



महाराष्ट्र शासन

शासकीय वैद्यकीय महाविद्यालय, व सर्वोपचार रुग्णालय बारामती, जि. पुणे

Govt. Medical college & General Hospital, Baramati, Dist. Pune

किरकोळ वस्तु भांडार विभाग

Email: deangmcbaramati@gmail.com Website:-www.gmcbaramati.org

प्लॉट नंबर १०७, एमआयडीसी, बारामती ४१३१३३

जा. क्र. शावैमवसरुबा/स्टेशनरी (फॉर्म) मागणी / दरपत्रक/ऑनलाईन जाहिरात/

११४१

दि: १५/०७/२०२६

शासकीय वैद्यकीय महाविद्यालय व सर्वोपचार रुग्णालय, बारामती या संस्थेच्या विविध विभाग व वॉर्डसाठी दैनंदिन कामकाजाकरिता लागणाऱ्या कार्यालयीन स्टेशनरी (फॉर्म) ची खरेदी सुविधा दरपत्रके सादर करण्याबाबत.

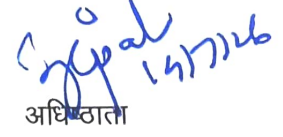
जाहिरात सूचना

इच्छुक पुरवठादारांना जाहिर सुचनेद्वारे कळविण्यात येते की, शासकीय वैद्यकीय महाविद्यालय व सर्वोपचार रुग्णालय, बारामती या संस्थेच्या रुग्णालयाकरिता रुग्णासाठी लागणाऱ्या स्टेशनरी (फॉर्म) ची आवश्यकता असून सोबतच्या तक्त्यानुसार मागणी केल्याप्रमाणे यादी सोबत जोडत आहे. तरी पुरवठा करण्यासाठी अनुभवी पुरवठादारांना या जाहीर सुचनेनुसार दरपत्रक सादर करण्याचा कालावधी दिनांक २३/०७/२०२६ रोजी सायंकाळी ५ पर्यंत राहिल याची नोंद घ्यावी. सोबत स्टेशनरी फॉर्मची यादी जोडत आहे.

अटी व शर्ती:-

- १) दरपत्रक सीलबंद लिफाफा दिनांक २३/०७/२०२६ रोजी ५ वाजेपर्यंत कार्यालयास पोहचतील या वेळेत पाठवावे. जाहीर केलेल्या तारखेनंतर अथवा कार्यालयीन वेळेनंतर दरपत्रक विचारात घेतले जाणार नाही/ग्राह्य धरले जाणार नाही.
- २) इतर दरपत्रकाधारक / अधिकृत विक्रेता / पुरवठादार कंपनी यांना देखील कार्यालयाच्या सुचना फलकानुसार दरपत्रक सिलबंद लिफाफा विहित मुदतीत सादर करण्याची मुभा राहिल.
- ३) दरपत्रक आवश्यक त्या तपशिलासह म्हणजेच पुरवठा करावयाच्या वस्तुचे नाव, लिफाफा जमा करण्याचा अंतिम दिनांक, दरपत्रक धाराकांच्या दुकानांच्या नावांचा शिक्का, अधिष्ठाता, शासकीय वैद्यकीय महाविद्यालय व सर्वोपचार रुग्णालय, बारामती यांचे नावे लिफाफा विहित मुदतीत सादर करावा.
- ४) सिलबंद लिफाफे हे दिनांक २४/०७/२०२६ रोजी १२.०० वाजता मा. अधिष्ठाता यांच्या कार्यालयामध्ये उघडण्यात येईल. त्याकरिता कमीत कमी तीन पुरवठादारांचे दरपत्रक प्राप्त होणे क्रमप्राप्त राहिल. आपणास जर दरपत्रके उघडण्याच्या प्रक्रियेमध्ये सहभाग घ्यावयाचा असल्यास नियोजित वेळेत स्वखर्चाने उपस्थित राहावे.
- ५) दरपत्रक धारकांनी दरपत्रके हे अधिकृत लेटरहेड वर शिक्कासह व स्वाक्षरीसह सादर करावे. दरपत्रक देणाऱ्या व्यक्तीने आपले दुकानाचा परवाना, जीएसटीचा परवाना, जीएसटीची प्रत, पॅनकार्डची प्रत, पुरवठादार हा संबंधित कामाबाबत म्हणजेच कंपनीचे अधिकृत विक्रेता असेल तर त्या बाबतची कागदपत्रे उत्पादक कंपनीचे अॅथराजेशन प्रमाणपत्र सादर करणे बंधनकारक आहे. सदर दस्तऐवज सिलबंद दरपत्रक लिफाफा सादर करतेवेळी लिफाफ्यात असणे गरजेचे आहे. त्याकरिता बेगळा लिफाफा देण्याची गरज नाही.
- ६) प्रत्येक दरपत्रकाधारकांस केवळ एक दरपत्रक भरता येईल.
- ७) सर्वात कमीत कमी दरांचे दरपत्रक व वस्तुंचा दर्जा चांगला असेल दरपत्रकांचा विचार करण्यात येईल. दरपत्रकात खाडाखोड करण्यात येऊ नये.
- ८) दरपत्रकात आकारण्यात आलेले दर हे बाजारभावापेक्षा अधिक नसावेत. फक्त एक नग प्रमाणे दर कळविण्यात यावे व जीएसटी कर समावेश करून दर्शविण्यात यावे, साहित्य हे पुरवठा आदेश प्राप्त झाल्यापासून आठ दिवसात कार्यालयीन वेळेत (सुट्टीचे दिवस वगळून) पुरवठा करण्यात यावे.
- ९) मागणी करण्यात आलेली वस्तु / सामग्री ही विनिर्दिष्टानुसार असणे अत्यंत आवश्यक आहे. सामग्री ही उत्कृष्ट दर्जाची असणे आवश्यक आहे.

- १०) प्रस्तावित सामुग्री विनिर्दिष्टानुसार असल्याबाबत संबंधीत विभागप्रमुख यांचेकडून प्रमाणित केल्यानंतरच देयकाची अदागयी करण्यात येईल.
- ११) सदरील कामाकरिता कोणतीही आगाऊ रक्कम (ADVANCE PAYMENT) अदा करण्यात येणार नाही. आपवादात्मक परिस्थितीमुळे देयक अदा करण्यास विलंबपोटी कोणत्याही स्वरूपाचे व्याज अथवा अतिरिक्त रक्कम हे कार्यालय अदा करणार नाही. त्या प्रकारची मागणी मान्य करता येणार नाही. अनुदान उपलब्ध नसल्यास, अनुदान उपलब्ध होण्याच्या अधिन राहुन देयकाची रक्कम अदागयी करण्यात येईल.
- १२) दरपत्रक ग्राह्य कालावधी हा दर पुरवठा आदेश नोंदविलेल्या दिनांकापासून एक वर्ष राहिल.
- १३) कोणतेही कारण न देता पुरवठा झालेली सर्व दरपत्रके स्विकारणे/ नाकारणे तसेच उक्त नमूद कोणत्याही अंशत बदल करणे इ. अधिकार कार्यालय प्रमुख यांनी राखुन ठेवलेले आहेत.
- १४) MAKE व SPECIFICATION नुसार आलेले दरपत्रक ग्राह्य घरले जाईल.


अधिष्ठाता

शासकीय वैद्यकीय महाविद्यालय
व सर्वोपचार रुग्णालय, बारामती.

(1)

ये.का.मु.-२५ ००, ००००-१०-२०२२-पीए५--(ओ)६५
 शा. नि. सा. वि. क्र. ६२६१, दि. १५-३-३३]
 G. G. D.No. 6261 of 15-3-33]

ना.वै.५ म.इं.
 C.M. 5m.e

रुग्णालय Hospital

प्रदायी
 Paying
 शुल्कमुक्त
 Free

पुरुष
 Man
 स्त्री
 Woman
 मुलगा
 Male Child
 मुलगी
 Female Child

क्रमांक
 No.

दिनांक
 Date

नांव
 Name

वय (वर्ष किंवा महिने)----
 Age (Years Months)

व्यवसाय
 Occupation

मासिक उत्पन्न
 Monthly Income

रोगाचे नांव
 Disease

जात
 Caste

किती काळ आजारी आहे (महिने किंवा वर्षे)
 How long ill (Months or Years)

घरचा पत्ता
 Residence

निष्कर्ष
 Result

दिनांक
 Date

रोगलक्षणे व रुग्णाची प्रगती
 Symptoms and Progress

औषधे योजना
 Prescriptions

किती दिवसांसाठी
 For how many days

(48)

दिनांक Date	रोगलक्षणे व रुग्णाची प्रगती Symptoms and Progress	औषधे योजना Prescriptions	किती दिवसांसाठी For how many days

2

नाव

Name _____

GMC 168

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नाव

वय

रोग

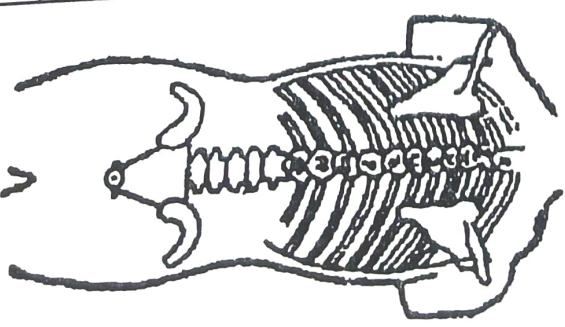
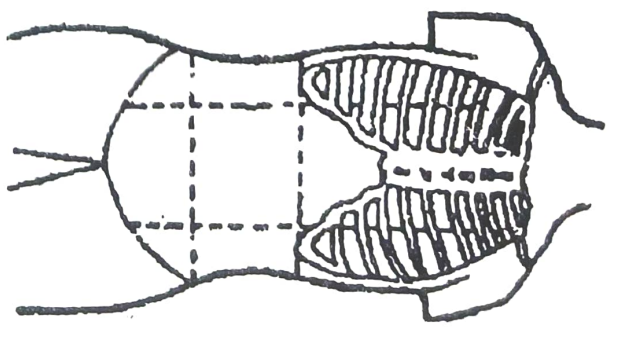
निष्कर्ष

टिपा

तापाचा तक्ता

C.M. 6 m.

महिना	दिवस	महिना												दिवस	रोगाचा दिवस
		सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.		
नोल	रक्त	रोगाचा दिवस	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.
श्वसन	नाडी	फॅन्टिड	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सो.स.	सी ग्रेड
६०	१६०	१०७													
५५	१५०	१०६													
५०	१४०	१०५													
४५	१३०	१०४													
४०	१२०	१०३													
३५	११०	१०२													
३०	१००	१०१													
२५	९०	१००													
२०	८०	९९													
१५	७०	९८													
	६०	९७													
	५०	९६													
		९५													
रक्त	हिवाताप														
	स्वर														
मल															
मूत्र प्रमाण															
मूत्र तपासणी	दिनांक	रंग	गंध	प्रतिक्रिया	वि. गु.	श्वेतधातू	शर्करा	मुत्रस %	स्वर						



GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMAT
CENTRAL CLINICAL LABORATORY
REQUISITION FORM

Central Biochemistry Laboratory

Name of the Patient : _____ Age : _____ Sex : - M /

IPD / OPD Reg. No. : _____ Ward No. _____ Date : / / 20

Department : _____ Unit : _____

Probable Diagnosis : _____

Investigation Required : _____

Referred by Dr : AP. / ASST. PROF. / SR. / JR. _____

Time of Sample Received :

Date : / / 20

Remarks

GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI,

6 CENTRAL CLINICAL LABORATORY

REQUISITION FORM

Central Microbiology Laboratory 6

Name of the Patient _____ Age: _____ Sex: - M/F
IPD/OPD Reg. No. _____ Ward No. _____ Date: ____ / ____ /20
Investigation Required _____

Referred by Dr: _____

शा. नि., आ. व रथा. स्व. वि., क्र. ९७९४, दि. १४-११-४७.]

