Ab Health Hamesha

RELIGARE Values that bind | Health Insurance

Denial Letter

To,

QRG HEALTH CITY (55265881)
PLOT NO-1,SECTOR-16,AMBEDKAR MARG,
Faridabad
Faridabad
121002

Date : 08/Jan/2019
AL No : 80238780-02

Subject :- Denial of Pre-Auth for NEERU MAHESHWARI

Dear Sir/Madam,

We are in receipt of your request for pre-authorization of cashless hospitalization of NEERU MAHESHWARI . as per the following detail:

Member ID	52204256	Provisional Diagnosis	Umbilical hernia
Class of Accommodation	Single	Policy Number	10316227

We have reviewed your request, and hereby inform you that the cashless hospitalization cannot be approved as per the terms and conditions of the policy stated below:

- PREVIOUS FINAL APPROVAL REMAIN SAME.
- WRONG ENTRY

Should you require any assistance, please call 1800-200-4488 or write to claims@religare.com

With warm regards,

For Religare Health Insurance Company Ltd

Authorized Signatory

1207
+ 200
46207/-

15/1

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With warm regards,

For Religare Health Insurance Company Ltd

Authorized Signatory

Revised Bill excluding mesh & tracker out of the bill.
Final Bill was sending again excluding mesh & tracker

LIST OF DOCUMENTS REQUIRED FOR SETTLEMENT OF HOSPITALISATION CLAIMS

1.	FOR CLAIMING HOSPITALISATION EXPENSES
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
H	DETAILED DISCHARGE SUMMARY - ORIGINAL
I	DEATH SUMMARY (INSTEAD OF Discharge Summary) IF PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
J	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
K	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
L	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
M	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
N	STICKER FOR THE IMPLANTS USED - ORIGINAL
O	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
P	HOSPITAL MAIN BILL - ORIGINAL
Q	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
R	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
S	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT
T	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
U	COPY OF THE PRE-AUTH DENIED LETTER, IF ANY, FOR CASHLESS DENIED
V	CONFIRMATION FROM THE HOSPITAL FOR NON-UTILISATION OF CASHLESS FACILITY, IF CASHLESS SANCTIONED
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT)
	a. NEFT FORMAT GIVING DETAILS OF BANK ACCOUNT CLAIM AMOUNT TO BE TRANSFERRED
	b. A COPY OF THE PAGE OF BANK PASS BOOK CONTAINING A/C NUMBER & NAME/ ADDRESS OF A/C HOLDER.
	c. A CANCELLED CHEQUE FOR THE ABOVE ACCOUNT IN TO WHICH CLAIM AMOUNT HAS TO BE TRANSFERRED
AA	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
AB	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS
2.	**FOR CLAIMING PRE-HOSPITALISATION EXPENSES**
a	CLAIM FORM - PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
e	PHARMACY CASH BILLS FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE PRIOR TO ADMISION, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE PRIOR TO HOSPITALISATION
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED PRIOR TO HOSPITALISATION

i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER & LIST OF DOCUMENTS ATTACHED
3. FOR CLAIMING POST-HOSPITALISATION EXPENSES	
a	CLAIM FORM – PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED - POST-DISCHARGE
e	PHARMACY BILLS FOR MEDICINES PURCHASED - POST-DISCHARGE
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE - POST-DISCHARGE, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE - POST-DISCHARGE
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED - POST-DISCHARGE
i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
4. FOR HOSPITALS CLAIMING CASHLESS HOSPIALISATION EXPENSES APPROVED	
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DU PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	PRE-AUTHORISATION REQUEST IN ORIGINAL DULY SIGNED BY THE INSURED AND THE HOSPITAL
H	PRE-AUTHORISATION APPROVAL LETTER COPY
I	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
J	DETAILED DISCHARGE SUMMARY - ORIGINAL
K	DEATH SUMMARY (INSTEAD OF Discharge Summary) IN CASE THE PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
L	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
M	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
N	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
O	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
P	STICKER FOR THE IMPLANTS USED - ORIGINAL
Q	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
R	HOSPITAL MAIN BILL - ORIGINAL
S	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
T	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
U	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT FOR THE NON-ADMISSIBLE AMOUNTS
V	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS

NOTE: (1) YOU SHOULD SUBMIT THE ABOVE DOCUMENTS ALONG WITH A COVERING LETTER (2) IF YOU ARE SUBMITTING PRE &/OR POST-HOSPITALISATION CLAIMS SEPARATELY YOU SHOULD SUBMIT THE CLAIM FORM DULY COMPLETED (3) ALSO SUBMIT THIS CHECKLIST

CLAIM FORM - PART A to CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City: State:

Pin Code Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health Insurance : : Yes No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if differnt from above):

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time H H M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption j) If Medico legal Yes No

k) Reported to Police l. MLC Report & Police FIR attached Yes No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses Rs.

ii. Hospitalization expenses Rs.

iii. Post-hospitalization expenses Rs.

iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

Total Rs.

vii. Pre -hospitalization period: days

viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash: Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs.

iv. Convalescence. Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- Claim form duly signed
- Copy of the claim Intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's request for Investigation
- Investigation Reports (including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealant of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date D D M M Y Y Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED		
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
b)	Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin code
	SECTION G -DETAILS OF INSURANCE HISTORY		
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of commencement of first Insurance with out break	Enter the date of commencement of first Insurance	Use dd-mm-yy-format
c)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the Insurance Company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
b)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f)	Occupation	Indicate occupation of patient	Tick the right option, If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION		
a)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	Indicate the room category occupied	Tick the right option
c)	Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d)	Date of Injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
f)	Time	Enter time of admission	Use hh-mm- format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
h)	Time	Enter time of discharge	Use hh-mm- format
i)	If injury give cause	Indicate cause of injury	Tick the right option
	If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	Indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j)	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLAIM		
a)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d)	Claim documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
	SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees			
	SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a)	PAN	Enter the permanent account number	As allotted by the Income Tax Department
b)	Account Number	Enter the Bank account number	As allotted by the Bank
c)	Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DC should be made out to	Name of the Individual / organization in full
c)	IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
	SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign.			

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issun of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE INITIAL

e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE INITIAL

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H M M h) Date of Discharge: D D M M Y Y i) Time: H H M M

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of Delivery: D D M M Y Y ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Code:	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: ☐ Yes ☐ No i. If Yes, give cause : Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MRI/USG/PE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. CT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y

Place:

Signature and Seal of the Hospital Authority:

SECTION A SECTION B SECTION C SECTION D SECTION E SECTION F

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd/mm/yy format), place (open text) and sign. and stamp		

OP 1208

Ab Health Hainesha

RELIGARE Health Insurance

706

1208

Authorization Letter

To,
QRG HEALTH CITY (55265881)
PLOT NO-1,SECTOR-16,AMBEDKAR MARG,
Faridabad
Faridabad
121002

Date : 08/Jan/2019
AL No : 30236780-01
Admission Date : 07/Jan/2019

In reference to the Pre-authorization Request submitted by you, we hereby authorize and guarantee payment up to Rs. 60500.00 The authorization details are as under:

Member ID	52204256	Claimed Amount	61200.00
Class of Accommodation	Single	Additional Sanction	-29500.00
Initial Authorized Limit	90000.00	Patient Name	NEERU MAHESHWARI
UnPaid Premium	0.00	Total Sanctioned Amount	60500.00

Notes to the hospital

1) KYC documents i.e. Identity Proof/Address Proof and Latest photo of the proposer to be sent if bill estimate is more than Rs. 1.0 Lakh.
2) If the hospital bill is estimated to be higher than the guarantee of payment, the additional amount would need to be sanctioned by RHICL
3) In absence of such additional guarantee, the hospital must collect the excess amount directly from the insured at the time of admission or prior to discharge.
4) The hospital bill summary and the detailed final bill will have to be authenticated with the insured's signature.This along with the original discharge summary and investigation reports will have to be submitted to the company.
5) Please collect an undertaking from the insured/patient for submitting his/her documents to RHICL in original.
6) Charges for the following miscellaneous services must be collected directly from the patient :

a) Registration charges	g) Charges for Tv, Laundry, Telephone, Fax etc
b) Attendant / Visitor charges	h) Food and Beverage for attendance/visitors
c) Ambulance charges unless authorized	i) Toiletries
d) Nursing charges not authorized	j) Medicines not related to treatment
e) Service charges	k) Stationary and other charges
f) Charges for extra bed	

Remarks APPROVED AS PER PROVIDED DETAILS & AGREED HOSPITAL TARIFF. RS 700/- DEDUCTED FOR NON-PAYABLE ITEMS.

For Religare Health Insurance Company Ltd

Authorized Signatory

Revise final Bill

www.religarehealthinsurance.com

Ab Health Hanesha

RELIGARE Values that bind | Health Insurance

Note:

- This authorization is valid for admission within 15 days from the date of issue or expiry / cancellation of the policy whichever is earlier.
- The authorization will not be valid if the patient is discharged before the date of issue of this letter.
- Co payment amount will be collected from insured.
- Claim Settlement will be as per agreed tariff structure between RHICL & the hospital.
- This is an initial approval and stands cancel where Misinterpretation of Facts is noticed.

All payment to hospital will be subject to deduction of tax at source as per prevailing government rates except where Nil/Low TDS certificates have been provided.

Please note that hospitalization for Treatment of following conditions is not payable:

i) Investigation and Evaluation, Infertility, STD, Self-inflicted injury, conditions caused by use of alcohol/tobacco/intoxicating drugs and others conditions as per policy terms.

ii) Religare Health Insurance Company will not be liable in the event of any discrepancy between the facts presented at the time of admission & at time of final discharge documentation.

Annexure i

		AL No.	80238780-01
Nature of Claim	HOSPITALIZATION -IPD		
Policy No	10316227	Name of Patient	NEERU MAHESHWARI
Hospital ID	55265881	Policy Owner Name	MANISH MAHESHWARI
Date of Admission	07-Jan-2019	Date of Discharge	08-Jan-2019
Total Approved Amount	60500.00	Claimed Amount	61200.00
Current Approved Amount	-29500.00	Co pay	0
Non Payable Items *	700.00	Hospital Discount (not to be collected from Patient)	0
UnPaid Premium	0.00	Total Deductions	700.00

* Annexure II

Particulars	Reason for Deduction	Remarks	Amount
Medicine and Consumable charges	Non Medical Expenses	700/- ADMISSION CHARGE	700.00
Total Deductions			700.00

LIST OF DOCUMENTS REQUIRED FOR SETTLEMENT OF HOSPITALISATION CLAIMS

1.	FOR CLAIMING HOSPITALISATION EXPENSES
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
H	DETAILED DISCHARGE SUMMARY - ORIGINAL
I	DEATH SUMMARY (INSTEAD OF Discharge Summary) IF PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
J	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
K	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
L	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
M	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
N	STICKER FOR THE IMPLANTS USED - ORIGINAL
O	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
P	HOSPITAL MAIN BILL - ORIGINAL
Q	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
R	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
S	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT
T	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
U	COPY OF THE PRE-AUTH DENIED LETTER, IF ANY, FOR CASHLESS DENIED
V	CONFIRMATION FROM THE HOSPITAL FOR NON-UTILISATION OF CASHLESS FACILITY, IF CASHLESS SANCTIONED
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT)
	a. NEFT FORMAT GIVING DETAILS OF BANK ACCOUNT CLAIM AMOUNT TO BE TRANSFERRED
	b. A COPY OF THE PAGE OF BANK PASS BOOK CONTAINING A/C NUMBER & NAME/ ADDRESS OF A/C HOLDER.
	c. A CANCELLED CHEQUE FOR THE ABOVE ACCOUNT IN TO WHICH CLAIM AMOUNT HAS TO BE TRANSFERRED
AA	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
AB	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS
2.	**FOR CLAIMING PRE-HOSPITALISATION EXPENSES**
a	CLAIM FORM - PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
e	PHARMACY CASH BILLS FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE PRIOR TO ADMISION, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE PRIOR TO HOSPITALISATION
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED PRIOR TO HOSPITALISATION

i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER & LIST OF DOCUMENTS ATTACHED
3. FOR CLAIMING POST-HOSPITALISATION EXPENSES	
a	CLAIM FORM – PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED - POST-DISCHARGE
e	PHARMACY BILLS FOR MEDICINES PURCHASED - POST-DISCHARGE
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE - POST-DISCHARGE, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE - POST-DISCHARGE
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED - POST-DISCHARGE
i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
4. FOR HOSPITALS CLAIMING CASHLESS HOSPIALISATION EXPENSES APPROVED	
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	PRE-AUTHORISATION REQUEST IN ORIGINAL DULY SIGNED BY THE INSURED AND THE HOSPITAL
H	PRE-AUTHORISATION APPROVAL LETTER COPY
I	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
J	DETAILED DISCHARGE SUMMARY - ORIGINAL
K	DEATH SUMMARY (INSTEAD OF Discharge Summary) IN CASE THE PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
L	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
M	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
N	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
O	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
P	STICKER FOR THE IMPLANTS USED - ORIGINAL
Q	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
R	HOSPITAL MAIN BILL - ORIGINAL
S	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
T	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
U	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT FOR THE NON-ADMISSIBLE AMOUNTS
V	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS

NOTE: (1) YOU SHOULD SUBMIT THE ABOVE DOCUMENTS ALONG WITH A COVERING LETTER (2) IF YOU ARE SUBMITTING PRE &/OR POST-HOSPITALISATION CLAIMS SEPARATELY YOU SHOULD SUBMIT THE CLAIM FORM DULY COMPLETED (3) ALSO SUBMIT THIS CHECKLIST

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: b) SI. No/ Certificate no.

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State:

Pin Code: Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health insurance: Yes No b) Date of commencement of first insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim/health insurance : : Yes No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name:

b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if different from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time: H H M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption j) If Medico legal Yes No

k) Reported to Police l) m) MLC Report & Police FIR attached Yes No n) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses	Rs.	ii. Hospitalization expenses	Rs.
iii. Post-hospitalization expenses	Rs.	iv. Health-Check up cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	Rs.
vii. Pre -hospitalization period:	days	viii. Post -hospitalization period:	days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash:	Rs.	ii. Surgical Cash:	Rs.
iii. Critical illness benefit:	Rs.	iv. Convalescence:	Rs.
v. Pre/Post hospitalization Lump sum benefit:	Rs.	vi. Others.	Rs.
		Total	Rs.

Claim Documents Submitted - Check List:

- Claim form duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's request for Investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in or other to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that , will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date D D M M Y Y Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm- format
i) If injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the Individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the Hospital:

a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: H A R S H A N A M E

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: S U J A T H A N A M E

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H M M h) Date of Discharge: D D M M Y Y i) Time: H H M M

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity l) Date of Delivery: D D M M Y Y m) Gravida Status: :

n) Status at time of discharge: Discharge to Home ☐ Discharge to another hospital ☐ Deceased ☐ o) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

g) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) h. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/PPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of birth	Enter date of birth	Use dd-mm-yy format
f) Date of admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of Inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

ELECTRONIC CLEARING SERVICE (CREDIT CLEARING) MANDATE FORM

For Claim under Policy No _____

1. (A) CARDHOLDER'S NAME

(B) ADDRESS

(C) TELEPHONE / MOBILE No:

(D) E-MAIL ID:

2. TTK ID No

3. PARTICULARS OF BANK ACCOUNT

A. BANK NAME

B. BRANCH NAME

C. ADDRESS

D. 9 DIGIT CODE NUMBER OF THE BANK & BRANCH APPEARING ON THE MICR CHEQUE ISSUED BY THE BANK

E. ACCOUNT TYPE (SAVINGS ACCOUNT/ CURRENT ACCOUNT)

F. ACCOUNT NUMBER (AS APPEARING ON THE CHEQUE BOOK)

G. BANK ACCOUNT HOLDER NAME

4. DATE OF EFFECT:

INFORMATION FOR PAYMENT THROUGH RTGS OR NEFT

5. IFSC CODE (INDIAN FINANCIAL SYSTEM CODE)

6. NEFT CODE (NATIONAL ELECTRONIC FUNDS TRANSFER CODE)

By submission of the above, I authorise M/s Vidal Health TPA Private Ltd (formerly known as TTK Healthcare TPA Pvt Ltd) / the Insurance Company to settle the claim under reference through direct payment by ECS. I hereby declare & confirm that the particulars given above are correct and complete. I agree that I shall not hold the TPA/ Insurance Company responsible for delay or non-receipt of payment for any reason whatsoever after issue of instructions for transfer of payment by Insurer/ TPA based on the above.

Date:
Place:

Signature of the Insured

121

Ab Health Mahesha

RELIGARE | Health Insurance
Values that bind

Authorization letter

To,
QRG HEALTH CITY (55265981)
PLOT NO-1,SECTOR-15,AMBEDKAR MARG,
Faridabad
Faridabad
121002

Date : 07/Jan/2019
AL No : 80238780-00
Admission Date : 07/Jan/2019

Final Bill
settled

In reference to the Pre-authorization Request submitted by you, we hereby authorize and guarantee payment up to Rs. 90000.00 The authorization details are as under:

Member ID	52204256	Claimed Amount	106200.00
Class of Accommodation	Single	Additional Sanction	0
UnPaid Premium	: **0.00**	Initial Authorized Limit	90000.00
Patient Name	NEERU MAHESHWARI	Total Sanctioned Amount	90000.00

Notes to the hospital

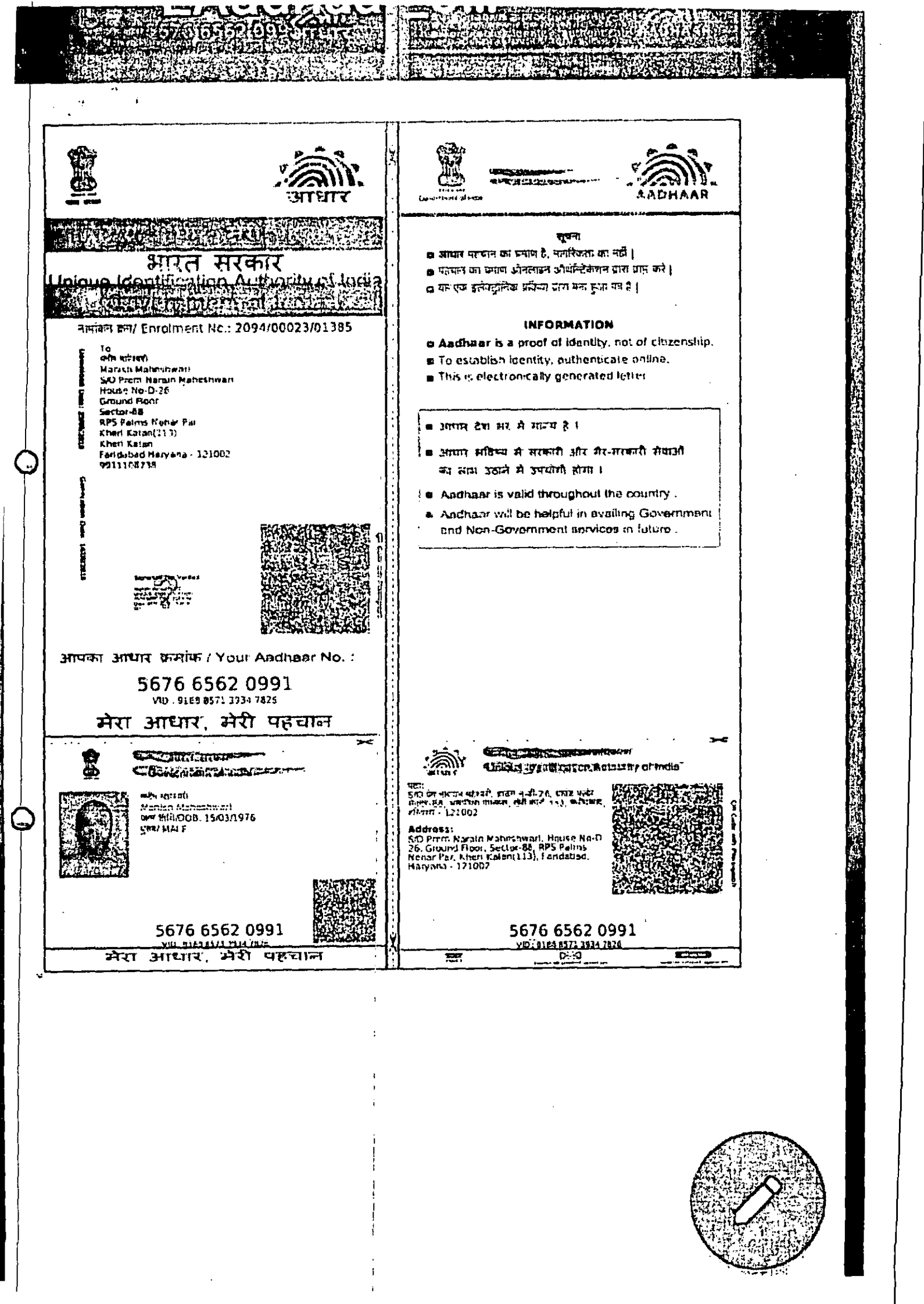
1) KYC documents i.e. Identity Proof/Address Proof and Latest photo of the proposer to be sent if bill estimate is more than Rs. 1.0 Lakh.
2) If the hospital bill is estimated to be higher than the guarantee of payment, the additional amount would need to be sanctioned by RHICL
3) In absence of such additional guarantee, the hospital must collect the excess amount directly from the insured at the time of admission or prior to discharge.
4) The hospital bill summary and the detailed final bill will have to be authenticated with the insured's signature.This along with the original discharge summary and investigation reports will have to be submitted to the company.
5) Please collect an undertaking from the insured/patient for submitting his/her documents to RHICL in original.
6) Charges for the following miscellaneous services must be collected directly from the patient :

a) Registration charges	g) Charges for Tv, Laundry, Telephone, Fax etc
b) Attendant / Visitor charges	h) Food and Beverage for attendance/visitors
c) Ambulance charges unless authorized	i) Toiletries
d) Nursing charges not authorized	j) Medicines not related to treatment
e) Service charges	k) Stationary and other charges
f) Charges for extra bed	

Remarks APPROVED AS PER AGREED HOSPITAL TARIFF FOR HOSPITALISATION FOR SURGICAL MANAGEMENT. KINDLY PROVIDE ID PROOF AND ADDRESS PROOF. AND RECENT PHOTOGRAPH OF PROPOSER FLAT NO. D26 GF SECTOR 88 NEHAR PAR FARIDABD HR FARIDABAD FARIDABAD 121002 HARYANA 06

For Religare Health Insurance Company Ltd

Authorized Signatory



भारत सरकार
Unique Identification Authority of India

नामांकन क्रमांक/ Enrolment No.: 2094/00023/01385

To
Manish Maheshwari
S/O Prem Narain Maheshwari
House No-D-26
Ground Floor
Sector-88
RPS Palms Nenar Par
Kheri Kalan(113)
Kheri Kalan
Faridabad Haryana - 121002
9911168739

आपका आधार क्रमांक / Your Aadhaar No. :

5676 6562 0991

VID : 9169 8571 3934 7826

मेरा आधार, मेरी पहचान

आधार

AADHAAR

सूचना

- आधार पहचान का प्रमाण है, नागरिकता का नहीं।
- पहचान का प्रमाण ऑनलाइन ऑथेन्टिकेशन द्वारा प्राप्त करें।
- यह एक इलेक्ट्रॉनिक प्रक्रिया द्वारा बना हुआ पत्र है।

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- To establish identity, authenticate online.
- This is electronically generated letter.

- आधार देश भर में मान्य है।
- आधार भविष्य में सरकारी और गैर-सरकारी सेवाओं का लाभ उठाने में उपयोगी होगा।
- Aadhaar is valid throughout the country.
- Aadhaar will be helpful in availing Government and Non-Government services in future.

Manish Maheshwari
DOB: 15/03/1976
MALE

5676 6562 0991

मेरा आधार, मेरी पहचान

पता:
S/O प्रेम नारायण माहेश्वरी, हाउस नं-डी-26, ग्राउंड फ्लोर, सेक्टर-88, आरपीएस पाल्मस, नेनी कलां (113), फरीदाबाद, हरियाणा - 121002

Address:
S/O Prem Narain Maheshwari, House No-D-26, Ground Floor, Sector-88, RPS Palms Nenar Par, Kheri Kalan(113), Faridabad, Haryana - 121002

5676 6562 0991

VID: 9169 8571 3934 7826

भारत सरकार

Government of India

नामांकन क्रम / Enrollment No 1211/71083/02704

To.
नीरू माहेश्वरी
Neeru Maheshwari
W/O: Manish Maheshwari
house no 1204
behind bank of baroda Sector 19 faridabad
Kheri Kalan(113)
Kheri Kalan Faridabad Faridabad
Haryana 121002
9911108738

04/06/2013

Ref: 7 / 17H / 12519 / 14985 / P

SH156546279FT

आपका आधार क्रमांक / Your Aadhaar No. :

9967 4659 8967

आधार - आम आदमी का अधिकार

भारत सरकार
Government of India

नीरू माहेश्वरी
Neeru Maheshwari
जन्म वर्ष / Year of Birth : 1977
महिला / Female

9967 4659 8967

आधार - आम आदमी का अधिकार

Ab Health Hamesha

RELIGARE Values that bind | Health Insurance

Note:

- This authorization is valid for admission within 15 days from the date of issue or expiry / cancellation of the policy whichever is earlier.
- The authorization will not be valid if the patient is discharged before the date of issue of this letter.
- Co payment amount will be collected from insured.
- Claim Settlement will be as per agreed tariff structure between RHICL & the hospital.
- This is an initial approval and stands cancel where Misinterpretation of Facts is noticed.

