STANDARD FORM USED IN DAY TO DAY PRACTICE

1. ACCIDENT / INJURY REPORT
2. DISCHARGED AGAINST MEDICAL ADVICE
3 DISCHARGED AGAINST MEDICA ADVICE
4. BIRTH REGISTER
5. M.T.P CONSENT FORM
6. BIRTH CERTIFICATE
7. MEDICAL CERTIFICATE FOR LEAVE
8. MEDICAL CERTIFICATE FOR FITNESS
9. CASE SHEET
10. INFORMED CONSENT FOR SURGICAL PROCEDURES AND ANESTHESIA
11. DANGEROUSLY ILL INFORMATION CONSENT FORM
12. VACCINATION SCHEDULE
13. EMERGENCY CASE REGISTER
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15. OP DEPARTMENT REGISTER
16. SURGERY RECORD
17. PRE ANESTHETIC CHECK LIST
18. SPECIFIC CONSENT FOR ANESTHESIA
19. SPECIFIC CONSENT FOR SURGICAL PROCEDURE
20. CONSENT FORM FOR THROMBOLYSIS AND DIL CONSENT
21. PRESCRIPTION FORMAT

ACCIDENT / INJURY REPORT

			Intimation Foil No.	
Name :	Age :	M ☐ F ☐	Hospital No.	
Father's / Husband Name :	Occupation :		Community :	
Address :	Identification marks			
	1. 2.			
Alleged Cause :	Occured On : (Date) Site		Time :	
Brough by : Date :	Relationship : Time :	Nature of Injury: Simple ☐	Grevious ☐	Opinion Reserved ☐
Police Intimated No ☐ Yes ☐ Where		Dying Declaration Yes ☐ No ☐		

Condition / injuries

Signature _____CMO

Name :

Date :

DISCHARGED AGAINST MEDICAL ADVICE

எனது மகன் / மகள் / தாய் / தந்தை / கணவன் / மனைவி / மாமா / மாமியார் / நண்பர்/ ..... திரு / திருமதி / செல்வன் / செல்வி .....அவர்களை வேற்கண்ட மருத்துவமனையிலிருந்து மருத்துவரின் அறிவுரைக்கு மாறாக சொந்த விருப்பத்தின் பேரில் அழைத்துச் செல்கிறேன். இதனால் ஏற்படும் பின் விளைவுகளுக்கு மருத்துவர்களோ, ஊழியர்களோ, மருத்துவமனையோ பொறுப்பல்ல என்பதை தெரிவித்துக்கொள்கிறேன்.

மேற்கூறிய தகவல்களை தமிழில் நன்கு படித்து / படிக்கக்கேட்டு கையெழுத்து போடுகிறேன்.

சாட்சி : 1 கையொப்பம்

பெயர்

விலாசம்

இவன்
கையொப்பம்

பெயர்

விலாசம்

சாட்சி : 2 கையொப்பம்

பெயர்

விலாசம்

மருத்துவர் கையொப்பம்

பெயர்

DISCHARGED AGAINST MEDICAL ADVICE

Name of Patient, Age, Sex	IP No.	Father's Name	Ward No.

Date of admission	Referring Dr	Diagnosis

BP	PR	TEMP	SPO_2	RR	CONSCIOUS	Ambulant	Venflon	Catheter	Ryle's	Bedsores

Date	Time of Discharge	Auto / Ambulance / Car	Wheel chair / Stretcher	O_2	GC at time of shift

I. ..... am getting my ..... Mr. / Mrs. ..... discharged from this Nursing Home against medical advice on this day of ..... due to personal reasons. I understand that the illness of the patient is not yet cured and I undertake the risk of taking a sick patient out of the medical supervision.

I reiterate that I am wholly responsible for the harm / Deterioration / Injury caused to the patient on getting discharged in such a condition and I will not hold the concerned Doctor / Consultant / Hospital staff responsible for any un toward outcome.

I also understand that the Doctor or Nursing Home cannot provide me any Certificate in the regard.