C. M. 3 m.e.

[illegible]

Name

[illegible]

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स.वै. १४१
C.M. 141

ये.का.मु. --- २,००,०००-७-२०१९ - पोर ५ - (ओ) ३८
 शा.नि.सा.वि.क्र. ६२६१, दि. १४-११-३३; शा.प., न.वि.आ.व
 गु.नि.वि.क्र. एफआरएस/१०७५/३९८७२/एमईडी-९, दि. ३१-७-७५
 अन्वये सुधारित व भाषांतरित)

क्ष-किरण वि०

दि. / / २०

क्र.

रुग्णाचे नांव :

खाट क्र.

रुग्णाचे किंवा पालकाचे उत्पन्न

कक्ष क्र.

प्रभारी शल्यचिकित्सक ---

Advice

प्रभारी भिषक ---

1) ECG

संक्षिप्त पूर्ववृत्तासह चिकित्सालयीन रोगनिदान ---

2) X-RAY

आवश्यक उद्भासमाची (एक्स्पोझरची) संख्या (कोणत्या भागाची व कोणत्या आसनात घ्यावयाची ते नमूद करावे)---

क्ष-किरण निष्कर्ष ---

घेतलेल्या उद्भासनाची संख्या ---

क्ष-किरणशास्त्रज्ञ

टीप : -- भिषक किंवा शल्यचिकित्सक यांनी क्ष-किरणशास्त्रज्ञाकडून आलेले प्रतिवृत्त पाहिल्यानंतर, हा नमुना त्वरित
 शल्यचिकित्सक किंवा निवासी वैद्यकीय अधिकारी किंवा रुग्णालय यांच्याकडे पाठवावा.

GMC

(१४)

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⑨

**GOVERNMENT MEDICAL COLLEGE AND GENERAL HOSPITAL
BARAMATI**

**DEPARTMENT OF RADIODIAGNOSIS AND IMAGING
WHOLE BODY C. T. SCAN**

Date _____

OPD / Indoor No. : _____

Patient's Name : _____ Age : _____ Sex : _____

Address and Tel. No. : _____

Referred by : _____ Unit : _____ Ward No. : _____

Clinical Details : _____

Provisional Diagnosis

Please P Mark Examination required		Office use
☐ Brain	☐ Chest	Appt.
☐ Orbit		
☐ Paranasal Sinuses	☐ Abdomen	C. T. No. :
☐ Neck	☐ Pelvic	Amount :
☐ Spine	☐ Cervical	Receipt No. :
	☐ Joints	
	☐ Thoracic	
	☐ Lumbar	
From	to Vertebrae PLAIN ☐	Singnature of Sister I/c.
	CONTRAST ☐	

(Singnature of Unit Incharge)

PREPARATION

FOR HEAD SCAN AND ALL OTHERS

(1) No food and water 4 hours before Scan.

FOR ABDOMEN, PELVIC AND SPINE

(1) Laxatives on previous night

(2) To come on empty stomach

Requirement : (1) Please bring all previous Medical Reports.

(2) Abdominal Pelvic Sonography Report; all relevant radiographs.

(3) Receipt of Payment.

GOVERNMENT MEDICAL COLLEGE AND GENERAL HOSPITAL

CONSENT OF PATIENT/GUARDIAN

I am willing for the C. T. Scan Procedure with administration of contrast medium if needed.
I have been fully informed about the risks involved.

(Signature and Name)

Office use	संमतीपत्र
Appdt.	
Receipt No.	
Signature of Sister No.	

मी माझ्या स्वतःच्या जबाबदारीवर शिरेतून औषध (कॉन्ट्रास्ट मीडिया) देऊन सी. टी. स्कॅन करून घ्यावयास तयार आहे. त्यातील संभाव्य धोक्याची कल्पना मला देण्यात आलेली आहे.

(Signature of Unit Incharge)

(सही व नाव)

FOR ABDOMEN, PELVIC AND SPINE

(1) laxatives or previous night

(2) To come on empty stomach

15

DEPARTMENT OF FORENSIC MEDICINE & TOXICOLOGY
PUNYASHLOK AHILYADEVI HOLKAR GOVERNMENT MEDICAL COLLEGE,
BARAMATI- 413133.

POST MORTEM CENTRE
Requisition for Pathological Examination

Date : ____/____/____

To,
The Professor and Head
Department of Pathology

Subject : Histopathological Examination in Post Mortem No.

FM _____ Date : ____/____/____

Respected Sir/Madam,
Forwarding following specimen for Histopathological examination, concerned with Medicolegal Post
Mortem No.

FM _____ Date : ____/____/____

Name of The Deceased : _____

Age : _____ Years, Gender _____ ADR/CR No. _____

Police Station : _____

(Preserved in 10% Formalin)

Tissue bits of Cerebrum, Cerebellum, Brain stem, Heart, Lungs, Aorta, Liver, Spleen, Pancreas, Adrenal,
Stomach, Intestine, Kidney, Uterus, Cervix, Ovaries/Testis/Epididymis, Skin.

Any other tissue/s : _____

The details of the case are as follows :

History/Clinical Summary, if any : _____

POST MORTEM FINDINGS :-

I) External Examination :- _____

II) Internal Examination (In-Situ Findings) :-

1) Cranial Cavity : _____

2) Thoracic Cavity : _____

3) Abdominal Cavity : _____

III) Systematic Examination :

- 1) CNS : _____
- 2) CVS : _____
- 3) RS : _____
- 4) Gastrointestinal System : _____
- 5) Hepatobiliary System : _____
- 6) Urinary System : _____
- 7) Genital System : Male/Female _____
- 8) Endocrine System :
Pituitary : _____
Thyroid : _____
Adrenals : _____
- 9) R.E. System : _____
- 10) Hematological Examination : (Bone Marrow Biopsy) _____
- IV) Any other Positive Findings : _____

Provisional Cause of Death : _____

Date and Time of Post Mortem Examination : _____

Name of Autopsy Surgeon : _____

Kindly examine and report with your valuable opinion.

Thanking you.

Date : _____.

Forwarding

Through PC No. _____

Police Station _____

Signature of Autopsy Surgeon

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GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI

DEPARMENT OF RADIODIAGNOSIS

3 TESLA MRI SCAN

Patient Name-----Age:-----Sex:-----

OPD/IPD No :----- MLC No. :----- Date :-----

Address and Tel. No :-----

Referred by :-----Unit :-----Ward No:-----

Clinical Details:.....

Part to be scanned:

Appointment Date:_____Time:_____

Provisional Diagnosis :

NEURO AND ADVANCED NEURO STUDY ☐ BRAIN PLAIN ☐ BRAIN PLAIN + CONTRAST ☐ BRAIN ANGIOGRAPHY [STROCK PROTOCOL] ☐ BRAIN VENOGRAPHY ☐ BRAIN ANGIOGRAPHY ☐ NECK ANGIOGRAPHY ☐ BRAIN SELLA DYNAMIC ☐ BRAIN CISS PROTOCOL ☐ BRAIN EPILEPSY PROTOCOL ☐ MR SPECTROSCOPY	SPINE ☐ CERVICAL SPINE ☐ DORSAL SPINE ☐ LUMBO SACRAL SPINE ☐ WHOLE SPINE SCREENING	Office use Appt. on: _____ MRI No.: _____ Amount: _____ Receipt No.: _____
MRI LOCAL ☐ TONGUE ☐ PNS ☐ FACE/NECK ☐ ORBIT ☐ TEMPORAL MANDIBAL JOINT [TMJ]	MRI ABDOMEN ☐ MRCP ☐ PELVIS ☐ PROSTATE ☐ FISTULAGRA ☐ ABDOMEN	
MSK ☐ KNEE JOINT ☐ HIP JOINT [PBH] ☐ SI JOINT ☐ SHOULDER JOING ☐ WRIST JOINT ☐ ELBOW JOINT ☐ HAND ☐ FOOT/ANKLE JOINT ☐ THIGH ☐ LEG	OTHER ☐ BREAST MRI ☐ CHEST/THORAX OTHER: _____	

(Signature of Unit Incharge)

PREPARATION

FOR CONTRAST SCANS OF HEAD AND OTHERS

(1) No food and water 4 hours before Scan.

FOR ABDOMEN & PELVIC STUDY

- (1) Laxatives on Previous night
(2) To come on empty stomach

Requirement: (1) Please bring all previous Medical Reports.
(2) Abdominal Pelvic Sonography Report. All relevant radiographs.
(3) Receipt of Payment.

SAFETY INSTRUCTIONS/ सुरक्षिततेसाठी महत्त्वाची सूचना

PLEASE INFORM US IF YOU HAVE THE FOLLOWING:

	YES / NO
* Pacemaker	□□
* Artificial Heart Valve	□□
* Removable Dental Work	□□
* Hearing Aid	□□
* Implants / Prosthesis	□□
* Aneurysm Clip	□□
* Wig / Hair clip / Body Pins	□□
* If you have done any welding, grinding or cutting of metal	□□
* If you had any allergic reactions to contrast for MRI, CT or X-Ray	□□

एमआर करण्यापुर्वी सर्व धातूच्या वस्तू काढून टाका, ज्यात चाव्या, केसांच्या पिन, , दागिने, घड्याळ, सेफ्टी पिन, पेपरक्लिप, मनी क्लिप, क्रेडिट कार्ड, नाणी, मोबाईल, पेन, बेल्ट, धातूची बटणे, खिशातील चाकू आणि धातू असलेले कपडे यांचा समावेश आहे.

WE WILL CALL YOU THE DAY BEFORE YOUR EXAM TO CONFIRM YOUR APPOINTMENT

CONSENT FORM

I..... wish to undergo a MRI Scan

The procedure has been explained to me. I have answered to above questions correctly.

माझी एम आर आय करून घेण्याची तयारी आहे ती ती कोणत्या प्रकारे करतात ते मला समजून सांगण्यात आले आहे वरील सर्व प्रश्नांचे उत्तरे मी बरोबर लिहिलेले आहेत

सूचना [1] प्रत्येक भेटीच्या वेळी रुग्णाने पूर्वक तपासणी केलेले रिपोर्ट एक्स-रे सोनोग्राफी व सिटीस्कॅन इत्यादी रिपोर्ट आणावेत

[2] स्कॅन करते वेळी रुग्णासोबत कुटुंबातील रुग्णाचे नातेवाईक सोबत असल्यास उत्तम राहिल.

CHECKED BY

Referring Dr

[signature]

Patient/ Relative Sign.

Screened By

Radiologist/Technician

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GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL,
BARAMATI.

DEPARTMENT OF RADIO DIAGNOSIS

PATIENT NAME -	SCAN NO -
AGE/SEX-	DATE- / /25
OPD/WD-	MRD/MLC NO-

3T MRI Scan

**GOVERNMENT MEDICAL COLLEGE AND GENERAL HOSPITAL
BARAMATI, DISTRICT PUNE**

Department of Radiodioagnosis

Patient's Name : Seat No.:

Age and Sex : Date :

OPD / WD : MRD No. :

LOCAL USG

Impression :

Radiologist

मृत्यु अहवाल
(नमुना क्रमांक २)
कायदेशीर माहिती
हा भाग मृत्यु नोंदवही म्हणून संबोधण्यात यावा.)

