MRD CHECK LIST

S.NO.	NAME	YES	NO
		✓	
1	UHID NO.	✓	
2	OPD NO.	✓	
3	OPD FILE	✓	
4	IPD	✓	
5	PATIENT TIME	✓	
6	PATIENT AGE	✓	
7	NUTRITION ASSCEMENT	✓	
8	ADMISSION	✓	
9	PANCHKARMA CANCENT	✓	
10	PROCEDURE DETAILS	✓	
11	COVIDE-19	✓	
12	DISCHARGE FILE	✓	
13	TEST REQUEST FORM	✓	
14	PROGRESS NOTE	✓	
15	VITAL CHART	✓	
16	PAIN SCORE	✓	
17	DAILY FEEDBACK FORM	✓	
18	DAILY MEDICINE CHART	✓	

Shuddhi

Jeena Sikho Lifecare Pvt. Ltd.

(CHAIN OF 160 SUPER SPECIALITY AYURVEDA CLINIC & 2 HOSPITALS)

Dr. Ajeet
BAMS

ORTHOCARE
- Joint Pain
- Cervical Pain
- Low Back Ache

PANCHKARMA
- Detoxification
- Rejuvenation
- Shirodhara, Shiro Basti
  Shiro Pichu
- Kati Basti, Prishta Basti
  Janu Basti
- Akshi Tarpana
- Nasya
- Basti
- Abhyanga
- Swedanam

GASTOCARE
- Acidity
- Constipation
- Liver Treatment

FACILITY
- Steamer
- Panchkarma Room
- Ayurvedic Treatment

Name:
W/o, D/o, S/o:
Chief Complain
History

Menstrual History

Diagnosis:

अष्टविध परिक्षा
स्पर्श
शब्द
Face (आकृति)
Eye (दृष्टि)
Jiwha (जिह्वा)
Urine (मूत्र)
Stool (मल)
Nadi (वात , पित, कफ)

(Dash Vidha)

1. Prakrutii
2. Vikruti
3. Sara
4. Samhana
5. Pramana
6. Satmya
7. Satva
8. Aahar Shakti
9. Vaya
10. Vyayam Shakti

Vitals:

B.P.:

Weight.:

Height:

RBS.:

NEXT CONSULATION DATE:.....

Awana Complex, Sector 49, Main Road Barola, Near Yamaha Vihar,
Opposite Dominos, Noida, Uttar Pradesh - 201307

+91 93136 66680

Shuddhi AYURVEDA

JEENA SHIKHO LIFECARE PVT LTD

(A Unit of Jeena Sikho Lifecare Pvt.Ltd)
Awana Complex, Sector 49, Main Road Barola, Noida-201307, UP

Nutritional Assessment Form

I. Identifying Information

Full Name: _____ *Date :*_____

UHID No : _____ *Age:*_____ *Sex :* _____

Ethnicity: Hindu ☐ Muslim ☐ Christian ☐Sikh ☐ Jain ☐ Tribe ☐ Other: - ☐

*Referring Clinician:*_____

*Reason(s) for visit:*_____

II. Medical History (please give full details)

- Diabetes YES/NO HBA1c.....since.....Medication
- HTN YES/NO Last recorded value .....since.....medication
- CAD YES/NO STENT/BYPASS/MEDICINE SINCE...MEDICATION
- THYROID YES/NO REPORTS.....SINCE.....MEDICATION
- MENTRUAL HISTORY MENSTRUALCYCLE.....MEDICATION

Are you allergic to any food or drink? Yes or No

If yes, please specify: -_____

Do you get a rash or edema from your allergy? Yes or No

Do you take any vitamins, minerals and/or food supplements? Yes or No

*If yes, which ones*_____

Have you had any major injuries, hospitalizations, or operations? Yes or No

If yes, what _____

Do you have any chronic illnesses? Yes or No

If yes, please explain_____

(Examples. Shortness of breath, Heartburn, Constipation, Excessive thirst, Headaches, Pain,bleeding etc)

Do you take any medications on a regular basis? Yes or No

If yes, what medication and what dosage_____

Please explain about

- Appetite :
- Food habits :
- Daily working hours:
- Exercise :
- Job profile :
- Height :
- Weight :

Have you ever been diagnosed or do you suffer from anxiety? Yes or No

If yes, please explain_____

Have you ever been diagnosed or do you suffer from depression? Yes or No

If yes, please explain_____

Have you ever been diagnosed or do you suffer from an eating disorder, such as, anorexia, bulimia, or binge eating? Yes or No

If yes, please explain_____

Doctor Signature	Patient Signature

Jeena Sikho Lifecare Pvt. Ltd.

