Annx.-5

# PRE AUTHORIZATION REQUISITION (PAR) FORM

(type or write with black ink ball pen, in capital letters, & don't use any abbreviations)

**To,**

SP/CO……..

……. Fax no.

| | | |
|---|---|---|
| Patients Name ..... <br> IP No.: …….. | | Age: …… Sex:..……., <br> Room No.: …… Bed No.: …… |
| Hospital Name & Address: <br> Telephone No. & Fax No | | |
| Employee's name: …… <br> Unique code ……date of retirement..... | | Designation/No. …….. <br> Unit: …… |
| Relationship / Self: …… | Referral no.: …….. | |
| Present Complaints / History: | | |
| Present General condition of Patient: | | |
| Investigations: Fax Important key investigation reports to support Diagnosis, with this form. (X-ray / ECG/ Doppler / US SCAN/ CAG/ CT/ MRI etc.- Digital Image print outs | | |
| **Diagnosis:** | | |
| Reasons for admission | | |
| Under Care of Doctor…… <br> Mobile No.: …… | Specialty…… <br> Timings: ……. | |
| DOA: ……..., Time: ……. | Approx. No. of days of stay : ……..……. Days. | |
| Treatment planned: Procedures, Surgery etc. with expected Date planned: …….. <br> (Don't use any abbreviations & Write in capital letters only) | Details | Cost of Treatment/ Packages (MPCS(MA) Rules 1958) Split up bill details |
| 1 <br> 2 <br> 3 <br> 4 <br> 5 | | |
| Employee / Attendant: <br> Contact person. :Mobile No. | Signature: <br> _____Ph.No.: _____ | |

**Hospital Authorized Signatory**
Name : ……
Designation……
Mobile No……..

Space for official use ⇩
( for approval)

**Hospital Seal**
Date & Time

**S.P./ Commandant./Unit in charge**
**Fax no.**

Copy to:-

(1) Addl. D.G. Police (Welfare), PHQ, BHOPAL (MP) Fax No. 0755- 2443391

(2) C.M.H.O. Distt..... Fax No.....