10.1.19 - 19/257

FHPL-PA-FT-02

Authorization Letter

Authorization Letter to the Hospital for the Treatment and Guarantee of Payment Valid for Admission before 14 Jan 2019.

FHPL

website:www.fhpl.net
Email: info@fhpl.net

To,
Qrg Health City (A Unit Of Qrg Medi Care Ltd)
Plot No:1, Sector-16, ,
Faridabad

Date : 10/01/2019
PA.No : 1049080/2

Organisation Name : Barclays Technology Center India Pvt Ltd : Parents

We are in receipt of the Admission / Pre Authorization request note with the following information :

Name of the patient	**Rakesh Verma**	UHID No	**UIIC.18450978**
Age	**56 Years**	Gender	**Male**
Room Board Category under	**ICU**	For(Ailment)	**CAD,PTCA**
We hereby authorize and guarantee for Payment up to (in figures) Rs.			**172608.00/-**
(In Words)	**One Lac Seventy Two Thousand Six Hundred Eight Only**		
The Probable Date of Admission is	**07/01/2019**		

Hospital Alert

1) If the hospital bill is estimated to be higher that the guarantee of payment, a request letter for additional amount needs to be sent to us. If no further guarantee is available, the hospital must collect the excess amount directly from the beneficiary at the time of admission / prior to discharge from the Hospital, as per Hospital Rules and Regulations.

2) FHPL will not be liable for payment to the Hospital in the event of the facts presented by the Hospital / Insued during the preauthorization are found to be incorrect/revised.

3) The Claim settlement would be as per the Tariff Discounts contracted in the Network agreement.

4) Please ensure to collect the charges pertaining to non-payable items. Please visit www.fhpl.net for list of non-payable items.

5)Please ensure to collect Copayment Rs. 34521 from the member.

Doctors Note :

Covered for CAG+PTCA .20% Copayment Applicable on Each & Every Claim.Room rent limit restricted upto 6000/- for Normal & 8000/-for ICU. Associated costs (excluding medicine charges) to be paid in Proportion to Room rent Capping.

For Billing : Please send the following Documents Within 7 days from the discharge of patient.

1) Enclose Photo ID card copy of the patient. 2) ARN(Admission Request Note). 3) Approval copy.
4) Hosp.bill summary with final bill showing details of units of each service(Authenticated by the patients signature.)
5) Discharge summary and reports of all Investigations(Original),prescription of Medicines.
6) The Above payment is subject to applicable TDS. 7) Enclose a copy of receipt given to patient for the amount paid by him.
8) Claim form of **United India Insurance Co. Ltd**
9) GIPSA declaration form on the hospital letter head filled by the patient/patient's attendants.

Dr.Dheeraj Kumar Tanwar
Authorized By

Date : 1/10/2019 11:43:46 AM

Disclaimer:The cashless access in FHPL network of Hospitals merely a facility extended by your health coverage payer. FHPL/Payer does not guarantee the availability, quality & outcome of the treatment. Choosing of a network or a non-network hospital is prerogative of the patient/Insured.

Please note that Admission only for Investigations and evaluations are not payable

Undertaking by the patient

I authorize the hospital/provider to submit the attested Indoor Case Papers(Case Sheet) & any other documents/information related to my treatement to FHPL if ask for.

Important: Please note that as stipulated by IRDAI all Network Providers should mandatorily register themselves with the Hospital Register "ROHINI" maintained by the Insurance Information Bureau (IIB), unless which the Hospitals cannot be a part of the network and Cashless Facility also cannot be extended to the Un-Registered Hospitals. You are hence requested to log on to https://rohini.iib.gov.in/ and complete the Registration at the earliest. Please ignore if you have already registered.

Sunita Verma
Signature of the Patient/Insured

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

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

(To be filled in block letters)

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:

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/ Health Insurance: Yes No

b) Date of commencement of first insurance without break:

c) If yes, company name:

Policy No:

Sum Insured (`.)

d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

Diagnosis:

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

f) If yes, Company Name :

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : Male Female c) Age: years months d) Date of Birth:

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

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

g) Address (If different from above):

City:

State:

Pin Code:

Phone No:

Email ID:

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:

e) Date of Admission: f) Time: g) Date of Discharge: h) Time:

i) If Injury, give cause: Self Inflicted Road Traffic Accident Substance abuse / Alcohol Consumption I. If Medico Legal: Yes No

k. Reported to police: Yes No III. MLC Report & Police FIR attached: Yes No j) System of medicine:

DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre Hospitalization Expenses

ii. Hospitalization Expenses

iii. Post Hospitalization Expenses

iv. Health Check up Cost

v. Ambulance Charges

vi. Others (code):

Total

vii. Pre hospitalization period: days

viii. Pre 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:

ii. Surgical Cash:

iii. Critical Illness Benefit:

iv. Convalescence:

v. Pre/Post hosp. Lump sum benefit:

vi. Others:

Total

Claim Documents Submitted- Check List:

- Claim FormDuly signed
- Copy of the claim intimation, if any
- Hospital Main bill
- Hospital Break-up bill
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT / MRI / USG / HPE)
- Doctor's Prescription
- Others

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (`)
1				Hospital Main Bill	
2				Pre hospitalisation Bills: ___ Nos	
3				Post hospitalisation Bills: ___ Nos	
4				Pharmacy Bills:	
5					
6					
7					
8					
9					
10					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN:

b) Account Number:

c) Bank Name and Branch

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

SECTION G

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

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this 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 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.

Date: Place: Signature of the Insured: Sunita Verma

SECTION H

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	License 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 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 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 admitted	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 Expenses	Enter the amount claimed as treatment expenses	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 benefit 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 amounts 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
d) 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
e) 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 admission of liability

Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

DETAILS OF HOSPITAL — SECTION A

a) Name of the Hospital:

c) Hospital ID: d) Type of Hospital: Network: ☐ Non Network: ☐ (if non network, fill Section E)

d) Name of the treating doctor:

e) Qualification: f) Registration No. with state code: g) Phone No.:

DETAILS OF PATIENT ADMITTED — SECTION B

a) Name of Patient:

b) IP Registration No.: c) Gender: Male ☐ Female ☐ d) Age: years months e) Date of Birth:

f) Date of Admission: g) Time: : h) Date of Discharge: i) Time: :

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity: l) Date of Delivery: ll) Gravida Status:

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

DETAILS OF AILMENT DIAGNOSED (PRIMARY) — SECTION C

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 ☐

ii. If injuries 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 - CHECKLIST — SECTION D

- ☐ 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/ HPE/ Investigation reports
- ☐ Doctor's reference slip
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital, where applicable
- ☐ Any other, please specify

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL) — SECTION E

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:

DECLARATION BY THE HOSPITAL — SECTION F

(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, suppress or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature of the Insured: Sunita Verma

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 Hospital	Enter the name of hospital	Name of 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
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications 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 hospital	Name of hospital 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 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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
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 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS 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 doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted 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 INSURED		
Read declaration carefully and mention date (in dd.mm.yy format), place (open text) and sign.		

FHPL-PA-FT-02

Authorization Letter

Authorization Letter to the Hospital for the Treatment and Guarantee of Payment Valid for Admission before 14 Jan 2019.

FHPL

To,
Qrg Health City (A Unit Of Qrg Medi Care Ltd)
Plot No:1, Sector-16, ,
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Date : 07/01/2019
PA.No : 1049080/1

Organisation Name : Barclays Technology Center India Pvt Ltd : Parents

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Name of the patient	**Rakesh Verma**	UHID No	**UIIC.18450978**
Age	**56 Years**	Gender	**Male**
Room Board Category under	**ICU**	For(Ailment)	**CAD,PTCA**
We hereby authorize and guarantee for Payment up to (in figures) Rs.			**10000.00/-**
(In Words)	**Ten Thousand Only**		
The Probable Date of Admission is	**07/01/2019**		

Final Bill Attached

Hospital Alert

1) If the hospital bill is estimated to be higher that the guarantee of payment, a request letter for additional amount needs to be sent to us. If no further guarantee is available, the hospital must collect the excess amount directly from the beneficiary at the time of admission / prior to discharge from the Hospital, as per Hospital Rules and Regulations.

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4) Please ensure to collect the charges pertaining to non-payable items. Please visit www.fhpl.net for list of non-payable items.

5)Please ensure to collect Copayment Rs. 0 from the member.

Doctors Note : KARAN KUMAR VERMA (9990976447) (9350492542)
covered for CAG .20% Copayment Applicable on Each & Every Claim.Room rent limit restricted upto 6000/- for Normal & 8000/-for ICU. Associated costs (excluding medicine charges) to be paid in Proportion to Room rent Capping.

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6) The Above payment is subject to applicable TDS. 7) Enclose a copy of receipt given to patient for the amount paid by him.
8) Claim form of **United India Insurance Co. Ltd**
9) GIPSA declaration form on the hospital letter head filled by the patient/patient's attendants.

Dr.Rupali Sahdev
Authorized By

Date : 1/7/2019 5:00:52 PM

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I authorize the hospital/provider to submit the attested Indoor Case Papers(Case Sheet) & any other documents/information related to my treatement to FHPL If ask for.

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Signature of the Patient/Insured

PCL no:- 500700261701929257 5.0

PLEASE ~~FAX~~ / SCAN PAGE 1 ONLY

FAMILY HEALTH PLAN (TPA) LIMITED

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital: Sky Health City

Hospital Location: Sector 16 Gurgaon

Hospital ID:

Hospital Fax No.: [illegible]

Hospital Phone No: 0124 4333000

DETAILS OF THIRD PARTY ADMINISTRATOR (To be Filled in block letters)

a) Name of TPA / Insurance company: FAMILY HEALTH PALN (TPA) LIMITED

b) Toll Free Phone Number:

c) Toll Free FAX Number:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient: RAJENDER VERMA

b) Gender: ☑ Male ☐ Female c) Age: Years 56 Months M M d) Date of birth D D M M Y Y Y Y e) Contact number:

f) Contact number of Attending Relative: 9810976444

g) Insured Card ID Number

g) Policy number/Name of corporate: h) Employee ID:

h) Currently do you have any other Mediclaim/Health Insurance: ☐ Yes ☐ No Company Name

Give details:

i) Do you have a family physician ☐ Yes ☐ No j) Name of the family physician

k) Contact number, if any:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: DR. SAHA b) Contact Number: 0124-4333000

c) Name of ILLNESS / Disease with presenting complaint: ① Side chest Pain, radiating towards ② Scapular region and ③ arm.

d) Relevant clinical findings:

e) Duration of the present ailments: [illegible] Days f) Date of first consultation D D M M Y Y g) Past history of present ailment (if any)

f) Provisional diagnosis: U/A c Strong Endy cardia d/w acute Vertigo

h) ICD 10 Code: R00.2 H81.1

Proposed Line of treatment: ☑ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If Investigation / or Medical Management provide details: Reports are awaited

i) Route of drug administration: Progressive in nature

i) If Surgical, name of surgery: CAG

j) If other treatments provide details: Lupo

ICD 10 PCS Code:

k) How did injury occur:

l) In case of accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of Injury: M M Y Y Y Y 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)

m) In case of Maternity: G P L A Date of Delivery / LMP: D D M M Y Y

Details of the patient admitted

a) Date of admission: D D - M M - 19 Y b) Time H H 4 M M P.M

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

d) Expected no. of days stay in hospital: Days e) Room Type: CCU

f) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs. 7000/-

g) Expected cost for investigation + diagnostics: Rs. 10,000/- approx

h) ICU Charges: Rs.

i) OT Charges: CAG (RS) Rs.

j) Professional fees Surgeon + Anesthetist Fees + Consultation Charges: Rs. 25000/-

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

l) All inclusive package charges if any applicable: Rs.

m) Sum Total expected cost of hospitalization: Rs. approx 90,000/-

Mandatory: Past history of any chronic illness

	If yes, since (Month / Year)
☒ Diabetes	M M Y Y
☐ Heart Disease CAD. (P.A TB)	M M Y Y
☒ Hypertension	M M Y Y
☒ Hyperlipidemias	M M Y Y
☒ Osteoarthritis	M M Y Y
☒ Asthma / COPD / Bronchitis	M M Y Y
☒ Cancer	M M Y Y
☒ Alcohol or drug abuse	M M Y Y
☒ Any HIV or STD / Related ailments	M M Y Y

Any other Ailment give details: nil

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declaration on the reverse of this form

a) Name of the treating doctor: DR. SAHA

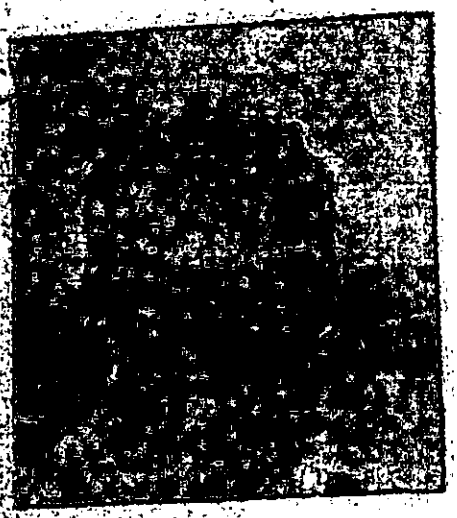
b) Qualification: MBBS c) Registration No with State Code:

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature: 9990976447

IMPORTANT: PLEASE TURN OVER

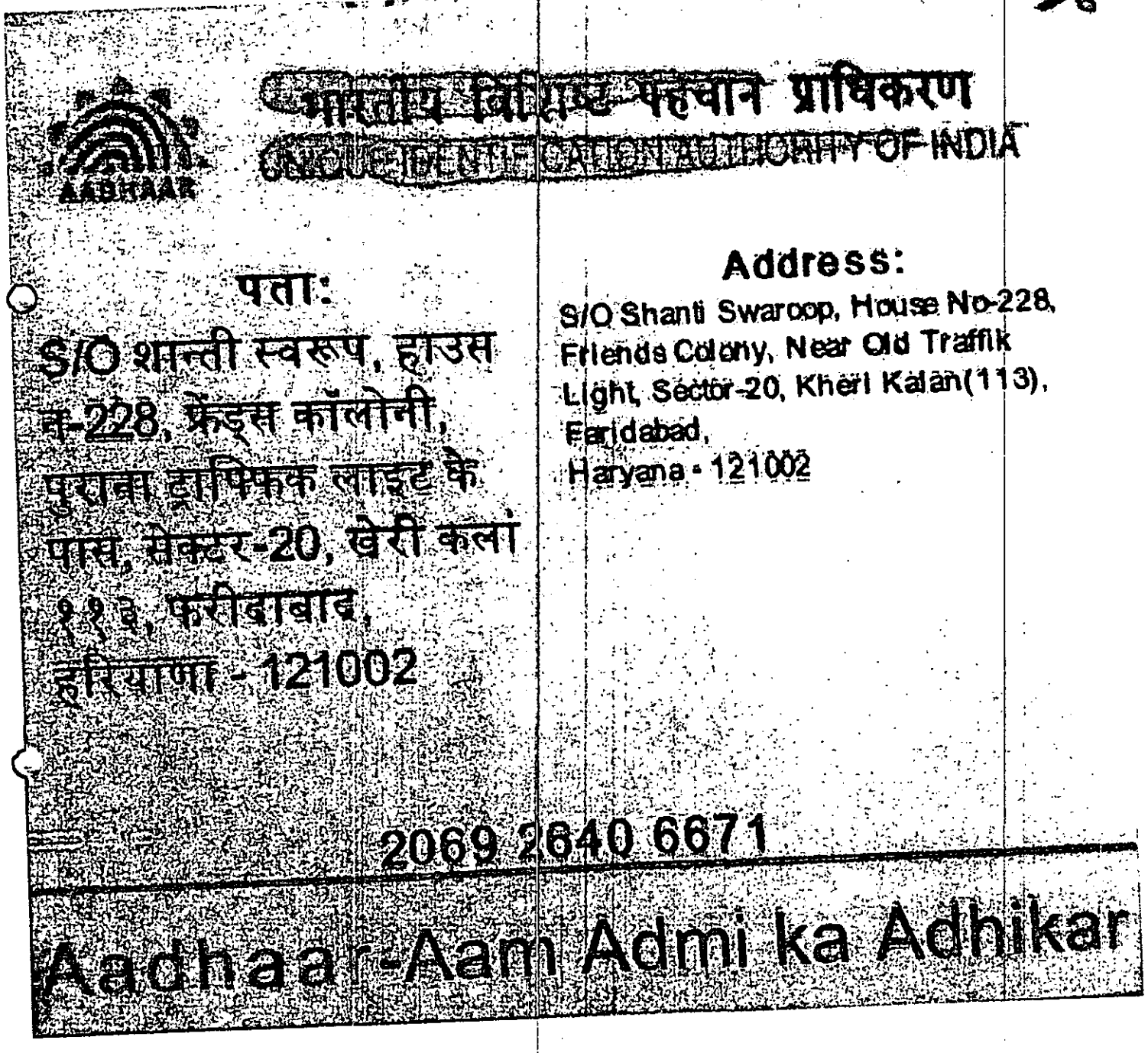
भारत सरकार
GOVERNMENT OF INDIA



राकेश वर्मा
Rakesh Verma
जन्म तिथि/ DOB: 03/01/1962
पुरुष / MALE

2069 2640 6671

आधार-आम आदमी का अधिकार



भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

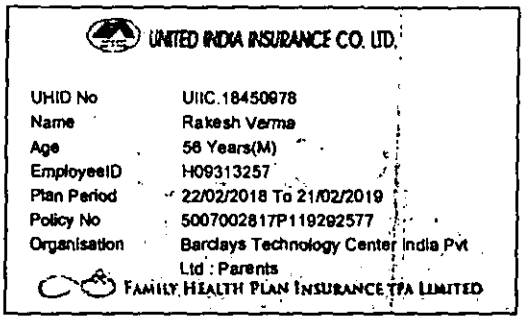
AADHAAR

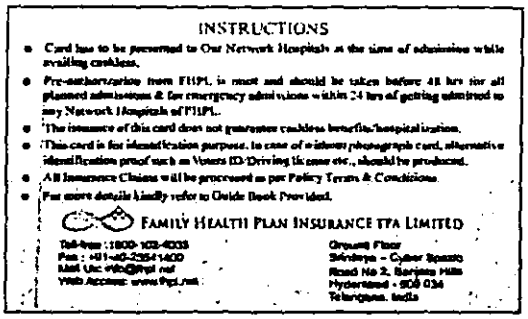
पता:
S/O शान्ती स्वरूप, हाउस
न-228, फ्रेंड्स कॉलोनी,
पुराना ट्राफिक लाइट के
पास, सेक्टर-20, खेरी कला
११३, फरीदाबाद,
हरियाणा - 121002

Address:
S/O Shanti Swaroop, House No-228,
Friends Colony, Near Old Traffik
Light, Sector-20, Kheri Kalan(113),
Faridabad,
Haryana - 121002

2069 2640 6671

Aadhaar-Aam Admi ka Adhikar





TERMS AND CONDITIONS:

1. This card is generated as per the details given by your employer/HR. Incase of any errors in the details you may confirm the same through your employer for making required corrections.
2. No physical card will be provided to you. For all requirements you may use this card printed in black and white or colour.
3. You can access our network hospitals list from our website https://www.fhpl.net for any information regarding hospitals available within your location or as required.
4. For the convenience of the members the guide book is made available on our website https://www.fhpl.net for understanding protocols in the event of any hospitalization assistance required for availing cashless service and also to forward any claim where the member has spent on his/her own.
5. All our network hospitals will accept the printed card and seek the preauthorization from FHPL in the event of any in-patient hospitalization.
6. Incase there is no photograph on the ID card, the member has to identify himself/herself with any other photo-card like: credit card, ration card, electoral card, Company ID card etc in conjunction with this card.
7. This card is not transferable and cannot be forwarded further to any other person by email/fax.
8. The card will be visible to any member as long the policy is valid after which this service will be withdrawn or till such time the member is employed with the current employer.
9. Usage of this card after the validity/policy expiry will not be entertained.
10. A fresh card will be generated subjected to the renewal of the policy.
11. For Any further queries, Please feel free to contact us on Toll-Free Helpline : 1800 - 425 - 4033

GIPSA PPN NETWORK-DECLARATION BY PATIENT/Patient's ATTENDER

(PART-A & PART-B must be filled to make the declaration valid)

Name of the Hospital:.....Date:.....

Address:.....

PATIENT

NAME: Rakesh Verma **AGE/SEX:** M

IP NO:_____ **UHID NO:**_____ **Mobile No of Patient:**_____

Date of Admission: 7th Jan 2019 **Time of Admission:**_____

Date of Discharge:_____ **Time of Discharge:**_____

ADDRESS of the Patient:_____

NAME OF THE ATTENDER: SUNITA VERMA **Relationship With the Patient:** WIFE **Mobile No. of Attender:** 9350492542 **Address:** H.NO-440, 1st Floor, Sec-16, Faridabad.

PART-A (To be filled Before admission)

A-1)Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No:_____

Insurance Company:_____

A-2) Whether patient opted for Eligible Room Category under Policy:

Yes / No

A-3) In case, policy holder wishes to avail better facility (Mention below the facility & provisional charges):

Name of the Additional Facility/ Provision/ Procedure/ Treatment .....
..... which costs Rs :.....
(In words: .....
.....
.....) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature :.....
Name of the Patient/Patient's attendant:
Date/Proposed Date of Admission:
Time of Admission

Signature :.....
Name of the Hospital Representative &
Hospital Seal

PART-B (To be filled at the time of Discharge)

B-1)Amount Paid (if any) by the patient before admission in

Rs .....towards.....

(In words.....)

B-2)Amount Paid (if any) by the Patient at the time of Discharge in

Rs .....towards.....

(In words.....)

I have not Paid any extra Amount towards Patient Bill,other than that, mentioned above in B-1 & B-2.

