NWH PATIENT REGISTRATION FORM

Eligibility Card * ❑ Health Card/ White Card ❑Journalist Card ❑Temporary House Hold Card *(Select the type of Card)*					
Is Patient Family Head ❑ *(Select this check box)*		Health Card / White Card No *: ❑❑❑❑❑❑❑❑❑❑❑❑❑❑/❑❑ *(Insert Card number)*			
PATIENT DETAILS					
Card Issue Date: * *(Select Date of Card issue from Calender)*	Name :* *(Insert Name of the patient)*	Gender:* ❑ M ❑F *(Select Gender)*	DOB:* *(Select date of Birth from calender)*	Age: (x)	Card PIC
Relationship with family Head:* (Select the relation of patient with)	Caste :* OC/BC/SC/ST/Minorities/ Others	Occupation:*	Contact Number :*		
Card address		Communication Address ❑ If card and communication address are same click here			
House No: *	Street: *	House No: *	Street: *		
District: (x)	Mandal :*	District: (x)	Mandal :*		
Village: *	Hamlet: *	Village: *	Hamlet: *		
Pincode: *		Pincode: *			
Source : ❑ Direct ❑ PHC ❑Health camp					

CASE DETAILS		
Hospital Name: * (x)	Source No: * *(Insert Referral card number)*	Date of Registration: * (x)
❑ Exemption Check		
Exemption reasons : * *(Select one of the exemptions reasons)*	Remarks : *(insert remarks)*	
Hand:* *(Select Left / Right hand)*	Fingers : * *(Select the finger)*	Capture Finger Print

SUBMIT

CMCO PATIENT REGISTRATION FORM (MITHRA)

Registration Type* : New/ Existing	CMO Reference No *: ❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑			
PATIENT DETAILS				
Card Issue Date: ** (Select Date of Card issue from Calender)*	Name :**(Insert Name of the patient)*	Gender:* ❑ M ❑F *(Select Gender)*	DOB:* *(Select date of Birth from calender)*	Age: (x)
Relationship with family Head:* (Select the relation of patient with)	Caste :* OC/BC/SC/ST/Minorities/ Others	Occupation:*	Contact Number :*	

Card address		Communication Address ❑ If card and communication address are same click here	
House No: *	Street: *	House No: *	Street: *
District: (x)	Mandal :*	District: (x)	Mandal :*
Village: *	Hamlet: *	Village: *	Hamlet: *
Pincode: *		Pincode: *	
ID Proof * : (Select form the drop down list)		ID No*:	

❑ Exemption Check		
Exemption reasons : * *(Select one of the exemptions reasons)*	Remarks : *(insert remarks)*	
Hand:* *(Select Left / Right hand)*	Fingers : * *(Select the finger)*	Capture Finger Print

SUBMIT

CMCO PATIENT REGISTRATION FORM (DOCTOR)

Registration Type* : New/ Existing	CMO Reference No *: ❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑

PATIENT DETAILS

Card Issue Date: ** (x)*	Name :**(x)*	Gender*: *(x)*	DOB:* *(x)*	Age: (x)
Relationship with family Head:* (x)	Caste :*(x)	Occupation:*(x)	Contact Number :*(x)	

Card address		Communication Address ❑ If card and communication address are same click here	
House No: *(x)	Street: *(x)	House No: *(x)	Street: *(x)
District: (x)	Mandal :*(x)	District: (x)	Mandal :* (x)
Village: *(x)	Hamlet: *(x)	Village: *(x)	Hamlet: *(x)
Pincode: *(x)		Pincode: *(x)	
ID Proof * : (x)		ID No*: (x)	

❑ Exemption Check	
Exemption reasons : * *(x)*	Remarks : *(x)*
Hand*: (x)	Fingers*: (x)

Case Details

Patient Type: CMO Patient	Referral date: (Select from the calender)	Type *: ❑Referred ❑Non referred

If Type: Referred

Complaint*: (Insert complaint)	Diagnosis*: (Insert diagnosis)
Referred Hospital*: (Select the hospital name from the dropdown)	Category*: (Select the Category from the dropdown)
Subcategory*: (Select the Subcategory form the dropdown)	Surgery /Therapy*: (Select the list form dropdown

If Type :Non Referred

Complaint*: (Insert complaint)	Diagnosis*: (Insert diagnosis)
Hospital*: (Select the hospital name from the dropdown)	Opinion of he Doctor*: (Insert the Opinion of the doctor)
Advice Given*: (Insert the Advice given)	

Submit Cancel

PATIENT REGISTRATION FORM (TELEPHONIC REGISTRATION)