	Name, Age, Sex, Address, Phone No.	Relationship	Signature LTI Date Time
PERSON			
WITNESS-1			
WITNESS-2			

BIRTH REGISTER

Reg No. Serial	Date & Time of Admission	Date & Time of Discharge	Name of the Patient & Address	Obstetrics History	Details of Child Birth	Type of Delivery & Indication of Intervention (if any	Birth Notifications to Municipal Authorities	Mother's Religion Education & Bl. Grp
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form NO.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	
	AM	AM		Male	Date- Sxe-		Form No.	
	PM	PM		Female	Time- Wt-			
Husband's Ful Name & Edu.			Age Yrs	Abortion-	Day- O.E/	Chil's Bl. Grp. Apgar Score :	Dt :	

M.T.P. CONSENT FORM

Patient's Information	Guardian's Information (In case of Minor)
Name :	Name :
Age : Yrs	Sex : ❒ Male / ❒ Female Age : Yrs
Registration No.	Add :
Diagnosis :	
Operation's Title :	Relationship with the Patient :

I _____ the undersigned GIVE CONSENT for ❒ MY OWN / ❒ AFOREMENTIONED PATIENT'S Pregnancy Termination Procedure and / anaesthesia / therapy / etc. for the following - Indication. A) Danger of life. B) Grave injury to physical health of pregnant women. C) Grave injury to mental health of pregnant women. D) Pregnancy caused by rape. E) Substantial risk that if the child is born, it would suffer from such physical or mental abnormalities so as to be seriously handicapped F) Failure of contraceptives. AND further I am given to understand that

1. Information regarding anaesthesia and operative procedure, the ill effects, hazards and complication of the same and other modalities have been explained to me by Dr. _____.
2. I have been explained clearly that any medication / operation / therapy is not totally safe and that such procedure or anaesthesia can be a risk to life of an otherwise healthy person also.
3. Doctors have explained to me that excessive bleeding, infection, cardiac arrest, pulmonary embolism and complications like this can arise suddenly and unexpectedly while undergoing medication / operation / therapy / procedure or anaesthesia.
4. I give consent for any change in the anaesthesia or operative procedure as well as for removal of any organ as deemed necessary by the Doctors at the time of medication / operation / therapy / procedure.
5. I have been made aware that after the above operation / medication / therapy / procedure and anaesthesia, instead of desired benefit, some complications may arise procedure and anaesthesia, instead of desired benefit, some complications may arise e.g. 1) Sterility. 2) P.I.D. (Pelvic inflammatory Disease). 3) Rarely, failure of Procedure i.e. continuation of pregnancy. 4) Perforation. 5) Any other _____ _____ and I believe that to avoid such complications, if any, appropriate care shall be take by the Operating Dr. _____ Dr. (Anaesthetist) _____ or any other doctors suggested by them.

❒ I have read the above writing. / ❒ The above writing has been read out to me.
I have understood the aforesaid and I am giving my consent willingly.

Witness	Patient / Relative
Sign :	Sing. and / or L.H.T.I
Name :	
Add :	
	Date : / /
Age : Yrs Date : / /	Time :

BIRTH CERTIFICATE (in triplicate)

Serial No_____ IP No_____ Date_____

This is to certify that Mrs…….....……Aged…… wife of

.....……. Residing at ……..……..

has delivered a live MALE / FEMALE baby in this hospital on Date _____ Time_____

NAME OF THE M.O with Signature

MEDICAL CERTIFICATE FOR LEAVE / EXTENSION or COMMUTATION OF LEAVE

I, Dr…….....……, after careful examination of the case, do hereby certify that ……..…… working as ……. In ……...…… whose signature is given below, is / was suffering from ……..…….. and I consider a period of absence in duty of ……...…….. days with effect from ……..…… is / was absolutely necessary for the restoration of his / her health.

Patient Ref No: LTI or Signature of the patient:

(NAME OF THE M.O WITH REGN NO & SEAL)

MEDICAL CERTIFICATE FOR FITNESS TO RETURN TO DUTY

I, Dr……, after careful examination of the case, do hereby certify that …… working as ……. In …… whose signature is given below, has recovered from his illness and is now fit to resume his / her duties from…….. . I also certify that, I examined the original Medical Certificate and statement of the case (or certified copies thereof), on which the leave was granted and have taken these into consideration in arriving at my decision.

Patient Ref No: LTI or Signature of the patient:

CASE SHEET

IP No.		MLC / non MLC
Name :		Age / Sex :
F/H Name :		Phone :

Address (Resi)	Address (Off.)