Signature :.....
Name of the Patient/Patient's attendant:
Date of Discharge:
Time of Discharge

Signature :.....
Name of the Hospital Representative &
Hospital Seal

QRG Health City

100055633

Admission Form

IP NO	33-19/237	UHID No.	100055633	Date of Admission	07/01/2019 13:43
Sponsor	FAMILY HEALTH PLAN LTD. -Credit				
Payer	FAMILY HEALTH PLAN LTD. -Credit			Bed Catg:	CCU
Ward:	CCU	Bed No:	CCU007	Bill Catg:	CCU
Speciality1	Interventional Cardiology			Admitting Consultant	Dr. Rakesh Rai Sapra
In case of joint admission:-				Admitting Team:	Dr. Rakesh Sapra/ Dr Suraj Singh
Speciality2				Secondary Consultant	

Patient Name	Mr. Rakesh Verma	Age	56 Yrs	Sex	Male	Marital Status :-	Married
S/O	SHANTI SWAROOP VERMA	Religion:	HINDU		Nationality	Indian	
Local Address	H NO. 440IST FLOOR, , FARIDABAD, Haryana, INDIA						
Ph No		Mobile	9990976447		Email		
Permanent Address	H NO. 440IST FLOOR, , FARIDABAD, Haryana, INDIA						
Contact No:	9990976447, 9350492542	KinName	KARAN KUMAR				

Booking Details :-

Booking Receipt No _____ **Amount** _____

Expected Date of Discharge

Condition of Discharge (Please Circle)

ICD Code : I25.1, I20.0, Z98.61

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

5.DOPR **6.Expired**

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

Consultant Signature **Date:**

The above information is correct to my knowledge

Date 07/01/2019 13:43

PATIENT /GUARDIAN SIGNATURE

Contact No. 9990976447

Printed at: 1/7/2019 1:45:31 PM

Tamanna Chaprana (28771)

DISCHARGE NOTIFICATION

IP NO	:	33-19/237	**UHID**	:	100055633
Patient Name	:	Rakesh Verma	**Age / Sex**	:	56 Yrs/Male
Address	:	H NO. 440IST FLOOR,,			
Nationality	:	Indian	**Payer**	:	UNITED INDIA INSURANCE CO. LTD.
Admission Date	:	07/01/2019 13:43	**Ward / Bed No**	:	Twin Sharing 4 / TS1250 A
Discharge Date	:	10/01/2019 13:46:00	**Consultant**	:	Rakesh Sapra/ Dr Suraj Singh
Bill No.	:	QHIR19/6664	**Bill Date**	:	10/01/2019 13:46

Reason for Discharge

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

Discharge By : Debika(25451)

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

ORG

DISCHARGE HANDOVER

IP No : 33-19/237 UHID : 100055633 3
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

Patient Name: - Mr. Rakesh Verma
UHID :- 100055633
IP NO:- 33-19/237

S.No.	Type of Document	Quantity	TPA	CASH	MLC	REMARKS
1	Discharge Summary		✓			
2	Refundable medicines returned					
3	Financial clearance form					
4	Diet chart					
5	Immunization Card					
6	REPORTS AND FILMS					
6.1	ECG	(5)				
6.2	EEG					
6.3	MRI					
6.4	CT					
6.5	X-Ray Chest	(1)				
6.6	Ultrasound USG KUB	(1)				
6.7	Bronchoscopy					
6.8	Colonoscopy					
6.9	ECHO	(1)				
7	Any other PTCA (Sticker)	(2)				
8	CD and wrapper cover (applicable in patients after cath lab procedure)					
9	Laboratory investigations					
9.1	Blood Report					
9.2	Urine/ Stool report					
10	Any other pending report					
11	Diet chart (If Applicable)					
12	Pediatric Education Brochure (If Applicable)					

***Click on the Discharge Approval icon once patient physically vacates the room.
Time(When clicked on the discharge approval icon) :-
Time (When patient has physically left the room) :-

Signature of Handover Nurse		Employee ID
Signature of Receiving Person		Employee ID
Date :-		Time :-

QRG Health City

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

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

FILE ARRANGEMENT - CUM - MRD CHECKLIST

Patient Name:
UHID : IPD No.

Date: 10/01/19

Date: 12/1/19

S. No.	CHECK LIST	To be filled by Nursing			To be filled by MRD
		TPA	BILLING	MRD	
1	Relieving slip / Clearance slip	✓		✓	—
2	Face sheet			✓	—
3	In patient charge sheet / Details of consultant's visit			✓	—
4	Emergency/OPD sheet			✓	✗
5	DOR/LAMA form				✗
6	Discharge/Death/LAMA/DOR summary			✓	—
7	History sheet / Neonatal assessment sheet				—
8	Death Certificate / Birth Certificate				✗
9	Doctor's notes			✓	—
10	Doctor's Handover notes			✓	✗
11	Blood sugar record			✓	—
12	Medication chart/Ventilator flow chart			✓	—
13	Vital sign chart / Clinical chart			✓	—
14	Intake output record			✓	—
15	Consent forms			✓	—
16	PAC			✓	✗
17	Post-operative evaluation			✓	✗
18	Pre-operative checklist			✓	✗
19	Surgical safety checklist			✓	—
20	Intra operative anaesthesia record			✓	✗
21	Angiography check list				✗
22	Cath lab nursing log				—
23	Adult Cardiac Catheterisation Laboratory			✓	✗
24	Operation/delivery notes			✓	✗
25	Alderete form			✓	—
26	Initial nursing assessment form			✓	—
27	Nursing care plan				✗
28	Pain assessment score sheet				✗
29	Bed sore assessment sheet / Phelebitis grading scale			✓	—
30	Nutritional assessment and Nutritional care plan			✓	✗
31	Checklist of patient handover			✓	—
32	Nurses notes			✓	—
33	Nurses inter department shifting notes			✓	—
34	Valuable handover form				✗
35	Blood transfusion record form				✗
36	TPA declaration/Transfer slip			✓	—
37	Pathology/lab reports / Radiology reports / Films			✓	—
38	ICU observation chart/Coronary care unit chart				✗
39	Others (Intdent, Bill copy, Blood Issue form etc.)				

Sign of Nurse: Krishna Devi
Employee ID: 2977

Sign of MRD:
Employee ID:

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

IP No: 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID: 100055633

(1)

QRG MEDICARE

INVESTIGATION RESULTS

HIV ..... HbsAg .....

HcV ..... VDRL .....

Investigation	Date	Date	Date	Date	Date	Date	Date
Hematology	7|1|19	8|1|19					
Hb	13.5	12.8					
TLC	6.8						
DLC	57|26|7|6|1						
ESR							
Platelet	228						
PT							
PTINR							
APTT							
Bio-Chemistry							
Blood Sugar (F/R)							
Blood Sugar (PP)							
BUN							
S. Creatinine	1.34	1.44	1.65				
Na+	139.0						
K+	5.0						
Cl-							
S. Calcium							
S. Phosphate							
S. Protein Total							
S. Albumin							
S. Globulin							
A:G Ratio							
S. Bilirubin							
Direct Bilirubin							
SGOT							
SGPT							
S. Alk. Phos							
GGT							
S. LDH							
S. Amylase							
S. Lipase							
S. CPK							
S. CPK-MB		1.24					
S. Chloesterol		117.0					
S. Triglycerides		112.8					
HDL		32.0					
LDL		62.0					
VLDL							
U. Acid							
Others							

Investigation		Date	Date	Date	Date	Date	Date	Date
Urine	R/E							
	M/E							
Stool	R/E							
Microbiology								
Culture / Sensitivity of Unine / Blood / Sputum / Stool / Body Fluid / CSF								
X-Ray								
CT Scan/MRI								
Biopsy (if any)								
Procedure based Investigation (BM/Paracentesis) etc.								
Histopathology								
Others								

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: 7.1.19 1343 Discharge Intimation Date/ Time:

Sl. No:

Patient label

Activity From Date & Time	Activity To Date & Time	Bed No
10.1.19 at 1345	10.1.19 11:30AM	1250A

Bed Transfer Details

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

Ambulance	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☐

Private Nurse / Equipments

OTHERS

Item	Qty
RBS - (1)	

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

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

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

Initials with Employee ID

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
				ECG - (1) a	

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

Assigned Nurse	Nurse Incharge	Billing Executive	Billing receiving Time	Medicine Returned	Morning Kit
				Yes☐ No☐	Yes☐ No☐

QRG Health City

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

QRG MEDICARE

DAILY ACTIVITY RECORD

Primary Consultant:

IP No : 33-19/237 UHID : 1000056033
Mr. Rakesh Verma DOA : 07/01/2019 12:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

Admission Date/ Time: 7/1/19

Discharge Intimation Date/ Time:

Sl. No:

Activity From Date & Time		Activity To Date & Time		Bed No.
9/1/19	12pm	9/1/19	11:59pm	H

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.

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

Particulars	Connected Time	Disconnected Time

Nebulization & Steam Inhalations

Ecg 2g 171582
RBS X1 done
RBS X1 - 171786

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 Subhash	Emyelove		
Dr Nawish			

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
S-creatinine |-|	171524.			USG KUB - 171	596
				2Decho |-|	171693

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☐

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

QRG MEDICARE

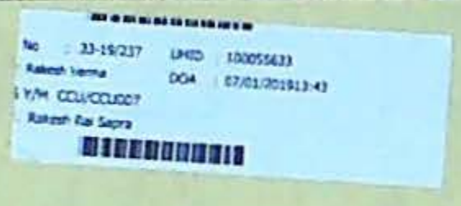
DAILY ACTIVITY RECORD

Primary Consultant:

Admission Date/ Time: 7/1/19

Discharge Intimation Date/ Time:

Sl. No:



Activity From Date & Time	Activity To Date & Time	Bed No.
8/1/19 10am	8/1/19 11 am	M

Bed Transfer Details

Date	Time	From Bed No	To Bed No

Pt. Category: Cash ☐ Credit ☐

Ambulance From	Private Nurse Mor ☐ Eve ☐	Equipments DVT Yes ☐ No ☐	OTHERS Item: RBS x 2 in 1 Qty: 1
To	Private GDA Mor ☐ Eve ☐	ALPHA Yes ☐ No ☐	
		Water Bed Yes ☐ No ☐	
From	Room Retainment Yes ☐ No ☐	Traction Yes ☐ No ☐	
To		Syringe Pump Yes ☐ No ☐	

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

Nebulization & Steam Inhalations: RBS x 1 8pm 6am 12/1/19

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. R.R. Sapra	entry done	entry done	

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

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

Initials with Employee ID

CONSUMABLES

Item	Qty

Particulars	Connected Time	Disconnected Time

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
Hb%, Lipid profile, CBC, ESR	done	CBG07			

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

Assigned Nurse	Nurse Incharge	Billing Executive	Billing receiving Time	Medicine Returned Yes ☐ No ☐	Morning Kit Yes ☐ No ☐

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:

55 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43

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
From	Mor ☐ Eve ☐
To	Private GDA
	Mor ☐ Eve ☐
From	Room Retainment
To	Yes ☐ No ☐

Equipments		
DVT	Yes ☐	No ☐
ALPHA	Yes ☐	No ☐
Water Bed	Yes ☐	No ☐
Traction	Yes ☐	No ☐
Syringe Pump	Yes ☐	No ☐

OTHERS

Item	Qty.

SURGERY/PROCEDURE DETAILS

Surgery/Procedure with code	Surgeon	Asst. Surgeon	Anaesthetist
CAG+PTCA	Dr Sapra		
	Dr Vijay		

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. R.K Sapra			

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

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

Initials with Employee ID

CONSUMABLES

Item	Qty.

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

Particulars	Connected Time	Disconnected Time

Nebulization & Steam Inhalations

RBS x1 →
ECG x1 →

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, S.cr, S.electrolytes, HIV, HCV, HBsAg, ECG, RBS, Troponin	[77022]			CXR(P)	77022

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.

Assigned Nurse	Nurse Incharge	Billing Executive	Billing receiving Time	Medicine Returned	Morning Kit
				Yes ☐ No ☐	Yes ☐ No ☐

C/IPD/Frm/20.15/ED2017/V1.0/Rev00

QRG Health City

DISCHARGE SUMMARY

QRG MEDICARE

UHID No.	: 100055633	**IP No.**	: 33-19/237
Name of patient	: Mr. Rakesh Verma	**Age/Gender**	: 56 Yrs/Male
C/O	: SHANTI SWAROOP VERMA	**Consultant**	: Dr. Rakesh Sapra/ Dr Suraj Singh
Bed No	: TS1250 A	**Bed Category**	: TWIN SHARING
Admission date/time	: 07/01/2019 01:43 PM	**Discharge date**	: 10/01/2019
Company name	: FAMILY HEALTH PLAN LTD. -Credit	**MLC / Non MLC**	: Non MLC
Sponser	: FAMILY HEALTH PLAN LTD. -Credit		

DEPARTMENT OF CARDIOLOGY

DIAGNOSIS:

CAD-Unstable Angina

CAG - Tripple vessel disease with patent stent in LCX/RCA

PTCA + stent to PDA & LAD done on 07.01.2019

POST PTCA TO RCA (Feb 2018) /LCX (SEP - 2018)

LVEF - 50%

PROCEDURE DONE

CAG-Triple vessel disease with patent stent in LCX/RCA (7/1/19)

Primary PTCA + stent to PDA and LAD done on 07.01.2019

RESUME OF HISTORY

Patient was admitted with complaints of left sided chest pain radiating towards left scapular region, shoulder and left arm associated with giddiness , DOE II-III gradually progressive since today morning.

Follow up case of CAD - Post PTCA to RCA (Feb 2018)/ LCX (Sep 2018)

PHYSICAL FINDINGS & SYSTEMIC EXAMINATION:

BP	:160/100mmHg
Pulse Rate	:98/min regular
Respiratory Rate	:18/min
Temperature	:Afebrile
Chest	:Bilateral air entry present
CVS	:S1, S2-normal
P/A	:Soft, non-tender, no distension
CNS	:Conscious, oriented, No focal neurological deficit
SPO2	:98% at room air

INVESTIGATIONS: Attached

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.	: 100055633	**IP No.**	: 33-19/237
Name of patient	: Mr. Rakesh Verma	**Age/Gender**	: 56 Yrs/Male
C/O	: SHANTI SWAROOP VERMA	**Consultant**	: Dr. Rakesh Sapra/ Dr Suraj Singh
Bed No	: TS1250 A	**Bed Category**	: TWIN SHARING
Admission date/time	: 07/01/2019 01:43 PM	**Discharge date**	: 10/01/2019
Company name	: FAMILY HEALTH PLAN LTD. -Credit	**MLC / Non MLC**	: Non MLC
Sponser	: FAMILY HEALTH PLAN LTD. -Credit		

COURSE IN THE HOSPITAL

Patient was admitted with above mentioned complaints. ECG showed sinus tachycardia, Q wave in inferior leads, T depression in III, AVF. Echo revealed hypokinetic inferior posterior wallI , EF 50%. After written consent patient was taken up for CAG which revealed Triple Vessel Disease with patent stent in LCX/RCA. He underwent PTCA + stent to PDA (using stent size **Abluminus 2.25 x 12** mm) & PTCA + Stent to LAD (using stent size **Evermine 2.25 x 16** mm) with TIMI III flow achieved successfully. Post procedure period was uneventful. Patient had retention of urine so urologist opinion optimized and treatment followed. Patient responded well to the given treatment. Now is being discharged in a stable condition with following advice.

CONDITION AT DISCHARGE: Stable.

TREATMENT ADVISED ON DISCHARGE

Tab. Ecosprin 150 mg twice daily
Tab. Clopitab 75 mg twice daily
Tab. Tonact 40 mg once daily
Tab. Vertin 16 mg thrice daily
Tab. Pantocid 40 gm twice daily
Tab. Silofast 8mg 1tab bed time
Tab. Levoflox 500mg 1tab once daily x 5 days

PREVENTIVE STRATEGIES :

Diet – Low salt & low fat diet.
Don't Stop or Reduce any Medicine without Consulting Cardiologist

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QRG Health City

DISCHARGE SUMMARY

QRG MEDICARE

UHID No.	: 100055633	**IP No.**	: 33-19/237
Name of patient	: Mr. Rakesh Verma	**Age/Gender**	: 56 Yrs/Male
C/O	: SHANTI SWAROOP VERMA	**Consultant**	: Dr. Rakesh Sapra/ Dr Suraj Singh
Bed No	: TS1250 A	**Bed Category**	: TWIN SHARING
Admission date/time	: 07/01/2019 01:43 PM	**Discharge date**	: 10/01/2019
Company name	: FAMILY HEALTH PLAN LTD. -Credit	**MLC / Non MLC**	: Non MLC
Sponser	: FAMILY HEALTH PLAN LTD. -Credit		

WHEN TO OBTAIN URGENT CARE:

In case of chest pain, unconsciousness, bleeding or sudden breathing difficulty immediately report to **CCU Duty Doctor** on **direct line no. 0129-4090300.**

NEXT APPOINTMENT :

Review after 7 days in Cardiology OPD with Dr. Rakesh Rai Sapra (with prior appointment) Morning OPD timings 10.30 am To 4.30 pm(Monday to Saturday).

For appointment contact at :- 0129-4330000.

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

DR. RAKESH RAI SAPRA
MD MEDICINE, DM (CARDIOLOGY)
DIRECTOR
DEPARTMENT OF INTERVENTIONAL CARDIOLOGY

DR. VIRENDRA
ASSOCIATE CONSULTANT

cd By: 28100

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

Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma - DOA : 07/01/2019 13:43

QRG MEDICARE

INITIAL ASSESSMENT SHEET

Patient's Name Mr. Rakesh Verma Age 56y Sex : ~~Male~~ Female

IPD No. 33-19/237 Consultant. Dr. R-Rsapra

Ward / Room CCU-04, Date of Admission 7/1/19

WONG - BAKER Facial Grimace Scale

Verbal Description Scale

0 No Pain 1 2 Mild Pain 3 4 Moderate 5 6 Severe 7 8 Very Severe 9 10 Worst Possible

CHIEF COMPLAINTS WITH DURATION : (LP) ~~Sided~~ sided chest pain radiating towards (LP) scapular region, shoulder and (LP) arm.

HISTORY OF PRESENT ILLNESS : - ~~Associated~~ diaphoresis / today
- ~~DOE~~ - II-III ~~Gradually~~ progressive, increasing.
Fu - CAD
- P/L PTCA 2 RCA Feb 2018
Lex Sept. 2018.
- LVEF 45%.

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
Ecosprin	150mg OD		
Cocrush	75mg OD		
Valzaar	20mg OD		
Lopace	25mg OD		

PERSONAL HISTORY :

Marital Status _____

Physical Activity _____

Veg / Non-Veg _____

Known Allergies _____

FREQUENCY WITH DURATION

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

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. 160/100 mm/hg

Pulse 98 /min. Regular/Irregular

SPO2 98%

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

GYNAE EXAMINATION. :

Breast _____

PA _____

PS _____

PV _____

LOCAL EXAMINATION

CVS - S1 S2 heard,
No murmurs, No loads, Thrills, Apex -

PROVISIONAL DIAGNOSIS

CAD - P. PTCA & RCA Feb 2018
LAD Sept 2018.
DM
HTN.
- USA

PLAN OF CARE & MANAGEMENT

→ Cath Package
→ Inj NTG acc to BP
IV infusion
→ Inj Rec Heavy IV SOS BD
→ Inj Tramadol 100 mg IV SOS over 1/2 hr.
→ Rest as per drug chart

DIET ADVISED :

EXPECTED OUTCOME :

Signature of Consultant .....

Name .....

Signature of Medical Officer .....

Name Dr. Vinod Singh

Date & Time 7/11/19

QRG Health City

IP No : 33-19/237
Mr. Rakesh Verma
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

UHID: 100055633
DOA : 07/01/201913:43

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121006
Tel: 0129 - 4330000

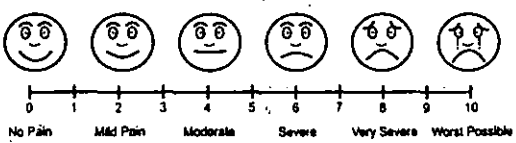
DOCTOR'S NOTES

Patient's Name ..... Age ..... Sex [ ] Male [ ] Female

PU ..... IPD .....

Unit ..... Room / Bed No. .....

Wong & Baker Facial Grimace Scale :



Plan of Care

Date / Time	Notes
	CAG - TVD c Patent RCA/LCX stent PTCA to LAD/PDA • Guide cath JR 3/6 EBU 3.0 6 Fr sheath • Guidewire Wisdom ultra • Pre dilation 2X10 mm balloon • PDA stenting 2.25X12 mm at 10 atm pressure • Post dilation 2.5X8 mm • LAD stenting 2.25X18 mm • Post dilation 2.5X8 mm Rx T. Ecospirin 150 mg - BD T. Clopitab 75 mg - BD T. Tonact 40 mg - OD T. Nikoran 5 mg - BD T. Pantop 40 mg - OD

Abluminus® Size:2.25mm X 12mm 2018-11-29 2020-11-28 SN: AD53104
(01)08906061900070(11)181129(17)201128(10)AD53(21)AD53104

Meril LOT EFA47 SN CS16EFA47013
REF EVF22516 2018-09 2020-08
Evermine 50™ 2.25 mm X 16 mm
01189042249067991720080021CS16EFA47013

Expe
[ ] E
[ ] Unstable
Preventive / Curative / Rehabilitative Aspects

Plan of Care

Date / Time	Notes
9/1/19 12:30 PM	c/o. Virahbra c/o. chest pain c heaviness. N/o ghabraheat / sweating BP - 147/90 HR - 80/min SPO2 - 100%. No = adequate Advice → Inj Emset 1amp IV stat → Inj Tramadol 1amp in 100ml NS over 1 hr. → Continue WF 50ml/hr

Expected Out Come

[ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Guarded [ ] Unstable

Preventive / Curative / Rehabilitative Aspects (If any) _____

QRG Health City

Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43

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

DOCTOR'S NOTES

Patient's Name ..... Age ..... Sex [ ] Male [ ] Female

PU ..... IPD .....

Unit ..... Room / Bed No. .....

Plan of Care

Date / Time	Notes
8/1/19 8:00AM	ESB. dr. Virendra CAD / P. PTCA & RCA Feb 2018 LCX Sept 2018 LVEF 45%. Unstable angina CAD-TVD & patent stents. PTCA + STO PDA & LAD done 7/1/19. Had vomit 1 episode at night. Now G.C. Stable Sleeping BP - 136/86 mmHg HR - 85/min SpO2 - 95% Add Tab Ventin 16mg TDS RR = 1805 / 900 ml Advised Sano

Expected Out Come

Plan of Care

Date / Time	Notes
9/1/19 8:00 AM	S/B Dr Vaibhav CHD - RCA PTCA to PDA/LAD CAG - TVD c Patent stent PTCA to PDA/LAD EF - 45%. O/E Pt elic. Pulse - 94/min BP - 130/80 mm Hg CVS - S1 S2 RS - BAE (+) C/o mild chest pain left axilla ↓ Tenderness +ve Rp - Same as charted - Tab Ultracet 1 tab SOS Dr Vaibhav Adv S. Cr.
5/1 2620 ml 2700	
TVL 1.5 c.7 50% collapse	
	Adv Urology Consultation for extraction of stent - I/V Fluid to be continued Dr Vaibhav

Expected Out Come

Shift today 1
Plan OK - Dr.

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56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43

DOCTOR'S NOTES

Patient's Name ..... Age ..... Sex [ ] Male [ ] Female

PU ..... IPD .....

Unit ..... Room / Bed No. .....