Eligibility Card * ❑ Health Card/ White Card ❑Journalist Card ❑Temporary House Hold Card *(Select the type of Card)*					
Is Patient Family Head ❑ *(Select this check box)*	Health Card / White Card No *: ❑❑❑❑❑❑❑❑❑❑❑❑❑❑/❑❑ *(Insert Card number)*				
PATIENT DETAILS					
Card Issue Date: * *(Select Date of Card issue from Calender)*	Name :**(Insert Name of the patient)*	Gender:* ❑ M ❑F *(Select Gender)*	DOB:* *(Select date of Birth from calender)*	Age: (x)	Card PIC
Relationship with family Head:* (Select the relation of patient with)	Caste :* OC/BC/SC/ST/Minorities/ Others	Occupation:*	Contact Number :*		

Card address		Communication Address ❑ If card and communication address are same click here	
House No: *	Street: *	House No: *	Street: *
District: (x)	Mandal :*	District: (x)	Mandal :*
Village: *	Hamlet: *	Village: *	Hamlet: *
Pincode: *		Pincode: *	

CALLER FORM HOSPITAL DETAILS	
Hospital Name*: (Select from the list)	Caller name*: (Insert Caller name)
Designation *: (Insert Designation)	Phone Number *: (Insert the Mobile Number)

PROVISIONAL APPROVAL DETAILS	
Category*: (Select the category form the list)	Sub Category*: (Select the Subcategory form the list)
Surgery*: (Select the surgery form the list)	Indication for Telephonic intimation*: (Insert the Remarks)

PROVISIONAL APPROVAL GIVEN BY			
Name of the Doctor*: (Insert doctor Name)	Designation*: (Insert doctor Designation)	Phone Number*: (Insert the doctor Phone Number)	
Remarks*: This is a Provisional Approval given for_____ (insert the procedure) Procedure for _____(Insert the Diagnosis) based on the indication stated by the treating doctor over phone. The Preauthorization has to be raised with in 72 Hrs with complete clinical and documentary evidence , from the Telephonic Intimation ID only.			Date*: (x)

Submit

IP/OP REGISTRATION FORM

MEDICAL DETAILS					
Complaints*: *(Select form list)*	Patient Complaint*: (Insert patient complaint)*	History of Present illness*: (Insert history of present illness*)			
Past History*: *(Insert past history)*	Examination findings *:(Insert examination findings)		Provisional diagnosis*: (Insert Provisional Diagnosis)		
Investigations *: (Select from list)	Patient Diagnosed By *: (Select from list)	Doctor Name*: (Select from list)	Registration No: (x)	Qualification *:(x)	
Mobile Number*: (x)	Patient Type*: (Select Inpatient / Out Patient)				
If Patient Type: Inpatient					
IP No*: (Insert IP number)	Admission Type*: (Select Planned/ Emergency)	Admission Date*: (x)			
Final Diagnosis *: (Insert Final diagnosis)	Prescription*: (Insert prescription)				
If Patient Type: Out Patient					
OP Number *: (Insert Outpatient number)	Date of OP*: (x)	Final Diagnosis*: (Insert final diagnosis)	Prescription:* (Insert prescription details)		

Submit Cancel

LANDING PAGE (CASE DETAILS)

CASE LANDING PAGE				
Name (x), Gender (x), Age(x)	Card No:(x)	District (x)	On bed Photo	Card PIC
Mandal (x)	Village (x)	Contact No:(x)		
Case No: (x)	Claim No: (x)	Telephonic Intimation details: (x)		
NWH Name: (x)	IP No: (x)	IP Registration date : (x)		
Category: (x)	Procedure : (x)	Case Status (x)		

IP	Past History	Attachments	Clinical notes	Preauth Details	Claim	Fraud

IP TAB

REGISTRATION DETAILS			
Card Issue Date : (x)	Caste: (x)	Occupation : (x)	Relationship with family head: (x)
Card Address		Communication Address	
House no: (x)	Street : (x)	House no: (x)	Street : (x)
Hamlet : (x)	Village : (x)	Hamlet : (x)	Village : (x)
Mandal : (x)	District : (x)	Mandal : (x)	District : (x)
Con tact No: (x)	Referral Card Number: (x)	Source: (x)	

ADMISSSION DETAILS		
Patient complaint: (x)	History of Present illness: (x)	Past History: (x)
Examination findings: (x)	Investigations: (x)	Provisional Diagnosis: (x)
Final Diagnosis (x)	Admission Type: (x)	Date of Admission: (x)

TREATING DOCTOR DETAILS		
Patient Diagnosed by : (x)	Doctor Name: (x)	Doctor Regn no: (x)
Qualification : (x)	Mobile No: (x)	

