

ESI

CAG

MHI/DP/2022/104



BILLING CARD

SAFETY FIRST



Patient Name

Mrs. DURGA VIJAYAKUMAR (ESI)

IP No.

Dr. K. JAISHANKAR

Room No.



D.O.A.

8/10/24

Time

10.05 AM

TRANSFER DETAILS

Rent Per Day

RL

Date	Time	From	To	Nurse's Signature
8/10/24	10:10	Admission	RL	RL
8/10/24	11:00	RL	CATH	RL
8/10/24	12:00	CATH cab	RL	RL

OPERATION THEATRE

Date	: 8/10/24	OT No.	: CATH cab - 1
Surgeon	: Dr. Jaishankar	Start Time	: 11.30 AM
I Asst. Surgeon	:	End Time	: 11.50 AM
II Asst. Surgeon	:	Dis. Pack	:
III Asst. Surgeon	:	Diathermy	:
Anaesthetist	:	C-Arm	:
OT Nurse	: R. N. D. R. D.	Arthroscopy	:
Name of Surgery	: CAG	Laprosopy	:
		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]

KK Nagar Chennai, TN (ESIC Model Hosp.)

Referral Letter



DO NOT MUTILATE THE QR CODE

Referral No : Tamil2024051385
 Name of the Patient : Ms. DURGA VIJAYAKUMAR
 UAN of IP :
 Address/Contact No :
 Identification marks (if any) :
 IP/Beneficiary/Staff : Beneficiary
 Relationship with IP/Staff : Dependant mother
 Entitled for Specialty Rx : YES
 Entitled Super Specialty Rx : YES
 Diagnosis : ICD - Rheumatic heart disease, unspecified - 109.9 Remarks :
 CGHS (Name and Code)* : 601 - Coronary angiography - Cardiovascular and Cardiac Surgery Procedures
 Treatment / Investigations - No Of Sessions Allowed - 1 - Validity Up to 14-Oct-2024

Insurance No/Staff/ Pensioner Card : 5131166210
 Age/Gender : 51 Years /Female
 UHID : MARN.0000005248



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 : 04-Oct-2024 09:44:21 AM

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

Or, Agreeing to / contradicting the above, I voluntarily choose
 for my (relationship).

Date and Time: 04/10/24

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:

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.

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04-10-2024