स्वशासी राज्य चिकित्सा महाविद्यालय, फतेहपुर

In Patient Case Record

पंजीकरणश ुल्करु . ..... नगदप ाप्ति किया **Receipt No. .....Date...../...../.....** मोहरह ०प्र ाप्तकर्ता	**MRD No. .....** **Sub. I/C Physician** **Name .....Sign. .....** **Name .....Sign. .....** **Name .....Sign. .....**

Date / Time of Admission :		**Date / Time of Discharge :**	
IPD No.	**Dept./Ward :**	**Bed No. :**	**MLC : Yes No**
Patient Name :		**S/D/W/o :**	
Age :	**Gender : M / F / Trans**	**ICD Code (by MRD Staff) :**	
Address :			
Admitting Doctor :			
Treating Doctor :			
Diagnosis :			

Allergic to / Risk Factors :

IPD No. **Name :** **Bed No.**

GENERAL CONSENT FORM
सामान्यस हमतिप त्र

I, ...do hereby agree and give my full consent/authorization as an act of my own free will for my ..... (relationship of patient) ..... (name of patient) admission to ..... I am giving my consent and authorize the hospital, the physicians, medical, nursing & housekeeping staff to provide relevant care and to conduct all necessary Diagnostic, Radiological/Therapeutic procedures including withdrawal of blood for investigations and references as the attending Doctors may necessary. I am also giving my consent to administer necessary drugs, medications, intravenous fluids and any non invasive procedure etc. if necessary.

I hereby release the Hospital, its attending Doctors, Anesthetists, Pathologists, Radiologists and its staff and all other person participating in my care from any liability whatsoever for any untoward or unfavourable consequences or results that may arise out of or in the course of my treatment (including surgery and anesthesia) at this Hospital. I further say that I have informed the Doctor of all my previous illnesses, allergies, drug reactions, surgical procedures and all others facts relevant to my treatment. I shall not hold the Hospital or the Doctor responsible for the consequences, which may arise due to any non-disclosure of any information that might be relevant in providing treatment.

I am further giving consent and agree to the disposal by the Hospital Authority for transfer in / Referral to any other Hospital as considered fit by my Doctor during any time of the treatment, if my Doctors feel that it is essential for any recovery. I have fully understood that rules & regulatrions of the Hospital and I agree to abide by the same.

The above has been explained in the language known to me and I have fully understood the same and I am signing this consent by my own free will and in a fully alert state of mind.

म .....उ म्र/आयु.....वर्षप ुत्र/पुत्री/पति/पत्नी .....एतद्द्व ारास हमति प्रदानक रता/करतीह ूँ िकम ें .....ि चिकित्सालयम ंे क ार्यरत् ि चिकित्सक,न र्सिगए वंस फाईक र्मचारीक ेत र्कसंगतउ पचार एवं सभी आवश्यक नैदानिक, रेडियोलॉजिकल, रक्त परीक्षण एवं उपचार प्रक्रिया हेतु सहमति देता हूँ एवं अधिकृत करता हूँ। इसके अलावा आवश्यकतानुसारअ ौषधि,अ ाई०वी०फ ल्यूड,न ॉनइ नवैसिवप्र क्रियायेंह ेतुस हमतिद ेताह ूँए वंअ धिकृतक रताह ूँ।

मैं ि चिकित्सालयम ंे क ार्यरत् ि चिकित्सक,ि नश्चेतक,प ैथोलॉजिस्ट,र ेडियोलॉजिस्ट,क र्मचारियोंए वंउ नस भी० यक्तियोंक ेज ेम ेरेउ पचार में ंभ ागीदारह ैंक ेि किसी भ ीत रहक ीद ेयतास ेम ुक्तक रताह ूँ।

मुझे ऑपरेशन/प्रक्रिया आकस्मिक स्थिति उत्पन्न अथवा प्रकट होने पर प्रारंभिक उपचार में समय आवश्यक शल्यक और अन्य आपात प्रक्रिया के अतिरिक्त अथवा उससे अलग जो अपेक्षिक समझते हैं, प्राधित करता हूँ।

मैंय हभ ीस पष्टह ूँि कम ैंि किसी भ ीप कारक ीए लर्जीअ थवाद वाईक ेप्र भावस ेप ीड़ितन हींह ूँ।

ऑपरेशन के प्रकार और प्रयोजन/अथवा प्रक्रियाओं की अनिवार्यता संभावित वैकल्पिक पद्धतियों उपचार पूर्वानुमान जाँच प्रक्रिया/जाँच केज ेखिमत थाज टिलताओंक ीस ंभाव्यतात थाम ेरि स्थिति/निदानक ेअ नुरूपउ पचारक ेब ारेम ंे म ुझेप ूरीत रहस ेस पष्टक र दियाग याह ैं। उक्तप रिस्थितियोंम ंे उ पचारक ेब ारेम ंे म ुझेज ानकारीह ैं।

