|  |  |  |
| --- | --- | --- |
| Treatment information |  | Check List |
| **Please furnish** all the Original Medical Documents in relation to the Patient Care. Treatment Charts / Operation Notes / Discharge Summary / Bills etc. Each document / bill should be signed by the Patient / the Doctor in charge of the Patient and the Hospital Administrator. Since Medical and Financial Audit is mandatory in Healthcare Services, we request you to follow a set pattern in Medical Examination / Clinical Investigation / Treatment regime / Medical documentation and Billing, It is mandatory that the charges collected or the Bills produced for payment is itemized, detailing the Healthcare Services rendered. Please forward the documents neatly filled in addressed Hospital File**.** | | |
| Name of the Patient: |  |  |
| Policy No | Validity: | From\_\_\_\_\_\_\_\_\_\_\_\_\_\_to |
| Date of Admission: |  | Date of Discharge |
| Diagnosis: |  |  |
| Hospital Name |  | Telephone number/s |
| Address: |  |  |
|  | City: | Pin Code |
| Fax no | E- mail: | Website: |
| Name Doctor in charge |  | Email ID |
| KMC Registration No |  | Mobile: |
| Investigation Details: |  |  |
| Procedure Done: |  |  |
| Treatment Details: |  |  |
| O T Charges: |  |  |
| Medicines charges: |  |  |
| Ward Charges: |  |  |
| Nursing Charges: |  |  |
| Other services (if any): |  |  |
| Remarks: |  |  |
| We state that the treatment given, bills submitted are genuine and was absolutely necessary for the ailment suffered | | |
|  | | |
| **Signatures.** Patient | Doctor in Charge | KMC Reg. No |
|  |  |  |
| Hospital Administrator |  |  |
| Place: | Date: | Establishment Rubber Stamp |