REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: MEDWAY HOSPITALS

Hospital location: No. 2, Old No. 29, [illegible] Hospital ID:

Hospital email ID: [illegible] Chennai-600 028 ROHINI ID:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd b) Phone no.: 080 22068666 c) Toll Free Fax no.: 1800 425 9559

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient: M. [illegible]

b) Gender: ☑ Male ☐ Female ☐ Third gender c) Contact no.: 9940289890 d) Alternate contact no.:

e) Age: Years 56 Months f) Date of birth: g) Insurer ID card no.: 403132565600

h) Policy number/Name of corporate: i) Employee ID:

j) Currently do you have any other medical claim/health Insurance: ☐ Yes ☑ No j.1) Insurer name:

j.2) Give details:

k) Do you have a family physician, if yes: Name: k.1) Contact no.:

L) Occupation of insured patient:

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: Dr. [illegible] b) Contact no.:

c) Name of Illness/disease with presenting complaints: Yo↑ High grade fever, intermittent in natural asso c chills & rigor x 3 days.

d) Relevant clinical findings:

e) Duration of the present ailment: 3 days e.1) Date of first consultation: 18/01/24

e.2) Past history of present ailment if any: Nil

f) Provisional diagnosis: Chronic cough & evaluation. / Fever under evaluation

f.1) ICD 10 code:

g) Proposed line of treatment: ☑ Medical management ☐ Surgical management ☐ Intensive care ☐ Investigation ☐ Non-Allopathic treatment

h) If investigation and/or medical management, provide details: Endoscopy

h.1) Route of drug administration: ☑ IV ☑ Oral ☐ Other IV/oral

i) If Surgical, name of surgery: Plan - Bronchoscopy & Medical management

i.1) ICD 10 PCS code:

j) If other treatments provide details: - Nil -

k) How did injury occur: - Nil -

L) In case of accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of injury: iii. Reported to Police: ☐ Yes ☐ No iv. FIR no.:

v. Injury/Disease caused due to substance abuse/alcohol consumption: ☐ Yes ☐ No vi. Test conducted to establish this, If yes attach reports: ☐ Yes ☐ No NA

m) In case of maternity: G P L A n) Expected date of delivery:

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 18/01/24 b) Time of admission: c) This is ☐ an emergency/ ☐ a planned hospitalization event

d) Expected no. of days stay in hospital: Days e) Days in ICU: Days f) Room type: Shared AC

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g) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs.

h) Expected cost for investigation + diagnostics: Rs.

i) ICU Charges: Rs.

j) OT Charges: Rs.

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs.

L) Medicines + Consumables cost of Implants: (specify if applicable) Rs.

m) Other hospital expenses if any: Rs.

n) All inclusive package charges if any applicable : Rs.

o) Sum Total expected cost of hospitalization Rs. ~~1,80,000~~ 1,20,000

₹ 1,20,000/-

p. Mandatory past history of any chronic illness. If yes (since month/year)

- 1. Diabetes
- 2. Heart Disease
- 3. Hypertension
- 4. Hyperlipidemias
- 5. Osteoarthritis
- 6. Asthma/ COPD / Bronchitis
- 7. Cancer
- 8. Alcohol or drug abuse
- 9. Any HIV or STD / related ailments
- 10. Any other ailment give details:

nil

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declaration of this form

a) Name of the treating doctor: Dr. [illegible]

b) Qualification:

c) Registration No. with State code:

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / TPA
e. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.
h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's name: Mahesh

b) Contact number:

c) Email ID: (Optional)

d) Patient's / Insured's signature:

Date: Time:

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
c. We agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital seal:

MEENAKSHI HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai - 600 024

Doctor's signature:

Date: Time:

United India Insurance Company Ltd.