Shuddhi AYURVEDA

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UHID..... OPD..... Room No..... Date.....

ADMISSION & DISCHARGED RECORD (Day Care)

Name Of Patient (रोगी का नाम) .....

Name Of Father/Husband(पिता/पति का नाम) .....

Date Of Treatment(उपचार की तिथि).....Time of Treatment(उपचार का समय)..... Age(उम्र)..... Sex(लिंग) .....

Assistant Doctor (सहायक उपचारक) .....

Doctor Incharge(संचालक उपचारक).....

Treatment end Date(उपचार समाप्ति तिथि) ..... Time End Of Treatment (उपचार का समय समाप्त).....

Operation (If Any) .....

Procedure(प्रक्रिया).....

Diagnosis(रोग निश्चय).....

Address & Phone No.(पता एवं फोन नं.) .....

.....

Result	Cured/Relived	Investigation Only	Expired

Payment :- CASH_____TPA Name/No._____GOVT.Insurance._____

UNDER TAKING FOR TREATMENT INVESTIGATION & FINANCE ETC.

I am getting admitted on day care basis at Jeena Sikho Lifecare Ltd. at my own risk and i am ready for the ayurveda treatment. I am giving my consent after understanding benefit and out come of treatment. the information given by me are absolutely correct .

मैं अपनी मर्जी से जीना सीखो लाइफ केयर लिमिटेड क्लिनिक मे दिवसीय उपचार के लिए भर्ती हो रहा/रही हूँ | मैं तैयार हूँ मेरे साथ होने वाली आयुर्वेदिक चिकित्सा पद्धति के लिए ,और मैं सब कुछ सोच कर एवं चिकित्सा से होने वाले फायदा और परिणाम को समझ कर करवा रहा/रही हूँ एवं मैंने जो विवरण दिया है वह पूर्णत: सही है |

Dated (दिनांक)..... Attendent (प्रत्यक्षी).....

Signature (हस्ताक्षर)..... Relationship with Patient (रोगी के साथ सम्बंध).....

Terms & Conditions

1. I have opted on my own for admission into this clinic and will pay the bills as clinic rules and regulations.
2. The management reserves the right to admit or discharge the case amendment /modify rules,regulation and the charges without notice or assigning any reason there of .
3. The facilities provided in the room are maintained in working order but any failure in their functioning does not affect the charge and the management accepts no liability for the same. The Clinic accepts no responsibility for any loss or inconvenience caused by strike, lock out, water, telephone,electricity and air-conditioning failure etc.
4. Patients are advise not be bring any valuable or any jewellery or any other luggage with them. The Clinic will not be responsible for any loss or theft .
5. Suggestions/complaints may be given in writing at the reception.
6. All bills to be paid in cash, govt. insurance/TPA / private insurance/ cheque's are not accepted.

