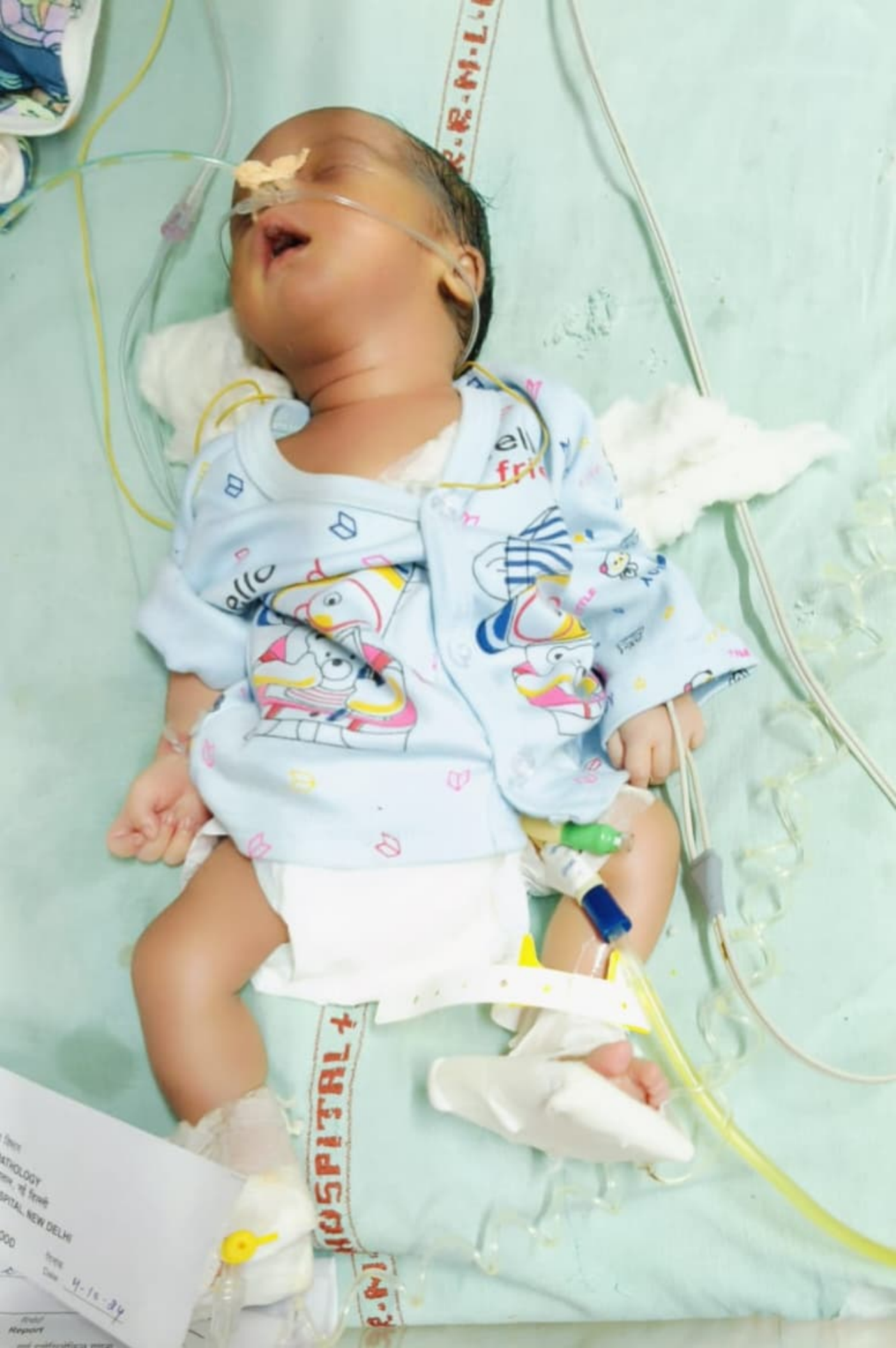
HOSPITAL

Name : B/o kiran के. पंजी. सं. CR No. 65478 पृष्ठ सं. Page No. 3

हिन्दी

ire .....

Grand Mother

ss of witnesses :—

..... 2. .....

.....

I CONFIRM THAT HAVE EXPLAINED THE NATURE AND EFFECTS OF THE OPERATION/TREATMENT THE PERSON WHO HAS SIGNED THE ABOVE CONSENT FORM.

Date :	SIGNATURE OF DOCTOR IN CHARGE NAME DESIGNATION

CONSENT FOR STOMA

हमें समझाया है कि तुम्हारे बच्चे की आँते सिकुड़ी है और पेट पर लेट्रीन का रास्ता निकालना पड़ सकता है

X. दादी
Grandmother

.tal Bihari Vajpayee Institute of Medical Sciences and
Dr Ram Manohar Lohia Hospital
Baba Kharak Singh Marg, New Delhi-110001

DOCTOR'S INITIAL ASSESSMENT SHEET

NT NAME: B/o Kiran AGE: 10 d 3 SEX: Male

D/O,W/O: C/o Ku CONTACT NO.:

NO./UHID: 65478 BED NO./WARD 4 / bed 30.

