

## MEDICAL AUTHORIZATION LETTER

### Annual Health Checkup - Cognizant Technology Solutions

#### Appointment

Employee name	MATHURRI SAI
Employee no	612810
Ta code	2262175
Appointment date	16/09/2017
Appointment time	8:00AM

#### Provider

Provider name	Apollo Clinic-Kotturpuram
Address	15/42,Gandhi Mandapam Road City:CHENNAI State:TAMIL NADU Pincode:600085 Mobile:0 Phone:24471155/24471212

#### Test Package

Package 1
Complete Hemogram
Blood Group and Rh factor
Fasting Blood Sugar
PPBS
Total Cholesterol
AST
ALT
GGT
Blood Urea Nitrogen
Uric Acid
Routine Urinalysis
ECG
Ultrasound Abdomen
Thyroid Stimulating Hormone
General Physical Examination and Physician Consultation
Gynecologist Consultation (including breast examination)
Blood pressure Systolic
Blood pressure Diastolic
Height
Weight
Waist circumference

#### Instructions

1. You are requested to be present at the medical center at the designated time.
  2. Kindly be aware of the following while your tests are done:
    - a. TMT
    - i. A qualified medical authority is present at the time of TMT.
    - ii. Please tell the cardiologist if you have any medical history.
    - b. Female nurses are present during ECG, ultrasound and X-Ray of female clients.
    - c. Hygiene is maintained at the time of tests.
    - d. While blood draw
    - i. Second puncture if required should be done with the consent of client.
    - ii. Needle should be opened in your presence and destroyed after blood draw.
    - iii. Blood sample should be labeled in your presence.
- Please call us at toll free no 180030008424 or email us at the following email id healthchecks.cts@uhcindia.com, if you observe a deviation in any of the above.
3. You will be required to present a copy of the Medical Authorization Letter and any one of your photo ID proofs(Employee ID Card/Driving License/PAN Card/Aadhar Card/Voter ID/Ration Card/Passport copy)
  4. Kindly ensure to maintain the fasting status (avoid consuming food and drinks) 10-12 hours before the appointment. Only water may be consumed.
  5. You are requested to carry along the morning Urine and Stool samples in a clean container(If it is part of your test package). You can collect the containers from the designated medical center in advance by showing a copy of this Authorization Letter; alternatively you may purchase the containers from pharmacy shops.
  6. It is advisable to wear comfortable clothes & running shoes(for TMT). You may be required to change into clothes provided by the center during the tests. (For males only - Chest area needs to be shaved for TMT for fixing the leads).
  7. If you are on any medication, then we request you to carry the same or its prescription along with you at the time of medical checkup and inform the co-coordinator.
  8. Kindly carry reports of the previous investigations, consultation notes or medications (for significant illness if any) as it will facilitate a better evaluation of the medical history.
  9. Prior Cardiac problems if any, need to be intimated to the consulting cardiologist before undergoing TMT.
  10. Partial completions of the tests are deemed to be completion of the master health check-up.
  11. You may have to return to the medical center after these tests for consultations. Please ensure all consultations are completed within 48 hours after your initial appointment.
  12. Kindly collect your medical reports directly from the medical center 48 hours after the appointment date.

Employee Signature

Date

## MEDICAL FORM

### Annual Health Checkup - Cognizant Technology Solutions

#### Personal Information

Name:		Date:		
Employee ID:		TA Code		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Package	Package 1	
Date of Birth:	DD/MM/YYYY		Package 2	
			Package 3	
Age:		Photo ID Proof	<input type="checkbox"/> Yes <input type="checkbox"/> No	

#### General Physical Examination

Height	Cms	Remarks :
Weight	Kgs	
Waist	Cms	
Hip	Cms	
Blood Pressure	mmHg	

#### Physician Remarks

Physician Name		Physician Signature
Qualification		
Reg. Number		

#### Gynaecologist Consultation

Breast Examination		
Remarks		
Gynaecologist Name		Gynaecologist Signature
Qualification		
Reg. Number		

Center Name and seal	
Employee Name	Employee Signature and date