Plan of Care

Date / Time	Notes
Date: 8/1/19 10 Am:	CSB Dr Rakesh. CAD- Post PTCA to RCA/LCx (Feb/sept-2018) Unstable Angina CAG- TVC & Patent Stent PTCA to PDA. ALAD LVEF 45%. CLD Constipation (Not passed motion from 8 days Pt Conscious/Oriented. HR- 100/min BP- 126/76 mm CVS S1 S2 (+) Chest B/L AE (+) Adv:- Syp. Lox 30 ml P.O stat if Not passed Motion then P/c enema. - USG - KUB - Plan to shift ward. Rakesh

Expected Out Come

Plan of Care

Date / Time	Notes
9.1.19	ECHO : Borderline High LA. • Inferior, Posterior walls Corrected Hypo * LVEF ~ 50%. * Mild TR. PASP ~ 43 mmHg * No significant valve abnormality. * E/E' < 14. IVC (N) & (N) Resp variation * No Clot / Mass / Veg / DVT * IAS (N) * RA, RV (N). Good LV function Dell 9/1/19 2.45pm Cardiologist Adv: Discharge on Tab.ivs / Rev in OPD Dr

Expected Out Come

QRG Health City

P No : 33-19/237 UHID : 100055637
Mr. Rakesh Verma DOA : 07/01/2019 12:1
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
P No : 33-19/237 UHID : 100055637

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

DOCTOR'S NOTES

Patient's Name .... Age .... Sex [ ] Male [ ] Female

PU .... IPD ....

Unit .... Room / Bed No. ....

Plan of Care

Date / Time	Notes
10/1/19.	CSB Dr Sapra
9 am	Unstable Angina
	CAD - Post PTCA + stent to RCA/LCx
	~~PTCA to~~ CAG - TVD c Patent Stent
	PTCA to RCA/LAD
	LVEF 45%.
	Pt Conscious / oriented
	HR - 86/min
	BP - 120/80 mmHg
	CVS - S1 S2 (+)
	Chest B/L A/E (+)
	Adv
	Discharge today
	with poly 4

Expected Out Come ____________________

Plan of Care

Date / Time	Notes

Expected Out Come _____

QRG Health City

Mr. Rakesh Verma DOA : 07/01/2019 13:4
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID : 100055633

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

DOCTOR'S REFERRAL NOTE

Patient's Name ..... Age/Sex .....

UHID/IPD No. ..... Diagnosis .....

Referring To Dr Manish K Referred By .....

Reason for Referral	**Doctor's Name & Signature:** **Date:**
Recommendation by Referring Consultant	9.1.15 Thanks for Reference Pt POP PYCA on 7.1.15 Acute Retention of urine Indwelt Foley's Catheterised No H/o LUTS o/e Cath ⊕, urine clear output - adequate Adv Tab RMB c BID / Tab Silodosin 8 mg HS Review after voiding trial - RVC with Report **Doctor's Name & Signature:** Dr MANISH **Date:**

QRG Health City

56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
Mr. Rakesh Verma
IP No : 33-19/237
UHID: 100055633
DOA : 07/01/201913:43

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

BLOOD SUGAR RECORD

Patient Name ..... Age ..... Sex .....

Diagnosis ..... Doctor Incharge .....

Date	Time	Blood Sugar	Hypoglycemia Agents	Signature	Remarks
9/1/19	2pm	235mg/dl.	—		
	7pm	299mg/dl	6 unit HIR		
	9pm	160mg			
	7pm	260mg/dl	14 unit HIR		
	1pm	240mg/dl	10 unit HIR		
	7pm.	195	HIR 4 unit		As per Doctor Lalitesh.
10/1/19	7am	800mg	HIR 10 unit		
	1pm	388	HIR 14 unit.		

Date	Time	Blood Sugar	Hypoglycemia Agents	Signature	Remarks

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

(2)

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra
[redacted]

Drug Allergies: Not known
Diet: DM normal diet
Diagnosis: CAD, DM.

MEDICATION PRESCRIPTION AND ADMINISTRATION CHART

Date & Time	Name of the Drugs	Dose	Route	Frequency	Name & Sign of Doctors	Date	10-1-19																	
						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
9-1-19	Tab Pantocid	40mg	P/O	BD		Time / Signature / ID Check		6am			6pm													
	Tab Ecosprin	150 mg	P/O	BD		Time / Signature / ID Check			10am			10pm												
	Tab TUNACT	40 mg	P/O	OD		Time / Signature / ID Check						10PM												
	Tab Clopitab	75mg	P/O	BD.		Time / Signature / ID Check			10am			10pm												
	Inj Evecet	1Amp	IV	SOS		Time / Signature / ID Check																		
	Tab Voveran	1mg	P/O	TDS		Time / Signature / ID Check		8am		2pm		10pm												
	Syp LOOZ	30ml	P/O	OD		Time / Signature / ID Check						10PM												
	Tab. Silofast	8mg	P/O	HS		Time / Signature / ID Check						10 PM												
	Tab. LEVOFLOX	500 mg	P/O	OD		Time / Signature / ID Check			D2	2pm														
						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
6pm	Tab. DOLO	650mg	P/O		
10/11/19	T. Ciprocet	1 tab	P/O		

IV FLUIDS

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

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

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

(1)

QRG Health City

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

[redacted]

IP No : 33-19/237 UHID : 100055033 IP
Mr. Rakesh Verma DOA : 07/01/2019 13:43 M
56 Y/M CCU/CCU007 St
Dr Rakesh Rai Sapra D
[redacted]

Drug Allergies NIL

Diet DM IND

Diagnosis CAD, ACS, DM

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						9/1/19					
						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.	T. PANTOCID	40mg	P/O	~~BBD~~		Time Signature ID Check					4pm			6am			4pm					6pm	
	T. ECOSPRIN	150mg	P/O	BD.		Time Signature ID Check						10pm			10am			10pm						8pm
	TAB-TONACT	40mg	P/O	OD.		Time Signature ID Check						10pm						10pm						
	T. NIKORAN	5mg	P/O	BD	STOP by Dr	Time Signature ID Check						10pm		8am			8pm							
	T. CLOPITAB	75mg	P/O	BD		Time Signature ID Check						10pm			10am			10pm						8pm
	Inj EMSET	1amp	I/V	SOS		Time Signature ID Check																		
	TAB VERTIN	16mg	I/V	TDS	yaw	Time Signature ID Check																		
9/1/19.	Syp. LODZ	30ml	P/O	~~BD~~	-Hs/alive	Time Signature ID Check																		10pm
	T. Sileafast	8mg	P/O	Hs		Time Signature ID Check																		10pm
	T. Levoflox	500mg	P/O	OD		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 at 4p	Inj Pan	40mg	IV	Dr Vinod	Soni
	Inj. Emeset	4mg	stat	Dr Virendra	Soni
	Inj. Tramdol	100mg	stat		
	Tab Lopesure	OD/stat	stat		
9/1/19	Inj. Ceftriaxone	1 vial	Stat	Dr Vinod	Soni
9/1/19	Syp. Lroz 30ml IVFLUIDS Stat			Dr Virendra	Soni at 10:15 am

Date & Time	Name of the Drugs	Dose	Route	Name & Sign of Doctors	Name & Sign of Nurse
7/1/19 at 7:30p	IVF NS@ 50ml	50ml	IV	Dr. Vinod	Soni
9/1/19. at 12pm	PC enema	1	P/R	Dr. Lalitesh	Staff

INFUSION CHARTING

Date & Time	Name of the Drugs	Dose	Route	Dilution	Flow Rate	Name & Sign of Doctors	Name & Sign of Nurse
7/1/19 at 2pm	Inj. NTG.	25mcg	IV	5ml of NS with	@ 2ml/hr	Dr. Vinod — DC @ 4pm.	Soni

HIGH RISK MEDICATION ADMINISTRATION AND MONITORING -

Date	Name of the Drugs	Dose	Route	Frequency	Flow Rate	Time	Administrated By	Verified By	Temp	RR	BP	Pulse	Any ADR	Temp	RR	BP	Pulse	Any ADR	Temp	RR	BP	Pulse	Any ADR

QRG/IHC/IPD/Frm/05/Ver.0.2

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

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

QRG MEDICARE

CLINICAL CHART

Day of Hospitlisation		9/01/19						10-1-19																					
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					86	84	80		96	90	92																		
Respiration					18	20	20		20	20	20																		
Blood Pressure					130/70	130/80	130/80		120/70	130/80	130/80																		
Pain Score					0/10	0/10	0/10		4/10	0/10	0/10																		
Urine					F	F	F		F	F	F																		
Bowels							1		Y	Y	∞																		
Diet		NORMAL						OM N.D.																					
Blood Transfusion		Nil						NT																					
Total Intake		1900																											
Total Output		1580																											
Antibiotics		—						—																					
Allergy		Not known						Not Known																					
Miscellaneous																													

Sleeping

QRG Health City

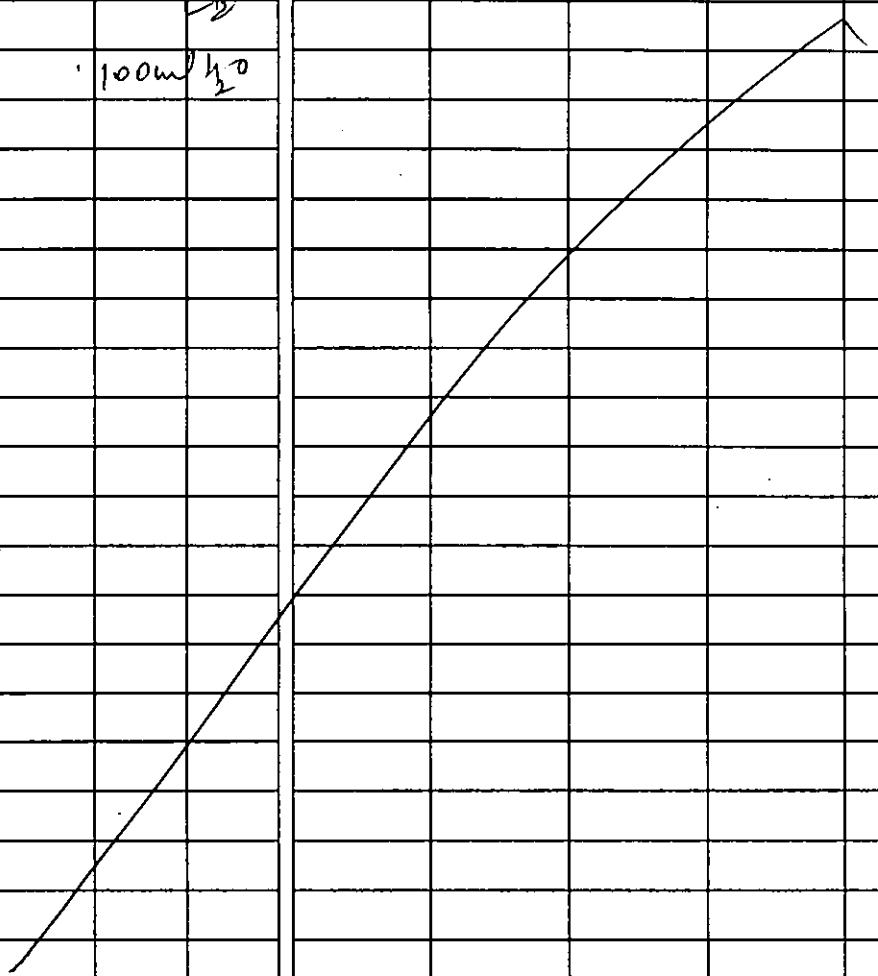
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

INTAKE AND OUTPUT RECORD

Patient Name Mr Rakesh Verma Age 56y Sex M Date 10-9-19

Hour	Intravenous Infusions			Oral		Urine	Vomit	Drainage	Aspirate	Others
	Volume Started	Volume Remaining	Volume Infused	Volume	Type					
8 AM				100ml	Tea					
9										
10				200ml	H2O					
11										
12 N				200ml	H2O					
1 PM										
2				100ml	H2O					
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										



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

Nurse Signature

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

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

INTAKE AND OUTPUT RECORD

Patient Name Rakesh Verma Age 56 Sex M Date 9/1/19

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				CCU-740ml						
2						CCU-1680ml				
3	NS		30ml							
4			30ml	100ml	Tea					
5			30ml							
6			30ml	200ml	H2O					
7			30ml							
8			30ml	200ml	Dinner					
9			80ml	100ml	H2O					
10			30ml	100ml	H2O	1500ml				
11			30ml							
12 MN			30ml							
1 AM			pt refused							
2										
3										
4										
5										
6				100ml	Tea	1400ml				
7				100ml	H2O					
Total			300	1600		4580				

Total INTAKE in 24 Hours 1900 Total OUTPUT in 24 Hours 4580

BALANCE

Nurse Signature

QRG Health City

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

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

ORAL 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.....

And I,.....(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 .....

रोगी/परीजन (सम्बन्ध) के हस्ताक्षर .....

दिनांक..... समय .....

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

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

CONSENT FORM FOR HIV TESTING AND PRETEST COUNSELING

एच आई वी परीक्षण और पूर्व परीक्षण परामर्श के लिए सहमति पत्र

Patient's Informed Consent:

This is to state that I have been counseled about the HIV test and have been explained about the implications of the test results. All the details pertaining to HIV, its transmission, prevention, testing procedures, its limitations & interpretation of the result have been explained to me in manner and language that I can understand.

I, hereby give my consent for the test (s) to be conducted in order to ascertain my HIV sero-status.

Signature/Left thumb impression of the Patient.....

Name of the Patient (In Block Letter).....

Signature/Left thumb impression of the Attendant.....Karan

Name of the Attendant (In Block Letter).....KARAN

Relation with the Patient.....SON

Date.....7/1/19.....**Time**.....2 pm.

मरीज की पूर्व सहमति पत्रः

मैं यह घोषणा करता/करती हूँ कि मुझे एच आई वी के बारे में सलाह दे दी गई है एवं टेस्ट के परिणामों के निष्कर्ष की विस्तरत जानकारी दे दी गई है। मुझे एच आई वी से जुड़ी विस्तृत जानकारी, इसका ट्रांसमिशन, रोकथाम, परीक्षण प्रक्रिया, इस की सीमाएँ एंम परिणाम के निष्कर्ष की पूरी जानकारी इस तरीके से दी गई है, जिसे मैं समझ सकता/सकती हूँ।

मैं इसके द्वारा मेरे एच आई वी सेरो–स्टेटस स्थिति जानने के लिए टेस्ट करने की सहमति प्रदान करता/करती हूँ।

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

मरीज का नाम .....

रिश्तेदार के हस्ताक्षर/बाएं अंगूठे का निशान.....

रिश्तेदार का नाम .....

रोगी के साथ सम्बंध .....

दिनांक.....समय .....

17 0223

Counselor / Doctor's Commitment:

I hereby state that the patient / client have been counseled about the HIV test & have been explained about tr implications of the test result. All details pertaining to HIV, its transmission, prevention testing procedures, its limitation & interpretation of result have been explained & the patient / client has given his / her free & informed consent to conduct an HIV test on him / her. I, the counselor, will do everything possible to assure that the consent of the patient while having over the report.

Dr. Virender

Signature of Counselor / Doctor

Name (In Block Letter) DR. VIRENDER

Date & Time 7/1/19 @ 9 am

परामर्शदाता / चिकित्सक की प्रतिबद्धता

मैं यह घोषणा करता / करती हूँ कि मरीज को एचआईवी टेस्ट के बारे में परामर्श दे दिया गया है एवं टेस्ट के परिणामों के बारे में विस्तृत जानकारी दे दी गई है। एचआईवी से जुड़ी विस्तृत जानकारी, इसका ट्रांसमिशन, रोकथाम, परीक्षण प्रक्रिया, इस की सीमाएँ एवं परिणामों के निष्कर्श की पूरी जानकारी दे दी गई है और रोगी ने [illegible] का एचआईवी टेस्ट करने की स्वतन्त्रता एंव पूर्व सहमति प्रदान की है। मैं, परामर्शदाता, यह आश्वस्त करूंगा की हर संभव कोशिश करुंगा की परामर्श सत्र की सहमति एवं टेस्ट के परिणाम गोपनीय रखे जाएंगे। मैं सुनिश्चित करता हूँ कि रोगी को रिर्पोट सौंपते समय टेस्ट के उपरांत परामर्श प्रदान किया जाएगा।

परामर्शदाता / चिकित्सक के हस्ताक्षर

नाम .....

दिनांक एवं समय .....

Notes:

1. In case of minor, the consent should be obtained from the parents.
2. In case of unconscious patient's where there is a need for diagnosis of HIV for management of the patient, consent should be obtained from the parents / spouse / closest relative available at that time
3. In case of no attendant (s) is available, the test, if necessary for management may be carried out on recommendations of two attending doctors.

दिशा निर्देश:

1. रागी के नाबालिग होने पर उसके माता पिता से पूर्व सहमति ली जाएगी।
2. मरीज के बेहोशी की अवस्था में जहाँ उसके उपचार के लिए एचआईवी की जाँच जरुरी है, उसके माता-पिता / पति–पत्नी / नजदीकी रिश्तेदार से सहमति ली लाएगी।
3. ऐसी स्थिति में जबकि मरीज की देखभाल के लिए कोई मौजूद नही है एवं उसके उपचार के लिए एचआईवी की जाँच जरुरी है, वहाँ उपस्थिति दो चिकित्सकों की सिफारिशों पर टेस्ट कराया जा सकेगा।

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

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

CONSENT FORM FOR HIV TESTING AND PRETEST COUNSELING

एच आई वी परीक्षण और पूर्व परीक्षण परामर्श के लिए सहमति पत्र

Patient's Informed Consent:

This is to state that I have been counseled about the HIV test and have been explained about the implication of the test results. All the details pertaining to HIV, its transmission, prevention, testing procedures, its limitations & interpretation of the result have been explained to me in manner and language that I can understand.

I, hereby give my consent for the test (s) to be conducted in order to ascertain my HIV sero-status.

Signature/Left thumb impression of the Patient.....

Name of the Patient (In Block Letter).....

Signature/Left thumb impression of the Attendant.....Karan

Name of the Attendant (In Block Letter).....KARAN

Relation with the Patient.....SON

Date.....7/1/19 **Time**.....2 pm.

मरीज की पूर्व सहमति पत्रः

मैं यह घोषणा करता/करती हूँ कि मुझे एच आई वी के बारे में सलाह दे दी गई है एवं टेस्ट के परिणाम निष्कर्ष की विस्तरत जानकारी दे दी गई है। मुझे एच आई वी से जुड़ी विस्तृत जानकारी, इसका ट्रांसमि रोकथाम, परीक्षण प्रक्रिया, इस की सीमाएँ एंम परिणाम के निष्कर्ष की पूरी जानकारी इस तरीके से दी गई है, मैं समझ सकता/सकती हूँ।

मैं इसके द्वारा मेरे एच आई वी सेरो–स्टेटस स्थिति जानने के लिए टेस्ट करने की सहमति प्रदान करता/करती

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

मरीज का नाम .....

रिश्तेदार के हस्ताक्षर/बाएं अंगूठे का निशान.....

रिश्तेदार का नाम .....

रोगी के साथ सम्बंध .....

दिनांक.....समय .....

Counselor / Doctor's Commitment:

I hereby state that the patient / client have been counseled about the HIV test & have been explained about implications of the test result. All details pertaining to HIV, its transmission, prevention testing procedures, limitation & interpretation of result have been explained & the patient / client has given his / her free & inform consent to conduct an HIV test on him / her. I, the counselor, will do everything possible to assure that the cons of the patient while having over the report.

Dr. Virender

Signature of Counselor / Doct

Name (In Block Letter) DR. VIRENDER

Date & Time 7/1/19 @ 9 am

परामर्शदाता / चिकित्सक की प्रतिबद्धता

मैं यह घोषणा करता/करती हूँ कि मरीज को एचआईवी टेस्ट के बारे में परामर्श दे दिया गया है एवं टेस्ट परिणामों के बारे में विस्तृत जानकारी दे दी गई है। एचआईवी से जुड़ी विस्तृत जानकारी, इसका ट्रांसमिशन रोकथाम, परीक्षण प्रक्रिया, इस की सीमाएँ एवं परिणामों के निष्कर्श की पूरी जानकारी दे दी गई है और रोगी ने र का एचआईवी टेस्ट करने की स्वतन्त्रता एंव पूर्व सहमति प्रदान की है। मैं, परामर्शदाता, यह आश्वस्त कर की हर संभव कोशिश करुंगा की परामर्श सत्र की सहमति एवं टेस्ट के परिणाम गोपनीय रखे जाएगें। मैं सुनिश्चित करता हूँ कि रोगी को रिर्पोट सौंपते समय टेस्ट के उपरांत परामर्श प्रदान किया जाएगा।

परामर्शदाता / चिकित्सक के हस्ताक्षर

नाम .....

दिनांक एवं समय .....

Notes:

1. In case of minor, the consent should be obtained from the parents.
2. In case of unconscious patient's where there is a need for diagnosis of HIV for management of the patient, consent should be obtained from the parents / spouse / closest relative available at that tim
3. In case of no attendant (s) is available, the test, if necessary for management may be carried out on recommendations of two attending doctors.

दिशा निर्देश:

1. रागी के नाबालिग होने पर उसके माता पिता से पूर्व सहमति ली जाएगी।
2. मरीज के बेहोशी की अवस्था में जहाँ उसके उपचार के लिए एचआईवी की जाँच जरुरी है, उसके माता पिता / पति–पत्नी / नजदीकी रिश्तेदार से सहमति ली लाएगी।
3. ऐसी स्थिति में जबकि मरीज की देखभाल के लिए कोई मौजूद नही है एवं उसके उपचार के लिए एचआ की जाँच जरुरी है, वहाँ उपस्थिति दो चिकित्सकों की सिफारिशों पर टेस्ट कराया जा सकेगा।

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

No : 33-19/237 UHID : 100055633
r. Rakesh Verma DOA : 07/01/201913:43
5 Y/M CCU/CCU007
r. Rakesh Rai Sapra

QRG MEDICARE

CONSENT FOR ANGIOPLASTY / ANGIOGRAPHY

I, Sunita Verma relative (wife) of

Mr./Mrs./Ms. Rakesh Verma, (Patient's Name) give the consent

to perform PTCA+Stent. (Procedure's Name) to Doctor

Dr R.R. Sapra under Local anaesthesia.

1. The procedure with alternative treatment required, prognosis and risks of not getting the surgery / procedure done are also explained to me.
2. I have been explained about the procedure in detail and I am aware that during Angioplasty the patient may require general anaesthesia / intubations or urgent CABG. The doctor has explained that if any complication / risk happens during the surgery, then they will be treated as appropriate.*
3. I have been explained about the usual rate of Restenosis (i.e. 3-5% with Drug Eluting Stents and 8-12% with Bare-metal Stents).
4. It is also explained to me that any photograph or video recording of the procedure or a part, may be taken during the surgery for educational or research purpose.
5. I have been explained about the financial charges for Revascularisation or Angioplasty.

I Sunita Verma Hereby authorize Dr R.R. Sapra to administer such necessary treatment, as considered therapeutically necessary during the course of mentioned procedure.