मृत्यु अहवाल
सांख्यिकी माहिती

या भागाची माहिती कापून पुढील संकलनासाठी पं.स./न.पा./म.न.पा./कॅ.बोर्डकडे पाठविण्यात यावी.

जिल्हा रकाने भरावेत.

व : _____

पुंज : _____

तृतीयपंथी : _____

गंध : _____

य - _____

पत्ता - _____

ज समयीचा पत्ता - _____

यमचा पत्ता - _____

१) रूग्णालय/संस्था _____

नांव व पत्ता _____

२) घर _____

पत्ता _____

३) इतर _____

जे नांव व पत्ता _____

क _____

माहिती देणाऱ्याने खालील रकाने भरावेत.

१) मृत व्यक्तीचे नेहमीचे राहण्याचे ठिकाण

(हे ठिकाण मृत्युपेक्षा ठिकाणापेक्षा वेगळे असू शकते.)

अ. गावाचे/शहराचे नांव

ब. गांव आहे का शहर आहे.

१. गांव २. शहर

क. तालुक्याचे नांव

ड. जिल्ह्याचे नांव

इ. राज्याचे नांव

१२) कुटुंबाचा धर्म

१. हिंदू २. मुस्लिम ३. ख्रिश्चन

४. इतर धर्म (धर्माचे नांव लिहावे)

१३) मृत व्यक्तीचा व्यवसाय/नोकरी

(जर नसेल तर निरंक लिहावे.)

१४) मृत्युपूर्वी घेतलेल्या वैद्यकीय सेवेचा प्रकार

१) वैद्यकीय संस्था -
२) या व्यतिरिक्त इतर वैद्यकीय सेवा -
३) वैद्यकीय सेवा मिळाली नाही.

१५) मृत्युचे कारण वैद्यकीयदृष्ट्या प्रमाणित आहे का?

अ) आहे ब) नाही

१६) रोगाचे नाव किंवा मृत्युचे नेमके कारण

(वैद्यकीयदृष्ट्या प्रमाणित आहे किंवा नाही याच्याशी संबंधित नाही)

१७) मृत व्यक्ती स्त्री असेल व मृत मृत्यु गरोदरपणी, प्रसूतीच्यावेळी किंवा प्रसूतीनंतर ६ आठवड्यात झाला तरचा रकाना माहिती भरावी.

१) होय २) नाही

१८) सिगारेट, डि किंवा तत्सम पदार्थाचे व्यसन होते का?

असल्यास किती वर्षे

१९) तंबाखू खाण्याचे व्यसन होते का?

असल्यास किती वर्षे

२०) सुपारी किंवा पान मसाला खाण्याचे व्यसन होते का?

असल्यास किती वर्षे

२१) दारू किंवा तत्सम पदार्थाचे व्यसन होते का?

असल्यास किती वर्षे

(नमूद रकाने पूर्ण भरून झाल्यावर डावीकडील स्तंभात माहिती देणाऱ्याने सही करावी.)

नोंदणी क्र. _____ नोंदणी दिनांक _____

मृत्युचा दिनांक _____ मृत्युचे वय _____

लिंग १. पुरुष २. स्त्री

जन्माचे ठिकाण : अ. हॉस्पिटल ब. घरी क. इतर

निबंधकाचा नावासहित शिक्षा व सही

STATEMENT OF CAUSE OF DEATH

(21)

(For institutional deaths. Not to be used for still births)
FORM No. 4 (See Rule 7)
 To be sent to Register along with Form No. 2 - (Death Report)

Name of the Hospital **GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI.** I hereby certify that the person whose particulars are given below died in the hospital in Ward No. on at A.M. / P.M.

Sex		Age at Death				For use of Statistical Office
		If 1 year or more, age in years	If less than 1 year age in Months	If less than 1 month, age in Days	If less than 1 day, age in Hours	
M	F					

CAUSE OF DEATH		
1. Immediate Cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc. Antecedent Cause Morbid conditions, if any giving rise to the above cause, stating underlying conditions last.	(a) Due to (or as consequences of) (b) Due to (or as consequences of) (c)	Interval between on set and death approx.
2. Other significant conditions contributing to the death but not related to the disease or conditions causing it.		

Manner of Death : (How did the injury occur ?)

1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending investigation

If deceased was a female, was the death associated with pregnancy ? 1. Yes 2. No

If Yes, was there a delivery ? 1. Yes 2. No

Name and Signature of the Medical Attendant certifying the cause of death

Date of Verification

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased.)

Certified that Shri. / Kum. Son / Wife / daughter of
 Shri. R / O was admitted to this hospital
 on and expired on at A. M. / P. M.

Doctor :

Medical Superintendent :

Name of the Hospital :

MEDICAL CERTIFICATION OF CAUSE OF DEATH

Directions for completing the Form

Name of Deceased : To be given in full. Do not use initials. If deceased is an infant, not yet named at time of death, Write 'Son of (S/o) or "Daughter of (D/o) followed by names of mother and father.

Age at Death : If the deceased was over 1 year of age, give age in completed years. If the deceased was below 1 year of age, give age in months and if below month give age in completed number of days and if below one day, in hours.

Cause of Death : This part of the form should always be completed by the attending physician personally.

The certificate of cause of death is divided into two parts, 1 and 2. Part 1 is again divided into three parts, lines (a), (b), (c) if a single morbid condition completely explains the deaths, then this will be written on line (a) of Part 1 and nothing more need be written in the rest of Part 1 or Part 2. For example, smallpox, lobar pneumonia, cardiac beriberi are sufficient cause of death and usually nothing more is needed.

Often, however, a number of morbid conditions will have been present at death and the doctor must then complete the certificate in the proper manner so that the correct underlying cause will be tabulated. First, enter in Part 1 (a) the immediate cause of death. This does not mean the mode of dying, e.g. heart failure, respiratory failure, etc. These terms should not appear on the certificate at all since they are modes of dying and not cause of death. Next consider whether the immediate cause is a complication or delayed result of some other cause. If so, line (c) will be completed. The underlying cause to be tabulated is always written last in Part 1.

Morbid condition or injuries may be present which were not directly related to the chain of events causing death but which contributed in some way to the fatal outcome. Sometimes the doctor finds it difficult to decide, especially for infant deaths, which of several independent conditions was the primary cause of death; but only one cause can be tabulated, so the doctor must decide. If the other diseases are not effects of the underlying cause, they are entered in Part 2.

Do Not write two or more conditions on a single line. Please write the names of the diseases (in full) in the certificates as legible as possible to avoid the risk of their being misread.

Onset : Complete the column for interval between onset and death whenever possible, even if very approximately, e.g. 'from birth' several years.

Accidental or violent deaths : Both the external cause and the nature of the injury are needed and should be stated. The doctor or hospital should always be able to describe the injury, stating the part of the body injured, and should give the external cause in full when this is shown. For example: (a) Hypostatic pneumonia, (b) Fracture of neck of femur, (c) fall from ladder at home.

Maternal deaths : Be sure to answer the questions of pregnancy and delivery. This information is needed for all women of child-bearing age, even though the pregnancy may have had nothing to do with the death.

Old age or senility : Old age (or senility) should be not given as a cause of death if a more specific cause is known. If old age was contributory factor, it should be entered in part 2. For example: (a) chronic bronchitis, II old age.

Completeness of information : A complete case history is not wanted, but if the information is available enough details should be given to enable the underlying cause to be properly classified. For example: Anaemia - Give type of anaemia, if known. Neoplasms - indicate whether benign or malignant and site with site of primary neoplasm, whenever possible. Heart disease - describe the condition specifically, if congestive, heart failure, chronic or pulmonale, etc. are mentioned, give the antecedent conditions. Tetanus - describe the antecedent injury, if known. Operation - state the condition for which the operation was performed. Dysentery - specify whether bacillary, amoebic etc. if known. Complications of pregnancy or delivery - describe the complication specifically. Tuberculosis - give organs affected.

Symptomatic statement : Convulsion, diarrhoea, fever, ascites, jaundice debility etc. are symptoms which may be due to any one of a number of different conditions. Sometimes nothing more is known, but whenever possible, give the disease which caused the symptom.

Manner of death : Deaths not due to external cause should be identified as 'Natural'. If the cause of death is known, but it is not known whether it was the result of an accident suicide or homicide and is subject to further investigation, the cause of death should invariably be filled in and the manner of death should be shown as

Government Medical College

And

GENERAL HOSPITAL, BARAMATI

Block -

Paed wd - 37

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Name of Patient :

Reg. No. : Age/Sex : Dr. Unit :

Date of Admission : Diagnosis :

INTAKE OUTPUT CHART

Date :

Previous Day Time	TPR	Intake (All entries to be made in ml.)						Output			Other
		I.V.		Oral		Other		Urine	Suction	Drain	A/G etc.
		Type	Qty.	Type	Qty.	Type	Qty.				
8 AM											
9											
10											
11											
12 Noon											
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12 Night											
1											
2											
3											
4											
5											
6											
7											
Total											

23

Paed wd

23

महाराष्ट्र आरोग्य सेवा विकास प्रकल्प

संदर्भ चिठ्ठी

Referral Card

जिल्हा : _____

संदर्भित करणाऱ्या संस्थेचे नांव :

Name of Referring Hospital :

रुग्णाचे नांव :

Name of the Patient :

वय :

स्त्री / पुरुष :

नोंदणी क्रमांक :

Age :

Female/Male

Registration No. :

पत्ता :

Address :

संदर्भाची तारीख व वेळ :

Date & Time of Referral :

संदर्भित करणाऱ्या वैद्यकीय अधिकार्याची निरीक्षणे :

Observations by referring Med Officer :

प्राथमिक निदान :

Provisional Diagnosis :

उपचार तथा चाचण्या :

Treatment / Investigation :

संदर्भित करावयाच्या रुग्णालयाचे नांव :

Name of Hospital Where Referred :

संदर्भित करण्याचे कारण :

Purpose of reference :

संदर्भित करणाऱ्या व्यक्तीची स्वाक्षरी व हुद्दा :

Signature & Designation of Referring Personal :

FEEDBACK CARD

Name of the Receiving Hospital :

Name of the Patient :

Age :

Sex :

Registration No. :

Remarks about the condition of patient by receiving Med. Officer :

Date & Time Received

Investigation / Treatment Provided

Followup advise

Date

Time

Signature of Receiving Med. Officer



HISTOPATHOLOGY

Note:- No specimen is accepted for microscopic examination unless accompanied by complete relevant clinical history and findings, summary of operation notes, suspected clinical diagnosis and results of X-rays, previous investigation etc.

Received on date: / /20

Pathology No:

Name: _____ Age _____ Sex: F/M Income Rs. _____

Dept./Unit: _____ Regd No. _____ Ward _____

Name of specimen _____ Operated on _____ 20
at: _____ A.M. /P.M

Clinical details including Exact Anatomic _____

Site and local Examination of lesion _____

Operation notes, if any _____

X-ray / other investigation _____

Probable clinical diagnosis _____

Previous Biopsy / Cytology No. _____

Path. Index

Signature:-

REPORT

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Punyashlok Ahilyadevi Holkar
Government Medical College, Baramati
Department of Microbiology
Requisition form - HIV Testing for IPD Patient

LAB ID: MRD. NO.

