

21/9/24

ESI

CAG

MHI/DP/2022/104



BILLING CARD

SAFETY FIRST



Mr. STANLEY DAVID P (ESI)
42/Male/MHI202485783

Patient Name 21/09/2024: IP112024002225

IP No. Dr. K. JAISHANKAR

Room No. 

D.O.A. 21/9/24 Time 11.06 AM

TRANSFER DETAILS

Rent Per Day RC.

Date	Time	From	To	Nurse's Signature
21/9/24	11.20	FO	PL	8/2/2
21/9/24		PL	CATH Lab	8/2/2
21/9/24	15.20.	CATH LAB	PL	8/2/2

OPERATION THEATRE

Date :	21/9/24	OT No. :	CATH LAB - I
Surgeon :	DR. JAISHANKAR	Start Time :	14.20
I Asst. Surgeon :		End Time :	14.55
II Asst. Surgeon :		Dis. Pack :	
III Asst. Surgeon :		Diathermy :	
Anaesthetist :		C-Arm :	
OT Nurse :	R/N Priya	Arthroscopy :	
Name of Surgery :	CAG	Laproscopy :	
		Sevoflurane / Isoflurane :	
		Inj. Fentanyl : 2ml 10ml/inj. monphi:	
		Others :	

MONITOR

INFUSION PUMP

Date	Start	Date	Disconnect	Date	Start	Date	Disconnect

OXYGEN

SYRINGE PUMP

Date	Start	Date	Disconnect	Date	Start	Date	Disconnect

ALPHA BED

SCD PUMP

VENTILATOR

Date	Start	Date	Disconnect	Date	Start	Date	Disconnect

[illegible]



DO NOT MUTILATE THE QR CODE

Referral No : Tamil2024047209
 Name of the Patient : Mr. STANLEY DAVID P
 UAN of IP :
 Address/Contact No : Default Default Default Chennai Tamilnadu INDIA
 Identification marks (if any) :
 IP/Beneficiary/Staff : Beneficiary
 Relationship with IP/Staff : Spouse
 Entitled for Specialty Rx : YES
 Entitled Super Specialty Rx : YES
 Diagnosis : ICD - Atherosclerotic heart disease - I25.1 Remarks :
 CGHS (Name and Code)* : 601 - Coronary angiography - Cardiovascular and Cardiac Surgery Procedures /
 Treatment / Investigations - No Of Sessions Allowed - 1 - Validity Upto -
 22-Sep-2024

Insurance No/Staff/ Pensioner Card : 5131287956
 UHID : TN01.0011233128



Remarks Additional Clinical Information/Procedure/Investigation

Reasons / Purpose for Referral Investigations/Rx/Procedure : lack of facility

Name of the empanelled hospital whereto refer Hospital MEDWAY HOSPITALS
 Department Cardiology

Date & Time of Referral : 12-Sep-2024 10:12:57 AM

Name and Designation of the Referring Doctor
 Dr. Ms. USHALAKSHMI S - Associate Professor

Or, Agreeing to / contradicting the above, I voluntarily choose MEDWAY Hospital for treatment of self or
 for my (relationship).

Date and Time: 12/9/24 Signature/Thumb Impression of IP/Beneficiary/Staff

Referred to Department of Hospital/Diagnostic

Centre for (Reason/purpose for referral).

(VERIFIED & RECOMMENDED BY)
 (Signature, Name & Designation)
 Date & Time:

(AUTHORISED SIGNATORY WITH STAMP)
 (Signature, Name & Designation)
 Date & Time:

ESIC Model Hospital
 K.K. Nagar, Chennai-78

N.B.
 The entitlement eligibility of the patient should also be verified through IP Portal at www.esic.in. Referral shall be governed by the rules and administrative instructions issued from time to time. Referred Hospital is instructed to perform only those procedure/treatment for which the patient has been referred to. In case any additional procedure / treatment / investigation is essentially required to be carried out, permission for the same is mandatorily required from the approving authority of the referring hospital. The validity of this referral is upto 7 days from the date of issuance or as per the contract whichever is later and is subject to fulfilment of other terms and conditions as defined in the contract/agreement.