All payment to hospital will be subject to deduction of tax at source as per prevailing government rates except where Nil/Low TDS certificates have been provided.

Please note that hospitalization for Treatment of following conditions is not payable:

i) Investigation and Evaluation, Infertility, STD, Self-inflicted Injury, conditions caused by use of alcohol/tobacco/intoxicating drugs and others conditions as per policy terms.

ii) Religare Health Insurance Company will not be liable in the event of any discrepancy between the facts presented at the time of admission & at time of final discharge documentation.

RELIGARE Health Insurance

AB Health Hamesha

Request for Cashless Hospitalisation for Medical Insurance Policy

Pol no :- 10316227

1. Please fill in CAPITAL LETTERS only
2. If space is insufficient please provide further details on a separate sheet
3. Please tick (✓) in the relevant box

Details of the Third Party Administrator

a) Name of TPA/Insurance Company :

b) Toll Free Phone No.: c) Toll Free FAX :

To be filled by the Insured/Patient

a) Name of the Patient : Neeru

(First Name) (Middle Name) (Last Name)

b) Gender : M F c) Age : / Years d) Date of Birth : / /

e) Contact Number : Contact Number of Attending Relative :

f) Insured Card ID Number :

g) Policy Number/Name of Corporate :

h) Employee ID :

i) Currently do you have any other Mediclaim/Health Insurance : Yes No

Company Name :

Give Details :

j) Do you have a family physician : Yes No

i) Name of the family physician :

k) Contact Number if any :

To be filled by the Treating Doctor/Hospital

a) Name of the hospital : BLG Health City

b) Address : Sector 16 Faridabad

c) Hospital ID : d) Contact Number :

e) Name of the treating doctor : Dr. PERBAL Roy

f) Nature of Illness/Disease with presenting complaints : Pain, Swelling anterior aspect

g) Relevant clinical findings: abdomen

h) Duration of the present ailment : days

i) Date of first consultation : / / (DD/MM/YYYY)

ii) Past history of present ailment if any :

i) Provisional diagnosis : Para-umbilical Hernia

i) ICD 10 Code :

j) Proposed line of treatment : Medical Management Surgical Management Intensive care Investigation

Non allopathic treatment

k) If investigation &/or Medical Management provide details :

i) Route of drug administration :

l) If Surgical, name of surgery : Hemorrhoidectomy

k) ICD 10 PCS Code :

m) If other treatments provide details :

n) How did injury occur : Slips

o) In case of accident: i) Is it RTA : Yes No ii) Date of injury : (DD/MM/YYYY)

iii) Reported to Police : Yes No iv) FIR No.:

v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No

vi) Test conducted to establish this : Yes No (If Yes attach reports)

p) In case of Maternity : G P L A Date of Delivery :

Details of the patient admitted

a) Date of Admission : 07/10/2019 (DD/MM/YYYY) b) Time of Admission :

c) Is this an emergency/a planned hospitalization event? Emergency Planned

d) Expected no. of days stay in hospital : 2-3 days e) Room Type : Single

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet : Rs.

g) Expected cost for Investigation + Diagnostics admin charges app : Rs. 7002

h) ICU Charges : Rs.

i) OT Charges : Rs.

j) Professional Fees Surgeon + Anesthetist Fees + Consultation Charges app ⇒ 45000/- : Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any : Rs.

l) All inclusive package charges if any applicable (Package) ⇒ 60,500/- : Rs.

m) Sum Total expected cost of hospitalization app ⇒ 106200/- : Rs.

Mandatory : Past History of any chronic illness **If yes, since (month/year)**

- Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemias
- Osteoarthritis
- Asthma/COPD/Bronchitis
- Cancer
- Alcohol or drug abuse
- Any HIV or STD / Related ailments

Nil

Any other Ailment give details:

Declaration

We confirm having read understood and agreed to the Declarations on the next page of this form. (Please read very carefully)

a) Name of the treating doctor : Dr Bakul Dey

b) Qualification :

c) Registration No. with State Code :

Plot No Sector-6

Hospital Seal (Must include Hospital ID)

Patient/Insured Name & Signature

9911108738

Declaration by the Patient/Representative — Not to be Faxed or Scanned

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer/TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer/TPA
5. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's/Insured's Name : NEERU MAHESHWARI

b) Contact Number : - 9911108738

c) Patient's/Insured's Signature :

Hospital Declaration

1. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured patient as per the checklist below will be sent to TPA/Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA/Insurance Co. OR arising out of incorrect information in the pre-authorization form will be collected from the patient.
4. We agree that TPA/Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

Documents to be provided by the hospital in support of the claim

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals/Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner/Surgeon that the patient is fully cured.

QRG Health City

QRG MEDICARE

Plot no. 1, Sector [redacted] IP No : 33-19/223 UHID : 100066150 - 4330033

Mrs. Neeru Maheshwari DOA : 07/01/201911:16

41 Y/F SINGLE WARD 2ND FLOOR/S1259

Dr. Prabal Roy

CUM - MRD CHECKLIST

Patient Nam

UHID : IPD No.:

S. No.	CHECK LIST	To be filled by Nursing			Date: 08/01/19 To be filled by MRD
		TPA	BILLING	MRD	
1.	Relieving slip			✓	✓
2.	Face sheet			✓	✓
3.	In patient charge sheet (On Discharge - not to be given to MRD; to be filed with Billing)			✓	✓
4.	Details of consultant's visit (On Discharge - not to be given to MRD; to be filed with Billing)			✓	✓
5.	Emergency/OPD sheet			✓	✓
6.	DOR/LAMA form			✗	✓
7.	Discharge/Death/LAMA/DOR summaryt			✓	✓
8.	History sheet			✓	✓
9.	Doctor's notes			✓	✓
10.	Blood sugar record			✓	✓
11.	Medication chart/Ventilator flow chart			✓	✓
12.	Clinical chart			✓	✓
13.	Vital sign chart			✓	✓
14.	Intake output record			✓	✓
15.	Consent forms			✓	✓
16.	PAC			✓	✓
17.	Pre-operative checklist			✓	✓
18.	Surgical safety checklist			✓	✓
19.	Intra operative aneasthesia record			✓	✓
20.	Angiography check list			✗	✓
21.	Cath lab nursing log			✗	✓
22.	Adult Cardiac Catheterisation Laboratory			✗	✓
23.	Operation/delivery notes			✓	✓
24.	Alderete form			✓	✓
25.	Initial nursing assessment form			✓	✓
26.	Nursing care plan			✓	✓
27.	Pain assessment score sheet			✓	✓
28.	Nutritional assessment and Nutritional care plan			✓	✓
29.	Checklist of patient handover			✓	✓
30.	Nurses notes			✓	✓
31.	Nurses inter deprtmental shifting notes			✗	✓
32.	Valuable handover form			✓	✓
33.	Blood transfusion record form			✗	✓
34.	Death Certificate/Birth certificate			✗	✓
35.	TPA declaration/Transfer slip			✗	✓
36.	Pathology/lab reports			✓	✓
37.	Radiology reports/films			✗	✓
38.	ICU observation chart/Coronary care unit chart			✗	✓
		Sign of Nurse: Employee ID: 2603			Sign of MRD: Employee ID:

DISCHARGE NOTIFICATION

IP NO	:	33-19/223	**UHID**	:	100066150
Patient Name	:	Neeru Maheshwari	**Age / Sex**	:	41 Yrs/Female
Address	:	D26 GF RPS PALMS ,			
Nationality	:	Indian	**Payer**	:	RELIGARE HEALTH INSURANCE -Credit
Admission Date	:	07/01/2019 11:16	**Ward / Bed No**	:	SINGLE WARD 2ND FLOOR / S1259
Discharge Date	:	08/01/2019 16:47:00	**Consultant**	:	Prabal/Dr De/Dr Sunil
Bill No.	:	Provisional	**Bill Date**	:	

Reason for Discharge

Discharge Clearance : The above mentioned Patient can be discharge as/she has cleared all dues to the hospital .

Discharge By : Sushil(27691)

Reports Handover **Original** **Duplicate**

QRG Health City

* 1 0 0 0 6 6 1 5 0 *

Admission Form

IP NO	33-19/223	UHID No.	100066150	Date of Admission	07/01/2019 11:16
Sponsor	RELIGARE HEALTH INSURANCE -Credit				
Payer	RELIGARE HEALTH INSURANCE -Credit			Bed Catg:	SINGLE
Ward:	SINGLE WARD 2ND FLOOR	Bed No:	S1259	Bill Catg:	SINGLE
Speciality1	General Surgery			Admitting Consultant	Dr. Prabal Roy
In case of joint admission:-				Admitting Team:	Dr. Prabal/Dr De/Dr Sunil
Speciality2				Secondary Consultant	

Patient Name	Mrs. Neeru Maheshwari	Age	41 Yrs	Sex	Female	Marital Status :-	Married
W/O	manish maheshwari	Religion:	HINDU		Nationality	Indian	
Local Address	D26 GF RPS PALMS , FARIDABAD, Haryana, INDIA						
Ph No		Mobile	9911108738		Email		
Permanent Address	D26 GF RPS PALMS , FARIDABAD, Haryana, INDIA						
Contact No:	9911108738	KinName	MR MANISH				

Booking Details :-

Booking Receipt No _____ **Amount** _____

Expected Date of Discharge

Condition of Discharge (Please Circle)

ICD Code : K42.9

1.Improved **2.LAMA** **3.Transferred** **4.Absconded**

5.DOPR **6.Expired**

Provisional diagnosis **Final diagnosis** **Name of Procedure**

Consultant Signature Para umbilical Hernia, **Date:**

Lap. IPOM Hemiplasty + C.I.Q.

The above information is correct to my knowledge

Date 07/01/2019 11:16

PATIENT /GUARDIAN SIGNATURE

Contact No. 9911108738

Printed at: 1/7/2019 11:18:01 AM

RUMARANI SAHOO (29759)

QRG Health City

Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

QRG MEDICARE

DAILY ACTIVITY RECORD

Primary Consultant:

41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259

Admission Date/ Time:

Discharge Intimation Date/ Time:

Sl. No:

Activity From Date & Time: 07/1/19
Activity To Date & Time: 04/1/19 08/1/19.

Bed No

Bed Transfer Details

Date	Time	From Bed No	To Bed No

Pt. Category: Cash ☐ Credit ☐

Ambulance	Private Nurse	Equipments	
From	Mor ☐ Eve ☐	DVT	Yes ☐ No ☐
To	Private GDA	ALPHA	Yes ☐ No ☐
	Mor ☐ Eve ☐	Water Bed	Yes ☐ No ☐
From	Room Retainment	Traction	Yes ☐ No ☐
To	Yes ☐ No ☐	Syringe Pump	Yes ☐ No ☐

OTHERS

Item	Qty.

SURGERY/PROCEDURE DETAILS

Surgery/Procedure with code	Surgeon	Asst. Surgeon	Anaesthetist

Laser used	Implant used	Special Equipment
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

CONSULTANT VISIT DETAILS	Mor (Initial with time)	Eve (Initial with time)	Emergency Visit

DIETICIAN VISIT	Mor (Initial with time)	Eve (Initial with time)

PHYSIOTHERAPIST VISIT	Mor (Initial with time)	Eve (Initial with time)

CONSUMABLES

Item	Qty.

VENTILATOR / EQUIPMENT(C-PAP, BIPAP ETC.)

Particulars	Connected Time	Disconnected Time

Nebulization & Steam Inhalations

DIALYSIS & BLOOD BANK SERVICES

Dialysis with Code	Qty	Blood service with Code	Unit	Blood Transfusion Arrangement	Unit

INVESTIGATION DETAILS

Investigation Name	Request No	Investigation Name	Request No	Radiology Services	Request No

Discharge Status: Normal ☐ LAMA ☐ DOR ☐ Expired ☐ Abscond ☐

Certified that I have personally checked the doctor's orders, nursing chart and the activity card and all relevant entries in doctor's orders and nursing charts have been truly reflected in the activity card

Initials with Employee ID	Assigned Nurse	Nurse Incharge	Billing Executive	Billing receiving Time	Medicine Returned	Morning Kit
	mim 23445				Yes ☐ No ☐	Yes ☐ No ☐

QRG/HC/IPD/Frm/20.15/ED2017/V1.0/Rev00

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

QRG MEDICARE

DAILY ACTIVITY RECORD

Primary Consultant:	Admission Date/ Time:	Discharge Intimation Date/ Time:	Sl. No:

Patient label

Activity From Date & Time		Activity To Date & Time		Bed No.

Bed Transfer Details				
Date	Time	From Bed No	To Bed No	Pt. Category
				Cash ☐
				Credit ☐

Ambulance	Private Nurse	Equipments
From	Mor☐ Eve ☐	DVT Yes ☐ No☐
To	Private GDA	ALPHA Yes ☐ No☐
	Mor☐ Eve ☐	Water Bed Yes ☐ No☐
From	Room Retainment	Traction Yes ☐ No☐
To	Yes ☐ No☐	Syringe Pump Yes ☐ No☐

OTHERS	
Item	Qty.
RBS 17/03	

VENTILATOR / EQUIPMENT(C-PAP, BIPAP ETC.)

Particulars	Connected Time	Disconnected Time

Nebulization & Steam Inhalations

SURGERY/PROCEDURE DETAILS

Surgery/Procedure with code	Surgeon	Asst. Surgeon	Anaesthetist

Laser used	Implant used	Special Equipment
Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐

CONSULTANT VISIT DETAILS	Mor (Initial with time)	Eve (Initial with time)	Emergency Visit
Dr Deepak Roy	M	E	

DIETICIAN VISIT	Mor (Initial with time)	Eve (Initial with time)

PHYSIOTHERAPIST VISIT	Mor (Initial with time)	Eve (Initial with time)

CONSUMABLES

Item	Qty

DIALYSIS & BLOOD BANK SERVICES

Dialysis with Code	Qty	Blood service with Code	Unit	Blood Transfusion Arrangement	Unit

INVESTIGATION DETAILS

Investigation Name	Request No	Investigation Name	Request No	Radiology Services	Request No
CBC, Peripheral Blood Smear	17/03			Xray chest	17/03
PT INR, ECG					

Discharge Status: Normal ☐ LAMA ☐ DOR ☐ Expired ☐ Abscond ☐

Certified that I have personally checked the doctor's orders, nursing chart and the activity card and all relevant entries in doctor's orders and nursing charts have been truly reflected in the activity card

Initials with Employee ID	Assigned Nurse	Nurse Incharge	Billing Executive	Billing receiving Time	Medicine Returned	Morning Kit
					Yes ☐ No☐	Yes ☐ No☐

Key kum –
8130277100

QRG Health City

QRG MEDICARE

Date	: 31/12/2018	UHID	: 100066150
Patient Name	: Mrs. Neeru Maheshwari	Age / Sex	: 41 Yrs/Female
Address	: D26 GF RPS PALMS	Mobile No	: 9911108738
Payer	: Cash Paying	Referred By	: Prabal/Dr De/Dr Sunil
Room No	:	Consultant	: Dr. Prabal/Dr De/Dr Sunil
Department Name	: General Surgery	Print Date	: 31/12/2018 15:20 PM

OPD Card

Presenting Complaints :

Paraumbilical Hernia
noted – 3-4 mths ago.

No Comorbidity

Past /Family History :

irreducible hernia

BP : 110/70 mmHg
Temp :
SpO2 : 99%.
Pulse : 84/mt
Mention Drug Allergy if any
Food Drug Interaction if any :
For Pediatric Patients :
HT :
WT : 66.7 Kg

Systemic & local Examination :

a USG whole abd.
- Pre op plog II.

PAC

Plan:-

Admit on Surgery on 7/1/19

Lap TAPM hernia repair

Mesh + Tacker

4 days.

QRG Medicare Ltd.
Plot No. 1, Sector -16, Faridabad - 121002, Haryana, Ph.: 0129-4330000, Toll Free: 18001802210, Website: www.qrgmedicare.com
Regd. Office: 904, 9th Floor, Surya Kiran Building, K G Marg, Connaught Place, New Delhi – 110001, INDIA, CIN: U74999DL2010PLC205776

QRG Health City

QRG MEDICARE

DISCHARGE SUMMARY

UHID No.	: 100066150	**IP No.**	: 33-19/223
Name of patient	: Mrs. Neeru Maheshwari	**Age/Gender**	: 41 Yrs/Female
C/O	: manish maheshwari	**Consultant**	: Dr. Prabal/Dr De/Dr Sunil
Bed No	: S1259	**Bed Category**	: SINGLE
Admission date/time	: 07/01/2019 11:16 AM	**Discharge date**	: 08/01/2019
Company name	: RELIGARE HEALTH INSURANCE -Credit	**MLC / Non MLC**	: Non MLC
Sponser	: RELIGARE HEALTH INSURANCE -Credit		

DEPARTMENT OF BARIATRIC & MINIMAL INVASIVE SURGERY

DIAGNOSIS

PARAUMBILICAL HERNIA

BRIEF HISTORY OF ILLNESS

1. PRESENTING COMPLAINTS :

The Patient presented with complaints of swelling over paraumbilical region for few weeks.

2. PAST HISTORY:

No history of Diabetes mellitus, Hypertension, COPD

GENERAL PHYSICAL EXAMINATION

Conscious alert and well oriented in time , place and person.
No icterus ,cyanosis ,clubbing, pallor or lymphadenopathy.
BP – 120/80, Temp - Afebrile, PR –80/min ,RR- 22/min.

SYSTEMIC EXAMINATION

Abdomen – P/A- soft, swelling present over para-umbilical region, cough impulse positive, BS (+)
CNS –no signs of neurological deficit, pupils bilaterally equal in size and normal reacting
CVS – heart sounds normal, no murmurs
RS – normal vesicular breath sounds, bilateral equal air entry

INVESTIGATIONS: Attached.

HOSPITAL COURSE :

Operative Procedure : Laparoscopic IPOM mesh hernioplasty (Ventralight ST 15 x 15cm circular) was done under G.A. on 07/01/2019.

Operative Findings : Para-umbilical hernial defect single size 2 x 2cm with omentum as content.

QRG Medicare Ltd.

Plot No. 1, Sector -16, Faridabad - 121002, Haryana, Ph.: 0129-4330000, Toll Free: 18001802210, Website: www.qrgmedicare.com
Regd. Office: 904, 9th Floor, Surya Kiran Building, K G Marg, Connaught Place, New Delhi – 110001, INDIA. CIN: U74999DL2010PLC205776

QRG Health City

DISCHARGE SUMMARY

QRG MEDICARE

UHID No.	: 100066150	**IP No.**	: 33-19/223
Name of patient	: Mrs. Neeru Maheshwari	**Age/Gender**	: 41 Yrs/Female
C/O	: manish maheshwari	**Consultant**	: Dr. Prabal/Dr De/Dr Sunil
Bed No	: S1259	**Bed Category**	: SINGLE
Admission date/time	: 07/01/2019 11:16 AM	**Discharge date**	: 08/01/2019
Company name	: RELIGARE HEALTH INSURANCE -Credit	**MLC / Non MLC**	: Non MLC
Sponser	: RELIGARE HEALTH INSURANCE -Credit		

CONDITION AT DISCHARGE: Vitals stable, afebrile, Tolerating orally

DISCHARGE ADVICE:
Tab. Nexpro (Esomeperazole) 40mg 1 tab once daily (before breakfast) for 5 days.
Tab. Ultracet (Tramadol +Paracetamol) 1 tab twice daily (after food) for 3 days and then SOS for pain.
Cap. Varsity 1 cap once daily for 20 days.

PREVENTIVE STRATEGIES:
Diet as advised
Avoid heavy weight lifting/strenuous exercise
Abdominal binder

PENDING REPORTS: Nil

WHEN & HOW TO OBTAIN URGENT CARE:
In case of severe pain, discharge & bleeding from wound (surgical site) or fever.
In case of any medical emergency come to QRG Health City, Plot No. 1, Sec-16, Faridabad or may call at 0129-4330000

NEXT APPOINTMENT:
REVIEW IN SURGERY OPD ROOM NO 1063/1061 ON 14/01/2019 (Monday) AT 10 AM TO 1:00 P.M. WITH DR PRABAL ROY/ DR ANUSHTUP DE/DR. SUNIL KUMAR with prior appointment, call at 0129-4330000.
For appointment call (Mr. Raj Kumar Bhardwaj -8130277100).

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QRG Health City

DISCHARGE SUMMARY

QRG MEDICARE

UHID No.	: 100066150	IP No.	: 33[illegible]
Name of patient	: Mrs. Neeru Maheshwari	Age/Gender	: 41 Y [illegible]
C/O	: manish maheshwari	Consultant	[illegible]
Room No	: S1259	Bed Category	: SPL
Admission Date	: 07/01/2019 11:16 AM	Discharge date	[illegible]
Company	: RELIGARE HEALTH INSURANCE -Credit	MLC / Non MLC	: Non
TPA/Insurance	: RELIGARE HEALTH INSURANCE -Credit		

I have post hospital care instruction set forth above have been explained to me. I understand the importance of following them as specified.
I have received all the copies/original documents.

Dr. Prabal Roy
Director
Bariatric & Minimally Invasive Surgery

Dr. Anushtup Das
Sr. Consultant/Asst. [illegible]
Bariatric & Minimally [illegible]

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QRG Health City
Plot No.1, Sector -16, Faridabad - 121002 (HR.).
Ph. 0129-4330000 ; Fax : 0129-4330033

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

QRG MEDICARE

INITIAL ASSESSMENT SHEET

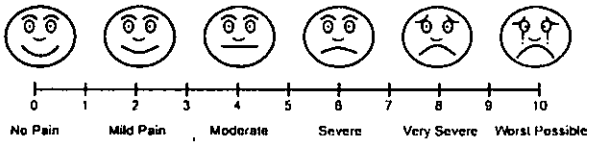
Patient's Name Mrs. Neeru Maheshwari Age 41 Yrs Sex F Male ~~Female~~

IPD No. 33-19/223 Consultant Dr. Prabal Roy

Ward / Room ~~DR~~ PR 1259 Date of Admission 07/01/19

WONG - BAKER Facial Grimace Scale

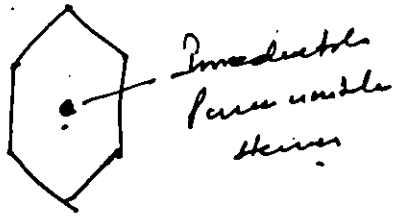
Verbal Description Scale



CHIEF COMPLAINTS WITH DURATION :

C/o Pain in Para umbilical Region.
Noted 3-4 month ago.

HISTORY OF PRESENT ILLNESS :



Δ Irreducible Para umbilical Hernia

No H/O DM$_L$, HTN.

HISTORY OF PAST ILLNESS :

	Type	Year & Month	Result
Surgery			
Trauma/Medical			
Drug/Food Allergy			
Others			

CURENT MEDICATION : NAME of Drug / Therapy	Dose	Since (Year / Month)	Any Remark

PERSONAL HISTORY :

FREQUENCY WITH DURATION

Marital Status _____

Physical Activity _____

Veg / Non-Veg _____

Known Allergies Not known.

