

Uluberia S.D. Hospital  
**DEPARTMENT OF HEALTH AND FAMILY WELFARE**  
**GOVERNMENT OF WEST BENGAL**  
**BED HEAD TICKET**

Printed By: IP

BABLU BAR

Male

36

PA19037079

27-Jun-2019

13:30

**Patient's Name :** RG19127443      **Charge Coll. No.:** \_\_\_\_\_      **Sex :** \_\_\_\_\_      **Age :** \_\_\_\_\_      **Yrs.** \_\_\_\_\_      **Months** \_\_\_\_\_      **Days** \_\_\_\_\_  
**Patient Srl. No. :** [LWRD0000013] DIALYSIS UNIT      **Admission Date :** \_\_\_\_\_      **Admission Time :** [Free] \_\_\_\_\_      **Patient Category :** PAYING/CABIN/GENERAL  
**Registration No. :** SONAMUI      **Indian** \_\_\_\_\_      **Bed No. :** \_\_\_\_\_      **Patient Type :** OPD/ER  
**Ward :** Amta P. S.      **Howrah** \_\_\_\_\_      **Address :** West Bengal      **Hindu** \_\_\_\_\_  
**Municipality / Village :** Single      **Post Office :** \_\_\_\_\_      **PIN :** \_\_\_\_\_  
**Police Station :** LT PANU BAR      **District :** \_\_\_\_\_  
**State :** SAKHI BAR      **Nationality :** \_\_\_\_\_      **Religion :** \_\_\_\_\_  
**Address for Communication :** [DOC0000062] DR. MANABENDRA ROY  
**Marital Status :** \_\_\_\_\_      **Patient's Occupation :** \_\_\_\_\_  
**Father's Name :** \_\_\_\_\_      **Husband's Name :** \_\_\_\_\_  
**Brought By :** \_\_\_\_\_      **Phone / Mobile No. :** \_\_\_\_\_  
**Doctor/UNIT :** \_\_\_\_\_  
**Whether Referred From :** \_\_\_\_\_  
**Provisional Diagnosis :** \_\_\_\_\_

.....  
*Signature of Admitting Officer*  
*Designation*

IPC Serial No. :

Diary No. :

Specify if it is a cause of accident/ Suicide/Homicide	How injury Occurred	Specify the place of injury Home/Farm Factory / Street / Others	Whether injury occurred while at work Specify by Yes / No.

(To be filled in BLOCK LETTERS at the end of Hospital Stay)

(a) Outcome : Discharged/Left Against Medical Advice / Absconded / Referred out / Death

(b) Final Diagnosis or Injury .....

(c) Principal Complications .....

(d) Principal Associated Diseases .....

Stay in Hospital (in days) .....

From ..... to .....

Date and Hour of Death .....

at ..... Hrs .....

.....  
*Counter Signature of the Visiting Staff / Medical Officer*  
 Regn. No. :

.....  
*Signature of the Doctor with Designation*  
 Regn. No. :

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