



Ocean Welfare Foundation
Let's Help Together

Patient Details

<u>Particulars</u>	<u>Details</u>
Patient Name	TANMAY
Gaurdian Name	LATE KAMAL JEET
Current Age	7 YEARS
Sex	MALE
Disease	CEREBRAL PALSY
Address	F-BLOCK, TILAK NAGAR, DELHI
Hospital Name	St. STEPHEN HOSPITAL
Treatment Required	OPERATION, THEREPY, MEDICINES
Estemated Cost	ABOUT INR:135000/-





Form No. 240



ST. STEPHEN'S HOSPITAL

TIS HAZARI, DELHI - 110 054

Tel. : 23966021-27

ELECTRO CARDIOGRAM

NAME *Tannay*

AGE *7y* SEX *Male*

I.P. No. O.P.D. No. *189.51*

WARD *OPD* BED No.

REFEREED BY DR.

(1) Dt. *4/9/22* (2) Dt. (3) Dt.

(4) Dt. (5) Dt. (6) Dt.

Female
Req. No. : Years

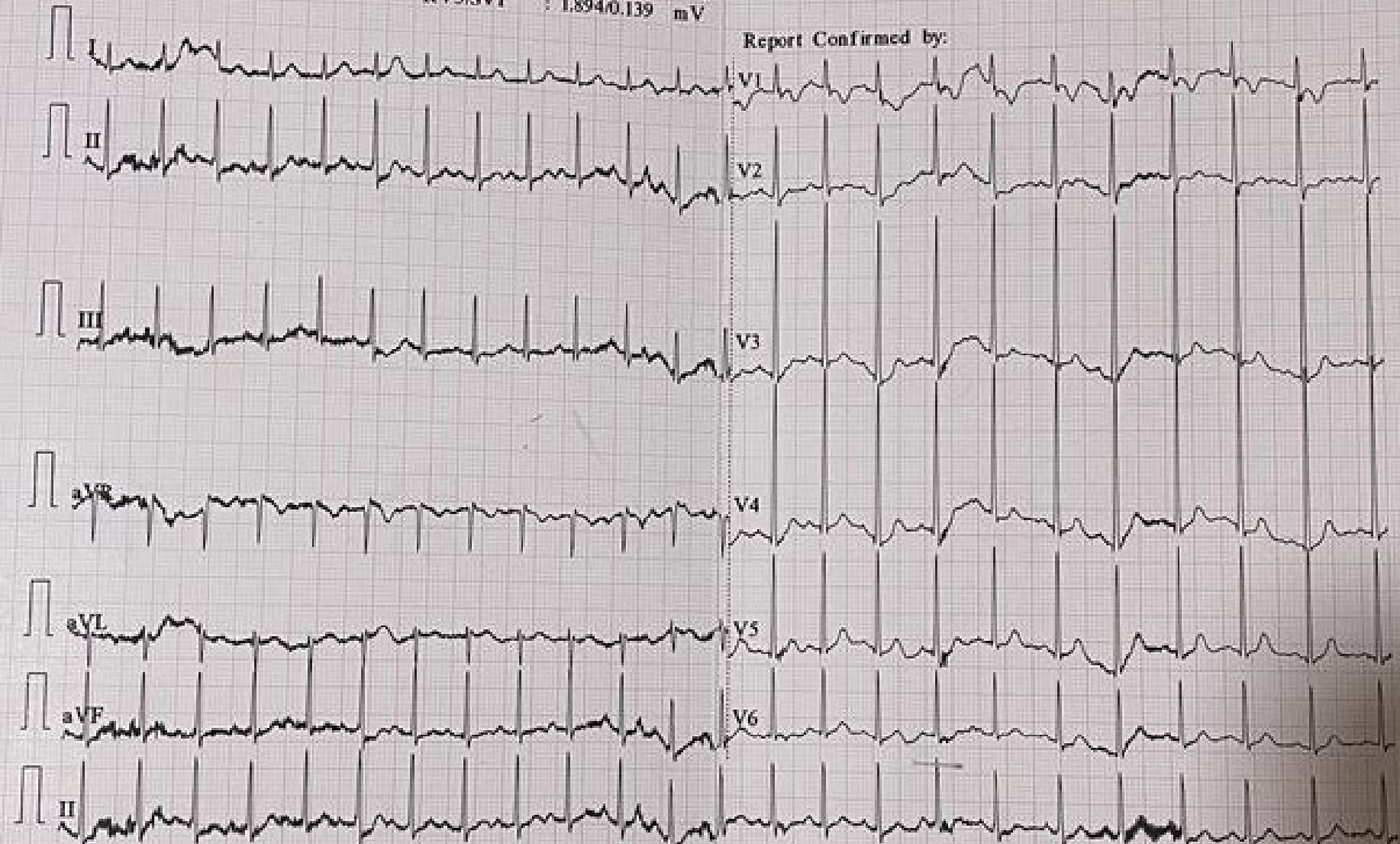
Tarmay

04-04-2022 12:46:13 *PM 6*

HR	: 141	bpm
P	: 108	ms
PR	: 144	ms
QRS	: 74	ms
QT/QTcBz	: 252/386	ms
PQRST	: 87/73/31	ms
RV5/SV1	: 1.894/0.139	mV

Diagnosis Information:
 Probable sinus tachycardia
 Borderline ECG

Report Confirmed by:



Star 2nd floor

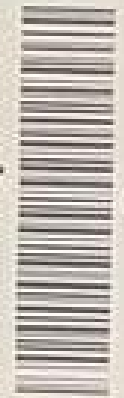
Serial No.: 132204040113
Name: Mr.TANMAY
Refd. By: ST STEPHEN
Machine ID: 1304113

Date: 04-Apr-22
Age / Sex: 7 YRS / MALE
Dept: ECHO
CARDIOGRAPHY



IN

Test Name: ECHO COLOR DOPPLER
Sample Collection
Time:
Clinical History/
Remarks:
Signature:



OUT

Date

S* on - 5/4/22

Care on - 4/4/22

COVID 19 RTPCR

[Signature]
Suresh

4/4

Paediatric Referral

Kindly Review ECG + give
clearance for surgery in view of
cong. anomaly surgery + stopping
