

Name of patient

1  
Age

I.P. Number

Ward / Unit

Name of Patient

Age

IP No

**HEALTH SERVICES DEPARTMENT,  
GOVERNMENT OF KERALA**

**HOSPITAL:**

**Ward No:**

**Bed No:**

**CASE RECORD**

ALLERGIC TO :

UHID :  
(Unique Health ID)

ICD Code Number:

Date of Admission :

Date of Discharge :

MLC : Yes  No

(Printed and supplied by Hospital Management Committee/ Society)

*Name of Hospital*

Name of patient

2  
Age

I.P. Number

---

### **Instructions to Doctors and staff directly involved in documentation**

- **Keep the record neat and clean**
- Case record is the only written evidence of what the physician has accomplished to the patient.
- All columns relevant to the case should be documented legibly, promptly and completely.
- Events / services rendered not recorded assumed as not done.
- Final diagnosis should be justifiable with treatment and end results and should record in scientific terms.
- In death cases both Direct cause and Antecedent causes should be specifically noted in the Case record, Death register Death notification and report forms.
- Whoever/whenever/whatever write in the Case record, should authenticate their statements with their name, designation and dated signature.

**The information contained in this case record is confidential and should not be disclosed to any person other than treating doctor or other healthcare providers like nurses and paramedics. The information may be given directly to patients if they request in writing. Parents of children below 18 years may be given the information, if needed.**

Name of Medical Records Officer :

Name of Medical Records Librarian :  
(or officer in charge of Medical Records)

---

*Name of Hospital*

Name of patient

3  
Age

I.P. Number

O.P. number:

**SUMMARY SHEET**

Head of Service / Unit Chief	Ward	Unit	Admission	
			Date	Time
Name of patient: (in block letters)	Sex	Occupation	Monthly income	
Address:				
Date of Birth	Year	Month	Date	

**BPL: Yes / No**

Diagnosis	ICD Code Number (by MRD Staff)

Surgery if any  
( specify nature of surgery/ procedure)

If Delivered, date and time of delivery: \_\_\_\_\_ Sex of baby: \_\_\_\_\_  
Weight : \_\_\_\_\_

Date and time of Discharge : \_\_\_\_\_

\_\_\_\_\_  
If referred to another institution, name of that institution:  
Cause of Referral :

\_\_\_\_\_  
If died, Cause of death 1. Direct cause :  
(in block letters )  
2. Antecedent cause :

Date and Time : \_\_\_\_\_

**DISCHARGE SUMMARY**  
(or a copy of the discharge card may be attached)

Signature, Name and designation of M.O

\_\_\_\_\_  
*Name of Hospital*

Name of patient

4  
Age

I.P. Number

Contact number of patient / Guardian

**സമ്മതപത്രം**

തീയതി :

ഈ ആശുപത്രിയിൽ.....തീയതി പ്രവേശിപ്പിക്കപ്പെട്ട ഞാൻ...../  
ട്രിയാളിന്റെ ബന്ധുവായ ഞാൻ എഴുതിക്കൊടുക്കുന്ന സമ്മതപത്രം.

ഈ ആശുപത്രിയിലെ സൗകര്യങ്ങൾ വച്ച് എന്നെ / ടി രോഗിയെ, രോഗകാരണം കണ്ടുപിടിക്കുന്നതിനും ചികിത്സിക്കുന്നതിനും ആവശ്യമായ ശാരീരിക പരിശോധനകൾ നടത്തുന്നതിനും മരുന്നുകൾ പ്രയോഗിക്കുന്നതിനും വേണ്ടി വന്നാൽ രക്തം കുത്തിവയ്ക്കുന്നതിനും മയക്കുമരുന്നും നൽകി ശസ്ത്രക്രിയ നടത്തുന്നതിനും പൂർണ്ണമായും സമ്മതിച്ചുകൊള്ളുന്നു.

രോഗി :

ബന്ധു :

ഒപ്പ് :

ഒപ്പ് :

പേര് :

പേര് :

മേൽവിലാസം :

രോഗിയുമായുള്ള ബന്ധം

**സത്യപ്രസ്താവന**

എന്റെ പ്രതിമാസ വരുമാനം.....രൂപയാകുന്നു. പുനർപരിശോധനയിൽ വരുമാനം കുടുതലാണെന്ന് തെളിഞ്ഞാൽ നിലവിലുള്ള നിയമപ്രകാരം ആശുപത്രിയിൽ ഒടുക്കേണ്ടിവരുന്ന തുക ഞാൻ ഒടുക്കിക്കൊള്ളാമെന്നതാണ്.