नियम व शर्तें

1. मैंने इस क्लिनिक में प्रवेश के लिए अपना खुद का चयन किया है और क्लिनिक के नियमों और विनियमों के अनुसार बिल का भुगतान करूँगा /करुँगी |
2. प्रबंधन नियमों को संशोधित करने का अधिकार सुरक्षित रखता है एवं विनियम और बिना किसी पूर्व सूचना के शुल्क या किसी भी |
3. कमरे में उपलब्ध सुविधाएँ कामकाजी क्रम में रखी जाती है लेकिन उनके कामकाज में कोई विफलता चार्ज को प्रभावित नहीं करती है और प्रबंधन इसके लिए कोई देयता स्वीकार नहीं करता है | क्लिनिक स्ट्राइक, लॉक आउट, वॉटर , टेलीफोन ,बिजली और एयर कंडीशनिंग विफलता इत्यादि के कारण होने वाली किसी भी हानि या असुविधा के लिए कोई ज़िम्मेदारी स्वीकार नहीं करता है
4. मरीजों को सलाह दी जाती है की वे उनके साथ कोई मूल्यवान या कोई आभूषण या कोई अन्य समान ना लाएं | अत: क्लिनिक किसी भी नुकसान या बकाया के लिए जिम्मेदार नहीं होगा |
5. रिसेप्शन पर लिखित में सुझाव/शिकायते दी जा सकती है |
6. सभी बिलों का भुगतान नकद में किया जाता है टीपीए /निजी बीमा / सरकारी बीमा आदि | चैक नहीं लिया जाता है |

Dated (दिनांक).....

Signature (हस्ताक्षर).....

Relationship of Patient (रोगी से सम्बंध).....

Witness(प्रत्यक्षी).....

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Panchkarma Consent

UHID..... OPD..... Room No..... Date.....

Patient's Name (रोगी का नाम) .....

Father's/ Husband's Name (पिता/पति का नाम) .....

Date (दिनांक) ..... Age (उम्र) ..... Sex (लिंग) .....

Address & Phone no. (पता एवं फोन नं.).....

Risk (जोखिम) .....

Alternative (विकल्प) .....

हमें हमारी थैरेपी के बारे में पूर्णत: बता दिया गया है एवं थैरेपी के आने वाले उपद्रवों के बारे मे भी बता दिया गया है |

जैसे :-

घुटनों में सूजन	☐	झनझनाहट	☐
पैरों में दर्द	☐	अकड़न	☐
पेट मे भारीपन	☐	सुन्नपन	☐
कमर में दर्द	☐	उल्टी	☐
दर्द में वृद्धि	☐	दस्त	☐
बुखार आना	☐	बी.पी कम होना	☐

आदि के बारे में डाक्टर द्वारा अवगत करा दिया गया है | मैं स्वत: अपनी इच्छानुसार अपनी होनी वाली थैरेपी ..... के बारे मे पूर्णत: ज्ञात होने के पश्चात इन्हें कराने के लिए तैयार हूँ | इसकी पूर्णत: ज़िम्मेदारी मेरी स्वयं की होगी |

- थैरेपिस्ट का नाम ..... थैरेपिस्ट हस्ताक्षर .....
- डाक्टर का नाम..... रोगी के हस्ताक्षर .....
- प्रत्याक्षी..... दिनांक.....

We are informed about the therapy & also about the complication in which e.g.....

Swelling in Joints	☐	Tingling sensation	☐
Pain in Legs	☐	Tenderness	☐
Tenderness in abdomen	☐	Numbness	☐
Backache	☐	Vomiting	☐
Increase pain	☐	Loose motion	☐
Fever	☐	Decrease B.P	☐

- After Explaining about the complication & the benefits I will be responsible for everything and give full permission to the doctors & the therapists to perform.....
- Therapist's Name: ..... Therapist's Signature .....
- Doctor's Name..... Patient's Signature.....
- Witness ..... Date .....

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UHID..... OPD..... Room No..... Date.....

PROCEDURE

I..... W/o, S/o, D/o.....

R/O.....

Date of Admission .....Age.....Sex.....

Has been clearly explained about the Procedure .....

By Dr.....

It have been clearly explained about the complications and other impacts of procedure by the doctor clearly in my own language. I have been explained about the expenses for the procedure clearly. I have been explained about the procedure and in case of any emergency or further referral to any higher centre, the required expenses in that case will be paid by me. I am giving my concent for the procedure mention about.

मैं.....पिता/पति का नाम.....पता .....

..... (दिनांक).....उम .....लिंग .....

