STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
Corporate Office - Claims Dept. : No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.
Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522
CIN : U66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE

POLICY PART – C (Revised) **(TO BE FILLED IN BLOCK LETTERS)**

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL.:

a. Name of TPA/Insurance company : STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital: MEDWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600 024

I.Address

ii.Rohini ID

iii.e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : Basarath Ahmed

B. Gender: [✓] Male [ ] Female [ ] Third Gender

C. Age: 64 (Years) / (Month)

D. Date of Birth: (DD/MM/YYYY)

E. Contact number: 9444122293

F. Contact number of attending Relative:

G. Insured Card ID number: 10688653-1

H. Policy number/Name of Corporate: 112200145/2604.

I. Employee ID :

J. Currently do you have any other mediclaim / health insurance: Yes [ ] No [✓]

i.Company Name:

ii.Give Details:

K. Do you have a family Physician: Yes [ ] No [✓]

L. Name of the family Physician: NA

M. Contact number, if any:

N. Current Address of Insured Patient:

O . Occupation of Insured Patient:

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: Dr. Balaraman

B. Contact number::

C. Nature of illness/Disease with presenting complaint : C/o, fever assoc chills and rigors x 3days, H/o. vomiting

D. Relevant Critical Findings:

E. Duration of the present ailment 3. Days 3 episodes. x1 day

iv. Date of First consultation 29/01/2024 (DD/MM/Y'YYY) Mild Abdominal pain.

v. Past history of present ailment, if an Nil

F. Provisional diagnosis:

ICD I0 code A: AFI

G. Proposed line of treatment:

I.	Medical Management	(✓)
II.	Surgical Management	( )
III.	Intensive care	( )
IV.	Investigation	( )
V.	Non-allopathic treatment	( )

H. If investigation and/or Medical Management, provide details: Enclosed.

i. Route of Drug Administration I/v/oral

I. If surgical, name of surgery:

i. ICD I0 PCS code - Nil -

J. If other treatment, provide details: - Nil -

K. How did injury occur:

L. In case of accident:

i. Is it RTA	Yes ☐	No ☐
ii. Date of injury	Yes ☐	No ☐
iii. Report to Police	Yes ☐	No ☐
iv. FIR NO	Yes ☐	No ☐ N/A.
v. Injury/Disease caused due to substance		
vi. abuse/alcohol consumption	Yes ☐	No ☐
vii. Test conducted to establish this (if yes, attach report)	☐	No ☐

M. In case of Maternity:

I. expected date of Delivery _____ (DD/MM/Y'YYY)

DETAILS OF PATIENT ADMITTED

A. Date of admission : (DD/MM/YYYY) 29/01/2024

B. Time of admission: (HH:MM) _____

C. Is this emergency/planned hospitalization event Emergency ☑ Planned ☐

D. Mandatory Past History of any chronic illness if yes (Since month/year)

i. Diabetes
ii. Heart disease
iii. Osteoarthritis
iv. Asthma/COPD/Bronchitis
v. Cancer
vi. Alcohol/Drug abuse
vii. Any HIV or STD Related ailment
viii. Rheumatoid Arthritis
ix. Cerebrovascular Accident(Stroke)
I. Liver disease
xi. Kidney disease
xii. Any other ailment,give details

nil

E. Expected number of Days/Stay in hospital : 4-5 Days

F. Level / Grade of Surgery: _____

G. Days in ICU: _____ Days

H. Room Type: Twin Sharing

I. Per day room rent + nursing and service charges +patients diet: _____

J. Expected cost of investigation + diagnostic: _____

K. ICU Charges: _____

L. OT Charges _____

M. Professional fees Surgeon + Anesthetist fees + consultation Charges: _____

N. Medicines + Consumable + Cost of Implants (if applicable please specify): _____

O. Other hospital expenses if any: _____

P. All-inclusive package charges if any applicable : _____

Q. Sum Total expected cost of hospitalization : ₹ 95,000/-

DECLARATION

(Please read very carefully)

A. Name of the treating doctor : Dr. T. Palanichamy

B. Qualification :

C. Registration number with state code :

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

Hospital Seal
(Must include Hospital Id)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A 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/T.P.A 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 / T.P.A

e. I agree and understand that T.P.A 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".

Authorization to Star health and allied Insurance Co. Ltd

I am admitted in your Hospital _____ from _____

I hereby authorize Star health and allied Insurance Co. Ltd. and its representatives, who is my Health Insurer to seek any medical information / records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information / records / indoor case papers, kindly oblige.

a) Patient's / Insured's Name : Bajarth Ahmed

b) Contact number : _____

c) e-mail Id : _____

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 liom 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.

MEDWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600.024

Hospital Seal

Doctor's Signature

Date :_____Time:_____

Star Health and Allied Insurance Company Limited

Attached to and forming part of Policy No: 11220014512604

Details of Insured Persons :

Name of the Insured	Gender	Date of Birth	Age in Yrs	Relationship with Proposer	ID Card No	Inception date
[illegible]	Male	30-Nov-1959	63	Self	[illegible]	[illegible]
Pre Existing Disease : No PED Declared						
[illegible]	Female	23-Oct-1966	56	Spouse	[illegible]	[illegible]
Pre Existing Disease : No PED Declared						
[illegible]	Male	24-Jul-2002	20	Son	[illegible]	[illegible]
Pre Existing Disease : No PED Declared						
[illegible]	Female	21-Apr-2006	16	Daughter	[illegible]	[illegible]
Pre Existing Disease : No PED Declared						

Nominee Details:

Nominee Details for the Proposer					Appointee Details		
S.No	Name	Relationship with proposer	Age	% of the claim	Appointee Name	Appointee Age	Relationship with nominee
1	FATIMA SHERSEN	Spouse	56	100			

Sector Classification:

[illegible]	No

CONSOLIDATED STAMP DUTY PAID VIDE G.O.(RT) NO.402 DATED.15TH SEP 2022"

Please check whether the details given by you about the insured persons in the proposal form are incorporated correctly in this policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the insured person given in the policy schedule will be deemed to have been accepted by you.

It is warranted that in case of dishonor of premium cheque(s), the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

Important

In the event of hospitalization of insured person, intimation should be given to the Company immediately. However, within 24 hrs from the time of admission.

Toll Free No : 1800 425 2255 / 1800 102 4477 Email: support@starhealth.in, Fax No: 1800 425 5522.

It is hereby made clear that all terms, conditions, clauses, warranties, exclusions etc., as already issued, form part of the policy of insurance originally issued at the time of inception of this relationship, shall continue to be operative and unaltered, forming part of this renewal insurance cover also.

Reference may be made to those terms, conditions etc., for identifying the scope/extent of coverage.

In witness whereof the undersigned being authorized by and on behalf of the company has set his hand at [illegible] on 05th Day of February 2023.

CUSTOMER PORTAL

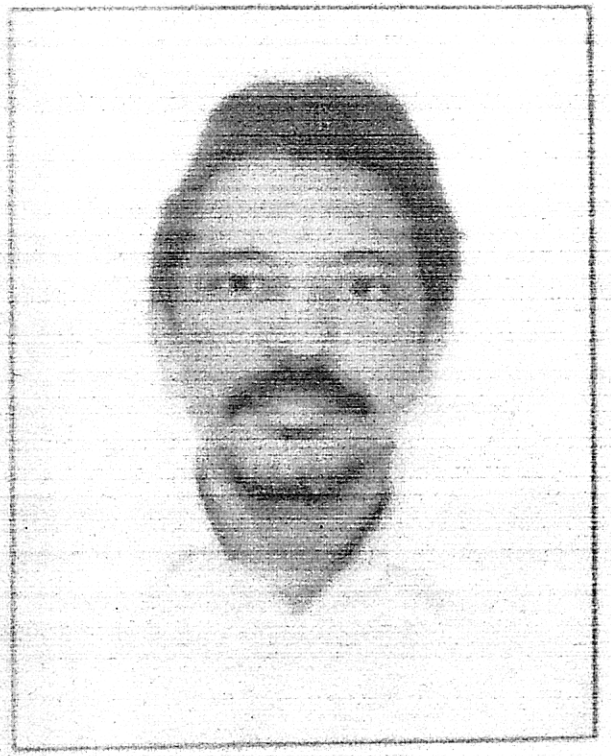
For Star Health and Allied Insurance Company Limited

Authorised Signatory

Registered Office : New Tank Street, Valuvar Kottam High Road, Nungambakkam, Chennai - 600 034. Phone : 044-28288800 / 43288800. Toll Free No : 1800-425-2255 / 1800-102-4477. CIN : U66010TN2005PLC056649. Email : [illegible]

भारत सरकार

GOVERNMENT OF INDIA



மீ.பஷாரத் அஹ்மது

M.Basarath Ahmed

பிறந்த நாள்/DOB: 30/11/1959

ஆண்/ MALE

Mobile No: 9444122273

5476 2193 7154

VID : 9192 5737 4417 7222

எனது ஆதார், எனது அடையாளம்

भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

முகவரி:
S/O: மீராஞ்ஷா, 30/11, 4வது குறுக்கு தெரு,
ட்ரஸ்ட்புரம் கோடம்பாக்கம், கோடம்பாக்கம்,
சென்னை,
தமிழ் நாடு - 600024

