

# KAMNENI HOSPITALS

**Token No:18**  
**Room No:10**

**OP CARD Receipt**

Date: 18-Dec-2020 11:59:48 AM

UHID : 20190722661

OPID : 2017071565

BillNo : 202012180449

Name : Mr. NARENDRA NATH  
LAL

Age/Sex : 71 YEARS/M

Visit NO : 1

Dept/Doctor : ORTHOPAEDICS/Dr. Kamaraju C (KAMC/24736)

Ref.Doctor : SELF

OP Consultation Fee : Rs.650

Recieved By Cash : Rs.650/-

2nd Visit Validity Upto 24/12/2020

**Dr. KAMARAJ C**  
D.Ortho, DNB Ortho  
Prof. & H.O.D.  
Reg. No. 24763  
Dept. of Orthopaedics

Cashier/Receptionist

anusha.c

Kamineni Hospital, L.B. Nagar, Hyd-58

**VITALS:**

PR:

RR:

BP:

TEMP:

**NUTRITIONAL SCREENING:** Obese / Normal / Mal Nourished

Height:

Weight:

**DIETICIAN CONSULTATION:** Required / Not Required**DRUG ALLERGIES:** YES/NO**Symptoms list:**

- |                         |   |                             |
|-------------------------|---|-----------------------------|
| 1. Fever                | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Myalgia (Body pains) | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| 3. Cough                | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Breathlessness       | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| 5. Cold                 | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| 6. Sore Throat          | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| 7. Loss of smell, taste | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |
| 8. Loose motions        | <input type="checkbox"/> Yes            | <input type="checkbox"/> No |

p.o. TICL, polyexchangers  
done for 2 weeks.

A  
My Right knee - An Slouch  
Lan

RT PCR

6.  
T. TENDOFIT x 1 month  
T. ULTRACET x 2 weeks

[http://10.10.40.11/khlonline/OP/ASP/op\\_opReceipt.asp](http://10.10.40.11/khlonline/OP/ASP/op_opReceipt.asp)

12/18/2020

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**PRESCRIPTION SLIP**

	Generic Name (In Capital Letters)	Strength	Dosage	Instructions	Duration	Total Quantity
1				KNEE CAP		
2				ICE PACK		
3						
4						
5						
6						
7						
8						
9						
10						



Pharmacist's Sign:

Doctor's Signature

Date:

(Stamp)

Name of Pharmacy:

KHL, L.B. Nagar.

*Wish you a Speedy Recovery*