of valproate

* 4/3/22 DDP Navin cardio

ECG in sinus tachycardia
No active cardiac complaints
H/O CP, febrile seizure ⊕ (on valproate)

Adv - ~~DDP~~ - echo

⊙ Review after echo for
clearance.

[Signature]
Suresh

4/4/22

Get 20 Echo &
care report
clearance.
Postponed to
12/4/22
Admit -> 11/4/22.
[Signature]
Suresh

Date

S* on - 5/4/22.

Case on - 4/4/22.

COVID 19 RTPCR,

[Signature]
Suresh

4/4

Pericardial Referral

Kindly Review ECG + Give

Clearance for Surgery in view of

cong. anomaly Surgery + stenting

of valvulopathy

* E/S/B DOD Navin cardio

ECG: sinus tachycardia

No active cardiac complaints

H/O CP, febrile sepsis ⊕ (on valvulopathy)

Adv - CD - echo

⊙ Review after echo for clearance.

[Signature]
Suresh

4/4/22

Date

C/S/B m/si

B/L we ABD \rightarrow 25-30°
 equim - curvabile \rightarrow (L) - beyond neck
 significant \rightarrow left \rightarrow not correctable at all
 Bone xechi - negative.
 good balance

1st.
 \downarrow
 OT
 \downarrow
 PAC

Cable plan big surgery

B/L Hamstring \rightarrow reassess
 Left vulpin \rightarrow Hamstring under anaesthesia.

PLS do PAC free
 the same.

24 MAR 2021

Commit 19 RTA/R - 17th April 2021.
 Admission - 19th April 2021
 Surgery - 20th April 2021.

[Signature]
 Shobha
 Dr. Arora



ST. STEPHEN'S HOSPITAL TIS HAZARI, DELHI-110054
 OUT PATIENT RECORD

Form No. 368

Form No. 483

PATIENT DATA

Sticker

Date

4 MAR 2021

C/S/B Neurology

11:15 pm. 6 y / Male.