Address :
S/O: Meeransha, 30/11, 4TH CROSS
STREET, TRUST PURAM
KODAMBAKKAM, Kodambakkam,
Chennai,
Tamil Nadu - 600024

5476 2193 7154

1947
help@uidai.gov.in
www.uidai.gov.in
P.O. Box No. 1947
Bangalore-560 001

आयकर विभाग

INCOME TAX DEPARTMENT

भारत सरकार

GOVT. OF INDIA

स्थायी लेखा संख्या कार्ड

Permanent Account Number Card

AAIPA6751A

नाम / Name

BASARTH AHMED

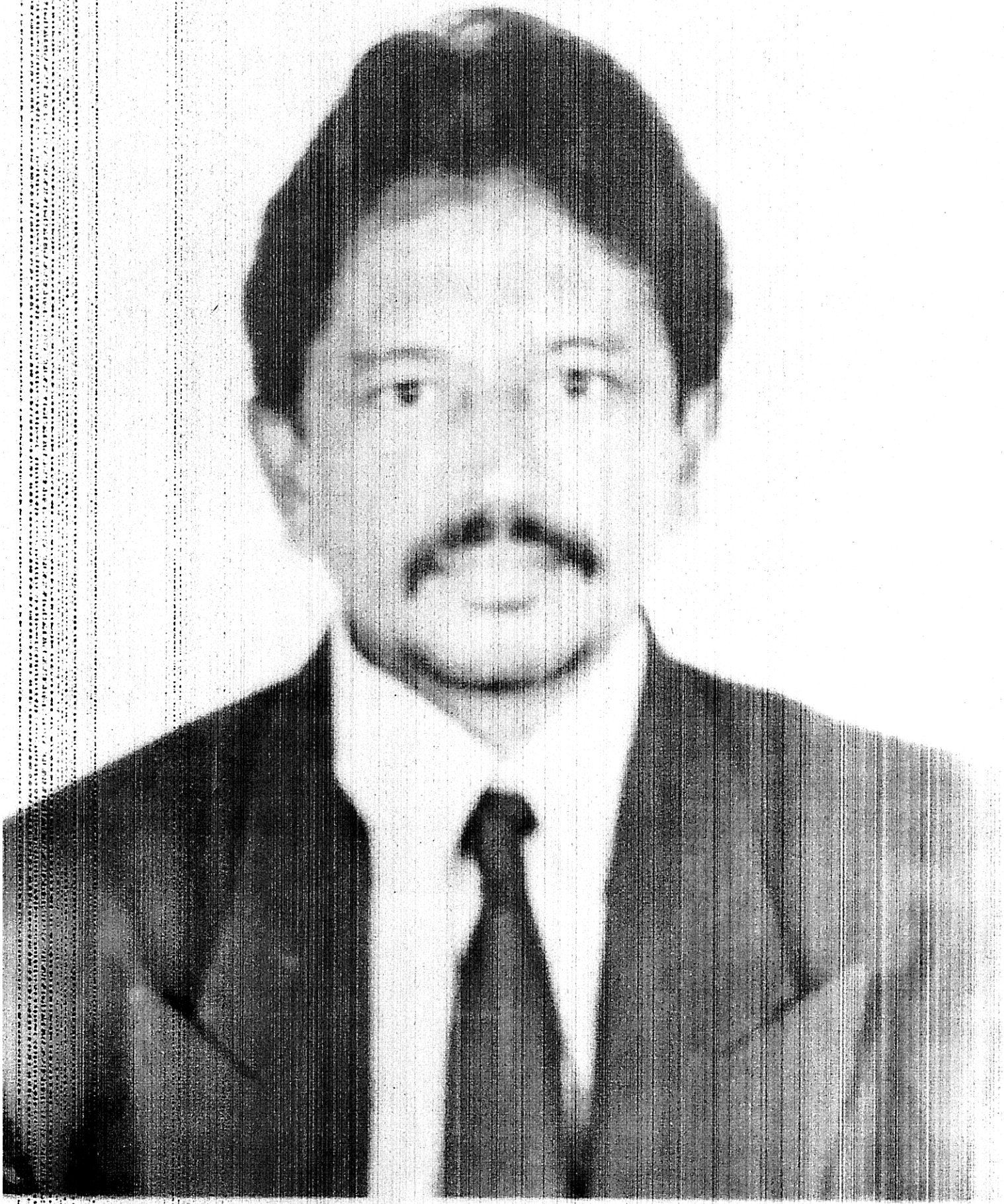
पिता का नाम / Father's Name

MEERANSHA

जन्म की तारीख / Date of Birth

20/11/1959

हस्ताक्षर / Signature



Star Health and Allied Insurance Company Limited

Family Health Optima Insurance Plan
Unique Identification No. SHAHLIP22030V062122

In Consideration of payment of Rs. 43,701/- towards renewal premium of policy number 11220014512603, the policy stands renewed for a further period of 1 Year as per the details given below

Renewal Endorsement No:11220014512604

Customer Code	: 10688683	GSTIN	: 33AAJCS4517L1Z...
Customer Name	: M BASARATH AHMED	SAC Code	: 997133 / Accident and Health Insurance Services
Proposer Code	: 10688683	Issuing Office Code	: 111121
Proposer Name	: M.BASARATH AHMED	Issuing Office Name	: AREA OFFICE - Parrys
Proposer Address	: 30, FOURTH CROSS STREET, TRUSTPURAM, KODAMBAKKAM, CHENNAI , Chennai Tamil Nadu 600024	Issuing Office Address	: P T Lee Chengalvaraya Naicker Trust Building No:23 , 2nd floor, ... George Town Chennai Tamil Nadu 600001
Phone No	: 9444122273	Phone No	: 044-42627776/044-422215...
E-mail Id	: basharathahmad@yahoo.co.in	E-mail Id	: chennai.parrys@star...
Proposer GSTIN	: NO	Place of Supply	: Tamil Nadu
Proposal date	: 07-Feb-2019	Fulfiller Code	: SH8254
Date of Inception of first policy	: 08-Feb-2019		
Renewal Year	: Fourth Year	Intermediary Code	:BA0000187450
Collection No	: 181184024654		
Collection Date	: 05-Feb-2023	Name	: K NANDHAGOPAL
Premium	: Rs. 37,035/-	Phone No	:9941475644/9941475644
CGST @ 9%	: Rs. 3,333/-	E-mail Id	:sakthitax2006@yahoo.com
SGST @ 9%	: Rs. 3,333/-		
Total Premium	: Rs. 43,701/-		
Stamp Duty	: Re. 1/		

Total Premium In Words : Rupees Forty Three thousand seven hundred one only

PERIOD OF INSURANCE **: From** : 08-Feb-2023 00:00 **To :** Midnight Of 07-Feb-2024

Installment Facility Option: No **Premium Payment Frequency :** Annual **Installment Amount Rs.** :

Basic Floater Sum Insured : Rs. 5,00,000/- | **Scheme Description** : 2A+2C

In Words : Rupees Five lakhs only

Bonus : Rs. 2,75,000/- **Limit of Coverage** : Rs. 7,75,000/- **Recharge Benefit** : Rs. 1,50,000

For Star Health and Allied Insurance Co. Ltd.

AUTHORISED SIGNATORY

IRDAI Regn. No. 129

Corporate Identity Number: L66010TN2005PLC056649

E-mail: info@starhealth.in

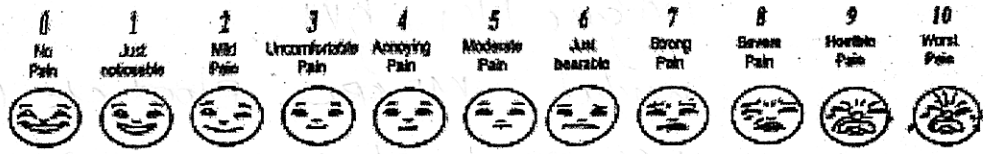
MH/PRINT /0054/ NRS

Medway Hospitals®

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM

Patient's Name : Mr. Basarath ahmed		I.P. No. : 0817	
Age : 64	Sex : M/F	Ward : 4th	Room No. : 23 (A)
Consultant Dr. : DR-T-Pachaiappan		D.O.P. : 29/11/24	
Temp : 97.8 Pulse : 80 Resp : 90		Allergies : Nonn	
B/P : 120/80 Height : ± Weight : ±		Current Medications : —	



Complaints

History of Present illness

pt. came to hospital with c/o - fever associated c chills and rigors for past (3) days.
- H/o - vomiting 4 about (3) episodes / day
- H/o - mild abdominal pain
- No c/o - loose stools
- pt. admitted here for further management.

Past history of relevance

family and **Personal**

- K/C/O - SHTN on Rx
- N/K/C/O - DDM / thyroid disorders.
- K/C/O - Apical HCM - non obstructive on Rx.

Clinical Examination

O/E: conscious, oriented, afebrile

S/E:

CVS: S_1S_2 (+)

RS: BAE (+)

P/A: soft.

