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DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
OPD Patient Card

Name : *[Faded]* Day : *[Faded]*
Sex : *[Faded]* Age : Yrs. Months Days Reg. No. : *[Faded]*
Ref. From : *[Faded]* Reg. Date : *[Faded]*
Card No. : *[Faded]*
Visit No. : 1 Department : *[Faded]* Visit Date : *[Faded]* Time : *[Faded]*
Doctor / Unit Name (DOW) : *[Faded]* Entry No. : *[Faded]*
Room No. : *[Faded]*

Visit No. : 2 Visit Date : Tm. Department : Doctor/Unit : <i>13 FEB 2019</i> Entry No. :	Visit No. : 3 Visit Date : Tm. Department : Doctor/Unit : Entry No. :	Visit No. : 4 Visit Date : Tm. Department : Doctor/Unit : Entry No. :
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Clinical Notes
BP \rightarrow 156/90
mmHg
(Ref to CTVS for AVF creation)
[Handwritten notes and dates on left side]
TCA 2 months

ADVICE
CKD (V) ON MHD 2/wkly X 6 months
20 AVF failure.
was access \rightarrow Femoral (RT)
Adv of MHD 3/wkly
1. T Nifedipine 20mg TID.
2. T Metoprolol 50mg BD.
3. T Prazosin XL 7.5mg qpm
4. T L thyroxin 50mg BBT
5. Hy ph Epo 4000 slc 2/wkly
6. Hy Iron sucrose 100mg N 2/wkly
7. + Folic acid 5mg 2pm.
[Handwritten signature]