- I also consent to the administration of any anaesthesia as considered necessary for the operation / procedure.
- I also certify that no guarantee or assurance has been made as to the results that may be obtained.
- I fully assure my co-operation to the treating doctor during the treatment course. I will follow the doctor's instruction after procedure, regarding diet, medication and any precautions.
- I certify that in case of any complications or mishappening, I will not blame the treating doctor or the hospital.

The possible complications that may arise during the procedure are:

1. Local Hematoma
2. Pseudo Aneurysm
3. Contrast Allergy
4. Arrhythmia
5. Myocardial Infarction (MI)
6. Or may even death

Name of Patient: ..... Signature: .....

Name of Witness: Sunita Verma Signature: .....

Date: 7-1-19 Relation with patient: wife

Signature of Cardiologist: ..... Name of Cardiologist: Dr R.R. Sapra

Note: 1. *Consent must be signed by the patient. In case of a minor or when the patient is physically or mentally incompetent then a nearest relative, may authorise.*
2. *It is clear that only local court shall be the place for all legal disputes.*

** Only in case of Angioplasty*

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Patient Label

QRG MEDICARE

एंजियोप्लास्टी / एंजियोग्राफी के लिए सहमति पत्र

मैं ..... सम्बन्धि(.....),

श्री / श्रीमती / सुश्री ..... (रोगी का नाम)

..... (चिकित्सा पद्यति का नाम) .....

चिकित्सक द्वारा निःसंज्ञा पद्यति के लिए चिकित्सा प्रारम्भ करने की सहमति देता / देती हूँ।

1. मुझे आवश्यक वैकल्पिक चिकित्सा पद्यति के विषय में और शल्य चिकित्सा पद्यति न प्राप्त करने के जोखिम के विषय में भी बताया जा चुका है।
2. मुझे चिकित्सा पद्यति के विषय में पूर्ण रुप से समझाया जा चुका है और मुझे ज्ञात है कि एंजियोप्लास्टी के समय रोगी की सामान्य निःसंज्ञा / नली द्वारा औषधी प्रयोग अथवा सीएवीजी की आवश्यकता हो सकती है। चिकित्सक ने यह भी समझाया है कि यदि शल्यक्रिया के समय कोई समस्या / जोखिम उत्पन्न होता है तो उसी के अनुरुप उचित चिकित्सा कर सकते है।*
3. मुझे रिस्टेनोसिस के स्वाभाविक दर के विषय में भी समझाया जा चुका है (उदाहाण– औषधीयुक्त स्टेन्ट्स 3–5% और धातु निर्मित सामान्य स्टेन्ट्स 8–12%)*
4. मुझे यह भी समझाया गया है कि शिक्षा अथवा शोध कार्य हेतु इस प्रक्रिया की फोटोग्राफी एवं वीडीयो रिकॉर्डिंग भी की जा सकती है।
5. मुझे रीवैस्कुलराइजेशन अथवा एंजियोप्लाष्टी के आर्थिक व्यय के विषय में भी समझाया जा चुका है।

मैं ..... डाक्टर .....

को उपर उल्लिखित चिकित्सा पद्यति के क्रियान्वयन के समय यदि आवश्यक हो तो उपयुक्त चिकित्सा करने के लिए अधिकृत करता हूँ।

- मैं शल्यक्रिया / विधि के समय जैसा कि आवश्यक माना जाए वैसा ही किसी प्रकार कि निःसंज्ञा विधि प्रयोग करने के लिए भी अपनी सहमती देता हूँ।
- मैं यह भी प्रमाणित करता हूँ कि इस चिकित्सा के परिणति के विषय में जो भी स्थिति होगी उसके विषय में कोई भी आश्वासन अथवा निश्चयता नही दी गई है।
- मैं सम्पूर्ण चिकित्सा के समय चिकित्सक को पूर्ण आश्वासन और अपना सहयोग देता हूँ। चिकित्सा पद्यति के उपरान्त भोजन, औषधी ग्रहण तथा किसी प्रकार की सावधानी के विषय में चिकित्सक के द्वारा दिए गए निर्देशों का मैं पालन करुंगा।
- मैं यह भी प्रमाणित करता हूँ कि किसी प्रकार की जटिलता अथवा संभावित घटना के होने पर मै चिकित्सक अथवा चिकित्सालय को दोषी नही बनाऊंगा।

चिकित्सा पद्यति में निम्न लिखित जटिलताएँ उत्पन्न हो सकती है:

1. स्थानीय रक्तक्षरण
2. स्यूडोएन्यूरिज्म
3. कन्ट्रास्ट एलर्जी
4. एरिथमिया
5. मायोकार्डियल इनफार्कशन (एम. आई)
6. अथवा संभावित मृत्यु

रोगी के नाम: ..... हस्ताक्षर: .....

साक्षी के नाम: ..... हस्ताक्षर: .....

तारिख: ..... रोगी के साथ सम्बंध .....

हृदय रोग विशेषज्ञ का हस्ताक्षर: .....

हृदय रोग विशेषज्ञ का नाम: .....

नोट: 1. *सहमति रोगी द्वारा ही हस्ताक्षरित की जाएगा। अवयस्क अथवा शारीरिक और मानसिक रुप से असमर्थ रोगी की स्थिति में एक घनिष्ट सम्बन्धि अधिकृत कर सकते है।*

2. *यह स्पष्ट है कि सभी प्रकार के न्यायिक मत विभिन्नता के लिए स्थानिय न्यायालय ही उचित स्थान होगा।*

* *एंजियोप्लाष्टी करने की स्थिति मे ही प्रयोज्य*

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INFORMED CONSENT FORM / सूचित सहमति पत्र

Patient Name ..... UHID .....

Age / Sex ..... Ward / ICU .....

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।
..... PTA-Stent .....
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।
.....
.....
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।
.....
.....

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. P. K. Sahoo .....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. It has been explained to me that during the course of the above said procedure, there may be reuse of certain consumables and devices as applicable after proper sterilization and it will be charged accordingly.
मुझे समझा दिया गया है कि उपर्युक्त प्रकिया के दौरान, कुछ कन्स्यूमेबल या डिवाईस का (उचित कीटाणुशोधन के उपरांत) पुनः प्रयोग किया जा सकता है तथा यह तदनुसार चार्ज किया जाएगा

12. 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।

13. ☐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।
.....

14. 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।

15. 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।

16. I hereby acknowledge that the information given including but not limited to my past history/hospitalization etc. are complete and true to the best of my knowledge and belief and nothing has been concealed there from. I shall not hold the Treating Consultant/his or her team/**QRG Health City Hospital** or any of the persons associated with **QRG Health City Hospital** liable for the consequences which may arise due to the non-disclosure/incorrect 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:.....Date.....Time.....
रोगी के हस्ताक्षर/अंगूठे का निशान:.....दिनांक.....समय.....
Name:.....
नाम:.....
Witness's Signature/Thumb Impression:.....Date 7-1-19 Time 4:35 PM
गवाह के हस्ताक्षर/अंगूठे का निशान:.....दिनांक.....समय.....
Name:.....
नाम: Sunita Verma
Doctor's Signature:.....Date.....Time.....
डॉक्टर के हस्ताक्षर:.....दिनांक.....समय.....
Name:.....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
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

No : 33-19/237 UHID : 100055633
Rakesh Verma DOA : 07/01/201913:43
Y/M CCU/CCU007
Rakesh Rai Sapra

INFORMED CONSENT FORM / सूचित सहमति पत्र

Patient Name ..... UHID .....

Age / Sex ..... Ward / ICU .....

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 रिश्तेदार–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।
   .....
   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।
   .....
   .....
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।
   .....
   .....

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. Rakesh Sapra 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. It has been explained to me that during the course of the above said procedure, there may be reuse of certain consumables and devices as applicable after proper sterilization and it will be charged accordingly.
मुझे समझा दिया गया है कि उपर्युक्त प्रकिया के दौरान, कुछ कन्स्यूमेबल या डिवाईस का (उचित कीटाणुशोधन के उपरांत) पुनः प्रयोग किया जा सकता है तथा यह तदनुसार चार्ज किया जाएगा

12. 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।

13. ☐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।
.....

14. 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।

15. 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।

16. I hereby acknowledge that the information given including but not limited to my past history/hospitalization etc. are complete and true to the best of my knowledge and belief and nothing has been concealed there from. I shall not hold the Treating Consultant/his or her team/**QRG Health City Hospital** or any of the persons associated with **QRG Health City Hospital** liable for the consequences which may arise due to the non-disclosure/incorrect 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 : कृपया 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:.....Date.....Time.....

रोगी के हस्ताक्षर/अंगूठे का निशान:.....दिनांक.....समय.....

Name:.....

नाम:.....

Witness's Signature/Thumb Impression:.....Date.....Time.....

गवाह के हस्ताक्षर/अंगूठे का निशान: Sunita Verma दिनांक.....समय.....

Name: w.i.fe

नाम:.....

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

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

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

QRG MEDICARE

ADULT CARDIAC CATHETERISATION LABORATORY

VASCULAR ACCESS MONITORING

Date 8/1/19

Name.....

IPD No..... Time of Sheath Removal 11.10pm

VASCULAR ACCESS SITE **RIGHT / LEFT** **FEMORAL / OTHER**

Time	Hematoma	Distal Pulses	Remarks
11.10pm	Absent	Present	No bleeding
12AM	Absent	Present	NO bleedy
1 AM	Absent	Present	NO bleedy
2am	Absent	Present	NO bleedy
3am	Absent	Present	NO bleedy
	Absent	Present	NO bleedy

Signature of Nurse

QRG Health City

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

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

PROCEDURE SAFETY RECORD

Patient Name MR. Rakesh Verma Age/Sex 56 Y/M

OPD/UHID NO 100055633 Date 7/1/19 Time 4 PM

LOCATION : ENDOSCOPY/BRONCHOSCOPY/CATH LAB/ OTHERS Cath Lab

KNOWN ALLERGY ☐ ~~No~~ ☐ YES (Specify)

Pre Procedure Check List	Yes	No	NA	Remarks
NPO Status checked	✓			
Part preparation done	✓			To be filled by the nurse
IV Line in situ with heplock	✓			Name: SINU
Dentures/Spectacles removed		✓		Signature
Prosthesis/Jewellery removed	✓			Emp ID 30423
Special medical equipment arranged	✓			Time 4:11 PM
Implant arranged	✓			

Pre Procedure Vitals

Vitals	Time	Blood Pressure	Heart Rate	Respiratory Rate	Saturation	GCS
Pre Procedure	4:10pm	150/80	94	24	99%	

Time out Before Procedure			Time out Participants	
Correct Patient	☑ ~~Yes~~	☐ No	PHYSICIAN(S):	DR. Sethi
Correct Procedure	☑ ~~Yes~~	☐ No	ANESTHETIST	
Consent Signed	☑ ~~Yes~~	☐ No	TECHNICIAN	Nursing Assistant
			NURSE(S)	Bablu
			TIME:	

Intra Procedure Monitoring of Vitals

Vitals	Time	Blood Pressure	Heart Rate	Respiratory Rate	Saturation	Level of Sedation
During Procedure (Regular Interval)	4:15pm	140/90	92	24	99%	

Medication Prescription And Administration Record During The Procedure							
Name of the Medication	Dose	Route	Frequency	Time	Sign of Physician	Nurses Signature	Emp. ID
INJ Heparin	25000 IU	IV	STAT	4:15pm	DR Sappa		8942
INJ HEPARIN	25000 IU	IV	STAT	4:35pm	DR Sappa		27567

ACT (Sec): ..... Time: .....

ACT (Sec): ..... Time: .....

Brief Description of the Procedure
Name of the procedure performed CAG + PCI
Any other relevant details: → No Specific during Procedure - → CAG via Left Right Radial artery → 6F Sheath present in right hand. → No Bleeding, No Hematoma from puncture site → Pt. Shifted to CCU

Any Equipment problem identified	NO	To be filled by the doctor
Condition at the time of Discharge/Transfer	Stable	Name: DR Sappa
Discharge / Transfer Advice	CCU	Signature
Discharge / Transfer Medications	Recording in Medication Chart	Emp ID

POST PROCEDURE MONITORING OF VITALS						
Vitals	Time	Blood Pressure	Heart Rate	Respiratory Rate	Saturation	Level of Sedation
Post Procedure						

Physician: DR. Sappa	Nurse: SINU	Technician: MUSKAN
Name:	Name: SINU	Name: MUSKAN
Signature: Sappa	Signature:	Signature:
Date: 6/1/18	Date: 6/1/18	Date: 6/1/18

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

(1)

Dr. Rakesh Rai Sapra

IP No : 33-19/237
Mr. Rakesh Verma
56 Y/M CCU/CCU007

UHID: 100055633
DOA : 07/01/201913:43

INITIAL NURSING ASSESSMENT FORM

Admission date	7/1/19.		
Department	[✓] Through OPD [ ] Through ER		[ ] Self
Time of Arrival in unit	1:30 pm	Time of Completion of assessment	2:00 pm
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): 98.6°F	Height(cm):	[ ] Bed control	[ ] Washroom
Pulse(/min): 98/m	Weight(kg):	[ ] Call bell	[ ] Visitation rules
Respiration(/min): 60/m		[ ] Television	[ ] Meal timings
BP(mm of Hg):		[ ] 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:

Chest pain

2. Past Surgical History:

No

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 ..... Normal .....

If Weight Loss/Gain is < 3Kg or > 3 Kg ..... NA .....

Any Digestive Problem ..... NA .....

VULNERABLE PATIENT- ANY OF THE BELOW CONSIDERED AS VULNERABILITY

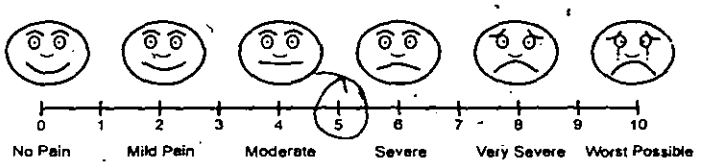
Categories	Age<16>65	Any mental or neurological disability	limited physical mobility	Communication barrier	patient on restraint	Immuno--supressed Patient	Victim of abuse & Neglect	Drug/Alcohal Dependent
(✓) Yes			✓					
( ) No	✓	✓		✓	✓	✓	✓	✓

Activities of Daily Living (ADL's)

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

WONG - BAKER FACIAL GRIMACE SCALE
NUMERICAL RATING SCALE

Pain Score: ..... 5/10 .....



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 ..... 18 .....

Location of bed sore	NA	Grade	NA

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 25

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 ..... **Relationship with patient** .....

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 ..... **Employee ID** ..... **Sign** .....

Name of Ward Supervisor ..... **Employee ID** ..... **Sign** .....

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

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

Date 10-1-19

DAILY NURSING ASSESSMENT SHEET

SHIFT/TIME	Morning	Evening	Night
Neurological status	A		
GCS	E4V5-M6		
Mode of oxygen	RA		
Cough	N		
Dressing	NA		
Skin status	I		
Vulnerable status	No		
VIP score	0		
Braden Score	21		
1.stage of pressure ulcer	NA		
2.location of pressure ulcer			
Morse Fall Score	25		
EWS score	0		
Pain score	8/10		
Signature of Nurse	KRISHNA		
Emp. ID	29771		

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

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3.	Use elbow and heel protectors.
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5.	Provide routine care and moisturize skin daily.
6.	Document individualized care plan.

High to very high risk	
1.	Include all above mentioned points
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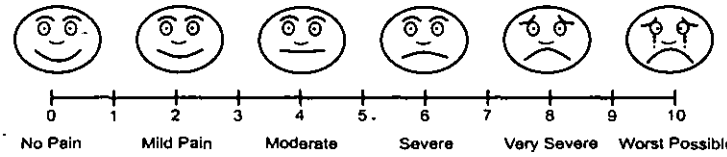
Score braden scale : At risk - 15-18 Moderate - 13 to 14 High risk - 10 to 12 Very high risk - 9 or less

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

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

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

3

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

IP No 33-19/237 UHID 100055633
Date 9/1/19

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	I	I	No
Skin status	I	I	I
Vulnerable status	Yes	Yes	Yes
VIP score	0	0	0
Braden Score	25	25	23
1.stage of pressure ulcer	NA	NA	NA
2.location of pressure ulcer	NA	NA	NA
Morse Fall Score	18	18	18
EWS score	0	0	0
Pain score	0/10	0/10	0/10
Signature of Nurse	Yogy		Ruya
Emp. ID	2540		30125

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
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	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
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AVPU				alert	Verbal	pain	Unresponsive

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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
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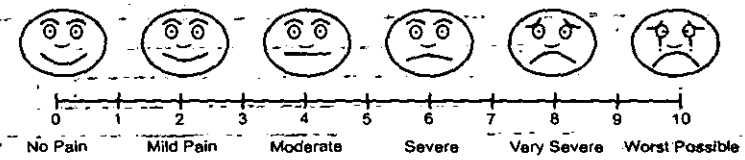

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PAIN MANAGEMENT

Date	Shift/Time	Pain score	Quality	Location	Interventions/Comfort	Medicine	Time/Sign
Inta							

COMFORT MEASURES

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S	Sharp/Stabbing	ES	Emotional support
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T	Tingling	IP	Ice pack
TH	Throbbing & Radiating	MA	Medication Administration

LINES & DRAINS

S. No.	Type	Site / Location	Day	Remarks
1.	IV line	Rt. Forearm	D3	good
2.	Foley	14Fr	D2	good

PAIN ASSESSMENT TOOL BEING USED

☐ FLACC: ☐ WB ☐ NRS

MORSE FALL RISK ASSESSMENT

	CATEGORY	CHARACTERISTIC	SCORE
1	Level of consciousness	Knows own limits, reliable safety awareness	0
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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

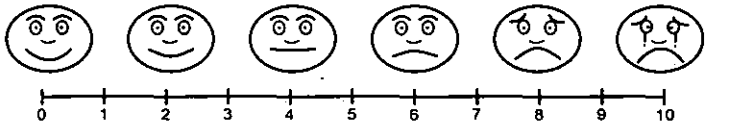
Sensory Mental	Moisture	Activity	Mobility	Nutrition	Friction / Shear
1 Total limited	1 Constantly moist	1 Bed fast	1 100% immobile	1 Very poor	1 freequent Sliding
2 Very limited	2 Very moist	2 Chair fast	2 Very limited	2 <½ daily portion	2 Feeble Corrections
3 Slightly limited	3 Occasionally moist	3 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	Medicine	Time/Sign

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
1.	I/V line	Rt hand	D2	good

PAIN ASSESSMENT TOOL BEING USED

☐ FLACC: ☐ WB ☑ NRS

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

Rakesh Rai Sapra

No : 33-19/237 UHID : 100055633
Rakesh Verma DOA : 07/01/201913:43
Y/M CCU/CCU007

Date ..... 7/1/19 .....

DAILY NURSING ASSESSMENT SHEET

SHIFT/TIME	Morning	Evening	Night
Neurological status		A	A
GCS		E4V5M6	E4M6V5
Mode of oxygen		RA	RA
Cough		NA	N
Dressing		NA	D
Skin status		I	I
Vulnerable status		Yes	Yes
VIP score		0	0
Braden Score		18	18
1.stage of pressure ulcer		NA	NA
2.location of pressure ulcer		NA	NA
Morse Fall Score		Yes	Yes
EWS score		0	0
Pain score		5/10	2/10
Signature of Nurse		Sman	Arya
Emp. ID		28527	28527

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

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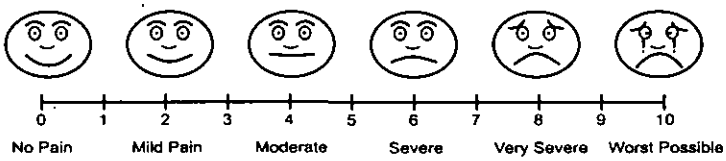

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PAIN MANAGEMENT

Date	Shift/Time	Pain score	Quality	Location	Interventions/Comfort	Medicine	Time/Sign
7/11/	5pm	5/10	A	chest	MA	Inj NSA	Asha 5pm
	10pm	2/10	A	chest	Position-gm	T. Wikoson	Asha/10pm

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
1.	Wlma	ocn	01	good

PAIN ASSESSMENT TOOL BEING USED

☐ FLACC: ☐ WB ☐ NRS

NURSES HANDOVER CHECKLIST

	ELEMENTS	Morning	Evening	Night
	Patient name & ID band		Checked	Checked
HYGIENE	Self/bed bath		Yes	Yes
	Skin care ....12h.....hourly		Yes	Yes
	Back Care .....12h.....hourly		Yes	Yes
	Mouth Care .....6h.....hourly		Yes	Yes
	Eye Care .....hourly		No	Yes
	Hair Care .....hourly		No	Yes
	Perineal care (for Female)		No	No
	Vaginal Pack		No	No
	Any special care		No	No
RESPIRATORY THERAPY	NGT care		No	No
	Chest physiotherapy		No	No
	Incentive Spirometery		No	No
	Steam inhalation		No	No
	Nebulization ____ hourly		No	No
	Suctioning ____ hourly (Oral/Nasopharyngeal/ Tracheal/ Endotracheal)		No	No
	Tracheostomy care		No	No
	Chest tube care		No	No
REHABIL-ITATION	Ambulation		No	No
	Physiotherapy		No	No
	ROM exercises		No	No
	Repositioning ____ hourly		No	No
GI & GENITO URINARY	Enteral feeding ____ hourly (NGT/PEG/J tubes)		No	No
	Enteral tube site care		No	No
	NG aspiration ____ hourly		No	No
	NPO status		No	No
	Type of diet		Yes	Pro. Clr
	Ostomy care		No	No
	Enema		No	No
	Catheterization		No	No
	Catheter care / Foley's Catheter care		No	No
	Sitz bath		No	No
	Drain site care (JP/Penrose/Hemovac)		No	No
OTHERS	Compress (hot/ cold)		No	No
	Barrier/ Reverse barrier Nursing		No	No
	Blood Transfusion		No	No
	Care of all lines(IV/Central/Arterial/PICC)		Yes (IV)	Yes
	Care of HD catheter		No	No
	Flushing Intermittent infusion lock		Yes (IV)	Yes
	Site care		No	No
	Specimen collection		No	No
	End of life care		No	No
SURGICAL	Any surgery planned		No	No
	Part preparation		No	No
	Skin preparation			No
	Pre-operative checklist complete		No	No
	Bill clearance(for surgery or Procedure)		No	No
	Abnormal reports/Critcal lab values		No	No
HEALTH EDUCATION	Medications(Action/side effects/Special Instructions)		No	Yes
	Diet (Type/ restrictions)		No	Yes
	Infection prevention		No	No
	Post procedure care		No	No
	Postnatal education (for mothers)		No	No
	Injury/ Fall prevention		No	Yes
	Symptoms to seek medical help		No	No
	Discharge education & follow up		No	No
PEND-ING	Investigation/procedure (Mention if any)		No	No
	Consultation (Mention if any)		No	No
	Medications (Mention if any)			No
Event	(Any special events)			