DOA : TIME			dIAGNOSIS :
DOS :			
DOD : TIME			

Blood Group :	Allergies :
Refd by Dr.	

PR :	Drugs Taken so far :	DOSE
Temp :		
RR :		
BP :		
Ht :		
Wt :		
BMI		

CASE NOTES

Proper History in chronological order

Proper General Examination

Proper System Wise Findings

Provitional Diagnosis

Base line Investigations and relevant special investigations

Treatment Schedule properly and legibly written with proper dosage ar and timings

Specialist consultation if needed

Periodical Notes with time, date, Instructions and Signature

Nurses record

Condition on Discharge. discharge Advice and Date of Review

Pt. Name	Father's Name	Age / Sex	Ward	IP. No.
Dr.	Unit	Diag		

INFORMED CONSENT FOR SURGICAL PROCEDURES AND ANESTHESIA

PART 1 (GENERAL CONSENT)

I _____ (Name of the person signing), _____ (Relationship) of _____ (Relation Name) residing at _____ (Full address with Phone No.) under the treatment of _____ (Name of hospital and primary Doctor who is now treating the patient) do hereby give consent for SURGICAL PROCEDURE DIAGNOSTIC PROCEDURE or _____ (Name of procedure) to be performed up on _____ (Name of the Patient)

I declare that I am above 18 years of age. I have been informed about the inherent and potential risks of undergoing the procedure.

I understand that the procedure may NOT be done by the Doctor treating _____ (Patient's Name) so far.

I also understand that any ADDITIONAL TESTS / PROCEDURES / TREATMENTS apart from the ones DESCRIBED in this form will be done ONLY if it is absolutely necessary in the best interest of _____ (Patient's Name) and can be justified for medical reasons.

PART 2 (ANAESTHETIC CONSENT)

I under that _____ (Route of Anesthesia) anesthesia will be administered upon _____ (Patient's Name) by Dr _____ (Anesthetist Name with Qualification), who is a qualified anaesthetist. I have been informed about the risks involved in this mode of anesthesia.

I also understand that additional or alternate mode of anaesthesia apart from the one DESCRIBED in this form may be administered upon ONLY if it is absolutely necessary in the best interest of _____ (Patient's Name), and can be justified for medical reasons.

I have signed this consent VOLUNTARILY out of my FREE WILL without any pressure and in my full senses.

PATIENT	Name, Age, Full Address, Phone No.	Date / Time	Signature with relationship
RELATIVE	Name, Age, Full Address, Phone No.	Date / Time	Signature with relationship
WITNESS 1	Name, Age, Full Address, Phone No.	Date / Time	Signature with relationship
WITNESS 2	Name, Age, Full Address, Phone No.	Date / Time	Signature

DATE TIME PLACE		**SIGNATURE OF THE DOCTOR**

DANGEROUSLY ILL INFORMATION CONSENT FORM

Name of Patient, Age, Sex	IP No.	Father's Name	Ward No.

Date of admission	Attenders Name & Address, Phone No	Diagnosis
Time		

BP	PR	TEMP	SPO2	RR	Conscious?	GC

Existing Problems	New Problem	Investigation Reports information

I, ……..…… , _____ of the above mentioned patient have admitted him / her under care of Dr……..

Doctor after **examining the patient thoroughly / going through the previous medical records / after the investigation reports,** has informed me that the condition of the aforesaid patient is VERY CRITICAL.

I am also informed and fully aware that the condition of the patient may worsen any time / there is no guarantee that patient will become better / or cured / and the patient may not survive despite the best efforts of the doctor and his team**.**

I, upon my free will and in full senses, without any compulsion, give full consent and admit / continue further treatment in this hospital under the treatment of the Doctor.

I am also aware that hospitals with better facilities are available / unavailable nearby, and I make a voluntary decision to admit the above said patient in this hospital for treatment.

I reiterate that Doctor and his team cannot be held responsible for any UNTOWARD OUTCOME of the patient at any time, despite his BEST EFFORTS to save the aforesaid patient.

I will also give assurance for the payment of the fees and other charges, as requested by the hospital, from time to time.