डॉ .....ने मुझे मुझ पर होने वाली प्रक्रिया (थैरेपी) के बारे में पूर्णत: बता दिया है। जिसमें आने वाले उपद्रवो के बारे में भी मुझे मेरी भाषा में बता दिया गया है। यदि किसी भी थैरेपी के दौरान आई आपातकालीन स्थिति में मुझे किसी दूसरे बड़े अस्पताल एवं क्लीनिक में जाना पड़ता है तो इसका पूर्ण खर्चा मुझे स्वय वाहन करना होगा। मैं क्लीनिक के सारे नियम व कानून पढ़ चुका/चुकी हूं एवं मुझे बता दिया गया है और मैं अपनी स्वीकृति दे रहा/रही हूं।

Patient's Name (रोगी का नाम) .....

Signature (हस्ताक्षर).....

Date (दिनांक) .....

Place (स्थान) .....

Witness (प्रत्यक्षी).....

Doctor's Name (चिकित्सक नाम).....

Signature (हस्ताक्षर).....

Date (दिनांक).....

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Charges Concern Form

Name (नाम): ..... DOA (भर्ती की तारीख): .....

Age (उम्र)..... Sex (लिंग)..... UHID :..... OPD : .....

W/O, S/O, D/O (पिता|पति) : ..... Day Panchkarma:.....

Consultant Name (चिकित्सक नाम) :.....

Provisional Diagnosis(रोग निश्चय).....

Final Diagnosis(रोग विनिश्चय) : .....

1. Procedure details (प्रक्रिया विवरण): .....
2. Doctor Consultation Charges (चिकित्सक परामर्श शुल्क).....
3. Nursing Charges (नर्सिंग शुल्क).....
4. Package Charges Procedure wise

   A: .....

   B: .....

   C : .....

   D: .....

   E: .....

5. Doctor Fees (चिकित्सक शुल्क).....
6. Medicine (approx) costing :.....
7. Consumable (approx) charges :.....
8. Accessory (approx) charges : .....
9. Diet Charges (आहार शुल्क) :.....

Total Estimated Package Rs. [ ]

.....

Patient Signature

Receptionist Signature

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UHID..... OPD..... Room No..... Date.....

PROCEDURE

Patient's Name(रोगी का नाम) .....

Father's/Husband's Name (पिता/पति का नाम) .....

Date (दिनांक) ..... Age (उम्र) ..... Sex (लिंग) .....

Procedure Perform (प्रक्रिया).....

Provisional Diagnosis (रोग निश्चय).....

Final Diagnosis (रोग विनिश्चय) .....

Doctor Name (चिकित्सक नाम) .....

Therapist Name(सहायक नाम) .....

Details of Therapy :

Doctor's Name (चिकित्सक नाम).....

Date (दिनांक).....

Signature (हस्ताक्षर).....

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UHID..... OPD..... Room No..... Date.....

F.H.NO.

DISCHARGE FILE

Patient's Name (रोगी का नाम) ..... Age (उम्र)..... Sex (लिंग) .....

W/o, S/o, D/o(पिता|पति) .....

Address (पता) .....

Treatment Start Date (उपचार प्रारंभ दिनांक) ..... End Date of Treatment (उपचार की अंतिम तिथि).....

Treatment Start Time (उपचार प्रारंभ समय).....Treatment End Time (उपचार समाप्ति समय).....

Chief Consultant (मुख्य चिकित्सक) .....

CHIEF COMPLAINT AND HISTORY (मुख्य तकलीफ एवं उसका वृतान्त)

Past Medical History (पुराना चिकित्सा वृतान्त)

Family History (कुटुंब वृतान्त)

Pain Scale –

VitaParameters

- B.P
- P/R
- SUGAR
- WEIGHT
- HEIGHT

MENSTRUAL HISTORY

Astha Sthana Pariksha

1. NADI
2. MALA
3. MUTRA
4. JIWHA
5. SHABDA
6. SPARSHA
7. AKRUTI
8. DRIKA

Dash vidha Pariksha

1) Prakruti
2) Vikruti
3) Sara
4) Samhana
5) Pramana
6) Satmya
7) Satva
8) Agni
9) Vaya
10) Vyayam Shakti

INVESTIGATION EXAMINATION (जाँच)

DIAGNOSIS AND TREATMENT SUMMARY (रोग चिकित्सा वृतांत)

DIET ADVISE ON DISCHARGE (आहार निर्देष)

Follow up (दोबारा कब आना है) _____

CONDITION AT THE TIME OF DISCHARGE

Home ☐ Dead ☐ Referred ☐ Lama ☐

1. WHEN TO OBTAIN EMERGENCY CALL (आपातकालीन समस्या में सम्पर्क)
PH No.011-40199634 / 7428177717

A)

B)

C)

2. Medicine After Diseases (औषधि छुट्टी के बाद)

Dr. Name.....