Continuation on the reverse side ☐

Own Rx:-

T. metoprolol 25mg
T. Cilnidipine 10mg
T. Atarax 5mg HS.

Investigation required

To do: CBC, RFT, LFT, Urine R/E
Dengue NS1, IgM
Widal, MP QBC, Blood c/s (1 set)
ECG, ECHO, Chest xray, CRP,
USG: Abdomen and pelvis
RDT - Negative.

Diagnosis

Δ: AFI

Plan of Care

Pt. admit under Dr. T. Palaniappan

- IVF NS / RL @ 50ml/hr c̄ Inj. MEL2
- Inj. PARA 1gm IV TDS
- Inj. PAN 40mg IV BD
- Inj. EMESET 4mg IV BD
- Tab. ALZ 0-1-0
SYP. Lupitus 5ml - 5ml - 5ml
T. Montelec LC HS
T. Pulmoclear BD, To get cardiologist opinion.

Signature Elango 17/01/24

Date: 29/1/24 Time: 1:30pm Examined by Dr. Sri Elango Kannan

Laboratory Test Result

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHWho23947
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
HAEMATOLOGY			
CBC			
TWBC	6260	Cells/cu mm	4000 - 10000
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **NEUTROPHILS**	60.6	%	40 - 80
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **LYMPHOCYTES**	32.9	%	20 - 40
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **EOSINOPHILS**	0.0	%	01 - 06
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **MONOCYTES**	6.4	%	02 - 10
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **BASOPHILS**	0.1	%	0 - 2
(Method : *Flow cytometry by laser)* (Specimen : *Whole blood)* **HAEMOGLOBIN**	11.5	g/dL	13 - 17

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHWho23947
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
(Method : *Colorimetric)* (Specimen : *Whole blood)* **HAEMATOCRIT**	34.0	%	40 - 50
(Method : *Calculated)* (Specimen : *Whole blood)* **TRBC**	3.98	Millions/cu mm	3.8 - 4.8
(Method : *Electrical Impedence)* (Specimen : *Whole blood)* **MCV**	85.5	fL	83 - 101
(Method : *Calculated)* (Specimen : *Whole blood)* **MCH**	28.8	pg	27 - 32
(Method : *Calculated)* (Specimen : *Whole blood)* **MCHC**	33.8	g/dL	31.5 - 34.5
(Method : *Calculated)* (Specimen : *Whole blood)* **PLATELET**	170000	Cells/cu mm	150000 - 400000
(Method : *Electrical Impedence)* (Specimen : *Whole blood)* **MP TEST by QBC**	NEGATIVE		
(Method : *Microscopy)* (Specimen : *Whole blood)* **BIOCHEMISTRY**			

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHSer23946
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
LIPID PROFILE			
TOTAL CHOLESTEROL	101	mg/dL	Desirable: < 200 Border line 200 - 239 High : > 240
(Method : *CHOD PAP)* (Specimen : *Serum)* **TRIGLYCERIDES**	74	mg/dL	Normal: <150 Borderline High: 150-199 High: 200-499
(Method : *Glycerol-3-phosphateoxidase(GPO))* (Specimen : *Serum)* **HDL CHOLESTEROL**	33	mg/dL	High Risk: < 40 Moderate Risk: 40-60 No Risk: > 60
(Method : *Homogenous Direct)* (Specimen : *Serum)* **LDL CHOLESTEROL**	53	mg/dL	Optimal: < 100 Near optimal: 100-129 Borderline high: 130-159
(Method : *Calculated)* (Specimen : *Serum)* **VLDL CHOLESTEROL**	15	mg/dL	< 30
(Method : *Calculated)* (Specimen : *Serum)* **TOTAL CHO/HDL RATIO**	3.0	%	< 4.0
(Method : *Calculated)* (Specimen : *Serum)*			

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHSer23946
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
LIVER FUNCTION TEST			
TOTAL BILIRUBIN	0.39	mg/dL	0.2 - 1.2
(Method : *Diazo)* (Specimen : *Serum)* **DIRECT BILIRUBIN**	0.16	mg/dL	0 - 0.2
(Method : *Diazo)* (Specimen : *Serum)* **INDIRECT BILIRUBIN**	0.23	mg/dL	0.2 - 0.7
(Method : *Calculated)* (Specimen : *Serum)* **SGOT**	26	U/L	Male: < 35 Female: < 31
(Method : *UV Without P5P)* (Specimen : *Serum)* **SGPT**	11	U/L	Male: < 45 Female: < 34
(Method : *UV Without P5P)* (Specimen : *Serum)* **Alkaline Phosphatase**	42	U/L	56 - 119
(Method : *PNPP AMP BUFFER)* (Specimen : *Serum)* **GGT**	13	U/L	08 - 61
(Method : *IFCC)* (Specimen : *Serum)*			