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

NURSES HANDOVER CHECKLIST

	ELEMENTS	Morning	Evening	Night
	Patient name & ID band	Checked	Checked	Checked
HYGIENE	Self/bed bath	Yes	Yes	Yes
	Skin care .....hourly	Yes	Yes	Yes
	Back Care .....hourly	Yes	Yes	Yes
	Mouth Care .....hourly	Yes	Yes	Yes
	Eye Care .....hourly	Yes	Yes	Yes
	Hair Care .....hourly	Yes	Yes	Yes
	Perineal care (for Female)	NO	No	NO
	Vaginal Pack	NO	No	NO
	Any special care	NO	No	NO
RESPIRATORY THERAPY	NGT care	NO	No	NO
	Chest physiotherapy	NO	No	NO
	Incentive Spirometery	NO	No	NO
	Steam inhalation	NO	No	NO
	Nebulization hourly	NO	No	NO
	Suctioning hourly (Oral/Nasopharyngeal/ Tracheal/ Endotracheal)	NO	No	NO
	Tracheostomy care	NO	No	NO
	Chest tube care	NO	No	NO
REHABIL-ITATION	Ambulation	NO	No	NO
	Physiotherapy	NO	No	NO
	ROM exercises	NO	No	NO
	Repositioning hourly	NO	No	NO
GI & GENITO URINARY	Enteral feeding hourly (NGT/PEG/J tubes)	NO	No	NO
	Enteral tube site care	NO	No	NO
	NG aspiration hourly	NO	No	NO
	NPO status	NO	No	NO
	Type of diet	DM, N.D	DM, N.D	DM, N.D
	Ostomy care	NO	No	NO
	Enema	NO	No	NO
	Catheterization	NO	No	NO
	Catheter care / Foley's Catheter care	NO	No	NO
	Sitz bath	NO	No	NO
	Drain site care (JP/Penrose/Hemovac)	NO	No	NO
OTHERS	Compress (hot/ cold)	NO	No	NO
	Barrier/ Reverse barrier Nursing	NO	No	NO
	Blood Transfusion	NO	No	NO
	Care of all lines(IV/Central/Arterial/PICC)	Yes IV	Yes	Yes
	Care of HD catheter	NO	No	NO
	Flushing Intermittent infusion lock	Yes IV	Yes	Yes
	Site care	NO	No	NO
	Specimen collection	NO	No	NO
	End of life care	NO	No	NO
SURGICAL	Any surgery planned	NO	No	NO
	Part preparation	NO	No	NO
	Skin preparation	NO	No	NO
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	Abnormal reports/Critcal lab values	NO	No	NO
HEALTH EDUCATION	Medications(Action/side effects/Special Instructions)	Yes	Yes	Yes
	Diet (Type/ restrictions)	Yes	Yes	Yes
	Infection prevention	Yes	Yes	Yes
	Post procedure care	NO	No	NO
	Postnatal education (for mothers)	NO	N/A	NO
	Injury/ Fall prevention	Yes	Yes	Yes
	Symptoms to seek medical help	NO	NO	NO
	Discharge education & follow up	NO	No	NO
PEND-ING	Investigation/procedure (Mention if any)	NO	No	NO
	Consultation (Mention if any)	NO	No	NO
	Medications (Mention if any)	NO	No	NO
Event	(Any special events)			

Signature of Departmental Incharge..... Emp. ID.....2563.....

QRG Health City

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
S6 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

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
10/01/19 9AM	Pain (4/10)	Acute pain related to procedure	→ To reduce the level of the pain.	→ Assess the general condition → Assess the level of the pain. → Provide analgesics → Do the re-assessment of the pain.	YES YES YES	Pain level is reduced.	finish 2977

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

QRG Health City

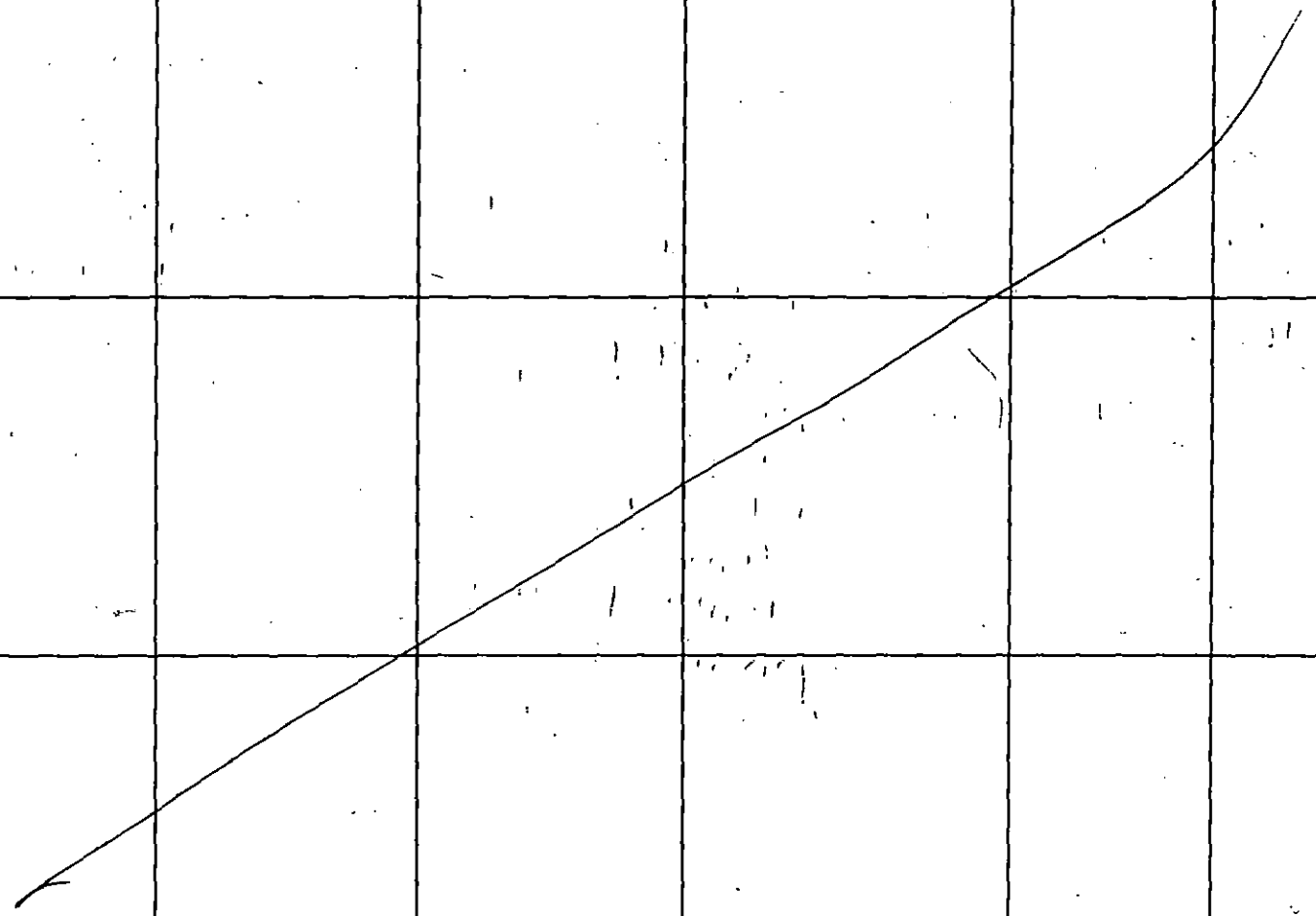
IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

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
9/1/19 @ 8am	Activity intolerance	Activity intolerance related to weakness	- Assess the nutritional status - Instructed patient to take diet diet on time - Psychological support given	yes yes yes	Hydration maintained	0582	0582
3pm	Weakness • fatigue.	→ Generalized weakness related to procedure.	→ To reduce the weakness.	→ Assess the general conditions. → Assist the patient during activities. → Keep the call bell with in reach.	YES YES YES YES	Weakness is reduced.	2971

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



Date/Time	Nursing Assessment	Nursing Diagnosis	Expected Outcome	Intervention / Planned care	Implementation	Evaluation	Signature
8/1/19 9pm	→ infection	→ Infect Reate to the I/V dline & Sneaty Site	→ Reduce the infect	→ Assess the Pt condition → Give Proper Nutrimeal diet → Give Pharmacological support	→ Yes → Yes	→ Reduce the infect	
8/1/19 9pm	→ Anxiety	Anxiety related to Pt condition as evidence by asking	Reduced Anxiety	→ Asses the condition → Administer medication	yes yes	Reduced Anxiety	29/1
		doughts					

QRG Health City

Rakesh Kal Sapra

No : 33-19/237 UHID : 100055633
Rakesh Verma DOA : 07/01/201913:43
Y/M CCU/CCU007
Rakesh Kal Sapra

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
7/1/19 @ 3pm	→ Pt had Chestpain	→ Acute Chest pain related to the disease Cvd.	→ To redu Chest pa	→ Assess col the level of pain → VS checked → Roped up Position → NTG on flw	→ yes yes	→ Pt feel Comfo	
10pm	chest pain	Acute pain related to Pt condition as evidenced by facial expression	Reduced pain.	Health educated the Pt - Administra medication	yes yes	Reduc Pain	

1950A

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 1:43PM	UHID - 100055633
Patient name - Mr. Rakesh Verma	Age/Gender - Male/56 Yr
Address - H NO. 440IST FLOOR,	Mobile no. - 9990976447
Department name - Interventional Cardiology	Consultant - Dr. Rakesh Sapra/ Dr Suraj Singh

NUTRITIONAL ASSESSMENT

NUTRITIONAL ASSESMENT

Admitting diagnosis :	CHEST PAIN,CAD,P.PTCA , Dm
Height (cm) :	na
Weight (kg) :	na
BMI (kg/m2) :	na
IBW (kg) :	70
Unable to stand :	uts
Nutritional status :	Normal Nourished
Type of activity :	Sedentary
Food habit :	Vegetarian
Allergies and food sensitivity :	No
Dietary limitations :	Yes
Remarks :	LOW SALT
Type of diet :	NPO
Total Calories (Kcal) :	1800
Protein (g-kgIBW) :	70
Carbohydrate (gm) :	250
Fat (gm) :	20

Diet note :

Date & Time	Dietary notes
07/01/2019@3:01PM	NPO
08/01/2018@12:06PM	Dm NORMAL DIET
09/01/2019@10:45AM	Dm NORMAL DIET
10/01/2019@9:55AM	Dm. NORMAL DIET

Diet consultation given to patient.
Rakesh Verma Dietitian/Nutritionist given.

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No : 33-19/237 UHID : 100055633
Rakesh Verma DOA : 07/01/201913:43
Y/M CCU/CCU007
Rakesh Rai Sapra

NURSES NOTES

Patient Name | Age | Sex | Date

Name of Consultant | Bed No.

Date / Time	Notes
7/1/19 2:15	Receiving Notes → Received Pt from OPD Came c/o chest pain → Cath Profile send @ dne. → ECG taken. → Inf. NTG @ 9ml/hr.
4pm	→ VI's checked & Recorded. → Plan of Care → Pt. shifted for Cath
5:30pm	→ Received pt from Cath lab. → ECG taken, Radial sheath pre
6pm	→ No fresh complaints
7pm	→ Dr. Sapra seen the pt & advised for INF-NS @ 50ml/hr
8pm	→ Handover given to ward duty staff.

Night duty Report

8pm	→ Care handed over taken over from ward staff. (Concern). — Pt is stable & conscious. — Pt in Room.

Date / Time	Notes
6pm	- NIf NIs on bed - Treatment given. - Pt have no other complaints. - Sheath present.
12am	- Pt complain of abdominal discomfort informed Dr. Ulenche. Inj. Emeset, Inj. Tramadol gm + 100ml N/S - Alprox 0.5mg given - Ecg taken.
2am	- Pt slept well no complaint
4am	- Morning Care done
6am	- Vital Signs checked - Treatment gm
7am	- Lab (P) scheduled, Ecg, RBS done
8am	- Clinic Hand over given to M/D staff
8/01/19	Morning duty Notes
8.30Am	Hand over taken from night duty staff Aya
→	Patient conscious oriented
→	IV Cannula Patent
→	Cag + PTCA done yesterday through Radial Sheath.
→	DM Normal diet allowed.
10Am →	patient condition stable and No fever complain
→	Give all due medicine as per chart
12pm →	patient condition stable and No fever complain
→	IV fluid normal saline running
2pm →	Patient Stable.
→	patient IV fluid normal saline running

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56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

IP No : 33-19/237 UHID : 100055633

NURSES NOTES

Patient Name | Age | Sex | Date

Name of Consultant | Bed No.

Date / Time	Notes
4pm	→ patient condition stable and no fresh complaint
5pm	→ patient complaint of ~~vomiting~~ Giddiness Informed Duty Dr Vaibhav and Advised tab. Vertin 16mg stat → I.V fluid 75 ml/hr continue
7pm	→ patient condition stable no fresh complaint
8pm	→ patient condition Stable → Hand over Night duty staff Yogi
	Night Duty Report
8pm	→ Case hand over taken from DID staff (Yogesh). → P.I is stable & conscious. → P.I to Room on. → NS fluid on flow.
10pm	→ Treatment given as per duty chart. → P.I have no complaint.
12am	→ P.I slept well no complaint → IV fluid NS on flow.
2am	→ P.I slept well no other fresh complaint
4am	no complain's.

Date / Time	Notes
8am	- Morning care given - Treatment given & advice clearly explained - Monitoring Vital signs recorded - Intake & Output monitoring - Encouraged
6am	- IV & NS on place, output normal - Pt complaint of chest pain. Ecg done & informed Dr. Nibeen - Ecg, RBS done.
8am	- Care handover given to morning duty staff
	Anjana
9/1/19	Morning Duty Report (S/N Meena
8Am	Handover taken from night duty staff, patient is stable, conscious and oriented, IV cannula 20G present on right side, IVF NS 30 ml/hr on going-
10am	vitals checked & recorded-
	All due medication given no any ADR-
11am	Dr. Subhash consultation done.
12pm	TPR charting maintained-
	USG KUB done-
1pm	RBS checked & recorded-
1.45pm	All due medication given, no any ADR-
2pm	Handover given to evening duty staff Meena

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

P No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 2:1
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

NURSES NOTES

Patient Name | Age | Sex | Date

Name of Consultant | Bed No.

Date / Time	Notes
9/1/19 2pm	Evening Duty Notes on 9/1/19 → Recieved the pt. from morng duty staff, while receiving time pt. P&C conscious and oriented. → IV cannula present on the Lt. hand and IVF NS 30ml/hr ongoing → Foleys catheter is present.
3pm	→ Dr. R R Sapra seen the pt. and advised to shift pt to ward. → Shifted the pt. to 1250 A, with all reports ECG-4, X-ray-0, and USG & Echo report to be collected → Hand over given to the next duty staff with records & reports.
4.30pm	Recieving Notes Introduction:→ Patient is Recieved from the CCU. → IV Cannula present. → Folley's Catheter present. → Patient CAG & PTCA done on 7/01/19 → CAG Original Report sent to TPA. → Patient USG KUB & 2D ECHO Report Pending during taking hand over.

Date / Time	Notes
	Patient is Recieved with EC4-4, X-Ray-(1) H/o CAD, DM, [Post PTCA - 2 stickers].
	→ Patient RBS checking TDS.
	→ P/D coming morning. IV fluid NS. 30ml/hr.
6pm.	→ Patient have c/o ↓ muscle pain in left side. Informed to Doctor Lalitesh. Doctor advise to give Tab - Dolo 650mg stat. Tab Dolo 650mg given
6pm	Vitals are checked.
6pm.	→ Medications given as per drug chart.
7.30pm	RBS is 115 mg/dl. HIR 4 unit advise by Doctor Lalitesh.
8.30pm	→ Hand over given to the Night Staff

Night duty notes by Surya on 9-1-19

8pm

Introduction :-

Hand over taken from (R2) duty staff Krishna.

Lines and drains :-

IV cannula present on Rt hand IVF NS @ 30ml/hr ongoing

Diet :-

On normal diet allowed.

Bedsores :-

Pt admitted with the c/o chest pain. CAG done, H/O CAD and DM.

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IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

NURSES NOTES

Patient Name | Age | Sex | Date

Name of Consultant | Bed No.

Date / Time	Notes
	Assessment :- Pt conscious and and oriented. ~~c/o~~. RBS. TDS. Plan clexcraige tommarow.
12am	Pt refused for IVF during night.
2.30am	Pt is sleeping
6.30am	Pt complaints. ~~abdomen~~ giddiness and chest pain, T. pan 40, T. vertin 16mg given.
7.45am	Pt don't have relative c/o pain. and RBS 300mg/dl. informed to ~~Dr~~ concern duty ent advised to give S. actrapid stat.
	Reassessment :- No fresh complaints. Bond ons given to (M) duty staff Surya 30-12-18
	MORNING DUTY NOTES
8.30 Am	Introduction :→ Hand over is taken from the → Night staff Surya. → ID Band present.
	Line & Drains :→ IV canulla present. → Folley's catheter present.

Date / Time	Notes
9Am	→ Diet :→ Patient is on Diabetic Normal diet.
	Situation :→ Patient have muscle pain in left side chest.
	Back ground :→ Patient is admitted with c/o chest pain. CAG & PTCA done on 7/01/19.
10Am.	Assessment :→ Patient is conscious and oriented. → Vitals are checked. → Medications given as per drug chart. → Patient examination by doctor. → Patient is discharge. → Final billing slip. Waiting for financial Approval. → Financial clearance done → IV canula removed. → Patient discharged with folley's →
	Reassessment :→ Patient is stable
	Event :→ No event.
2.Sopn.	→ Patient left the room.

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

HOURLY ROUND LOG

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

DATE: 9-1-19

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								
8AM								
9AM								
10AM								
11AM								
12N								
1PM								
2PM								
3PM								
4PM								
5PM								
6PM								
7PM								
8PM								
9PM	Surya	9PM	N	N	N	N	N	
EVERY 2 HOUR ROUNDS (10PM - 6AM)								
10PM	Surya	10 PM	N	N	N	N	Y	4 DIA
12AM	Surya	12 am	N	N	N	N	N	
2AM	Surya	2-10m	N	N	N	N	N	
4AM	Surya	4-30 m	N	N	N	N	N	
6AM	Surya	6-Am	N	N	N	N	N	
CHECKED BY:								VERIFIED BY:
STAFF NURSE NAME(MORNING):				SIGN:				NURSING INCHARGE (Name & Emp I.D.)
EMP I.D.:								Nirmala 30363
STAFF NURSE NAME(EVENING):				SIGN:				
EMP I.D.:								
STAFF NURSE NAME(NIGHT): Surya				SIGN: Surya 30363				
EMP I.D.: 30363								

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

Y/M CCU/CCU007
Rakesh Rai Sapra
No : 33-19/237 UHID : 100055633
Rakesh Verma DOA : 07/01/201913:43
Y/M CCU/CCU007

VALUABLE HANDOVER FORM

Patient Name ..... Age. ..... Sex ..... Date .....

DOA No. ..... IPD No. .....

Diagnosis ..... Unit .....

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 Yes
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 ..... ID ..... Sign .....

Received By :

Name of Patient ..... Date ..... Sign .....

Name of Attendant ..... Sunita Verma ..... Relationship ..... Sign .....

Date 7/1/19 Time 2pm

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

Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID: 100055633

QRG MEDICARE

PATIENT TRANSFER SUMMARY

Patient Name ..... Age ..... Sex : ☑ Male ☐ Female

IPD No. ..... Date of Transfer 9/1/19

Time of Transfer ..... Shifting From ..... Shifting To 1250 A

Mode of transfer ☐ Bed ☐ Stretcher ☑ Wheelchair ☐ Ambulatory Informed attendant ☐ Yes ☐ No

Diagnosis:

P. BLCA

Course of treatment (significant findings & investigations)

Medication reconciliation & other treatment (to be continued)

As per drug chart.

Pending investigations (to be collected)

No.

Pending referrals / follow up consultations

No.

Reasons For Transfer: ☑ Clinical improvement ☐ Family / Surrogate Request ☐ Other's(specify) _____

Patient Condition at Transfer:

Vitals: BP: 140/80 HR: 86bpm SpO2: 98% Temp: 98.6F Pain Score: 0/10 (1-10)

Level of Consciousness: ☐ Lethargic/Sleepy ☐ Stupourous ☐ Comatose/Unresponsive

Conscious & Oriented

Skin Integrity : ☑ Intact ☐ Non-intact

a) Dressing _____ Dry _____ Soaked NA

Bed Sore: ☑ No ☐ Yes Site _____ Degree _____

Intake 1400ml Output 1680ml

Handover Details :

Diagnostic Report Handed Over (Total no) nil

1. Lab reports: Blood reports. , PPCA Cover (2),
2. Old reports: _____
3. Radiological films: CT/MRI/USG/X-RAY/Doppler Studies/Others: ECG, X-ray (1)

Pending Medication/ Investigation reports:

Echo - (1), USG P. (1)

Valuables (if any)
(Clothes/Dentures/Glasses/ others _____) : Handed over to _____

Invasive lines / drains / tubes(Mention type/site/day)

1. IV cannula 20.20G Lt. hand.
2. Foley catheter.
3. _____
4. _____

Transferring Nurse Name & ID No.	Receiving Nurse Name & ID No.
Aswathy 28401	
Date / Time : 9/1/19	Date / Time :

Transfer Out Details (outside hospital) :

Name of the Receiving Healthcare Organization _____

Patient Condition During Transfer : N/A

Transferring Doctor's Name & Signature	Receiving Doctor's Name & Signature
Dr. Lakshmanan	
Date / Time : 9/1/19	Date / Time :

QRG Health City

QRG MEDICARE LTD.