Tobacco (Smoking/Chewing _____

Alcohol _____

FAMILY HISTORY :

	Age	L/D	DM	HT	Asthma	IHD	Malignancy	Cause of Death
Father			☐	☐	☐	☐	☐	
Mother			☐	☐	☐	☐	☐	
Siblings			☐	☐	☐	☐	☐	

L/D : L (Living) D (Dead)

REVIEW OF SYMPTOMS :

Specify Symptoms with Duration

1. General / Constitutional Symptom
   (Fever, Weight loss, Loss of Appetite, Body ache)

2. Cardiovascular Symptoms

3. Respiratory Symptoms

4. Gastrointestinal Symptoms Para Umbilical Hernia

5. Genito Urinary Symptoms

6. Neurological Symptoms

7. Symptoms Pertaining to Eyes, Nose, Throat, Ears, Joints & Skin

PHYSICAL EXAMINATION :

Height _____ cm

Weight _____ kg

Resp. Rate _____ /min

B.P. 110/70 mm/hg

Pulse 86 /min. Regular/Irregular

SPO2 98% Room air

GENERAL PHYSICAL EXAM :	Pallor	Absent ☐	Present ☐	
	Ieterus	Absent ☐	Present ☐	
	Lymph nodes	Absent ☐	Present ☐	NAD
	Pedal Edema	Absent ☐	Present ☐	
	JVP	Normal		
SKIN :	Normal			
RESPIRATORY :	Inspection	Normal		
	Auscultation	Normal		NAD
	Added Sound	Nil		
CARDIOVASCULAR SYSTEM :	S1, S2	Normal		
	S3, S4	Absent ☐	Present ☐	NAD
	Murmurs/Rub	Absent ☐	Present ☐	
GASTROINTESTINAL SYSTEM :	Inspection	Normal		
	Liver	Palpable ☐	Non-Palpable ☐	
	Spleen	Palpable ☐	Non-Palpable ☐	NAD
	Kidney	Palpable ☐	Non-Palpable ☐	
	Auscultation	Bowel Sound		
NEUROLOGICAL EXAM. :	HMF	Normal		
	Cranial Nerves	Normal		NAD
	No Neurological Focal Deficit			

GYNAE EXAMINATION. :

Breast _____

PA _____

PS _____ NAD

PV _____

LOCAL EXAMINATION

- Irreducible Para umblical Swelly.

PROVISIONAL DIAGNOSIS

Δ Para Umblical Hernia

PLAN OF CARE & MANAGEMENT

Lap. IPOM & G.A

DIET ADVISED : as advised.

EXPECTED OUTCOME : good.

Signature of Consultant ..... Signature of Medical Officer .....

Name ..... Name .....

Date & Time 7/1/19 11:45 am

QRG Health City

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259.
Dr. Prabal Roy

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

DOCTOR'S NOTES

Patient's Name Mrs. Age 41 yrs. Sex [ ] Male [ ] Female

PU IPD 33-19/223

Unit Room / Bed No. 1259.

Plan of Care

Date / Time	Notes
	C/S/B Surgery team (Dr. Prabal Roy).
7/1/19 11.45am	C/o Para umbilical swelling.
	D Irreducible Para Umbilical Hernia
	Plan Lap. TPOM + G.A.
	- CBC. - S. Creatn - PT/INR - Viral Marker. - ECG. - CXR PA View - RBS.
	- NPO - inj. Supracef 1.5gm IV Stat - inj. Pan 40mg IV - Stat - inj. Emset Lup IV - SOS.
	- IVF DNS @ 100ml/hr. - OT. Consent - OT. Clearance. - PAC.

Expected Out Come

QRGHC/IPD/Frm/06/Ver0.2

Plan of Care

Date / Time	Notes
	C/S/B Surgery teem (Dr. Probal Roy)
7/7/19	Lap. IPOM.
	Vitals stable. Adv - NPO till 9pm Afebrile ↓ G.c.fair Liquid diet allowed ↓ Soft diet allowed. - Stop IV fluid. - Rest ct. - Plan Discharge tomorrow. Dr. R. Paul

Expected Out Come

QRG Health City

11 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
11 Y/F SINGLE WARD 2ND FLOOR/S1259

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

DOCTOR'S NOTES

Patient's Name Mrs. Neeru Age 41 Yrs Sex [ ] Male [ ] ~~Female~~

PU IPD 33-19/223

Unit Room / Bed No. 1259

Plan of Care

Date / Time	Notes
	CS/B Surgery team (Dr. Prabal Roy).
8/7/18	Lap. RPOM Herniaplasty + C.A.
	V/t/s stable
	Afebrile
	G.C. Fair Adv - Soft diet allowed.
	- Rest c/t.
	- Dressing change.
	- Plan Discharge today.
	Dr. R. Bansal

Expected Out Come

Plan of Care

Date / Time	Notes

Expected Out Come _____

QRG Health City

41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

BLOOD SUGAR RECORD

Patient Name Mrs. Neeru maheshwari Age 41 yr Sex F

Diagnosis Gyn Umbilical Hernia Doctor Incharge Dr. Prabal Roy

Date	Time	Blood Sugar	Hypoglycemia Agents	Signature	Remarks
7/1/19	11:50am	89mg/dl	—	Soniya	

Date	Time	Blood Sugar	Hypoglycemia Agents	Signature	Remarks

QRG Health City

Plot no. 1, Sector -16, Faridabad, Haryana - 121002, Tel: 0129 - 4330000

Dr. Prabal Roy

IP No : 33-19/223 UHID: 100066150

Mrs. Neeru Maheshwari DOA 07/01/2019 11:16

41 Y/F SINGLE WARD 2ND FLOOR/51259

Drug Allergies: Not known

Diet: NPO

Diagnosis: Lap TPOW.

MEDICATION PRESCRIPTION AND ADMINISTRATION CHART

Date & Time	Name of the Drugs	Dose	Route	Frequency	Name & Sign of Doctors	Date	7/1/19						8/1/19											
						Std. Time	2 am	6 am	10 am	2 pm	6 pm	10 pm	2 am	6 am	10 am	2 pm	6 pm	10 pm	2 am	6 am	10 am	2 pm	6 pm	10 pm
7/1/19 6 PM	① Inj SUPRACEF	1.5gm	IV	Stat		Time / Signature / ID Check																		
	② Inj PAN	40mg	IV	Stat		Time / Signature / ID Check																		
	③ Inj EMSET	1 amp	IV	SOS		Time / Signature / ID Check																		
	④ INF ON @ 100 ml/hr.					Time / Signature / ID Check																		
7/1/19 5:30 PM	Inj Supace f	1.5gm	IV	TWICE DAILY		Time / Signature / ID Check				3 PM ✓ OT			3 AM	HOME NEBZ 5MG			10 PM						
	Inj Nexpro	40mg	IV	ONCE DAILY		Time / Signature / ID Check				R/15PM ✓				6 AM MIDI SHIFT										
	Inj DYNAPAR	1 amp	IV	TWICE DAILY		Time / Signature / ID Check				3:20 PM ✓ OT		12 AM MIDI SHIFT	3:20 PM		6 AM MIDI SHIFT		6 PM							
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		
						Time / Signature / ID Check																		

Instructions:

Reviewed by Treating Team:

Reviewed by Clinical Pharmacologist:

Reviewed by Treating Team:

Reviewed by Clinical Pharmacologist:

Reviewed by Treating Team:

Reviewed by Clinical Pharmacologist:

STAT MEDICATIONS

Date & Time	Name of the Drugs	Dose	Route	Name & Sign of Doctors	Name & Sign of Nurse
7/1/19 @ 12:15 PM	Inj: Pantoid	40mg	IV		Soniya 25/20
7/1/19	Inj Cefoxid	0.1mg	IV		
7/1/19 @ 3:20pm	Inj Supacef	1.5g	IV	OT	OT
3:20pm	INJ Dynapar	75mg	IV	OT	OT
3:30pm	Inj PCM	1g	IV	OT	OT

IV FLUIDS

Date & Time	Name of the Drugs	Dose	Route	Name & Sign of Doctors	Name & Sign of Nurse
12:15pm 7/1/19	IVF. DNS	100ml	IV	-	Soniya 25/20

INFUSION CHARTING

Date & Time	Name of the Drugs	Dose	Route	Dilution	Flow Rate	Name & Sign of Doctors	Name & Sign of Nurse

HIGH RISK MEDICATION ADMINISTRATION AND MONITORING

Date	Name of the Drugs	Dose	Route	Frequency	Flow Rate	Time	Administ rated By	Verified By	Temp	RR	BP	Pulse	Any ADR	Temp	RR	BP	Pulse	Any ADR	Temp	RR	BP	Pulse	Any ADR
7/1/19	INJ TRAMADOL	100mg	IV	Stat		4:15 PM	[redacted]	Dr. Amit Singh	98.F	18/mt	120/80	88/mt	NO	98.F	18/mt	125/81	84/mt	NO					

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OD - Once a day BID - Twice a day TID - Three times a day QID - Four times a day IV - Intravenous IM - Intramuscular SC - Subcutaneous

QRG Health City
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Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16

QRG MEDICARE

CLINICAL CHART

Day of Hospitlisation	7/1/19						8/1/19						08/1/19.															
Temperature	AM			PM			AM			PM			AM			PM			AM			PM			AM			PM	
C / F	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10
41.1° 106°																														
40.5° 105°																														
40° 104°																														
39.4° 103°																														
38.8° 102°																														
38.3° 101°																														
37.7° 100°																														
37.2° 99°																														
37° 98.4°																														
36.6° 98°																														
36.1° 97°																														
35.1° 96°																														
Pulse Rate				78	72	76		80																						
Respiration				20	22	24		20																						
Blood Pressure				110/80	116/80	110/80		110/80																						
Pain Score				2/10	0	0		2/10																						
Urine				✓	X	X		✓																						
Bowels				X	X	X		X																						
Diet	NPO						Soft diet																							
Blood Transfusion																														
Total Intake	1950mL																													
Total Output	200ml+2hrs>																													
Antibiotics	Inj Supacef																													
							D1																							
Allergy	NOT known.																													
Miscellaneous																														

QRG Health City

41 Y/F SINGLE WARD 2ND FLOOR/S1259

Dr. Prabal Roy

IP No : 33-19/223 UHID : 100066150

Mrs. Neeru Maheshwari DOA : 07/01/201911:16

41 Y/F SINGLE WARD 2ND FLOOR/S1259

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

VITAL SIGN CHART

Patient Name Mrs. Neeru Maheshwari Age 41y Sex F Date 08/1/19

Ward Semi 324 UHID No. 66156 Bed No. 1257

Date	Time	Pulse	BP	Resp. Rate	SPO_2	Temp	Signature

Date	Time	Pulse	BP	Resp. Rate	SPO_2	Temp	Signature

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Tel: 0129 - 4330000 Fax: 0129 - 4330033

Dr. Prabal Roy

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

INTAKE AND OUTPUT RECORD

Patient Name Mrs. Neeru maheshwari Age 41yr Sex F Date 08/1/19.

Hour	Intravenous Infusions			Oral		Urine	Vomit	Drainage	Aspirate	Others
	Volume Started	Volume Remaining	Volume Infused	Volume	Type					
8 AM				200ml	BF					
9						✓				
10	Inj Supracef CS			100ml	H2O					
11			100ml							
12 N										
1 PM										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12 MN										
1 AM										
2										
3										
4										
5										
6										
7										
Total										
Total INTAKE in 24 Hours						Total OUTPUT in 24 Hours				
BALANCE										

Nurse Signature
Mini

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Tel: 0129 - 4330000 Fax: 0129 - 4330033

41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16

INTAKE AND OUTPUT RECORD

Patient Name Mrs. Neeru Maheshwari Age 44 Sex F Date 06/1/19

Hour	Intravenous Infusions			Oral		Urine	Vomit	Drainage	Aspirate	Others
	Volume Started	Volume Remaining	Volume Infused	Volume	Type					
8 AM										
9										
10										
11										
12 N										
1 PM	DNS	IVF	500ml			✓				
2	OT									
3	I.V.F	RL	1000ml							
4	Inj	Tramadol	100ml							
5	Inj	Supacef	100ml							
6										
7	IVF DNS 500ml									
8				50ml	Juice					
9				200ml	Dinner					
10				1 cup	Tea					
11	Inj Pantop (iv)					200ml				
12 MN										
1 AM										
2										
3										
4										
5										
6	Inj Pantop		100ml			✓				
7				100ml	Tea					
Total										
Total INTAKE in 24 Hours				1450ml		Total OUTPUT in 24 Hours				200ml + stool
BALANCE										

QRG/HC/IPD/Frm/20.03/ED2017/V1.0/Rev00

Nurse Signature

TPA

QRG Health City

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

GENERAL CONSENT

I hereby authorize the hospital and those it may designate as medical personnel including doctors or staff to perform any examination, diagnostic procedure, Administration of medication, vaccination & Immunization by doctors or healthcare providers, as may be considered necessary during my/ my patient's hospital stay. I understand that I retain the right to refuse any particular examination, tests, procedures, treatment,therapy or medication recommended or deemed medically necessary by treating doctors.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/ or treatment. I understand that I have the right to discuss treatment details along with the risks, benefits, alternatives and undertake to do so; I am given to understand that the onus of this shall rest with me.

I understand that the confidentiality of all medical records shall be protected to the fullest extent of the law. I also consent to the use of my medical information for research purpose or for insurance purpose.

I understand that the estimate of the treatment given to me is approximate and depending on my / patient's condition /course of illness there may be a significant variation in the medical cost. I agree that the running bill of the hospital will be settled within the specified period of time during the stay at the hospital. I undertake to pay the amount due to the hospital, prior to discharge of the patient. Incase, we change to higher category of bed, we agree to pay the requisite room charges, surgical and other allied charges, as applicable to higher category for the entire stay.

I also consent the use of my / my patient's medical information, tissue samples or body fluids (specimens) for insurance cover. I also understand that the Hospital also has the authority to dispose off the specimens taken for laboratory / pathology examination

I understand that during hospitalization, we are not supposed to bring any valuables to the hospital. The hospital shall not be liable for the loss or damage to any valuables placed herein.

I have received visitors pass and attendant pass. I hereby agree to abide by hospital rules and regulations.

All disputes shall be under exclusive jurisdiction of Delhi Courts.

Authorisation by patient

I acknowledge that I have had enough opportunities to discuss this procedures, as stated above, with my/ my patient's physician/his/her designee, and hereby consent to this procedures.

Authorisation by next of kin

The patient is unable to give consent because.....Sick.....

And I,.....Husband.....(name/relationship with the patient), therefore, give consent for the patient, I acknowledge that I have had enough opportunities to discuss my patient's management, with the physician/designee, and hereby consent for the same.

I certify that the information shared by me is true & correct to the best of my knowledge & belief & nothing has been concealed therefrom.

Signature of Patient/ Next of Kin (relationship)

.....

QRG Health City

Patient Label

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

सहमति–पत्र

मैं एतद् द्वारा अस्पताल को अधिकृत चिकित्सक व अन्य कर्मचारियों को मेरे/अपने मरीज के सर्वश्रेष्ठ हित में अस्पताल में रहने के दौरान आवश्यक परीक्षण, नैदानिक प्रक्रिया, दवाओं का प्रयोग, टीकाकरण व प्रतिरक्षा के लिए पूर्ण सहमति देता हूँ। मैं समझता हुँ कि अपने डॉक्टर द्वारा सलाह किसी विशेष परीक्षण, प्रक्रियाओं, उपचार चिकित्सा एवं दवा के प्रयोग को इन्कार करने का अधिकार मुझमें निहित है।

मैं समझता हूँ दवा का अभ्यास एक सटीक विज्ञान नहीं है और मेरा मूल्यांकन और/या उपचार के परिणाम के बारे में कोई गारंटी नही दी गयी है। बीमारी के जोखिम, लाभ एवं विकल्प के साथ इलाज के बारे मे चर्चा करने के अधिकार मुझ मे है, इसकी जिम्मेदारी के साथ आराम से समझने का मौका दिया गया है।

मैं समझता हूँ सभी मेडीकल रिकॉर्ड की गोपीनियता कानून की पूर्ण सीमा के अन्दर संरक्षित है। अनुसंधान एवं बीमा उद्देश्य से मेरे चिकित्सा जानकारी का उपयोग करने के लिए सहमति देता हूँ।

मैं समझता हूँ की मुझे दिए गए उपचार की लागत अनुमानीत है और मेरे/मरीज की हालत पर निर्भर करता है कि बीमारी के चिकित्सा उपचार बढ़ने पर लागत में एक महत्वपूर्ण बदलाव हो सकता है। अस्पताल में रहने के दौरान समय की निर्धारित अवधि के भीतर चालू बिल के भुगतान के लिए सहमत हूँ। अस्पताल के सभी बकाया राशि का भुगतान मरीज को अस्पताल से छुट्टी करने से पहले करुंगा । यदि मैं उपलब्ध तय श्रेणी से उच्च श्रेणी वाली बिस्तर की सुविधा लेता हूँ, जो भी राशि का अन्तर होगा उसकी बिल भुगतान के लिए सहमत हूँ।

मैं इस बात की भी सहमति देता/देती हूँ कि मेरा/मेरे मरीज की चिकित्सा से संबंधित जानकारी, टिश्यु के नमूने या शरीर के तरल पदार्थ (प्रतिरुप) बीमा से संबंधित प्रक्रिया के लिए प्रयोग किए जा सकते है। मैं यह भी समझता/समझती हूँ कि अस्पताल का अधिकार है कि वह पैथोलॉजी जाँच/प्रयोगशाला में लिए गये प्रतिरुप को नष्ट भी कर सकते है।

मैं समझता हूँ कोई भी कीमती सामान अस्पताल में लाना मना है। किसी भी कीमती सामान के नुकसान वा क्षति के लिए अस्पताल जिम्मेवार नहीं है।

मुझे विजिटर पास एवं परिचारक पास मिला है, मैं अस्पताल के कानून और नियम पालन करने के लिए सहमत हूँ।

सभी विवादों का निपटान दिल्ली न्यायालयों के क्षेत्राधिकार के तहत किया जायेगा।

रोगी द्वारा स्वीकृति

मै स्वीकार करता हूँ कि सम्बन्धित चिकित्सक से परामर्श करने का पर्याप्त अवसर मिला था जैसा कि ऊपर वर्णित है, और इसलिए मै इस प्रक्रिया के लिए अपनी सहमति देता हूँ।

रोगी के संम्बन्धी का स्वीकृति

रोगी स्वीकृति देने में असमर्थ है क्यों कि .....

और मैं .....(नाम, रोगी से सम्बन्ध), इसलिए मरीज के लिए स्वीकृति देता हूँ, मै स्वीकार करता हूँ कि सम्बन्धित चिकित्सक से परामर्श करने का पर्याप्त अवसर मिला था जैसा कि ऊपर वर्णित है, और मै इस प्रक्रिया के लिए अपनी सहमति देता हूँ।

मैं प्रमाणित करता/करती हूं कि मेरे द्वारा दी गई सूचना मेरी उत्तम जानकारी और विश्वास के अनुसार सत्य तथा सही है और कोई भी महत्वपूर्ण जानकारी छुपाई नही गई है।

फ्रंट आफिस कार्यकारी के हस्ताक्षर

.....

दिनांक..... **समय** .....

रोगी/परीजन (सम्बन्ध) के हस्ताक्षर

.....

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259

INFORMED CONSENT FORM FOR ANESTHESIA
एनेस्थीसिया के लिए पूर्व सूचित सहमति पत्र

Name : नाम Mrs. Neeru Maheshwari		
Age आयु 41 F Yrs : वर्ष	Gender : लिंग Male पुरूष ~~Female~~ स्त्री	UHID No. : 66150
Interpreter Services : दूभाषिया सेवा	Yes हाँ ~~No~~ नहीं	Consultant : सलाहकार :

TO BE FILLED BY THE PATIENT OR THE DOCTOR TO DOCUMENT IN PATIENT'S OWN WORDS

I/my patient Mrs. Neeru Maheshwari have been scheduled for surgery/procedure IPOM
under Dr. Prabal Roy

I understand that anesthesia service are needed so that my doctor can perform the operation or procedure.

I am aware that anesthesia will be provided to me by trained and skilled anesthesiologists, who will be monitoring my health throughout the surgery/procedure and whose goal will be to ensure a safe and comfortable surgery/procedure for me.

It has been explained to me, however, that all forms of anesthesia involve some risk, even at the hands of competent and experienced anesthesiologists.

रोगी द्वारा या रोगी के शब्दों में चिकित्सक द्वारा भरा जाएगा ।

मैं ..... डॉ० ..... के तहत सर्जरी/प्रकिया.....
के लिए नियुक्त किया गया हूं।

मैं एनेस्थीसिया सेवा की जरूरत से अवगत हूँ ताकि चिकित्सक ऑपरेशन/प्रक्रिया का निष्पादन कर सकें।

मैं इस बात से पूरी तरह अवगत हूँ कि मुझे एक प्रशिक्षित एंव कुशल एनेस्थीसियोलेजिस्ट द्वारा एनेस्थीसिया दिया जाएगा। इस सर्जरी/प्रकिया. में मेरा स्वास्थ्य उनकी निगरानी में रहेगा। इनका लक्ष्य मेरी सुरक्षित एवं आरामदेह सर्जरी/प्रकिया. सुनिश्चित करना होगा ।

मुझे यह जानकरी दी गई है कि एनेस्थीसिया के सभी प्रकारों में कुछ जोखिम है। यहाँ तक कि एक योग्य एवं अनुभवी एनेस्थीसियोलॉजिस्ट द्वारा निष्पादित किए जाने पर भी जोखिम निहित है ।

Common Risks	Uncommon Risks	Extremely Rare Risks
Bruising at the site of injection / drip	Infection	Drug allergies including severe life threatening reactions
	Bleeding	Blood clot or air lock in the leg/heart/lungs/brain
Nausea & Vomiting	Temporary muscle pains	Heart attack
	Wheezing & diffculty in breathing	Burn following use of cautery / laser
		Death

सामान्य जोखिम	असामान्य जोखिम	अति दुर्लभ जोखिम
इंजेक्शन / ड्रिप वाले स्थान पर नीला पड़ना	संक्रमण	दवाइयों से एलर्जी, यहाँ तक कि जीवन को खतरा होने की हद तक रिएक्शन होना
	रक्तस्राव	खुन का थक्का या पैर / हृदय / फेफड़ों मस्तिष्क में एयर लॉक
	मांसपेशियों में अस्थाई दर्द	हृदयघात
मिचली एंव उल्टी आना	श्वास लेने में परेशानी	लेजर / कॉटरी के कारण दग्ध
		मृत्यु

I understand that these risks apply to all forms of anesthesia, additional risk apply to specific methods.

I understand the type(s) of anesthesia checked below will be used for my surgery/procedure, according to my doctor's preference, as well as my own desire.

It has been explained to me that sometimes an anesthesia technique which involve the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

मैं इससे अवगत हूं कि ये जोखिम सभी तरह के एनेस्थीसिया पर लागू होते हैं विशेष तरीको पर अतिरिक्त जोखिम लागू होता है ।

मैं इससे अवगत हूं कि नीचे बताए गए एनेस्थीसिया के सभी प्रकार मेरी चिकत्सीय प्रकिया में इस्तेमाल होंगे और एनेस्थीसिया की यह तकनीक कई कारकों से निर्धारित होगी। इससें मेरी शारीरिक अवस्थाएं, प्रकिया का प्रकार, मेरे चिकित्सक की वरीयता, इसके साथ ही मेरी स्वयं की इच्छा शामिल है।

मुझे यह जानकारी दी गई कि कई एनेस्थीसिया तकनीक जिसमें लोकल एनेस्थीसिया शामिल है बेहोशी के साथ या बिना बेहोश किए, पूरी तरह सफल नहीं हो सकती है और इसलिए अन्य तकनीक का इस्तेमाल किया जा सकता है इससें सामान्य एनेस्थीसिया शमिल है।

Complications : I understand that these complications have been listed and explained to me to help me make an informed decision, and that the possibility of a major complication is remote.

जटिलताए :– मैं इससे अवगत हूं कि ये जटिलताएं सूचीवद है एवं किसी निर्णय लेने में सहायता हेतू मुझे विस्तृत रूप से जानकारी दी गई है तथा बड़ी जटिलता की संभावना बहुत क्षीण है।

☒ General anaesthesia	Expected result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the blood stream, breathed into the lungs or by other routes.
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth awareness under anaesthesia, injury to blood vessels, aspiration, pneumonia, vomiting
☐ Spinal or epidural or combined Spinal epidural / Labour epidural ☐ With sedation ☐ Without sedation	Expected Result	Temporary descreased or loss of feeling and / or movement to lower part of the body (unilateral / bilateral)
	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal.
	Risks	Headache, backache, buzzing in the ears, convulsion, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal", failed spinal, arrhythmia.
☐ Major / minor nerve block ☐ With sedation ☐ Without sedation	Expected result	Temporary loss of feeling and / or movment to specific limb or area.
	Technique	Drug injected near nerves causing loss of sensation to the area of the operation.
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood, vessels, allergic reactions arrhythmia.

☐ Intravenous regional Anaesthesia ☐ With sedation ☐ Without sedation	Expected result	Temporary loss of feeling and / or movement of a limb
	Technique	Drug injected into the veins of arm or leg while using a tourniquet.
	Risks	Infection convulsion, weakness, persistent numbness, residual pain, injury to blood vessels allergic reactions, anaphylaxis, arrhythmia.
☐ Monitored anaesthesia care (with sedation)	Expected result	Reduced anxiety and pain, partial or total loss of feeding
	Technique	Drug injected into the blood stream breathed into the lungs or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing injury to blood vessels, awareness.
☐ Monitored anaesthesia care (without sedation)	Expected Result	Measurement of vital signs, availability of anaesthesia provider for further intervention
	Technique	Monitors applied as per guidelines.
	Risks	Increased awareness, anxiety and / or discomfort.