Mohan P

Beneficiary name	Mohan P
Member ID	4031325550
Employee code	A661108
Relation	Father
Date of Birth	15-Jun-1964
Primary insured	M Yuvaraj
Valid upto	23-Oct-2024
Policy Holder	Fidelity Business Services India Private Limited
Insurer ID	5004002823P111431535010022350

இந்திய அரசாங்கம்
Government of India

மோகன் பெ
Mohan P
பிறந்த நாள்/DOB: 15/06/1964
ஆண்/ MALE

3999 9580 3999

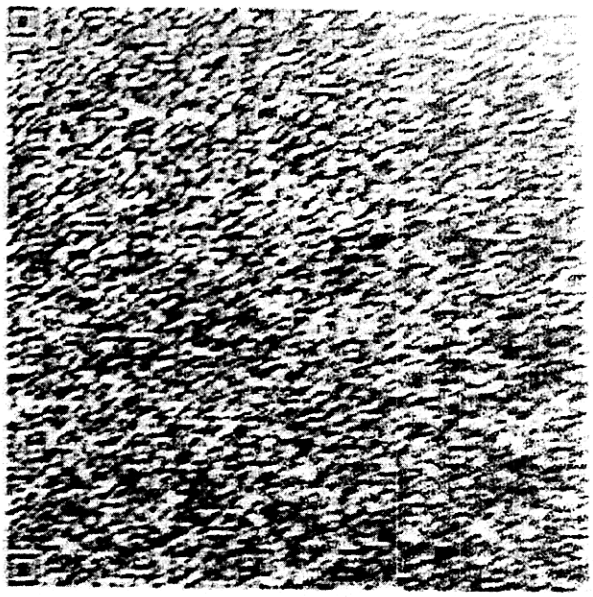
VID : 9112 9769 2757 4834

எனது ஆதார், எனது அடையாளம்

Unique Identification Authority of India

முகவரி:
S/O: பெருமாள், 12/29, பெருமாள் கோவில்
விரிவு தெரு, சைதாப்பேட்டை,
சைதாப்பேட்டை, சென்னை,
தமிழ் நாடு - 600015

Address:
S/O: Perumal, 12/29, PERUMAL KOIL
EXTENSON STREET, SAIDAPET,
Saidapet, Chennai,
Tamil Nadu - 600015



3999 9580 3999

VID : 9112 9769 2757 4834

1947

help@uidai.gov.in

भारत सरकार

आधार

இந்திய அரசாங்கம்

Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 0000/00328/23156

Download Date: 10/12/2020

To
யுவராஜ் மோ
Yuvaraj M
S/O P Mohan
29/12, Perumal koil Extn Street
Saidapet S.O
Chennai Tamil Nadu - 600015
9840596768

Signature Not Verified
Digitally signed by AS UNIQUE IDENTIFICATION AUTHORITY OF INDIA 04
Date: 2020.10.19 23:22:51 IST

Issue Date: 29/11/2016

உங்கள் ஆதார் எண் / Your Aadhaar No. :

9544 3176 7799

VID : 9119 0634 5428 7642

எனது ஆதார், எனது அடையாளம்

Government of India

Download Date: 10/12/2020

யுவராஜ் மோ
Yuvaraj M
பிறந்த நாள்/DOB: 19/08/1990
ஆண்/ MALE

Issue Date: 29/11/2016

9544 3176 7799

VID : 9119 0634 5428 7642

எனது ஆதார், எனது அடையாளம்

Government of India

AADHAAR

தகவல்

- ஆதார் அடையாளத்திற்கான சான்று குடியுரிமைக்கு அல்ல.
- பாதுகாப்பான QR குறியீடு/ ஆப்லைன் XML / ஆன்லைன் அங்கீகாரத்தைப் பயன்படுத்தி அடையாளத்தை சரிபார்க்கவும்
- இது எலக்ட்ரானிக் செயல்முறை மூலம் தயாரிக்கப்பட்ட கடிதமாகும்.

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code/ Offline XML/ Online Authentication.
- This is electronically generated letter.

- ஆதார் நாடு முழுவதிலும் செல்லுபடியாகும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா சேவைகளை எளிதில் பெற ஆதார் உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்
- mAadhaar செயலியைப் பயன்படுத்தி உங்கள் ஸ்மார்ட் போனில ஆதாரை எடுத்துச் செலலுங்கள்

- Aadhaar is valid throughout the country.
- Aadhaar helps you avail various Government and non-Government services easily.
- Keep your mobile number & email ID updated in Aadhaar.
- Carry Aadhaar in your smart phone – use mAadhaar App.

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

முகவரி:
S/O பெ மோகன், 29/12, பெருமாள் கோயில் விரிவு தெரு, சைதாப்பேட்டை, சென்னை, தமிழ் நாடு - 600015

Address:
S/O P Mohan, 29/12, Perumal koil Extn Street, Saidapet S.O, Chennai, Tamil Nadu - 600015

9544 3176 7799

VID : 9119 0634 5428 7642

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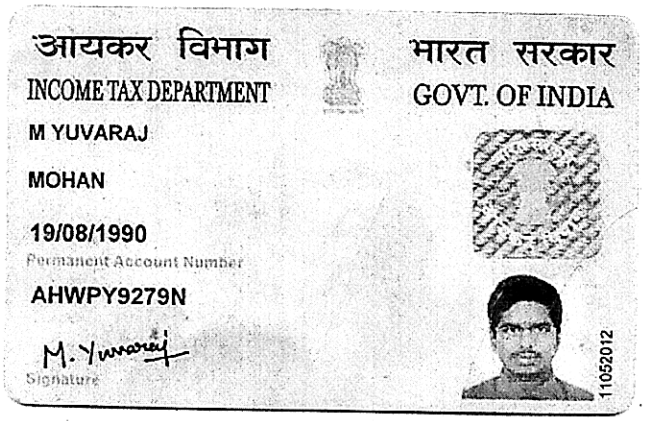

आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
M YUVARAJ
MOHAN
19/08/1990
Permanent Account Number
AHWPY9279N
Signature
11052012

MH/PRINT /0054/ NRS

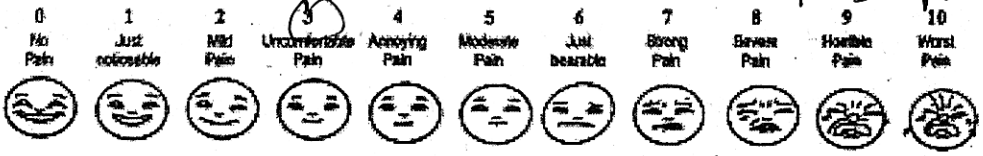
Medway Hospitals®

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Patient's Name : Mr. Mohan P			I.P. No. :
Age : 59	Sex (M) / F	Ward : 4th floor	Room No. : E1B
Consultant Dr. : Dr. T. palaniappan			D.O.R. : 18/1/24

Temp :	Pulse :	Resp :	Allergies :
B/P :	Height :	Weight :	Current Medications : T. GLYCOMET GP 3/850 OD BF T. DAPAGLYN 10mg OD



Complaints

patient was admitted with complaints of high grade fever, It is intermittent in nature associated with chills & Rigor for past 3 days. Recently got treated for typhoid fever

History of Present illness

H/o fever for every 15 days once
c/o dry cough (severe) for past 3 days → on
off for past 1 month
c/o difficulty passing urine x 4 days
c/o B/L LL pain

Past history of relevance

family and Personal
c/o pain over epigastric region only after taking food.
No H/o Nausea / vomiting / loose stools

Clinical Examination

K/c/o DM ↓ Medication
No H/o previous SX
No H/o drug / food allergy

O/E - Pt conscious
oriented
febrile
GC fair, NO pallor, NO cyanosis

Continuation on the reverse side ☐

No Icterus

No Generalised Lymphadenopathy

C|E – CNS – Sluggish

R|S – B|A.E

P|A – Soft

CNS – NFND

Investigation required

C.B.C, R.F.T, L.F.T, Urine R|E, E.S.R, Blood c|s, Urine c|s, Echo, HbA1c, CT chest, CT abdomen, ABG

Diagnosis

Fever under evaluation

Chronic cough 1/2 evaluation

Plan of Care

pt admitted under Dr. J.P sir

- To get pulmonologist opinion Dr. Gayathiya (for fever | chronic cough ? T.B)
- F|U reports for further Management
- INJ pan 40 mg IV stat F|b bd
- INJ emeset 4 mg IV stat F|b BD
- Syp Lupituss 1 tsp – 1 ml – 5 ml
- T. Pulmoclear 1-0-1
- INJ Cefoperazone 1.5 gm IV BD ADD

Signature A. Jah 18.03.25

Date : 18/3/25 Time : 10:40 pm Examined by Dr. Janani

PATIENT NAME:	MR.MOHAN	AGE/GENDER :	56YRS/MALE
PATIENT ID :	MH-23756	DATE :	18.01.2024
REFD DR :	DR.T PALANIAPPAN	MODALITY :	CT
		ACC NO :	CT-2455

CT WHOLE ABDOMEN PALIN REPORT

LIVER: Normal in size with normal density noted. The porta hepatis is normal. The intrahepatic portal venous radicals are normal. No evidence of intrahepatic billiary radicular dilatation. The hepatic veins and intrahepatic portion of inferior venacava are normal.