തീയതി :

ഒപ്പ് : രോഗി :

/ ബന്ധു :

പേര് :

ഈ ആശുപത്രിയിൽ ചികിത്സയിലായിരുന്ന ഞാൻ ...../.

എന്ന രോഗിയെ സ്വന്തം ഇഷ്ടപ്രകാരം കൊണ്ട് പോകുന്നു. ഇതുകൊണ്ട് ഉണ്ടാകാവുന്ന ഭവിഷ്യത്തുകൾ ഉള്ളപ്പറ്റി ചികിത്സിക്കുന്ന ഡോക്ടർ പറഞ്ഞു മനസ്സിലാക്കി തന്നിട്ടുള്ളതും അങ്ങനെയുണ്ടാകുന്ന തകരാറുകൾക്ക് ഞാൻ മാത്രം ഉത്തരവാദിയുമാകുന്നു.

തീയതി :

ഒപ്പ് : രോഗി :

/ ബന്ധു :

പേര് :

Name of Hospital

Name of patient

5  
Age

I.P. Number

---

Present Complaints	Duration

**History of illness**

---

**Past History**

*(gestational / birth history in the case of infants)*

---

**Family history**

---

**Immunization**

---

**Socio-economic status**

---

**Personal History**

Smoking

Alcohol

Chewing

Vegetarian

Non vegetarian

---

**Other details**

<b>H/O Allergy</b>	
--------------------	--

Current Medication if any

---

*Name of Hospital*

Name of patient

6  
Age

I.P. Number

---

**PHYSICAL EXAMINATIONS**

General examination

Pulse /min	Respiration /min	BP mmHg	Height cm	Weight kg	

Sensorium : Conscious/ Drowsy / Comatose

Pallor : Yes/ No

Jaundice: Yes/ No

Cyanosis: Yes/ No

Oedema: Yes/ No

Clubbing: Yes/ No

Hair :

Skin :

Nails :

---

**Systemic Examination:** (Respiratory system/ Cardiovascular system/ Central Nervous system/ Alimentary system/ Genito-urinary system/ Musculoskeletal system/ Endocrine system/ Lymphatic system)

Other examinations

Provisional Diagnosis	
--------------------------	--

---

*Name of Hospital*

Name of patient

7  
Age

I.P. Number

---

**CLINICAL INVESTIGATION REPORTS**

	Date	Value	Date	Value	Date	Value
<b>Blood Hb</b>						
T C						
D C						
E S R						
Bleeding time						
Clotting time						
Platelet count						
<b>Blood Sugar</b>						
F B S						
P P B S						
R B S						
Cholesterol						
<b>Renal Function</b>						
Urea						
Creatinin						
Sodium						
Potassium						
<b>Serum Bilirubin</b>						
<b>Blood grouping &amp; Rh typing</b>						
H B S Ag						
H I V						
<b>Urine</b>						
Albumin						
Sugar						
Acetone						
Bile Salt						
Bile Pigment						
Urobilirubin						
Deposits						

**RESULT OF HISTOPATHOLOGY EXAMINATIONS**

---

*Name of Hospital*

Name of patient

8  
Age

I.P. Number

---

**SPECIAL INVESTIGATION**

---

X – ray

---

E C G

---

Sonology: U S S

---

C T Scan

---

M R I

---

Other Investigations

**PLAN OF TREATMENT**

---

*Name of Hospital*

Name of patient

9  
Age

I.P. Number

---

**OBSTETRIC & GYNECOLOGY EXAMINATIONS**

Complaints

---

Family History

---

Previous History

---

Menstrual history: Age of onset

LMP

PMP

---

Inter menstrual symptoms

---

Menopause

---

Marital and Obstetric history

---

History of present illness

---

**General examination (Page 6)**

---

Pelvic Examination

---

Rectal examination

---

Provision Diagnoses

---

**Investigations: (Page 7 & 8 )**

**Treatment advised**

---

*Name of Hospital*



Name of patient

11  
Age

I.P. Number

---

**INFORMED CONSENT FOR SURGERY/ INVASIVE PROCEDURE**

Name and signature of the patient :

Name and signature of the relative:

Name, Designation and Signature of the doctor informed the patient:

**INFORMED CONSENT FOR ANESTHESIA**

Name and signature of the patient :