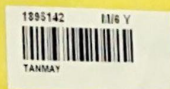
youngest of 2 sibling
 20y old son expired
 in RTA
 father: rapised.

Premature - 7 month antenatal
 bleeding NVD
 Cerebral palsy
 H/O seizure - febrile seizure.
 on syp valproate 6ml
 last seizure 3 year ago
 posted for bilateral hamstring
 release.

CIA/WSi Gaurav K Mittal

can be taken up for surgery
 continue syp valproate 6ml
 OD, HK as told by mother

No. _____
 I certify that the consent is
 () have been
 for the proposed surgical/
 operations, benefits and possible
 anesthetic release
 sore throat, nausea, vomiting
 the anaesthesiologist of St. Stephen's
 at the anaesthesiologist has
 I signed this consent after
 (another)
 risks, complications and
 understood by the patient
 understood what I explained.
 20-01-21
 Stamp of Doctor



ST. STEPHEN'S HOSPITAL

Tis Hazari, Delhi -110054

Form No. 483

Informed Consent Form for Anaesthesia

Name: _____ Hosp. No. _____

_____ the undersigned (specify relation if the consent is given by anyone other than the patient (_____) have been informed of the anaesthetic techniques and related procedures noted below for the proposed surgical/ diagnostic/medical procedures, (Name of the proposed procedure _____) including its indications, benefits and possible complications and risks.

Anaesthetic Techniques and related procedures:

- General Anaesthesia
- Regional Anaesthesia : Epidural, Spinal, Nerve Blocks
- Intravenous Sedation : MAC, Central Lines, Any other

B/L Hamstring release

Caudal

Common complications and risks of the proposed anaesthetic techniques are sore throat, nausea, vomiting /headache/backache/muscle/cramps/itching/confusion/amnesia _____

I understand that the anaesthesiologist who counseled me or any one of the anaesthesiologist of St. Stephen's Hospital, Tis Hazari, Delhi will anaesthetize me/my patient. I hereby state that the anaesthesiologist has explained all the noted details to me in a language that I understand and that I signed this consent after completing all the blanks.

Name and Signature of the Patient / Relative : *Kingi Bala (mother)*

Name, address and Signature of the witness : _____

I / that I have explained the nature purpose, anticipated benefits material risks, complications and the alternatives to the patient / patient's legal representative. I / answered all questions fully to the best of my ability in terms and language understood by the patient representative and I believe that the patient / legal representative fully understood what I explained.

Date and Time *24/3/21*
10:10 AM

[Signature] *21811*
Signature and Stamp of Doctor

Difficult airway anticipated


Form No. 342

ST. STEPHEN'S HOSPITAL

Tis Hazari, Delhi-110054

Pre Anaesthesia Record

Hospital No. _____

Patient Name:  e

Age: _____

Premature, delayed milestones

Pre Operative Diagnosis: B/L FFD. microcephaly Proposed Operation: B/L Hamstring release.

Medical History: ASD, delay cry, small (home delivery)

Sexual history (+)

Previous Operation/Anaesthesia:

None

Medications:

S. valproate

Allergy:

Not yet known

Hb:

Urine:

CXR

ECG:

Others

Heart last H/O

Sexual - 3 years back

HR: X 100/min

BP:

WT: - 15 kg

Airway: Lower incisor

loose, deformed

ASA: froth -

- micrognathia

- protrudent maxilla

NPC could not be assessed.

PHYSICAL EXAMINATION

General Condition

CVS S, S₂ HO

RS B/L A/E equal

NS conscious, crying

Any Others

- Speech not well developed

- Hb - 9.3 (g)

Tlc - 10.9 x 10³

PIT - 4.17 lakh

W/R - 1.36

ADVICE

-> NPO < 8hrs solid food

2hrs - clear fluid

-> continue valproate

-> Informed

consent taken

+ Arrange ABC etc

- Get an ecg done

- Evaluate with pediatrician for

long anomaly & stopping/continuing therapy of valproate

Anaesthesia Problem/Risk

Plan: GA / Regional / Local

Pre operative Instructions :-

Signature : (Nurse) :

Date :

Time :

Anaesthesiologist (Name : and/signature)

Name :

24/3/24
10:10 AM

Date :

