

Surname EKPah	Other names MINI Doo	Occupation: Teacher		
Age: 32 yrs	Sex:			
Tribe: TIV	Religion Christian	Phone Number 08034707656		
Address: (RESIDENTIAL) Behind unique Secondary School				
PLACE OF ORIGIN (TOWN, LG, STATE, COUNTRY) Makurdi				
NAME OF NEXT OF KIN Monday EKPah	ADDRESS OF NEXT OF KIN Same as above	RELATIONSHIP Husband		

ADMISSION HISTORY

Date attended or Admitted	Referred by	Attending Physician or Surgeon	Ward	Date Discharged	Discharged to	Cured/Improved/ I.S.O/Worse/Died

DIAGNOSIS

Date	Diagnosis	Code Number

SURGERY

Date	Surgeon	Operation	Code Number

PERMISSION FOR OPERATION

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

1 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

2 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

3 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

4 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

5 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

This is to certify that I give permission for an operation to be performed on and anesthetic administered to:

.....
And that I leave the extent of the operation to the discretion of the surgeon.

Signature: _____

6 Relationship to Patient: _____

Address: _____

Witness: _____

Date: _____

PERMISSION FOR POST-MORTEM

Mr. Mrs. Dr. Alhaji: _____

Address: _____

Has granted permission for post-mortem to be performed on the deceased.
Name: _____

Relationship: _____

Name of Doctor in full: _____

Qualification: _____

Signature: _____

Date: _____

ADOOSE SPECIALIST HOSPITAL, MAKURDI

INVESTIGATIONS REQUEST FORM

Patient details

Name:			
Hospital Number:			
Telephone number:			
Date of Birth/Age:			
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Sample details:

Sample taken from patient:			
Date:	-(dd/mm/yyyy)		
Time:	-(hh/mm)		
<input type="checkbox"/> Blood	<input type="checkbox"/> Urine	<input type="checkbox"/> Swab	<input type="checkbox"/> Tissue
<input type="checkbox"/> Faeces	<input type="checkbox"/> Sputum	<input type="checkbox"/> Fluids	<input type="checkbox"/> Cytology
<input type="checkbox"/> Other, namely: _____			

Relevant Clinical information

Drug therapy:-	Last dose:-
Date:-	(dd/mm/yyyy) Time:-
(hh/mm)	

Examinations requested

- 1.
- 2.
- 3.
- 4.

Requesting Doctor's Name:
Signature: Date:



ADOOSE SPECIALIST HOSPITAL, MAKURDI

TREATMENT SHEET

Surname..... Other Names..... Number

Date	Time/Initials						
Name of Drug:							
Route, Dose, Frequency, Duration:							
Signature/Date:							
Name of Drug:							
Route, Dose, Frequency, Duration:							
Signature/Date:							
Name of Drug:							
Route, Dose, Frequency, Duration:							
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Name of Drug:							
Route, Dose, Frequency, Duration:							
Signature/Date:							



ADOOSE SPECIALIST HOSPITAL

KEGHEM MALU STREET NEW GRA MAKURDI

GENERAL PRESCRIPTION FORM

<i>Surname</i>	<i>First Name(s)</i>	<i>Patient Number</i>
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Prescription

<i>Date</i>	<i>Name</i>	<i>Signature</i>
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ADOOSE SPECIALIST HOSPITAL, MAKURDI

ADDRESS: NO 12 Keghem Malu Street, off Victor Malu Road, New GRA Makurdi. TEL: 08103088519

LABORATORY REQUEST/REPORT FORM

Surname	Other surnames	Age	Sex	Hospital No	Lab. No	Requesting Doctor	Ward/Clinic
Provisional Diagnosis		Specimen	Investigation Request		Date & Time Received	Date of Assay	

HAEMATOLOGY

INVESTIGATION		REFERENCE RANGE
Hb.....		14-16g/dl
RBC.....		4.0-5.0 million/cmm
PVC.....		35-50%
WBC.....		400-10,000/cmm
Retics.....		0.2-2.0%
Platelets.....		150,000-400,000/cmm
DIFFERENTIAL COUNT.....		
Neutrophil.....	%	
Lymphocyte.....	%	
Monocyte.....	%	
Faslnophil.....	%	
Basophil.....	%	
Total.....	(100)%	
ESR.....	3-15mn/h	

BLOOD FILM COMMENTS

Blood Group.....	
Hb Genotype(Electrophoresis)	
Cd4.....	

URINE MICROSCOPY

Plus cells.....	
RBC.....	

Yeast cells

Granular Casts.....

Other Casts.....

Cryatals.....

Epithelia.....

URINE ANALYSIS

Ketones.....	
Protein.....	

Specific Gravity.....

Sugar.....

Bilirubin.....

Urobilinogen.....

Colours.....

Transparency.....

PH.....

Ascorbic Acid.....

Leucocyte.....

Nitrite.....

Pregnant Test.....

STOOL MICROSCOPY

Appearance.....	
Microscopic Examination.....	

CULTURE & SENSITIVITY

Organism	Antibiotic	Sensitivity
1.		
2.		

Name.....

Signature.....

Date.....

CHEMICAL PATHOLOGY

INVESTIGATION		REFERENCE RANGE
Nat.....		134-145mmol/1
K1.....		3.5-5mmmol/1
CL.....		.95-106mmol/1
HCO3.....		21-32mmol/1
Urea.....		2.5-6.6.mmol/1
Creatinine.....		72-126mmol/1
Creatinine clearance.....		120mls/h
Uric Acid.....		120-420umol/1
Glucose.....		3.9-5.9mmol/1
Total protein.....		62-80g/1
Albumin.....		28-40g/1
Calcium.....		2.1-2.6mmol/1
Phosphate.....		0.8-14mmol/1
Bilirubin(Total).....		
Bilirubin(Con).....		
Alk Phosphate.....		
ALT(GPT).....		
AST(GOT).....		
Amylase.....		
Acid Phos. (Total).....		
Acid Phos.(Prost).....		
PSA.....		(4ng/ml)
Total Cholestrol.....		
HDL Cholestrol.....		(9.1mmol/1)
LDH Cholestrol.....		
Triglycerides.....		0.50-1.7mmol/1
T4.....		58-125mmol/1
T3.....		1.0-3.7mmol/1
TSH.....		0.5-50Mu/1
CSF FINDINGS		
Protein.....		150-400mg/1
Glucose.....		2.8-4.4mmol/1
Chloride.....		100-12mmol/1
OTHER INVESTIGATION		
HBsAg.....		
Anti-HCV.....		
VDRL.....		
RVS.....		
Western Blot.....		
Alpha Feto Protein.....		

Organism

Antibiotic

Sensitivity



ADOOSE SPECIALIST HOSPITAL

No. 12 Keghem Malu Street, Off Victor Malu Road, New GRA, Makurdi

Name: _____

Hospital No. _____

OBSERVATION SHEET

DATE	TIME	PULSE RATE	BP	RESP. RATE	TEMP

ADOOSE SPECIALIST HOSPITAL

SERVICES RENDERED FORM

PATIENT NAME..........**HOSP. NO.....**

DATE OF ADMISSION..........**DATE OF DISCHARGE.....**