	Name, Age, Full Address, Phone No.	Relationship	Signature Date Time
ATTENDER			
WITNESS 1			
WITNESS 2			

VACCINATION SCHEDULE

Baby Name			D.O.B:			REF No.	
VACCINE	**AGE DUE**	**DUE DATE**	**GIVEN ON**	**VACCINE**	**AGE DUE**	**DUE DATE**	**GIVEN ON**
BCG	0-3 month	0-Jan-00		Chicken Pox	15 Months	1-Apr-01	
O' dose OPV	at birth	o-Jan-00		HIB	15 Months	1-Apr-01	
Hepatitis-B	at birth	0-Jan-00		Mmr	15 Months	1-Apr-01	
DPT+OPV+IPV		15-Feb-00		DPT+OPV+IPV	18 Months	1-Jul-01	
Hepatitis-B	1-1/2 Months	15-Feb-00		Hepatitis - A	18 Months	1-Jul-01	
HIB		15-Feb-00		Typhoid	2 yrs	31-Dec-01	
DPT + OPV + IPV		16-Mar-00		DPT + OPV	4-1/2 Yrs	1-Jul-04	
HIB	2-1/2 Months	16-Mar-00		Typhoid	5 yrs	30-Dec-04	
DPT + OPV + IPV		16-Apr-00		Typhoid	8 yrs	31-Dec-07	
Hepatities - B	3-1/2 Months	16-Apr-00		dT	10 yrs	31-Dec-09	
HIB		16-Apr-00		Typhoid	11 yrs	31-Dec-10	
OPV	4-1/2 Months	16-May-00		Typhoid	14 yrs	31-Dec-13	
OPV	5-1/2 Months	15-June-00		MMR (girls)	15 yrs	31-Dec-14	
Measles	9 Months	30-Sep-00		dT	16 yrs	31-Dec-15	
Hepatitis-A	12 Months	30-Dec-00		Typhoid	17 yrs	30-Dec-16	

STICK VACCINE LABELS HERE

VACCINATE AS PER THE SCHEDULE

WISH YOUR BABY A LONG HEALTHY LIFE

EMERGENCY CASE REGISTER

Date	S. No.	Name of Patient	Age/Sex	s/o w/o d/o with address	Brought by	Rx given

POLICE INTIMATION

(Prepare in duplicate and obtain acknowledgment on second copy from the receiving police officer)

Time _____ AM / PM

Date _____

To,

(The Police Officer)

Dear Sir,

A patient with the following particulars has come / been brought to the Emergency / OPD and is being treated / Discharged / has expired / is brought dead.

This is for your information and necessary action please.

Name _____

Father's Name _____

Age _____ Sex _____ I.P. No. _____ AR No. _____

Address _____

_____

Brought By _____

Date & Time of admission _____

Diagnosis _____

RTA	**MLC**	**Injuries**	**Poisoning**	**Burns**	**Snake Bite**		

Site of Incident _____

(Signature of MO, Regn No. Name in capital letters)

OP DEPARTMENT REGISTER

Date	S. No.	Name of Patient	Age/Sex	s/o w/o d/o with address	Service Rendered	Fees	Receipt	Remarks

SURGERY RECORD

Name of Patient, Father's / Spouse name, Age, Sex	Ward No.	IP No.	Date

Pre operative Diagnosis	Pre Op Anesthetists Notes

Surgeon	Assistant Surgeon	Anesthetist	Type of Anesthesia

Pt Position	Skin Prep	Start time	End Time

Findings

Operative Procedure			Post Operative Orders	
Incision	Closure with	Biopsy taken?		

Blood loss (approx)	Remarks

Surgeon	Asst Surgeon	Anesthetist

PRE ANESTHETIC CHECK LIST

Name of the patient :

IP No. :

Weight of the pt:

Date of Admission:

Caste of the pt:

Identification Marks:

Allergies :

Informed about surgery? | Time of last food intake :

Taken bath? | Type of food taken last

Consent Form Signed? | Approx. duration of surgery

Type of anasthesia: | Alcoholism?

Dentures if any, removed? | Loose teeth?

Jewels if any, removed? | Smoker?

Serious illness in the past

Previous operations?

Problems with anasthesia?

Drug Allergy

BP Patient? | Heart problem?

Joint swelling in past? | Fainted?

Bleed excessively? | Anemia?

Cold Now? | Asthma / wheeze?

Nose block / sneeze | Fits?

Drugs Taken so far: | Recent injury?

Breathlessness?

Jaundice in past?