DATE: / /20

PATIENT NAME

AGE:

GENDER:

ADDRESS

MOBILE NUMBER

EDUCATION

MARRIED/UNMARRIED

OCCUPATION

REASON FOR TESTING

Signature of Doctor

GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL
BARAMATI.

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DEPARTMENT OF RADIO DIAGNOSIS.

Patient's Name : _____ Age: _____ yrs:

Name of Referring Doctor : _____ Date : _____

NT Scan Report

EDD by LMP :

LMP :

Study Shows a single , Intrauterine fetus with good fetal movements and cardiac activity .

No gross fetal structural abnormality seen at present .

Placenta - Developing _____

Liquor - Adequate/ Less than expected.

Cervical length - _____ mm. Internal Os Closed.

CRL - _____ mm, Corresponding to gestational age of _____ weeks _____ days.

FHR - _____ bpm , Regular

NT - _____ . Nasal Bone- Ossified/not ossified

Ductus venosus flow - Normal / Abnormal

EDD by USG - _____

Impression : Normal NT, NB Scan. Fetal Maturity is about _____ Wks: _____ Days:

Advice : follow up at 19 -21 Wks for Evaluation of Anomalies .

RADIOLOGIST

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**MINISTRY OF HEALTH AND FAMILY WELFARE
NOTIFICATION**

New Delhi, The 31st January 2014

G. S. R. 77(E). - In exercise of the powers conferred by Section 32 of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (57 of 1994), the Central Government hereby makes the following rules further to amend Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996, namely.—

1. (i) These rules may be called the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Amendment Rules, 2014.
(ii) They shall come into force on the date of their Publication in the Official Gazette.
2. In the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996, for Form F, the following forms shall be substituted.

[See Provision to Section 4 (3), Rule 9 (4) and Rule 10 (1A)]

**FORM FOR MAINTENANCE OF RECORD IN CASE OF PRE-NATAL DIAGNOSTIC
TEST / PROCEDURE**

BY GENETIC CLINIC / ULTRASOUND CLINIC / IMAGING CENTRE

SECTION - A : To be filled in for all Diagnostic Procedures / Tests

1. Name and complete address of Genetic Clinic / Ultrasound Clinic / Imaging Centre - Government Medical College and Hospital, Baramati - 413 102.
2. Registration No. (Under PC and PNDT Act, 1994) : PUNE/554/23
3. Patient's Name :
Mrs. _____ Age : _____
4. Total number of living Children :
(a) Number of living Sons with age of each living son (in years or months) : _____

(b) Number of living Daughters with age of each living Daughter (in years or months) :

5. Husband's / Wife's / Father's / Mother's Name :

6. Full postal address of the patient with contact number, if any :

7. (a) Referred by (Full name and address of Doctor/s / Genetic Counselling Centre) :

(Referral slips to be preserved carefully with Form - F)
(b) Self-Referral by Gynaecologist / Radiologist / Registered Medical Practitioner conducting the diagnostic procedures :

(Referral note with indications and case papers of the patient to be preserved with Form - F)
(Self-referral does not mean a client coming to a clinic and requesting for the test or the relative/s requesting for the test of a pregnant woman)
8. Last menstrual period or weeks of pregnancy : _____

SECTION - B : To be filled in for performing Non-invasive Diagnostic Procedures

9. Name of the Doctor performing the procedure/s : _____
10. Indication/s for diagnosis procedure _____
(Specify with Reference to the request made in referral slip or in a self-referral note) (Ultrasono-
graphy pre-natal diagnosis during the pregnancy should only be performed when indicated). The
following is the representative list of indications for ultrasound during the pregnancy. (Put a "Tick"
against the appropriate indication/s for ultrasound.)
- (i) To diagnose intra-uterine and / or ectopic pregnancy and confirm viability.
 - (ii) Estimation of gestational age (dating).
 - (iii) Detection of number of fetuses and their chorionicity.
 - (iv) Suspected pregnancy with IUCD *insitu* or suspected pregnancy following contraceptive / MTP failure.
 - (v) Vaginal bleeding / leaking.
 - (vi) Follow-up of cases of abortion.
 - (vii) Assessment of cervical canal and diameter of internal OS.
 - (viii) Discrepancy between uterine size and period of amenorrhea.
 - (ix) Any suspected adnexal or uterine pathology / abnormality.
 - (x) Detection of chromosomal abnormalities, fetal structural defects and other abnormalities and their follow-up.
 - (xi) To evaluate fetal presentation and position.
 - (xii) Assessment of liquor amnii.
 - (xiii) Preterm labour/preterm premature rupture of membranes.
 - (xiv) Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retro placental haemorrhage, abnormal adherence etc.)
 - (xv) Evaluation of umbilical cord - presentation, insertion, nuchal encirclement, number of vessels and presence of true knot.
 - (xvi) Evaluation of previous Caesarean Section Scars.
 - (xvii) Evaluation of fetal growth parameters, fetal weight and fetal well being.
 - (xviii) Colour flow mapping and duplex Doppler studies.
 - (xix) Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc. and their follow-up.
 - (xx) Adjunct to diagnostic and therapeutic invasive intercentions such as chorionic villus sampling (CVS), amniocenteses, fetal blood sampling, fetal skin biopsy, amnioinfusion intrauterine infusion, placement of shunts etc.
 - (xxi) Observation of intrapartum events.
 - (xxii) Medical / surgical conditions complicating pregnancy.
 - (xxiii) Research / scientific studies in recognized institutions.
11. Procedures carried out (Non-invasive) (Put a "Tick" on the appropriate procedure) :
- (i) Ultrasound
(**Important Note** : Ultrasound is not indicated / advised / performed to determine sex of the fetus except for diagnosis of sex-linked diseases such as Duchenne Muscular Dystrophy, Hemophilia A & B etc.)
 - (ii) If any other (specify) : _____
12. Date on which declaration of pregnant woman / person was obtained : _____
13. Date on which procedures carried out : _____
14. Result of the non-invasive procedure carried out (report in brief of the test including ultrasound carried out) _____
15. The result of Pre-natal Diagnostic Procedures was conveyed to _____
_____ on _____

16. Any indication for MTP as per the abnormality detected in the diagnostic procedure / tests : _____

Date : _____

Place : Baramati

**Name, Signature and Registration number with seal of
Gynaecologist / Radiologist / Registered Medical Practitioner
performing Diagnostic Procedures.**

SECTION - C : To be filled for performing investive Procedures / Tests only.

17. Name of the Doctor/s performing the procedure/s : _____

18. History of genetic / medical disease in the Family (specify) : _____

Basis of diagnosis ("Tick" on appropriate basis of diagnosis)

(a) Clinical

(b) Bio-chemical

(c) Cytogenetic

(d) Other (e.g. radiological,
ultrasonography etc. specify) _____

19. Indication/s for the diagnosis procedure ("Tick" on appropriate indication/s)

A. Previous child / children with :

(i) Chromosomal disorders

(ii) Metabolic disorders

(iii) Congenital anomaly

(iv) Mental Disability

(v) Haemoglobinopathies

(vi) Sex linked disorders

(vi) Single gene disorder

(vi) Any other (specify) _____

B. Advanced maternal age (35 years).

C. Mother / Father / Sibling has genetic disease (specify).

D. Other (specify) : _____

20. Date on which consent of pregnant woman / person was obtained in Form-G prescribed in PC & PNDT Act, 1994 _____

21. Invasive procedures carried out ("Tick on appropriate indication/s)

(i) Amniocentesis

(ii) Chorionic Villi aspiration

(iii) Fetal biopsy

(iv) Cordocentesis

(v) Any other (specify) : _____

22. Any complication/s of invasive procedure (specify) : _____

23. Additional tests recommended (Please mention if applicable)

(i) Chromosomal studies

(ii) Biochemical studies

(iii) Molecular studies

(iv) Pre-implantation gender diagnosis

(v) Any other (specify) : _____

24. Result of the Procedures / Test carried out (report in brief of the invasive tests / procedures carried out : _____

25. Date on which procedures carried out : _____

26. The Result of Pre-natal Diagnostic Procedures was conveyed to _____
_____ on _____

27. Any indication for MTP as per abnormality detected in the diagnostic procedure / tests :

Date :

Place :

Name, Signature and Registration number with seal of Gynaecologist / Radiologist / Registered Medical Practitioner performing Diagnostic test Procedures.

SECTION - D : Declaration

DECLARATION OF THE PERSON UNDERGOING PRE-NATAL DIAGNOSTIC TEST / PROCEDURE

I, Mrs./Ms. _____ declare that, by undergoing ultrasonography (Pre-natal Diagnostic Test / Procedure). I do not want to know the sex of my foetus.

Date :

Place : Baramati

Signature / thumb impression of the person undergoing the Pre-natal Diagnostic Test / Procedures.

In Case of Thumb Impression :

Identified by (Name) _____ Age : _____ Sex : _____

Relation (if any) : _____ Address & Contact No. : _____

Date : _____

Signature of a person attesting thumb impression

DECLARATION OF THE DOCTOR / PERSON CONDUCTING PRE-NATAL DIAGNOSTIC PROCEDURE / TEST

I, _____ (name of the person conducting ultrasonography / image scanning) declare that while conducting ultrasonography / image scanning on Ms. / Mrs. _____

(name of the pregnant woman or the person undergoing pre-natal diagnostic procedure / test), I have neither detected nor disclosed the sex of her fetus to anybody in any manner.

Date :

Signature. _____

Place : Baramati

Name, in Capitals, Registration number with seal of Gynaecologist / Radiologist / Registered Medical Practitioner Conducting Diagnostic Procedure.

[F. No. V. 11011/6/2013-PNDT]
Dr. RAKESH KUMAR, Jt. Secy.

Note : - The Pincipal notification was published in the Gazette of India, vide G. S. R. 1 (E). Dated the 1st January 1996 and amended vide notification numbers G. S. R. 109 (E). Dated the 14th February 2003. G. S. R. 426 (E), dated the 31st May 2011 G. S. R. 80 (E). Dated the 7th February 2012, G. S. R. 418 (E), dated the 4th June, 2012, G. S. R. 13 (E). Dated the 9th January 2014.

(28)

GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL BARAMATI.

DEPARTMENT OF RADIODIAGNOSIS.

PATIENT NAME : Age : Yrs:

OPD / WD : MRD NO. : Date :

USG ABDOMEN + PELVIS

Liver :

GB:

creas :

Spleen :

RT Kidney :

LT Kidney.:

Urinary Bladder :

Uterus / prostate :

Ascites / Lymphadenopathy :

Impression :

Adv :

RADIOLOGIST

Patient Name :-----Age: ----yrs.

Referring by Doctor :-----Date:

OBSTETRICS SONOGRAPHY

LMP :

GA by LMP:

E/o Single Live intrauterine gestation with Changing/Vertex/ Breech Presentation:

Foetal Parameters

BPD-----mm-----Wks-----days

HC-----mm-----Wks-----days

AC-----mm-----Wks-----days

FL-----mm-----Wks-----days

Placenta-----

Cardiac Activity -----Foetal Movements-----

Amniotic Fluid is Adequate / less than expected :

Cervical length is ----- mms. Internal Os Closed.

No e/o any gross congenital anomalies.

E.D.D.By USG-----

Impression – Single live Intrauterine Foetus Of average gestational Age

of -----Wks-----days.

No gross fetal structural anomaly .