Name and signature of the relative:

Name, Designation and Signature of the doctor informed the patient:

---

*Name of Hospital*

Name of patient \_\_\_\_\_ 12 Age \_\_\_\_\_ I.P. Number \_\_\_\_\_

Name of patient: Verified  Site of Surgery: Verified

Side of Surgery: Verified

**REPORT OF SURGERY**

Name of Surgeon : \_\_\_\_\_ Date : \_\_\_\_\_  
Anesthesiologist: \_\_\_\_\_

Name of Nurse : \_\_\_\_\_

Pre-operative Diagnosis \_\_\_\_\_

Pre – operative medications \_\_\_\_\_

Surgery- Major/ Minor \_\_\_\_\_ Begins at : \_\_\_\_\_ Ended at : \_\_\_\_\_

**DESCRIPTION OF SURGERY**

Post Operative Assessment and plan of Treatment

Name, designation and  
Signature of Surgeon

\_\_\_\_\_  
*Name of Hospital*

Name of patient

13  
Age

I.P. Number

---

**PRE ANESTHESIA CHECK UP**

Date:

Time:

Planned procedure:

History

Physical Examination

PR /min		BP mm Hg		Pallor	
Icterus					
Airway					
Mouth opening					
TMJ Neck movements					
Mallampattic class					
Venous access					
Spine					

CVS

Respiratory System

CNS

Other systems

ECG/ X Ray and other investigations

Remarks

Instructions

---

*Name of Hospital*











Name of patient

19  
Age

I.P. Number

---

**SPECIAL CONSULTATIONS & REPORTS**

---

*Name of Hospital*

Name of patient

20  
Age

I.P. Number

---

**SPECIAL CONSULTATION & REPORTS**

---

*Name of Hospital*





Name of patient

23  
Age

I.P. Number

- Code**  
 Mouth  
 Rectal

### GRAPHIC SHEET

Name ..... Age ..... Ward ..... I.P. No .....

DATE																										
DAY POSTOP.																										
TEMP HOUR	A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.				
	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8
°C °F																										
106																										
41																										
105																										
40.5																										
104																										
40																										
103																										
39.5																										
102																										
39																										
101																										
38.5																										
100																										
38																										
99																										
37.5																										
98																										
37																										
97																										
36.5																										
36																										
PULSE	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
RESP	40																									
	30																									
	20																									
	10																									
INTAKE	7A.M.																									
	7P.M.																									
URINE	7A.M.																									
	7P.M.																									
STOOLS																										
DRAINAGE																										

Name of Hospital

Name of patient

24  
Age

I.P. Number

---

**GRAPHIC CHART & PAIN SCORE**

---

*Name of Hospital*

Name of patient

25  
Age

I.P. Number

HEALTH SERVICES DEPARTMENT, KERALA

..... Hospital , .....

DICHARGE CARD / DISCHARGE SUMMARY

Head of services Dr.	Department/Specialty	Head of the institution Dr.
-------------------------	----------------------	--------------------------------

Name of patient : Age      Sex  
 Address :

I. P Number Unit / ward

Date of admission Date of discharge

Other Specialists / Consultants attended the case

Final Diagnosis

Operation / delivery if any (*if delivery, date & time of delivery and sex of baby*)

Brief history and Clinical Notes

Investigations

Treatment

Advice on discharge

(To be reviewed on / after ..... at .....OPD)

Name & Designation of Medical Officer

( Keep this card clean and neat ; don't damage or destroy ; bring on subsequent visits )

Name of Hospital



Name of patient

27  
Age

I.P. Number

**(carbon copy- to be retained in the case sheet)**

HEALTH SERVICES DEPARTMENT , KERALA

..... Hospital , .....

**DICHARGE CARD / DISCHARGE SUMMARY**

Head of services Dr.	Department/Specialty	Head of the institution Dr.
-------------------------	----------------------	--------------------------------

Name of patient :

Age

Sex

Address :

I. P Number

Unit / ward

Date of admission

Date of discharge

Other Specialists / Consultants attended the case

Final Diagnosis

Operation / delivery if any (*if delivery, date & time of delivery and sex of baby*)