☐ Invasive Vascular Procedure (Central Venous Line, Arterial Line) ☐ With sedation ☐ Without sedation	Expected result	Venous access for fluid replacement. Monitoring of VP, BP and ABG
	Technique	Arterial- Radial/Femoral/Dorsalis Pedis artery is cannulated. CVP- Internal Jugular/Subclavian/Femoral/Bacillus vein is cannulated
	Risks	Infection, Bleeding, Pneumothorax, Injury to vital structure in neck, Chest and other site of insertion.

1. सामान्य एनेस्थीसिया	संभावित परिणाम	पूर्णरूप से बेहोशी की अवस्था, श्वास की नली में एक संभावित ट्यूब
	तकनीक	दवा को रक्त प्रवाह में इंजेक्ट करना श्वास द्वारा फेफड़ो में जाना या किसी अन्या मार्ग से
	जोखिम (शामिल, लेकिन सीमित नहीं)	मुंह या गले में दर्द, गला बैठना, मुह या दांत में चोट, एनेस्थीसिया के दौरान होश रहना, रक्तवाहनियों की चोट, फेफडों में उल्टी, निमोनिया, उल्टी आना
2. रीढ़ की हड्डी/एपीड्यूरल/ लेवर एपीड्यूरल एनेस्थीसिया • बेहोश करके • बिना बेहोश किए	संभावित परिणाम	अस्थाई रूप से महसूस करने में कमी या न कर पाना एंव/या शरीर के निचले हिस्से का चलना–फिरना बंद।
	तकनीक	सूई के जरिए दवा इंजेक्ट करना/कैथेटर सीधा रीढ़ की हड्डी में लगाना या इसके एकदम बाहर लगाना ।
	जोखिम (शामिल, लेकिन सीमित नहीं)	सिरदर्द, पीठ का दर्द, कानों में आवाज़, ऐठंन, संक्रमण, तंत्रिकाओं में क्षति के कारण कमजोरी, मूत्र त्यागने में परेशानी, सुन्न होना, दर्द रक्तशिराओं में चोट, हेमाटोमा ।
3. तंत्रिका बाधित होना • बेहोश करके • बिना बेहोश किए	संभावित परिणाम	अस्थाई रूप से महसूस करने मे कमी/या किसी अंग का काम न कर पाना
	तकनीक	तंत्रिकाओं के पास दवा इंजेक्ट करने से महसूस न कर पाना
	जोखिम (शामिल, लेकिन सीमित नहीं)	संक्रमण, ऐंठन, लगातर सुन्न होना, दर्द, रक्तवाहिनियों मे चोट

4. आईवी रीजिनल / एनेस्थीसिया • बेहोश करके • बिना बेहोश किए	संभावित परिणाम	अस्थाई रूप से महसूस करने मे कमी / या किसी अंग का काम न कर पाना
	तकनीक	टॉरनिकेट (रक्त रोधी) का इस्तेमाल कर बाजू या पैर की नसों मे दवा इंजेक्ट करना
	जोखिम (शामिल, लेकिन सीमित नहीं)	संक्रमण, ऐंठन, लगातर सुन्न होना, दर्द, रक्तवाहनियों मे चोट
5. निगरानी में एनेस्थीसिया देखभाल (बेहोश करके)	संभावित परिणाम	बैचेनी एंव दर्द में कमी, आंशिक या पूर्ण रूप से बेहोशी
	तकनीक	खून में दवा इंजेक्ट करना, फेफड़ों में श्वास द्वारा लेना या अन्य मार्गों से जिससे अर्द्ध बेहोशी की हालत होना
	जोखिम (शामिल, लेकिन सीमित नहीं)	बेहोशी की स्थिति, श्वास लेने मे बाधा, रक्तवाहिनियों में चोट ।
6. निगरानी मे एनेस्थीसिया देखभाल (बिना बेहोश किए)	संभावित परिणाम	महत्वपूर्ण जीवनधार संकेतों का माप, आगे की जांच के लिए एनेस्थीसिया आपूर्तिकर्त्ता की उपलब्धतता।
	तकनीक	रेडियल / फेमोरल / सबकलेवियन रक्तवाहिनी में कन्युला द्वारा
	जोखिम (शामिल, लेकिन सीमित नहीं)	सचेतता, बैचनी में बढ़ोत्तरी और / या तकलीफ में होना

INDIVIDUAL RISKS (to be completed by the anesthesiologist completing this from)
I understand that according to my medical history and type of surgery/procedure planned, I come under the following risk stratification for surgery/procedure and anesthesia.

व्यक्तिगत जोखिमः (एनेस्थीसियालॉजिस्ट द्वारा यह फॉर्म भरा जाए)
मैं इससे अवगत हूं कि मेरे चिकित्सीय इतिहास एंव तय की गई सर्जरी / प्रकिया के अनुसार मैं सर्जरी / प्रकिया एंव एनेस्थीसिया के लिए जोखिम के निम्न स्तरों के तहत आता हुँ।

Risk Category	Factors Contributing High Risk	Possible Adverse Events
Standard Risk (ASA 1 & 2)	Difficult Airway Upper/Lower Respiratory Infection Diabetes Hypertension Frequent Attacks of Asthma / COPD Obesity / Obstructive Sleep Apnea Thyroid Disorders Anemia Taking Blood Thinners Coronay Artery Disease Poor Myocardial Function Heart Valve Abnormalities Heart Rhythm Abnormalities Recent Cardiac Bypass / Stenting Presence of Blood Clot In Lower Limbs Renal Failure Electrolyte Imbalance Substance Abuse Full Stomach Massive Bleeding Preoperatively Inadequate Time For Medical Workup History Not Elicitable Ongoing Heart Attack Collapse During An Interventional Procedure Smoking Others	Inraoperative bronchospasm Food particles in windpipe Preoperative myocardial infarction Postoperative mechanical ventilation Postoperative ionotropic support Blood clot in legs / lungs / brain Blockade of coronary stent Stroke / brain damage ICU Stay Related to blood transfusion Others
Moderate Risk (ASA 3)		
High Risk (ASA 4 & 5)		
Emergency Surgery		

जोखिम श्रेणी		संभावित विपरीत परिणाम
मनक जोखिम (एएसए 1 एवं 2)	मुश्किल वायुमार्ग ऊपरी / निचली श्वसन संबंधी संक्रमण मधुमेह उच्च रक्तचाप अस्थमा का बार–बार अटैक / सीओपीडी मोटापा / बाधित स्लीप एपनिया थाइरायड़ एनीमिया (खून की कमी) रक्त को पतला करने के लिए दवा लेना, धमनी रोग खराब हार्ट फंक्शन खराब हृदय गति असामान्य हृदय गति हाल में कराई गई बाईपास / स्टेन्टिंग निचले अगों में रक्त के थक्के की मौजूदगी गुर्दो का काम न करना इलेकट्रोलाइट असन्तुलन मादक द्रव्यों का सेवन भरा हुआ पेट ऑपरेशन से पूर्व अत्यधिक रक्तस्राव मेडीकल वर्क अप के लिए अपर्याप्त समय पूर्व चिकित्सीय इतिहास की जानकरी ने होना हृदयघात के दौरान ऑपरेशन हस्तक्षेपीय प्रक्रिया के दौरान निपात अन्य	आपरेशन के समय सांस की नली में सिकुड़न श्वासनली में खानें के टुकड़े आपरेशन के पहले, दौरान एवं बाद में हार्ट अटैक आपरेशन के बाद में हार्ट की दवाईयों का सपोर्ट पैर / फेफड़ों / मस्तिष्क में खून के थक्के हार्ट स्टेंट में रूकावट आघात / मस्तिष्क आघात आई. सी. यू. प्रवास रक्त चढ़ाने से संबंधी अन्य
मध्यम जोखिम (एएसए 3)		
उच्च जोखिम (एएसए 4 एवं 5)		
आपातकालीन सर्जरी		

Patient Specific Risks other than ticked above:

1) _____

2) _____

3) _____

4) _____

रोगी विशिष्ट जोखिम उपर चिन्हित के अलावा:–

1) _____

2) _____

3) _____

4) _____

DECLARATION BY PATIENT / GUARDIAN (In case of minors) CLOSE RELATIVE (If patient is unable to make an informed consent) PROXY

I acknowledge that anesthesiologist has informed me about the anesthesia plan and the alternatives available. All my specific queries and concerns about this matter have been addressed.

I acknowledge that I have discussed with the anesthesiologist about significant risks and complications specific to me / the patient's individual circumstances.

I consent to the anesthesia service (s) and other eventualities discussed above and authorize that it be administered to me / my ward by anesthesia care team, under the supervision of a consultant / senior consultant in anesthesia. I also consent to any alternative from of anesthesia if necessary, as deemed appropriate by the anesthesia care team.

रोगी / अभिभावक (नाबालिग के होने पर) / नजदीकी रिश्तेदार (यदि मरीज पूर्व सहमति देने में असमर्थ है) / प्रतिनिधि

मैं स्वीकार करता / करती हूं कि एनेस्थीसियोलॉजिस्ट ने मुझे एनेस्थीसिया प्लान और उपलब्ध विकल्पों के बारे में सूचित किया है।

मैं स्वीकार करता / करती हूं कि मैने, मुझसे / मेरे रोगी की विशिष्ट परिस्थितियों के बारे में एनेस्थीसियोलॉजिस्ट के साथ जोखिमों और जटिलताओं के बारे मे विचार–विमर्श किया है ।

मैं उपरोक्त बताई गई एनेस्थीसिया सेवाओं एवं अन्य संभावनओं के लिए अपनी सहमति प्रदान करता हूं तथा इन्हे एनेस्थीसिया केयर टीम / वरिष्ठ / परामर्शदाता की निगरानी में मुझे / मेरे रोगी के उपचार के लिए अधिकृत करता / करती हूँ। इसके साथ ही मैं जरूरत पड़ने पर एनेस्थीसिया केयर टीमद्वारा सही समय आने पर एनेस्थीसिया के किसी विकल्प के इस्तेमाल की भी सहमति प्रदान करता / करती हूँ।

Please Tick whichever is Applicable :	
	In view of the above mentioned problems that are specific to me / my ward, I understand that I / my ward is a very high risk case for anesthesia and surgery. Post operative ventilator and ICU care may be needed.

कृपया जो भी लागू हो, सही निशान लगाएं।	
	मुझसे / मेरे रोगी से जुड़ी ऊपर बताई गई समस्याओं के मद्दे नजर, मैं इससे अवगत हूं कि मैं / मेरा रोगी एनेस्थीसिया और सर्जरी के लिए एक अति जोखिम केस है। रोगी को ऑपरेशन के बाद कृत्रिम सांस की मशीन और आई. सी. यू. केयर का जरूरत पड़ सकती है।

I certify that I have received complete information and fully understood the above consent statement, that all of my questions have been answered to my satisfaction, that all blanks requiring insertion or completion were filled in, prior to the time of any signature, and that this consent is given with stable mind, freely, voluntarily and without reservation.

मैं प्रमाणित करता हूं कि मेरे हस्ताक्षर करने से पूर्व मुझे पूरी सूचना दी गई थी तथा ऊपर दिए गए सहमति वक्तव्य को पूरी तरह समझता हूं, कि मुझे मेरे सभी प्रश्नों के संतोषजनक उत्तर दिए गए है, एवं सभी रिक्त स्थानों की पूर्ति की गई है यह सहमति स्थिर दिमाग, स्वतंत्र, ऐच्छिक एंव बिना पूर्वाग्रह की दी गई है।

To be filled by the patient or the Doctor to document in patient's own words:

Knowing the above risk, on my own responsibility, I hereby authorize Dr. Amit Garg /anaesthesia team and those he may designate as associates or assistants to go ahead on anesthesia and surgery/procedure at my own risk. All pros and cons have been explained and discussed with me. I have read & understood the entire 7 pages form. I have asked all the relevant questions pertaining to the form from the anesthesiologist

रोगी के अपने शब्दों में दस्तवेज तैयार करने हेतू रोगी या चिकित्सक द्वारा भरा जाएगा।

ऊपर बताये गये जोखिम को जानते हुए अपनी जिम्मेदारी पर, मैं डॉ0 .....को अधिकृत करता/करती हूं एवं जिन्हे वे मेरी जिम्मेदारी पर एनेस्थीसिया एवं सर्जरी/प्रकिया के लिए अपने सहयोगीयों या सहायकों को नियुक्त करें । सर्जरी/प्रकिया से जुड़े सभी प्रश्नों पर मुझे जानकारी दी गई है और विचार –विमर्श किया गया है। मेरे द्वारा पूरा 7 पृष्ट का फार्म पढ़ व समझ लिया गया है मैने फार्म से संबंधित सभी प्रश्न/जानकारी एनेस्थीसियोलॉजिस्ट से पूछ व समझ लिए है।

Patient / Guardian / Close Relative रोगी/अविभावक/करीबी रिश्तेदार	Witness गवाह	Interpreter दुभाषिया
Name नाम Mrs Neeru	Name नाम Manish Maheshwari	Name नाम
Relationship संबंध Self	Relationship संबंध Husband	Relationship संबंध
Signature/Thumb Impression हस्ताक्षर/अंगूठे का निशान Neeru	Signature/Thumb Impression हस्ताक्षर/अंगूठे का निशान	Signature/Thumb Impression हस्ताक्षर/अंगूठे का निशान
Date दिनांक 7/1/19	Date दिनांक 7/1/19	Date दिनांक

DECLARATION BY THE ANESTHESIOLOGIST REGARDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of general and / or regional anesthesia to be given and discussed the risks that particularly concern this patient. I have explained the patients' condition, the procedure and the risks, consequences if those risks occur and are of significant and problem specific to this patient. I have given the Patient/ Guardian an opportunity to ask questions about any of the above matters and raise any other concerns, which I have answered as fully as possible. I am of the opinion that the Patient / Substitute Decision maker have understood the above information.

इस सहमति के लिए सूचना देते हुए एनेस्थीसियोलॉजिस्ट द्वारा घोषणाः–

मैं घोषणा करता हूं कि मैने रोगी को दिए जाने वाले जनरल एंव / या रीजिनल प्रकार के एनेस्थीसिया की जानकारी दी है और इस रोगी से विशेष रूप से जुड़े जोखिम के बारे में विचार–विमर्श किया है। मैने इस रोगी की स्थिति, प्रक्रिया एवं जोखिम, यदि कोई जोखिम है, तो उसके परिणाम एंव महत्वपूर्ण जोखिमों और समस्याओं के बारे में जानकारी दी है । मैने रोगी/अभिभावक को ऊपर बताए गए किसी भी प्रकरण के बारे में सवाल करने एवं अन्य कोई जानकारी लेने को अवसर दिया है। जिनका मैंने जहां तक संभव है पूरा उत्तर दिया है। मेरी पूरी मान्यता है कि रोगी/निर्वाचक संबंधी को उपरोक्त सूचना समझ में आई है ।

Name of Doctor: चिकित्सक का नाम : Dr Amit Garg	Signature : हस्ताक्षर : Dr. Amit Garg PMC 40134 QRGML
Designation : पद :	Date : दिनांक : 7/1/19
Time : समय :	

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16

INFORMED CONSENT FORM / सूचित सहमति पत्र

Patient Name Mrs. Neeru maheshwari UHID 66150
Age / Sex 41 Y/F Ward / ICU 1259

Authorization for medical treatment/performance of surgical operation(s) and/or diagnostic / therapeutic procedure(s)
चिकित्सकीय उपचार / शल्य क्रियाएं एवं / या निदान / चिकित्सकीय प्रोसीजर के लिए प्राधिकृति

Instructions / निर्देश

1. The Treating Consultant or his/her team member is responsible for obtaining the informed consent.
चिकित्सक या उनकी टीम के सदस्य सूचित सहमति प्राप्त करने के लिए जिम्मेदार हैं।
2. Informed consent should be obtained from the patient: if he/she is an adult (18 yrs or older), physically competent and capable of making an informed decision. In any other case, by Patient's next of kin in the following order- Spouse, male adult child, female adult child, parents, close blood relative, relative, friend, acquaintance.
यदि रोगी वयस्क ;18 वर्ष या इससे अधिकद्ध, शारीरिक रुप से सक्षम और सूचित निर्णय देने मे सक्षम है तब ही वह सूचित सहमति फॉर्म पर हस्ताक्षर करेगा / करेगी। किसी भी अन्य स्थिति में उसका पति / उसकी पत्नी / वयस्क बेटा / वयस्क बेटी / माता / पिता / नजदीकी सगे–संबंधी / रिस्तेदार / मित्र / जान–पहचान वाले हस्ताक्षर करेंगे।
3. If the medical treatment/performance of surgical operation (s) and/or diagnostic/therapeutic procedure (s) is life saving and the patient is unconscious or is otherwise unable to give consent and no relations can be easily contacted without jeopardizing patient's life, the medical treatment/operation (s)/diagnostic/therapeutic procedure (s) should be carried out, stating the reason of patient's/his or her relative's inability to give consent. Same shall be certified by head of medical services or any other person nominated by him/her.
यदि रोगी के चिकित्सकीय उपचार / शल्य क्रियाएं एवं / या निदान / चिकित्सकीय प्रोसीजर उसके जीवन की रक्षा के लिए महत्वपूर्ण है और मरीज बेहोश है या फिर सहमति देने में असमर्थ है और उसके किसी भी रिस्तेदार से आसानी से सम्पर्क नहीं हो पा रहा है, उस स्थिति में यह कारण बताते हुए कि रोगी या उसके संबंधी सहमति देने में सक्षम नहीं हैं, मरीज का जीवन खतरे में डाले बिना चिकित्सकीय उपचार / शल्य क्रियाएं / प्रोसीजर की जा सकती हैं। यह चिकित्सा सेवाओं के प्रमुख या उनके द्वारा नामित व्यक्ति द्वारा प्रमाणित किया जाएगा।

Consent :(To be filled by the Treating Consultant or his/her team member)
सहमति (चिकित्सक या उनकी टीम के सदस्य द्वारा भरा जाए)

1. I, hereby authorize the performance of the following operation(s), diagnostic / therapeutic procedures(s), or treatment(s) (hereinafter referred to as "Procedures")
मैं निम्नलिखित ऑपरेशन, निदान / चिकित्सकीय प्रोसीजर या उपचारों के निष्पादन के लिए अधिकृत करता / करती हूँ।
Lap. TLOM + G.A.
2. I have been explained the nature and purpose of the aforesaid Procedures. I have also been informed and explained about the following benefits and advantages of the aforesaid Procedures. I understand and acknowledge that no guarantee have been or can be given regarding the likelihood of success or outcome of the said Procedures.
मुझे उपर्युक्त प्रोसीजर की प्रकृति और उद्देश्य समझा दिय गये हैं। मुझे उपर्युक्त प्रोसीजर से संबंधित निम्नलिखित फायदे बता और समझा दिय गये हैं। मैं समझता / समझती हूँ और स्वीकार करता / करती हूँ कि उपर्युक्त प्रोसीजर का परिणाम या सफलता निश्चित नहीं है।
Yes
3. I have been informed that below mentioned are the common risks and potential complications involved in and after the above Procedures. I also understand and acknowledge that there may be certain unforeseen risks/complications in addition to those listed below.
मुझे प्रोसीजर से संबंधित (और उसके बाद में होने वाले) जोखिम और संभावित जटिलताएं समझा दी गई हैं। मैं यह भी समझता / समझती और स्वीकार करता / करती हूँ कि निम्नलिखित के अलावा अकल्पित कुछ जोखिम / जटिलताएं भी हो सकती हैं।
Hemorrhage, Infection, Reoperation

4. I have been informed and explained of the following existing alternatives, treatment and prognosis if the aforesaid Procedures is/are not done.
यदि उपर्युक्त प्रोसीजर नहीं की जाती है तो इस स्थिति में मुझे मौजूदा विकल्पों, उपचार और रोग के निदान के विषय में बता और समझा दिया गया है।

.....

.....

5. I authorize Dr. Prakash Reddy and his/her team members or such assistants and associates as may be selected by him / her to perform any part of the above Procedures. I have been informed and I agree that any of the aforesaid persons may perform any part of the said Procedures according to his / her stage of training and ability.
मैं डॉ .....और उनकी टीम के सदस्य या सहयोगी, जिनका चिकित्सकीय प्रोसीजर लिए चयन किया गया है इन्हें इलाज (चिकित्सकीय प्रोसीजर) करने के लिए अधिकृत करता / करती हूँ। मुझे सूचित कर दिया गया है और मेरी सहमती है कि चयन किये गये किसी भी व्यक्ति द्वारा (उनके प्रशिक्षण एवं क्षमता के स्तर के अनुसार) उपर्युक्त चिकित्सकीय प्रोसीजर पूरी की जा सकती है एवं वे मेरे प्रोसीजर के किसी भी चरण में भाग ले सकता / सकती है।

6. It has been explained to me that during the course of the said Procedures, an unforeseen/emergency condition may be revealed/may arise, which may necessitate a surgical or other emergency procedures in addition to or different from those listed above. Also other unforeseen risks such as blood infection, heart failure, change in blood pressure, anesthetics / allergic reactions, paralysis etc. may arise necessitating additional medical procedure(s)/treatment(s) in addition to or different from those listed above. Therefore, I further consent and authorize the rendering of such other medical care and treatment as the Treating Consultant or his/her team member reasonably believes necessary.
मुझे यह भी समझा दिया गया है कि प्रोसीजर के दौरान, कोई भी अकल्पित / आपातकालीन स्थिति भी हो सकती है जिसमें शल्य क्रिया या अन्य आपातकालीन प्रोसीजर (उपर्युक्त लिखी हुई के अलावा) की जरुरत पड़ सकती है। इसके अलावा अन्य अकल्पित जोखिम जैसे रक्त संक्रमण, हृदय की गति रुकना, रक्तचाप में परिवर्तन, एनेस्थेटिक्स / एलर्जिक प्रक्रियाएं, लकवा आदि हो सकती है। ऐसी स्थिति में अतिरिक्त चिकित्सकीय प्रोसीजर / उपचार (उपर्युक्त लिखी हुई के अलावा) की जरुरत पड़ सकती है। इसलिए मैं उपचार करने वाले चिकित्सक या उनके सहयोगी / सहायक को, जैसा भी चिकित्सकीय देखभाल और उपचार करना जरुरी हो, उसे अमल में लाने की सहमति देता / देती हूं और अधिकृत करता / करती हूं।

7. I also hereby give consent to administration of such drugs or infusions as may be deemed necessary for appropriate medical treatment and management.
मैं हॉस्पिटल प्रबंधक को यह अधिकार देता / देती हूं कि चिकित्सकीय उपचार के समय जरुरी किसी भी प्रकार की दवाई का उपयोग किया जा सकता है।

8. I consent/ donot consent to the photographing or video filming of the Procedures for the purpose of advancing medical education or its publication in scientific journals etc. provided the patient's identify is not revealed by the images or descriptions in the accompanying texts. In an effort to further medical science and education, I consent to the admittance of qualified observers to the operation room, as may be authorized by **QRG Health City Hospital.**
मैं चिकित्सकीय शिक्षा / वैज्ञानिक पत्रिका में प्रकाशन आदि कार्यों के लिए चिकित्सकीय प्रोसीजर की फोटोग्राफी और वीडियो फिल्म बनाने की अनुमति देता / देती / नहीं देता। यदि मेरी चिकित्सकीय प्रोसीजर को चिकित्सकीय शिक्षा / वैज्ञानिक पत्रिका आदि कार्यों के लिए उपयोग में लाया जाता है / प्रकाशन किया जाता है तो ऐसी स्थिति में रोगी की पहचान गोपनीय रखी जाएगी। मैं बेहतर चिकित्सकीय शिक्षा की सीख देने के लिए क्यू.आर.जी. हेल्थ सीटी हॉस्पीटल द्वारा अधिकृत योग्य-पर्यवेक्षकों को ऑपरेशन कमरे में आने की भी अनुमति देता / देती हूं।

9. I also understand that use of cautery / laser etc. has hazards of mechanical / chemical / thermal injuries.
मैं यह समझता / समझती हूं कि चिकित्सकीय प्रोसीजर में प्रदाह यंत्र / लेजर आदि से मशीनी / रसायनिक / तापीय जोखिम हो सकता है।

10. I understand that while performing Laparoscopic Surgeries, there may occasionally be a need of an 'Open' procedure, in which an incision is made in the abdomen. This decision may be required for my safety & for successful completion of this procedure. Accordingly, I hereby give consent to the above
मैं यह समझता / समझती हूं कि लैप्रोस्कोपिक / रोबोटिक सर्जरी करते समय (जैसे कि पेट में चीरा लगाते समय) ओपन प्रोसीजर (शल्य क्रियाओं) की भी जरुरत पड़ सकती है। मैं यह जानता / जानती हूं कि यह निर्णय मेरी सुरक्षा और चिकित्सकीय प्रोसीजर को सफलतापूर्वक पूरा करने के लिए किया जाएगा। इसलिए मैं उपर्युक्त ओपन प्रोसीजर (शल्य क्रियाओं) को करने की सहमति देता / देती हूं।

11. I further authorize the release of information from the medical or other records of **QRG Health City Hospital.**, as may be deemed necessary in furtherance to any Court's order or applicable law/rules/regulations/notifications etc. as may be issued by the Competent Authority from time to time.
मैं क्यू.आर.जी. हेल्थ सीटी हॉस्पीटल प्रबंधन को यह अधिकार देता / देती हूं कि वह न्यायालयीय आदेश / कानून / अधिसूचना आदि द्वारा मांगे जाने पर मेरे चिकित्सकीय विवरण या अन्य रिकार्ड को जारी कर सकता है।

12. ☐I am/ ☐I am not suffering from any known allergies/drug reactions. If allergic please provide details:
मैं किसी चीज या दवा से एलर्जी / रिएक्शन संबंधी समस्या से ग्रसित हूँ / नही हूँ। यदि एलर्जी है तो कृप्या विवरण दें।
Not Known

13. I have been given an opportunity to ask any questions/queries and to seek second opinion, if desired.
मुझे जब भी जरुरत हुई उस समय चिकित्सकीय प्रोसीजर संबंधित विकल्पों से जुड़े प्रश्न पूछने का अवसर दिया गया था।

14. I also hereby consent to disposal of any diseased/unwanted tissues/other body parts which may be removed during the course of such Procedures.
मैं अनुमति देता / देती हूं कि चिकित्सकीय प्रोसीजर के दौरान किसी भी प्रकार के रोग ग्रस्त / अवांछित टिश्यूज / शरीर के अन्य अंगों (जिनको शरीर से हटाया गया हो) का निपदान किया जा सकता है।

15. I hereby acknowledge that the information given including [illegible] to my past history/hospitalization etc. are complete and true to the best of my knowledge and belief and no[illegible]ed there from. I shall not hold the Treating Consultant/his or her team/**QRG Health City Hospital** [illegible]ciated with **QRG Health City Hospital** liable for the consequences which may arise due to the non-[illegible] disclosure of any such facts.
मैं स्वीकार करता / करती हूं कि मेरे द्वारा दी गई सूचना पूर्ण है और मेरी ओर से कोई भी जानकारी छिपाई नही गई है। मैं गलत तथ्यों को बताने या तथ्यों को छुपाने की स्थिति में सामने आने वाले परिणाम के लिए किसी भी प्रकार से इलाज करने वाले डॉक्टर या उनकी टीम के सदस्य या क्यू.आर.जी. हेल्थ सीटी हॉस्पिटल या क्यू.आर.जी. हेल्थ सीटी हॉस्पिटल से संबंधित किसी भी व्यक्ति को जिम्मेदार नहीं ठहराऊंगा / ठहराऊंगी

HIGH RISK CONSENT / सूचित सहमति पत्र

WHETHER THE PROCEDURE IS HIGH RISK? YES ☐ No ☐

क्या इस प्रोसीजर में उच्च जोखिम है? हाँ ☐ नहीं ☐

If yes, please provide reasons for **HIGH RISK:**

यदि हां, तो कृपया उच्च जोखिम के कारणों का उल्लेख करें:

(1)..... (3).....