Kidney problem?

Blood Glucose: | BP: | PR:

Venflon working? | TT inj: | Xylo test Dose? | Hb

Fundus examn: | BT: | CT:

Urine passed? | Grp/Rh | ECG:

Teeth : | Grp x matched? | Checked?

Blood reserved? | CXR1: | Temp: | PCV:

Urine Acetone: | u/s abd:

Platelet Count | HBsAG: | HIV:

CVS: | Nose: | Throath | Teeth

RS: | Abd:

CNS: | Joints:

LMP: | Skin infection? | Beta HCG urine

Echo: | TMT: | Advance?

SPECIFIC CONSENT FOR ANESTHESIA

Name of Patient		Father's Name	IP NO
Room No	Treating Doctor		Diagnosis
Date	Time	Anesthetist	Procedure

I_____ name of th person signing_____, _____relationship_____ of _____relation_____ resident of _____ do hereby give consent for administering _____anesthesia upon_____patient's name_____by

Dr _____(ANESTHETIST NAME)_____, a qualified anesthetist for the _____(PROCEDURE)_____

I understand the following risks are involved in this mode of anesthesia. Doctor has clearly and without any bias EXPLAINED in detail about these. I am aware of my predisposing diseases like which also has effect on Anesthesia

RISKS OF _____ ANESTHESIA

I have signed this consent out of my free will without any pressure and in my full sense.

Date, Time	Name, Father's Name, Age, Sex, Full address, Phone No.	Relationship	Signature
		WITNESS 1	
		WITNESS 2	

SPECIFIC CONSENT FOR THE SURGICAL PROCEDURE

Name of Patient	Father's Name	IP NO
Room No	Treating Doctor	Diagnosis
Date	Time	Anesthetist	Procedure

I_____ name of th person signing_____, _____relationship_____ of _____relation_____ resident of _____ do hereby give consent for performing _____procedure upon_____patient's name_____by the qualified surgeon Dr _____, (Surgeon's Name)

Nature of Ailment	
Consequences of ailment	
Consequences of not treating the ailment	
Nature of proposed procedure & alternative or additional procedures that are likely to be done	Duration of Procedure (appox)
Success probability of Rx, Post procedure events that are likely	
Risks of the intervention	
Benefits of the intervention	
Unfortunate results of the proposed intervention	
Alternative methods of Rx	
Risks, Benefits and likely outcomes of alternative Rx	
Risk of unforeseen conditions within the body and methods to tackle them	
Cost of the intervention, when uncomplicated (EXCLUDING DRUGS AND INVESTIGATIONS)	
Approximate duration of stay, if uncomplicated	
Additional Remarks, if any	

I understand the above said INFORMATION & risks involved in this procedure. Doctor has clearly and without any bias EXPLAINED in detail about them.

I have signed this consent out of my free will without any pressure and in my full senses.

	Date, Time	NAME, FATHER'S NAME, AGE, SEX, FUL ADDRESS, PHONE No.	RELATIONSHIP	SIGNATURE / LTI
PATIENT				
RELATIVE				
WITNESS 1				
WITNESS 2				

CONSENT FROM FOR THROMBOLYSIS AND DIL CONSENT

Name of Patient, Age, Sex	IP No.	Father's Name	Ward No.

Date of admission	Attenders Name & Address, Phone No.	Diagnosis
Time		

BP	PR	TEMP	SPO2	RR	Conscious?	Ambulant	GC

Existing Problems	New Problems	Investigation Reports information

Contra to Thrombolysis	Relative CI	Indications
✓ Internal Bleeding ✓ Prolonged or Traumatic CPR ✓ Heavy vaginal Bleeding ✓ Acute pancreatitis ✓ Active lung disease with cavitation ✓ Recent surgery (<2 weeks) ✓ Recent trauma (<2 weeks) ✓ Cerebral Neoplasm ✓ Severe hypertension (>200/120) ✓ Suspected Aortic dissection ✓ Previous allergic reaction ✓ Pregnancy ✓ <18 weeks post natal ✓ Server Liver disease ✓ Esophageal varices ✓ Recent head trauma ✓ Recent Hemorrhagic stroke	✓ H/o severe hypertension ✓ Peptic ul cer ✓ H/O CVA ✓ Bleeding diathesis ✓ Anti coagulants	Presenting within12 hrs of chest plain with ST->2mm in ^{3} chest leads ST->1mm in ^{3} limb leads Postr Infarction (dominant R Waves with ST^{-} in V1-V3 New onset LBBB Presenting within 12-24 hrs of chest pain if chest pain continuing +/- ST^{-} ongoing.