PAST HISTORY TAB

CARD UTILISATION HISTORY												
Case No	**Name**	**Reg Dt**	**Phase**	**Policy Period**	**Preauth status**	**On bed status**	**Case status**	**Claim paid cost**	**Pkg Price**	**Category**	**Sub Category**	**Therapy**

HOSPITAL HISTORY													
NWH Details													
NWH Name: (x)		Address: (x)							Contact no: (x)				
Bed Details													
Hospital Bed Capacity: (x)						Current Bed Capacity: (x)							
Specialities Empanelled													
Speciality 1													
Specilaity 2													
Score Card													
Speciality Name	Surgery/ Therapy Name	No of Preauths Approved				Surgeries Performed				Discharges			
		Lst 24 hrs	Lst 1 week	Lst 1 month	Lst 1 Year	Lst 24 hrs	Lst 1 week	Lst 1 month	Lst 1 Year	Lst 24 hrs	Lst 1 week	Lst 1 month	Lst 1 Year
Grand Total													
Speciality 1	Total												
	Procedure 1												
	Procedure 2												
	Procedure 3												
Speciality 2	Total												
	Procedure 1												
	Procedure 2												
	Procedure 3												

Clinical Notes TAB

Admission Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Admission									

Pre-Op Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Pre-Op									

Surgery Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Surgery									

Surgeon Details			
Name:	Regn No:	Qualification:	Contact Number:
Asst Surgeon Details			
Name:	Regn No:	Qualification:	Contact Number:

Paramedic Name:	Nurse Name:	Floor :	Room No:	Expected Hospital Stay:

Anesthetist Details:

Anesthetist Name:	Regn No:	Contact No:
Surgery Date:	Surgery In time:	Surgery Outtime:

Add attachments | Surgery photos | Surgery Attachments

Treatment Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Treatment									

Treating doctor Details:			
Name:	**Regn no:**	**Qualification**	**Contact no:**

Paramedic Name:	Nurse Name:	Floor :	Room No:	Expected Hospital Stay:

Treatment Protocol:

Drugs

S.No	No of Days	Total	Drug Name	Batch Number	Expiry Date	Morning	Afternoon	Evening	Bed Time	Quantity per day

Post -OP Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Post -Op									

Discharge Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Discharge									

Treatment given*: (Insert treatment given)	Operative findings*: (Insert operative findings)	Post operative period*: (Insert remarks)
Post Surgery/Therapy special investigations given: (Insert remarks)	Status at the time of Discharge*: (Insert the status of the patient)	Review: (Insert review)
Advice : (Insert Advice given)	❑ Discharge ❑ Death	
Discharge Date*: (Select the discharge date from calendar)	Next follow up Date*: (Select the discharge date from calendar)	
Consult at Block Name*: (Insert the block name)	Floor *: (Insert floor number)	Room no*: (insert Room Number)

Save | Submit | Add Discharge Photo | Add Discharge Summary | Add Letters

Drugs

S.No	No of Days	Total	Drug Name	Batch Number	Expiry Date	Morning	Afternoon	Evening	Bed Time	Quantity per day

Death Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Death									

Treatment given*: (Insert treatment given)	Operative findings*: (Insert operative findings)	Post operative period*: (Insert remarks)
Post Surgery/Therapy special investigations given: (Insert remarks)	Status at the time of Discharge*: (Insert the status of the patient)	Review: (Insert review)
Advice : (Insert Advice given)	❑ Discharge ❑ Death	
Discharge Date*: (Select the discharge date from calendar)	Next follow up Date*: (Select the discharge date from calendar)	
Consult at Block Name*: (Insert the block name)	Floor *: (Insert floor number)	Room no*: (insert Room Number)

Save | Submit | Add Death Photo | Add Death Summary | Add Letters

Follow up Notes

Clinical ID	Date & time	Ward		Status	BP	Pulse Rate	Temp	Respiratory Rate	Heart sounds	Lungs	Fluid In	Fluid Out	Daily Progress Notes
		RAMCO	NAM										
				Follow Up									

Drugs

S.No	No of Days	Total	Drug Name	Batch Number	Expiry Date	Morning	Afternoon	Evening	Bed Time	Quantity per day

Next follow up Date*: (Select the discharge date from calendar)	Consult at Block Name*: (Insert the block name)	Floor No: (Insert the Floor number)	
Block No*: (Insert the block name)	Consultant Name*: (Insert the consultant name)	Mobile Number*: (Insert mobile number)	Designation*: (Insert designation)

Submit Cancel Add reports Add attachments Add Photos