Basement-02, 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	: 33-19/237	**Issue No**	: H0138619/78559
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 08/01/2019 7:00PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77892	**Indent Date**	: 08/01/2019 6:56PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	FOLEY CATHETER 14 2WAY (RUSCH) (SUB OF :- FOLLY CATHETER 14NO(TRUCATH))-(NOS)	90183990	P18302	RUSCH	30/06/2023	114.00		1	114.00	0.00	114.00
2	UROMETER (POLYMED)-(NOS)	9018	1814673M		30/10/2023	440.00	1	1	440.00	0.00	440.00
3	LOX 2% JELLY (SUB OF :- XYLOCAINE JELLY(LOX))-(NOS)	30049099	U2180	NEON	30/09/2020	33.90		1	33.90	0.00	33.90

Sub Total : 587.90 Disc Amount : 0.00 **Net Bill Amount : 587.90**

Checked By :

Prepared By : Dheeraj Kumar

Acknowledge By : Dheeraj Kumar

QRG MEDICARE LTD.
Plot No - 01, Sector 16,Faridabad-121002 Haryana-
Tel :91-129-4330000
E-mail :info@qrgmedicare.com
Website:www.qrghealthcity.com

PAN No. : AAACQ2238D
GST No. : 06AAACQ2238D1ZW

* 1 0 0 0 5 5 6 3 3 *

Advance Deposit Receipt

Receipt no	: QHA-19/26033	Receipt Date	: 07/01/2019 1:57PM
UHID	: 100055633	IP No .	: 33-19/237
Patient Name	: Mr. Rakesh Verma	Admission Date	: 07/01/2019
Gender/Age	: Male/ 56 Yr	Payer .	: FAMILY HEALTH PLAN LTD.
Contact No	: 9990976447		
Address	: H NO. 440IST FLOOR , SECTOR-16 - 121002, FARIDABAD, Haryana, INDIA		

Particulars	Amount
IPD Collection	15000.00
Total Amount (Rs.):	**15000.00**

Remarks :

By Credit Card: Rs. 15000.00/- xxxx-xxxx-xxxx-9008

Received with thanks from Mr. Rakesh Verma an amount of (Rs.) Fifteen Thousand only.

Authorised Signatory
(TamannaChaprana)

*** Online payment option is also available in our website www.qrghealthcity.com**

Printed By: 28771 Prepared By: 28771 Print Date & Time: 07/01/2019 PM

QRG MEDICARE LTD.
Plot No - 01, Sector 16,Faridabad-121002 Haryana
Telephone: 91-129-4330000, fax: 0129-4330033

Counseling Detail

Counseling No :	18-19/4841	**Counseling Date :**	07/01/2019
Registration No :	100055633	**Patient Name :**	Rakesh Verma
Gender/Age :	Male/24/09/1962	**Mobile No :**	9990976447
Expected Date Of Admission :	07/01/2019	**Doctor :**	Dr. Rakesh Sapra/ Dr Suraj Singh
Company :	FAMILY HEALTH PLAN LTD. - Credit		
Address :	H NO. 440IST FLOOR,		
About Counceling :	CONSERVATIVE		
Remarks :			
Service Remarks :	ESTIMATE FOR 1 DAY		

HEAD NAME	SERVICE NAME	CCU
ADMIN CHARGE	Admin Charge	700.00
INVESTIGATION		15000.00
ROOM CHARGE		7000.00
VISIT FEE		2400.00
MEDICINE & CONSUMABLE CHARGES		20000.00
MISC CHARGES		0.00
	Total	**45100.00**

This is just an estimate and the final charges may vary depending upon the medical condition, treatment plan, actual drugs and consumables used, extra investigation/Doctor visit or the prolonged stay of the patient.

Draft/ corporate cheques should be in the name of "QRG MEDICARE LTD."

I hereby state that i take the full resposibility of setting the hospital bill before leaving the hospital at the patient discharge.

Patient'S / Attendant Singnature & Name With Contact Number	
Name Of The Counselor With Employee Id Code	Tamanna Chaprana (28771)

 Print Date & Time : 07/01/2019 01:38 PM

[redacted] CHECKLIST FOR ADMISSION

A	PRESCRIPTION /ADMISSION REQUEST	✓
B	TIME AND DATE	7/1/19 1.42PM
C	REGISTRATION FORM (IF NON -REGISTERED)	✓
D		
E	TPA DOCUMENT	✓
F	COUNSELLING	✓
G	PENDING DOCUMENTS (IF ANY)	✓
H	PASSES (ATTD./VISITOR)	✓

E
98771

QRG Health City

CORONARY ANGIOPLASTY REPORT

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	**IPD NO:33-19/04**
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	**PTCA No: 0487**

INDICATION / DIAGNOSIS: -

Unstable Angina

CAD- Triple Vessel Disease

PROCEDURAL DETAILS:- (Right Radial Artery)

PTCA + stent to PDA

GUIDING CATHETER :		6F JR 3.5
GUIDE WIRE	:	Whisper ES 0.014 x 190cm
BALLOON	:	Across HP 2.0 x 10mm, Sapphire 2.25 x 8mm
STENT	:	**ABLUMINUS 2.25 X 12MM**

DETAILS OF PROCEDURE:-

LMCA hooked with 6F JR 3.5 guiding catheter. PDA Lesion crossed with Whisper ES 0.014 x 190cm guide wire. Pre dilatation done with balloon Across HP 2.0 x 10mm at 10 atmospheric pressure. Stenting done with stent **ABLUMINUS 2.25 X 12MM** deployed in PDA at 10-12 atmospheric pressure. Post dilatation done with balloon Sapphire 2.25 x 8mm at 12-20 atmospheric pressure with good end result TIMI III flow achieved.

PROCEDURAL DETAILS:- (Right Radial Artery)

PTCA + stent to LAD

GUIDING CATHETER :		6F EBU 3.0
GUIDE WIRE	:	Whisper ES 0.014 x 190cm
BALLOON	:	Across HP 2.0 x 10mm, Sapphire NC 2.25 x 8mm
STENT	:	**EVERMINE 2.25 X 16MM**

DETAILS OF PROCEDURE:-

LMCA hooked with 6F EBU 3.0 guiding catheter. LAD Lesion crossed with Whisper ES 0.014 x 190cm guide wire. Pre dilatation done with balloon Across HP 2.0 x 10mm at 10 atmospheric pressure. Stenting done with stent **EVERMINE 2.25 X 16MM** deployed in LAD at 10 atmospheric pressure. Post dilatation done with balloon Sapphire NC 2.25 x 8mm at 20 atmospheric pressure with good end result TIMI III flow achieved.

QRG Health City

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	IPD NO:33-19
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	PTCA No: 048

ANGIOPLASTY RESULTS:-

Post procedure.
TIMI 3 Flow.
Successful, good end results.

POST PTCA RECOVERY:-

Uneventful.
Uncomplicated local puncture site.

FOLLOW UP PLAN:-

A. Diet
B. Activity
C. Medication
D. Follow up

As advised in discharge summary.

DR. RAKESH RAI SAPRA
MD Medicine, DM (Cardiology)
Sr. Consultant Interventional Cardiologist
& Director of Cardiology

QRG Health City

MED

CORONARY ANGIOGRAPHY REPORT

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	**IPD No:**
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	**Angio No.**

Provisional Diagnosis	:	**Unstable Angina**
BP	:	120/80mmHg
Hardware	:	Tiger 5F
Route	:	Right Radial Artery
Contrast	:	Omnipaque
LV Angiogram	:	Not done
Dominant	:	RCA

QRG Health City

Name: Mr. Rakesh Verma	Age/ Sex: 56/M	IPD No:
Cath Doctor: Dr. Rakesh Rai Sapra	Date: 07/01/2019	Angio No..

Left Main	:	Normal
Left Anterior Descending	:	Type III vessel, 80% stenosis in dista
Diagonal 1	:	Normal
Diagonal 2	:	Small vessel, 95% stenosis in
Left Circumflex Artery	:	Patent stent in proximal to mid LCX.
OM1	:	Normal.
OM2	:	Normal
Right Coronary Artery	:	Dominant vessel, Patent ste
PDA.	:	Normal.
PLV	:	Normal
Impression	:	Triple Vessel Disease
Advice	:	**PTCA + stent to PDA/LAD.**

DR. RAKESH RAI SAPRA
MD Medicine, DM (Cardiology)
Sr. Consultant Interventional Cardiologist
& Director of Cardiology

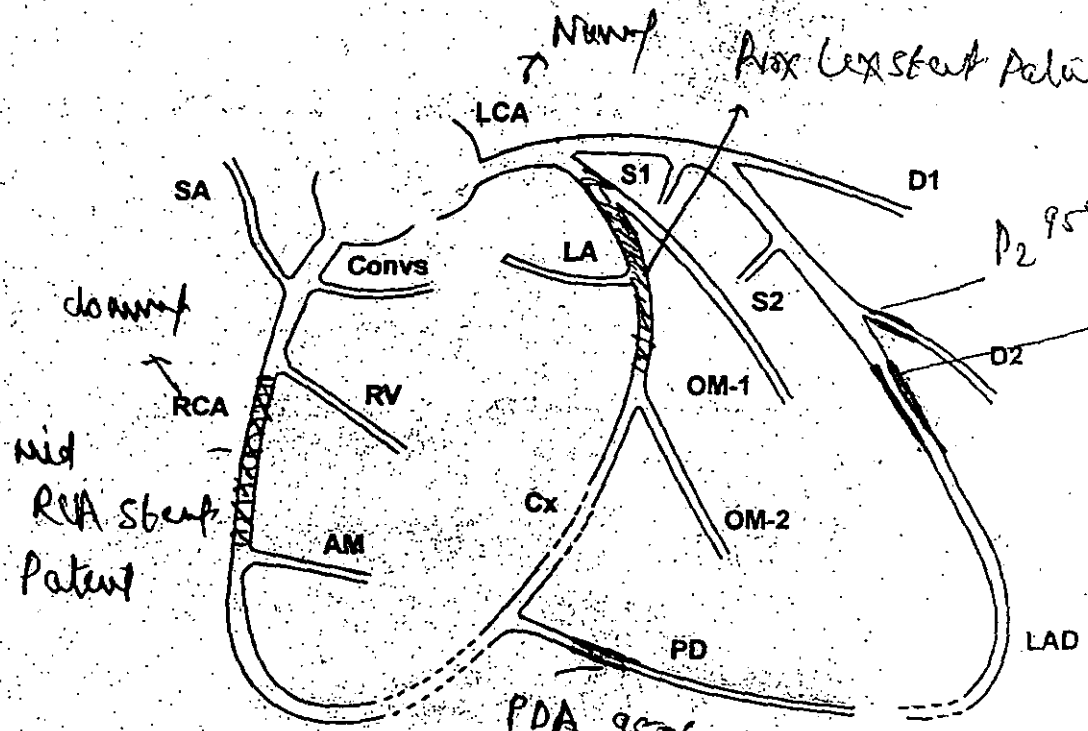
QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

CORONARY ANGIOGRAM

Angio No. 923 IPD No. 237 Date 07-1-19

Name Mr. Rakesh Verma Age/Sex 56/M Dr. R.R. Sapra



Normal Prox LexStent Patent.

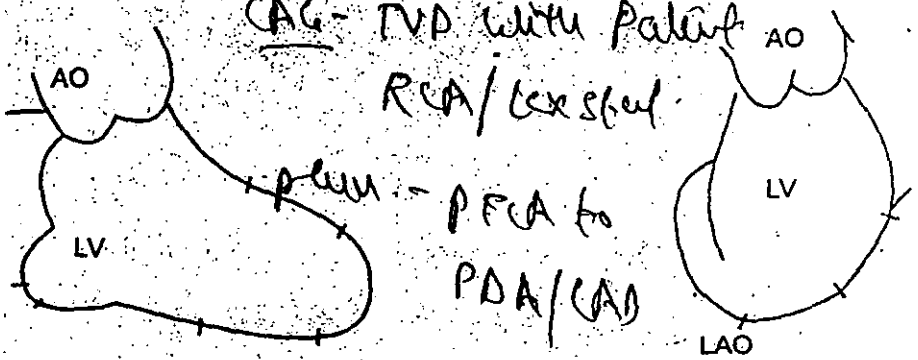
P2 95% Stenosis small vess distal LAD 80% Stenosis

dominant

Mid RCA Stent Patent

PDA 95% Stenosis

CAG - TVD with Patent RCA/LexStent. Plan - PCA to PDA/LAD



EDV ..... ESV ..... EF .....

1/9/2019 07:14:29

4

Chest pain

Rate	100	. Age not entered, assumed to be 50 years old for purpose of ECG interpretation
		. Sinus tachycardia.....rate> 99
PR	150	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	82	. Inferior infarct, age indeterminate.....Q>35mS, T neg, II III aVF
QT	332	
QTc	429	

--AXIS--

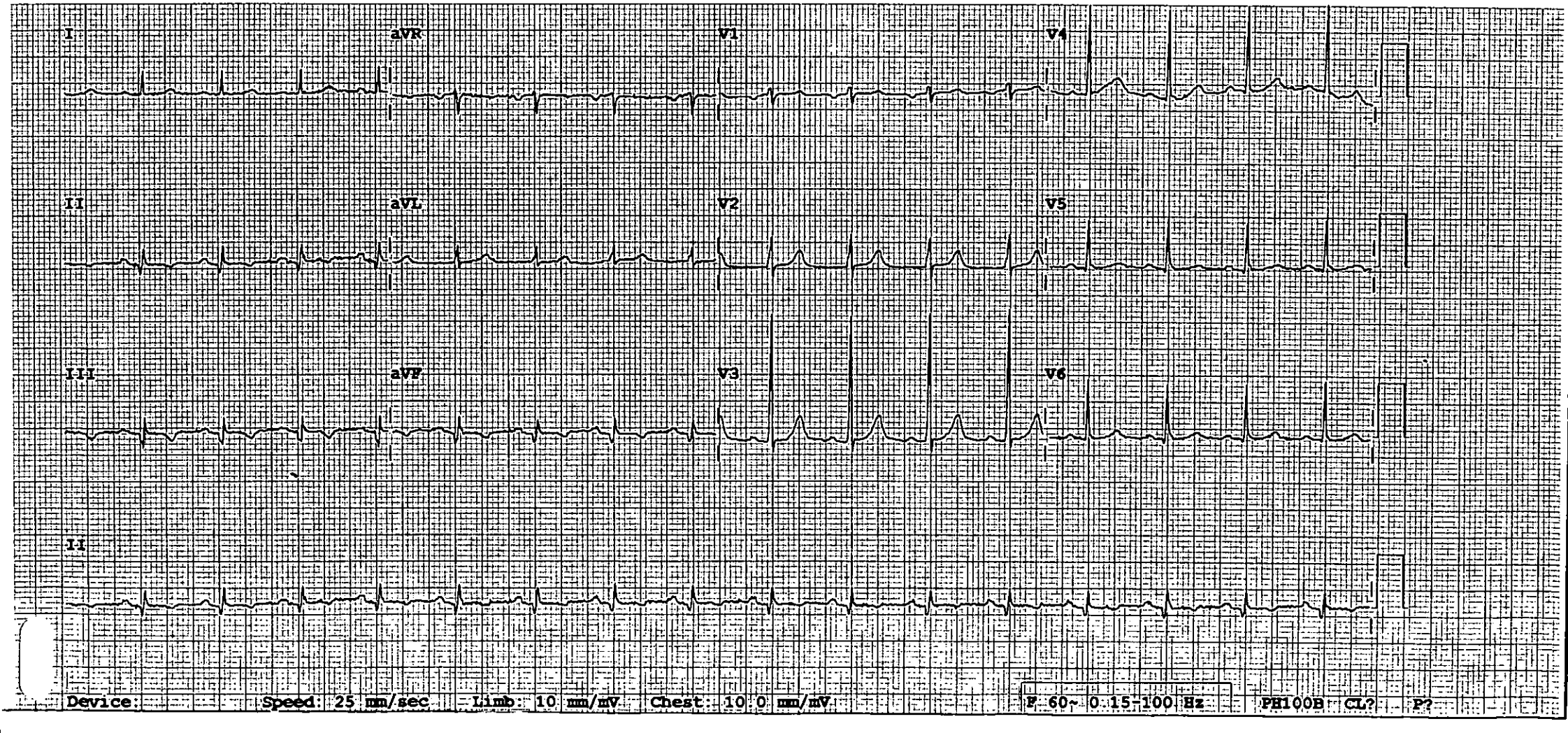
P	71
QRS	-1
T	-39

12 Lead; Standard Placement

- ABNORMAL ECG -

Unconfirmed Diagnosis

Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra
IP No : 33-19/237 UHID : 100055633



1/8/20 05:37:52

Rate	79	. Age not entered, assumed to be 50 years old for purpose of ECG interpretation
		. Sinus rhythm.....normal P axis, V-rate 50- 99
PR	150	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	88	. Inferior infarct, age indeterminate.....Q>35mS, T neg, II III aVF
QT	368	
QTc	422	

--AXIS--

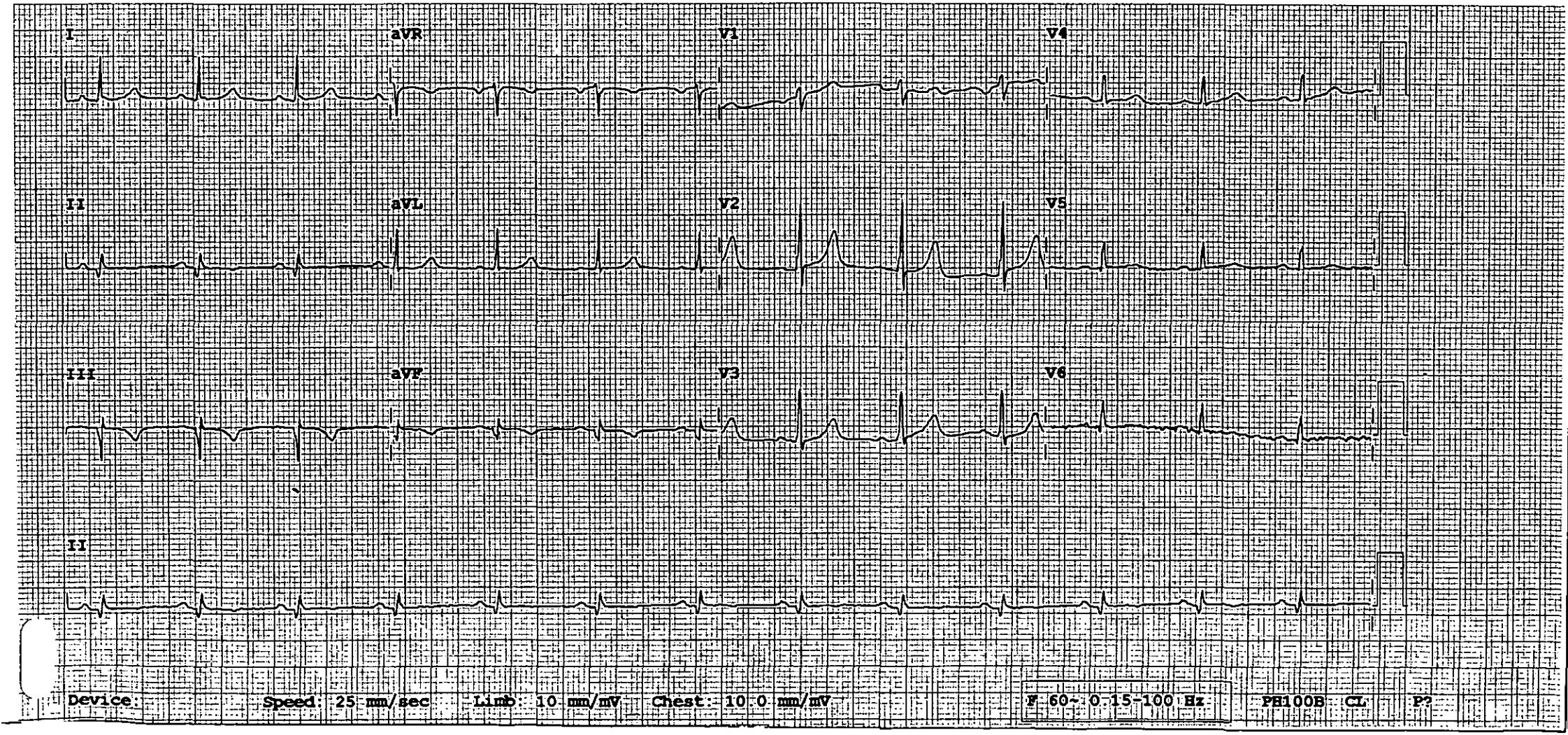
P	36
QRS	-18
T	-28

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

IP No : 33-19/237 UHID : 100055633
Mr. Rakesh Verma DOA : 07/01/2019 13:43
56 Y/M CCU/CCU007
Dr. Rakesh Ral Sapra



1/7/2019 17:19:48

(2)

Mr. Rakesh

P-PTCA

Rate	84	. Age not entered, assumed to be 50 years old for purpose of ECG interpretation
		. Sinus rhythm.....normal P axis, V-rate 50- 99
PR	168	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	83	. Inferior infarct, age indeterminate.....Q>35mS, T neg, II III aVF
QT	358	
QTc	424	

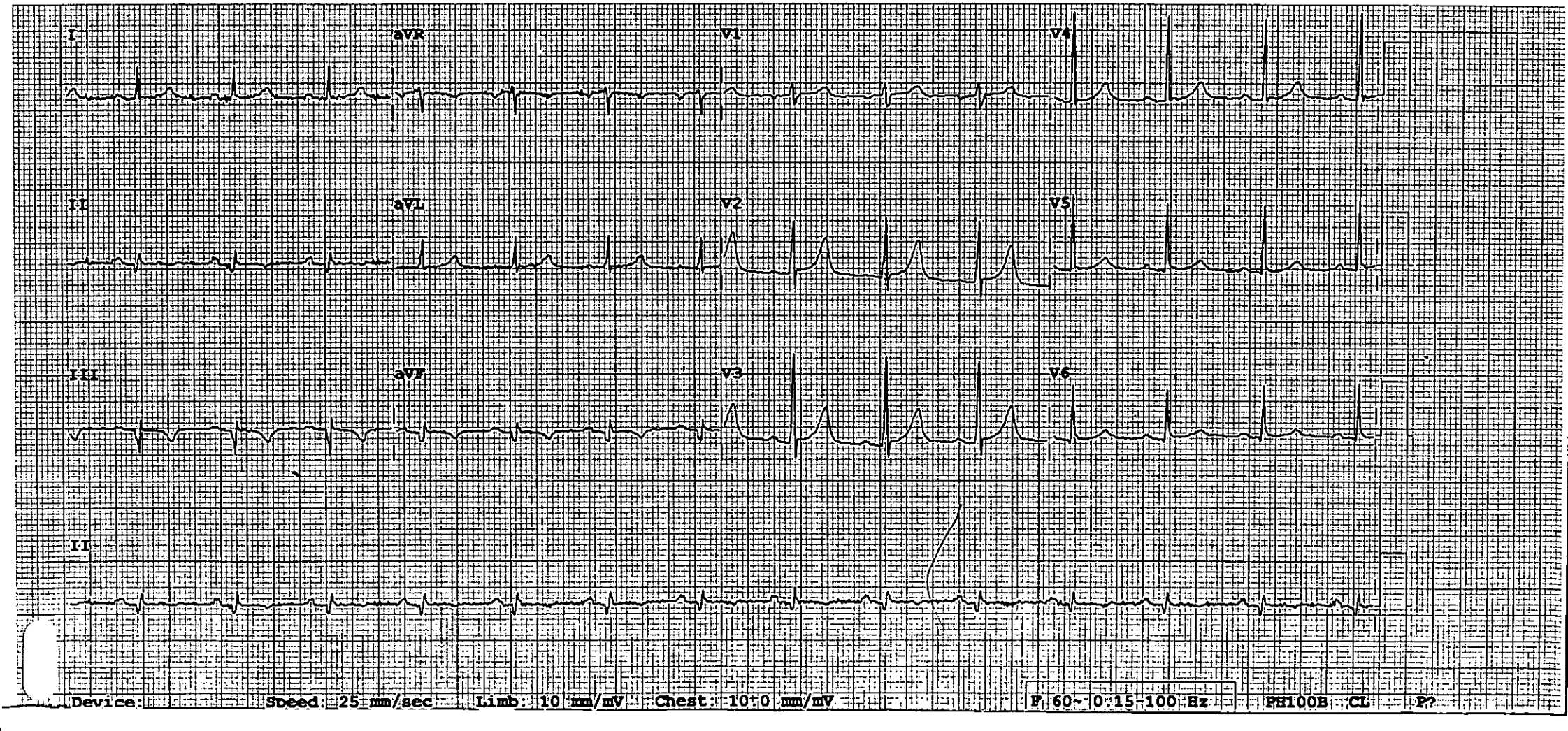
--AXIS--

P	50
QRS	-24
T	-32

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



mr rakesh verma

1/7/2019 12:22:33 PM

Born 1/3/1962 57 Years Male

Rate	103	. Sinus tachycardia.....rate> 99
		. Ventricular premature complex.....V complex w/ short R-R interval
PR	171	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	98	. Inferior infarct, age indeterminate.....Q>35mS, T neg, II III aVF
QT	331	
QTc	434	

