OFFICE OF THE MEDICAL SUPERINTENDENT

GOVT. OF NATIONAL CAPITAL TERRITORY OF DELHI

GB PANT HOSPITAL, J.L.N. Marg – NEW DELHI

(Estimate Form for All Surgeries & procedures of G.B. Pant Hospital)

(To be filled by the Dotor):- Column 1,2,3,4 as per the documents i.e. Ration Card/Voter I Card/OPD Card. Date

1. Name of the Patient Afia Naz s/o/D/o/W/o Mhd. HARUN
2. Address Amroha, U.P.
3. Age 8yr Sex Female Dept. Gastroenterology
4. OPD/CR No 2097329 Treating Doctor/ Consult. D.R.G.Sharma
5. Diagnosis of the Diseases Hepatitis (B)
6. Details of treatment/ operation alongwith items required.
   Inj Pegylated Interferon x 48 weeks (40 mg)

7. Whether the patient pertains to:-
   a) BPL Card Holder b) Self Paid c) DAN/RAN

   d) Anyother source of funding to be done free by hospital (Process to be attached)

Note:- The patient will be tentatively admitted/operated on .....

Sign & Stamp of treating consultant

(To be filled by the Purchase Department) Amount:- Vat:-

Rs in words 1,75,000/-) **Signature** 21/3/2016

Note:- The demand draft/pay order must be issued in favour of MEDICAL SUPERINTENDENT G.B. PANT HOSPITAL, NEW DELHI alongwith forwarding letter from the dependent concerned. This certificate is issued on one time.

DECLARATION BY PATIENT

2. I have not applied for another Estimate Form from any other department DAN/RAN, PMO etc.

Sign o Patient/Relative

Relation with Patient_____

Signature of MEDICAL SUPERINTENDENT

Copy To:- Treating Doctor

Purchase office (with the Photocopy of received of payment)

Medical Superintendent
G.B. Pant Institute of PG
Medical Education & Research
Govt. of NCT of Delhi
New Delhi-110002