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HAH CENTENARY HOSPITAL

(Associated Speciality Teaching Hospital of Hamdard Institute of Medical Sciences & Research)

Guru Ravidas Marg, Hamdard Nagar, New Delhi – 110062

Helpline No.: 011-29901111, 8588890999



H-2022-1041

ADMISSION / CONSENT FORM

UHID NO. P3092580

IPD NO.

IP1098621

Bed No.

MUF07(MEDICINE WARD-FEMALE)

Admission Date 11-Mar-2024 5:08 pm

Pt.Name: Mrs. SHEELA DEVI

55 Y / F

Guardian: W/o RAM KARAN

IPD Type: General

Address : HN-C-1069 G/F SANGAM VIHAR

PermanantAddress :

Nationality: INDIAN

Panel: BELOW POVERTY LINE EWS

Mobile No.: 7053024900

Consultant InCh.: MEDICINE UNIT-1

Speciality: MEDICINE

Provisional Diagnosis:

Secondary Diagnosis & complication:

Operative procedures with Date:

Sign & Stamp of Jr. Resident/Sr. Resident

Signature of Consultant

AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT

AUTHORIZATION OF TREATMENT: Permission is hereby given for the performance of any diagnosis, examination, biopsy, transfusion, operation and administration of any kind of anaesthesia as may be deemed advisable in the course of Hospitalization. The risk of various procedure, Surgery, advantages and disadvantages and risk and possible complication of alternative treatments has been explained to me. Although it is impossible for the Doctors to inform me of every possible complication that may occur, the Doctor has answered all my questions to my satisfaction. I am stating that I have read this informed consent (or it has been read to me) and benefits that can result from the surgery if I decide to have an operation.

Blood : I am prepared to arrange blood as per necessity.

Financial agreements: I understand fully financial responsibility to pay all hospital bills and agree to make payments as per hospital rules. I am willing to avail hospital facilities beyond my entitlements and shall be responsible for paying the difference from my own pocket. I shall be responsible for whatever money valuables I bring to the hospital and keep it at my own risk & responsibility. And I have received visitor pass and agree to abide by hospital rules and regulations.

Name: KAPIL

Signature of the Patient/Attendant

Relation: SON

Address: HN-C-1069 G/F SANGAM VIHAR

Signature of Front Office Personnel

Tel: 7053024900

User Name: SHIVANI



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ADMISSION SLIP

Please admit Mr./Miss/Mrs Sheela Devi S/O. D/O. W/O

Mr. O.P.D. No.

in Special / Semi-Special General Ward / EWS

Medicine Ward

Date

11/3/24

Dr. PRANATI SINGH
M.B.B.S.
DMC
Signature of the Consultant
HAHC Hospital

FOR WARD USE

Patient admitted in Ward. Advance of Rs. deposited

vide R/ No. Admission No.

Date

LRT1

Signature : Nurse on duty
(Name & Emp. Id)

(Associated Speciality Teaching Hospital of Hamdard Institute of Med

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HAH CENTENA

(Associated Specialty Teaching Hospital of Har
Guru Ravidas Marg, Hamd
Helpline No.: 011-7

Mrs. SHEELA DEVI

55 Y/F 1)

W/o RAM KARAN

UHID P3092580

Reg No. IP1098621

DOA 11-Mar-2024 17:08 EWS F-7

Dr. VINDU AMITABH Dr. AFROZ JAMAL
MEDICINE

TRANSFER / REFERRAL FORM

Patient's Name: Sheela Devi Age 55 Sex F
IPD No. Room No. Date of Admission
Consultant: Specialty
Transferred from (Date Time)
Transferred/Referred To (Date Time)
Remarks/Reason for transfer /Referral

TO BE FILLED BY THE NURSING STAFF

Latest Vital Signs:
B.P. Respiratory Pulse Rate SpO2
Temperature RBS (if needed) Pain Score (0-10)
Reports handed over
Medication/Consumable hand over
(Kindly fillup the Details overleaf)

Name of Nurse with Signature & Employ ID

TO BE FILLED BY THE DOCTORS

Final Diagnosis: Lt. middle lobe pneumonia
Allergies
CNS- conscious / oriented to T/P/P
CVS- GB+
Respiration- Rt. A/E + ; Rt. crepts (P)
Abdomen: SDH / ND / NT
Condition at the time of transfer Stable ☒ Not stable ☐

Name of Doctor with Signature & Stamp

Dr. S. KHAN
MBBS
PG MEDICINE DEPARTMENT
DMC/R/23941