GALL BLADDER: Normal in size, shape and outlines. Peri-cholecystic area is normal. The common bile duct is not dilated.

SPLEEN: Normal in size, shape and attenuation values. The splenic hilum and splenic vein are normal.

PANCREAS: Normal in size, contour and attenuations values. No evidence of focal mass lesion/pancreatic duct dilatation.

ADRENAL GLANDS: Normal in size, shape and attenuations values.

KIDNEYS:

RIGHT KIDNEY :Right kidney - Mild perinephric fat strandings noted.

Renal pelvis appears mildly prominent with mild wall thickening of renal pelvis.

LEFT KIDNEY :is normal in size and shape. The renal outlines are normal. No evidence of focal mass lesion/hydronephrosis/ calculi.

PATIENT NAME:	MR.MOHAN	AGE/GENDER :	56YRS/MALE
PATIENT ID :	MH-23756	DATE :	18.01.2024

G.I TRACT: The stomach is normal in site and size. The duodenum and proximal jejunal loops are normal in caliber. The ileum and ileo–caecal junction are normal. The colon and rectum are unremarkable.

URINARY BLADDER: Diffuse urinary bladder wall thickening noted.

The aorta and IVC appear normal.

PROSTATE appear normal.

IMPRESSION:

MILD RIGHT RENAL PERINEPHRIC FAT STRANDINGS WITH PROMINENT RENAL PELVIS AND MILD WALL THICKENING.

CYSTITIS.

- FEATURES ARE SUGGESTIVE OF URINARY TRACT INFECTION.

DR.CHRIS JOSEPH M.D (RD)
Consultant Radiologist

PATIENT NAME:	MR.MOHAN	AGE/GENDER :	56YRS/MALE
PATIENT ID :	MH-23756	DATE :	18.01.2024
REFD DR :	DR.T PALANIAPPAN	MODALITY :	CT
		ACC NO :	CT-2454

CT SCAN – CHEST PLAIN REPORT

Lung fields appear normal with normal branching pattern of bronchial tree.

The pulmonary arteries appear grossly normal. The pulmonary vascular branches show normal branching pattern.

The anatomical configuration of the structures in the mediastinum is within normal limits.

Both hila appear normal.

There is no significant mediastinal lymphadenopathy.

There is no evidence of pleural effusion.

Soft tissue of the chest wall and bony thorax shows no obvious abnormality.

IMPRESSION:

CT SCAN CHEST DID NOT REVEAL ANY SIGNIFICANT ABNORMALITY.

DR.CHRIS JOSEPH M.D (RD)
Consultant Radiologist

PATIENT NAME	MR.MOHAN.P	PATIENT ID	MH23756
CONSULTANT	DR.T.PALANIAPPAN	AGE/ GENDER	56Y/MALE
IP/ OP	IP-0130	STUDY DATE	19.01.2024

ECHOCARDIOGRAM REPORT

Aorta: 31**mm** (25-37mm) **Left Atrium:** 33**mm** (19-40mm)

Result		Normal Range	Result		Normal Range
LVIDD	45mm	33-55mm	EDV	95ml	56-104 ml
LVIDS	29mm	24-42mm	ESV	33ml	19-49 ml
IVSD	09mm	6-11mm	EF	65%	55-75 %
LVPWD	09mm	6-11mm	FS	35%	30-40 %

VALVE:

Mitral Valve : Normal.
Tricuspid Valve : Normal.
Aortic Valve : Normal
Pulmonary Valve : Normal.

CHAMBERS:

Left Ventricle : Normal.
Left Atrium : Normal.
Right Ventricle : Normal.
Right Atrium : Normal.