मैंस वीकारक रताह ूँि कि किसी भ ीप्र क्रिया/उपचारस ेस ंबंधितप रिणामक े लिएम ुझेक ोईग ारंटीअ थवाव चनन हीं दियाग याह ैं।

मैं ऑपरेशन अथवा प्रक्रिया के निस्पादन के लिए अपने शरीर के उपयुक्त अंग की चिकित्सा वैज्ञानिक अथवा शैक्षिक उद्देश्य के लिए फोटोग्राफिंगत थाट ेलिविजनिंगक रनेक ीस हमतिप्र दानक रताह ूँब शर्ते ि कि चत्रअ थवाउ ससेव र्णनात्मक ि वषयोंद्व ाराम ेरीप हचानउ द्घाटित नह ो।

मैंप्र माणितक रताह ूँि कउ पर्युक्तस हमतिप त्रम ें ि ववरणम ैंने प ूरीत रहप ढ लियाह ैं य ाम ुझेम ातृभाषाम ंे प ढ़करस ुना दियाग याह ैं त थाम ैं उपर्युक्तस हमतिक ेल ाभअ ोरह ानिस ंभ ालीभाँतिप रिचितह ूँ।

	Name न ाम	Signature and thumb impression हस्ताक्षरए वंअ ंगूठेक ा निशान	Date दिनांक	Time समय
Patient or Patient's Relative मरीजअ थवा ि रश्तेदारक ान ाम				
Admission Staff भर्तीक रनेव ालास् टाफ				

IPD No. **Name :** **Bed No.**

INITIAL ASSESSMENT (INDOOR PATIENT)

Chief complaint(s) :				
H/o of present illness :				
Past History :				
Family History :				
Personal History :				
Occupational History :				
History of previous treatment :				
History of Drug allergy Any other allergy :				
General physical Examination	**Pulse /min**	**Pallor: present / absent**	**Pulse /min**	
	Temp °F	**Icterus: present / absent**		
	RR /min	**Oedema: present / absent**		
	BP mm Hg	**Dehydration : Mild / Mod./Severe**		
Systemic Examination	**CVS :**	**Resp :**		
Per Abdomen :	**Distension : present/absent**	**Guarding : present /absent**	**Tenderness : present / absent**	
	Region			
	Spleen : palpable/not palpable	**Kidney : palpable/not palpable**	**Liver : palpable/not palpable**	**Gall Bladder : palpable/not palpable**	**Bowel sound : present/absent**

IPD No. **Name :** **Bed No.**

	Shifting Dullness/Ascities : present / absent	**Lump : present / absent**	**Any Other :**
CNS	**Mental Status :**	**Sensory Pain : present/absent**	**Gait : normal/abnormal**
	Neck Rigidity :		**Any Other :**
PR / PV / PS / Proctoscopy/ Others			
Any Other Examination			
Provisional Diagnosis			
Investigations			
Plan of Treatment			
Preventive aspects **(Drug Allergy, Restraints, Diet, Smoking Habits, etc.)**			

IPD No. **Name :** **Bed No.**

Extra Details

Signature :

Name :

Seal :

(Admitting Doctor) **(Consultant)**

IPD No. **Name :** **Bed No.**

NURSING ASSESSMENT
(TO BE DONE ON ASMISSION IN WARDS)

ADMISSION DATE :

Name :		**Age/Sex :**	
IPD No. :		**Unit :**	
Date/Time of arrival :		**Admitted by**	**Stretcher/W-chair/by walking/.....**
Patient accompanied by : Family/Friend/Police/Other			

Contact Person ..... Relation ..... Phone No. .....

Reason for coming to hospital :

Past Medical History : DM/Hypertension/CAD/Kidney disease/others .....

Temperature : °F	**Pulse /min**	**BP mm HG**	**Respiration /min**	**Height cm**	**Weight Kg**

BODY / SAFETY SEARCH

	Yes	No	Location
Contusion			
Laceration			
Rashes			
Scars			
Bruises			
Pain			
Others			

ALLERGIES/ADVERSE REACTIONS (Known or suspected allergies to) :

Related to	Tick (As Applicable)			Details if Known
Medication / Drugs	**Yes**	**No**	**Not Known**	
Blood Transfusion	**Yes**	**No**	**Not Known**	
Food	**Yes**	**No**	**Not Known**	

ABILITY TO PERFORM ACTIVITIES OF DAILY LIFE

Activity	Independently	Assisted	Dependent
Bathing			
Eating			
Dressing			
Toilet Use			