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHSer23946
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
Total Protein	5.9	g/dL	6 - 8.3
(Method : *Biuret)* (Specimen : *Serum)*			
ALBUMIN	3.5	g/dL	3.5 - 5.2
(Method : *Bromocresol green (BCG))* (Specimen : *Serum)*			
GLOBULIN	2.4	g/dL	2.0-3.5
(Method : *Calculated)* (Specimen : *Serum)*			
A/G RATIO	1.5	%	0.9 - 1.6
(Method : *Calculated)* (Specimen : *Serum)*			
RENAL FUNCTION TEST			
Urea	23	mg/dL	12.8 - 49.2
(Method : *Urease)* (Specimen : *Serum)*			
Creatinine	0.97	mg/dL	0.9 - 1.3
(Method : *Jaffes)* (Specimen : *Serum)*			
Uric Acid	4.3	mg/dL	3.5 - 7.2
(Method : *Uricase)* (Specimen : *Serum)*			

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHSer23946
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
Calcium	7.9	mg/dL	8.6 - 10.2
(Method : *NMBAPTA)* (Specimen : *Serum)*			
Phosphorous	2.7	mg/dL	2.5 - 4.5
(Method : *Molybdate UV)* (Specimen : *Serum)*			
Sodium (Na+)	125	mmol/L	136-145
(Method : *ISE Indirect)* (Specimen : *Serum)*			
Potasium (K+)	3.97	mmol/L	3.5-5.1
(Method : *ISE Indirect)* (Specimen : *Serum)*			
Chlorides (CL-)	90.1	mmol/L	96 - 106
(Method : *ISE Indirect)* (Specimen : *Serum)*			
Bicarbonate (HCo3)	22	mmol/L	21 - 28
(Method : *PEP Carboxylase)* (Specimen : *Serum)*			
SEROLOGY			
C.R.P. (C-Reactive Protein)	35.3	mg/L	< 5.0
(Method : *Particle-enhanced immunoturbidimetric assay)* (Specimen : *Serum)*			

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHSer23946
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 1:47:34PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:07:27PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 3:36:07PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
DENGUE IG M ELFA	0.07		< 1.0 (Index Value) NEGATIVE >1.0 (Index Value) POSITIVE
(Method : *ELFA)* (Specimen : *Serum)*			
DENGUE NS1 ELFA	0.03		< 1.0 (Index Value) NEGATIVE >1.0 (Index Value) POSITIVE
(Method : *ELFA)* (Specimen : *Serum)*			
WIDAL SLIDE			
S. Typhi ' O '	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Typhi ' H '	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'A (H)'	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			
S. Para Typhi 'B (H)'	1:20 DILUTION NEGATIVE		
(Method : *Slide Agglutination)* (Specimen : *Serum)*			

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

Dr.Monica Kumbhat.,

LAB DIRECTOR

Monica Kumbhat

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 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

PATIENT NAME	MR.BASARATH AHMED.M	PATIENT ID	MH42184
CONSULTANT	DR.T.PALANIAPPAN	AGE/ GENDER	64Y/MALE
IP/ OP	IP-0217	STUDY DATE	29.01.2024

ECHOCARDIOGRAM REPORT

Aorta: 28mm (25-37mm) **Left Atrium:** 30mm (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	17mm	6-11mm	EF	65%	55-75 %
LVPWD	13mm	6-11mm	FS	35%	30-40 %

VALVE:

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

CHAMBERS:

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

SEPTUM:

IAS : Intact
IVS : Intact

PATIENT NAME	MR.BASARATH AHMED.M	PATIENT ID	MH42184

DOPPLER PARAMETERS:

VALVES	VELOCITY MAX(m/sec)	MAX GRADIENT (mmHg)	MEAN GRADIENT(mmHg)
AORTIC	1.3	6	3
MITRAL	0.6/0.9		
TRICUSPID	0.9		
PULMONARY	0.7		

MEDIAL E/E' : 11.50
LATERAL E/E' : 6.66
E/A RATIO : 0.69

IMPRESSION:

- **APICAL HYPERTROPHIC CARDIOMYOPATHY. -HYPERTROPHY INVOLVING APICAL SEPTUM, APEX, APICOLATERAL SEGMENTS.**
- APEX: 22mm, APICAL SEPTUM: 15mm, APICOLATERAL: 13mm.
- NO APICAL GRADIENT.
- CHAMBERS NORMAL SIZED.
- NO REGIONAL WALL MOTION ABNORMALITY.
- NORMAL LV SYSTOLIC FUNCTION.
- GRADE I DIASTOLIC DYSFUNCTION.
- NORMAL RV SYSTOLIC FUNCTION **RVTDI:** 13cm/s, **TAPSE:** 23mm
- AORTIC VALVE SCLEROSIS.
- OTHER VALVES STRUCTURALLY NORMAL.
- MILD AR.
- MILD MR.
- TRIVIAL TR / NO PAH
- IVC NORMAL IN SIZE AND COLLAPSING
- NO VEGETATION / EFFUSION / CLOT

HEART RATE:67bpm

DONE BY

MS.ILAKIYA.K

(CARDIAC TECHNOLOGIST)

Patient Name	MR.BASARATH AHAMED 64YRS/M	Patient ID	IP - 0217
Ref By	DR.T.PALANIAPPAN	Study Date	29.01.2024

ULTRASONOGRAPHY OF WHOLE ABDOMEN

TECHNIQUE: B mode real time ultrasound abdomen was performed by transabdominal technique.

LIVER
Normal in size 13.6cm and shows normal echotexture.
No evidence of focal lesion is seen.
No Intra-hepatic biliary radical dilatation seen.
Portal and hepatic veins appear normal.

GALL BLADDER
Well distended. Wall thickness is normal.
No calculi / mass lesion are seen in the visualised parts of gall bladder.
CBD appeared normal.

PANCREAS
Normal in size and echotexture. No evidence of ductal ectasia / parenchymal calcification / peripancreatic fluid collection.

SPLEEN
Normal in size 8.7cm and shows normal echotexture.

RIGHT KIDNEY
Right kidney measures 9.3 x 4.3cm. Normal in size.
Cortical thickness and echoes are normal.
Cortico-medullary differentiation is well maintained.
Pelvicalyceal system is not dilated.
No sonographically evidence of calculi / mass lesion is seen.

LEFT KIDNEY
Left kidney measures 9.8 x 4.8cm. Normal in size.
Cortical thickness and echoes are normal.
Cortico-medullary differentiation is well maintained.
Pelvicalyceal system is not dilated.
No sonographically evidence of calculi / mass lesion is seen.

Patient Name	MR.BASARATH AHAMED 64YRS/M	Patient ID	IP - 0217

URINARY BLADDER

Well distended. Wall thickness is normal.
No evidence of calculi is seen within the bladder lumen / UVJ's.
No evidence of mass lesion.
Pre void urine volume – 161 cc.
Post void residual urine volume – 46cc.

PROSTATE

Prostate measured 4.1 x 3.3 x 4.1cm, Volume : 30cc.
Enlarged in size and shows normal echotexture.

Aorta, IVC, bowel loops are normal.
RIF & LIF unremarkable.
No evidence of lymphadenopathy.
No free fluid is seen within the peritoneal / pleural cavities.

IMPRESSION:

- **PROSTATOMEGALY WITH SIGNIFICANT POST VOID RESIDUAL URINE VOLUME.**

DR.SUBASHINI
SONOLOGIST

DR. MURALI
RADIOLOGIST

Laboratory Test Result

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHUri24002
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 3:51:12PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:51:32PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 6:31:16PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	Dr.T.PALANIAPPAN

Investigation	Value	Unit	Biological Reference Value
CLINICAL PATHOLOGY			
URINE ROUTINE ANALYSIS			
COLOR	PALE YELLOW		STRAW YELLOW
(Method : *Macroscopy)*			
(Specimen : *Urine)*			
APPEARANCE	CLEAR		CLEAR
(Method : *Macroscopy)*			
(Specimen : *Urine)*			
PROTEIN	NIL		NEGATIVE
(Method : *Automated (Protein Error Reaction))*			
(Specimen : *Urine)*			
GLUCOSE	NIL		NEGATIVE
(Method : *Automated (Glucose Oxidase Reaction))*			
(Specimen : *Urine)*			
PUS CELLS	3-5	/HPF	< 3
(Method : *Microscopy)*			
(Specimen : *Urine)*			
Epi. Cells	1-2	/HPF	< 5
(Method : *Microscopy)*			
(Specimen : *Urine)*			
RBCs	NIL	/HPF	