Sign.....

Date.....

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Feedback Form (प्रतिक्रिया फॉर्म)

Name/नाम : ..... Age(आयु)..... Sex(लिंग).....

OPD: ..... UHID No.....

Address /पता: .....

Phone No./ फोन न.: ..... Email / ईमेल : .....

Name of Doctor /डॉक्टर का नाम: .....

Dear Sir/Madam,प्रिय महोदय/ महोदया

We want know your opinion. We would appreciate if you would spare us a moment of your valuable time in providing us your feedback regarding various aspects of medical care and hospitality that were extended to your stay here with us.

हम आपकी राय जानना चाहते हैं हम आप की सराहना करेंगे अगर आप हमें अपने मूल्यवान समय का एकक्षण देंगे जो हमें आपकी चिकित्सा, देखभाल और आतिथ्य के विभिन्न पहलुओं के बारे में आप की प्रतिक्रिया प्रदान करने में मदद करता है | जो हमारे यहाँ इलाज के दौरान अनुभव किया।

S.No	Services/ सेवाएं	Good / अच्छा Yes/ हाँ	Not good/ अच्छा नहीं No/नहीं
1.	Do you found ,Time period spent on your assessment is sufficient or not ?		
	आपकी जाच के लिए डॉक्टर के द्वारा दिया गया समय पर्याप्त है या नहीं ?		
2.	Explained about diagnosis and treatment ?		
	निदान और उपचार के बारे मे समझाया ?		
3.	How is work experience of staff ?		
	कर्मचारियों का कार्य अनुभव कैसा है ?		
4.	During your problem did employee or staff respond you on time or not ?		
	जब आप अपनी समस्या बताते हैं, तो कर्मचारी ठीक से सुनते हैं ?		
5.	Did staff treat you with dignity and respect ?		
	क्या कर्मचारी आप से गरिमा और सम्मान के साथ व्यवहार करते हैं ?		
6.	How would you feel during treatment ?		
	ईलाज के दौरान आपने कैसा अनुभव किया ?		
7.	Did you have confidence and trust in the staff ?		
	क्या आप कर्मचारी के कार्य क्षमता से संतुष्ट हैं ?		
8.	What one thing would you change about the department ?		
	इस विभाग में कोई एक भी ऐसी चीज जिस में आप सुधार चाहते हैं ?		
Your comments / आपके सुझाव			

Date: .....

Signature (Patient/Guardian)

Signature (Clinic Authority)

Signature (MD/MS)

Prakurti Chart Form

UHID..... Room No..... Date.....

Kindly add mental, behavioral, emotional and physical profile subtotals to attain the final total. The dash with the highest total is your mind body type.

