

I have counselled the patient / guardian / attendants / relatives about the risks and benefits in the surgery / therapy in his / her own language and attached the documents for the same. I have done the video counselling for mandatory cases / high risk cases and the same is attached in the video attachments slot.

Counselling remarks

Name of Counselling Doctor

Date and Time: 10/07/2024 15:32:32

Signature

Approval form.

PART-IV Consent by beneficiary/guardian/attendant.

I / We hereby declare that I am having EHS Health Card no. **PEN124330/01** (Village) **49th Ward** (Mandal) **Kakinada (Urban)** District **EAST GODAVARI** by Govt of A.P and is presently residing at (H.No) **65-11-2** (Village) **49th Ward** (Mandal) **Kakinada (Urban)** District **EAST GODAVARI** .I/We have been explained by treating doctors in my own language the risks and benefits involved in the surgery/therapy and I have given consent for **SUB TROCANTERIC FRACTURE** procedure. I/We further state that I am not covered by any other insurance/reimbursement scheme by government.

Signature/Left Thumb impression of patient :

Name of Patient:Vasadi Bhasakara Rao

Signature/Left Thumb impression of patient relative

(If patient is child/if patient is unfit to sign)

Name of the patient relative :

Relationship with patient :

Mobile No of the relative :

PART-V DECLARATION BY AAROGYA MITHRA

The Patient Mr/Ms **Vasadi Bhasakara Rao** admitted in **SANJIVI INSTITUTE OF ORTHOPAEDICS & SUPERSPECIALITIES PVT.LTD** hospital on **04/07/2024 04:30:27 PM** is a card holder with EHS Health Card no: **PEN124330/01** and belonging to **49th Ward** village **Kakinada (Urban)** Mandal **EAST GODAVARI** District. The details have been personally verified by me. I declare that the patient is on bed in the hospital **SANJIVI INSTITUTE OF ORTHOPAEDICS & SUPERSPECIALITIES PVT.LTD** and the preauthorisation request is genuine and there is no duplication.

Signature of Aarogya Mithra

Name:MR/MS JANAPANEEDI ANILKUMAR

Code:SIO-KKD

Date:05/07/2024 11:10:01 AM

PART-VI DECLARATION BY PRE-AUTHORIZATION(By Panel Doctor)

The network hospital **SANJIVI INSTITUTE OF ORTHOPAEDICS & SUPERSPECIALITIES PVT.LTD** code**SIO-KKD** which has admitted Mr/Ms **Vasadi Bhasakara Rao** (the patient) on **04/07/2024 04:30:27 PM**(date and time) having EHS Health Card No **PEN124330/01** and belonging to District **EAST GODAVARI** suffering from **Unknown and unspecified cause of morbidity (Illness, unspecified)** having given consent for **SUB TROCANTERIC FRACTURE**surgery/therapy is hereby authorised by the Panel Doctor to undertake the procedure/treatment subject to maximum package rate of **Rs35900**

Authorized Signature

Name:Panel Doctor

Date:05/07/2024 01:25:59 PM

PART-VII DECLARATION BY PRE-AUTHORIZATION(By Trust Committee)

The network hospital **SANJIVI INSTITUTE OF ORTHOPAEDICS & SUPERSPECIALITIES PVT.LTD** code**SIO-KKD** which has admitted Mr/Ms **Vasadi Bhasakara Rao** (the patient) on **04/07/2024 04:30:27 PM**(date and time) having EHS Health Card No **PEN124330/01** and belonging to District **EAST GODAVARI** suffering from **Unknown and unspecified cause of morbidity (Illness, unspecified)** having given consent for **SUB TROCANTERIC FRACTURE**surgery/therapy is hereby authorised by the Trust to undertake the procedure/treatment subject to maximum package rate of **Rs35900**

Authorized Signature

Name:Trust Doctor



BILLING CARD

Patient Name Vasodi. Bhaskararas; 31/11
IP No. 314
Room No. Male general ward

POD: 10/2/24
D.O.A. 4/2/24 Time 12:53 PM
"A" 585 KT It Same H
Rent Per Day

TRANSFER DET AILS

Date	Time	From	To	Sister Signature
4/2/24	1 pm	EMR	102 Room	P. Sandya 0017
6/7/24	12:20 pm	102 R	OT	Vandhini (0090)
6/7/24	2:50 pm	OT	SICU	moni 0003
6/7/24	2:00 pm	SICU	Room 102	moni 0009

OPERATION THEA TRE

Date	: 6/7/24	OT No.	: I
Surgeon	: Dr. Suryaprasad	Start Time	: 12:45 pm
I Asst. Surgeon	: -	End Time	: 2:30 pm
II Asst. Surgeon	: -	Dis. Pack	: -
III Asst. Surgeon	: -	Diathermy	: 12:50 pm to 1:20 pm
Anaesthetist	: Dr. Sandee P	C-Arm	: 1 pm to 2 pm
OT Nurse	: Drevi Karuna	Arthroscopy	: -
Name of Surgery	: (R) DHS	Laprosopy	: -
		Sevoflurane / Isoflurane	: -
		Inj. Fentanyl	: -
		Others	: -

MONITOR

Date	Start	Date	Disconnect
6/07/24	2:50 pm	6/07/24	8:00 pm

INFUSION PUMP

Date	Start	Date	Disconnect

OXYGEN

Date	Start	Date	Disconnect

SYRINGE PUMP

Date	Start	Date	Disconnect

ALPHA BED / SCD PUMP

Date	Start	Date	Disconnect

VENTILATOR

Date	Start	Date	Disconnect

OPERATION THEA TRE

Date :	OT. No. :
Surgeon :	Start Time :
I Asst. Surgeon :	End Time :
II Asst. Surgeon :	Dis. Pack :
III Asst. Surgeon :	Diathermy :
Anaesthetist :	C-Arm :
OT Nurse :	Arthroscopy :
Name of Surgery :	Laproscopy :
	Sevoflurane / Isoflurane :
	Inj. Fentanyl :
	Others :

[illegible]

[illegible]

