

Shrishankara Superspeciality Hospital

**Plot No 58, Opposite Galaxy Hospital, Near Dr Ban's Prasad Hospital,
Old Borban Factory Area, Nanded. ☎ 96577 13801**

OPD INITIAL ASSESSMENT FORM

Patient Name: _____

UHID: _____ **Age/ Sex:** _____ **Date:** / /

BP: _____ **Pulse:** _____ **Weight:** _____

Temperature: _____ **SPO2:** _____ **BMI:** _____

Complaints:

Diagnosis: _____

Advice: _____

Plan of Care: _____

Rx.

Sign & Stamp of Consultant

Date & Time:

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ADMISSION RECORD प्रवेशनोंद

UID No: _____ IPD No : _____ Ward /ICU: _____ Bed/Room No : _____

Patient's Full name रुग्णाचे नाव: _____ Age वय: _____ Sex लिंग: Male (पुरुष) Female (महिला)

Date & Time of admission प्रवेशाची तारीख व वेळ: _____ / _____ / _____ AM/PM

Date & Time Of Discharge / Death डिस्चार्ज / मृत्यूची तारीख आणि वेळ _____ / _____ / _____ AM/PM

Aadhar No. आधार क्रमांक _____ Occupation व्यवसाय _____ MLC No & Police Station: _____

Address पत्ता _____

Consultant Name डॉक्टर नाव _____ Referring Doctor संदर्भ डॉक्टर नाव _____

In case of Emergency, Contact: आपल्कालीन स्थितीत संपर्क साधा : Name नाव _____

Relationship नाते. _____ Address & Mobile No. पत्ता/दूरध्वनी क्रमांक _____

Status of Discharge: Cured/ Improved/Relived/ Status Quo/ Transferred/ DAMA/Absconded/ Expired

Provisional Diagnosis _____ Final Diagnosis _____ ICD Code _____

Cause of Death: _____

PATIENT INITIAL ASSESSMENT RECORD

CHIEF COMPLAINT AND CONDITION AT THE TIME OF ADMISSION:

O/E: Temp: _____ Pulse: _____ BP: _____ Respiration: _____ Height: _____
Weight: _____

PAST HISTORY (MEDICAL& Surgical)-

RELEVANT FAMILY HISTORY-

MEDICATION HISTORY-

ANY HABBIT- (TOBACO/ALCOHOL/SMOKING/OTHER)

RELEVANT PREVIOUS INVESTIGATIONS/ REPORT-

IMMUNIZATION RECORDS & NUTRITIONAL & GROWTH HISTORY

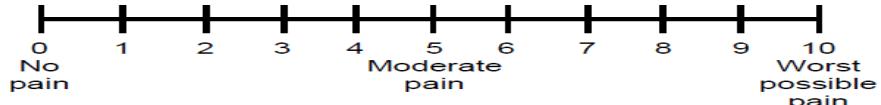
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GENERAL EXAMINATIONS ON ADMISSION

General condition		Skin	
Anaemia		Any Others	
Cyanosis		Temperature	
Oedema		Pulse	
Jaundice		Respiration	
Throat		B.P	
Tongue		Pain Score	
Lymph Nodes			

**NUMERIC PAIN
SCALE**



SYSTEMIC EXAMINATION

RS:

CVS:

CNS:

AS:

OTHER:

PROVISIONAL DIAGNOSIS:

FINAL DIAGNOSIS:

PLAN OF CARE Rx. : _____

INVESTIGATIONS/TESTS:-

X-Ray	Hb	Blood Group	Bilirubin
E.C.G	Tc	RBS	Direct
ECHO	Dc	Urea	Protein (T)
U.S.G / C.T / M.R. I	ESR	Creat	Albumin
ENDOSCOPY	Pl.Count	HIV	Globulin
H.P.E	BT	HBSAg	A/G
OTHERS	CT	LFT	SGOT
SGPT	AlkPo4	Na+	K+
Other			

Name & Signature of the Consultant:

Date & Time:

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GENERAL INFORMED CONSENT FORM

For Authorization of Medical Treatment, Administration of Anesthesia, Performance of Surgery or any Procedure, Diagnostic/ Therapeutic Procedures or any Investigations

UID No:	IPD No:	Date & Time Of Admission:	/ /	AM/PM
Patient's Name:	Age: _____ Sex : _____ ICU/Ward/Room			
Consultant:	Diagnosis: _____ Bed No: _____			