FUNCTIONAL ASSESSMENT

Activity	Independently	Assisted	Dependent
Bed Activities			
Sitting			
Standing			
Ambulation			
Stair Climbing			
Disability			

IPD No. **Name :** **Bed No.**

GRAPHIC (T.P.R.) CHART

Date		
Day of disease		
Days Post - OP		
Time		
Pulse 210	C° 41.1	F° 106
200	40.6	105
190	40.0	104
180	39.4	103
170	38.9	102
160	38.3	101
150	37.8	100
140	37.2	99
130	36.7	98
120	36.1	97
110	35.6	96
100	35.0	95
90	60	
80	50	
70	40	
60	30	
50	20	
40	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 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

BP
Stools
Urine
Weight
Bath

NB : Pulse, Day of disease, post - op days to be marked in red link only.

IPD No. **Name :** **Bed No.**

NUTRITIONAL ASSESSMENT FORM
(To be done by dietician)

Assessment Date :	**Assessment Time :**
Ptient's Name :	**ID No. :**
Age : **Sex : M/F/Trans**	
Date of Admission :	**Consultant :**
Ward / Bed :	
Diagnosis :	**Wt :**

BMI :

Current nutritional status :

Normal	Under weight	Over weight	Obeset

PATIENT DIET HISTORY :

1. **Physical activity :** a) Sedentary, b) Moderate c) Heavy
2. **Exercise :** a) Routinely, b) Occasionally, c) None
3. **Smoking :** a) Yes, b) No
4. **Alcohol :** a) Yes, b) No
5. **Food allergy :** a) Yes, b) No

If yes please mention .....

6. **Weight reduction within two months :** a) Yes, b) No **If yes please mention ..... Kg**
7. **GI Function disorder :** a) Nausea, b) Vomiting, c) Constipation, d) Loose stools, e) Other
8. **Mode of diet :** a) Vegetarian, b) Non-vegetarian, c) Ova--vegetarian

DIETARY MANAGEMENT :

DATE	DIET TYPE	CALORIE	CARBO HYDRATE	PROTEIN	FAT	DIETICIAN'S NOTE	SIGN.

IPD No. **Name :** **Bed No.**

MEDICATION ORDER AND ADMINISTRATION SHEET

Date	Name of Medicine Prescribed by Doctor	Route	Dose	Freq.	Time	Signature of Doctor	Time of Administration (To be filled by Nurse)			Signature of staff Nurse
							Morn.	Eve.	Night	

IPD No. **Name :** **Bed No.**

CONTINUATION SHEET
(To be used by Doctor)

Date	Time	Progress & Treatment	Signature

IPD No. **Name :** **Bed No.**

Laboratory Test Report Form

	Unit	Normal Range	Date & Report	Date & Report	Date & Report
Haematology					
[ ] Hb					
[ ] CBS					
[ ] ESR					
[ ] Blood Group & Rh factor					
[ ] BT & CT					
[ ] Platelets Count					
[ ] Malerial parasite					
[ ] Microfileria					
[ ] HBS Ag					
[ ] HIV					
Urine Examination					
[ ] Urine routine					
[ ] Pregnancy Test					
Stool Examination					
[ ] Routine					
Bio Chemistry					
[ ] Blood Sugar					
F/PP/PG/Random					
[ ] GTT					
[ ] Billirubin					
[ ] SGOT					
[ ] SGPT					
[ ] Alk. Phosphate					
[ ] Serum Protein					
[ ] Serum Albumin					
[ ] Serum Cholesterol					
[ ] Serum Triglycerides					
[ ] HDL					
[ ] Blood Urea					
[ ] Serum Createnine					
X-ray					
USG					
Other Investigations					

IPD No. **Name :** **Bed No.**

INFORMED CONSENT FOR BLOOD TRANSFUSION

Unit ..... Date ..... IPD No. .....

I, ...hereby give my consent for whole blood transfer / blood components as part of treatment to myself / my patient (Name of Patient) ..... while being admitted at hospital. I have been explained all the known risks of transfusion reactions, I have also been explained that the donor blood has been screened for HIV antibodies, Hepatitis B surface antigen, Hepatitis antibodies, Malaria and syphilis. I have also been explained that transfusion transmitted infections can very rarely occur even with screened blood, especially if it is in the “window Period” and also due to various other infections which have not been screened for.

All the above-mentioned risks have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for the whole blood / component transfusion to me / my Patient named .....

DOCTOR’S NAME	SIGNATURE	SEAL
PATIENT’S/RELATIVES NAME	SIGNATURE	PHONE NO.

रक्त/रक्तअ वयवर थानान्तरणह ेतुर वीकृतिप ्रपत्र

आई०पी०डी०न ं० ..... यूनिट ..... दिनांक .....

