PAGE 1 TEMPLATE — ANESTHESIA CHART

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

ANESTHESIA CHART

Patient Identification

- Patient Name: _____
- Age: _____ Years
- Sex: ☐ Male ☐ Female ☐ Other
- MR No.: _____
- IP No.: _____
- Date: ____ / ____ / _____

Category (Tick Applicable)

- ☐ CCU
- ☐ Day Care
- ☐ Intensive Care
- ☐ Deluxe
- ☐ Suite

Surgical & Medical Team

- Surgeon Name: _____
- Anaesthetist Name: _____

Surgery Details

- Operation / Procedure Name: _____
- Surgical Site / Side: ☐ Right ☐ Left ☐ Bilateral

Premedication (Tick / Specify)

- ☐ Inj. Ondansetron
- ☐ Inj. Paracetamol
- ☐ Inj. Pantoprazole
- ☐ Other (Specify): _____

Timings

- Time In OT: _____ AM / PM
- Induction Time: _____ AM / PM

Monitoring (Tick Applicable)

- ☐ ECG
- ☐ SpO_2
- ☐ NIBP
- ☐ $EtCO_2$
- ☐ Temperature

Pre-Induction Vitals

- Weight (kg): _____
- Blood Pressure (mmHg): _____ / _____
- Pulse Rate (/min): _____
- SpO_2 (%): _____

Lines / Tubes / Status

- IV Cannula:
  - ☐ 18G
  - ☐ 20G
  - ☐ 22G
- IV Site: _____
- Urinary Catheter:
  - ☐ Inserted in OT
  - ☐ Inserted in Ward
  - ☐ Not Inserted
- NPO Status (Hours): _____

Anaesthesia Details

- Type of Anaesthesia:
    - ☐ General Anaesthesia (GA)
    - ☐ Spinal Anaesthesia (SA)
    - ☐ Epidural
    - ☐ Local Anaesthesia (LA)
    - ☐ Combined Spinal Epidural
- Technique / Level (if applicable): _____

Temperature Management

- ☐ Forced Air Warmer
- ☐ Fluid Warmer
- ☐ Warm Blankets
- ☐ Not Used

Remarks / Notes

Authentication

- Anaesthetist Name & Signature: _____
- Date & Time: _____

📄 PAGE 2 TEMPLATE — PRE-OPERATIVE EVALUATION (HOLDING AREA)

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

PRE-OPERATIVE EVALUATION – HOLDING AREA

Patient Identification

- Patient Name: _____
- Age: _____ Years
- Sex: ☐ Male ☐ Female ☐ Other
- MR No.: _____
- IP No. / OPD No.: _____
- Date: ____ / ____ / _____

Surgical & Anaesthesia Details

- Planned Surgery / Procedure: _____
- Surgical Site / Side: ☐ Right ☐ Left ☐ Bilateral
- Surgeon Name: _____
- Anaesthetist Name: _____

Pre-Anaesthetic Assessment

- ASA Physical Status:
  - ☐ ASA I
  - ☐ ASA II
  - ☐ ASA III
  - ☐ ASA IV
- Airway Assessment:
  - Mallampati Grade: ☐ I ☐ II ☐ III ☐ IV
- Dentures / Loose Teeth:
  - ☐ No
  - ☐ Yes (Removed)

Nil By Mouth (NBM) Status

- NBM Since (Hours): _____
- Last Oral Intake Time: _____ AM / PM

Pre-Operative Medications Given

- ☐ Inj. Pantoprazole
- ☐ Inj. Ondansetron
- ☐ Inj. Paracetamol
- ☐ Antibiotic (Specify): _____
- ☐ Other (Specify): _____

Vital Signs

- Pulse Rate (/min): _____
- Blood Pressure (mmHg): _____ / _____
- Respiratory Rate (/min): _____
- SpO_2 (%): _____
- Temperature (°C): _____
- Weight (kg): _____

Investigations Reviewed

- ☐ Hemoglobin
- ☐ Blood Sugar
- ☐ Renal Function Tests
- ☐ ECG
- ☐ Chest X-Ray
- ☐ Others: _____

Safety & Preparation Checklist

- Consent Taken:
  - ☐ Surgery
  - ☐ Anaesthesia
- IV Line Secured:
  - ☐ Yes
  - ☐ No
- IV Antibiotic Given:
  - ☐ Yes
  - ☐ No

