STANDARDIZED CLINICAL PROTOCOLS

Standardized Medical Records

Aravind Eye Care System
1, Anna Nagar, Madurai - 625 020,
Tamilnadu, India

Registration Information Card	
Name:	Token No.
F/o.S/o.D/o.W/o.H/o.	Age
Door No./Street:	
Village/Town	Male/Female
Pincode	District
Phone with Area Code	Email

Patient Identity Card			
Hospital Name		**Hospital Name**	
		Out-Patient Cash Reciept	
M.R.No.	Date:	M.R.No.	Receipt No
Name:		Name	
Address:		Details	Amount(Rs)
		Consulting Fees	
Please Bring this Card When you come for review check-up. **Conulting hours on week days: 7.00 AM - 6.00 P.M.** Emergency, Examination and Admission at any time **Sunday Holiday**		Date	Cashier

Alpha Index Card	
Name, Age, Sex	MR No.:
Relation Name	
Address	
District&State	
Pincode	
Phone/Cell No.	

OUTPATIENT RECORD

Page 1

Out-Patient Record Format				
Hospital Name		**Out-patient Record**		
Bill No:		M.R.No.		Unit:
Time:		Date		
Name:		Age:		
		Sex:		
Address:		Phone No. with Code		
		Cell Phone No.		
		Email		
Complaints:				
	Right Eye	Left Eye		
Diagnosis				
Lids				
Conjuntiva				
Cornea				
Anterior Chamber				
iris				
Pupil				
Lens				
Ocular movements				

OUTPATIENT RECORD

Page 2

Vision without glasess					
Vision with glasess					
Tension					
Ducts					
B.P		Urine Sugar		Blood Sugar	
Fundus		Rt		Lt	
Detailed history:(Immediate past and treatment history)					ICD Code
Allergic To:					
ONE EYED		HYPERTENSIVE		ASTHMATIC	
CARDIAC		DIABETIC		OTHERS	

INPATIENT RECORD

Page 1

Hospital Name **In - Patient Record** Name:_____ Age _____ Sex M/F Address:_____		M.R.No. _____ Date of Admission _____ Discharge _____
Diagnosis		Diagnosis Code No.
RE		
LE		
Admitted For:		
Treatment/Surgery		Treatment/Surgery Code No.
Pre-Operative Instruction		
Asthmatic		
Hypertensive		
Diabetic		
Cardiac		
Allergic		
Others		
Remarks:		

INPATIENT RECORD

Page 2

Authorisation for giving Anesthesia and doing Operation

I hereby agree whole heartedly for performing operation and / or giving anaesthesia in_____Eye Hospitl,_____ for the undermentioned patient. If anything untoward happens during the course of anaesthesia and / or operation, I also admit that neither the hospital administration nor the doctors and other employees of the hospital will be held responsible for the same.

Name of the Patient _____

Date signature _____

Patient/Parents/Guardian

Authorisation for giving Anesthesia and doing Operation

Regional Language

Name of the Patient _____

Date signature _____

Patient/Parents/Guardian

Hospital name

Discharge Summary Report

Name: Age: I.C.N.:

Address: Sex: M.R.N.:

Diagnosis: RE:

LE:

Date of Admission:

Illnes Period:

Operation Notes

Type of Surgery: Date of Surgery:

Eye:

Discharge notes:

Date of Discharge:

Visual Acuity:

Postoperative Instruction Pinhole:

Medication	Days	Date		Timings					
		From	To	1	2	3	4	5	6

Follow-up Instructions

1st Review:

2nd Review:

Ward Nurse Medical Officer

Avoid Coming on Sunday and Monday