Dr.Monica Kumbhat.,
LAB DIRECTOR

MONISHA
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

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

Patient Name	:	**Mr.BASARATH AHMED M**	Patient Id	:	MH41184
Visit No	:	IP2024000217	Sample ID	:	MHUri24002
Age	:	64	Order Date	:	29/01/2024
Gender	:	Male	Collection Date & Time	:	29/01/2024 3:51:12PM
Visit Type	:	IP	Receiving Date & Time	:	29/01/2024 3:51:32PM
Patient Ph No	:	9444122273	Report Date & Time	:	29/01/2024 6:31:16PM
Ward/Bed	:	TWIN SHARING / 308 - A	Doctor Name	:	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	NIL	/HPF	
(Method : *Microscopy)* (Specimen : *Urine)*			

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

Dr.Monica Kumbhat.,

LAB DIRECTOR

MONISHA

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

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

n No. :

Mr.BASARATH AHMED M
64/Male/MH4: 184
29/01/2024/II 2024000217
Dr.T.PALANIAPPAN

Dr. Na

Name

Date 3

Medway Hospitals®
The way to better health

MH/PRINT /000

I P INSTRUCTIO AND MONITORING CH

PR	BP	30/1/24 Day / Night							Day / Night	31/1/24 Day / Night	Day / Night	Day / Night	Day / Night	Day / Night
		12	4	8	12	4	8		6 8 12 4 6 8	6 8 12 4 6 8				

on admission

Hb/plt							
Urea / Creat							
CBG							
RX							
Inv							
ABX							
Culture							
Misc							

10 10 10 10 99 98.6 98° 97°

Medway Hospitals®
The way to better health

DRUG CHART

MH/ PRINT / 0042 / NRS

Name of the Patient : MR. Basarathahmed Age 84 Sex M, Bed No. E3(A)
Clinical Diagnosis : fever for evaluation IP No. 0217 Ht. – Wt. –
Primary Consultant Name : DR. T. Dalai [illegible] PID No. 1884

Name of the Medicine	Dose	Route	Frequency	29/1/24	30/1/24	31/1/24				
INJ. PARA	1gm	IV	1-1-1		9 am					
INJ. PAN	40 mg	IV	1-0-1	11am	[illegible] 8 am	[illegible] 9 am				
INJ. EMESET	4 mg	IV	1-0-1	11am	[illegible] 8 am	[illegible] 9 am				
T. A to Z	1 tab	P.O	0-1-0	2pm						
T. MONTEK LC	1 tab	P.O	0-0-1	2pm [illegible]		[illegible]				
T. PULMO CLEAR	1 tab	P.O	1-0-1	2pm [illegible]	9 am	[illegible] 9 am				
SYP. LUPITUS	5 ml	P.O	1-1-1	2pm [illegible]	9 am	[illegible] 9 am				
INJ. CEFOL - S	1.5 gm	IV	1-0-1	2pm [illegible] D1	9 am D2	[illegible] 9 am				
T. BETALOC	25 mg	P.O	1-0-1	[illegible]	9 am	[illegible] 9 am				
T. CILACAR	10 mg	P.O	1-0-1	[illegible]	9 am	[illegible] 9 am				
Administered by (Nurse Signature) :				[signature]	[signature]	[signature]				
Verified by (DMO Signature) :										

Nurse Signature : [signature]	DMO Signature : Dr. Elango	Primary Consultant Signature : For [signature]
Nurse Name : NANIMA	DMO Name : Dr. [illegible] Elango	Primary Consultant Name :
Date & Time : 29/1/24	Date & Time : 29/1/24, 2:40pm	Date & Time :
		Reg No. :

Allergic to – Adverse Reaction, if any

Medway Hospitals ®
The way to better health

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS
29/11/24	1:30 pm	Inj. MEI2 in NS	1 amp	IV STAT		

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS

Medway Hospitals®
The way to better health

DRUG CHART

MH/ PRINT / 0042 / NRS

Name of the Patient : Mr. Basarat ahmed Age 64 Sex M Bed No. F3(A)

Clinical Diagnosis : fever for evaluation IP No. 02M Ht. ✗ Wt. ✗

Primary Consultant Name : Dr. T. Pelani appan PID No. 1884

Name of the Medicine	Dose	Route	Frequency	29/1/24	30/1/24	31/1/24				
T. STROVAS	5mg	PO	0-0-1	9PM						
T. TAMIFLU	75mg	PO	1-0-1		9am 9pm					
Administered by (Nurse Signature) :				[signature]	[signature] [signature]					
Verified by (DMO Signature) :										

Nurse Signature : [signature]
Nurse Name : VANI
Date & Time : 29/1/24 2PM

DMO Signature : Dr. Elango 1790
DMO Name : Dr. Sri Elango
Date & Time : 29/1/24, 2:40pm

Primary Consultant Signature : For Elango 1790
Primary Consultant Name :
Date & Time :
Reg No. :

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