--AXIS--

P	76
QRS	-51
T	-32

12 Lead; Standard Placement

- ABNORMAL ECG -

Unconfirmed Diagnosis

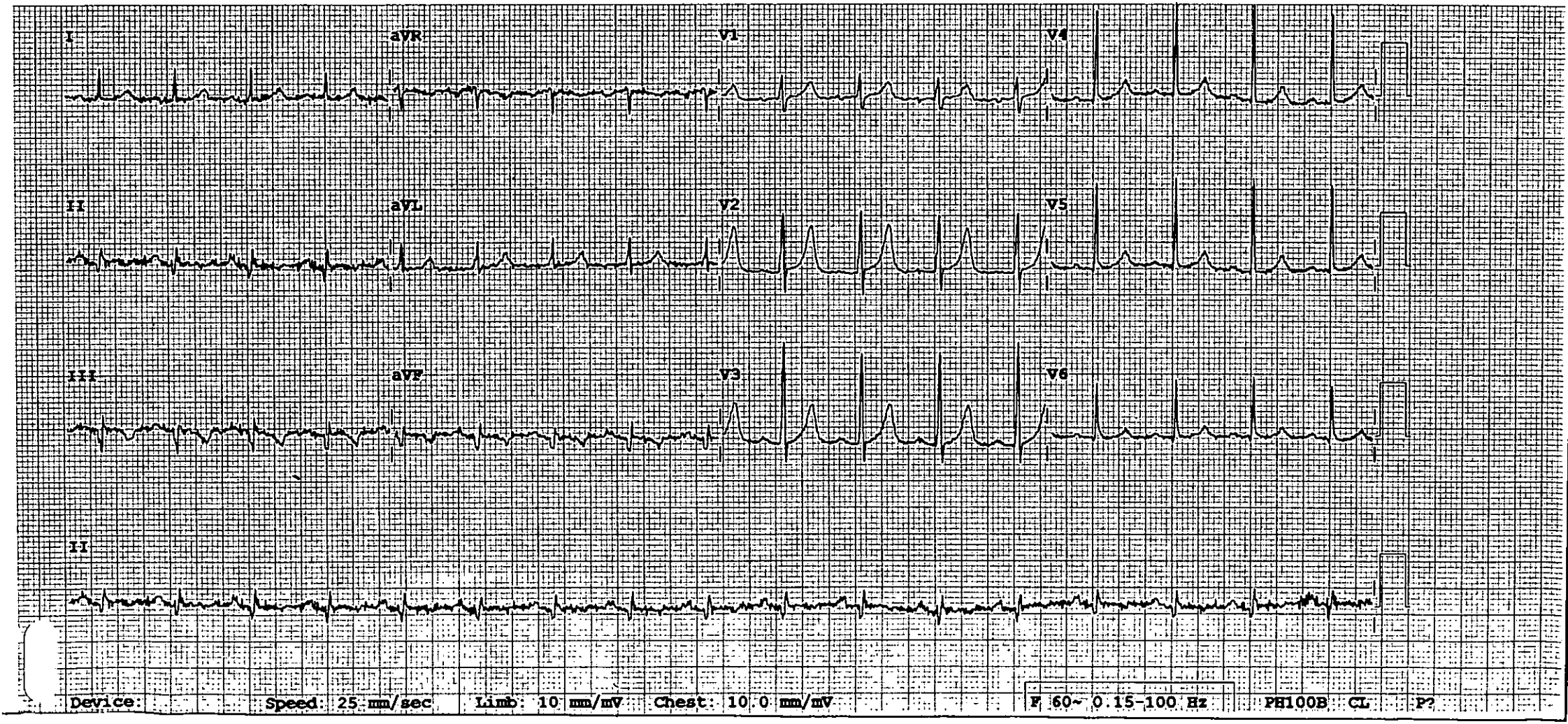
[redacted]

No : 33-19/237 UHID : 100055633

Rakesh Verma DOA : 07/01/201913:43

5 Y/M CCU/CCU007

Rakesh Rai Sapra



QRG Health City

MEDICAF

TRANSTHORACIC ECHO REPORT

Patient Name	Mr. Rakesh Verma	Age/Sex	56Years/ M	OPD/IPD	IPD
Lab No.	9726	UHID. No.	100055633	Date	09.01.20
Indication:	CAD post PTCA		Referred by	Dr Rakesh Rai Sapra	

MEASUREMENTS	OBSERVED VALUE	NORMAL REFERENCE LIMITS
Aortic Root Diameter	2.9	2.0-3.7 cm <2.2cm/m^2
Aortic Valve Opening		1.5-2.6 cm
Left Atrial Dimension	4.0	1.9-4.0 cm<2.2 cm/m^2
RV Dimensions ED		0.7-2.6 cm
	LEFT VENTRICULAR STUDY	
LV ED Dimension	4.3	3.7-5.6 cm<3.2 cm/m^2
LV ES Dimension		2.2-4.5 cm
IVS Thickness	ED 1.2 ES	0.6-1.2 cm
LVPW Thickness	ED 0.9 ES	0.5-1.1 cm
LV Ejection Fraction	50%	60+/6%

MITRAL VALVE

E Velocity = 86 cm/sec A Velocity=44 cm/sec E' = 7.4
Max.PG = mmHg Mean PG = mmHg
Mitral regurgitation = Nil
Mitral Stenosis = Nil

AORTIC VALVE

Max Velocity = 128 cm/sec Mean Velocity= cm/sec
Max.PG = mmHg Mean PG = mmHg
Aortic regurgitation = Nil
Aortic Stenosis = Nil

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TRICUSPID VALVE

Max. Velocity = cm/sec	Max.PG = mmHg	TAPSE : 18mmHg
Tricuspid Regurgitation = Mild	PASP = 43 mmHg	
Tricuspid Stenosis = Nil		

PULMONARY VALVE

Max. Velocity = 71 cm/sec	Max.PG = mmHg
Pulmonary Regurgitation : Nil	PAEDP = mmHg
Pulmonary Stenosis : Nil	

Impression:

1. Inferior, posterior wall scarred and hypokinetic, LVEF : 50%
2. Borderline high LA.
3. RA, RV normal in size. Good RV systolic function.
4. Mitral Inflow Pattern – Normal, E/E' is less than 14.
5. Mild TR (PASP : 43mmHg)
6. IVC normal in size more than 50% respiratory variation.
7. No pericardial effusion/ thrombus/ intracardiac clot seen.

Dr. Samir Bahl
Senior Consultant & HOD
Non Invasive Cardiology

QRG Health City

QRG MEDICARE LTD.

Basement-02, 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	: 33-19/237	**Issue No**	: H0138619/78152
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 07/01/2019 8:10PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:		
Remarks	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Indent No	: 77482	**Status**	: Post
		Indent Date	: 07/01/2019 8:07PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	NS 500ML FLEXIDRIP-(NOS)	30049099	2184121	CLARIS OTSUKA PVT. LTD.	30/08/2021	74.26	4	4	297.04	0.00	297.04
2	PEDIA DRIP SET (POLYMED) (SUB OF :- PEDIA DRIP SET)-(NOS)	90189099	1814799N		30/11/2023	194.00		1	194.00	0.00	194.00

Sub Total : 491.04 **Disc Amount : 0.00** **Net Bill Amount : 491.04**

Checked By:

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar Printed Date : 07/01/2019 20:10 PM

QRG Health City

QRG MEDICARE LTD.

Basem[illegible]02, Block-A, Plot No - 01, Sector 16,F[illegible]ad-121002 Haryana

PAN No. : AAACQ2238D

GST No. : 06A[illegible]Q2238D1ZW

DL No . 4150-[illegible]50-B,4149-X
HR-770700-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/237	**Issue No**	: H0138619/78490
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 08/01/2019 5:17PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77825	**Indent Date**	: 08/01/2019 4:57PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	VERTIN 16MG TAB 1X15-(15N)	30049099	RBIB8016	ABBOTT HEALTHCARE	30/07/2021	13.47		15	202.05	0.00	202.05

Sub Total : 202.05 **Disc Amount : 0.00** **Net Bill Amount : 202.05**

Checked By :

Prepared By : Dheeraj Kumar

Acknowledge By : Dheeraj Kumar

Printed By: DheerajKumar Printed Date : 08/01/2019 17:16 PM

QRG Health City

QRG MEDICARE LTD.

Basement-02, B[illegible]k-A, Plot No - 01, Sector 16,Faridabad-1[illegible]02 Haryana

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

DL No . 4150-OB,41[illegible]149-X
HR-770700-[illegible]
HR-770700-WH

IN PATIENT ISSUE SLIP

IP No	: **33-19/237**	**Issue No**	: **H0138619/78096**
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 07/01/2019 6:09PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77425	**Indent Date**	: 07/01/2019 6:04PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	EMESET 4ML INJ-(NOS)	30049035	L680112	CIPLA LTD.	30/06/2020	23.79	1	1	23.79	0.00	23.79
2	PANSEC IV-(NOS)	30049039	AFM8116	CIPLA LTD.	30/08/2020	46.80	1	1	46.80	0.00	46.80
3	NS 500ML FLEXIDRIP-(NOS)	30049099	2184121	CLARIS OTSUKA PVT. LTD.	30/08/2021	74.26	2	2	148.52	0.00	148.52
4	Pressure Monitoring Kit - Single-(NOS)	90189099	18124030	B L LIFESCIENCE	30/11/2021	1851.00	1	1	1851.00	0.00	1851.00
5	VENFLON 20 CANULA B.D.-(NOS)	90183930	18H2441M	BECTON DICKINSON	30/07/2023	132.00	1	1	132.00	0.00	132.00

Checked By :

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar

Printed Date : 07/01/2019 18:08 PM

QRG Health City

QRG MEDICARE LTD.
Basement-02, 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	: 33-19/237	**Issue No**	: H0138619/78737
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 09/01/2019 10:51AM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 78063	**Indent Date**	: 09/01/2019 10:23AM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	PANSEC IV-(NOS)	30049039	AFM8112	CIPLA LTD.	30/08/2020	46.80	1	1	46.80	0.00	46.80
2	NS 500ML FLEXIDRIP-(NOS)	30049099	2184121	CLARIS OTSUKA PVT. LTD.	30/08/2021	74.26	2	2	148.52	0.00	148.52
3	SILOFAST 8MG TAB-(15N)	30049099	BC1809033	CIPLA LTD.	30/08/2020	26.00	15	15	390.00	0.00	390.00
4	LOOZ 200 ML SYRUP-(NOS)	30049099	X34194	INTAS	30/09/2020	216.30	1	1	216.30	0.00	216.30
5	SYRINGE DISPOSABLE 2ML (B.D)-(NOS)	90183100	1830781		30/08/2023	10.00	5	5	50.00	0.00	50.00
6	SYRINGE DISPOSABLE 5ML (B.D)-(NOS)	90183100	1830881		30/08/2023	15.50	5	5	77.50	0.00	77.50

Checked By :

Prepared By : Rajesh Kumar

Acknowledge By : Rajesh Kumar

Printed By: RajeshKumar

Printed Date : 09/01/2019 10:50 AM

QRG Health City

QRG MEDICARE LTD.
Basement-02, Block-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D
GST No. : 06AAACQ2238D1ZX
DL No . 4150-OB,4150-B,4[illegible]-X
HR-770700-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/237	**Issue No**	: H0138619/78737
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 09/01/2019 10:51AM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 78063	**Indent Date**	: 09/01/2019 10:23AM

7	ECG ELECTRODS-(NOS)	90181100	37518S5ML5	MEDICO ELECTRODE	31/03/2021	18.00	5	5	90.00	0.00	90.00
8	LEVOMAC 500 MG (SUB OF :- LEVOFLOX 500MG)-(05N)	30049069	KLB706A		30/09/2020	6.82		10	68.20	0.00	68.20

Sub Total : 1087.32 **Disc Amount : 0.00** **Net Bill Amount : 1087.32**

Checked By :

Prepared By : Rajesh Kumar

Acknowledge By : Rajesh Kumar

Printed By: RajeshKumar Printed Date : 09/01/2019 10:50 AM

QRG Health City

QRG MEDICARE LTD.

Basement-[illegible]ock-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

DL No . 4150-G[illegible]50-B,4149-X
HR-77[illegible]0-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/237	**Issue No**	: H0138619/78302
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 08/01/2019 10:58AM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77637	**Indent Date**	: 08/01/2019 10:46AM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	NS 500ML(CLARIS)-(NOS)	30049099	1184397	CLARIS OTSUKA PVT. LTD.	30/07/2021	29.44	3	3	88.32	0.00	88.32
2	EMESET 4ML INJ-(NOS)	30049035	L680112	CIPLA LTD.	30/06/2020	23.79	2	2	47.58	0.00	47.58
3	Insulin Syringe U 40 1ml-(NOS)	90183100	849011AG	HMD	30/11/2023	7.50	5	5	37.50	0.00	37.50
4	VENFLON CANNULA NO. 22 (BD)-(NOS)	90183930	8306563	BECTON DICKINSON	30/10/2023	145.00	1	1	145.00	0.00	145.00
5	Smart Site Triple-extension(BD) (SUB OF :- K-SITE 3 WAY EXT.)-(NOS)	9018	18076526		30/07/2021	650.00		1	650.00	0.00	650.00
6	PEDIA DRIP SET (POLYMED) (SUB OF :- PEDIA DRIP SET)-(NOS)	90189099	1814799N		30/11/2023	194.00		1	194.00	0.00	194.00

Checked By :

Prepared By : Naveen Kaushik

Acknowledge By : Naveen Kaushik

Printed By: NaveenKaushik

Printed Date : 08/01/2019 10:57 AM

QRG Health City

QRG MEDICARE LTD.

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

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

DL No . 4150-C,150-B,4149-X
HR-77[illegible]0-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: **33-19/237**	**Issue No**	: **H0138619/78302**
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 08/01/2019 10:58AM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77637	**Indent Date**	: 08/01/2019 10:46AM

7	SYRINGE DISPOSABLE 1ML (B.D) (SUB OF :- DISPOVAN 1ML SYRINGE)-(NOS)	90183100	8211176		30/07/2023	14.50		3	43.50	0.00	43.50
8	SYRINGE DISPOSABLE 10ML (B.D) (SUB OF :- DISPOVAN SYRINGE 10ML)-(NOS)	90183100	18K0181		30/09/2023	21.00		5	105.00	0.00	105.00
9	GLOVES 6-(NOS)	40151100	18K3331V	KANAM LATEX	30/10/2023	65.00	1	1	65.00	0.00	65.00

Sub Total : 1375.90 **Disc Amount : 0.00** **Net Bill Amount : 1375.90**

Checked By :

Prepared By : Naveen Kaushik

Acknowledge By : Naveen Kaushik

Printed By: NaveenKaushik

Printed Date : 08/01/2019 10:57 AM

QRG Health City

QRG MEDICARE LTD.
Basement-02, Block-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D
GST No. : 06AAACQ22[illegible]1ZW
DL No . 4150-OB,4150-B,4149-X
HR-770700-OW/H
HR-770700-W/H

IN PATIENT ISSUE SLIP

IP No	: 33-19/192	**Issue No**	: H0138619/78231
Patient Name	: Mr. Prem Chand Kukreja	**Date/Time**	: 08/01/2019 8:16AM
UHID	: 200083394	**Ward/Bed No**	: Economy-1 (1289)/EC1289_001
Sponsor	: NATIONAL INDIA INSURANCE CO. LTD.	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	: CCU	**Status**	: Post
Indent No	: 77575	**Indent Date**	: 08/01/2019 8:14AM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	UROMETER (POLYMED) (SUB OF :- UROMETER (ROMSON))-(NOS)	9018	1814673M		30/10/2023	440.00		1	440.00	0.00	440.00

Sub Total : 440.00 **Disc Amount : 0.00** **Net Bill Amount : 440.00**

Checked By :

Prepared By : Naveen Kaushik

Acknowledge By : Naveen Kaushik

Printed By: NaveenKaushik Printed Date : 08/01/2019 08:16 AM

QRG Health City

QRG MEDICARE LTD.

Basement-07, Block-A, Plot No - 01, Sector 16,Faridabad-121002 Haryana

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

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

IN PATIENT ISSUE SLIP

IP No	: 33-19/237	**Issue No**	: H0138619/78096
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 07/01/2019 6:09PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Remarks	:	**Status**	: Post
Indent No	: 77425	**Indent Date**	: 07/01/2019 6:04PM

6	TEGADERM 1633-(NOS)	30051020	R1018090 4	3M	30/09/2021	123.00	1	1	123.00	0.00	123.00
7	Smart Site Triple-extension(BD) (SUB OF :- K-SITE 3 WAY EXT.)-(NOS)	9018	18076526		30/07/2021	650.00		1	650.00	0.00	650.00
8	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
9	TRD CONJECT INJ 2ML (SUB OF :- TRAMAZAC INJ)-(NOS)	30049099	M8097		30/05/2021	22.00		1	22.00	0.00	22.00
10	ECG ELECTRODS-(NOS)	90181100	37518S5M L5	MEDIC O ELECT RODE	31/03/2021	18.00	10	10	180.00	0.00	180.00
11	ECOSPRIN 150MG TAB-(14N)	30049099	52000659	USV	30/07/2020	0.59	14	14	8.26	0.00	8.26
12	CERUVIN 75MG (SUB OF :- CLOPITAB 75MG TAB)-(15N)	30049099	EST0605A	SUN PHAR MA	30/06/2020	7.30		15	109.50	0.00	109.50
13	PANSEC 40MG TAB (SUB OF :- PANTOCID 40MG TAB)-(15N)	30049039	E780701	CIPLA LTD.	30/08/2020	11.86		15	177.90	0.00	177.90

Checked By :

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar

Printed Date : 07/01/2019 18:08 PM

QRG Health City

QRG MEDICARE LTD.

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

PAN No. : AAACQ2238D

GST No. : 06AAACQ2238D1ZW

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

IN PATIENT ISSUE SLIP

IP No	: **33-19/237**	**Issue No**	: **H0138619/78096**
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 07/01/2019 6:09PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:		
Remarks	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Indent No	: 77425	**Status**	: Post
		Indent Date	: 07/01/2019 6:04PM

14	AZERVA 40MG TAB (SUB OF :- TONACT 40 MG TAB)-(10N)	30049099	KX2421	INTAS	30/08/2021	20.28		10	202.80	0.00	202.80

Sub Total : 3753.07 **Disc Amount : 0.00** **Net Bill Amount : 3753.07**

Checked By :

Prepared By : Satish Kumar

Acknowledge By : Satish Kumar

Printed By: SatishKumar Printed Date : 07/01/2019 18:08 PM

QRG Health City

QRG MEDICARE LTD.

