

Paste
Photograph
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ORDI Patients Registration form

Name of the Patient	
Sex	Male / Female
Age	DOB:
Kid is good at/Hobbies	
Name of the Father	
Name of the Mother	
Occupation of Father	
Siblings other than Patient.	Male : Female : Total: Expired:
Name of Disease	
Name of the Hospital	
Name of the Doctor	
Contact Details of the Doctor/Hospital	
Email ID of the doctor	
Member Contact Details	Phone No /Mobile 1: Phone No /Mobile 2: STD Code if landline
Member E mail ID	Email ID 1: Email ID 2:
Correspondence Address Full	Landmark: City : Taluka : District : PIN code :

Permanent Address if it is different from above	Landmark: City : Taluka : District : PIN code :
Referred by and Contact Details	
Remarks	

I confirm the above details are true to the best of my knowledge. I agree to all the rules and regulations of the society and society decision is final.

Date:

Signature of the member

Note: Please attach any important photo /Information which you would like to share voluntarily.

For Office

Date of Membership Confirmation :

Amount Paid in Rs. :

Mode of Payment :

Receipt no and Date :

Membership No :

Member State :

Member ID :

Accounts

Treasurer

Please attach a Photo(Other)

(Note: You can strike out for the pints not willing to provide consent)

ORDI – Patient Consent Form and Non-Disclosure Undertaking

Date:

I, _____,
son/daughter/wife/father/Mother /Guardian of _____
_____ residing at _____

Photo of the RD
member /Patient

And suffering from _____ Disease, being a member of ORDI bearing Membership No _____ wish to voluntarily participate in all the activities organized by ORDI and agree to give my consent for the ORDI activities listed below in the interest of ORDI patients, parents and caregivers.

- For discussing my disease and case history.
- I hereby authorize ORDI to use my name, patient history, Medical records, treatment that I have undergone, history and any useful information in whatever form as may be necessary.
- I do not hold ORDI for any claims/liabilities/obligations relating to privacy/confidentiality with respect to the disclosure of the aforesaid information for the purposes of the ORDI activity.
- I hereby authorize ORDI to use my collected human sample for diagnostic or research purpose in India or abroad as deemed necessary by ORDI
- I further authorize the Society to record and use any of the information by way of audio/video recording or any other form in whole or in part, for dissemination of information.
- I also authorize ORDI to use my information, photo, video, Records to press, media or for research, publication, raising funds or any other useful purpose.
- I acknowledge that any interaction and discussions with the ORDI society would be for my benefit. It would help in understanding in managing and treating my disease / disorders better.
- I agree to any decision taken on my behalf for the betterment of my disorder and lifestyle.
- I also agree to go wherever the society invites me for my betterment.

I acknowledge and understand that information- other ORDI member information, other patient information and medical details or any other information, that would be disclosed to me as a member of ORDI is confidential.

I hereby give an undertaking to the ORDI that I shall not disclose the any information to any third party and shall keep the same confidential. The above information has also been explained to me in a language I understand.

Patient/ Guardian's Name (in case of minors):

Address:

Contact Details:

E mail ID:

Signature: