REQUEST FOR ADMISSION

Please admit Mr./Ms		Father's / Husband's Name:	
Age…… (Yrs.) Sex ……..	UHID No.	Date of Admission:	Time of Admission
Payer Category -	□ CASH □ CORP. □ TPA □ INTL.		
Payment Details _____			
Room Category		Under Dr. :	
Provisional Diagnosis			Allergies
Procedures and Treatment Contemplated: Expected Length of Stay :		MLC : Yes/No IF Yes : Inside MLC / Outside MLC No. : ……	
T.P.A. Yes/No.		Auth. Letter Enclosed Yes/No	

Instructions for Staff Nurse						
Inform me and my Resident/ Register/ Dr. _____						
Diet	NBM	Liquid	Repeated	Diabetic	Renal	Others
	Soft Solid	Normal	Cardiac	Salt Free	Hepatic	
(B) Lab. Investigations		(D) Radiological Investigations		Medications		
Special Instructions (If any)				Pre-op Instructions (If applicable)		
Att. Name_____ Relation_____ Phone No._____						

Please tick as appropriate: □Preventive □Diagnosis □Curative □Palliative □Rehabilitative	
Name of Consultant/Authorised Signatory:	Signatures: Date & Time:

GENERAL CONSENT FOR ADMISSION

I,_____, □the Patient, or □ (representative of patient) _____, have (please tick the correct option above and below)

- read
- been explained this consent form in _____(name of language) which I fully understand.

I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me,

I consent and authorize the hospital, treating doctors, nursing, technical & paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor/team.

I also consent for insertion of peripheral venous catheters and administration of necessary drugs, medications, intravenous fluids, as advised by the treating doctor/ team.

I also consent to use of assistants such as resident doctors, other doctors, nurses, & other healthcare workers including trainees by the hospital and treating doctor/ team.

I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.

I understand that the hospital will take due care of me/ my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and/or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed and informed consent shall be taken by treating team or responsible team.

I declare that, I have & will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise

due to non– disclosure of relevant information on my part.

I declare that I have been explained about my rights and responsibilities as a patient as outlined in the patient handbook.

Instruction: All pages (Part A & Part B) to be printed together in a single Booklet form, on an A3 or a similar Sheet and NOT as separate sheets

I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.

I also consent and agree to the use and/or publication of my treatment details/ medical record for medical, scientific or educational purposes (Teaching, research & academics) provided the pictures or the descriptive texts accompanying them do not reveal my identity.

I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital/healthcare organization, as considered appropriate by my treating doctor.

I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

I declare that I have received & fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

I, the above named Patient/named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this

form, mentally sound and am giving consent without any fear, threat or false misconception.

Signed on _ _/_ _/_____at AM/PM

	Signature/ Thumb Impression	Name
Patient		
Surrogate/Guardian (if applicable[#]		(Write name & relationship with patient)
Reason for Surrogate consent	Patient is unable to give consent because:	
Witness		
Interpreter (if applicable)		

#only if Patient is a minor or unable to give consent

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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.