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List of Forms for Patient Medical Record

This checklist covers the list of forms/formats to be maintained in patient medical records/patient files. The hospital may add or delete any of these documents, as deemed relevant to its practice and scope of services. Certain topics included in the checklist may be combined into a single format and need not necessarily be maintained as separate individual formats. The hospital may decide which formats are to be combined and which are to be maintained separately, based on its requirements. All consents and patient medical records should be as per the requirements of the law of the land.

List of Forms for Patient Medical Record:

- Patient Registration form
- Admission request form
- General consent form
- Transfer in- transfer out/ referral form
- Initial assessment form for OP, IP, Day care, ER, physiotherapist, dietitians
- Pain Screening and Assessment Format
- Nutritional screening and assessment tool
- Care Plan format
- Reassessment form for nursing staff, doctors, physiotherapists, dietitians
- Early warning sign format
- Handover form for doctors and nurses
- Lab requisition form
- Blood transfusion consent form
- Anaesthesia /Sedation consent and Monitoring form
- Surgery/ Procedure consent form
- Pre anaesthesia check-up form
- Operation Notes
- Post Anaesthesia recovery form
- WHO safe surgery checklist
- Discharge summary format

Disclaimer

The content of the E-mitra is intended to serve as a sample and guide for better understanding the NABH Entry Level Standards. It is not prescribed by NABH as the exclusive or only way to meet the standards. Healthcare organizations are encouraged to adapt and modify the materials according to their own scope of services and operational needs. NABH is not liable for any misinterpretations or errors resulting from the unmodified use of this material, or for any non-compliance during assessments that may arise because of such actions.