



GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

ADMISSION SLIP

Hospital Name		District				
Patient's Name:		MRD No./UHID No.				
Age:	Gender	M	F	O	Ward No.	
Father's/Mother's/Spouse's Name						
Address:	Bed No.					
	Date of Admission					
Occupation:	Time of Admission		AM/PM			
Contact No:	MLC: (Tick)		Yes	No		
Provisional Diagnosis:						
Admitting Physician	Emergency		Outpatient			

HISTORICAL EXAMINATION

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

2. History of Present Illness:

3. Relevant and Significant Past History:

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

5. Any Relevant Family History:

6. Any Relevant Social History/Occupational History:

7. 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: _____



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8. Obstetrics & Gynaecology History (if any):-

PHYSICAL EXAMINATION

1. Vital Signs:

Ht: _____ Wt: _____ BP: _____ Temp: _____ Pulse: _____ 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) **CNS/Locomotor System:**



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4. Provisional Diagnosis:

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) X-Ray: e) USG:
- f) CT Scan/MRI:
- g) Others:

6. Rx and Advice:

ICD Code:

Name of the Medical Officer/Admitting Physician: _____

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

Date: _____



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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 Nongpang: _____

Tarik: _____

Ma'sigrike Songgirikani

Sagipamandeni/ma'drang maharini ku'monggrike see joteon'ani: Anga an'tangko/angni/chingni ma'drang bakskako, ia _____ hospitalo, donge sanna-banna gita ku'mong nangrime, see on'enga. Be'entangko, sabisiko sandienina/ be'enni sabisiko porikka ba be'enko rate (operation) sannaniko dakna, mamungba nengnikani ba champenganigri pakwate on'enga. Anga/chinga hospitalo chalaidilenggearangni niam reti-rangko mamung nengnikanigrian jarikna ku'rachake ra'enga.

Sagipanisoi/bimung: _____

Ma'drangnisoi: _____

Tarik: _____

Name of the Medical Officer/Admitting Physician: _____

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

Date: _____