- I Hereby authorize the hospital and those to whom hospital recognize as "Hospital Staff" to perform upon me- Medical Treatment, Administration of Anaesthesia, Performance of Surgery or any Procedure, Diagnostic/ Therapeutic Procedures or any Investigations or any other as required by my treating Consultant.
मी वरील हॉस्पिटल आणि हॉस्पिटल तरफे नियुक्त करण्यात आलेल्या कर्मचाऱ्यास माझ्यावर/माझ्या रुग्णावर चिकित्सेसाठी कुठल्याही प्रकारची भूल देणे, शब्दक्रिया करणे, तपासण्या करणे, किंवा इतर कोणत्याही बाबी ज्ञा माझे डॉक्टर सुचवतील त्याकरण्याची संमती देत आहे.
- It has been explained to me that during the course of operation or procedures, unforeseen conditions may be revealed which may require surgical or other emergency procedures in addition or different from those contemplated at the time of initial diagnosis. I therefore further authorize the above designated staff to perform such additional surgical or other procedures as they deem necessary or desirable.
शल्य चिकित्सा/चिकित्सा करताना उद्भव शकणाऱ्या आपत्कालीन परिस्थिती बाबत मला सविस्तर माहिती देण्यात आलेली आहे. आपत्कालीन परिस्थिती मध्ये आधी निश्चित करण्यात आलेल्या प्रक्रिये पेक्षा इतर शल्य चिकित्सा किंवा इतर आपत्कालीन चिकित्सा करण्यात येवू शकते याबाबत मला कल्पना देण्यात आलेली आहे. मी रुग्णालया तरफे नियुक्त करण्यात आलेल्या कर्मचाऱ्यांना अशा प्रकारची चिकित्सा करण्यास संमती देत आहे.
- I consent to the administration of anesthesia and for such anesthetics may be required or desirable other than the procedure recommended for me.
मी माझ्या वर ठरविण्यात आलेल्या चिकित्से व्यतिरिक्त भूल देणे तसेच इतर गरजेच्या प्रक्रियेस संमती देत आहे.
- I state that I will not hide my past medical History and Allergic Conditions, Drug reactions, any past adverse medical events to my consultant.
मी आची खात्री देत आहे. किमी माझा/माझ्या रुग्णाचा मागील वैद्यकीय इतिहास, अलर्जी, औषधाची रिएक्शन या बाबत डॉक्टरांना पूर्ण कल्पना देईन.
- I have been explained in detail about the purpose and nature of procedures proposed to carried out on me. I have also been told the possible alternative methods, the prognosis and possibility of complication.
मला शल्य क्रियेचा प्रकार, उद्देश, पद्धत, आवश्यक अन्य संभाव्य वैकल्पिक प्रक्रिया, चिकित्सेचे धोके तसेच संभाव्य नुटाग्रंत या बाबत कल्पना देण्यात आलेली आहे.
- I further consent to the administration of such drugs, infusions, plasma or blood transfusion or any other procedure that deemed to be necessary.
मी संपूर्ण माहिती जाणून संबंधित कर्मचाऱ्यास औषधी/रक्त/प्लास्मा/द्रानस्फूजन किंवा अन्य आवश्यक किया करण्यास संमतीदेत आहे.
- I have been given an opportunity to ask all questions and I also have been given opportunity to ask for any second opinion.
शब्दक्रिया/चिकित्से संबंधी प्रश्न विचारणाची पूर्ण संधी मला देण्यात आलेली आहे.
- I acknowledge that no guarantee and promises have been made concerning the result of any procedure or treatment.
शब्दक्रिया/उपचारा बाबत कोणतीही खात्री देता येत नाही. याबाबत मला जाणीवकरून देण्यात आलेली आहे.
- I consent to Photographing or recording of the operation or procedures for medical, scientific or educational purpose provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.
माझी ओळख उघड न करण्याच्या अटीवर वैज्ञानिक किंवा शैक्षणिक कारणासाठी माझ्या वर करण्यात येणाऱ्या शब्दक्रिया/उपचाराचे चित्रीकरण करण्यास किंवा फोटो काढण्यास मी संमतीदेत आहे.
- For the purpose of advanced medical education, I hereby give consent to the attendance of observers to the operating Room.
वैद्यकीय शिक्षणाच्या दृष्टीने माझ्या शब्दक्रियेच्या/उपचाराच्या दरम्यान निरिक्षका सउपस्थित राहण्याची परवानगी देत आहे.
- I also give consent to the disposal by hospital authorities any tissues or parts, which may be removed during the course of operative procedure /treatment.
शब्दक्रियेच्या दरम्यान काढलेला शरीराचा निकामी अवयव/मासलभाग नष्ट करण्याची परवानगी मी रुग्णालयास देत आहे.
- I certify that the statements made in above consent letter have been read over and explained to me in the language I understand. I totally understood the implications of the above consent and agree for it.
मी प्रमाणित करतोकि, उपरोक्त सम्मती पत्रकातील मजकूर संपूर्णपणे समजावून घेतला आहे. संमतीच्या परिणामा बाबत मला खात्री असून मी याबाबत पूर्णपणे सहमत आहे.
- I understand that all papers related to my treatment in this hospital would be kept safe custody of hospital which is also legally essential for the hospital. I give consent that if I require, I will get the summery and/or attested photocopy of the same.
माझ्या चिकित्से संबंधित सर्व कागद पत्रे सुरक्षित ठेवतील याबाबत मला खात्री आहे. जे कि कायद्याच्या तरतुदी नुसार आवश्यक आहे. मला संबंधित कागदपत्राची गरज भासून्यास हॉस्पिटल प्रशासनाकडून मला ती संक्षिप्त स्वरूपात किंवा घायांकित स्वरूपात स्वीकारण्याची मी संमती देत आहे.

