GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

GYNAECOLOGY ADMISSION SLIP

Hospital Name		District		
Patient's Name:		MRD No./UHID No.		
Father's/Mother's/Husband's Name				
Age:		Ward No.		
Address:		Bed No.		
		Date of Admission		
Occupation:		Time of Admission		AM/PM
Contact No:		MLC:	Yes	No
Provisional Diagnosis:				
Admitting Physician		Emergency	Outpatient	

HISTORICAL EXAMINATION

1. Patient's Chief Complaint (with onset/Duration):

2. History of Present Illness:

3. Obstetrical History :

4. Gynaecological History:

5. Relevant and Significant Past History:

6. Treatment History/Present Medication (if any):

7. Any Relevant Family History:

Multiple Pregnancy	Diabetes	Hypertension	Congenital Malformations	Others

8. Any Relevant Social History/Occupational History:

9. Personal History:

a. Tobacco Use: YES/NO;

If Yes, Smoking/Chewing cessation and counselling provided? YES/NO.

Duration: _____.

b. Alcohol Use: YES/NO.

c. Recreational Drugs Use: YES/NO.

d. History of Allergy: _____

PHYSICAL EXAMINATION

1. Vital Signs:

Ht: ____ Wt:____BMI:_____Temp:_____ Resp Rate:____/ SPO2: ____

2. On Examination:

a) **General Physical Examination: The patient is conscious/unconscious, cooperative/not cooperative, oriented/not oriented to time, place & person.**
b) **Physical Attitude:**
c) **Mental State:**
    a. **Gait:**
    b. **Physique:**
    c. **Face:**

Skin	Pallor	Pigmentation
	Jaundice	Eruptions
	Cyanosis	Oedema
Hands	Nails	Contractures
	Clubbing	Joints
	Nodes	
Neck	Neck Veins	
	Thyroid	

Lymph Nodes:

Breast Examination (if Indicated):

Feet: Oedema: _____ **Pulses: _____**

3. Systemic Examinations:

a) **Cardiovascular System:**

b) **Respiration System:**

c) **Abdomen:**

d) **Locomotor System:**

4. Provisional Diagnosis:

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5. LABORATORY INVESTIGATION:

a) **Blood: CBC, LFT, KFT, Electrolytes, Lipid Profile, Uric Acid, Amylase & Lipase, Widal, Weils Felix, Typhidot, MP (Smear/QBC), C/S, RBS (Fasting/ PP)**
b) **CRP/ASO/RAF:**
c) **TSH/T3/T4:**
d) **S.Ferritin/D-Dimer/LDH, Trop-T, Trop-I :**
e) **HBsAg, HCV, Retro:**
f) **Sputum for AFB, CBNAAT, C/S:**
g) **Urine: R/E, M/E, C/S :**
h) **Stool: R/E :**
i) **Pap Smear :**
j) **X-Ray:** **e) USG:**
f) **CT Scan/MRI:**
g) **Others:**

6. Rx and Advice: **ICD Code:**

7. Communication and Education:

Nutrition	Exercise	Breast Feeding	Contraceptives

8. Name of Medical Officer/Admitting Physician: _____

9. Signature & Seal of the Medical Officer/Admitting Physician: _____

10. Date: _____

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HEALTH & FAMILY WELFARE DEPARTMENT

Consent for Treatment:

Informed Consent

Patient's/Relative's General Consent: I/we agree to get myself/my/our relative admitted under this Hospital _____ to undergo Examination/Investigation/Operation/Treatment as decided by the Hospital authorities and I am to also abide by the Schedule of changes, rules and regulations as they arise and as desired by the Hospital/Hospital Authority.

Patient's Signature:_____

Signature of Relative/Responsible person: _____

Date: _____

Ka Jingmynjur

Ka Jing ai jingbit jong U/Ka Nongpang/Bahaiing Nongpang: Nga u Nong pang ne Nga (U/Ka Bahaiing jong u/ka Nongpang) nga mynjur ba ka Hospital kan ai ia ka/ki jingsumar na ka bynta ka jingkoit jingkhiah jong nga/(U/Ka bahaiing jong nga) kat kum ki jingpynbeit na ka hospital. Nga/Nga (U/ka Bahaiing u/ka Nongpang nga) kular ba ngan iai neh bad kino kino ki jingkylla ha ki rukom sumar kat kum ka jingpynbeit bad jing donkam jong ka hospital na ka bynta ka koit ka khiah jong nga/(u/ka bahaiing jong nga).

Ka Shap (Signature) U/Ka Nongpang:_____

Ka Shap (Signature)jong U/Ka Bahaing jong U/ka Nongpang: _____

Tarik: _____

Ma'sigrikeSonggigrikani

Sagipamandeni/ma'drangmahariniku'monggrike see joteon'ani: Angaan'tangko/angni/chingnima'drangbakskako, ia _____ hospitalo, dongesannabannagitaku'mongnangrime, see on'enga. Be'entangko, sabisikosandienina/ be'ennisabisikoporikka ba be'enko rate (operation) sannanikodakna, mamungbanengnikani ba champenganigripakwateon'enga. Anga/chingahospitalkochalaidilenggiparangniniamreti-rangkomamungnengnikanigrianjariknaku'rachakera'enga.

Sagipanisoi/bimung: _____

Ma'drangnisoi: _____

Tarik: _____

Name of Medical Officer/Admitting Physician: _____

Signature & Seal of the Medical Officer/Admitting Physician: _____

Date: _____