Talwar 21816



ST. STEPHEN'S HOSPITAL

TIS HAZARI, DELHI-54

FINANCIAL ASSESSMENT SHEET

Form No. 227

1895142 M/6 Y



TANMAY

Assessment

152

To be filled by Doctor

Admission Order: Admit in (ward / ICU) _____ Specialty ortho

Expected days of stay; ICU/Post ICU / Post Op _____ Ward: 1-2 day

Name of Surgery/Procedure/Mode of Delivery/Diagnosis vulvular Release

Name of Implants:- IOL/Mesh/Nail/Screws/Stent/Pacemaker etc. _____ Implant Approx cost _____

If required:- Ventilator / NIVP Yes No Approximate Days _____ Blood / Component Transfusion _____ (unit)

Doctor's signature _____ Emp. No. 511047 - Date 1/1

To be filled by Assessment Office (Room No. 44)

General / Private Category _____
ICU/Post ICU / Post Op/1st SW / Nursery / Nursery ICU - Approx per day cost- _____

ID Proof Obtained : Yes No Signature & Employee No. _____

Room Charges :

General	Cubicle	Semi Private	Semi Pvt Deluxe	Private	Private Special	Pvt Deluxe
<u>2300/-</u>						

Services	Rate / Charges	Amount Rs.	Amount Rs.
1. Operation / OT / Anaesthesia : Category - _____	Package for _____ days	11000	
2. ICU / Post ICU / Post Op / ISW / Nursery / Nursery ICU	@ _____ /day x _____ days		
3. Ventilator/NIVP <u>Actm. fee</u>	@ _____ /day x _____ days	600	
4. Blood Transfusion:	@ _____ /unit x _____ days		
5. Room Charges	@ <u>2300</u> /day x <u>2</u> days	4600	
6. Consultation fee	@ <u>250</u> /day x <u>2</u> days	500	
7. Delivery Charges (inclusive of Labour Room Charge)	Normal / Forceps / Breech / Twin		
8. Special Labour Room/ painless delivery charges	@ _____		
9. Drugs & Consumables	on actual consumption as per usage (as per hospital rates)		} extra as per bed/room available in the duration of stay.
10. Investigations	on actual as per detail		
11. Procedure	as per hospital rates		
	Sub Total =		

Submission of Documents for TPA / Empanelled patients - Explained : Yes No

In case of foreign nationals
Passport copy submitted : YES / NO

In case of Indian
Copy of Address proof submitted : YES / NO

08/2021

Undertaking by the Patient / Attendant

26.02.22

- Kiran Bala (Mother) on (date) _____
- have attended the Financial Counselling Desk for understanding the expected cost of treatment.
 - I have been explained about the estimated expenses for hospitalization and treatment for myself / my patient.
 - I have been explained all the charges will be according to the room category opted by me.
 - I have understood that, in case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigation charges and operation charges / procedure charges etc from the date of admission will be according to the higher category.
 - I have understood that, if the patient is treated in day care and requires staying overnight, the charges would be according to room category opted from the time of admission.

TPA / Empanelled patient: (if applicable)

_____ have understood and take full responsibility that at the time of discharge, I shall pay the following:

- Non-medical expenses / inadmissible expenses will be born by me irrespective of the amount approved by the Insurance Company
- Difference, if any between the final bill and the amount permitted / approved by the TPA/ Company.
- Total amount of bill if denial comes from TPA or if authorization/ approval letter is not received from TPA/ Company
- Difference amount in relation to higher than the permitted category opted by the patient.

I undertake to pay Rsin advance. I understand that this is just a rough estimate towards treatment and Final Bill can vary depending upon the length of stay and medical condition of the patient. I undertake to make payment of interim bills whenever issued to me and also to settle the final bill of the patient before discharge.

