

		<div>LITTLE STARS CHILDRENS HOSPITAL</div> <div>(A UNIT OF THIRUMALA CHILDHEALTH SERVICES PVT LTD)</div> <div>Plot No. 30, Nagarjuna Hills, Punjagutta Hyderabad-500 082, Ph: 040-6666 2345,6699 2345.</div> <div>ADMISSION AND DISCHARGE RECORD</div>												
IP No. : <input type="text" value="IP201244"/>		U.M.R.No : <input type="text" value="UMR35235"/>		Admission Date : 24-Jun-21 03:31 PM										
Name of the Patient : B/O. Anitha														
Father/Husband Name : Anitha		Age : 1M(s) 26D(s)		Sex : FEMALE										
Mother's Name : Anitha		Marital Status :		Occupation :										
Address : Khachiguda														
Phone Number : (R) (O) 9191919191		Nationality : INDIA		Religion :										
Consultant Doctor : Dr.MEHUL A SHAH		Department : PEDIATRIC NEPHROLOGY												
Ref. By Doctor :		Ref. Source :												
Credit Organisation :		Ward / Bed No : DELUXE ROOM/308												
Diagnosis on Admission :														
Final Diagnosis :				I.C.D Code :										
Secondary Diagnosis :				I.C.D Code :										
Surgical Operation :				I.C.D Code :										
Date :		Type of Anaesthesia :												
Cause of Death :		Under 48hrs. :		Above 48hrs. : Date of Death:										
Date Of Discharge :		Hospital Days :												
Result : Recovered		Improved		Diagnosis Only LAMA MLC EXP										
Signature of Resident				Signature of Consultant										
<div>Obstetric Data :</div> <table><tr><td>Normal</td><td>Live Birth</td><td>Date</td></tr><tr><td>Abnormal</td><td>Twin</td><td>Male</td></tr><tr><td>Weight</td><td>Still Birth</td><td>Female</td></tr></table>						Normal	Live Birth	Date	Abnormal	Twin	Male	Weight	Still Birth	Female
Normal	Live Birth	Date												
Abnormal	Twin	Male												
Weight	Still Birth	Female												

AUTHORISATION FOR INVESTIGATIONS, PROCEDURES, SURGICAL OPERATIONS AND TREATMENT

I \_\_\_\_\_ S/O D/O W/O F/O \_\_\_\_\_ resident of necessary for the diagnosis and treatment . any Procedures like Biopsy, Dialysis, Surgical Operations under any anaesthesia as and when required or deemed investigations including HIV Testing and administer necessary drugs, injections and blood transfusion and to undertake authorise all medical, nursing and paramedical staff of The Little Stars Children's Hospital, to conduct all necessary

Witness Name :

Signature :

Date : Signature of Patient / Attendant

AUTHORISATION FOR RELEASE OF INFORMATION

I hereby authorise the Little Stars Childrens Hospital, Hyderabad to release any document from any Medical record for the purpose of research, claim or settlements to any person or agency or settlements to any company permitted under law. I shall not hold the authorities liable for any legal consequences arising from the release of the said information.

Witness Name :

Signature :

Date : 26-Jun-2021 Signature of Patient / Attendant

DISCHARGE AGAINST MEDICAL ADVISE FORM

I am responsible for taking the patient \_\_\_\_B/O. Anitha\_\_\_\_\_ at my own risk. The patient condition and prognosis was explained to me by the consultant and Doctor on duty in the vernacular language understand by me. Yet, we have decided to take patient against medical advice. In case of any eventuality i will not hold the hospital authorities responsible.

SIGNATURE OF  
CONSULTANT /  
DOCTOR ON DUTY }

Name :

Registration No :

Date : 26-Jun-2021

Time : 10:33:24 AM

Signature

Name :

Relation to the Patient :

Date : 26-Jun-2021 Time : 10:33:24 AM

Wittness Name :

Signature

Date : 26-Jun-2021 Time : 10:33:24 AM