I, …… , _____ of the above mentioned patient have admitted him / her under care of Dr……..

Doctor after examining the patient thoroughly / going through the previous medical records AND after the preliminary investigation reports, has informed me that the aforesaid patient is suffering from HEART ATTACK and his / her condition is VERY CRITICAL.

I was informed that out of the three major blood vessels that supply the heart muscle, ONE is / TWO are TOTALLY blocked by a BLOOD CLOT NOW. Because of this, the aforesaid patient has CHEST PAIN, BREATHLESSNESS / SWEATING / COUGHS/ FAINTED. He/ She needs the Blocked Blood Vessel to be opened up IMMEDIATELY to save the HEART MUSCLE which is dying due to lack of blood supply.

For this the blocked blood vessel will have to be opened by a DIRECT method called PTCA. Dr informed me that urgent PTCA is the best method to open up the blocked blood vessel of the heart. Or else, the drug STREPTOKINASE / TENECTEPLASE has to be given immediately, to dissolve the clot, without wasting time. This drug is effective in about 60% of the patients in completely opening up the blocked vessel. If this drug fails to open up the blocked vessel, then patient will need PTCA as a rescue measure urgently.

I am fully aware that this Nursing Home has/ does not have Cardiac Cath lab facility to perform PTCA. But still I decide to stay here and request the Doctor to administer STREPTOKINASE / TENECTEPLASE as the first line of treatment for the patient now.

Doctor also told me that 4 out of 100 patients receiving the drug treatment for Heart attack may bleed anywhere inside the body – BRAIN, STOMACH ULCER, URINARY TRACT etc. Sometimes blood transfusion may be necessary to make good the loss of blood or stop bleeding. Brain bleed may even cause DEATH of the patient or if he survives may have one or more parts PARALYSED for life.

Having known all the SIDE EFFECTS of the Drug treatment and the GRAVE NATURE of illness (HEART ATTACK), I request Doctor to administer the drug to the patient.

Doctor has informed me about the COST of Streptokinase (Rs 4000.00) and TENECTEPLASE (Rs.) and I request Dr to administer STREPTOKINASE / TENECTEPLASE. He also told me that the costly drug TENECTEPLASE causes lesser bleeds elsewhere within the body, can be quickly administered, and is more effective than STREPTOKINASE.

I also understand that the condition of the patient and the urgency of sedation PRECLUDE him/her from giving a valid informed consent and the ability to make choice between the TWO modalities of treatment. So I stand on his behalf and give this consent to Doctor.

I am also informed and fully aware that the HEART function of the patient may worsen or stop any time and there is no guarantee that patient will become better / or cured / and the patient may not survive despite the best efforts of the doctor and his team.

I, upon my free will and in full senses, without any compulsion, give full consent and admit / continue further treatment in this hospital under the treatment of the Doctor.

I reiterate that Doctor and his team cannot be held responsible for any UNTOWARD OUTCOME of the patient at any time, despite his BEST EFFORTS to save the aforesaid patient.

I will also give assurance for the payment of the fees and other charges, as requested by the hospital, from time to time.

	Name, Age, Full Address, Phone No.	Relationship	Signature Date Time
ATTENDER			
WITNESS 1			
WITNESS 2			

PRESCRIPTION FORMAT

DATE	TIME	Appt	Residence	Emergency	House Vst	Fees

Pt. Name	Father's name	Age / Sex	Ref. No.

Ht	Wt	PR	BP	SpO2	Temp	RR	Bp1	Bp2	RBG	GC

Clinical History / Important lab reports	Allergy	Diagnosis

Rx name of Drug / Generic Name	Strength	Nos.	Freq	AF/BF	Remarks
Special Instructions					
Special Instructions					
Special Instructions					
Special Instructions					
Special Instructions					
Special Instructions					

General Advice / Dos & Donts

Investigations	Referrals	Review on	Report immediately if

Notes	In Emergency contact

Emergency lab Reports	Pts Signature	Drs Signature