- Dentures Removed:
  - ☐ Yes
  - ☐ No
- Nail Polish / Jewellery Removed:
  - ☐ Yes
  - ☐ No

Fitness for Surgery

- Patient Declared:
  - ☐ Fit for Surgery
  - ☐ Unfit for Surgery
- Remarks (if any):

Transfer to OT

- Patient Shifted to OT at: _____ AM / PM
- Accompanied By:
  - ☐ Nurse
  - ☐ Attendant
  - ☐ Anaesthesia Staff

Authentication

- Anaesthetist Name & Signature: _____
- Date & Time: _____

📄 PAGE 3 TEMPLATE — SURGICAL SAFETY CHECKLIST (SIGN IN)

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

SURGICAL SAFETY CHECKLIST — SIGN IN

(To be completed BEFORE induction of anaesthesia)

Patient & Procedure Verification

- Patient Identity Confirmed (Name & ID): ☐ Yes ☐ No
- Surgical Procedure Confirmed: ☐ Yes ☐ No
- Surgical Site / Side Confirmed:
  - ☐ Right
  - ☐ Left
  - ☐ Bilateral
  - ☐ Not Applicable
- Surgical Site Marked:
  - ☐ Yes
  - ☐ No
  - ☐ Not Applicable
- Valid Consent Available:
  - ☐ Yes
  - ☐ No

Allergy & Risk Assessment

- Known Allergy:
  - ☐ No
  - ☐ Yes (Specify): _____
- Difficult Airway / Aspiration Risk:
  - ☐ No
  - ☐ Yes
- Risk of Blood Loss > 500 ml:
  - ☐ No
  - ☐ Yes

Anaesthesia Safety Check

- Anaesthesia Machine Check Completed: ☐ Yes ☐ No
- Suction Available & Functional: ☐ Yes ☐ No
- Emergency Drugs Available: ☐ Yes ☐ No

Monitoring & Equipment

- Pulse Oximeter Applied & Working: ☐ Yes ☐ No
- ECG Monitoring Ready: ☐ Yes ☐ No
- NIBP Monitoring Ready: ☐ Yes ☐ No

Medication History (Last 48 Hours)

- Oral Antiplatelet Drugs Taken:
  - ☐ No
  - ☐ Yes (Specify): _____
- Oral Anticoagulants Taken:
  - ☐ No
  - ☐ Yes (Specify): _____
- Parenteral Anticoagulants Taken:
  - ☐ No
  - ☐ Yes (Specify): _____

Pre-Induction Confirmation

- IV Line Secured & Patent: ☐ Yes ☐ No
- Antibiotic Prophylaxis Given:
  - ☐ Yes
  - ☐ No
  - ☐ Not Applicable
- Blood / Blood Products Arranged (if required):
  - ☐ Yes
  - ☐ No
  - ☐ Not Required

Team Confirmation

- Surgeon Present: ☐ Yes ☐ No
- Anaesthetist Present: ☐ Yes ☐ No

- OT Nurse Present: ☐ Yes ☐ No

Signatures

- Surgeon Name & Signature: _____
- Anaesthetist Name & Signature: _____
- OT Nurse Name & Signature: _____
- Date & Time: _____

📄 PAGE 4 TEMPLATE — SURGICAL SAFETY CHECKLIST (SIGN OUT)

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

SURGICAL SAFETY CHECKLIST — SIGN OUT

(To be completed before the patient leaves the Operating Theatre)

Procedure & Timing

- Date: ____ / ____ / _____
- Time (Before Leaving OT): _____ AM / PM
- OT No.: _____

Procedure Confirmation

- Name of Procedure Recorded: ☐ Yes ☐ No
- Surgical Site / Side Confirmed:
  - ☐ Right
  - ☐ Left
  - ☐ Bilateral
  - ☐ Not Applicable

Instrument, Sponge & Needle Count

- Sponge Count:
  - ☐ Correct
  - ☐ Incorrect (Explain): _____
- Needle Count:
  - ☐ Correct
  - ☐ Incorrect (Explain): _____
- Instrument Count:
  - ☐ Correct
  - ☐ Incorrect (Explain): _____