Radiologist

**GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL,
(WOMEN'S HOSPITAL) BARAMATI, DIST-PUNE.**

Radiology Department

(30)

Patient's Name : _____ Age _____ yrs.

Name of Referring Doctor _____ Date : _____

USG OBSTETRICS

LMP :

EDD by LMP :

Uterus is gravid and shows, single defined intra uterine gestational sac
Fetal pole seen of CRL measuring mm corresponding to estimated gestational

Age of _____ weeks _____ days.

Foetal cardiac activity is present Fetal heart rate is _____ bpm.

Secondary Yolk is seen and appears normal. Decidual reaction is good.

Placenta is _____ with lower end _____ cm away from internal os.

Internal OS is closed Cervical length measures _____ cm.

No obvious collection or subchorionic haemorrhage is noted around the sac

Bilateral adnexa are normal

No Collection noted in the cul de sac

EDD by USG :

IMPRESSION :

- * Single, Live, early intra uterine pregnancy of average gestational age of _____ weeks _____ day
+/-1 week by USG.
- * ADV. : Follow up scan at _____ weeks .

Radiologist

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Dr.

Unit

**GOVERNMENT MEDICAL
COLLEGE & GENERAL
HOSPITAL, BARAMATI**

Reg. No.

OPERATION THEATRE NOTE

Name Age Sex $\frac{M}{F}$ Ward

Pre-operative Diagnosis

Post-operative Diagnosis

Operation

Time Started Time Completed Blood Gr. Amount Transfused

Premedication

Anaesthesia Surgeon

Anaesthetist Assistants : 1.

Nurse 2.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION :

FINDINGS AND PROCEDURE

Date

Type of procedure -

Include -

**Incision Ligatures
Sutures etc.**

FINDINGS

Include -

**Macroscopic
Pathological
findings etc.
and condition of all
organs examined**

Specimen removed

Drainage

Closure

Blood loss

**Immediate post
operative condition.**

**DEPARTMENT OF ANAESTHESIOLOGY,
GOVERNMENT MEDICAL COLLEGE, BARAMATI**

ANAESTHESIA NOTES (ELECTIVE / EMERGENCY)

Date :-

Duration : From _____ to _____

Patient's Name :

Age : _____ Sex : Male/Female

Reg. No. :

Diagnosis :

Procedure :

Anaesthesia : Spinal / Epidural / Combined SA+EA / General / Block / MAC / Local / Others

Anaesthesiologist :

Surgeon :

Preanaesthetic evaluation done

History reviewed - No fresh complaints.

NBM status - NBM / Not NBM

Written informed valid consent - present.

O/E - Pt. Conscious, oriented, afebrile

PR - _____ / min. RR - _____ / min

SPO₂ - _____ %

BP - _____ / _____ mm. of Hg.

Oral Examination - Dentures, Present / Absent, .

Teeth Missing / Loose

Pallor / cyanosis / icterus / clubbing / edema feet

RS :

ABCD & 4T

CVS :

Site / Procedure

P/A :

Risk of Anaesthesia

Spine :

Risk of Surgery

Exp. Duration

IV Line Rt. () / Lt. () Set up with A.....

Exp. Blood loss

SPINAL ANAESTHESIA :-

Name & Sign :

Under all aseptic precautions, painting and draping of back done.

LP done in sitting / Lateral position in space with spinal needle No. G.

Clear and free flow CSF obtained. Inj. Lignocaine 5% Inj. Lignocaine 5% with Adrenaline / Inj. Bupivacaine 0.5% / Inj. Ropivacaine 0.75% ml. Inj. ml. injected into the subarachnoid space. Adequate level of analgesia obtained upto Additives :

EPIDURAL ANAESTHESIA / NERVE BLOCK :- Single shot / continuous

MAC / GENERAL ANAESTHESIA - TIVA / Mask :

GENERAL ANAESTHESIA WITH INTUBATION :

Monitors Attached : SPO₂ / ECG / NIBP /

Premedication : Atropine / Glyco, Midaz, Fortwin / Fentanyl, Emset

Pre-oxygenation with 100% O₂ for 5 min.

Induction :

Under effect of Inj. mg. IV intubation done with Plain / cuffed ETT No.

Air entry checked. Air entry equal on both sides. Cuff inflated. Tube fixed. Throat pack +/-

Tube connected to Bain's Circuit / JR Circuit / Closed Circuit.

**GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL,
BARAMATI.**

DEPARTMENT OF RADIODIAGNOSIS

Patient's name :-	Scan No.:
Age & Sex	Date :-
OPD/WD	MRD No.:-

CT SCAN

Radiologist

शासकीय वैद्यकीय महाविद्यालय व सर्वोपचार रुग्णालय, बारामती, जि. पुणे.

गर्भवती स्त्रीचे घोषणापत्र

मी, सौ.-----घोषित

करते की; मला माझ्या गर्भातील बाळाचे लिंग काय आहे, याची माहिती नको आहे.

रुग्णाची स्वाक्षरी

सोनोग्राफी करणाऱ्या डॉक्टरांचे घोषणापत्र

मी, डॉ.-----

घोषित करतो/करते की, श्रीमती-----

----- यांची सोनोग्राफी करताना मी गर्भाच्या लिंगाची तपासणी

केली नाही. तसेच गर्भाच्या लिंगाबाबतची माहिती कोणत्याही व्यक्तीस दिलेली नाही.

अल्ट्रा सोनोलॉजिस्ट

Dialysis Unit
HEMODIALYSIS CHART

Name of Patient _____ A/S _____

MRD No. _____ MLC No. _____ Dr. Name _____

Date:- _____ Time On _____ Time off _____

Access Mode /AVF/Permcath/Jugular/Femoral Right/Left HD No. _____

Dialysis Type _____ Dialyzer Reuse _____ Tubing Reuse _____

Content	Pre Dialysis	Post Dialysis
Temp.		
Pluse		
BP		
SPO ₂		
Weight		
Flow Rate		

Time	Temp.	Pulse	BP	SPO ₂	UFR	VP	QB	Total UF

Total Fluid Removed: _____

Heperin Bolus: _____

Heparin Infusion Rate: _____

Rx. _____

Dr. Signature

~~पुणे~~ शासकीय वैद्यकीय महाविद्यालय व सर्वोपचार रुग्णालय, बारामती. जि.पुणे
डायलेसिस युनिट
हिमोडायलेसीस करण्यासाठी परवानगी मिळणे बाबतचे संमतीपत्र

रुग्णाचे नांव : _____

वय/लिंग:- _____

दिनांक:- / /२०

निदान:-

MRD No:-

यांनी मला माझ्या किडनीच्या आजारामुळे झालेली वाईट शारीरिक स्थिती सुधारण्यासाठी हिमोडायलेसीस करण्याबाबत समजावून सांगितले आहे व मला ते समजले आहे.

- १) हिमोडायलेसीस चालू असताना किंवा संपल्यानंतर काही धोके उदा. रक्तदाब कमी होणे, उलटी होणे (सुई) आऊट जाणे, थंडी वाजून येणे, वात उठणे इत्यादी आणि रक्तस्राव होणे, मिरगीचे झटके येणे, हृदयाची गती अनियमित होणे, हृदय बंद पडणे, असे धोके उद्भवू शकतात. याची पूर्ण कल्पना डॉक्टरांनी मला दिलेली आहे.
- २) जे रुग्ण जास्त दिवसापासून हिमोडायलेसीसवर आहेत त्यांना कावीळ ब / कावीळ क अशा विषाणूचे संक्रमण होण्याची शक्यता असू शकते.
- ३) सुरुवातीला कॅथेटर मधून नंतर हाताला बनविलेल्या (AV Fistula) मधून डायलेसीस करावे लागते. ते दोन्ही वापरण्यात काही अडचणी येऊ शकतात त्यासाठी योग्य ती तडजोड करणे गरजेचे असते.
- ४) कॅथेटर टाकतांना रक्तस्राव होणे (Pneumothorax) (हाताला बधीरता येणे) अथवा तात्काळ हृदय बंद पडणे असे धोके उद्भवू शकतात.
- ५) रक्तप्रवाह कमी येणे, इन्फेक्शन होणे, (Venous Pressure) जास्त असणे, असे प्रकार आढळून आल्यानंतर तात्काळ कॅथेटर काढणे आवश्यक असते.
- ६) संपूर्ण डायलेसीस संपेपर्यंत तज्ञ डॉक्टरांनी उपस्थिती असणे आवश्यक आहे असे नाही याची मला समज आहे.
- ७) आर्थिक परिस्थितीचा विचार करून जगभरामध्ये डायलेसीसचा सेट त्याच रुग्णासाठी (Reuse) (ठराविक वेळ) केला जातो. त्यासाठी माझे काही दूमत नाही.
- ८) दिलेल्या वेळेवर डायलेसीस करण्यासाठी हजर असणे आवश्यक असते.
- ९) आठवड्यातून रुग्णांच्या गरजेनुसार डायलेसीस करणे गरजेचे असते व याची मला समज आहे. हिमोडायलेसीस करण्यास संमती देत आहे. मी कोणतीही तक्रार करणार नाही.
- १०) माझी हॉस्पिटल, डॉक्टरर्स, नर्सेस व इतर कर्मचारी विषयी काहीही तक्रार नाही.

नातेवाईकांची सही :-

रुग्णाची सही:-

नातेवाईकांचे नाव:-

नाते व मोबाईल नंबर-

BLOOD CENTRE GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI.

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Date : / / 20 Time :

REQUEST FORM FOR BLOOD TRANSFUSION

(Please send 5ml. clotted & 2 ml. EDTA blood of the patient with this form)

Patient's Full Name : _____ Age : _____ Gender : _____

Date of Admission : _____ Reg. No. : _____ Ward : _____ Bed : _____

Physician / Surgeon : _____ Houseman : _____

Diagnosis & brief History : _____ Indication : _____

Degree of Urgency : 1) Urgent (Blood needed as soon as matching is done)

2) Routine

3) Reserve

4) Date & Time of Operation/ Requirement _____

Blood / Blood Product Required	Whole Blood	Fresh Frozen Plasma (FFP)	HRBCC (Human Red Blood Cell Concentrate)	Platelet Concentrate (RDP)	Platelet by Apheresis (SDP)	Cryoprecipitate
No. of Units Required						

Patient's blood group (including Rh/Hb/Platelet Count/PT/PTTK) if known _____

Has the Patient been previously transfused ? Yes / No. / Not known _____

Any evidence of haemolytic disease in her infants ? Yes / No. / Not known _____

Any observed reaction in her infants ? Yes / No. _____

Are H/O 1) Any Transfusion reactions Yes/No 2) Any Pregnancies Yes/No 3) Any Miscarriages Yes/No _____

Are there any donors ? _____

Time & Date of dispatch of this request from ward _____

Any other relevant Instruction / Information _____

Name of Phlebotomist/
Nurse

Signature

Signature &
Rubber Stamp
of the Doctor

Note : The Blood bag is kept reserved only for 24 hrs beyond the date & time of requirement of blood mentioned on the requisition form-subject to availability of STOCK. The reservation can be extended by sending a separate note. A separate letter (issue note) must be sent by the doctor at the time of issue of Blood; otherwise Blood will not be issued.