रोगी / रिश्तेदार / एटैन्डेंट द्वारा आश्वासन

- मैंने दिनांक को वित्तीय परामर्श विभाग से अनुमानित खर्च के बारे में जानकारी प्राप्त की।
- मुझे मेरे / मेरे रोगी के हस्पताल के इलाज में होने वाले अनुमानित खर्च समझा दिया गया है।
 - मुझे ये समझा दिया गया है सभी शुल्क मेरे द्वारा लिए गए कमरे की श्रेणी के अनुसार होंगे।
 - मैंने यह समझ लिया है कि यदि मरीज को निचली श्रेणी से उच्च श्रेणी में बदला जाता है तब सभी शुल्क जैसे डॉक्टर की फीस, जाँचों के खर्च, ऑपरेशन या कोई अन्य प्रक्रिया, भर्ती की तारीख से उच्च श्रेणी के अनुसार होंगे।
 - मैं यह समझ गया/गई हूँ कि यदि मरीज डे केयर में किसी इलाज के लिए आया हो और उसे भर्ती की जरूरत होगी तब उसके सभी शुल्क भर्ती के समय लिए गए कमरे की श्रेणी के अनुसार होंगे।

टी0पी0ए0 / सूचीबद्ध मरीजों के लिए

मैं इस बात की पूरी जिम्मेदारी लेता/लेती हूँ कि मरीज की छुट्टी के समय निम्नलिखित का भुगतान करूँगा/करूँगी :

- > अस्वीकृत खर्च / चिकित्सा के अलावा खर्च।
- > पूरे बिल और कम्पनी द्वारा अधिकृत राशि का अंतर।
- > पूरे बिल की राशि, यदि टी0 पी0 ए0 या कम्पनी से नामंजूरी की चिट्ठी आती है अथवा मंजूरी की चिट्ठी नहीं आती है।
- > अधिकृत श्रेणी और उच्च श्रेणी के बिल का अंतर, यदि मैं उच्च श्रेणी का कमरा लेता/लेती हूँ।

मैं रु0..... जमा करवाने का आश्वासन देता/देती हूँ। मैं यह समझ गया/गई हूँ कि यह राशि हस्पताल के इलाज का केवल एक अनुमान है और अंतिम बिल इस राशि से अलग हो सकता है जो मरीज की परिस्थिति और उसके हस्पताल में रहने के कुल दिनों पर निर्भर करता है। मैं अन्तरिम बिल के भुगतान का आश्वासन देता/देती हूँ तथा मरीज की छुट्टी से पहले अंतिम बिल के भुगतान का भी आश्वासन देता/देती हूँ।

Advance Payment (अग्रिम भुगतान) 30,000/-

Signature of the Patient/ Relative (Legal Guardian)
रोगी / रिश्तेदार / अभिभावक के हस्ताक्षर

Kiran Bala
(Mother)

A. K. Bala



St. Stephen's Hospital
Tis Hazari, Delhi-110 054
LABORATORY DIAGNOSTIC SERVICES
HAEMATOLOGY

Form No. : N-105

TEST REQUISITION FORM

Hospital No.: _____

Name: _____

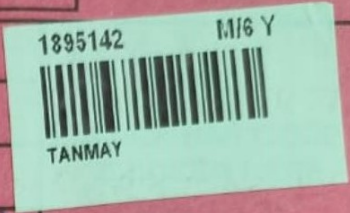
Sex/Age: _____ Date/Time : _____

Urgent Routine OPD/Ward: _____

Provisional Diagnosis
cp

Doctor's Signature and Stamp
[Signature]

Collection Time: _____ Collected By : _____



HM01	Hemoglobin		
HM02	CBC (Hb, TLC, DLC, PLTs Indices)		
HM03	ESR		
HM04	Reticulocyte count		
HM05	AEC (Absolute Eosinophil Count)		
HM06	Smear for Malarial Parasite		
HM27	Malaria Antigen (Rapid Test)		
HM07	Microfilaria		
HM08	Bleeding Time		
HM09	Prothrombin Time (PT/INR)		
HM10	Activated Partial Thromboplastin Time (APTT)		
HM15	Lupus anticoagulant panel (APTT, KCT, dRVVT)		
HM16	D-dimer		
HM17	Fibrinogen		
HM20	G6PD screening		
HM21	Sickle cell preparation		
HM22	Hemoglobin HPLC (HbA2/F)		
HM24	Bonemarrow examination		
HM48	Iron stain for haemosiderin		
HM49	Peripheral Smear		
HM32	Platelet Count		