Specimen Management

- Specimen Collected:
  - ☐ No
  - ☐ Yes
    - Specimen Name: _____
    - Label Verified:
      - ☐ Yes
      - ☐ No
- Sent To:
  - ☐ Laboratory
  - ☐ Histopathology
  - ☐ Microbiology

Equipment & Device Check

- Any Equipment / Device Problems Identified:
  - ☐ No
  - ☐ Yes (Specify): _____
- Action Taken (if any):

Post-Operative Management Review

(Confirmed verbally with the team)

- Key Concerns for Recovery Reviewed:
  - ☐ Surgeon
  - ☐ Anaesthetist
  - ☐ Nursing Team
- Post-Op Instructions Discussed:
  - ☐ Monitoring Requirements
  - ☐ Pain Management Plan
  - ☐ Antibiotics
  - ☐ Fluids / Diet
  - ☐ Special Instructions (Specify): _____

Patient Transfer Plan

- Destination After OT:
  - ☐ Recovery Room
  - ☐ ICU
  - ☐ HDU
  - ☐ Ward

- Mode of Transfer:
    - ☐ Bed
    - ☐ Trolley
    - ☐ Wheelchair
- Oxygen Required During Transfer:
    - ☐ Yes
    - ☐ No

Final Verification

- Sign-Out Checklist Completed: ☐ Yes ☐ No
- Patient Safe to Leave OT: ☐ Yes ☐ No

Team Authentication

- **Surgeon Name & Signature: _____**
- **Anaesthetist Name & Signature: _____**
- **OT Nurse Name & Signature: _____**

Date & Time: _____

📄 PAGE 5 – OPERATION RECORD

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

OPERATION RECORD

Patient & OT Details

- Date of Surgery: ____ / ____ / _____
- OT No.: _____
- Department: _____

Surgery Timings

- Patient In OT: _____ AM / PM
- Induction Time: _____ AM / PM
- Incision Time: _____ AM / PM
- Closure Time: _____ AM / PM
- Shifted to Recovery Room at: _____ AM / PM

Diagnosis

- Pre-Operative Diagnosis:
  _____
- Post-Operative Diagnosis:
  _____

Anaesthesia

- Type of Anaesthesia:
  - ☐ General
  - ☐ Spinal
  - ☐ Epidural
  - ☐ Local
  - ☐ Combined
- ASA Grade:

- ☐ I ☐ II ☐ III ☐ IV

Surgical Team

- Surgeon: _____
- Assistant Surgeon: _____
- Anaesthetist: _____

Implants / Devices Used

Implant / Device	Size / Model	Batch / Lot No

Counts

- First Count: ☐ Correct ☐ Incorrect
- Second Count: ☐ Correct ☐ Incorrect
- Final Count: ☐ Correct ☐ Incorrect

Surgeon Signature

- Name & Signature: _____ Date: _____

📄 PAGE 6 – OPERATION NOTES

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

DETAILED OPERATION NOTES

Procedure Name

Patient Position

- ☐ Supine
- ☐ Prone
- ☐ Lateral
- ☐ Lithotomy
- ☐ Fracture Table
- ☐ Other: _____

Equipment Used

- ☐ C-Arm
- ☐ Tourniquet
- ☐ Endoscope
- ☐ Microscope
- ☐ Other: _____

Intra-Operative Details

- Reduction Method:
  - ☐ Closed
  - ☐ Open
- Approach Used: _____
- Findings:

Procedure Description

(Write step-by-step operative details)

Blood Loss

- Estimated Blood Loss (ml): _____

Complications

- Intra-Operative Complications:
  - ☐ No
  - ☐ Yes (Specify): _____

Closure & Dressing

- Closure Method:
  - ☐ Primary
  - ☐ Secondary
- Drain Used:
  - ☐ No
  - ☐ Yes (Type): _____
- Dressing Applied: ☐ Yes ☐ No

Surgeon Authentication

- Surgeon Name & Signature: _____
- Date & Time: _____

📄 PAGE 7 TEMPLATE — OT BILLING SHEET

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

OPERATION THEATRE (OT) BILLING SHEET

OT & Admission Details

- OT No.: _____
- Date of Surgery: ____ / ____ / _____
- OT Start Time: _____ AM / PM
- OT End Time: _____ AM / PM
- Department: _____