Signature of compatibility Testing done by : _____

Signature of compatibility Testing Reviewed by : _____

Group of Patient

Sr. No.	Blood Unit No.	Blood Product	Blood Group	Date	Time	Cross Matching	
						Certified by	Non-compatible

We crossmatch the sample received from the Hospital / Ward. We are not responsible for any error in collection or Labelling of the sample received from the Hospital / ward

Blood once issued will neither be taken back

Please fill up form completely

Instructions

- 1) Check the identity of Patient
- 2) Collect 5 ml of Blood in plain bulb & 2 ml in EDTA
- 3) Request for planned transfusion are acceptable between 8 am - 11 am.
- 4) For planned transfusion sanction from BTO must be obtained prior 24 hour.
- 5) Necessarily case paper should accompany the requisition form & to be send along with ward servant (Interns only)
- 6) Blood bags once issued will not be accepted for reissue in under any circumstances, the same Is valid with VBD card from outside patient even though requisition ask was cancelled later on.
- 7) Supply of blood for transfusion is subject to availability priority on receipt decided by BTO
- 8) Cross matched bags will be ready after 2 hr of receiving the samples in blood centre in emergency cases.
- 9) In surgical cases for routine operations blood requisitions should not be sent unless patient is fit for surgery by anaesthetist.
- 10) On Saturday or day prior to holiday routine samples will be accept upto 1 pm
- 11) Routine samples will bot be accepted on public holidays

By order
Blood Centre Incharge
GMC, Baramati

211

CYCLE NATURE NATURAL STI/PCOS
/ASYNCHRONISED
/SYNCHRONISED/RESISTANT /FOR IUI

STIMULATION PROTOCOL BY DRUG DOSE DURATION-----

[illegible]

CYCLE NATURE-NATURAL STI/PCOS
/ASYNCHRONISEL
/SYNCHRONISED/RESISTANT /FOR IUI

STIMULATION PROTOCOL BY DRUG DOSE DURATION-----

[illegible]

CYCLE NATURE-NATURAL
STI/PCOS /ASYNCHRONISED
/SYNCHRONISED/RESISTANT
/FOR IUI

LMP -

STIMULATION PROTOCOL BY DRUG DOSE DURATION-----

	/SYNCHRONISED/RESISTANT /FOR IUI	RT OVARY	LT OVARY	ET	DOMINANT FOLLICLE----- SHAPE /CONTENT/SEI MENT/BLOOD FLOW	COMMENT FOR FUTURE DOSE REGULATION ADJUVANT	HUSBAND ADJUVANT
DAY 2 /3/4 SCAN AFC-----							
DAY-							
DAY-							
DAY-							
DAY-							
DAY-							
DAY-							
DAY-							
DAY-							

CYCLE NATURE-NATURAL STI/PCOS
/ASYNCHRONISED
/SYNCHRONISED/RESISTANT /FOR IUI

LMP -

STIMULATION PROTOCOL BY DRUG DOSE DURATION-----

[illegible]

(दंतशास्त्र विभाग/Department of Dentistry)

संमतीपत्र

दिनांक-

रुग्णाचे नाव: _____ वय: _____ लिंग: _____

MRD No.: _____ माझ्या/नाते _____ वर होणाऱ्या

तपासणी/उपचार पद्धती _____

बाबत खालील बाबी मला समजणाऱ्या भाषेत समजावून सांगण्यात आल्या असून त्या मला समजल्या आहेत व कोणत्याही दबावाशिवाय स्वेच्छेने मी सदर तपासणी/उपचारासाठी संमती देत आहे.

- माझ्या आजारासंदर्भातील निदानात्मक तपासणी/उपचार पद्धती याबाबतची सर्व आवश्यक माहिती मला देण्यात आली आहे. तसेच माझ्या सर्व शंकांबाबत प्रश्न विचारण्याची संधी मला देण्यात आली असून त्या शंकांबाबत माझे समाधान करण्यात आले आहे.
- सदर आजाराच्या तपासणी/उपचाराचे स्वरूप, त्याचा उद्देश तसेच त्याचे फायदे व तोटे मला स्पष्टपणे समजावून सांगण्यात आले आहेत.
- तपासणी किंवा उपचारा दरम्यान किंवा उपचारानंतर होऊ शकणाऱ्या संभाव्य गुंतागुंती, धोके तसेच उपचारानंतर आजार पुन्हा होण्याची शक्यता असल्यास त्याची माहिती मला देण्यात आली आहे.
- सदर उपचारासाठी आवश्यक असलेली स्थानिक भूल पद्धती (Local Anesthesia) व इतर वैद्यकीय उपचार पद्धती तसेच त्याचे क्वचित उद्धवू शकणारे धोके, याची माहिती मला देण्यात आली आहे.
- उपचाराच्या कालावधीत किंवा नंतर पूर्ण बरे होण्याची हमी देता येत नाही तसेच उपचाराचा परिणाम रुग्णाच्या शारीरिक स्थितीवर अवलंबून असतो, हे मला समजावण्यात आले आहे.
- माझ्या माहितीप्रमाणे असलेला संपूर्ण वैद्यकीय इतिहास मी डॉक्टरांना प्रामाणिकपणे कळविला आहे. भविष्यात नवीन माहिती लक्षात आल्यास ती देखील कळवेल.

आजार	Diab. (साखर)	HTN/BP (उच्च रक्तदाब)	HIV (एडस)	Hepatitis (कावीळ)	TB (क्षयरोग)	Cancer(कर्करोग)/ उपचार पद्धती	दमा (Asthama)	Other (इतर)
होय- v नाही- x								

- मी जाणीवपूर्वक काही वैद्यकीय माहिती लपविल्यास व त्यामुळे उद्भलेल्या वैद्यकीय अडचणीसाठी डॉक्टरांना व इतर कर्मचारी यांना दोषी ठरवणार नाही.
- काही प्रसंगी उपचारादरम्यान अथवा उपचारानंतर काही वैद्यकीय अडचणी/धोके निर्माण झाल्यास किंवा गरज पडल्यास रुग्णाला रुग्णालयामध्ये दाखल करण्याची आवश्यकता पडू शकते, याची मला माहिती देण्यात आली आहे.
- उपचारानंतर डॉक्टरांनी सुचविलेल्या नियमित तपासणीसाठी मी नियमितपणे येईन. उपचारानंतर कोणतीही गुंतागुंत, वेदना, सुज, रक्तस्राव, संसर्ग किंवा इतर त्रास उद्भवल्यास मी त्वरित डॉक्टरांशी संपर्क साधून आवश्यक ते उपचार घेईन.

रुग्णाची सही/अंगठा: _____

नातेवाईकाची सही/अंगठा (असल्यास): _____

नातेवाईकाचे नाव व रुग्णाशी नाते: _____

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PAP REQUEST FORM

Cyto No.: _____ Name: _____ OPD: _____
Age & Sex: _____ Unit: _____ Date: _____ Reg No.: _____
Chief C/O: _____ Refer No.: _____
P/S Findings: _____
P/V Findings: _____

.....

PAHGMC BARAMATI

Department of Pathology

PAP SMEAR REPORT (As per Bethesda System)

Cyto No.: _____ Name: _____ OPD: _____
Age & Sex: _____ Unit: _____ Date: _____ Reg No.: _____
Specimen: Adequate / Non-Adequate / Fixed / Unfixed
Cell type:
Superficial / Intermediate / Parabasal / Metaplastic / Endocervical / Basal / Endometrial
Background:
Clear / PMN / Histiocytes / RBCs
Infective agents:
HPV (Koilocytes) / Trichomonas / Candida / Others
Intra epithelial lesion:
ASCUS / AGCUS / LSIL / HSIL / NIL
Malignancy:
No evidence / Squamous cell carcinoma / Adenocarcinoma
Remark: _____

IMPRESSION:

Pathologist

GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI.
DEPARTMENT OF PATHOLOGY
CONSENT FORM FOR FNAC PROCEDURE

Name of Patient : _____

Patient ID : _____

Referred by : _____

Date: _____

Name of the Doctor doing FNAC. : _____

I have given my full consent for performing Fine Needle Aspiration Cytology (FNAC)

site : _____

I have been explained and have understood the procedure in a language which I am conversant with. I also know that the procedure may or may not require local anesthesia. I have been made aware of the possible risks and complications that can occur suddenly and unexpectedly, these include excessive pain, bleeding, infection, vaso-vagal syncopal attacks and any other complications occurring under unforeseen circumstances.

I am willing to undergo this procedure on my own risk without any reservation. My questions and doubts regarding the procedure have been fully and clearly answered to my entire satisfaction.

Signature of Patient :

Name :

Date :

Signed by other than patient :

Name :

Address :

Age / Sex :

Relationship with patient :

ULTRASOUND PELVIS (TRANSVAGINAL SONOGRAPHY) REPORT

Indication:

LMP:

Uterus:

- **Position:** (Anteverted / Retroverted / Midposition)
- **Dimensions:** ____ x ____ x ____ mm **Volume:**
- **Shape & Contour:** (Normal / Globular / Irregular)
- **Myometrium:**
- **Endometrium:** * Thickness: ____ mm.
 - Echogenicity: (Triple line / Secretory / Post-menopausal thin)
 - Midline: (Intact / Disrupted)

Cervix:

- **Size & Echotexture:**

Right Ovary:

- **Dimensions:** ____ x ____ x ____ mm (Volume: ____ cc)
- **Echotexture:**

Left Ovary:

- **Dimensions:** ____ x ____ x ____ mm (Volume: ____ cc)
- **Echotexture**

Adnexa:

- **Right Adnexa**
- **Left Adnexa**

Pouch of Douglas (POD):

- (Clear / Minimal free fluid / Significant collection / Obliterated - sliding sign positive/negative)

Impression:

Signature



PZACH. GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI

Patient Name: _____

Age/Gender: _____ year/

Date: _____ / _____ / 2026

2-D ECHO & CARDIAC DOPPLER REPORT

Mitral Valve:

Aortic Valve:

Tricuspid Valve:

Pulmonary Valve:

Right Atrium:

Right Ventricle: TAPSE = _____ mm

Left Atrium: _____ mm

Aorta: _____ mm

Left Ventricle: RWMA PRESENT / ABSENT

IVSd= _____ mm, LVPWd= _____ mm, LVIDd= _____ mm, LVIDs= _____ mm, LVEF= _____ %

IAS/ IVS: Intact

Other:

IMPRESSION:-

CONSULTANT CARDIOLOGIST



PUNYASHLOK AHILYADEVI HOLKAR GOVERNMENT MEDICAL COLLEGE, BARAMATI.
CLINICAL MICROBIOLOGY LABORATORY

Patient's Name : Age / Sex :

MRD No. : OPD / IPD :

Date :

Serology Section		
Test	Interpretation	Result
Dengue	NS - 1 Antigen - IgM Antibody - IgG Antibody -	
Weil Felix	OXK - OX19 - OX2 -	
Widal	O - H - AH - BH -	
CRP		
RA		
Chikungunya		
HBsAg		
AS O		
RPR		
Malaria Ag (Rapid)		
HIV		
Leptospira IgM/IgG		

Sign of Lab In-charge



PUNYASHLOK A. AHILYADEVI HOLKAR GOVERNMENT MEDICAL COLLEGE, BARAMATI.
CLINICAL MICROBIOLOGY LABORATORY

Patient's Name : Age / Sex :

MRD No. : OPD / IPD :

Date :

Serology Section		
Test	Interpretation	Result
Dengue	NS - 1 Antigen - IgM Antibody - IgG Antibody -	
Weil Felix	OXK - OX19 - OX2 -	
Widal	O - H - AH - BH -	
CRP		
RA		
Chikungunya		
HBsAg		
AS O		
RPR		
Malaria Ag (Rapid)		
HIV		
Leptospira IgM/IgG		

Sign of Lab In-charge



महाराष्ट्र शासन

पुण्यश्लोक अहिल्यादेवी होळकर शासकीय वैद्यकीय महाविद्यालय, बारामती. जिल्हा-पुणे
Punyashlok Ahilyadevi Holkar Government Medical College, Baramati

Department of Microbiology

Lab ID:	MRD. No.	Date: / /2025
Patient name		
Age:		
Gender:		
OPD/IPD		
Investigation	AFB (Z-N) staining / TRUENAT MTB	
Result		
Signature of the In-charge		



सहाय्य शाला

Punyashlok Ahilyadevi Holkar
Government Medical College, Baramati
Department of Microbiology
Bacteriology section

LAB ID: MRD. NO. DATE OF SAMPLE RECEIVED : / / 2025
DATE OF REPORTING : / / 2025

PATIENT NAME

AGE:

GENDER:

OPD/IPD

CLINICAL DIAGNOSIS

HISTORY OF
ANTIBIOTICS GIVEN

INVESTIGATION

RESULT

Signature of the In-charge



महाराष्ट्र शासन

पुण्यश्लोक अहिल्यादेवी होळकर शासकीय वैद्यकीय महाविद्यालय, बारामती. जिल्हा-पुणे

Punyashlok Ahilyadevi Holkar Government Medical College, Baramati.