SEPTUM:

IAS : Intact
IVS : Intact

MW/LH/202311/189638

PATIENT NAME	MR.MOHAN.P	PATIENT ID	MH23756

DOPPLER PARAMETERS:

VALVES	VELOCITY MAX(m/sec)	MAX GRADIENT (mmHg)	MEAN GRADIENT(mmHg)
AORTIC	1.2	5	2
MITRAL	0.6/0.8		
TRICUSPID	0.9		
PULMONARY	0.8		

MEDIAL E/E' : 7.49
LATERAL E/E' : 5.95
E/A RATIO : 0.75

IMPRESSION:

- CHAMBERS NORMAL SIZED.
- NO REGIONAL WALL MOTION ABNORMALITY.
- NORMAL LV SYSTOLIC FUNCTION.
- GRADE I DIASTOLIC DYSFUNCTION.
- NORMAL RV SYSTOLIC FUNCTION **RVTDI:**17cm/s, **TAPSE:**22mm
- ALL VALVES STRUCTURALLY NORMAL.
- TRIVIAL TR / NO PAH
- IVC NORMAL IN SIZE AND COLLAPSING
- NO VEGETATION / EFFUSION / CLOT

HEART RATE:98bpm

DONE BY

MS.ILAKIYA.K

(CARDIAC TECHNOLOGIST)

Laboratory Test Result

Patient Name	:	**Mr.MOHAN P**	Patient Id	:	MH23756
Visit No	:	IP2024000130	Sample ID	:	MHUri20018
Age	:	56	Order Date	:	18/01/2024
Gender	:	Male	Collection Date & Time	:	19/01/2024 12:11:44AM
Visit Type	:	IP	Receiving Date & Time	:	19/01/2024 12:12:15AM
Patient Ph No	:	9940281980	Report Date & Time	:	19/01/2024 12:57:17AM
Ward/Bed	:	ELITE SHARING DLX / E2 - B	Doctor Name	:	Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
CLINICAL PATHOLOGY			
URINE ROUTINE ANALYSIS			
COLOR	YELLOW		STRAW YELLOW
(Method : *Macroscopy)*			
(Specimen : *Urine)*			
APPEARANCE	TURBID		CLEAR
(Method : *Macroscopy)*			
(Specimen : *Urine)*			
PROTEIN	NIL		NEGATIVE
(Method : *Automated (Protein Error Reaction))*			
(Specimen : *Urine)*			
GLUCOSE	(+)		NEGATIVE
(Method : *Automated (Glucose Oxidase Reaction))*			
(Specimen : *Urine)*			
PUS CELLS	8 - 10	/HPF	< 3
(Method : *Microscopy)*			
(Specimen : *Urine)*			
Epi. Cells	2 - 4	/HPF	< 5
(Method : *Microscopy)*			
(Specimen : *Urine)*			
RBCs	NIL	/HPF	

Dr.Monica Kumbhat.,
LAB DIRECTOR

PRIYA
Result Entered By

Tests marked with NABL symbol are accredited by NABL vide Certificate no MC- 5409

@MedwayHospitals @medwayhospitals @medway-hospitals @medwayhospitals
#5/11, Corporation Colony Main Road, Rangarajapuram, Kodambakkam, Chennai - 600024
Contact No : 044-35007072 / +91 72990 67800 | email : medwaymedicallabs@gmail.com
PATIENT HELPLINE 94457 94457 1800 572 3003

Medway Group of Hospitals

Kodambakkam	Mogappair	Kumbakonam	Chengalpattu	Villupuram
044-2473 4455	044-26530011	044-2473 4455	044-27426829	04146-242000

Medway Centre of Excellence (Chennai)

Heart Institute	Institute of Pulmonology
044 - 4310 8959	044-2473 4451

Email : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Patient Name	:	**Mr.MOHAN P**	Patient Id	:	MH23756
Visit No	:	IP2024000130	Sample ID	:	MHUri20018
Age	:	56	Order Date	:	18/01/2024
Gender	:	Male	Collection Date & Time	:	19/01/2024 12:11:44AM
Visit Type	:	IP	Receiving Date & Time	:	19/01/2024 12:12:15AM
Patient Ph No	:	9940281980	Report Date & Time	:	19/01/2024 12:57:17AM
Ward/Bed	:	ELITE SHARING DLX / E2 - B	Doctor Name	:	Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
(Method : *Microscopy)* (Specimen : *Urine)*			
Casts	NIL	/HPF	
(Method : *Microscopy)* (Specimen : *Urine)*			
Crystals	NIL	/HPF	
(Method : *Microscopy)* (Specimen : *Urine)*			
Others	BACTERIA PRESENT	/HPF	
(Method : *Microscopy)* (Specimen : *Urine)*			

