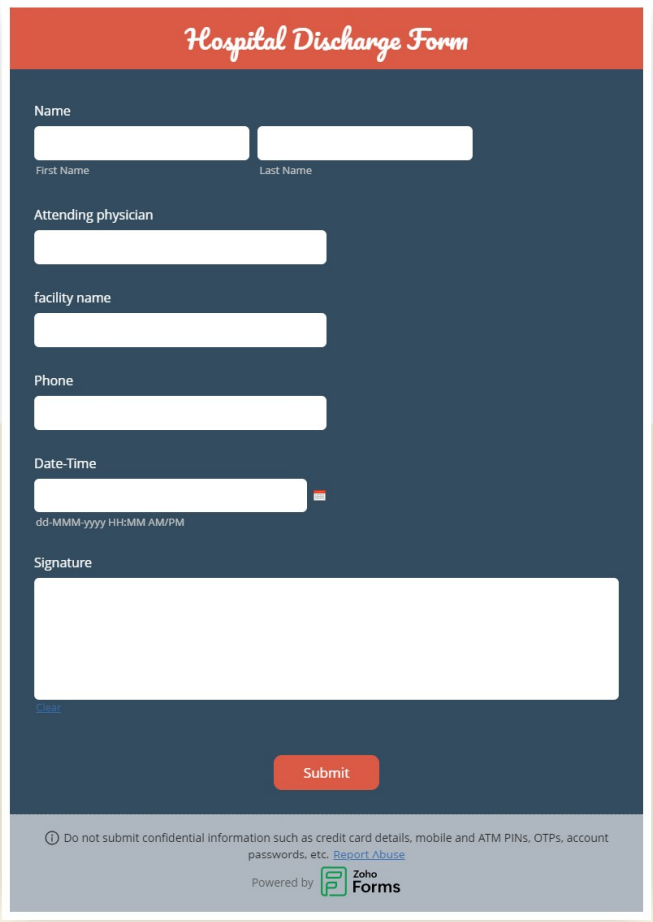
Hospital Discharge Form
Name
First Name
Last Name
Attending physician
facility name
Phone
Date-Time
dd-MMM-yyyy HH:MM AM/PM
Signature
Clear
Submit
Do not submit confidential information such as credit card details, mobile and ATM PINs, OTPs, account passwords, etc. Report Abuse
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