Department of Microbiology

Mycology section

Lab ID:

MRD. No.

Date:- / /

Patient name

Age:

Gender:

OPD/IPD

Investigation

(KOH Mount)

Result

Signature of the In-charge



Punyashlok Ahilyadevi Holkar
Government Medical College, Baramati
Department of Microbiology
Bacteriology section

LAB ID: **U-43** MRD. NO:

DATE OF SAMPLE RECEIVED : / /2025

DATE OF REPORTING : / /2025

PATIENT NAME		
AGE:		
GENDER:		
OPD/IPD		
CLINICAL DIAGNOSIS		
HISTORY OF ANTIBIOTICS GIVEN		
INVESTIGATION		
Organism Isolated	1)	
	2)	
Antibiotic sensitivity	Sensitive	Resistant

Signature of the In-charge

DEPARTMENT OF RADIODIAGNOSIS AND IMAGING GOVERNMENT
MEDICAL COLLEGE & GENERAL HOSPITAL, BARAMATI

U. S. G. REPORT OF ABDOMEN

Date : / /20

Name _____ Age _____ Sex _____

CLINICAL DIAGNOSIS

1. LIVER

Size : Normal/Enlarged/Reduced
Surface : Normal / Nodular
Echotexture :
Focal Lesions :
Portal Vein : C. B. D.

2. GALL BLADDER

Distensibility :
Wall Thickness : (N-3 mm.)
Gall stones :

3. PANCREAS

Echotexture :
Size :
Calcification :
Pancreatic Duct :
Splenic Vein :

4. SPLEEN

Size : Normal / Enlarged/Reduced
Echotexture :
Focal Lesions :
Hilum :

5. KIDNEYS	RIGHT	LEFT
Size	CC x AP x Trans.	CC x AP x Trans.
CM Difference	Poor / Fair / Good	Poor / Fair / Good
C. Thickness		
H. Nephrosis		
Calculi		
Any other findings		

6. URINARY BLADDER

Distensibility :
Wall Thickness : (N-3 mm.)
Calculi :

7. PROSTATE / UTERUS

8. E/O FREE FLUID / Lymphadenopathy

9. OTHER FINDINGS :

ULTRASONOLOGIST.

**GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL,
(WOMEN'S HOSPITAL) BARAMATI, DIST. PUNE.**

DEPARTMENT OF RADIOLOGY

Patients Name _____ Age _____ yrs.

Name of Referring by Doctor _____ Date : _____

USG OBSTETRICS

LMP :

EDD by LMP :

Uterus is gravid and shows, single _____ defined intra uterine gestational sac

Fetal pole seen of CRL measuring _____ mm corresponding to estimated gestational

Age of _____ weeks _____ days.

Foetal cardiac activity is present, Fetal heart rate is _____ bpm.

Secondary Yolk is seen and appears normal. Decidual reaction is good.

Placenta is _____ with lower end _____ cm away from internal os.

Internal OS is closed Cervical length measures _____ cm.

No obvious collection or subchorionic haemorrhage is noted around the sac

Bilateral adnexa are normal

No Collection noted in the cul de sac

EDD by USG :

IMPRESSION :

- * Single, Live, early intra uterine pregnancy of average gestational age of _____ week _____ day +/-1 by USG.
- * ADV. : Follow up scan at _____ weeks.

Radiologist

GOVERNMENT MEDICAL COLLEGE & GENERAL HOSPITAL,
(WOMEN'S HOSPITAL) BARAMATI, DIST-PUNE.

DEPARTMENT OF RADIOLOGY

Patient's Name : _____ Age : _____ yrs.

Referring by Doctor : _____ Date : _____

OBSTETRICS SONOGRAPHY

LMP : _____

GA by LMP : _____

E/o Single Live intrauterine gestation with Changing / Vertex / Breech Presentation :

Foetal Parameters

BPD _____ mm _____ Wks _____ days

HC _____ mm _____ Wks _____ days

AC _____ mm _____ Wks _____ days

FL _____ mm _____ Wks _____ days

Placenta _____

Grade _____ Maturity _____

Cardiac Activity _____

Foetal Movements _____

Amniotic Fluid is Adequate

AFI : _____

Internal os is Closed.

Cervical length measures _____ mms.

No e/o any gross congenital anomalies.

E.D.D. By USG _____

Foetal wt. _____

Impression : Single live Intrauterine Foetus.

of average gestational Age of _____ Wks _____ days.

Radiologist

**GOVERNMENT MEDICAL COLLEGE AND GENERAL HOSPITAL
BARAMATI, DISTRICT PUNE**

Radiology Department

Venous Doppler of Lower Limbs

(A) GSV :-

(1) SFJ

(2) Varicosities

(3) Perforators

(B) SSV :-

(1) SPJ

(2) Varicosities

(3) Perforators

Impression :-

Radiologist

Assessment of Permanent Physical Impairment in Amputation

Score Sheet

Based on Form B (Assessment Proforma for Amputation)

Date:

Name:

Gender: Male/ Female

Age:

Based on Gazette: 2018 Gazette Notification Ministry of Social Justice & Empowerment. GOI, Regd No: DL3300/99
(Extra Ordinary Part II) Section 3 Sub Section (II) January 5 2018 Appendix II Form B Page No 109.

Amputation

Upper limb	Left	Right
Fore quarter amputation (100%)		
Shoulder Disarticulation (90%)		
A/E upto upper 1/3 of arm (85%)		
A/E upto lower 1/3 of arm (80%)		
Elbow Disarticulation (75%)		
B/E upto upper 1/3 of arm (70%)		
B/E upto lower 1/3 of arm (65%)		
Wrist Disarticulation (60%)		
Hand through carpel bones (55%)		
Thumb through CM/MCP joint (30%)		
Thumb Disarticulation through Proximal Phalynx (25%)		
Thumb Disarticulation through Distal Phalynx or IP (15%)		
Index Finger-		
PP/MCP- (15%)		
Mp/PIP (10%)		
DP/DIP (5%)		

Middle Finger	Left	Right
PP/MCP- (5%)		
Mp/PIP (4%)		
DP/DIP (2%)		

Ring Finger	Left	Right
PP/MCP- (3%)		
Mp/PIP (2%)		
DP/DIP (1%)		
Little Finger	Left	Right
PP/MCP- (2%)		
Mp/PIP (1%)		
DP/DIP (1%)		

Lower Limb	Left	Right
Hind quarter amputation (100%)		
Hip Disarticulation (90%)		
A/K upto upper 1/3 of thigh (85%)		
A/K upto lower 1/3 of thigh (80%)		
Knee Disarticulation (75%)		
B/K upto upper 1/3 of thigh (70%)		
B/K upto lower 1/3 of thigh (60%)		
Ankle Disarticulation (55%)		
Syme's Amputation (50%)		
Chopart's Amputation (40%)		
Lis Franc (30%)		
All Toes (20%)		
Loss of first toe (10%)		
Loss of second toe (5%)		
Loss of third toe (4%)		
Loss of fourth toe (3%)		
Loss of fifth toe (2%)		
Amputation Additional Points	Left	Right
Stump unfit for prosthesis (5%)		
Dominant upper Extremity (10%)		
Stiffness of Proximal Joint /Neuroma/Infection (10%)		
Multiple Limb Involvement (Toes/Fingers) (5%)		
Multiple Limb Involvement (Beyond toes/fingers) (10%)		

Assessment of Permanent Physical Impairment in Spine / Neurological

Score Sheet

Based on Form B (Assessment Proforma for Spine)

Date:

Name:

Gender: Male/ Female

Age:

Based on Gazette: 2018 Gazette Notification Ministry of Social Justice & Empowerment. GOI, Regd No: DL3300/99

(Extra Ordinary Part II) Section 3 Sub Section (II) January 5 2018 Appendix II Form B Page No 109.

Spinal Affection Traumatic Affection

Cervical Traumatic lesions

1. 25% or more of compression (Post elements spared) (20%)
2. Posterior element damage with dislocation/subluxation-reduced dislocation (10%)
3. Posterior element damage with dislocation/subluxation-with fusion (10%)
4. Posterior element damage with dislocation/subluxation-inadequate reduction with persistent pain (15%)
5. Posterior element damage with dislocation/subluxation-with instability and pain

Cervical Disc Lesions

1. Treated case with persistent pain but no deficit (10%)
2. Treated case with persistent pain and instability (15%)

Thoracic Traumatic Lesions

1. Compression of single body less than 50% without deficit (10%)
2. Compression more than 50% with posterior element, no pain
3. Instability with fractures/dislocations with persistent pain

Lumbar Traumatic Lesions

1. Compression less than 25% (one or two vertebra) without deficit (10%)
2. Compression more than 25% with posterior elements involved and pain (20%)
3. Instability with pain (30%)

Lumbar Disc Lesions

1. Treated case with persistent pain (10%)
2. Treated case with persistent pain and instability (20%)
3. Treated case with persistent pain and moderate lifestyle modification (25%)
4. Treated case with persistent pain and severe lifestyle modification (30%)

Spinal Affection Scoliosis

Scoliosis

1. Cobb's angle 10-20(1-5%)
2. Cobb's Angle 21-30(6-9%)
3. Cobb's Angle 32-50(10-19%)
4. Cobb's Angle 50-75(20-29%)
5. Cobb's Angle 76-100(30-39%)
6. Cobb's Angle 101-125(40-60%)
7. Cobb's Angle 120 or more (more than 60%)

Scoliosis extra Points

1. Maximum Chest Expansion
2. More than 4cm-Nil
3. 3 to less than 4cm-5%
4. 2 to less than 3cm-10%
5. 1 to less than 2cm-15%
6. Less than 1cm-20%

OR

Single Breath Count

1. More than 40-Nil
2. 31-40-5%
3. 21 to 30-10%
4. 11 to 20-15%
5. 5 to 10-20%
6. Less than 5-25%

Scoliosis More Extra Points

1. Torso Imbalance
2. Deviation of plumb line upto 1.5cm (4%)
3. Deviation of plumb line 1.6 to 3.0cm (8%)
4. Deviation of plumb line 1.3 to 5.0cm (16%)
5. Deviation of plumb line 5.1cm and above (32%)
6. Head tilt over C7 spine upto 15deg (4%)
7. Head tilt over C7 spine more than 15deg (10%)