म ैं.....(स्वीकृतिदाताक ान ाम).....एतद्द्व ारा

अपनीअ ोरस ` .....(स्वीकृतिदाताक ान ाम) केइ लाजक ेि हस्सेक ेत ौरप रस म्पूर्णर क्त/रक्तअ वयव स्थानान्तरणक ीर वीकृतिप ्रदानक रताहूँ।म ुझेर क्त स्थानान्तरणप्र क्रियाक ेज्ञ ातज ोखमोंक ेस म्बन्धम ेंभ ालीप ्रकारस ेर पष्टक र दियाग याह ै।

म ुझेय हभ ीस मझाा दियग याह ैि कर क्तदाताक ेर क्त/रक्तअ वयवक ीए च०आई०वी०,ह ेपाटाइटिस-बी,म लेरियाए वं िसफलिसक ीज ाँच कीज ाच ुकीह ै,ह ालांकिर क्तच ढ़ानेक ेद ौरान िकन्हींद ुर्लभप रिस्थितियोंम ेंि कन्हींअ न्यक ारणोंस ेस ंक्रमणह ोस कताह ै।

उ परोक्तस भीख ातरेक ेस म्बन्धम ेंम ेरे िचकित्सकड ा०. .....द्व ाराम ुझे/मेरेम रीजक ोम ेरेद्व ारास मझीज ाने वालीम ातृभाषाम ेंस मझायाज ाच ुकाह ै।

अतःम ैं/ म ेरीम रीजोंक ेर क्त/ र क्तअ वयवच ढ़ानेह ेतुस हमतिप ्रदानक रताहूँ।

चिकित्सकक ान ाम	हस्ताक्षर	मुहर
मरीज/रिश्तेदारक ान ाम	हस्ताक्षर	फोनन ं०

IPD No. **Name :** **Bed No.**

LAMA (LEFT AGAINST MEDICAL ADVICE) DECLARATION

Date :	**Patient Name :**	**D/S/W of :**
Age / Sex :	**OPD / IPD No. :**	
Address :		
Bed No. :		

I, ... Spouse/Guardian of patient, Mr. / Ms. ..... Age/Sex..... hereby affirms that, I am taking the patient, Being treated in the hospital, with IP No. ..... Against medical advice I was explained clearly by the hospital authorities :

a. That the patient is admitted under Medico Legal category
b. It is a police case
c. That the patient's condition is very critical and the condition may deteriorate any time.

I declare that

a. I take the responsibility of getting the patient discharged against the medical advice of doctors.
b. I am fully responsible for any loss that may happen to the patient which may include death.
c. I am fully satisfied with the treatment given to the patient by this hospital.
d. In case the patient dies, I will hand over the body to the police.
e. I am fully aware that if I fail to hand over the body to the police, I am Liable for severe punishment and prosecution.
f. I am fully aware that the hospital will not give any records, certificates and medical briefing of the patient.
g. I am fully aware that the legal heirs may get into problems due to non-availability of certificates in future.

I am taking the patient with me in spite of knowing clearly about his/her serious medical condition. I am fully aware of the consequences of taking the patient at this condition against the Medical Advice of the doctors. I declare that I am fully responsible and liable for the consequence of taking the patient against medical advice.

I am fully aware, and agree whole heartedly that no one in the hospital is responsible for may act. I also declare that Nobody including me or the legal heirs of the patient shall hold the institution or the treating doctors responsible any time pertaining to the patient or the records of the patient.

All the above information has been explained to me by the hospital authorities in a language, which I know.

Patient relatives Signature : ..... Left Thumb impression .....

Relationship .....

Witness Name : Left thumb impression and sign.

1.

2.

IPD No. **Name :** **Bed No.**

स्वशासी राज्य चिकित्सा महाविद्यालय, फतेहपुर

DISCHARGE SUMMARY (PATIENT COPY)

Date / Time of Admission :	Date / Time of discharge :	IPD No.
Dept/Ward :	Bed No. :	MLC : Yes ☐ No ☐
Patient Name :	S/D/W/o :	
Age / Sex :	***ICD Code (by MRD Staff)*** **:**	
Address :		
Treating Doctor :		
Brief history and Clinical Notes : **ALLERGIC TO :**		
Investigations done :		
Diagnosis :		
Treatment / Surgery / Procedure done during hospitalization :		
Follow-up medication :		

Name	Dose	Repetition/day	Route	Duration

Follow-up advice :

In case of emergency please contact Dr. ..... Phone No. .....

IPD No. **Name :** **Bed No.**

PATIENT TRANSFER

Sl.	No Current Location/Bed	Sending Time & Date	Patient moved to Location/Bed	Purpose of the movement	Sending by (Staff)	Receiving Time & Date	Received by (Staff)	Status Stable/Serious/Critical