(2)..... (4).....

Please elaborate on any specific post-op management that might be required because of being a **HIGH RISK** case:

कृपया उच्च जोखिम की स्थिति में रोगी की देखभाल के लिए प्रोसीजर के बाद की देखभाल संबंधी प्रबंधन का विस्तार से उल्लेख करें।

(1)..... (3).....

(2)..... (4).....

Doctor's Signature..... Date..... Time.....

चिकित्सक का हस्ताक्षर ..... तिथि..... समय.....

PATIENT OR PATIENT'S NEXT OF KIN CONSENT FOR HIGH RISK:

उच्च जोखिम की स्थिति में रोगी या रोगी के परिजन द्वारा दी गई सहमति

Signature/Thumb Impression:..... Date..... Time.....

हस्ताक्षर या अंगूठे का निशान:..... तिथि..... समय.....

Name:..... नाम:.....

Note : Please enter high risk status on the progress note/नोट : कृप्या रोगी के चिकित्सकीय नोट पर उच्च जोखिम की स्थिति का उल्लेख करें।

Authorization of Patient / रोगी द्वारा प्राधिकृति

I acknowledge that I have had an opportunity to discuss and understand the Procedures, as stated above, with the Treating Consultant or his/her team member. I certify that the statements made in this consent form along with attached Annexure (if any) have been read over and explained to me in a language best understood by me. I have fully understood the contents and implications of the consent along with attached Annexure (if any) and further submit that the statements herein referred to, were filled in before I signed / applied my thumb impression.

मैं स्वीकार करता/करती हूं कि मुझे चिकित्सक अथवा उनकी टीम के सदस्य द्वारा उपर्युक्त प्रक्रिया से संबंधित विचार–विमर्श करने एवं समझने का अवसर दिया गया था। मैं प्रमाणित करता हूं इस पत्र में दिये सभी कथन मुझे मेरी समझ में आने वाली भाषा में समझा दिये गये हैं। मैंने इस सहमति पत्र एवं संलग्न अनुबंध के सभी भावार्थ अच्छी तरह समझ लिये हैं। मैं यह स्वीकार करता हूं कि यहां पर दिये गये सभी कथन मेरे हस्ताक्षर करने/अंगूठे का निशान लगाने से पहले लिखे गये थे।

Patient's Signature/Thumb Impression: Neeru Date 7/1/19 Time 12pm

रोगी के हस्ताक्षर/अंगूठे का निशान: दिनांक समय

Name: Neeru Maheshwari

नाम:

Witness's Signature/Thumb Impression: Date 7/1/19 Time 12pm

गवाह के हस्ताक्षर/अंगूठे का निशान: दिनांक समय

Name: Manish Maheshwari

नाम:

Doctor's Signature: Date 7/1/19 Time 11.45am

डॉक्टर के हस्ताक्षर: दिनांक समय

Name: Dr. R Ahmad नाम:

Authorization of Patient's Next of Kin/ मरीज के निकटतम परिजन द्वारा अधिकृति/प्राधिकृति

The patient is unable to given an informed consent because.....

.....and therefore

I.....

(Full name, permanent residential address and relationship with the patient), give my informed consent for the performance of the aforesaid Procedures upon the patient. I acknowledge that I have had an opportunity to discuss the said Procedures, as stated above, with the Treating Consultant or his/her team member. I certify that the statements made in this consent form along with attached Annexure (if any) have been read over and explained to me in a language best understood by me. I have fully understood the contents and implications of the consent along with attached Annexure (if any) and further submit that the statements herein referred to, were filled in before I signed / applied my thumb impression.

रोगी सहमति प्रदान करने में असमर्थ है क्योंकि .....

इसलिए मैं .....

.....

इसलिए मैं (पूरा नाम, स्थाई पता और रोगी के साथ संबंध) उपर्युक्त प्रक्रियाओं को रोगी के ऊपर करने की सहमति देता/देती हूं। मैं स्वीकार करता/करती हूं कि मुझे चिकित्सक अथवा उनकी टीम के सदस्य द्वारा उपर्युक्त प्रक्रिया से संबंधित विचार–विमर्श करने एवं समझने का अवसर दिया गया था। मैं प्रमाणित करता हूं इस पत्र में दिये सभी कथन मुझे मेरी समझ में आने वाली भाषा में समझा दिये गये हैं। मैंने इस सहमति पत्र एवं संलग्न अनुबंध के सभी भावार्थ अच्छी तरह समझ लिये हैं। मैं यह स्वीकार करता हूं कि यहां पर दिये गये सभी कथन मेरे हस्ताक्षर करने/अंगूठे का निशान लगाने से पहले लिखे गये थे।

Patient's Next of Kin's Signature/Thumb Impression..... Name.....

रोगी के हस्ताक्षर/अंगूठे का निशान..... नाम.....

Date...../Time..... दिनांक...../समय.....

Witness's Signature/Thumb Impression:..... Name.....

गवाह के हस्ताक्षर/अंगूठे का निशान:..... नाम.....

Date...../Time..... दिनांक...../समय.....

Doctor's Signature:..... Date..... Time.....

डॉक्टर के हस्ताक्षर:..... दिनांक..... समय.....

QRG Health City

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

PAC FORM

Name Mrs. Neeru Age 41Y Sex : M / F IPD. No.
PAC No. Date 7/1/19

History From : ☑ Patient ☐ Parent / Guardian ☐ Language Barrier ☐ Medical Records Height Cms / in Weight kgs

Surgeon Name : Prabal Proposed Surgery Lscs
Elective / Emergency

ALERTS :
1. Allergies : Nil 3. Implants
2. HIV / HBsAg : 4. Venous Access

PREVIOUS ANESTHESIA / SURGERY / EVENTS : Yes (No) (If Yes, Details)

CURRENT MEDICATION (S) : Nil

AIRWAY
☐ MP 1 ☑ MP 2 ☐ MP 3 ☐ MP 4
☐ T-M Distance = N ☐ M-O Distance =
Neck ROM : Full / Limited / None
☐ Morbid Obesity ☐ Hx Difficult Airway ☐ Teeth Poor Repair / Loose
☐ Edentulous ☐ Facial Hair ☐ Short Muscular Neck

GENERL PHYSICAL EXAMINATION : Good / Fair / Toxic / Conscious / Drowsy / Unconscious

Pulse Rate : 102/MT Blood Pressure : 120/80 JVP : Edema : Pupils :
Temperature : SpO2 : 99% Cyanosis : Jaundice : Pallor :

☑ WNL	RESPIRATORY		EXAMINATION FINDINGS & COMMENTS
Asthma	Recurrent Tonsillities	Pleural Effusion	Pulmonary Examination : Clear
Bronchiolitis	Productive Cough	Sinusitis / Rhinitis	
COPD	Recent URI	Environ, Allergies	
Emphysema	TB	Dyspnea	
Bronchitis	Pneumonia	Sleep Apnea	
Respiratory Failure	Recurrent OM	Ortho Apnea	Smoking / Tobacco :

☑ WNL	CARDIOVASCULAR		Cardiovascular Examination : S1S2 (+)
Hypertension	Myocardial Infarction	Abnormal ECG	
Rheumatic Fever	CHF DOE PND	Cardiomyopathy	
CAD	PVD	Hypovolemia	
Angina	Exercise Tolerance	Pacemaker	
Stable / Unstable	METs : > 4 < 4	AICD	
Murmur	Endocarditis	Aneurysm	
Valvular Dz / MVP			NYHA : I II III / IV

☑ WNL	HEPATO / GASTROINTESTINAL		Abdominal Examination : NAD
Obesity	Bowel Obstruction	Pancreatitis	
Mainutrition	Hiatal Hernia	Gallbladder DZ	
Cirrhosis	Worms	Diverticulum	
Jaundice	Bleeding P / R	Diarrhea	
N & V	Gastric Reflux		Alcohol : No / Yes

☑ WNL	NEURO / MUSCULOSKELETAL		Neuro-muscular Examination : NAD
Arthritis	Headaches	Paralysis	
OA / RA / Gout	CVA / TIA	Muscle Weakness	
Back Problems	LOC / Unconscious	Paresthasia	
Scoliosis	Head Injury	Psychiatric Dz	
Kyphosis	Seizures		

☑ WNL	RENAL / ENDOCRINE		Spine Examination :
Prostrate : BPH / CA	Renal Stones	Thyroid Dz	
UTI / Incontinence	Renal Insufficiency	Pituitary Disorder	
Bladder Dz / Tumor	Adrenocortical Unstuff	Diabetes Mellitus	

☑ WNL	OTHER			
Anemia	Weight loss / gain	Sickle Cell Dz / Trait		HIV / AIDS
Bleeding Disorder	Peripheral Edema	Immunosuppressed		Cancer
Transfusion Hx	Radiation Tx	Chemotherapy		Steroid Use
Sepsis / Infection	Menstrual History	Family History of Anaesthesia Problem : Yes / No		
Loss of Appetite	Pregnant	LMP :		

DIAGNOSTIC STUDIES

- ☐ ECG : Nr
- ☐ X-Ray Chest : Nr
- ☐ Pulmonary Function Tests
- ☐ ABG Analysis :
- ☐ Special Investigation : ECHO / TMT / Cardiac Cath :
- ☐ Viral Marker —ve
- ☐ DSE
- ☐ Thyroid Profile
- ☐ Others :

LABORATORY STUDIES

- ☐ Hemoglobin 13.2
- ☐ TLC
- ☐ DLC
- ☐ Platelets 460
- ☐ Blood Sugar
  - ☐ Fasting ☐ PP ☐ Random
- ☐ Blood Urea
- ☐ Serum Creatinine 0.63
- ☐ Serum Electrolytes
- ☐ Blood Group
- ☐ Urine Examination
  - ☐ Routine
  - ☐ Microscopic
  - ☐ Pregnancy
- ☐ Liver Function Tests
  - ☐ Serum Billirubin
  - ☐ Total Direct
  - ☐ Indirect
  - ☐ SGOT
  - ☐ SGPT
  - ☐ SAP
  - ☐ Serum Proteins
  - ☐ Total Direct
  - ☐ Albulin
  - ☐ Globulin
- ☐ Coagulation Profile
  - ☐ PT ☐ INR ☐ APTT
  - 0.98

PHYISICAL STATUS : 1 (2) 3 4 5 6 E

Patient acepted for Anaesthesia : (yes) no

Plan of Action for Optimizing the Patient

VENTILATION FOLLOWING ANAESTHESIA ☐ Required ☑ Not Required

PLANED ANAESTHESIA TECHNIQUE / DRUGS

☐ GA/MAC ☐ Premed ..... Induction ..... Maint ..... Rev .....

☐ Regional ☐ Epidural ☐ SAB ☐ CSE ☐ Nerve Blocks

PREMEDICATION & INSTRUCTION

Nil Orally After : am / pm Last Feed at : am / pm

Arrange Blood : No Of Units :

Written Informed Consent / High Risk Consent

Repeat Investigation :

Medication to be Taken :

Pre medication :

Tab/syp..... At.....am / pm

Injection..... At.....am / pm

(NB : Artificial Dentures, Hearing aids, Contact Lenses, Jewellery, Lipstick, Nail Polish and Make Up to be Removed)

Anaesthetist's Name : **Signature :** **Date & Time**

Dr. Amit Garg PMC 40134 QRG ML

Review of Patient in Pre Hold before Surgery:

Antibiotic given at :

NPO status : Adequate

Blood Arranged :

Vitals : P 85/mt BP 121/81 SpO_2 99% RR 20/mt Temp

Medication :

Consent

Anaesthetist's Name : **Signature :** **Date & Time** 7/1/15

Dr. Amit Garg PMC 40134 QRG ML

QRG Health City

Dr. Prabal Roy

IP No : 33-19/223 UHID : 100066150

Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16

41 Y/F SINGLE WARD 2ND FLOOR/S1259

Dr. Prabal Roy

QRG MEDICARE

PRE- OPERATIVE CHECKLIST

(To be filled by the assigned nurse and counter checked by In-charge)

Patient's Name: Mrs. Neeru Maheshwari UHID No: GG150

IPID: 33-19/223 Age: 41 Y/F Sex: F

DOA: 7/1/19 Unit: Semi Delux 2nd

Date of Surgery: 7/1/19 Name of Surgery: I&D M

ID Band Checked: Yes ☑ No ☐ Fasting for 6-8 hrs Yes ☑ No ☐

Consent: Yes ☑ No ☐ Part preparation on ..... at .....

Clearance: Yes ☑ No ☐ Surgical Clipper: Used ☐ Not Used ☐ NA ☐

Allergies: Yes ☐ No ☑ (Reason for Not used / NA: .....)

Nail cut short: Yes ☑ No ☐ FBS for Diabetic patient: .....

RBS for non-diabetic patient: ..... Any medicine given for DM (specify): NO

Removal of: Dentures ☑ Plate ☑ Crowns ☑ Loose teeth ☑ Jewellery ☑ Makeup ☑ Nail Varnish ☐

Any other devices on patient Yes ☐ No ☑ If Yes Specify .....

All necessary investigations done: ECG ☑ CT Scan ☐ MRI ☐ Chest X ray ☑ Lab Investigations ☑ Radiology ☑ USG ☐

If yes specify: .....

Vital Signs:

BP: 120/70 Temp: 98.6°F Pulse: 86b/m Resp: 24b/m Height: 150cm. Weight: SPO2 100

Relatives meet the patient: Yes ☑ No ☐

Patient/ Significant/ other education about procedure and questions answered Yes ☑ No ☐

Patient's family member to be contacted:

Name: Mr Manish Relationship: Husband Tel. No: 9911108738

Pre-operative

Patient seen by surgeon	Yes ☑	No ☐
Patient seen by Anaesthetist	Yes ☑	No ☐
Antiseptic bath done	Yes ☐	No ☑
Antiseptic painting done	Yes ☐	No ☑
Antiseptic mouth wash done.	Yes ☑	No ☐
Skin condition checked	Yes ☐	No ☐
All equipment / instruments checked and available	Yes ☐	No ☐

pre-operative X ray done on .....

pre-operative medicines:

1. Inj Supace-j AST ..... on 7/1/19 ..... at 2pm
2. Inj Pan 40mg ..... on 7/1/19 ..... at 12.15pm
3. ..... on ..... at .....
4. ..... on ..... at .....
5. ..... on ..... at .....

Mention correct side .....

Mention correct site .....

Site marked Yes ☐ No ☐

Pre-catheterization

IV cannula(Venflone Size 20G) Yes ☑ No ☐

IV cannula site Rt.

IV infusions:

DNS at 100 ml/hr

..... at ..... ml/hr

Foley's Cath present Yes ☐ No ☑ Ryle's Tube present Yes ☐ No ☑

Peripheral pulses code 0, +1 +2, +3, +4

	Right	Left
Radian	+2	+1
Femoral	+1	+1
PT	+1	+1
DP	+1	+1

Code 0 = absent, +1 = Feeble, +2, Normal, +3 = Strong, +4 = Bounding

Recent Lab reports: PTT ..... ACT ..... RFT .....

Hep B ..... HCV ..... HIV ..... Bloog group & Rh .....

Blood Available:

WB ..... Units PRC ..... Units

FFP ..... Units Platelets ..... Units

Checked by Assigned Nurse: Name Dolly Signature Dolly Emp ID 30351

Counter checked by In-charge: Name Nirmala Signature ..... Emp ID 30363

Checked / Received by OT Staff: Name Kamal Signature Kamal Emp ID 23057

Prosthesis arranged, if required (To be filled by OT Staff) Yes ☐ No ☑

File and all document sent with patient Yes ☐ No ☐

Any Comments .....

QRG Health City

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Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

SURGICAL SAFETY CHECKLIST

Date:
Patient's Name: Mrs. Neeru Maheshwari
IPID: 19/223
DOA: 7/1/19
O. R No.:
UHID No:
Age: 41 yrs F Sex: F
Unit: Trauma

SIGN IN	TIME OUT (Operating Room)	SIGN OUT (Operating Room)
A. IN PRE-OP AREA BEFORE SHIFTING PATIENT TO OPERATING ROOM. B. IN PRE-OP AREA/ IN OPERATING ROOM BEFORE INDUCTION OF ANAESTHESIA	C. BEFORE SKIN INCISION (SAFETY PAUSE)	D. BEFORE PATIENT LEAVES OPERATING ROOM

A. IN PRE-OP AREA BEFORE SHIFTING THE PATIENT TO OR REVIEW WITH PATIENT & CASE FILE

- [x] Patient identification (Name, Age, IPID, ID band)
- [x] Surgical procedure to be performed Lap IPOM
- [ ] Site/ Side of surgical procedure with marking
- [ ] Consent forms(surgery, Anaesthesia) & signed
- [ ] Known allergies NO
- [x] Airway assessed for difficulty. MPG

Anaesthetist Sign. Dr. Amit Gautam

To transfer the patient to OR only after part A is completed and signed by Anaesthetist

B. IN PRE- OP AREA/IN OR BEFORE INDUCTION

ANAESTHESIA REVIEW

1. Is patient identification confirmed Yes ☑ No ☐
2. Any anaesthesia equipment issues or concerns Yes ☐ No ☑
3. Anaesthesia safety check has been completed Yes ☑ No ☐
4. Risk of blood loss > 500ml/ 7ml/Kg in children Yes ☐ No ☑
5. Two IVs / Central access and fluids planned Yes ☑ No ☐
6. Blood products arranged Yes ☐ No ☑
7. In case of difficult airway, whether Equipment / Assistance available Yes ☑ No ☐

Time patient Wheeled in O R: 3:00 pm

Anaesthetist Dr. Amit Gautam

Surgeon Dr. Prabal Roy

1. Does everyone know each other?
Yes ☐ No ☐ (if no, introduce - name , role)

SURGEONS REVIEWS WITH TEAM

2. What is patient Name? Mrs. Neeru
3. Name of the procedure planned Lap IPOM
4. Is the correct site prepared and draped? Yes ☑ No ☐
5. Expected duration of the surgery 1 hrs
6. Discuss if there is anything unique or non routine about the surgery?
☑ Routine ☐ Non- routine/ Any issues
7. Implants or special equipment required
☑ Yes Mesh ☐ Not applicable
8. Is essential imaging displayed?
☑ Yes ☐ Not applicable Lap port

ANAESTHETIST REVIEWS WITH THE TEAM

9. Antibiotic prophylaxis given within last 15 60 minutes (90-120 for Vanco, Metro etc.)?
☐ Yes ☐ No ☐ Not applicable
10. Drug Name : Inj. Supacef 1.5 gm
Time of administration: at 3:00 pm
11. Is there anything unique or non-routine about anaesthesia administration? ☑ No
☐ If yes .....

NURSING TEAM REVIEWS

12. Has sterility been confirmed? Yes ☑ No ☐

Incision Time: 3:15 pm

Circulating Nurse

OT-incharge

NURSE REVIEWS WITH TEAM

1. Instrument, sponge and needle counts are correct
☑ Yes ☐ No ☐ Not applicable
2. Whether there are any equipment problems to be addressed
☐ Yes ☑ No ☐ Not applicable
3. Name of the actual procedure performed
Lap IPOM
4. Specimen Labelling Read Back Specimen Labelling including patients name, UHID/IPID N/A

SURGICAL TEAM DISCUSS

5. Any surgical precaution to be taken in post- operative patient management
☐ No ☐ If yes

AUTO 02 10
STEAM 05.01.19 05.07.19 STEAM

Time Patient Wheeled Out: 8:15 pm

Circulating Nurse

Scrub Nurse Neeru

This checklist is only a quality improvement tool. To be included in patient file

QRG Health City

OT NOTES

Lap IPOM Hernioplasty

QRG MEDICARE

Please attach patient sticker

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

Height:..... cm Weight:.....kg BMI:.....
Address: D-26 GF RPS PALMS FBD HR Faridabad
Phone no: 9911108738

Operation Date : / /20	**Operating surgeon**: Dr. Prabal Roy
Assist. surgeon: Dr. Anushtup De/ Dr Sunil	**2 nd Asst**
Anaesthetist: Dr. Amit garg.	**Anesthesia**: GA
Scrub Nurse Meenu	**Circulatory Nurse:** Susmi/Komal
Starting Time 3:15 pm	**Finishing time**
Diagnosis : Paraumbilical / ~~Epigastric / Incisional~~ hernia	**Procedure** : Lap IPOM Hernioplasty

Standard 3 ports placed , Extra ports – location ... None.....

Operative Findings :

- Paraumbilical ~~/ Incisional/ Epigastric Hernia –~~ Single/ ~~Multiple defects~~, Size 2 x 2 cm
- ~~Incisional Hernia – single / multiple defects , size ..... Cm~~
- Contents – omentum ~~/ bowel~~

Operative Procedure

- Hernial contents reduced
- Mesh placed (Ventralight ST 15x15 cm / ~~Ventralex ..... cm / Dyna CICAT ..... cm~~) and held with tackers and transfixation sutures
- Ports closed

Additional findings (If any)

Post Operative Notes

- NPO x .....5.....hrs , Liquids allowed after ....5..... hrs 9 pm.
- IVF .....100..... ml/ hr DNS/RL /~~NS x ..... hrs~~
- Inj Supacef 1.5 gms IV twice daily x .....5. day
- ~~Inj Augmentin 1.2 gms IV twice daily x ..... day~~
- ~~Inj Metrogyl 400 mg thrice daily x ..... day~~
- Inj Nexpro 40 mg once daily x ..... day
- Inj Dynapar 1 amp twice daily x ..... day
- ~~Inj Tramadol 1 amp twice daily x ..... day~~

Others
Abdominal Binder
Soft diet allowed after 9pm
Plan Discharge c/m.

