GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

PAEDIATRIC ADMISSION SLIP

Hospital Name						District		
Patient's Name:						MRD No./UHID No.		
Age:		Gender	M	F	O	Ward No.		
Father's/Mother's/Guardian's Name						Bed No.		
Address:						Date of Admission		
Occupation:						Time of Admission		AM/PM
Contact No:						MLC:	Yes	No
Provisional Diagnosis:								
Admitting Physician						Emergency	Outpatient	

HISTORICAL EXAMINATION

1. Patient's Chief Complaint (with onset/Duration):

2. History of Present Illness:

3. Relevant and Significant Past History:

4. Developmental History:

5. Treatment History/Present Medication (if any):

6. Any Relevant Family History:

7. Dietary History:

8. Socio-Economic History:

PHYSICAL EXAMINATION

Weight		% Expected		Head Circumference		% Expected	
Height/Length		% Expected		Appearance			
Mental Health				Build			
Hair		Pallor		Cyanosis		Icterus	
Clubbing		Koilonychia		Oedema		Skin	
Jugular Vein Pressure		Lymph Nodes		Thyroid		Tongue	
Teeth		Gums		Lips		Buccal Cavity	
Pharynx				Tonsils			
BP			PR			RR	

Any other abnormalities: _____

1. Systemic Examination:

a) Respiratory System:

b) Cardiovascular System:

c) Abdomen:

d) Central Nervous System:

2. Provisional Diagnosis:

3. Laboratory Investigation (if any):

a) **Blood: CBC, LFT, KFT, Electrolytes, Lipid Profile, Uric Acid, Amylase & Lipase, Widal, Weils Felix, Typhidot, MP (Smear/QBC), C/S, RBS (Fasting/ PP)**
b) **CRP/ASO/RAF:**
c) **TSH/T3/T4:**
d) **S.Ferritin/D-Dimer/LDH, Trop-T, Trop-I :**
e) **HBsAg, HCV, Retro:**
f) **Sputum for AFB, CBNAAT, C/S:**
g) **Urine: R/E, M/E, C/S**
h) **Stool: R/E**
i) **X-Ray:** **e) USG:**
f) **CT Scan/MRI:**
g) **Others:**

4. Rx and Advice: **ICD Code:**

5. Name of Medical Officer/Admitting Physician: _____

6. Signature & Seal of the Medical Officer/Admitting Physician: _____.

7. Date: _____.

8. Consent for Treatment:

Informed Consent

Patient's/Relative's General Consent: I/we agree to get myself/my/our relative admitted under this Hospital _____ to undergo Examination/Investigation/Operation/Treatment as decided by the Hospital authorities and I am to also abide by the Schedule of changes, rules and regulations as they arise and as desired by the Hospital/Hospital Authority.

Patient's Signature:_____

Signature of Relative/Responsible person: _____

Date: _____

Ka Jingmynjur

Ka Jing ai jingbit jong U/Ka Nongpang/Bahaiing Nongpang: Nga u Nong pang ne Nga (U/Ka Bahaiing jong u/ka Nongpang) nga mynjur ba ka Hospital kan ai ia ka/ki jingsumar na ka bynta ka jingkoit jingkhiah jong nga/(U/Ka bahaiing jong nga) kat kum ki jingpynbeit na ka hospital. Nga/Nga (U/ka Bahaiing u/ka Nongpang nga) kular ba ngan iai neh bad kino kino ki jingkylla ha ki rukom sumar kat kum ka jingpynbeit bad jing donkam jong ka hospital na ka bynta ka koit ka khiah jong nga/(u/ka bahaiing jong nga).

Ka Shap (Signature) U/Ka Nongpang:_____

Ka Shap (Signature)jong U/Ka Bahaiing jong U/Ka Nongpang: _____

Tarik: _____

Ma'sigrikeSonggigrikani

Sagipamandeni/ma'drangmahariniku'monggrike see joteon'ani: Angaan'tangko/angni/chingnima'drangbakskako, ia _____ hospitalo, dongesannabannagitaku'mongnangrime, see on'enga. Be'entangko, sabisikosandienina/ be'ennisabisikoporikka ba be'enko rate (operation) sannanikodakna, mamungbanengnikani ba champenganigripakwateon'enga. Anga/chingahospitalkochalaidilenggiparangniniamreti-rangkomamungnengnikanigrianjariknaku'rachakera'enga.

Sagipanisoi/bimung: _____

Ma'drangnisoi: _____

Tarik: _____

Name of Medical Officer/Admitting Physician: _____

Signature & Seal of the Medical Officer/Admitting Physician: _____.

Date: _____.