**35.Paperless Hospital Service**

**Abstract:**

There are many Different document-related activities that can be analyzed for investigating the practical implications of migrating towards a paperless medical organization. For example, analysis of the preoperative risk assessment (PRA) form can illustrate how the practical use of documents by medical practitioners can often fundamentally be at odds with organizational aims and purposes. Data entry into electronic format by anesthetists using the PRA form is tedious and an additional activity that is required purely for reasons outside the local concerns of the medical professional.

**Existing system:**

Many general hospital practices are they are maintaining patients records in papers or documents so that managing those bundle of records is very difficult to manage in future like: delay when transferring paper medical records. Information can be shared difficult. Less security and confidentiality because it is readable every one. Modify of data very difficult. Increase costs of storage space.

**Proposed System:**

There are many Different document-related activities that can be analyzed for investigating the practical implications of migrating towards a paperless medical organization. For example, analysis of the preoperative risk assessment (PRA) form can illustrate how the practical use of documents by medical practitioners can often fundamentally be at odds with organizational aims and purposes. Data entry into electronic format by anesthetists using the PRA form is tedious and an additional activity that is required purely for reasons outside the local concerns of the medical professional.

**Modules:**

**Patient/Relative**

Patient will go to hospital and get admitted by giving their information to the admitting clerk. If patient is in serious state, relative will help in giving information about the patient to the admitting clerk. If the incoming patient is new, then admitting clerk will create a new record in Web portal and store the patient information by collecting all necessary details and also about health history. And will provide patient ID.

**Admitting Clerk:**

Admitting clerk will assign the In-coming patient record to the Department Admin and direct the Patient to meet the Department Admin.

**Department Admin:**

Department Admin will assign the Patient to the respective Department like ENT, ICU, Surgery, etc and also will assign Doctors/Nurses who will be responsible to treat the patient.

**Doctor/Nurse:**

Doctor will get patient information by querying on Patient ID and will conduct series of tests and will update their test report along with comments in the Application.

**Billing Department:**

Billing Department will calculate the expense and will be responsible to verify if Patient has Insurance Policy, if so then they will open a secure session to charge the cost to Insurance Providers, If Patient doesn’t have Insurance Policy, Then he must pay either in cash.

**Healthcare Insurance Providers:**

Insurance Providers will verify the claim and will confirm whether the Insurance Id and Policy coverage is valid or not.