Dr. Signature

ORG Health City
Plot no. 1, Sector -16, Faridabad, 121002
Tel: 0129 - 4330000

Dr. Prabal Roy

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/2019 11:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

POST ANESTHESIA CARE CHART

Patient Profile:

Name : Mrs. neeru maheshwari Age 41Y [ ] Male [ ] Female

Surgeon : Dr. prabal. Operation : Lap. I pcm

Anesthesia: [✓] GA [ ] Regional [ ] LA Time of Arrival in RR 3:55pm

RECOVERY ROOM OBSERVATION CHART

3:55pm 4pm 4:15pm 4:30pm 4:45pm 5pm

	On Arrival	0.5 Hr.	1.0 Hr.	1.5 Hr.	2.0 Hr.	2.5 Hr.	3.0 Hr.	3.5 Hr.	4.0 Hr.
Pulse	72/mt	80/mt	73/mt	78/mt	80/mt	81/mt			
BP	131/85	138/88	131/85	114/70	116/71	117/72			
Spo2	100%	100%	100%	100%	100%	100%			
Resp. Rate	15/mt	16/mt	16/mt	18/mt	17/mt	16/mt			
Consciousness Level	conscious	conscious	conscious	conscious	conscious	conscious			
Urine Output	—	—	—	—	—	—			
Soakage	—	—	—	—	—	—			
Blood Sugar in Diabetic Patient	—	—	—	—	—	—			
Presence of Limb Movement	present	present	present	present	present	present			

IV Fluids in RR : .....

Any Medication : Inj Tranasol 100 mg IV 4:15 pm

Anaesthetist I/C ..... Sister I/C .....

Post Operative status:

Shifted to: Recovery

Vitals: P 80 BP 110/80 SPO_2 98% RR 20 VAS

Remarks: H I R

Post Operative instructions:

1. NPO till ~~6 hrs~~ / as Sugeon orders am/pm
2. Oxygen by mask 4 litres/min
3. IV Fluids: 100 ml/h
4. Analgesics Inj Tramadol 100 mg in 100 ml NS
5. Monitor Vitals 4th hourly
6. Others: -

ABG Report:

Time	pH	PaO_2	$PaCO_2$	HCO_3	SaO_2	B.E	Lactate	Hb	BS	Na	K	Cl

Name of Anesthetist: Dr. Amit Garg

Designation:

Signature:

Date: Time:

QRG/HC/OT/Frm/34.08/ED2017/V1.0/Rev00

QRG Health City

P No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
11 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

QRG Health City
Plot no. 1, Sector -16, Faridabad-121001
Haryana. Tel: 0129 - 4330000

INTRA OPERATIVE ANESTHESIA RECORD

Name Mrs. Neeru Maheshwari Age 41Y/F Sex : M / F IPD. No. 19/223
Wt.: BMI Date 7/1/19

Anesthesiologists Dr. Amit Garg Procedure LAP I POLY
Surgeon Dr. Prabal Roy Position Supine
Anesthesia GA / Regional/ Nerve Blocks/ MAC

Wheel in 3:20
Induction Time 3:05 pm
Incision time 3:15 pm
Reversal at 3:50 pm
Wheel Out 3:55 pm

PRE-PROCEDURE

- ☑ Consent Signed
- ☑ Chart reviewed
- NPO since ☐ Full Stomach
- ☑ Patient reassessed prior to anesthesia

Pre - Anesthetic state

☑ Awake ☐ Anxious ☐ Uncooperative
☐ Calm ☐ Sedated ☐ Reduced LOC

Pre - Procedure Vital Sign

Pulse 88 BP 110/80 Airway M/N
Resp 20 Temp 103 SpO2 98%

MONITORS & EQUIPMENTS

Steth: ☐ Esophageal ☐ Precordial ☐ Suprasternal

- ☑ Non-Invasive BP
- ☑ Continous ECG
- ☑ Pulse oximeter
- ☐ Prominent Incisors
- ☑ End tidal CO_2
- ☑ Oxygen / FiO_2 monitor
- ☐ Temp
- ☑ Airway humidifier
- ☑ NG / OG tube
- ☐ Foley Catheter
- ☑ V lead ECG
- ☐ ST / Dysrhy analysis
- ☐ Nerve stimulator
  - ☐ Ulnar ☐ Tibial
  - ☐ Facial
- ☐ Fluid / Blood warmer
- ☐ Arterial Line
- ☐ C-line / CVP
- ☐ PA Line
- ☐ IV (Peripheral)

PATIENT SAFETY

- ☑ Anesthesia machine checked
- ☑ Critical Clinical Alarms Checked & Activated
- ☑ Eye Care
- ☐ Prone-no pressure on orbits/ nose/ears/ genitals
- ☑ Pressure points checked, padded, monitered

ANESTHETIC TECHNIQUE

GA

Induction: ☑ Intravenous ☑ $PreO_2$ ☐ RSI
☑ Inhalation ☐ Pre Medication
☐ Cricoid Pressure

- ☑ IV Induction agent Inj Propofol 120 mg Dose
- ☑ Inhalation agent Sevo Conc
- ☑ Muscle relaxant for intubation Inj Atra 40 mg Dose
- ☐ Others

Maintenance: O2 + N2O + Sevo
Reversal: Inj Neostigmine (1mg)

Regional: ☐ SAB ☐ Epidural ☐ CSE
☐ Caudal ☐ Nerve Block ☐ Others

Site:
Needle Type: Size:
Position:
Drug: Test Dose:
Total Dose:
Remarks

AIRWAY MANAGEMENT

- ☐ Oral ETT ☐ RAE ☐ Magills
- ☐ Nasal ETT ☐ LMA* ☑ Igel - 3
- ☐ Stylet ☐ Classic ☐ Fastrach ☐ Pro Seal
- ☐ DL ☐ Flexible ☐ Other
- ☐ Tube Size ☐ FOI ☐ Awake
- ☐ Blade: ☐ Tracheostomy
- ☑ Attempt 1
- ☐ Grade I II III IV V Others:
- ☐ Secured at Nam cm
- ☑ ET CO_2 present
- ☑ Breath sound = bilateral
- ☐ Cuffed - min occ pressure
- ☐ Oral pack
- ☐ Oral Airway ☐ Nasal Airway ☐ Bite Block
- Circuit: ☐ Circle system ☐ Bain ☐ Ayres T piece
- Others:

QRG/HC/OT/Frm/34.08/ED2017/V1.0/Rev00

	TIME				
AGENTS	GA Maintainance				
	Propofol / Etomidate				
	ISO / Desflurance / Sevo				
	Vec / Panc / Atrac / Roc				
	Mor / Fenta	100 µg			
	Others	Inj PCM 1gm IV; Inj Pantop 40mg IV			
TRANSFUSION	IV Fluids	RL @ 125 ml/hr			
		Inj Pyrexia 8mg IV			
	BLOOD				
OUT PUT	Urine (ml)				
	Blood Loss (ml)				
MONITORS	ECG	NSR	NSR	NSR	NSR
	% Oxygen Inspired (FiO_2)	50%	50%	50%	
	O^2 Saturation(SaO^2)	100%	100%	100%	
	End Tidal CO^2	34	34	34	
	Temp.				
	TOF				
	Blood Sugar				
	DVT Pump	✓			

SYMBOLS BASELINE VALUE

Pulse ●
BP Cuff V ^
BP Art +
MAP ▲
CVP □
Spont vent ○
Assisted ∅
Controlled ⊘

200
180
160
140
120
100
80
60
40
20

TOURNIQUET
Location:

	Rt	Lt	mmHg
Up at			am / pm
Down at			am / pm
Total Time			mins

VENTILATOR SETTINGS
Tidal Volume (ml) 500
Respiratory Rate 12
Peak Pressure
PEEP / CPAP

ALDRETE SCORE

* Patient's scoring should be 10/10, and than patient can be discharged/transferred from recovery area e.g. post-op OT recovery / ICU area

S. No.		Scoring		
1.	Level of Consciousness	☐ 0	☐ 1	☑ 2
2.	Muscle Power	☐ 0	☐ 1	☑ 2
3.	blood Pressure	☐ 0	☐ 1	☑ 2
4.	Color of Patient	☐ 0	☐ 1	☑ 2
5.	Respiration	☐ 0	☐ 1	☑ 2

S. No.	Score	Scoring Criteria
1		**Level of Consciousness**
	0	Patient not responding to painful / Verbal stimulus
	1	Patient is responding to painful / Verbal stimulus
	2	Patient is responding full-oriented to time, place and person
2		**Muscle Power**
	0	Not able to move any limb
	1	Able to move 1-3 limbs
	2	Able to move all 4 limbs
3		**Blood Pressure**
	0	Blood pressure more than +/- 50mm Hg of normal
	1	Blood pressure +/- 20-50mm Hg of normal
	2	Blood pressure +/- 20mm Hg of normal
4		**Color of Patient**
	0	Blue
	1	Pink but not normal
	2	Normal
5		**Respiration**
	0	No efforts
	1	Respiration not regular, spontaneous and adequate
	2	Respiration regular, spontaneous and adequate

Dr. Amit Gupta RMC 34 QRG

Signature of Anesthesiologist / Doctor

Date & Time

QRG Health City

Plot No. 1, Sector-15, Faridabad - 121002 (HR.)
Ph. 0129-4330000 : Fax : 0129-4330033

Patient Narcotics Sheet

Sr. No. _____

FORM No. 3E — **Details Of The Patient To Whom Essential Narcotic Drugs Dispensed** — Date: 7/8/19

UHID : 1000 66150	Complete postal address (with contact number, if any): SEC-16 M.no 3014 FBD
Name : RAKESH KUMAR	Diagnosis / Surgery: Hip TPOM
Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details to be recorded)	

Details of the essential narcotic drugs dispensed

Date	Name Of The Essential Narcotic Drug	Quantity	Signature/Thumb impression of the patient/ Attendant	Remarks If Any
7-1-19	Inj. FENTANYL	01 amp	Dr. Unconscious	

Daily Prescription

Dosage Form (Inj / Patch) & Drug Name	Daily Dose: Dose	Daily Dose: Frequency	Route	Period Of Consumption
Inj Fentanyl 2ml	1 vial	once	IV	Stat

Signature Of The Prescribing Doctor		Name Of The Doctor	Dr Amit Garg	Registration Number	PMC-40134

Indent cum Administration

Drug Name	Dose	Route	Drug Strength issued Eg. 2ml (2mg/ml)	Issued by (Name/ Employee ID & Sign)	Received by (Name/ Employee ID & Sign)	Received by during Shift Change	Administered by (Sign & ID)	Date	Time	Quantity Wasted (If Any)	Witnessed by (Nurse Sign & ID)	Witnessed by (Dr. Sign & ID)	Empty Ampule Returned By	Empty Ampule Received By
Inj FENTANYL	100 mcg	IV	2ml					7-1-19	3:10 PM	NIL				
		IV												

Return Slip

Dosage Form (Inj / Patch)	Drug Name	Drug strength Eg. 2ml (2mg/ml)	Quantity	Reason For Return (Patient Discharged / Expired etc.)	Returned By	Received By	Entered As Quantity Received In 3H & Stock Register / Ledger By

ORG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

INITIAL NURSING ASSESSMENT FORM

Admission date	7/1/19		
Department	(✓) Through OPD [ ] Through ER [ ] Self		
Time of Arrival in unit	11:30 am	Time of Completion of assessment	11:40 am
Mode of Arrival	(✓) Ambulatory [ ] Wheel Chair [ ] Stretcher [ ] Ambulance [ ] Others		
Accompanied by	[✓] Family [ ] Friend [ ] Others		
Primary language Spoken	[ ] English [✓] Hindi [ ] Others	Interpreter Needed	[ ] Yes [✓] No
Vulnerable Staus	[ ] Yes [✓] No	Actions taken	[ ] Yes [✓] No

VITAL SIGNS		ORIENTATION	
Temperature(°F) 98.2°F	Height(cm):	[ ] Bed control	[ ] Washroom
Pulse(/min): 84/mt	Weight(kg): 65kg	[ ] Call bell	[✓] Visitation rules
Respiration(/min): 20/mt		[ ] Television	[ ] Meal timings
BP(mm of Hg): 110/70		[ ] Phone	[ ] No smoking

ALLERGIES (✓) No known allergies ( ) Yes | Allergic to:

PERSONAL ESSENTIAL LIST/ SPECIAL NEEDS

Hearing aid	(✓) No	( ) Left	( ) Right		
Contact lens	(✓) No	( ) Left	( ) Right	( ) Eyeglasses	
Dentures	**Full:** ( ) Upper	( ) Lower	**Partial:** ( ) Upper	( ) Lower	(✓) No
Artificial prosthesis	(✓) No	( ) Yes	Type		
Visual Impairment	(✓) No	( ) Yes			
Speech problem	(✓) No	( ) Yes			
Hearing impairment	(✓) No	( ) Yes			

NEUROLOGIC STATUS (✓) Conscious/Oriented ( ) Disoriented ( ) Unconscious ( ) Stuporous ( ) Confused/Anxious

HEALTH ASSESSMENT

1. Current Complaint/ Reason for hospitalization:

c/o ℄ para umbilical swelling.
procedure for lap ipan.

2. Past Surgical History: NIL

3.Past Medical History:

(✓) Diabetes	(✓) Resp. disorder	(✓) Blood disorder	(✓) Mental illness	(✓) Cancer
(✓) Hypertension	(✓) Kidney disorder	(✓) Seizure disorder	(✓) STD	(✓) Others
(✓) Heart disease	(✓) Thyroid disorder	(✓) GI disorder	(✓) Hepatitis	
(✓) Tuberculosis	(✓) Neuro muscular	(✓) Skin disorder	(✓) Arthritis	

Disposition of Medications	( ) Not brought with patient	( ) Sent home with family	( ) Educated not to use

NUTRITIONAL STATUS

Appetite - Normal/Altered .....

If Weight Loss/Gain is < 3Kg or > 3 Kg ...No.....

Any Digestive Problem .....No.....

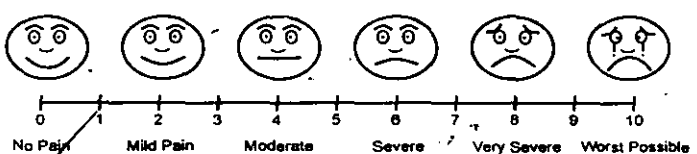
VULNERABLE PATIENT- ANY OF THE BELOW CONSIDERED AS VULNERABILITY

Categories	Age<16>65	Any mental or neurological disability	limited physical mobility	Communication barrier	patient on restraint	Immuno--supressed Patient	Victim of abuse & Neglect	Drug/Alcohal Dependent
( ) Yes								
( )No	✓	✓	✓	✓	✓	✓	✓	—

Activities of Daily Living (ADL's)

	Bathing	Dressing	Eating	Mobility	Toilet use
Independent	✓	✓	✓	✓	—
Dependent					

WONG - BAKER FACIAL GRIMACE SCALE
NUMERICAL RATING SCALE



Pain Score: 0/10

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Sensory Mental	Moisture	Activity	Mobility	Nutrition	Friction / Shear
1 Total limited	1 Constantly moist	1 Bed fast	1 100% immobile	1 Very poor	1 freequent Sliding
2 Very limited	2 Very moist	2 Chair fast	2 Very limited	2 <½ daily portion	2 Feeble Corrections
3 Slightly limited	3 Occasionally moist	3 Walks with assistance	3 Slightly limited	3 Most of portion	3 Independent Corrections
4 No impairment	4 Dry	4 Walks without assistance	4 Full mobility	4 Eats everything	

Interventions At risk to Moderate risk	
1.	Offer toilet as necessary
2.	Use devices to optimize independent positioning
3.	Use elbow and heel protectors.
4.	Reposition every 2 hourly
5.	Provide routine care and moisturize skin daily.
6.	Document individualized care plan.

High to very high risk	
1.	Include all above mentioned points
2.	Protect sacral/perineal wounds from fecee & infected urine.
3.	Reposition every 1-2 hourly incorporate frequent small shifs in position between turns.

Score braden scale : At risk - 15-18 Moderate - 13 to 14 High risk - 10 to 12 Very high risk - 9 or less

Total Score for Patient ..23.....

Location of bed sore No **Grade**

MORSE FALL RISK ASSESSMENT

	CATEGORY	CHARACTERISTIC	SCORE
1	Level of consciousness	Knows own limits, reliable safety awareness	0
		Diminished safety awareness	15
2	History of falls	No falls	0
		Yes	25
3	Predisposing diseases	Following Conditions: Hypotention/Vertigo/CVA/Parkinsonism/seizures/arthritis/ osteoporosis/ fractures	
		No	0
		Yes	15
4	Ambulatory aids	Ambulatory without assistance/bedrest/wheelchair	0
		Crutches/cane/walker needed	15
		Furniture used for support	30
5	Gait	Normal walking/striding without hesitation	0
		Weak walking & short, shuffled steps, lightly touching furniture for support	10
		Impaired walking with difficulty rising from chair, head down, grasps furniture	20
6	Medications	Following type of medications: anesthetics/antihistamines/cathartics/diuretics/antihypertensives antiseizure/ benzodiazepines/ hypoglycemics/ psychotropics / sedatives/ hypnotics	
		None of the medications taken	0
		Medications taken	15

SCORE FALL RISK ASSESSMENT		
Low risk 0-24	Medium risk 25 - 44	High risk Above 45

Total score 0

PATIENT & ATTENDANT INFORMATION EDUCATION (ON UFPP & OUTSIDE PRESSURE SORE)

Preventive measures and risk explained ..... YES ..... NO

Outside bedsore shown and grade explained ..... YES ..... NO

Sign/Name of witness Manish Maheshwari **Relationship with patient** Husband

ACTUAL PROBLEMS

( ) Activity Intolerance	( ) Pain, Acute	( ) Nutrition, less than body need
( ) Airway clearance, Ineffective	( ) Pain, Chronic	( ) Nutrition, more than body need
( ) Breathing Pattern, Ineffective	( ) Verbal communication, Impaired	( ) Skin integrity, Impaired
( ) Decreased cardiac output	( ) Sensory Perception, Altered	( ) Oral Mucous Membrane, Altered
( ) Gas Exchange, Impaired	( ) Thought process, Altered	( ) Swallowing , Impaired
( ) Health Maintenance, Impaired	( ) Fluid volume, Deficit	( ) Body Image Disturbance
( ) Physical Mobility, Impaired	( ) Fluid volume, Overload	( ) Sleep Pattern Disturbance
( ) Self care deficit	( ) Knowledge deficit	( ) Self Esteem Disturbance
( ) Incontinence, Bowel	( ) Urinary Elimination, Altered	( ) Role performance , Altered
( ) Incontinence, Bladder	( ) Urinary Retention, Altered	( ) Fear & Anxiety
( ) Injury, Altered	( ) Spiritual Distress	( ) Rape trauma syndrome

POTENTIAL PROBLEMS

( ) Infection, Potential for	( ) Activity Intolerance, Potential for
( ) Injury, Potential for	( ) Others
( ) Skin Integrity, Potential for	

Name of admitting Nurse Soniya **Employee ID** 28120 **Sign**

Name of Ward Supervisor [illegible] **Employee ID** 25609 **Sign**

QRG Health City

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000

DAILY NURSING CARE PLAN

Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature
8/1/19	c/o. weakness	due to surgical procedure	To relieve weakness	- Does the conditions of the patient - Comfortable	Yes	Healthy 2005 Goal met	Health 20m
				positioning done - Provide food diet to the patient - provide help	Yes		
				to ambulate the patient	Yes		

Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature

QRG Health City

P No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
11 Y/F SINGLE WARD 2ND FLOOR/S1259
Mr. Prabal Roy

P No : 33-19/223 UHID : 100066150

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000

DAILY NURSING CARE PLAN

Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature
6 7/1/19 1:30pm	→ Anxiety	→ Anxiety Related to Surgery	→ To Reduce Anxiety	→ Assess & Condition → Provide Psychological Support	→ Done → Done	→ Anxiety Reduced Some extent	Sunil 30351
	Pain	Acute Pain related to Surgical procedure	To reduce pain	→ Assess the Patient Condition → Administer medicine as prescribed	→ Assessed the patient → Administered as prescribed		

Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature

11 Y/F SINGLE WARD/ FLOOR/

Mr. Prabal Roy

IP No : 33-19/223 UHID : 00066150

Mrs. Neeru Maheshwari DOA : 07/01/201911:16

Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature
7/1/19 6pm	Anxiety & fear	Anxiety & fear related to Hospitalization	To Reduce the Anxiety & fear	→ To Assess the General Condition of Pt → Provide	Yes Yes	To Reduce the Anxiety & fear	Manju
				keep a Calm environment → Provide Psychological Support	Yes		

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

Date 08/1/19

DAILY NURSING ASSESSMENT SHEET

SHIFT/TIME	Morning	Evening	Night
Neurological status	A	A	
GCS	E4V5M6	E4V5M6	
Mode of oxygen	RA	RA	
Cough	N	N	
Dressing	D	D	
Skin status	I	I	
Vulnerable status	NA	NA	
VIP score	~~2~~	0	
Braden Score	20	20	
1.stage of pressure ulcer	NA	NA	
2.location of pressure ulcer	NA	NA	
Morse Fall Score	0-45	0-45	
EWS score	0	0	
Pain score	0/10	0/10	
Signature of Nurse	Neelam	Neelam	
Emp. ID	26083	26083	

NEUROLOGICAL STATUS

Alert	A
Lethargic, Sleepy, easily aroused falls asleep without stimulation	L
Stupourous- Difficult to arouse except with repeated stimuli	S
Comatose	C

DRESSING

Intact	I
Dry	D
Soaked	S

SKIN STATUS

Intact	I
Non-Intact	NC

MODE OF OXYGEN

Nasal canula	NC
Mask	M
Venturi mask	VM
BIPAP	B
Room air	RA
Ventilator	V

GLASSGOW COMA SCALE

Behaviour	Response	Score
Eye opening	Spontaneously	4
	To speech	3
	To pain	2
	No response	1
Verbal Response	Oriented to time, place & person	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Motor response	Obeys commands	6
	Moves to localized pain	5
	Flexion withdrawl from pain	4
	Abnormal flexion	3
	Abnormal extension	2
	No response	1
Total Score	Best response	15
	Comatose client	8 or less
	Totally unresponsive	3

Cough

None	N
Productive	P
Non-productive	NP

MORSE FALL RISK ASSESSMENT

	CATEGORY	CHARACTERISTIC	SCORE
1	**Level of consciousness**	Knows own limits, reliable safety awareness	0
		Diminished safety awareness	15
2	**History of Falls**	No falls	0
		Yes	25
3	**Predisposing diseases**	Following Conditions: Hypotention/Vertigo/CVA/Parkinsonism/seizures/arthritis/ osteoporosis/ fractures	
		No	0
		Yes	15
4	**Ambulatory aids**	Ambulatory without assistance/bedrest/wheelchair	0
		Crutches/cane/walker needed	15
		Furniture used for support	30
5	**Gait**	Normal walking/striding without hesitation	0
		Weak walking & short, shuffled steps, lightly touching furniture for support	10
		Impaired walking with difficulty rising from chair, head down, grasps furniture	20
6	**Medication**	Following type of medications: anesthetics/antihistamines/cathartics/diuretics/antihypertensives antiseizure/ benzodiazepines/ hypoglycemics/ psychotropics / sedatives/ hypnotics	
		None of the medications taken	0
		Medications taken	15

SCORE FALL RISK ASSESSMENT		
Low risk 0 - 24	Medium risk 25 - 44	High risk Above 45

Vulnerable patient- any of the below considered as vulnerability

CATEGORIES					NA
Age <16 or >65		Communication barrier		Immunosupressed patients	
Any mental or neurological disability		Un attended unconscious patient		Victim of abuse & neglect	
Limited physical mobility		Patient on restraint		Drug/Alcohol dependent	

VULNERABILITY STATUS

If Yes, Action Required

- ☐ Place safety first Signage to patient side
- ☐ Ensure call bell within reach of patient
- ☐ Bed side rails always up
- ☐ 2nd hourly assessment

EARLY WARNING SIGNS

SCORE	3	2	1	0	1	2	3
RR	>35	31-35	21-30	9 to 20			<7
SPO2	<88	88-89	90-92	>92			
Temperature		>102.2	100.4-102.2	96.8-100.2	95-96.6	93.2-94.8	<93.2
Systolic BP		>170		100-170	80-99	70-79	<70
Heart rate (bpm)	>129	110-129	100-109	50-99	40-49	30-39	<30
AVPU				alert	Verbal	pain	Unresponsive

Visual infusion phlebitis score (V.I.P.)