----- End of the Report -----

Dr.Monica Kumbhat.,

LAB DIRECTOR

PRIYA

Result Entered By

Tests marked with NABL symbol are accredited by NABL vide Certificate no MC- 5409

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Contact No : 044-35007072 / +91 72990 67800 | email : medwaymedicallabs@gmail.com

PATIENT HELPLINE 94457 94457 1800 572 3003

Medway Group of Hospitals

Kodambakkam 044-2473 4455 | Mogappair 044-26530011 | Kumbakonam 044-2473 4455 | Chengalpattu 044-27426829 | Villupuram 04146-242000

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959 | Institute of Pulmonology 044-2473 4451

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MC-5409

Medway Labs
(A Unit of United Alliance Healthcare Pvt Ltd)

Laboratory Test Result

Patient Name	:	**Mr.MOHAN P**	Patient Id	:	MH23756
Visit No	:	IP2024000130	Sample ID	:	MHWho20017
Age	:	56	Order Date	:	18/01/2024
Gender	:	Male	Collection Date & Time	:	19/01/2024 12:11:34AM
Visit Type	:	IP	Receiving Date & Time	:	19/01/2024 12:12:09AM
Patient Ph No	:	9940281980	Report Date & Time	:	19/01/2024 12:18:50AM
Ward/Bed	:	ELITE SHARING DLX / E2 - B	Doctor Name	:	Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
CBC			
TWBC (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	9850	Cells/cu mm	4000 - 10000
NEUTROPHILS (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	66.3	%	40 - 80
LYMPHOCYTES (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	25.3	%	20 - 40
EOSINOPHILS (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	2.1	%	01 - 06
MONOCYTES (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	6.2	%	02 - 10
BASOPHILS (Method : *Flow cytometry by laser*) (Specimen : *Whole blood*)	0.1	%	0 - 2
HAEMOGLOBIN	13.9	g/dL	13 - 17

Dr.Monica Kumbhat.,
LAB DIRECTOR

PRIYA
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Patient Ph No	:	9940281980	Report Date & Time	:	19/01/2024 12:18:50AM
Ward/Bed	:	ELITE SHARING DLX / E2 - B	Doctor Name	:	Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
(Method : *Colorimetric)* (Specimen : *Whole blood)* **HAEMATOCRIT**	41.7	%	40 - 50
(Method : *Calculated)* (Specimen : *Whole blood)* **TRBC**	4.76	Millions/cu mm	3.8 - 4.8
(Method : *Electrical Impedence)* (Specimen : *Whole blood)* **MCV**	87.5	fL	83 - 101
(Method : *Calculated)* (Specimen : *Whole blood)* **MCH**	29.2	pg	27 - 32
(Method : *Calculated)* (Specimen : *Whole blood)* **MCHC**	33.3	g/dL	31.5 - 34.5
(Method : *Calculated)* (Specimen : *Whole blood)* **PLATELET**	255000	Cells/cu mm	150000 - 400000
(Method : *Electrical Impedence)* (Specimen : *Whole blood)* **ESR**	25	mm/hr	Male: 17–50 years = <10 51–60 years = < 12 61–70 years= < 14 >70 years
(Method : *westergren method)*			

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Ward/Bed	:	ELITE SHARING DLX / E2 - B	Doctor Name	:	Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
(Specimen : *Whole blood*)			
BIOCHEMISTRY			
LIVER FUNCTION TEST			
TOTAL BILIRUBIN	0.46	mg/dL	0.2 - 1.2
(Method : *Diazo*) (Specimen : *Serum*)			
DIRECT BILIRUBIN	0.21	mg/dL	0 - 0.2
(Method : *Diazo*) (Specimen : *Serum*)			
INDIRECT BILIRUBIN	0.25	mg/dL	0.2 - 0.7
(Method : *Calculated*) (Specimen : *Serum*)			
SGOT	13	U/L	Male: < 35 Female: < 31
(Method : *UV Without P5P*) (Specimen : *Serum*)			
SGPT	12	U/L	Male: < 45 Female: < 34
(Method : *UV Without P5P*) (Specimen : *Serum*)			
Alkaline Phosphatase	86	U/L	0 – 14 days: 83-248 15 days - 3 yearsr: 122-469 4 -15 Years: 54-369 16- 50 Years Male: 53-128 16 - 50 Years Female:42-98 > 60Years Male: 56-119 > 60 Years Female: 53-141

