{LOGO}
{NAME & ADDRESS OF THE HOSPITAL}

STANDARD

DISCHARGE SUMMARY

a. Patient's Name* : _____

b. Telephone No / Mobile No* : _____

c. IPD No : _____ d. Admission No: _____

e. Treating Consultant/s′ Name : _____

   a. Contact Numbers : _____

   b. Department/Specialty : _____

f. Date of Admission with Time : ___/ ___/ _____ ___:___ Hours

g. Date of Discharge with Time : ___/ ___/ _____ ___:___ Hours

h. MLC No* : _____ FIR No*: _____

i. Provisional Diagnosis at the time of Admission : _____

j. Final Diagnosis at the time of Discharge : _____

k. ICD-10 code(s) for Final Diagnosis*: _____

l. Presenting Complaints with Duration and Reason for Admission: _____

_____

_____

_____

m. Summary of Presenting Illness : _____

_____

n. Key findings, on physical examination at the time of admission: _____

_____

_____

_____

o. History of alcoholism, tobacco or substance abuse, if any : _____

p. Significant Past Medical and Surgical History, if any* : _____

_____

_____

q. Family History if significant/ relevant to diagnosis or treatment: _____

_____

_____

r. Summary of key investigations during Hospitalization* : _____

_____

_____

s. Course in the Hospital including complications if any* : _____

_____

_____

_____

_____

_____

t. Advice on Discharge* : _____

_____

_____

_____

_____

Treating Consultant/ Authorized Team Doctor*	Name	
	Signature	

Patient/ Attendant *	Name	
	Signature	

* These are mandatory fields.

{LOGO}
{NAME & ADDRESS OF THE HOSPITAL}

SUMMARY BILL FORMAT

Provider Name	.....	Bill Number	.....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

DETAILED BREAKUP FORMAT

PART-I

Provider Name	....	Bill Number	....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00