Associated problems

1. Pain
2. Mildly interfering with ADL (6%)
3. Moderately restricting ADL (6%)
4. Severely Restricting ADL (10%)

Cosmesis

1. No Disfigurement with clothes on (Nil)
2. Mild Disfigurement (2%)
3. Severe Disfigurement (4%)

Leg Length Discrepancy

1. First half inch shortening (Nil)
2. Every half inch thereafter (4%)

Spinal Affection Kyphosis

1. Less than 40deg (Nil)
2. 40-50deg (10%)
3. 51-60deg (20%)
4. 61-70deg (30%)
5. 71-80deg (40%)
6. 81-90deg (50%)
7. 91-100deg (60%)

Deviation of Plumbline

1. Less than 5cm in front of ankle (40%)
2. 6-10cm on front of ankle (8%)
3. 10-15cm in front of ankle (16%)
4. More than 15cm in front of ankle (32%)

Spinal Affection Miscellaneous Medical Conditions

1. Pain (Nil)
2. Pain, spasm, stiffness, mild radiological changes (20%)
3. Pain, spasm, stiffness, moderate radiological changes (25%)
4. Pain, spasm, stiffness, severe radiological changes (30%)
5. Pain, spasm, stiffness, severe radiological changes in whole spine (40%)

Spinal Affection Neurological Deficit

Motor

1. Quadriplegia (90%)
2. Paraplegia (75%)
3. Cauda Equina Syndrome without B/B involment (40%)

Sensory

1. Anesthesia (10% for each limb)
2. Hypoesthesia (depending upon loss of sensation)
3. Paraaesthesia (up to 30% depending upon loss of sensation)
4. Hand and feet sensory loss (depending upon loss of sensation)

Bladder

1. Mild (Hesitancy/Frequency) (25%)
2. Moderate (Precipitancy 50%)
3. Severe (recurrent incontinence) (75%)
4. Very severe (Retention/Total incontinence) (100%)

Ataxia

1. Mild (less than 40%)
2. Moderate (40-60%)
3. Severe (greater than 60%)

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Assessment of Permanent Physical Impairment in Lower Limb

Score Sheet:

Based on Form B (Assessment Proforma for lower extremity) in Appendix II

Date: Name: Age: Gender: Based on Gazette :

GAZETTE NOTIFICATION Ministry of Social Justice & Empowerment, GOI, Regd No. DL33004/99 (Extraordinary) Part II, Sec. 3, Subsection(ii) January 5, 2018, Appendix II Form B Page 109

Division Name	Max Val	Sub Division	Sub Divn particulars	Normal Value (Std) %	Observed Value Rt	Observed Value Lt
Active ROM (Range of movement)	90%	Hip Joint AROM	Flexion	125		
			Extension	15		
			Abduction	45		
			Adduction	30		
			Rotation – Extnl	45		
			Rotation – Intl	40		

Knee Joint AROM	Flexion	135		
	Hyper Extension	10		

Foot and Ankle AROM	Dorsiflexion	20		
	Plantar flexion	50		
	Inversion	35		
	Eversion	25		
	Abduction	10		
	Adduction	20		
	Toes Movement #	100		

Division Name	Max Val	Sub Division	Sub Divn particulars	Normal Value (Std)	Observed Value Rt	Observed Value Lt
Muscle Strength	90%	Hip Joint Muscle Strength	Flexion	5		
			Extension	5		
			Abduction	5		
			Adduction	5		
			Rotation – Extnl	5		
			Rotation – Intl	5		

Knee Joint Muscle Strength	Flexion	5		
	Extension	5		

Foot and Ankle Muscle Strength	Dorsiflexion	5		
	Plantar Flexion	5		
	Inversion	5		
	Eversion	5		
	Abduction	5		
	Adduction	5		
	Toes Strength #	5		

Lower Limb Stability Component (SC)

Division Name	Max Val	Sub Division	Sub Divn particulars	Normal Value (Std)	Observed Value Rt	Observed Value Lt
Stability related	90%	Walking on plain surface		10		
Activities		Walking on slope		10		
(Clinical Method)		Climbing Stairs		10		
10 for Normal		Standing on both legs		10		
0 for not possible		Standing on affected leg		10		
		Squatting on floor		10		
		Sitting Cross leg		10		
		Kneeling		10		
		Taking turns		10		

Extra Points

Non Limited Extra Points

* 4% per 1/2 inch after 1/2 inch	Depends	Shortening in inches	0.00				
----------------------------------	---------	----------------------	------	--	--	--	--

10% Limited Extra Points

0 / 3 / 6	Deformity (Functional 3, Non functional 6)	0.00		
0 / 3 / 6 / 9	Pain (Mild 3, Mod 6, Severe 9)	0.00		
0 / 3 / 6	Loss of Sensation (Complete 9, Partial 6)	0.00		
0 / 3 / 6	Complications (Superficial 3, Deep 6)	0.00		

Assessment of Permanent Physical Impairment in Upper Limb

(Score Sheet of Impairment in upper limb function)*

Name

Age

Date

Gender

Issued on GAZETTE NOTIFICATION Ministry of Social Justice & Empowerment, GOI, Regd No. DL33004/99 (Extraordinary) Part II, Sec. 3, Subsection(ii) January 5, 2018, Appendix II Form A Page 107

Division 1: Active ROM

Upper Limb Arm Component

Weightage: Shoulder 20, Elbow 20, Wrist 20 and Hand 40 Total Max value 90

Weightage: Shoulder 20, Elbow 20, Wrist 20 and Hand 40 Total Max value 90						
Sub Division	Max. Value	Area	Area particulars	Normal Value (Std) \$	Observed Value Rt	Observed Value Lt
AROM Arm Component excluding Hand joints	50	Shoulder Joint Active ROM MLS	Flexion	180		
			Extension	50		
			Abduction	180		
			Adduction	50		
			Internal Rotation	80		
			External Rotation	90		
Elbow Joint Active ROM MLE			Flexion Extension arc	150		
			Pronation	80		
			Supination	85		
Wrist Joint MLW			Flexion	80		
			Extension	70		
			Radial deviation	20		
			Ulnar deviation	50		

Contd Division 1: Active ROM

Upper Limb Arm Component:

Weightage: Shoulder 20, Elbow 20, Wrist 20 and Hand 40 Total Max value 90

Ray of Hand	Raywise Weightage	Area	Area particulars	Normal Value (Std) \$	Observed Value Rt	Observed Value Lt
Thumb Movements WT 30/55		Thumb CMC Joint	Abduction	70		
			Flexion	15		
			Extension	20		
			Opposition (Full = 100)	100		
		Thumb MCP Joint	Flexion	50		
		Thumb IP Joint	Flexion	80		
Index Finger Movements WT 15/55		Index MCP Joint	Flexion	90		
			Extension	30		
		Index PIP Joint	Flexion	90		
			Index DIP Joint	Flexion	90	
					Hyper Extension	10
Middle Finger Movements WT 5/55		Middle Finger MCP Joint	Flexion	90		
			Extension	30		
		Middle Finger PIP Joint	Flexion	90		
			Middle Finger DIP Joint	Flexion	90	
					Hyper Extension	10
Ring Finger Movements WT 3/55		Ring Finger MCP Joint	Flexion	90		
			Extension	30		
		Ring Finger PIP Joint	Flexion	90		
			Ring Finger DIP Joint	Flexion	90	
					Hyper Extension	10
Little Finger Movements WT 2/55		Little Finger MCP Joint	Flexion	90		
			Extension	30		
		Little Finger PIP Joint	Flexion arc	90		
			Little Finger DIP Joint	Flexion	90	
					Hyper Extension	10

Upper Limb Arm Component:						
Division 2: Muscle Strength		Maximum value 90				
Sub Division	Max. Value	Area	Area particulars	Normal Value (Std) \$	Observed Value Rt	Observed Value Lt
Strength Loss Shoulder SLS		Shoulder Joint	Flexion	5		
			Extension	5		
			Rotation - Ext	5		
			Rotation - Int	5		
			Abduction	5		
			Adduction	5		

Strength Loss Elbow SLE		Elbow Joint	Flexion	5		
			Extension	5		
			Pronation	5		
			Supination	5		

Strength Loss Wrist SLW		Wrist Joint	Dorsiflexion	5		
			Palmar Flexion	5		
			Radial Dev.	5		
			Ulnar Dev.	5		

Upper Limb Arm Component:						
Division 3: Coordinated Activities		Maximum value 90				
Sub Division	Max. Value	Activities	Normal Value (Std) \$	Observed Value Rt	Observed Value Lt	
Coordinated Activities	90	Lifting overhead objects (Remove and place at same level)	9			
		Touching nose with end of extremity	9			
		Eating Indian Style	9			
		Combing and Plaiting	9			
		Putting on a shirt/kurta	9			
		Ablution glass of water	9			
		Drinking Glass of water	9			
		Buttoning	9			
		Tie Nara Dhoti	9			
		Writing	9			

Assessment of Permanent Physical Impairment in Upper Limb

(Score Sheet)

Date :

Name :

Age :

Gender :

Upper Limb		Hand		Component		
Group Name	Max. Value	Sub Group	Sub-Group particulars	%Normal Value (Std) in %age	Observed Value Rt	Observed Value Lt
Prehension PLH	30					
2 or 3 or 5 = Possible or Normal 0 = Not possible		Opposition	Against Index	2		
			Against Middle	2		
			Against Ring	2		
			Against Little	2		
		Lateral Pinch Cylindrical Grasp	Holding Key	5		
			4 " dia object	3		
			1 " dia object	3		
		Spherical Grasp	4 " dia object	3		
			1 " dia object	3		
		Hook Grasp	Lift Bag	5		

Group Name	Max. Value	Sub Group	Sub-Group particulars	%Normal Value (Std) in %age	Observed Value Rt	Observed Value Lt
Sensations NLH	30					
4.8 or 1.2 = Normal Sensation 0 = Absent or Altered Sensation		Thumb	Radial Side	4.8		
			Ulnar Side	1.2		
		Index Finger	Radial Side	4.8		
			Ulnar Side	1.2		
		Middle Finger	Radial Side	4.8		
			Ulnar Side	1.2		
		Ring Finger	Radial Side	4.8		
			Ulnar Side	1.2		
		Little Finger	Radial Side	4.8		
			Ulnar Side	1.2		

Group Name	Max. Value	Sub Group	Sub-Group particulars	%Normal Value (Std) in %age	Observed Value Rt	Observed Value Lt
Strength SLH	30					
4 % per grade of 1 to 5 2 % per grade of 1 to 5		Grip Strength	Wt = 20	20		
		Pinch Strength	Wt = 10	10		

Upper Limb – Additional Weightage[‡]

Description	Wt	Particulars	Normal Value (Std)	Observed Value Rt	Observed Value Lt
Non Limited Additional Weightage					
10% for Yes / 0 for No	0 / 10	#REF!	Yes or No	No	No
* 2% / inch after 1 inch	Depends	Shortening in inches	0.00		
10% Limited Additional Weightage					
(In arm component)	0 / 3 / 6	Deformity (Functional 3, Non functional 6)	0.00		
	0 / 3 / 6 / 9	Pain (Mild 3, Mod 6, Severe 9)	0.00		
	0 / 3 / 6	Loss of Sensation (Complete 9, Partial 6)	0.00		
	0 / 3 / 6	Complications (Superficial 3, Deep 6)	0.00		