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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Patient Name	: **Mr.MOHAN P**	Patient Id	: MH23756
Visit No	: IP2024000130	Sample ID	: MHSer20016
Age	: 56	Order Date	: 18/01/2024
Gender	: Male	Collection Date & Time	: 19/01/2024 12:11:33AM
Visit Type	: IP	Receiving Date & Time	: 19/01/2024 12:12:09AM
Patient Ph No	: 9940281980	Report Date & Time	: 19/01/2024 12:18:50AM
Ward/Bed	: ELITE SHARING DLX / E2 - B	Doctor Name	: Dr.Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
(Method : *PNPP AMP BUFFER)* (Specimen : *Serum)* **GGT**	18	U/L	08 - 61
(Method : *IFCC)* (Specimen : *Serum)* **Total Protein**	6.1	g/dL	6 - 8.3
(Method : *Biuret)* (Specimen : *Serum)* **ALBUMIN**	3.6	g/dL	3.5 - 5.2
(Method : *Bromocresol green (BCG))* (Specimen : *Serum)* **GLOBULIN**	2.5	g/dL	2.0-3.5
(Method : *Calculated)* (Specimen : *Serum)* **A/G RATIO**	1.4	%	0.9 - 1.6
(Method : *Calculated)* (Specimen : *Serum)* **RENAL FUNCTION TEST**			
Urea (Method : *Urease)* (Specimen : *Serum)*	27	mg/dL	12.8 - 49.2
Creatinine (Method : *Jaffes)*	0.88	mg/dL	0.9 - 1.3

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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC080...

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DRUG CHART

MH/ PRINT /

Name of the Patient : Mr. MOHAN Age 56 Sex M Bed No. E1(B)

Clinical Diagnosis : fever ? evaluation IP No. 0130 Ht - Wt -

Primary Consultant Name : Dr. TP Sir PID No. -

Name of the Medicine	Dose	Route	Frequency	18/1/2024				19/1/24.			
INJ CEFOLS	1.5gm	IV	BD (STD)	~~8~~		12pm	~~8pm~~	~~8pm~~	8pm		
INJ PAN	40mg	IV	bd				~~8pm~~	~~8pm~~	8pm		
INJ EMESET	4mg	IV	Bd				~~8pm~~	~~8pm~~	8pm		
INJ PARA	1gm	IV	Bd			12pm	~~8pm~~	~~8pm~~	8pm		
TAB. PULMOCLEAR	1tab	P/O	1-0-1			12pm	~~8pm~~	~~8pm~~	8pm		
SYP. LUPITUSS	-	P/O	7ml-7ml-8ml			12pm	~~8pm~~	~~8pm~~	8pm	D/C	
SYP. LUPITUSS	5ml	P/O	1-1-1								
NEB. FORALORT	0.5mg	P/N	1-0-1								
Administered by (Nurse Signature) :						~~8~~	~~8~~				
Verified by (DMO Signature) :				~~8~~		~~12~~	~~8~~				

Nurse Signature : [signature]
Nurse Name : Kala
Date & Time : 18/1/2024. 20:44pm.

DMO Signature : [signature] 18/1/24
DMO Name : Dr. Janani
Date & Time : 18/1/24 at 10:40 PM

Primary Consultant Signature :
Primary Consultant Name :
Date & Time :
Reg No. :

Allergic to .....**Adverse Reaction, if any** .....

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I P INSTRUCTION AND MONITORING CHART

ne

Date		18/1/24.		19/1/2024.								
PR	BP	Day / Night		Day / Night		Day / Night	Day / Night	Day / Night	Day / Night	Day / Night		Day
		12 4 8 12 4 8		8 12 4 6 8								Temp.
												106°
												105°
												104°
												103°
												102°
												101°
												100°
												99°
												98.6° 98°
												97°
on admission		Hb/plt										
		Urea / Creat										
		CBG										
		RX										
		Inv										
		ABX										
		Culture										
		Misc										