	Signature-सही	Name-नाव	Date-तारीख	Time-वेळ
Patient/Relative रुग्ण/नातेवाईक				
Witness(Relation with Patient) साक्षीदार (रुग्णाशी नाते)				
Doctor (डॉक्टर)				
Interpreter-माहिती समजावून सांगणारे.				

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DOCTORS ORDER SHEET

UID No: _____ IPD No: _____ Date & Time Of Admission: / / AM/PM
Patient's Name: _____ Age: _____ Sex : _____ ICU/Ward / Room
Consultant: _____ Diagnosis: _____ Bed No: _____

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NURSES DAILY RECORDS

UID No: _____ IPD No: _____ Date & Time Of Admission: / / AM/PM

Patient's Name: _____ Age: _____ Sex : _____ ICU/Ward / Room

Consultant: _____ Diagnosis: _____ Bed No: _____

ALLERGY: _____

SPECIAL CARE: _____

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DRUG ADMINISTRATION FORM

UID No: _____ IPD No: _____ Date & Time Of Admission: / / ___ AM/PM

Patient's Name: _____ Age: ___ Sex : ___ ICU / Ward / Room

Consultant: _____ Diagnosis: _____ Bed No: _____

Drugs	Date							
	Time							
Name Of Drug :								
Dosage:								
Frequency:								
Route :								
Date :	Sign :							
Name Of Drug :								
Dosage:								
Frequency:								
Route :								
Date :	Sign :							
Name Of Drug :								
Dosage:								
Frequency:								
Route :								
Date :	Sign :							
Name Of Drug :								
Dosage:								
Frequency:								
Route :								
Date :	Sign :							

TPR / BP CHART

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UID No: _____ IPD No: _____ Date & Time Of Admission: / / _____ AM/PM

Patient's Name: _____ Age: _____ Sex: _____ ICU/Ward / Room _____

Consultant: _____ Diagnosis: _____ Bed No: _____

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DISCHARGE CARD SUMMARY

UID No:	IPD No:	Date & Time Of Admission:	/ /	AM/PM
Patient's Name:		Age:	Sex :	ICU/Ward / Room
Consultant:	Diagnosis:	Bed No:		

Discharge Type _____ Admission Type-_____ Discharge Date & Time _____

Final Diagnosis _____

Procedure Performed

Brief History of Presenting Illness

Chief Complaints on Admission

Past History-

Drug Allergy

Clinical Findings-

Relevant Investigations

Operative Notes

Treatment Given

Condition of Patient at Discharge -

Medication Advised on Discharge

Follow up Advice-

When to obtain urgent care

Contact Number in case of Emergency -

Keep the records carefully and bring them along during Next visit to Hospital