IV site appears healthy - 0	All present:- pain at IV site, Erythema, induration - 3
One of the following is evident:- slight pain/redness at or near IV site - 1	All are evident and excessive:- pain along the path of canula, Erythema, Induration, palpable venous cord - 4
Two of the following is evident :-Pain at IV site, erythema, induration - 2	All are evident and excessive:- pain along the path of canula, Erythema, Induration, palpable venous cord, pyrexia - 5

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

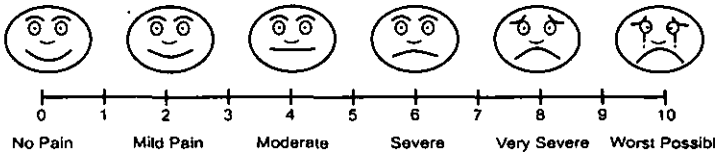
Sensory Mental	Moisture	Activity	Mobility	Nutrition	Friction / Shear
1 Total limited	1 Constantly moist	1 Bed fast	1 100% immobile	1 Very poor	1 freequent Sliding
2 Very limited	2 Very moist	2 Chair fast	2 Very limited	2 <½ daily portion	2 Feeble Corrections
3 Slightly limited	3 Occasionally moist	3 Walks with assistance	3 Slightly limited	3 Most of portion	3 Independent Corrections
4 No impairment	4 Dry	4 Walks without assistance	4 Full mobility	4 Eats everything	

Interventions At risk to Moderate risk	
1.	Offer toilet as necessary
2.	Use devices to optimize independent positioning
3.	Use elbow and heel protectors.
4.	Reposition every 2 hourly
5.	Provide routine care and moisturize skin daily.
6.	Document individualized care plan.

High to very high risk	
1.	Include all above mentioned points
2.	Protect sacral/perineal wounds from feaces & infected urine.
3.	Reposition every 1-2 hourly incorporate frequent small shifs in position between turns.

Score braden scale : At risk - 15-18 Moderate - 13 to 14 High risk - 10 to 12 Very high risk - 9 or less

WONG - BAKER FACIAL GRIMACE SCALE
NUMERICAL RATING SCALE



THE FLACC SCALE

CATEGORIES	0	1	2
Face	No Particular expression or smile	Occasional grimace or frown, withdrawn disinterested	Frequent to constant quivering chin clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back & forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers: occasional complaint	Crying steadily, screams or sobs frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

Score FLACC Scale : 0 - Relaxed / Comfortable, 1-3 - Mild discomfort, 4-6 - Moderate pain, 7-10 - Severe Discomfort

PAIN MANAGEMENT

Date	Shift/Time	Pain score	Quality	Location	Interventions/Comfort

COMFORT MEASURES

A	Aching	P	Positioning
B	Burning	B	Breathing
C	Crushing	ED	Education pain management
D	Dull pain	M	Massage
S	Sharp/Stabbing	ES	Emotional support
Sh	Shouting	W	Walking
T	Tingling	IP	Ice pack
TH	Throbbing & Radiating	MA	Medication Administration

LINES & DRAINS

S. No.	Type	Site / Location	Day	Remarks

PAIN ASSESSMENT TOOL BEING USED

☐ FLACC: ☐ WB ☐ NRS

NURSES HANDOVER CHECKLIST

	ELEMENTS	Morning	Evening	Night
	Patient name & ID band	Yes	Yes	
HYGIENE	Self/bed bath	Bed bath	Bed bath	
	Skin care .....hourly	NA	NA	
	Back Care .....hourly	NA	NA	
	Mouth Care ....12.....hourly	Self	Self	
	Eye Care .....hourly	NA	NA	
	Hair Care .....hourly	NA	NA	
	Perineal care (for Female)	NA	NA	
	Any special care	NA	NA	
RESPIRATORY THERAPY	Foley's cath care	NA	NA	
	NGT care	NA	NA	
	Chest physiotherapy	NA	NA	
	Incentive Spirometery	NA	NA	
	Steam inhalation	NA	NA	
	Nebulization ____ hourly	NA	NA	
	Suctioning ____ hourly (Oral/Nasopharyngeal/ Tracheal/ Endotracheal)	NA	NA	
	Tracheostomy care	NA	NA	
	Chest tube care	NA	NA	
REHABIL-ITATION	Ambulation	Yes	Yes	
	Physiotherapy	NA	NA	
	ROM exercises	NA	NA	
	Repositioning ____ hourly	NA	NA	
GI & GENITO URINARY	Enteral feeding ____ hourly (NGT/PEG/J tubes)	NA	NA	
	Enteral tube site care	NA	NA	
	NG aspiration ____ hourly	NA	NA	
	NPO status	NA	NA	
	Type of diet	S/D	S/D	
	Ostomy care	NA	NA	
	Enema	NA	NA	
	Catheterization	NA	NA	
	Catheter care	NA	NA	
	Sitz bath	NA	NA	
	Drain site care (JP/Penrose/Hemovac)	NA	NA	
OTHERS	Compress (hot/ cold)	NA	NA	
	Barrier/ Reverse barrier Nursing	NA	NA	
	Blood Transfusion	NA	NA	
	Care of all lines(IV/Central/Arterial/PICC)	IV line	IV Line	
	Care of HD catheter	NA	NA	
	Flushing Intermittent infusion lock	NA	NA	
	Site care	NA	NA	
	Specimen collection	NA	NA	
	End of life care	NA	NA	
SURGICAL	Any surgery planned	NA	NA	
	Part preparation	NA	NA	
	Skin preparation	NA	NA	
	Pre-operative checklist complete	NA	NA	
	Bill clearance(for surgery or Procedure)	NA	NA	
	Abnormal reports/Critcal lab values	NA	NA	
HEALTH EDUCATION	Medications(Action/side effects/Special Instructions)	NA	NA	
	Diet (Type/ restrictions)	NA	NA	
	Infection prevention	NA	NA	
	Post procedure care	NA	NA	
	Postnatal education (for mothers)	NA		
	Injury/ Fall prevention	NA	NA	
	Symptoms to seek medical help	NA	NA	
	Discharge education & follow up	NA	NA	
PEND-ING	Investigation/procedure (Mention if any)	NIL	NA	
	Consultation (Mention if any)	NA	NA	
	Medications (Mention if any)	NA	NA	
Event	(Any special events)	NA	NA	

Signature of Departmental Incharge..... Nurse ..... Emp. ID..... 20262 .....

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

P No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

Date 06/11/19

DAILY NURSING ASSESSMENT SHEET

SHIFT/TIME	Morning	Evening	Night
Neurological status	A	A	A
GCS	E4V5M6	E4V5M6	E4V5M6
Mode of oxygen	RA	RA	RA
Cough	N	N	N
Dressing	NA	NA	NA
Skin status	I	I	I
Vulnerable status	N	N	N
VIP score	0	0	0
Braden Score	17	17	17
1.stage of pressure ulcer	NA	NA	NA
2.location of pressure ulcer	NA	NA	NA
Morse Fall Score	0	0	0
EWS score	0	0	0
Pain score	0/10	0/10	0/10
Signature of Nurse	Dany		
Emp. ID	30251	29485	

NEUROLOGICAL STATUS

Alert	A
Lethargic, Sleepy, easily aroused falls asleep without stimulation	L
Stupourous- Difficult to arouse kept with repeated stimuli	S
Comatose	C

DRESSING

Intact	I
Dry	D
Soaked	S

SKIN STATUS

Intact	I
Non-Intact	NC

MODE OF OXYGEN

Nasal canula	NC
Mask	M
Venturi mask	VM
BIPAP	B
Room air	RA
Ventilator	V

GLASSGOW COMA SCALE

Behaviour	Response	Score
Eye opening	Spontaneously	4
	To speech	3
	To pain	2
	No response	1
Verbal Response	Oriented to time, place & person	5
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Motor response	Obeys commands	6
	Moves to localized pain	5
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	No response	1
Total Score	Best response	15
	Comatose client	8 or less
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Cough

None	N
Productive	P
Non-productive	NP

MORSE FALL RISK ASSESSMENT

	CATEGORY	CHARACTERISTIC	SCORE
1	Level of consciousness	Knows own limits, reliable safety awareness	0
		Diminished safety awareness	15
2	History of Falls	No falls	0
		Yes	25
3	Predisposing diseases	Following Conditions: Hypotention/Vertigo/CVA/Parkinsonism/seizures/arthritis/ osteoporosis/ fractures	
		No	0
		Yes	15
4	Ambulatory aids	Ambulatory without assistance/bedrest/wheelchair	0
		Crutches/cane/walker needed	15
		Furniture used for support	30
5	Gait	Normal walking/striding without hesitation	0
		Weak walking & short, shuffled steps, lightly touching furniture for support	10
		Impaired walking with difficulty rising from chair, head down, grasps furniture	20
6	Medication	Following type of medications: anesthetics/antihistamines/cathartics/diuretics/antihypertensives antiseizure/ benzodiazepines/ hypoglycemics/ psychotropics / sedatives/ hypnotics	
		None of the medications taken	0
		Medications taken	15

SCORE FALL RISK ASSESSMENT		
Low risk 0 - 24	Medium risk 25 - 44	High risk Above 45

Vulnerable patient- any of the below considered as vulnerability

CATEGORIES					NA
Age <16 or >65	☐	Communication barrier	☐	Immunosupressed patients	☐
Any mental or neurological disability	☐	Un attended unconscious patient	☐	Victim of abuse & neglect	☐
Limited physical mobility	☐	Patient on restraint	☐	Drug/Alcohol dependent	☐

VULNERABILITY STATUS

If Yes, Action Required

☐ Place safety first Signage to patient side ☐ Ensure call bell within reach of patient

☐ Bed side rails always up ☐ 2nd hourly assessment

EARLY WARNING SIGNS

SCORE	3	2	1	0	1	2	3
RR	>35	31-35	21-30	9 to 20			<7
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Temperature		>102.2	100.4-102.2	96.8-100.2	95-96.6	93.2-94.8	<93.2
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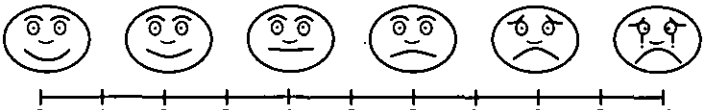
High to very high risk	
1.	Include all above mentioned points
2.	Protect sacral/perineal wounds from feaces & infected urine.
3.	Reposition every 1-2 hourly incorporate frequent small shifs in position between turns.

Score braden scale : At risk - 15-18 Moderate - 13 to 14 High risk - 10 to 12 Very high risk - 9 or less

WONG - BAKER FACIAL GRIMACE SCALE
NUMERICAL RATING SCALE



THE FLACC SCALE

CATEGORIES	0	1	2
Face	No Particular expression or smile	Occasional grimace or frown, withdrawn disinterested	Frequent to constant quivering chin clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back & forth, tense	Arched, rigid or jerking
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PAIN MANAGEMENT

Date	Shift/Time	Pain score	Quality	Location	Interventions/Comfort

COMFORT MEASURES

A	Aching	P	Positioning
B	Burning	B	Breathing
C	Crushing	ED	Education pain management
D	Dull pain	M	Massage
S	Sharp/Stabbing	ES	Emotional support
Sh	Shouting	W	Walking
T	Tingling	IP	Ice pack
TH	Throbbing & Radiating	MA	Medication Administration

LINES & DRAINS

S. No.	Type	Site / Location	Day	Remarks

PAIN ASSESSMENT TOOL BEING USED

☐ FLACC: ☐ WB ☐ NRS

NURSES HANDOVER CHECKLIST

	ELEMENTS	Morning	Evening	Night
	Patient name & ID band			
HYGIENE	Self/bed bath			
	Skin care .....hourly			
	Back Care .....hourly			
	Mouth Care .....hourly			
	Eye Care .....hourly			
	Hair Care .....hourly			
	Perineal care (for Female)			
	Any special care			
RESPIRATORY THERAPY	Foley's cath care			
	NGT care			
	Chest physiotherapy			
	Incentive Spirometery			
	Steam inhalation			
	Nebulization hourly			
	Suctioning hourly (Oral/Nasopharyngeal/ Tracheal/ Endotracheal)			
	Tracheostomy care			
	Chest tube care			
REHABIL-ITATION	Ambulation			
	Physiotherapy			
	ROM exercises			
	Repositioning hourly			
GI & GENITO URINARY	Enteral feeding hourly (NGT/PEG/J tubes)			
	Enteral tube site care			
	NG aspiration hourly			
	NPO status			
	Type of diet			
	Ostomy care			
	Enema			
	Catheterization			
	Catheter care			
	Sitz bath			
	Drain site care (JP/Penrose/Hemovac)			
OTHERS	Compress (hot/ cold)			
	Barrier/ Reverse barrier Nursing			
	Blood Transfusion			
	Care of all lines(IV/Central/Arterial/PICC)			
	Care of HD catheter			
	Flushing Intermittent infusion lock			
	Site care			
	Specimen collection			
	End of life care			
SURGICAL	Any surgery planned			
	Part preparation			
	Skin preparation			
	Pre-operative checklist complete			
	Bill clearance(for surgery or Procedure)			
	Abnormal reports/Critcal lab values			
HEALTH EDUCATION	Medications(Action/side effects/Special Instructions)			
	Diet (Type/ restrictions)			
	Infection prevention			
	Post procedure care			
	Postnatal education (for mothers)			
	Injury/ Fall prevention			
	Symptoms to seek medical help			
	Discharge education & follow up			
PEND-ING	Investigation/procedure (Mention if any)			
	Consultation (Mention if any)			
	Medications (Mention if any)			
Event	(Any special events)			

Signature of Departmental Incharge..... Emp. ID.....

1959

QRG MEDICARE LTD.
Plot No - 01, Sector 16,Faridabad-121002, Haryana
Phone:91-129-4330000 Fax:0129-4330033 Email:info@qrgmedicare.com
www.qrghealthcity.com

Date - 07/01/2019 11:16AM	UHID - 100066150
Patient name - Mrs. Neeru Maheshwari	Age/Gender - Female/41 Yr
Address - D26 GF RPS PALMS	Mobile no. - 9911108738
Department name - General Surgery	Consultant - Dr. Prabal/Dr De/Dr Sunil

NUTRITIONAL ASSESSMENT

NUTRITIONAL ASSESMENT

Admitting diagnosis :	PARA UMBILICAL HERNIA POST IOPM HERNIOPLASTY
Height (cm) :	na
Weight (kg) :	na
BMI (kg/m2) :	na
IBW (kg) :	55
Unable to stand :	uts
Nutritional status :	Normal Nourished
Type of activity :	Moderate
Food habit :	Vegetarian
Allergies and food sensitivity :	No
Dietary limitations :	No
Type of diet :	NPO
Total Calories (Kcal) :	1900
Protein (g-kgIBW) :	55
Carbohydrate (gm) :	300
Fat (gm) :	20

Diet note :

Date & Time	Dietary notes
07/01/2019@2:44PM	NPO
08/01/2019@9:55AM	SOFT DIET

Diet Consultation Done: Yes

Diet counselling given to patient's attendants given

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
1 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
No : 33-19/223 UHID : 100066150

NURSES NOTES

Patient Name Mrs. Neeru Maheshwari Age 41yr Sex F Date 06/1/19
Name of Consultant Dr. Prabal Roy Bed No. 1287

Date / Time	Notes
2/1/19 @ 11:30AM	→ patient came for Surgical Daycare with the purpose of upon Surgery today. consent taken.
	→ patient conscious and oriented.
	→ Vitals checked and recorded.
	→ No H/O of DM, HTN.
	→ patient in cannulation done. IPAC done-informed
	→ Dose medication given.
	→ all necessary investigation done. (R) done
	→ patient shift to ward @
	→ ECG, USG (R) handover to duty staff Sonia/2512
	Morning Duty Nots -
12:30pm →	✓ Received from Sonia Day Care Ward
	- Checked Vital & Regular IV fluid DNS Continue.
1:45pm	✓ Shifted OT
	✓ Cannula is present in Right hand
2pm	Inj Supacef AST given
	IV fluid DNS Continue.
	ECG Chest X-Ray in file.

Date / Time	Notes
2pm	Patient have Anxiety Xanalovese given to OT Steny Komal Doctor (30351)
	pre-op notes
7/1/19 2pm	Received pt to pre-op for Cap IPCM & CA pt conscious & oriented I.V. Canula no (A) on right hand F.U.T. N.P.O. continuing
Documents ECG-1 Chest (P)-1 Lab (12)	No H/o allergy D.M. HTN pre, consent, Clearance done pt shifted to OT. Hand over given to SIN Jaya Doda
	OT notes
7/1/19 at 3:40pm	pt Received in OT at 2:40pm to position Surgical procedure - Cap TPCM & CA procedure performed by Dr Prabal Roy & Team procedure done Ventilator - 15cm x 15cm Circular Mushroom pt shifted to RR at pt file Hand over to SIN

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/223 UHID : 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

NURSES NOTES

Patient Name Mrs Neeru maheshwari Age 41 Sex F Date 7/1/19
Name of Consultant Dr prabal Bed No. 1259

Date / Time	Notes
	Post op notes
7/1/19	⇒ Patient Received from OT after completing
@ 3:55pm	⇒ The Procedure Lap IPOM & GA
	⇒ Anesthesia given by Dr Amit Garg
	⇒ Procedure done by Dr prabal
Dauners	⇒ Patient is conscious & oriented
CCU	⇒ Vital Bs Stable
Chest (P)	⇒ NPO till 9pm Then S/D.
Abdn (P)	⇒ surgical site clean & neat
CNS (P)	⇒ no H/O DM-HTN
	⇒ no Allergy
	⇒ Pt shifted to ot Room
	⇒ Hand over given to the S/N monika
	Remya 88852 – 5:20pm
7/1/19	Evening Receiving Notes
5:20PM –	⇒ Hand over taken from OT staff. S/N Renuka
	⇒ Patient Conscious & oriented
	⇒ Vitals Checked & Recorded
	⇒ Patient NPO on 9Pm after that liquid diet thereafter that Soft diet
	⇒ IV @ DNS/RL @100ml/hr on Flow
6:30Pm –	⇒ DNS IV Fluid Changed.
	⇒ vitals Checked & Recorded
7 Pm	⇒ Dr. Ahmed rounds done & Plan Discharge Tomorrow.

Date / Time	Notes
8pm	→ Hand over given to Night duty Staff S/N Mini

Incharge
29435

07/11/19.
8pm

Night duty notes

Introduction

Patient handovered taken bun evening duty staff Nanika.

IV line Dsin

IV line Present
Diet → Soft diet
Ballegxemed

patient admitted under doctor present

Diet

Liquid → Soft diet.

Assessment

9.30pm → Patient Consciously oriented.
→ 22 Canula, ID band present
→ Patient having Normal diet
→ Patient body Cap Pom done.
→ Clm Plan discharge
→ IV Fluid stopped.

QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

NURSES NOTES

Patient Name Mrs. Neeru maheshwari Age 41yrs Sex F Date 07/1/19

Name of Consultant Dr. Prabal Roy Bed No. 1259

Date / Time	Notes
10am	→ Vitals checked and recorded.
11.20pm	→ Patient wife pressed.
1pm	→ Patient had effective therapy well
3pm	→ patient sleeping well No fresh Complaints
5pm	→ sponge done
6pm	→ Vitals shall be recorded.
	→ Due medications given to the Patient
8pm	→ Now no fresh Complaints.
	Reassessment
	Now no fresh Complaints. pain pain
	events
	NO events.
8.30pm	→ I/c handover given to morning duty S/N Neethy
08/01/19	Morning Note
	Introduction
	patient received over taken from Night duty staff mini and the patient is conscious and oriented to time & place
	IV Cannula is present and Re site

Date / Time	Notes
→	Assessment
	patient have done ~~ORIF~~ RPFN + HD yesterday and the patient is conscious and oriented
→	patient Vitals checked and Recorded and given medications given as prescribed
→	Brief
	patient is c/o/c/o
	Background
	patient is admitted c/o. Abdominal pain related to Hernia
	Reassessment
→	Scan thereby no Swelling observed by Dr discharge today NO respiratory pain
	Event :- NO Event
→	Billing sheet and Clearance awaited
→	patient ID Band IV Cannula Removed and patient left the ward at 8pm

Jeelbs
26/08/23

QRG/HC/IPD/Frm/20.14/ED2017/V1.0/Rev00

QRG Health City

Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/225 UHID : 100001130
Mrs. Neeru Maheshwari DOA : 07/01/201911:16
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

PATIENT AND FAMILY EDUCATION FORM

Pt. Name Mrs. Neeru maheshwari Age / Sex 41/F UHID No. 100001130

Litracy Level	Preferred Language	Special Religious Considerations
1. Illiterate ☐	1. English ☐	1. Yes ☐
2. Under Graduate ☐	2. Hindi ☐	2. No ☐
3. Graduate ☐	3. Other specify	3. Other specify .....
4. Post Graduate ☐	.....	.....
5. Health Care Literacy ☐	.....	.....

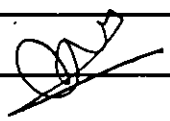
Emotional Barrier / Physical Limitations		Motivations	Ability to Learn	Willingness
1. None ☐	1. Anxiety ☐	1. Motivated ☐	1. Able to modify Behaviour ☐	1. Willing to learn ☐
2. Disinterest ☐	2. Pain / Discomfort ☐	2. Partially Motivated ☐	2. Able to retain Information ☐	2. Unwilling ☐
3. Cognitive Impairment ☐	3. Language Barrier ☐	3. Not Motivated ☐	3. Unclear at this time ☐	3. Unable to learn ☐
4. Cultural Barrier ☐	4. Privacy Concern ☐			
☐				

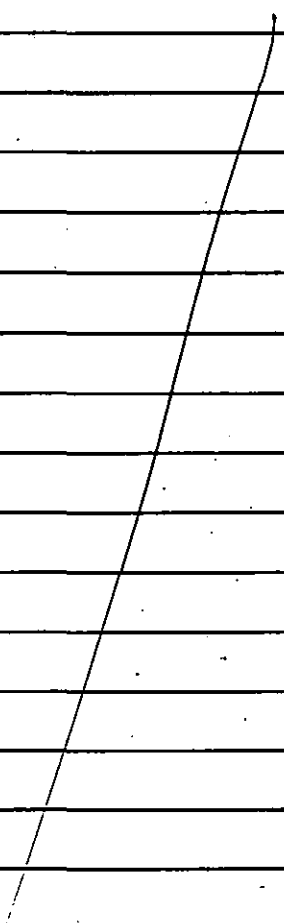
Learning Needs	Interventions to Reduce Barrier	Teaching Method	Outcomes
1. Treatment plan ☐	1. None ☐	1. Demonstration ☐	1. Understood ☐
2. Safe use of Medication / Equipment ☐	2. Limit Content ☐	2. Discussion ☐	2. Not Understood ☐
3. Vulnerable Patient ☐	3. Obtain Translator ☐	3. Handouts ☐	3. Requires additional Information / Training ☐
4. Dietary Intervention ☐	4. Review / Repeat ☐		
5. Fall Prevention ☐	5. Teach Family ☐		
6. Drug food Interaction ☐	6. Other ☐		
7. Pain Management ☐			
8. Disease specific (Surgery specific, informed consent, Procedure) ☐			
9. Rehab Techniques ☐			
10 Infection Control Practices ☐			
11. Others			
.....			

12. Room Orientation Done Yes ☐ No ☐
13. Patient Information Booklet Briefed Yes ☐ No ☐
14. Transportation Need Yes ☐ No ☐
15. Information on delay of treatment (if any) Yes ☐ No ☐ Specify.....
16. Reason for delay.....
17. Alternative Treatment suggested .....

Medications

M - Medication history to be Collected
O - Over the Counter drug restrictions
N - NO Skipping adding / doses
I + Interactions drug / - drug.
T - Therapeutic system
O - Outstanding orders
R - Reassurance for adherence.