		VATA		PITTA		KAPHA
MENTAL PROFILE						
Mental activity	☐	Quick mind restless	☐	Sharp intellect aggressive	☐	Claim stead stable
Memory	☐	Short-term best	☐	Good general memory	☐	Long –term best
Thoughts	☐	Constantly charging	☐	Fairly steady	☐	Steady stable fixed
Concentration		Short-learn focus best	☐	Better than average mental concentration	☐	Good ability for long term focus
Ability to learn	☐	Quick grasp of learning	☐	Medium to moderate grasp	☐	Slow to learn
Dreams	☐	Fearful flying running jumping	☐	Angry , fiery ,violent adventurous	☐	Includes water clouds relationship , romance
Sleep	☐	Interrupted light	☐	Sound ,medium	☐	Sound ,heavy long
Speech	☐	Fast sometimes missing words	☐	Fast sharp clear cut	☐	Sound ,clear ,sweet
Voice	☐	High pitch	☐	Medium pitch	☐	Low pitch
Mental profile						
Eating speed	☐	Quick	☐	Medium	☐	Show
Hunger level	☐	irregular	☐	Sharp need food when hungry	☐	Can easily miss meals
Food and drink	☐	Prefers warm	☐	Prefers cold	☐	Prefers dry and warm
Achieving goal	☐	Easily distracted	☐	Focused of driven	☐	Slow and steady
Giving/donation	☐	Gives small amounts	☐	Gives nothing or large amount infrequently	☐	Gives regularly and generously
Relationships	☐	Many casual	☐	Intense	☐	Long and deep
Sex drive	☐	Variable or law	☐	Moderate	☐	Strong
Works best	☐	White supervised	☐	Alone	☐	In groups
Weather preference	☐	Aversion to cold	☐	Aversion to heat	☐	Aversion to damps cool
Reaction to stress	☐	Excites quickly	☐	Medium	☐	Slow to get excited
Finances	☐	Doesn't save spends quickly	☐	(Save but big heat)	☐	Save regularly accumulates wealth
Friendship	☐	Tends towards short term friendship makes friends	☐	Tends to be a longer friends related to occupation	☐	Tends to form long lasting

Vata type	Dry to rough skin ,insomnia , constipation ,fatigue , headaches , intolerance of cold underweight or losing weight anxiety ,worry ,and restlessness , attention deficit with hyperactivity disorder .
Pitta type	Rashes inflammatory, skin condition, stomach ache, diarrhea, controlling and manipulative behavior, visual problems, excessive body heat, hostility irritability and excessive competitive drive.
Kapha type	Oily skin shows digestion, digestion, sinus congestion, nasal allergies, asthma, and obesity. Skin growths, possessiveness, neediness, apathy, depression, difficulty, paying attention.

INSTRUCTIONS FOR PANCHKARMA TREATMENTS

1. Warm and hot water for drinking.
2. Hot water for bathing.
3. Avoid day sleep.
4. Avoid awakening in night.
5. Pass natural urges (urine & stools) before Panchkarma treatments.
6. Don't suppress natural urges.
7. Don't do excessive workout exercise
8. Don't expose to clod air of hot sun.
9. Avoid stress and strain during treatment.
10. Don't travel on vehicles immediately after treatment.
11. Immediately after traveling or exercise should be not taking and panchkarma treatment.
12. Avoid coitus during treatment period.
13. Take proper rest during and after treatment.
14. During treatment patient should be kept on light and hot diet.

Jeena Sikho Lifecare Pvt. Ltd.

Shuddhi AYURVEDA

Awana Complex, Sector 49, Main Road Barola, Near Yamaha Vihar,
Opposite Dominos, Noida, Uttar Pradesh - 201307
+91 9313666680

VITAL CHART

Patient Name :..... Gender :..... DoA :..... UHID No. :.....

DATE	WEIGHT	TEMPERATURE	BLOOD PRESSURE	PULSE	RESPIRATION RATE	PAIN	SIGN

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+91 9313666680

Test Request Form

Name (नाम): ..... DOB (जन्म की तारीख): .....

Age (उम्र)..... Sex (लिंग)..... UHID :..... OPD : .....

W/O, S/O, D/O (पिता|पति) : ..... Day Panchkarma:.....

Provisional Diagnosis(रोग निश्चय).....

Confirm Diagnosis(रोग विनिश्चय) : .....

Name of Consultant (चिकित्सक नाम) :.....

Time of request .....Date.....

1. Lab.....

2. Radiology:.....

3. Scanning :.....

4. Markers :.....

Schedule time :	Information for test :

Request that my reports should not be share with anyone without my permission.

मैं अपनी पूर्ण इच्छा से डॉक्टर की सलाह पर अपनी जाँच की अनुमति प्रदान करता हूँ एवं अपनी जाँच का परिणाम की विनती करता हूँ की यह जाँच मेरी अनुमति के बिना सार्वजनित नहीं की जायें |

Signature :

Signature of Doctor/Nurse

Relation with Patient :

Shuddhi
AYURVEDA

Jeena Sikho Lifecare Pvt.Ltd.