Surgery Details

- Name of Surgery / Procedure: _____
- Surgical Site / Side:
  - ☐ Right
  - ☐ Left
  - ☐ Bilateral
- Emergency / Elective:
  - ☐ Emergency
  - ☐ Elective

Medical Team Charges

- Principal Surgeon Name: _____
  - Surgeon Fees: ₹ _____
- Assistant Surgeon Name: _____
  - Assistant Fees: ₹ _____
- Anaesthetist Name: _____
  - Anaesthesia Fees: ₹ _____

Anaesthesia Details

- Type of Anaesthesia:
  - ☐ General Anaesthesia (GA)
  - ☐ Spinal Anaesthesia (SA)
  - ☐ Epidural
  - ☐ Local Anaesthesia (LA)
  - ☐ Combined
- Anaesthesia Time (Minutes): _____

OT Usage Charges

- OT Charges (Hourly / Fixed): ₹ _____
- OT Duration (Hours): _____
- C-Arm Usage:
  - ☐ Yes
  - ☐ No
  - Charges (if applicable): ₹ _____
- Equipment / Instrument Charges:
  - ☐ Yes
  - ☐ No
  - Details: _____

Implants / Consumables

Item Name	Company / Model	Quantity	Amount (₹)

Medicines & Disposable Charges

- Medicines Charges: ₹ _____
- Disposable / Consumables Charges: ₹ _____

Additional Charges (if any)

- _____ ₹ _____
- _____ ₹ _____

Total OT Billing Summary

- Subtotal (₹): _____
- GST / Taxes (₹): _____
- **Total Amount (₹): _____**

Billing Verification

- Prepared By (OT Staff): _____
- Signature: _____
- Date & Time: _____

Accounts / Billing Department

- Verified By: _____
- Signature & Stamp: _____
- Date: ____ / ____ / _____

📄 PAGE 8 TEMPLATE — SURGICAL INFECTION PROPHYLAXIS FORM

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

SURGICAL INFECTION PROPHYLAXIS FORM

Patient Identification

- Patient Name: _____
- Age: _____ Years
- Sex: ☐ Male ☐ Female ☐ Other
- MR No.: _____
- IP No. / OPD No.: _____
- Date of Surgery: ____ / ____ / _____

Surgery Details

- Name of Surgery / Procedure: _____
- Surgical Site / Side:
  - ☐ Right
  - ☐ Left
  - ☐ Bilateral
- Surgeon Name: _____
- Department: _____
- OT No.: _____
- Time of Skin Incision: _____ AM / PM
- Expected / Actual Duration of Surgery (Hours): _____

Wound Classification (Tick One)

- ☐ Clean
- ☐ Clean–Contaminated
- ☐ Contaminated
- ☐ Dirty / Infected

Antibiotic Prophylaxis Details

1. Pre-Operative Antibiotic

- Antibiotic Name: _____
- Dose: _____
- Route:
    - ☐ IV
    - ☐ IM
    - ☐ Oral
- Time Given (Before Incision): _____ AM / PM

2. Intra-Operative Antibiotic (If Applicable)

- Antibiotic Name: _____
- Dose: _____
- Time Given: _____ AM / PM

3. Post-Operative Antibiotic Plan

- Antibiotic Name: _____
- Frequency: ☐ OD ☐ BD ☐ TDS ☐ QID
- Duration (Days): _____

Compliance Check

- Antibiotic Given Within 60 Minutes Before Incision:
    - ☐ Yes
    - ☐ No
- Redosing Required (Long Surgery / Blood Loss):
    - ☐ Yes
    - ☐ No
    - If Yes, Specify: _____

Post-Operative Wound Assessment (48 Hours)

Tick all applicable:

- ☐ Clean & Dry
- ☐ Redness / Erythema
- ☐ Swelling
- ☐ Oozing
- ☐ Purulent Discharge
- ☐ Fever
- ☐ No Signs of Infection

Remarks

Authentication

- Surgeon Name & Signature: _____
- Date & Time: _____

If you want, next I can give:

📄 PAGE 9 TEMPLATE — COUNT RECORD FOR SURGERY

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

COUNT RECORD FOR SURGERY

Patient & OT Details

- Date: ____ / ____ / _____
- OT No.: _____
- Surgery / Procedure Name: _____
- Surgeon Name: _____
- Anaesthetist Name: _____