Brief history and Clinical Notes

Investigations

Treatment

Advice on discharge

*(To be reviewed on / after ..... at .....OPD)*

Name & Designation of Medical Officer

*Name of Hospital*

Name of patient

28  
Age

I.P. Number

---

---

*Name of Hospital*

---

***Back Cover (inside)*****General Instructions**

- Patients and/or family members should be explained about the proposed care, expected results, possible complications and expected costs.
- The initial assessment for in patients should be documented within 24 hours or earlier as per the patient's condition. The initial assessment should include screening for nutritional needs.
- Document plan of care including preventive aspects of care, which should be monitored.
- All patients should be reassessed at appropriate intervals and documented, to determine their response to treatment and to plan further treatment or discharge.
- Care of patients should be coordinated in all care settings within the organization.
- Patient discharge process should be planned in consultation with the patient and/or family.
- Summary of patient condition and the treatment given should be provided in case of transfer or referral of patients.
- A discharge summary should be given to all the patients leaving the organization, including patients leaving against medical advice at the time of discharge.
- Discharge summary should contain the reason for admission, significant finding, diagnosis, investigation results, any procedure performed, medication and other treatment given, patient condition at the time of discharge, follow up advice, medication and other instruction in an understandable manner.
- Discharge summary incorporates instructions about when and how to obtain urgent care.
- The care and treatment orders should be signed, named, timed and dated by concerned doctor.
- The care plan should be countersigned by clinician in charge of the patient within 24 hours.
- Evidence based medicine and clinical practice guidelines are adopted to give patient care whenever possible.
- Admission or discharge to home or transfer to another organization should also be documented.
- In case of cardiopulmonary resuscitation the events should be recorded.
- Informed consent should be obtained for donation and transfusion of blood and blood products.
- In case of transfusion reactions, it should be analyzed for preventive and corrective actions.
- Infection control practices should be followed
- High risk obstetric patient's assessment also includes maternal nutrition.
- Assessment of children should include detailed nutritional, growth, psychological and immunization assessment.
- The children's family members should be educated about nutrition, immunization and safe parenting and this should be documented in the medical record.
- All patients for anesthesia should have a pre anesthesia assessment by a qualified doctor.
- The pre anesthesia assessment should result in formulation of an anesthesia plan which should be documented.
- An immediate pre operative re evaluation should be documented.
- Informed consent for administration of anesthesia should be obtained by the anesthesiologist.
- Surgical patients should have a preoperative assessment and provisional diagnosis documented prior to surgery.
- An informed consent should be obtained by a surgeon prior to the procedure.
- A brief operative note should be documented prior to transfer out of patient from recovery area.
- Surgeon documents the post operative plan of care. The plan also includes monitoring of surgical site infection rates.

---

*Back Cover*

- Medication orders should be clear, legible, dated, timed, named and signed. Orders are written in uniform location in the medical records.
  - High risk medication orders should be verified prior to dispensing.
  - Expiry date of drugs should be checked prior to dispensing.
  - Patient should be identified prior to dispensing. Dosage, route and time should be verified from the order prior to administration. Medication administration should be documented.
  - Patient and family members should be educated about safe and effective use of medication and food drug interactions.
  - Patients are monitored after medication administration. Any adverse drug events should be reported within a specified time. Adverse drug events should be collected and analyzed.
  - A proper record should be kept of the usage, administration and disposal of narcotic drugs and psychotic substances.
  - Chemotherapy should be prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy. Chemotherapy should be prepared and administered by qualified personnel. Chemotherapy drugs should be disposed off in accordance with legal requirements.
  - General consent for treatment should be obtained when patient admitted to the hospital.
  - Informed consent includes information on risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.
  - Patient and families should be educated about the safe and effective use of medication and the potential side effects of the medication.
  - Patients and families should be educated about diet and nutrition, immunization, specific disease process, complications, prevention strategies and preventing infections. Patients and family should be taught in a language and format that they can understand.
  - Patients and family should be educated about estimated costs of treatment. Patients and family should be informed about the financial implications, when there is a change in the patient condition or treatment setting.
  - Every medical record should have a unique identifier. Every medical record entry should be dated and timed.
  - When patient is transferred to another hospital, the medical record contains the date of transfer, the reasons for the transfer and the name of the receiving hospital.
  - The medical records should contain information regarding reasons for admission, diagnosis and plan of care.
  - Operative and other procedures performed should be incorporated in the medical records.
  - The medical records should contain a copy of the discharge note duly signed by appropriate and qualified personnel.
  - In case of death, the medical records should contain a copy of the death certificate indicating the cause, data and time of death.
  - Whenever medical autopsy is carried out, the medical records should contains a copy of the report of the same.
-