QRG Health City

Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

Mrs. Neeru Maheshwari DOA : 07/01/201911:16
1 Y/F SINGLE WARD 2ND FLOOR/S1259
r. Prabal Roy

No : 33-19/223 UHID : 100066150

VALUABLE HANDOVER FORM

Patient Name Mrs. Neeru Maheshwari Age 41 Sex F Date 7/1/19

DOA No. 7/1/19 IPD No. 33-19/223

Diagnosis Unit Semi Deluxe 2nd wing

Money	Y / (N)	Old Medical Record	Y / (N)
Wallet	Y / (N)	Old X-Rays / CT Scan / MRI Film	Y / N
ID Card	Y / (N)	Clothing	(Y) / N
Mobile Phone	Y / (N)	Shoes	(Y) / N
Nackless / Chain	Y / (N)	Hearing Adis	Y / (N)
Bangles	Y / (N)	Spectacles	Y / (N)
Finger Ring	Y / (N)	Keys	Y / (N)
Watch	Y / (N)	Ladies Purse	Y / (N)
Cosmetic	Y / (N)	Any Other Thing	Y / (N)

NOTE : FOR JEWELLERY PLEASE SPECIFY EACH ITEM AS BLACK, WHITE & YELLOW METAL

Handed Over By :

Name of Assigned Staff Soniya ID 2010 Sign

Received By :

Name of Patient Date Sign

Name of Attendant Manish Maheshwari Relationship Husband Sign

Date 7/1/19 Time 1.2pm

HOURLY ROUND LOG

Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy
IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1

DATE: 07/1/19. Legends: Mark (Y) for Yes & (N) fc

TIME PERIOD	STAFF INITIALS	TIME OF ROUND	PAIN	POSITION	POTTY	POSSESSIONS	PERSONAL NEEDS	COMMENTS (* If patient is sleeping)
EVERY 1 HOUR ROUNDS (7AM - 10PM)								
7AM								
8AM								
9AM								
10AM								
11AM								
12N								
1PM								
2PM								
3PM								
4PM								
5PM	Monika	5pm	Y	N	N	N	N	
6PM	Monika	6pm	Y	N	N	N	N	
7PM	Monika	7pm	N	Y	N	Y	Y	
8PM	Monika	8pm	N	Y	N	Y	N	
9PM	Mini	9pm	N	N	N	N	N	
EVERY 2 HOUR ROUNDS (10PM - 6AM)								
10PM	Mini	10pm	Y	N	N	N	N	
12AM	Mini	12 AM	N	N	N	N	N	
2AM	Mini	2am	N	N	N	Y	N	
4AM	Mini	4am	N	N	N	N	N	
6AM	Mini	6am	N	N	N	N	N	
CHECKED BY:								VERIFIED BY:
STAFF NURSE NAME(MORNING):				SIGN:				NURSING INCHARGE (Name & Emp I.D.)
EMP I.D.:								
STAFF NURSE NAME(EVENING):	Monika			SIGN:				Nirmala 30363
EMP I.D.:								
STAFF NURSE NAME(NIGHT):	Mini			SIGN:				
EMP I.D.:	28445							

QRG Health City

QRG MEDICARE LTD.

Basement-02, Block-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D

GST No. : 06AAACQ[illegible]8D1ZW

DL No . 4150-OB,4150-B,4149-X
HR-770700-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/223	**Issue No**	: H0138619/78105
Patient Name	: Mrs. Neeru Maheshwari	**Date/Time**	: 07/01/2019 6:17PM
UHID	: 100066150	**Ward/Bed No**	: SINGLE WARD 2ND FLOOR/S1259
Sponsor	: RELIGARE HEALTH INSURANCE -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Prabal/Dr De/Dr Sunil (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77434	**Indent Date**	: 07/01/2019 6:09PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	DYNATROY AQ INJ (SUB OF :- DYNAPER-AQ INJ)-(NOS)	30049066	D105565	TROIKAA	30/08/2020	27.66		4	110.64	0.00	110.64
2	NEXPRO INJ-(NOS)	30049039	K676E003	TORRENT	30/12/2019	102.60	4	4	410.40	0.00	410.40
3	DNS 500ML FLEXIDRIP-(NOS)	30045020	2183393	CLARIS OTSUKA PVT. LTD.	30/06/2021	72.21	2	2	144.42	0.00	144.42
4	NS 100ML FLEXIDRIP-(NOS)	3004	2184661	CLARIS OTSUKA PVT. LTD.	30/09/2021	35.52	3	3	106.56	0.00	106.56
5	IV SET (POLYMED) (SUB OF :- IV SET)-(NOS)	9018	4141018M		30/10/2023	129.00		1	129.00	0.00	129.00

Checked By :

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar

Printed Date : 07/01/2019 18:17 PM

QRG Health City

QRG MEDICARE LTD.

Basement-03, Block-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

DL No . 4150-OB,4150-B,4149-X
HR-770700-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/223	**Issue No**	: H0138619/78105
Patient Name	: Mrs. Neeru Maheshwari	**Date/Time**	: 07/01/2019 6:17PM
UHID	: 100066150	**Ward/Bed No**	: SINGLE WARD 2ND FLOOR/S1259
Sponsor	: RELIGARE HEALTH INSURANCE -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:		
Remarks	:	**Doctor Name**	: Dr. Prabal/Dr De/Dr Sunil (QRG MEDICARE LTD.)
Indent No	: 77434	**Status**	: Post
		Indent Date	: 07/01/2019 6:09PM

6	SYRINGE DISPOSABLE 5ML (B.D) (SUB OF :- DISPOVAN SYRINGE 5ML)-(NOS)	90183100	18J0881		30/08/2023	15.50		5	77.50	0.00	77.50
7	SYRINGE DISPOSABLE 10ML (B.D) (SUB OF :- DISPOVAN SYRINGE 10ML)-(NOS)	90183100	18K0181		30/09/2023	21.00		4	84.00	0.00	84.00
8	BACTILEM INJ 1.5GM (SUB OF :- SUPACEF 1.5GM)-(NOS)	30042019	Z01CT180 04		30/08/2020	338.20		3	1014.60	0.00	1014.60
9	RL 500ML FLEXIDRIP-(NOS)	30045020	2183320		30/06/2021	47.69	4	4	190.76	0.00	190.76

Sub Total : 2267.88 **Disc Amount : 0.00** **Net Bill Amount : 2267.88**

Checked By :

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar Printed Date : 07/01/2019 18:17 PM

IP No : 33-19/223 UHID: 100066150
Mrs. Neeru Maheshwari DOA : 07/01/201911:1
41 Y/F SINGLE WARD 2ND FLOOR/S1259
Dr. Prabal Roy

IP No : 33-19/223 UHID: 100066150

HOURLY ROUND LOG

DATE: 08/1/19

Legends: Mark (Y) for Yes & (N) for No

TIME PERIOD	STAFF INITIALS	TIME OF ROUND	PAIN	POSITION	POTTY	POSSESSIONS	PERSONAL NEEDS	COMMENTS (* If patient is sleeping)
EVERY 1 HOUR ROUNDS (7AM - 10PM)								
7AM	Mini	7 Am.	Y	N	N	N	Y	
8AM	Mini	8am	N	N	N	N	N	
9AM	Neelu	9am	N	N	N	N	N	
10AM	Neelu	10am	N	N	N	N	N	
11AM	Neelu	11am	N	N	N	N	N	
12N	Neelu	12N	N	N	N	N	N	
1PM	Neelu	1Pm	N	N	N	N	N	
2PM	Neelu	2Pm	N	N	N	N	N	
3PM	Neelu	3Pm	N	N	N	N	N	
4PM	Neelu	4Pm	N	N	N	N	N	
5PM	Neelu	5Pm	N	N	N	N	N	
6PM	Neelu							
7PM								
8PM								
9PM								
EVERY 2 HOUR ROUNDS (10PM - 6AM)								
10PM								
12AM								
2AM								
4AM								
6AM								

CHECKED BY: VERIFIED BY:

STAFF NURSE NAME(MORNING): Neelu
EMP I.D.: 26033
SIGN: Neelu 26033

STAFF NURSE NAME(EVENING): Neelu
EMP I.D.: 26033
SIGN: Neelu 26033

STAFF NURSE NAME(NIGHT):
EMP I.D.:
SIGN:

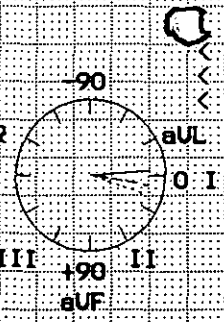
NURSING INCHARGE (Name & Emp I.D.)
Nirmala 30363

CHECKLIST FOR ADMISSION

A	PRESCRIPTION /ADMISSION REQUEST	✓
B	TIME AND DATE	✓
C	REGISTRATION FORM (IF NON -REGISTERED)	✓
D		✗
E	TPA DOCUMENT	✓
F	COUNSELLING	✓
G	PENDING DOCUMENTS (IF ANY)	✓
H	PASSES (ATTD./VISITOR)	✓

HR 00bpm

Measurement Results:			
QRS		78	ms
QT/QTcB	348 /	410	ms
PR		138	ms
P		92	ms
RR/PP	722 /	725	ms
P/QRS/T	20/ -5/	10	degrees
QTD/QTcBD:	36 /	42	ms
Sokolow			mV
NK		12	

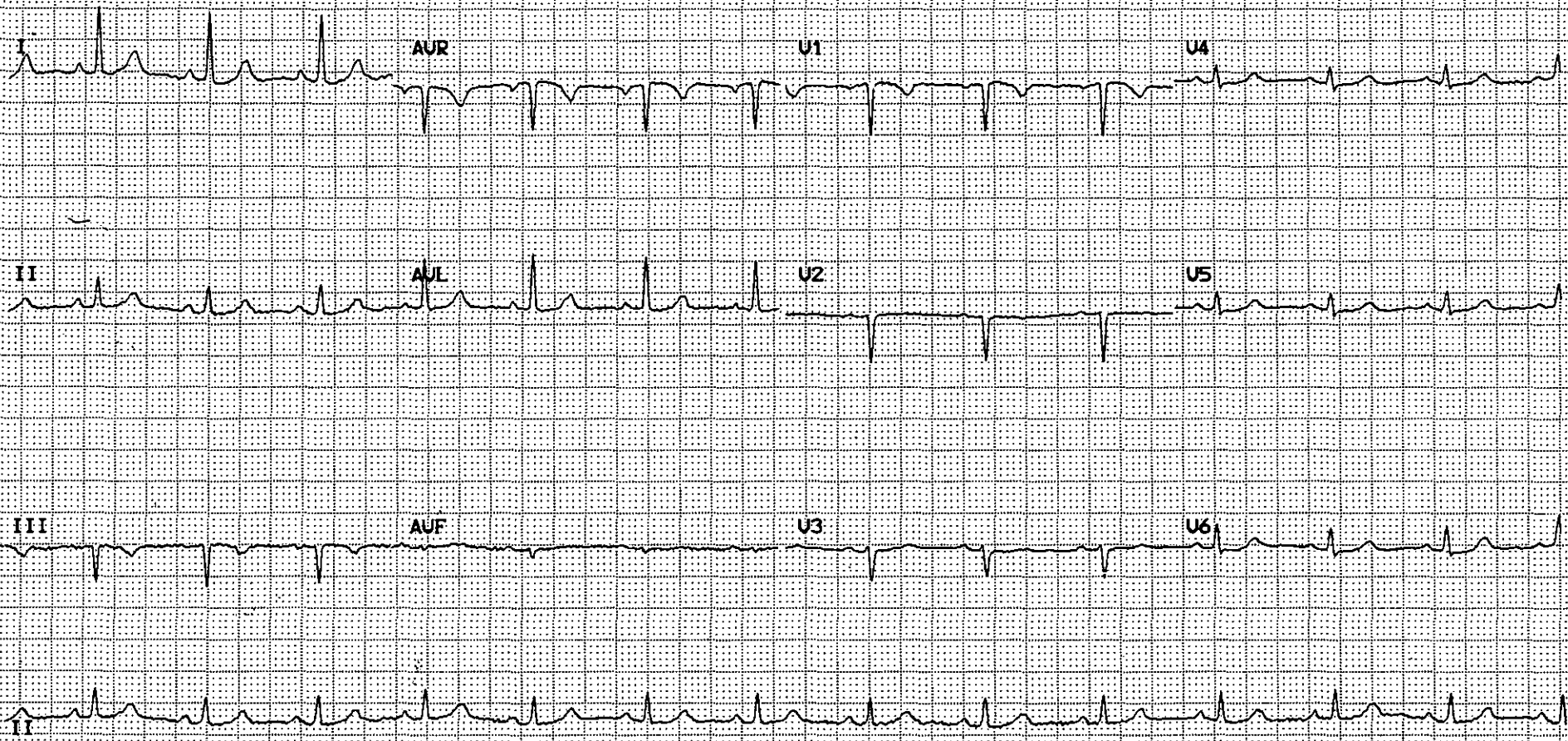


Interpretation:

low QRS amplitudes
probably abnormal ECG

No : 33-19/223 UHID : 100066150
S. Neeru Maheshwari DOA : 07/01/201911:16
Y/F SINGLE WARD 2ND FLOOR/S1259 -
Prabal Roy

Unconfirmed report.



Jan/01/2001 00:05:34 25mm/s 10mm/mV ADS 50Hz 0.08 - 20Hz 3_F1_R Automatic V6.2 121 (1)

DEPARTMENT OF RADIODIAGNOSIS & IMAGING

Patient Name	Mrs. Neeru Maheshwari	**Lab No/ManualNo**	827394/
UHIDNo/IPNO	100066150 / 33-19/223	**Order Date**	07/01/2019 11:44AM
Age/Gender	41 Yrs/Female	**Receiving Date**	07/01/2019 12:25PM
Bed No/Ward	SINGLE WARD 2ND FLOOR	**Report Date**	08/01/2019 11:54:AM
Referred By	Dr. Prabal/Dr De/Dr Sunil	**Report Status**	Final

X-Ray

XRAY CHEST PA

Investigation: X-Ray - Chest PA View

No focal lesion seen in the lung parenchyma.

CP angles and domes of the diaphragm are normal.

Cardiac size and configuration is normal.

Trachea is central; no mediastinal shift is seen.

IMPRESSION: No abnormality detected.

Please correlate clinically.

End Of Report

Dr. Vaibhav Pandey
MBBS, MD Radio Diagnosis
Associate Consultant

Note :For the perusal of medical professional only. The Content of this report is only an opinon on image and is therefore subject to inherent technical limitation.It is not the diagnosis & must be correlated clinically. NOT FOR MEDICOLEGAL PURPOSES.

MC-2922
NABL ACCREDITED

827394

DEPARTMENT OF LABORATORY SERVICES

Patient Name	Mrs. Neeru Maheshwari	**Lab No/ManualNo**	827394/
UHIDNo/IPNO	100066150 / 33-19/223	**CollectionDate**	07/01/2019 11:44
Age/Gender	41 Yrs/Female	**Receiving Date**	07/01/2019 12:08
Bed No/Ward	SINGLE WARD 2ND FLOOR	**Report Date**	07/01/2019 12:44
Referred By	Dr. Prabal/Dr De/Dr Sunil	**Report Status**	Final

Haematology

COMPLETE BLOOD COUNT (CBC) EDTA WHOLE BLOOD — Sample: EDTA

Test Name		Result	Unit	Biological Ref. Range	Method
Hematocrit/PCV		39.8	%	36.0 - 46.0	Pulse height detection
Haemoglobin		13.2	g/dL	12.0 - 15.0	SLS Method
RBC COUNT		4.71	10^6/µL	3.80 - 4.80	Hydrodynamic focussing impedance
MCV		84.5	fl	83.0 - 101.0	Calculated
MCH		28.0	pg	27.0 - 32.0	Calculated
MCHC		33.2	g/dL	31.5 - 34.5	Calculated
RDW	H	**14.4**	%	11.6 - 14.0	Calculated
Platelet count	H	**460**	10^3/µL	150 - 410	Hydrodynamic focussing impedance
TLC		7.6	10^3/µL	4.0 - 10.0	Flow Cytometry
Differential Leucocyte Count					
Neutrophils		72	%	40 - 80	Fluorescence flow cytometry/Microscopic
Lymphocytes	L	**19**	%	20 - 40	Fluorescence flow cytometry/Microscopic
Monocytes		7	%	2 - 10	Fluorescence flow cytometry/Microscopic
Eosinophils		2	%	1 - 6	Fluorescence flow cytometry/Microscopic
Basophils		0	%	0 - 2	Fluorescence flow cytometry/Microscopic

Interpretation:-
Complete blood count (CBC) is used to evaluate overall healthand detect a wide range of disorders, including anemia, infection and leukemia.A complete blood count test measures several components and features of blood,including: Red blood cells, which carry oxygen, White blood cells, which fightinfection, Hemoglobin, the oxygen-carrying protein in red blood cells,Hematocrit, the proportion of red blood cells to the fluid component, orplasma, in blood, Platelets, which help with blood clotting, Abnormal increaseor decrease in cell counts as revealed in a complete blood count may indicatethat an underlying medical condition that calls for further evaluation

End Of Report

Dr. Gurdeep Singh
MBBS, MD, DNB(PATHOLOGY)
HOD-LAB Medicine & Surgical Pathology

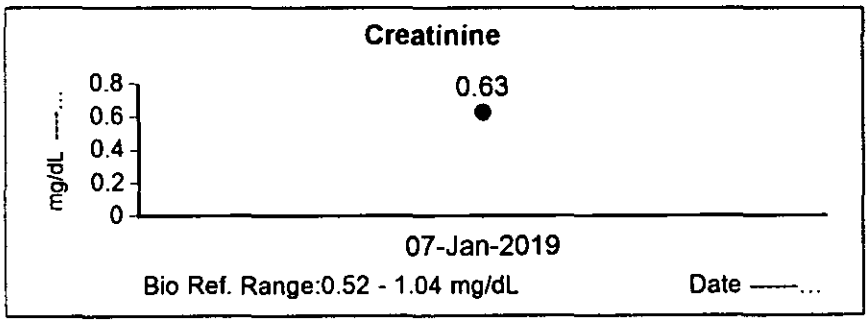
MC-2923
NABL ACCREDITED

827394

DEPARTMENT OF LABORATORY SERVICES

Patient Name	Mrs. Neeru Maheshwari	**Lab No/ManualNo**	827394/
UHIDNo/IPNO	100066150 / 33-19/223	**CollectionDate**	07/01/2019 11:44
Age/Gender	41 Yrs/Female	**Receiving Date**	07/01/2019 12:08
Bed No/Ward	SINGLE WARD 2ND FLOOR	**Report Date**	07/01/2019 02:41
Referred By	Dr. Prabal/Dr De/Dr Sunil	**Report Status**	Final

Test Name	Result	Unit	Biological Ref. Range	Method
Biochemistry				
SERUM CREATININE				Sample:
Creatinine	0.63	mg/dL	0.52 - 1.04	Enzymatic method



Interpretation:-
Serum creatinine and urinary creatinine excretion is a function of lean body mass in normal persons and shows little or no response to dietary changes. The serum creatinine concentration is higher in men than in women. Since urinary creatinine is excreted mainly by glomerular filtration, with only small amounts due to tubular secretion, serum creatinine and a 24-hour urine creatinine excretion can be used to estimate the glomerular filtration rate.Serum creatinine is increased in acute or chronic renal failure, urinary tract obstruction, reduced renal blood flow, shock,dehydration, and rhabdomyolysis. Causes of low serum creatinine concentration include debilitation and decreased muscle mass. common in the elderly, in the bedridden, and in patients with advanced malignancy.

End Of Report

Dr. Neha Rathor
MBBS,DNB
Consultant Microbiologist

MC-2923
NABL ACCREDITED

827394

DEPARTMENT OF LABORATORY SERVICES

Patient Name	Mrs. Neeru Maheshwari	**Lab No/ManualNo**	827394/
UHIDNo/IPNO	100066150 / 33-19/223	**CollectionDate**	07/01/2019 11:44
Age/Gender	41 Yrs/Female	**Receiving Date**	07/01/2019 12:08
Bed No/Ward	SINGLE WARD 2ND FLOOR	**Report Date**	07/01/2019 02:01
Referred By	Dr. Prabal/Dr De/Dr Sunil	**Report Status**	Final

Test Name	Result	Unit	Biological Ref. Range	Method
Serology				
HIV I & II				
HIV I & II , Serum	NON REACTIVE.			

Interpretation:-
A REACTIVE TEST INDICATES PRESENCE OF ANTIBODIES TO HIV 1&2.
A non-reactive result indicates absence of antibodies to HIV 1&2 as testedby this assay. However, such a result does not totally preclude the possibilityof exposure to HIV.
Uses of the assay:
(1) To screen current and past infection with HIV 1&2.
(2) Blood units for evidence of HIV 1&2 INFECTION.
Causes of false- positive results
(1) Autoimmune diseases/states
(2) Multiple blood transfusions.
(3) Antibody to class 2 HLA Ag (HLA-DR4)
(4) Hypergammaglobutinemia/agammaglobutinemia
(5) Antipolystyrene antibodies
(6) Chronic alcoholism
(7) Immunization for (HBV)
(8) Technical error etc.
Cause of false -negative results:
(1) Early acute HIV infection (window period)
(2) Late stage HIV disease/AIDS (immune collapse)
(3) Technical errors etc.
Human immunodeficiency virus (HIV) is non-transforming human RNA virus belonging to family Reteroviridae. Genetically, the virus is of two types HIV1and2, and both are the cause of Acquired immune deficiency syndrome (AIDS).HIV is transmitted sexual contact, exposure to blood/blood products, and prenatal infection of a fetus or perinatal infection of the newborn.
NOTE- The results of serological assay in themselves should not be the only reason for any therapeutic consequences. They should always be assessed in conjunction with the patient history, clinical observation and other diagnostic test.
HIV positive results confirmed by two method ELFA/ELISA
Note :The report is being issued after post test counselling
Note:This is just a screening test not a confirmatory test. All the reactive results should be supplemented by confirmatory test such as western blot,HIV PCR etc. This report is not for medico legal purpose

End Of Report

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Test Name	Result	Unit	Biological Ref. Range	Method

Serology

HBSAG

HBsAG Result	NEGATIVE			

Sample Type : Serum

Interpretation:-

A **Positive** result indicates presence of HBsAg as tested by this assay.

A **Negative** result indicates absence of HBV surface antigen (HBsAg) as tested by this assay.

However such a result does not totally preclude the possibility of exposure to HBV infection. The above assay is an immunochromatography for the qualitative determination of HBsAg in the serum and plasma. Hepatitis B virus (HBV) is DNA virus belonging to the family Hepadnaviridae. The principle modes of transmission of the virus include perinatal acquisition (from mother to the newborn) and sexual transmission. HBsAg is a complex antigen found on the surface of HBV and was formerly designated as the Australian Antigen. It can be detected in acute as well as chronic infection with HBV. In acute viral hepatitis, it appears in the blood before onset of symptoms, peaks during overt disease and then declines to undetectable levels in about 3 to 6 months. Presence of HBsAg for at least 6 months is indicative of progression to chronic hepatitis.

NOTE- The results of serological assay in themselves should not be the only reason for any therapeutic consequences. They should always be assessed in conjunction with the patient history, clinical observation and other diagnostic test.

This is just a screening test and all positive results should be confirmed by supplemental serological assays or PCR for HBV.

End Of Report

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Test Name	Result	Unit	Biological Ref. Range	Method
Serology				
ANTI-HCV				
HCV Result	NON REACTIVE.			

Sample Type : Serum

Interpretation:-

A NON-REACTIVE TEST INDICATES ABSENCE OF ANTIBODIES TO HCV.

A REACTIVE TEST INDICATES PRESENCE OF ANTIBODIES TO HCV.

LIMITATIONS-

This test is only a screening test, Further confirmation, should be done either with supplemental serological assay e.g. RIBA, or preferably with RT - PCR for HCV RNA. A reactive result indicates the presence of antibodies to HCV as tested by this assay, these antibodies may developed due to either a recent or past infection with HCV. A non- reactive result indicates absence of antibodies to HCV as tested by this assay. However it does not rule out the possibility of the infection with HCV. Hepatitis C virus (HCV) is an enveloped RNA virus belonging to the family Flaviviridae. The principle mode of acquisition of the virus are transfusion of HCV contaminated blood and intravenous drug needle sharing less common / rarer modes of acquisition include sexual transmission and transfer of the virus from a pregnant mother to her foetus. About 15% patient who acquire HCV are able to clear the virus completely and never develop clinical disease. The remaining 85% develop chronic infection (HEPETITIS), but most of these patient remain asymptomatic. A fraction (about 20%) of these chronically infected patient develop hepatic cirrhosis. Detectable antibodies to HCV develop in about 10-12 weeks after acquiring infection with HCV.

NOTE- The results of serological assay in themselves should not be the only reason for any therapeutic consequences. They should always be assessed in conjunction with the patient history, clinical observation and other diagnostic test.

End Of Report

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Referred By	Dr. Prabal/Dr De/Dr Sunil	**Report Status**	Final

Test Name	Result	Unit	Biological Ref. Range	Method
		Coagulation		
PROTHROMBIN TIME (PT INR) PLASMA				Sample: PLASMA (CIT
PT Test	10.9	Sec	9.9 - 13.1	Turbodensitometric
Control	11.2	Sec		
INR (International Normalized Ratio)	0.97			

Interpretation:-
Prothrombin Time measures the integrity of the extrinsic pathway and the adequacy of critical coagulation factors involved in it, namely, Factor VII. This test is therefore, used for monitoring oral anticoagulation therapy which lowers the levels of multiple vitamin K dependent coagulation factors in blood (Factors II, VII, IX and X) including Factor VII. The result of PT is expressed as International Normalized Ratio (INR) to neutralize the influence of variable sensitivity of the reagents (thromboplastin) used in the assay by different laboratories. Prolonged PT/INR is observed ir hereditary or acquired deficiency of the relevant coagulation factors, vitamin K deficiency, liver disease, specific coagulation factor inhibitors and nonspecific inhibitors of PT (eg, monoclonal immunoglobulins, elevated fibrin degradation products).

End Of Report

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