OT Timings

- Time In OT: _____ AM / PM
- Time Out OT: _____ AM / PM

Surgical Count Record

Item Name	Initial Count	Added During Surgery	Final Count	Correct (✔/✖)
Mops (Large)				
Mops (Small)				
Gauze Pieces				
Needles				
Blades				
Other (Specify)				

Count Verification

- All sponge, needle & instrument counts correct:
    - ☐ Yes
    - ☐ No
- Surgeon informed of count status:
    - ☐ Yes
    - ☐ No

Signatures

- Scrub Nurse Name & Signature: _____
- Circulating Nurse Name & Signature: _____
- Surgeon Name & Signature: _____
- Date & Time: _____

📄 PAGE 10 TEMPLATE — SURGERY TIME SHEET

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

SURGERY TIME SHEET

Patient & Surgery Details

- Date: ____ / ____ / _____
- OT No.: _____
- Surgery / Procedure Name: _____
- Surgeon Name: _____
- Anaesthetist Name: _____
- Type of Anaesthesia:
  - ☐ GA
  - ☐ SA
  - ☐ Epidural
  - ☐ LA
  - ☐ Combined

Surgery Timings

- Patient In OT: _____ AM / PM
- Anaesthesia Induction Time: _____ AM / PM
- Incision Time: _____ AM / PM
- Procedure Completion Time: _____ AM / PM
- Closure Time: _____ AM / PM
- Patient Out of OT: _____ AM / PM

Intraoperative Observation / Remarks

Post-Procedure Status

- Patient Shifted To:

    - ☐ Recovery Room
    - ☐ ICU
    - ☐ Ward
- Condition on Transfer:
    - ☐ Stable
    - ☐ Unstable

Authentication

- Surgeon Name & Signature: _____
- Anaesthetist Name & Signature: _____
- Date & Time: _____

📄 PAGE 11 TEMPLATE — CRITICAL CARE / POST-OP TRANSFER FORM

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

POST-OPERATIVE TRANSFER FORM

Transfer Details

- Transferred From:
  - ☐ Operation Theatre
  - ☐ Ward
- Transferred To:
  - ☐ ICU
  - ☐ HDU
  - ☐ Ward

Reason for Transfer

- ☐ Post-operative monitoring
- ☐ Medical observation
- ☐ Surgical observation
- ☐ Others: _____

Patient Condition at Transfer

- Level of Consciousness:
  - ☐ Conscious
  - ☐ Drowsy
  - ☐ Unconscious
- Vitals:
  - ☐ Stable
  - ☐ Unstable
- Oxygen Support:
  - ☐ Room Air
  - ☐ Oxygen Mask
  - ☐ Nasal Prongs
  - ☐ Ventilator

Monitoring & Lines

- IV Line: ☐ Yes ☐ No
- Urinary Catheter: ☐ Yes ☐ No
- Drain(s): ☐ Yes ☐ No
- Central Line: ☐ Yes ☐ No

Handover Given To

- Doctor Name: _____
- Nurse Name: _____

Transfer Timing

- Transfer Start Time: _____ AM / PM
- Transfer End Time: _____ AM / PM

Authentication

- Anaesthetist / Doctor Signature: _____
- Date & Time: _____

📄 PAGE 12 TEMPLATE — RECOVERY ROOM RECORD (PART 1)

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

RECOVERY ROOM OBSERVATION SHEET

Procedure Details

- Surgery / Procedure Name: _____
- Anaesthesia Type:
  - ☐ GA
  - ☐ SA
  - ☐ Epidural
  - ☐ LA

Recovery Scoring (0–2 Scale)

Parameter	0	1	2
Movement	☐	☐	☐
Respiration	☐	☐	☐
Pulse	☐	☐	☐
Blood Pressure	☐	☐	☐
Consciousness	☐	☐	☐

Total Score: _____ / 10

Pain & Nausea Assessment

- Pain Score (0–10): _____
- Nausea / Vomiting:
  - ☐ No
  - ☐ Yes

Vitals Monitoring

- Pulse (/min): _____
- BP (mmHg): _____ / _____
- SpO_2 (%): _____
- Respiratory Rate (/min): _____