LC NO.(IF ANY) DATE: 3/10/24 TIME: 12:45 pm

ADDRESS:

Informant: Grandmother Reliable.

ADMITTED WITH COMPLAINT OF:

c/o bilious vomiting since birth
c/o abdominal distension since birth.

DOB 29/9/24
TOB 7:15 pm

HISTORY OF PRESENT ILLNESS:

S/Term/ NVD in hospital / 1st order child/ CIAB/ passed meconium & urine in <24hrs of birth/ continuous multiple episodes of bilious vomiting since birth x 3days
c/o abdominal distension x 2days.
No fever / jaundice / constipation
No h/o top feed/ gutti feed

HISTORY OF PAST ILLNESS:

Nil surgical
Not ANC detected

RISK FACTORS

LOCAL EXAMINATION:

PA: Soft, Diffuse distension (+)
Palpable loops (+), No colour change
GR (-), RE (-), BS (+)
No mass palpable

GENERAL PHYSICAL EXAMINATION: Cry good

BP(MmHG):

PULSERATE (PER MINUTE): 130 bpm, feeble pulse
cold peripheries
CRT > 5 sec

TEMPERATURE: Afebrile

SpO2: 97% RA

PALLOR:
OEDEMA:
ICTERUS:
CLUBBING:
(-)

CVS:

$S_1 S_2$ (+)

no murmurs

P/A:

L/E

Atal Bihari Vajpayee Institute of Medical Sciences and
Dr Ram Manohar Lohia Hospital
Baba Kharak Singh Marg, New Delhi-110001

CONSENT FORM FOR SURGICAL OPERATION AND / OR DIAGNOSTIC / THERAPEUTIC PROCEDURE

me: B/o Kiran Age : 0 day Sex: Male

No/UHID 65478 MRD No. Date : 3/10/21 Time 1:00 AM

o, D/o, W/o: ARJUN

uthorization for Surgical operation and / or Diagnostic / Therapeutic Procedure.

1. I ..... authorize Dr. ..... and who so ever he / she may designate to perform the following medical treatment, surgical operation and diagnostic / therapeutic procedures ..... Exploratory Laparotomy & proceed .....

2. It has been explained to me that, during the course of the operation / procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other emergency procedures in addition to or different from those contemplated at the time of initial diagnosis. I, therefore, further authorize the above designated staff to perform such additional surgical or other procedure as they deem necessary or desirable.

3. I further consent to the administration of drugs, infusions, blood or blood product transfusions or any other treatment or procedures deemed necessary.

4. The nature and purpose of the operation and / or procedures, the necessity thereof, the possible alternative methods, treatment, prognosis, the risks involved and the possibility of complication in the investigative procedures / investigations and treatment of my condition/diagnosis have been fully explained to me and I have understood the same.

5. I have been given an opportunity to ask all/any questions and I have also been given option to ask for second opinion.

6. Please tick, if applicable. I have been informed that ..... (name of item/device) being used for the Suregery/Diagnostic/Therpeutic Procedure is -
   - ☐ Fresh
   - ☐ Reprocessed ..... number of times for re-use.

7. I acknowledge that no guarantee and promise has been made to me concerning the result of any procedure/ treatment.

8. I consent to the photographing or televising of the operation or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by pictures or by descriptive texts accompanying them.

9. I also give consent to the disposal by hospital authorities of any deceased tissues or parts thereof necessary to be removed during the course of operative procedure/treatment.

I CERTIFY THAT THE STATEMENT MADE IN THE ABOVE CONSENT FORM HAVE BEEN READ OVER AND EXPLAINED TO ME IN MY MOTHER TONGUE AND I HAVE FULLY UNDERSTOOD THE IMPLICATIONS OF THE ABOVE CONSENT.

Name & Signature of the Witness

.....

.....

Signature of the Patient / Parent / Guardian or Thumb impression

Name .....

Relationship with patient: Grand Mother

.....

I CONFIRM THAT I HAVE EXPLAINED THE NATURE AND EFFECTS OF THE OPERATION/PROCEDURE / TREATMENT TO THE PERSON WHO HAS SIGNED THE ABOVE CONSENT FORM.