Basement-02, 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	: **33-19/237**	**Issue No**	: **H0138619/78114**
Patient Name	: Mr. Rakesh Verma	**Date/Time**	: 07/01/2019 6:27PM
UHID	: 100055633	**Ward/Bed No**	: CCU/CCU007
Sponsor	: FAMILY HEALTH PLAN LTD. -Credit	**Location**	: IP Pharmacy Healthcity (A004)
Mobile No	:		
Remarks	:	**Doctor Name**	: Dr. Rakesh Sapra/ Dr Suraj Singh (QRG MEDICARE LTD.)
Indent No	: 77425	**Status**	: Post
		Indent Date	: 07/01/2019 6:04PM

Sno	Item Name	HSN Code	Batch No	MFG	Expiry	MRP	Req. Qty	Issue.Qty	Gross Amt.	Conc. Amt.	Net Amt.
1	NIKORAN 5MG TAB-(NOS)	30049099	2964E019	TORRENT	30/03/2020	250.40	1	1	250.40	0.00	250.40

Sub Total : 250.40 **Disc Amount : 0.00** **Net Bill Amount : 250.40**

Checked By :

Prepared By : **Satish Kumar**

Acknowledge By : **Satish Kumar**

Printed By: SatishKumar Printed Date : 07/01/2019 18:26 PM

QRG Health City

CORONARY ANGIOGRAPHY REPORT

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	**IPD No: 33-19[illegible]**
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	**Angio No.: 394[illegible]**

Provisional Diagnosis	:	**Unstable Angina**
BP	:	120/80mmHg
Hardware	:	Tiger 5F
Route	:	Right Radial Artery
Contrast	:	Omnipaque
LV Angiogram	:	Not done
Dominant	:	RCA

QRG Health City

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	**IPD No: 35-1[illegible]**
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	**Angio N[illegible]**

Left Main	:	Normal
Left Anterior Descending	:	Type III vessel, 80% stenosis [illegible]
Diagonal 1	:	Normal
Diagonal 2	:	Small vessel, 95% stenosis in pro[illegible]
Left Circumflex Artery	:	Patent stent in proximal to mid LC[illegible]
OM1	:	Normal.
OM2	:	Normal
Right Coronary Artery	:	Dominant vessel, Patent stent mid [illegible]
PDA	:	Normal.
PLV	:	Normal
Impression	:	Triple Vessel Disease
Advice	:	**PTCA + stent to PDA/LAD.**

DR. RAKESH RAI SAPRA
MD Medicine, DM (Cardiology)
Sr. Consultant Interventional Cardiologist
& Director of Cardiology

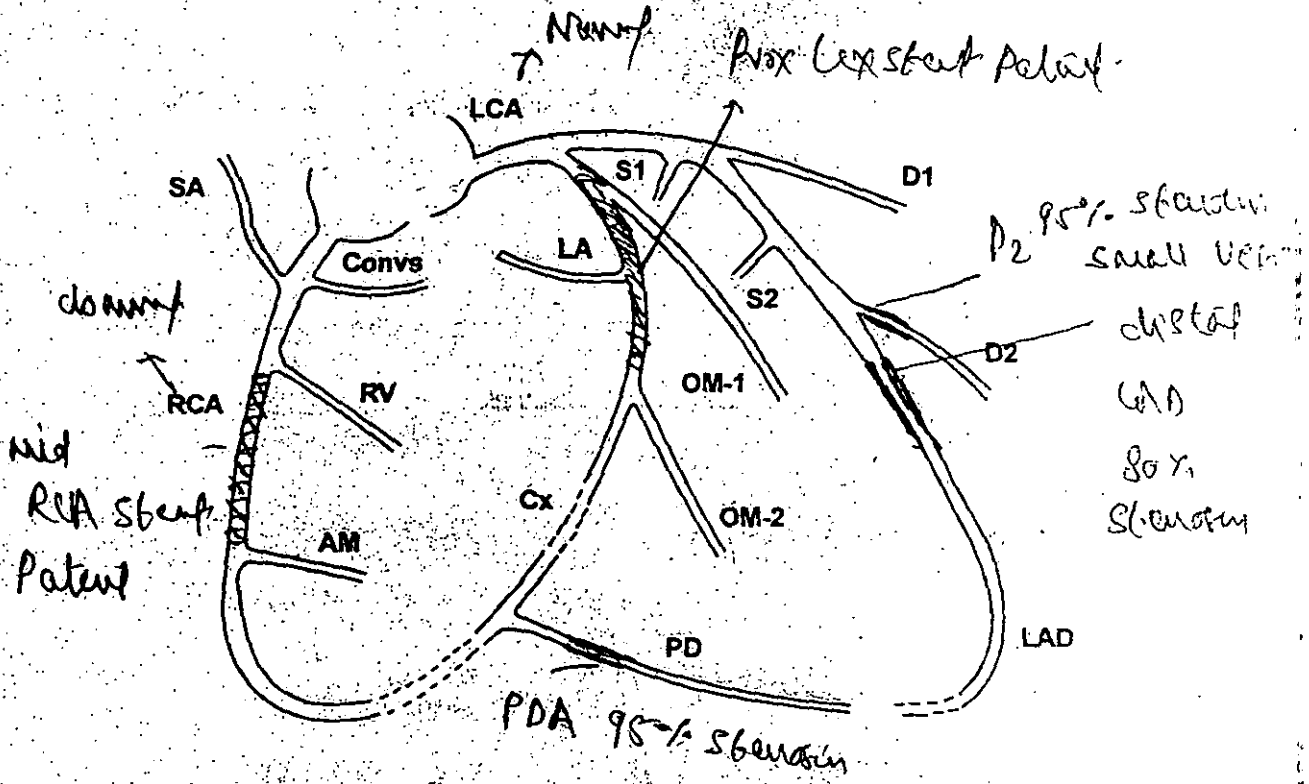
QRG Health City
Plot no. 1, Sector -16, Faridabad, Haryana
Tel: 0129 - 4330000 Fax: 0129 - 4330033

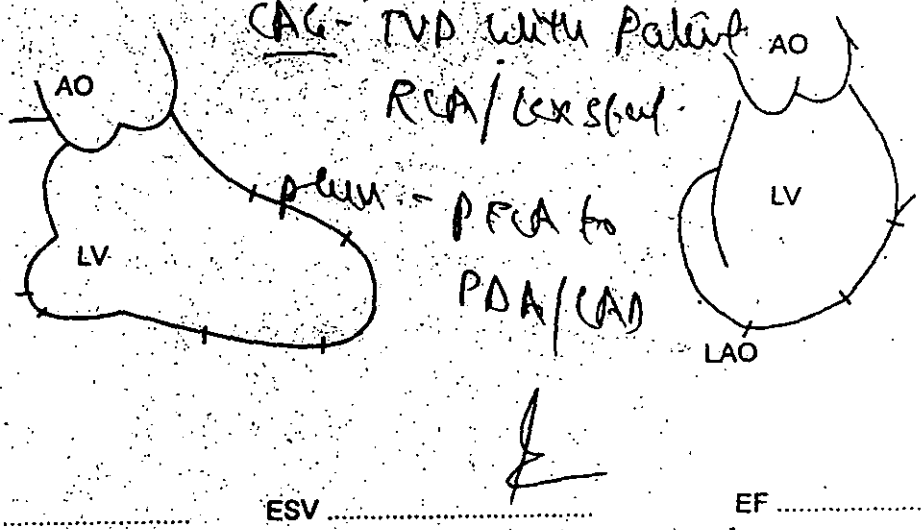
IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M CCU/CCU007
Dr. Rakesh Rai Sapra

CORONARY ANGIOGRAM

Angio No. 923 IPD No. 237 Date 07-1-19

Name Mr. Rakesh Verma Age/Sex 56/M Dr. R.R. Sapra





EDV ..... ESV ..... EF .....

QRG Health City

CORONARY ANGIOPLASTY REPORT

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	IPD NO:33-[illegible]
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	PTCA No: 043[illegible]

INDICATION / DIAGNOSIS: -

Unstable Angina

CAD- Triple Vessel Disease

PROCEDURAL DETAILS:- (Right Radial Artery)

PTCA + stent to PDA

GUIDING CATHETER :		6F JR 3.5
GUIDE WIRE	:	Whisper ES 0.014 x 190cm
BALLOON	:	Across HP 2.0 x 10mm, Sapphire 2.25 x 8mm
STENT	:	**ABLUMINUS 2.25 X 12MM**

DETAILS OF PROCEDURE:-

LMCA hooked with 6F JR 3.5 guiding catheter. PDA Lesion crossed with Whisper ES 0.[illegible] x 190cm guide wire. Pre dilatation done with balloon Across HP 2.0 x 10mm at [illegible] atmospheric pressure. Stenting done with stent **ABLUMINUS 2.25 X 12MM** deployed [illegible] at 10-12 atmospheric pressure. Post dilatation done with balloon Sapphire 2.25 x 8mm at 12-20 atmospheric pressure with good end result TIMI III flow achieved.

PROCEDURAL DETAILS:- (Right Radial Artery)

PTCA + stent to LAD

GUIDING CATHETER :		6F EBU 3.0
GUIDE WIRE	:	Whisper ES 0.014 x 190cm
BALLOON	:	Across HP 2.0 x 10mm, Sapphire NC 2.25 x 8mm
STENT	:	**EVERMINE 2.25 X 16MM**

DETAILS OF PROCEDURE:-

LMCA hooked with 6F EBU 3.0 guiding catheter. LAD Lesion crossed with Whisper ES 0.0[illegible] x 190cm guide wire. Pre dilatation done with balloon Across HP 2.0 x 10mm at [illegible] atmospheric pressure. Stenting done with stent **EVERMINE 2.25 X 16MM** deployed [illegible] at 10 atmospheric pressure. Post dilatation done with balloon Sapphire NC 2.25 x [illegible] 20 atmospheric pressure with good end result TIMI III flow achieved.

QRG Health City

Name: Mr. Rakesh Verma	**Age/ Sex: 56/M**	IPD NO:33-16/0[illegible]
Cath Doctor: Dr. Rakesh Rai Sapra	**Date: 07/01/2019**	PTCA No: [illegible]

ANGIOPLASTY RESULTS:-

Post procedure.
TIMI 3 Flow.
Successful, good end results.

POST PTCA RECOVERY:-

Uneventful.
Uncomplicated local puncture site.

FOLLOW UP PLAN:-

A. Diet
B. Activity
C. Medication
D. Follow up

As advised in discharge summary.

DR. RAKESH RAI SAPRA
MD Medicine, DM (Cardiology)
Sr. Consultant Interventional Cardiologist
& Director of Cardiology

IP No : 33-19/237 UHID: 100055633
Mr. Rakesh Verma DOA : 07/01/201913:43
56 Y/M Twin Sharing 4/TS1250 A
Dr. Rakesh Rai Sapra

HOURLY ROUND LOG

DATE: 10-1-19

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	Bhuvya	7am	Y	N	Y	NO	NO	
8AM	Bhuvya	8am	Y	N	N	N	N	
9AM	Krishna	9AM	Y	N	N	N	N	
10AM	Krishna	10AM	Y	N	N	N	N	
11AM	Krishna	11AM	N	N	N	N	N	
12N	Krishna	12N	N	N	N	N	N	
1PM	Krishna	1pm	Y	N	N	N	N	
2PM	Krishna	2pm	N	N	N	N	N	
3PM								
4PM								
5PM								
6PM								
7PM								
8PM								
9PM								
EVERY 2 HOUR ROUNDS (10PM - 6AM)								
10PM								
12AM								
2AM								
4AM								
6AM								

CHECKED BY: VERIFIED BY:

STAFF NURSE NAME(MORNING): KRISHNA DEVI SIGN: Krishna 21pm
EMP I.D.: 29771

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

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

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

TPH (3)

CORONARY CARE UNIT CHART

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121008
Tel: 0129 - 4330000

DIET: DM, NORMAL DIET

Total Intake: 2620
Total Output: 2700
Balance: -80ml

Pt. Name: MR. RAKESH VERMA
IP No.: 287 UHID No.: 5889
Age: 56Y Sex: M
DOA: 7/1/19 Day: D3
Diagnosis: CAD, USA
Procedure: CAG + PTCA - LAD, PDA
Consultant: DR. R. R. SAPRA

Injections
1.
2.
3.
4.
5.
6

Tablets
1.
2.
3.
4.
5.
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8.
9.
10.

Others:

TIME	VITAL MONITORING									INTAKE													OUTPUT				NURSES REMARKS
	HR / MT	RHYTHM	ABP	NBP	RESP	SPO,	O2 FLOW	TEMP	CVP	IVF NS	NTG	DOPAMIN	NORAD	DOBATA	LASIX	CORDARONE	INSULIN	HEPARIN	ANTIBIOTIC	KCL	BLOOD	ORAL	HOURLY	TOTAL	DRAIN	URINE	HOURLY	TOTAL	
8AM	99/m	SR	–	130/80	14/m	96%	RA	98.1F		70ml												Meal 150ml	220ml	220ml		100ml		100ml	
9AM	98/m	SR	–	117/66	18/m	97%	RA	98.6F		80ml													30ml	250ml		150ml		250ml	
10AM	96/m	SR	–	127/74	18/m	98%	RA	98.6F		30ml												V	30ml	280ml		250ml		500ml	
11AM	88/m	SR	–	132/78	18/m	98%	RA	98.4F		30ml												HW 50ml	80ml	350ml		–		500	Foley's Clamp
12AM	84/m	SR	–	130/70	18/m	98%	RA			30ml													30ml	380ml		700ml		1200ml	
1PM	86/m	SR	–	132/72	20/m	98%	RA			30ml												Lunch 200ml	230ml	610ml		100ml		1700ml	
2PM	80/m	SR	–	130/80	20/m	98%	RA			30ml												HW 100ml	120ml	1140ml		150ml		1145ml	motion passed
3PM	84 b/m	SR	–	139/78	16/m	97%	RA	98.8F		30ml																230ml	230ml	1680ml	
4PM																													
5PM																													
6PM																													
7PM																													
8PM																													
9PM																													
10PM																													
11PM																													
12PM																													
1AM																													
2AM																													
3AM																													
4AM																													
5AM																													
6AM																													
7AM																													

PLANNED PROCEDURE / INVESTIGATION

- ECG
- RBS
- (1250/A)
- S. Creat.
- Urology Consult.
- IVD 90ml/Hr
- Shift out
- Plan D3 D/C

Echo, USG report d/c.

Blood	RBS	INSULINE	DOCTOR	STAFF
70ml	262 mg/dl	Actrapid 6U HR-6U Grins	Dr. Vishal	APHP 139/82 Roy.
1Pm	240mg/dl	10 unit Hut	Dr. Vishal	Roy.

INVESTIGATIONS

TIME	9/1/19		TIME		
HB%			TROP-I		
TLC			CPK MB		
DLC			CHOL		
PLT			LDL		
Na+			HDL		
K+			TRIGLY CERIDES		
U. ACID			S. BILI		
UREA			SGOT		
CREAT	1.6		SGPT		
APTT			ALK PHOS		
PT / C			S. PROT		
INR			S. ALBUMINE		
HIV			AMYLACE		
Hb SAG			LYP		
BLOOD GROUP					

ARTERIAL BLOOD GAS

PH			
Po_2			
PCO_2			
NCO_3			
BE			
So_2			
Na+			
K+			

VENTILATORY PARAMETERS

MODE	T.V.	FiO_2	RESP	PEEP	PEN AM	INSP

ACT	Sheats Removal	Site Condition	Pulse	Staff

DETAILS OF VARIOUS CANNUNAE

IV Cannula	Size	Day	Condition
Wline	20G	D3	Good
Arterial Line			
Foley's	14G	D2	Good
RT			
ET Tube			
Tracheoti Tube			

QRG Health City — CORONARY CARE UNIT CHART

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121006
Tel: 0129 - 4330000

DIET: DM, NORMAL DIET

Total Intake: 1806ml
Total Output: 900
Balance: +906ml

Pt. Name: MR. RAKESH VERMA
IP No.: 237 UHID No. 55639
Age: 56 Y Sex: M
DOA: 7/1/19 Day: D2
Diagnosis: CAD, P PTCA
Procedure: CAG + PTCA
Consultant: DR. R. R. SAPRA

Injections
1.
2.
3.
4.
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6.

Tablets
1.
2.
3.
4.
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8.
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Others:

TIME	VITAL MONITORING: HR / MT	RHYTHM	ABP	NBP	RESP	SPO2	O2 FLOW	TEMP.	CVP	INTAKE: IVF N/S	NTG	DOPAMIN	NORAD	DOBATA	LASIX	CORDARONE	INSULIN	HEPARIN	ANTIBIOTIC	KCL	BLOOD	ORAL	HOURLY	TOTAL	OUTPUT: DRAIN	URINE	HOURLY	TOTAL	NURSES REMARKS
8AM	82/bnt	SR		135/71	11/mt	94%	RA	98°F		50ml												100ml	150ml	150ml					
9AM	74/mt	SR	–	141/91	15/mt	96%	RA			50ml												–	50ml	200ml					
10AM	86/mt	SR	–	142/88	15/mt	97%	RA			50ml												100ml	150ml	350ml					
11AM	82/bnt	SR	–	140/80	16/bnt	98%	RA			50ml													50ml	400ml		~~200ml~~	~~200ml~~	~~400ml~~	
12AM	82/bnt	RA	–	138/78	18/bnt	98%	RA			50ml													50ml	450ml					
1PM	80/bnt	SR	–	130/80	18/bnt	98%	RA	98°F		50ml												150ml	200ml	650ml					
2PM	82/bnt	SR	–	118/60	20/bnt	98%	RA	–		50ml													50ml	700ml					
3PM	84/bnt	SR	–	104/78	24/bnt	95%	RA	–		50ml																			
4PM	90/bnt	SR	–	130/80	24/bnt	96%	RA			70ml												Tab 100mg	170ml	870ml					
5PM	92/bnt	SR	–	126/76	20/bnt	98%	RA	98.4°F		70ml													70ml	940ml		1300ml	1300ml	1300ml	
6PM	80/bnt	SR	–	120/80	20/bnt	98%	RA	–		70ml													70ml	1010ml		50ml	50ml	1350ml	
7PM	88/bnt	SR	–	130/70	22/bnt	96%	RA	–		70ml												Soap 100ml	170ml	1180ml		50ml	50ml	1400ml	
8PM	84/bnt	SR	–	120/78	20/bnt	98%	RA	–		70ml													70ml	1250ml		50ml	50ml	1450ml	
9PM	93/bnt	SR	–	131/74	20/bnt	95%	RA	–		70ml												mint 200	270ml	1520		600ml	600ml	1510	
10PM	94/bnt	SR	–	125/78	24/bnt	95%	RA	–		70ml												milk 200	270ml	1790		80ml	80ml	1590	
11PM	94/bnt	SR	–	122/74	20/bnt	96%	RA			70ml													70ml	1860		100	100	1690	
12PM	88/bnt	SR	–	118/74	22/mt	97%	RA			70ml													70ml	1930		200	200	1890	
1AM	92/bnt	SR	–	119/74	18/mt	98%	RA			70ml													70ml	2000		200	200	2090	
2AM	78/bnt	SR	–	124/74	16/mt	97%	RA			70ml													70ml	2070		90ml	90ml	2180	
3AM	98/mt	SR	–	111/69	18/mt	98%	RA			70ml													70ml	2140		70	70	2250	
4AM	94/mt	SR	–	102/65	14/bnt	97	RA			70													70ml	2210		100	100	2350	
5AM	65/mt	SR	–	117/65	16/bnt	97	RA			70													70ml	2280		100	100	2450	
6AM	97/bnt	SR	–	117/67	16/bnt	97	RA			70													70ml	2350		150	150	2600	
7AM	98/bnt	SR	–	121/71	18/bnt	97	RA			70													270ml	2620		100	100	2700	

PLANNED PROCEDURE / INVESTIGATION

PTCA Patient
Foley's catheterization

Blood	RBS	INSULINE	DOCTOR	STAFF
7pm	242 mg%	Hlf 8unit	Dr. Sharma	Dipti 2492
1pm	160 mg%	6		Dipti
7pm	260 mg%	14 unit HRI	Dr. Sharma	Yogi

INVESTIGATIONS

TIME			TIME		
HB%	12.8		TROP-I		
TLC			CPK MB	1.24	
DLC			CHOL	117.0	
PLT			LDL	62.0	
Na+			HDL	32.0	
K+			TRIGLY CERIDES	112.8	
U. ACID			S. BILI		
UREA			SGOT		
CREAT	1.44		SGPT		
APTT			ALK PHOS		
PT / C			S. PROT		
INR			S. ALBUMINE		
HIV			AMYLACE		
Hb SAG			LYP		
BLOOD GROUP					

ARTERIAL BLOOD GAS

PH			
Po_2			
PCO_2			
NCO_2			
BE			
So_2			
Na+			
K+			

VENTILATORY PARAMETERS

MODE	T.V.	FiO_2	RESP	PEEP	PEAK	INSP

ACT	Sheath Removal	Site Condition	Pulse	Staff

DETAILS OF VARIOUS CANNULAE

	Size	Day	Condition
IV Cannula			
CVP	7Fr	D2	Good
Arterial Line			
Foley's			
RT			
ET Tube			
Tracheol Tube			

CORONARY CARE UNIT CHART

QRG Health City

QRG Health City
Plot no. 1, Sector -16, Faridabad, 121006
Tel: 0129 - 4330000

DIET: DM / ND.

Total Intake:
Total Output:
Balance:

Pt. Name: Mr. Rakesh Verma.
IP No.: 33-19/237 UHID No. 55633
Age: 56yr Sex: M
DOA: 7/1/19 Day:
Diagnosis: CAD, P-PTCA
Procedure: PTCA TO LAD, PDA
Consultant: DR. R.R Saptya.

Injections
1.
2.
3.
4.
5.
6.

Tablets
1.
2.
3.
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9.
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Others:

TIME	VITAL MONITORING									INTAKE															OUTPUT				NURSES REMARKS
	HR / MT	RHYTHM	ABP	NBP	RESP	SPO2	O2 FLOW	TEMP	CVP	IVF @ 50ml/hr	NTG	DOPAMIN	NORAD	DOBATA	LASIX	CORDARONE	INSULIN	HEPARIN	ANTIBIOTIC	KCL	BLOOD	ORAL	HOURLY	TOTAL	DRAIN	URINE	HOURLY	TOTAL	
8AM																													
9AM																													
10AM																													
11AM																													
12AM	Receive	from	OPD	at	1:30PM.																								
1PM	99/m	SR	–	160/100	23/m	99%	RA	98.6°			2ml												2ml	2ml					
2PM	92/m	SR.	–	150/100	18/m	98%	RA	–			2ml.												2ml	4ml					
3PM	94/m	SR	–	150/100	18/m	98%	RA	–			2ml								9% 10ml				102ml	106ml		500ml		500ml.	
4PM	Shifted to cath Lab							–																					
5PM	84	SR	145/82	–	19/m	98%	RA	98.6°											100ml			Tab 150mg.		25ml					Re-
6PM	86/m	SR	148/86	–	16/m	98%	RA	–																					
7PM	88/m	SR	148/81	–	18/m	98%	RA	–		50ml.												Neb 200ml	50ml	50ml		200ml		700ml.	
8PM	88	SR	140/80	–	18	98%	RA	98.6		50ml.													250ml	550ml.					
9PM	88/m	SR	150/78	–	14/m	98%	RA	–		50ml																			
10PM	91/m	SR	151/78	–	14/m	99%	RA	–		50ml																			
11PM	210/m	SR	151/77		–	98%	RA	–		50ml																			
12PM	89/m	SR		14/m	18/m	99%	RA	98.6F		50ml																			
1AM	88/m	SR	140/90		–	98%	RA	–		100ml (Received)																			
2AM	88/m	SR		18/21	18/m	98%	RA	–		50ml																			
3AM	88/m	SR		140/80	18/m	99%	RA	–		50ml																			
4AM	82/m	SR		138/78	18/m	99	RA	–		50																			
5AM	84/m	SR		138/80	17/m	98	RA			50																			
6AM	88/m	SR		138/80	17/m	97	RA	98.6F		50																			
7AM	82/m	SR		140/78	18/m	97	RA	–		50																			

PLANNED PROCEDURE / INVESTIGATION

) CAG Refill
ECG, RBS
PTCA package

Blood	RBS	INSULINE	DOCTOR	STAFF
7/1/19 7pm	235mg/dl 299mg/dl	6 unit HIR given		

INVESTIGATIONS

TIME	7/1/19.	TIME		
HB%	13.5	TROP-I		
TLC	6.4	CPK MB		
DLC	52/26	7/9/19 CHOL		
PLT	228	LDL		
Na+	139.6	HDL		
K+	5.0	TRIGLY CERIDES		
U. ACID		S. BILI		
UREA		SGOT		
CREAT	1.34	SGPT		
APTT		ALK PHOS		
PT / C		S. PROT		
INR		S. ALBUMINE		
HIV		AMYLACE		
Hb SAG		LYP		
BLOOD GROUP				

ARTERIAL BLOOD GAS

PH			
Po_2			
PCO_2			
NCO_2			
BE			
So_2			
Na^+			
K^+			

VENTILATORY PARAMETERS

MODE	T.V.	FiO_2	RESP	PEEP	PEAM	INSP

ACT	Sheats Removal	Site Condition	Pulse	Staff
	11:30pm	good	palp	given

DETAILS OF VARIOUS CANNUNAE

IV Cannula	Size	Day	Condition
CVP			
Arterial Line			
Foley's			
RT			
ET Tube			
Tracheol Tube			