Remarks

📄 PAGE 13 TEMPLATE — RECOVERY ROOM RECORD (PART 2 / DISCHARGE)

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

RECOVERY ROOM DISCHARGE FORM

Timing

- Arrival in Recovery Room: _____ AM / PM
- Discharge from Recovery Room: _____ AM / PM

Condition at Discharge

- Conscious: ☐ Yes ☐ No
- Vitals Stable: ☐ Yes ☐ No
- Pain Controlled: ☐ Yes ☐ No

Shifted To

- ☐ Ward
- ☐ ICU
- ☐ HDU

Handover Given To

- Nurse Name: _____
- Ward / Unit: _____

Authentication

- Anaesthetist Signature: _____
- Date & Time: _____

📄 PAGE 14 TEMPLATE — CENTRAL LINE / VENTILATOR / DEVICE BUNDLE

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

DEVICE & BUNDLE CHECKLIST

- Urinary Catheter:
  - ☐ Inserted
  - ☐ Not Inserted
- Central Line:
  - ☐ Present
  - ☐ Not Present
- Ventilator:
  - ☐ Yes
  - ☐ No

Daily Care Checklist

- Hand Hygiene Followed: ☐ Yes ☐ No
- Catheter Care Done: ☐ Yes ☐ No
- Line Site Clean: ☐ Yes ☐ No

Remarks

📄 PAGE 15 TEMPLATE — ADMISSION DETAILS

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

ADMISSION DETAILS

- Date & Time of Admission: _____
- Department: _____
- Bed Category:
  - ☐ General
  - ☐ Semi-Private
  - ☐ Deluxe
  - ☐ Suite
- Bed / Room No.: _____

Attendant / Relative Details

- Name: _____
- Relation: _____
- Contact No.: _____

📄 PAGE 16 TEMPLATE — ADMISSION CONSENT CUM UNDERTAKING

Gravity Hospital & Research Centre

Address: Gat No, 167, Sahyog Nager, Triveni Nagar, Chowk, Pimpri-Chinchwad, Maharashtra 411062
Mob.: +91 1234567890
Email: support@gravityhospital.com

CONSENT CUM UNDERTAKING

☐ I consent for medical treatment
☐ I consent for surgical procedure
☐ I consent for anaesthesia

I understand the risks, benefits, and alternatives involved.

Signatures

- Patient / Relative Name: _____
- Signature / Thumb Impression: _____
- Date & Time: _____

📄 PAGE 17 TEMPLATE — ADMISSION BRIEFING CHECKLIST

Gravity Hospital & Research Centre

PATIENT & ATTENDANT BRIEFING

- Billing Policy Explained: ☐ Yes ☐ No
- Insurance Policy Explained: ☐ Yes ☐ No
- Emergency Charges Explained: ☐ Yes ☐ No
- Visiting Hours Explained: ☐ Yes ☐ No

Staff Signature

- Name & Signature: _____

📄 PAGE 18 TEMPLATE — GENERAL GUIDELINES & POLICIES

Gravity Hospital & Research Centre

HOSPITAL GUIDELINES

☐ Visitor Policy Explained
☐ Attendant Responsibility Explained
☐ Billing & Payment Responsibility Explained
☐ Hospital Rules Acknowledged

Patient / Relative Signature

- Name: _____
- Signature: _____

📄 PAGE 19 TEMPLATE — HISTORY & PHYSICAL EXAMINATION

Gravity Hospital & Research Centre

CLINICAL HISTORY

- Chief Complaint: _____
- Duration: _____

Past Medical History

- Hypertension: ☐ Yes ☐ No
- Diabetes: ☐ Yes ☐ No
- Cardiac Disease: ☐ Yes ☐ No
- Respiratory Disease: ☐ Yes ☐ No
- Others: _____

Physical Examination

- General Condition: _____
- Systemic Examination Notes:

📄 PAGE 20 TEMPLATE — LABORATORY INVESTIGATIONS

Gravity Hospital & Research Centre

INVESTIGATION RECORD

Test Name	Result	Unit	Normal Range
Hemoglobin			
TLC			
Platelets			
Blood Sugar			
Creatinine			
ECG			

Doctor Signature

- Name & Signature: _____
- Date: _____