Signature of the Surgeon / Doctor Performing the procedure

डॉ. राम मनोहर लोहिया अस्पताल, नई दिल्ली
DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI
ऑपरेशन संबंधी नोट
OPERATION NOTES

नाम NAME	B/o Kiran	आयु AGE 2024	लिंग SEX Male
वैवाहिक स्थिति MARITAL STATUS			
विभाग DEPTT.	Paediatric Surgery	वार्ड WARD 4	पलंग BED
व्यवसाय OCCUPATION			

ऑपरेशन पूर्व निदान Pre-Operative Diagnosis	? Medical Mesia
ऑपरेशन के बाद निदान Post Operative Diagnosis	
प्रस्तावित ऑपरेशन की प्रक्रिया Operative Procedure Proposed	बड़ा/Major छोटा/Minor
ऑपरेशन के लिए अपनाई गई प्रक्रिया Operative Procedure Executed	EL + Primary anastamosis
शल्यचिकित्सक Surgeon	Dr Sdu / Dr Babita — सहायक 1 Assistant 1 Dr Bhanu — सहायक 2 Assistant 2 Dr Prab
निश्चेतना विज्ञानी Ansesthetic :	निश्चेतना Ansethetic : — नर्स Nurse :
विकृति विज्ञान विभाग को भेजा गया नमूना Material forwarded to Pathology Department for Examination	
Skin Preparation	तारीख/Date 3/10/24

निष्कर्ष/Findings - Rt transverse incision kept-
समस्त रिकार्ड/Record of all - Skin, subcut, sheath, peritoneum
परीक्षित अंग/Organs examined opened.
शामिल प्रक्रिया/Procedure includes - whole of ileum from ic to
चीरा/Incision upto 5cm length proximally and stoma
बंध/Ligatures
पृथक किया गया नमूना/Specimen seen removed
अपवहन/Drainage
स्पंज काउंट/Spouge count - Atretic segment sent for
संवरन/Closure HPE
रक्तहानि/Blood loss - Proximal and distal ends
ऑपरेशन का समय/Operative time anastamosed after chittelbij

रिपोर्ट लिखने वाले चिकित्सक द्वारा रिपोर्ट के अंत में नाम सहित हस्ताक्षर किए जाएं
(Reporter to sign. in full at the end of Reports)

OIC, GIPRB, ND/24RMLH(20,000)/2020

ATAL BIHARI VAJPAYEE INSTITUTE OF
DR. RAM MANOHAR LOHIA HOSP
PAEDIATRIC
PRE-OPERAT
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भारत सरकार
Government of India

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

नामांकन क्रम/ Enrolment No.: 2714/30270/20453

To
अर्जुन
Arjun
C/O: Shyam Lal
E-523, J.J.Colony
Raghubir Nagar
Tagore Garden
West Delhi Delhi - 110027
9582878618

आपका आधार क्रमांक / Your Aadhaar No. :

6011 0879 3333

VID : 9109 6750 9090 3888

मेरा आधार, मेरी पहचान

Government of India

AADHAAR

सूचना

- आधार पहचान का प्रमाण है, नागरिकता का नहीं।
- सुरक्षित QR कोड / ऑफलाइन XML / ऑनलाइन ऑथेंटिकेशन से पहचान प्रमाणित करें।
- यह एक इलेक्ट्रॉनिक प्रक्रिया द्वारा बना हुआ पत्र है।

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code/ Offline XML/ Online Authentication.
- This is electronically generated letter.

- आधार देश भर में मान्य है।
- आधार कई सरकारी और गैर सरकारी सेवाओं को पाना आसान बनाता है।
- आधार में मोबाइल नंबर और ईमेल ID अपडेट रखें।
- आधार को अपने स्मार्ट फोन पर रखें, **mAadhaar App** के साथ।

- Aadhaar is valid throughout the country.
- Aadhaar helps you avail various Government and non-Government services easily.
- Keep your mobile number & email ID updated in Aadhaar.
- Carry Aadhaar in your smart phone – use mAadhaar App.

भारत सरकार
Government of India

अर्जुन
Arjun
जन्म तिथि/DOB: 01/01/2003
लिंग/ MALE

Issue Date: 10/04/2015

6011 0879 3333

VID : 9109 6750 9090 3888

मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:
द्वारा: श्याम लाल, ई-523, जे.जे.कॉलोनी, रघुबीर नगर, टैगोर गार्डन, पश्चिम दिल्ली, दिल्ली - 110027

Address:
C/O: Shyam Lal, E-523, J.J.Colony, Raghubir Nagar, Tagore Garden, West Delhi, Delhi - 110027

Download Date: 21/12/2015

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Regd. No. 2021

ABHISHIKHA TRUST

S. No. 15

Date: 03 / 10 / 2019

सेवा में

श्रीमान ट्रस्टी महोदय जी
अभिषिका ट्रस्ट
G-3, Gali No.-7, पुस्ता
सोनिया विहार, दिल्ली-110039

महोदय जी,

मेरा नाम अर्जुन है और मेरी बच्ची का किरन है जो कि राम मनोहर लोहिया अस्पताल में भर्ती है किरन के किडनी में इन्फेक्शन है जिसका इलाज कराना है और इसके दिल में भी दिक्कत बताई है। जिस का इलाज करवाना है कृपा करके हमारी मदद करे हम आपके बहुत आभारी होंगे।

धन्यवाद

ABHISHIKHA TRUST DELHI

Office Address : G-3, Gali No. 7, Pusta, Sonia Vihar, Delhi-110094
Website : www.abhishikha.org E-mail ID : info@abhishikha.org
Contact No. : 9958524587