Awana Complex, Sector 49, Main Road Barola, Near Yamaha Vihar,
Opposite Dominos, Noida, Uttar Pradesh - 201307
+91 9313666680

Daily Medication Schedule

UHID:________________ OPD________________ Date :________________

Patient Name :________________________ DOA:________________

Allergies :____

Consultant :________________________

PERSONAL MEDICATION RECORD		
Name :	Pharmacy:	Physician:
Name :	Pharmacy:	Physician:
Name :	Pharmacy:	Physician:
Name :	Pharmacy:	Physician:
Name :	Pharmacy:	Physician:

NAME OF DRUG	DOSE	DATE	TIME OF DRUG										

Shuddhi AYURVEDA

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Opposite Dominos, Noida, Uttar Pradesh - 201307

UHID: ..... OPD: ..... Room No. .....

PH No. +919313666680

PROGRESS NOTES

B.P. :

P/R :

Temp. :

Pain :

B.P. :

P/R :

Temp. :

Pain :

Shuddhi

Jeena Sikho Lifecare Pvt Ltd

Awana Complex, Sector 49, Main Road Barola, Noida, Uttar Pradesh - 201307

Covid-19 Mandatory Self Declaration Form

Name :.....**Date** :.....

Address :.....

.....

Age :.....**Contact Number** :.....**Gender :M/F**.....

OPD : ..... **IPD** ..... **UHID** : .....

Due to the ongoing and rapidly changing situation with the novel-corona virus (COVID-19), we are requiring all visitors to the Jeena Sikho Lifecare Pvt Ltd Clinic to fill-out the self-declaration form below.

Do you have any of the following flu-like symptoms?

Fever	Yes	No
Dry Cough	Yes	No
Sore Throat	Yes	No
Diarrhea	Yes	No
Breathlessness	Yes	No
Asthma	Yes	No
Other . Please specify	Yes	No

- History of travel in the recent one month nationally and internationally?

  _____

- Any contact history with a person who had returned from foreign country? If yes, please specify.

  _____

- Purpose of your visit. For consultation, Patient attendant/other reason?

  _____

- Have you come in contact with the covid-19 positive patient in last one month?

  _____

- Have you attend any gathering or visited any crowded market place in the last 14 days? If you, please specify.

  _____

- Are you taking any precautionary measures for boosting your immunity prior to coming? If you, please specify.

  _____

- Kindly share your status of Arogya Setu app? Red/Orange/Green.

  _____

I hereby assure that whatever information I have provided is correct and true to the best of my knowledge.

If I am an asymptomatic carrier or an undiagnosed patient with covid-19, I know it may endanger doctors and clinic staff. It is my responsibility to take appropriate precaution and to follow the protocols prescribed by them.

I also know that I may get an infection from the clinic or form a doctor and I will take every precaution to prevent this from happening but I will not at all hold Doctors and clinic staff accountable if such infection occurs to me or my accompanying persons.

JEENA SIKHO LIFECARE PVT LTD

(A Unit of Jeena Sikho Lifecare Pvt.Ltd)
Awana Complex ,Sector-49, Main Road Barola,Near Yamaha Vihar, Opposite Dominos ,Noida-201307, Uttar Pradesh

PAIN SCORING CHART

UHID: ..... IPD:..... OPD:.....

Name. ..... Age:..... Sex : .....

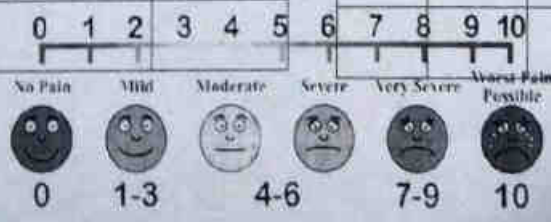
Consultant: ..... Date of admission : .....

Before Treatment

S.No.	Time	Date	Checked by	Pain Scoring

After Treatment

S.No.	Time	Date	Checked by	Pain Scoring



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