

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 Doctor) :- Column 1,2,3,4 as per the documents i.e. Ration Card/Voter

I/ Card/OPD Card

1. Name of the Patient

Ayush

Date

5/5/2016

Vishkarma

2. Address

Sambhowali Delhi

3. Age

1 1/2

Sex

Male

Dept.

4. OPD/CRNo.

2075736

Treating Doctor (Signature)

Diagnosis of the Disease:

PDA

5. Date of treatment/operation along with item required:-

device closure
E COCCON padding
Rs. 37000/- + Vaf 5%
Rs. 1850/-
38850/-

Whether the patient pertains to

(a) BPL Card Holder

(b) Self Paid

(c) DAN/RWA

(d) Other source of funds

(to be done free by hospital) (Proof to be attached)

Note:- The patient will be tentatively admitted on 5/5/16

Sign & Stamp of treating Consultant

SUMIT KURIAN

(To be filled by the Purchase Office)

Department of Cardiology
GIPMER, New Delhi-02

Rs. in words

Signature

The demand draft/pay order must be issued in favour of MEDICAL SUPERINTENDENT, G.B. PANT HOSPITAL, NEW DELHI, alongwith forwarding letter from the department concerned if this certificate is issued on line.

DECLARATION BY PATIENT

I have not applied for another Estimate Form from any other department of G.B. Pant Hospital, New Delhi.

Signature of Patient/Relative

Done with patient

SIGNATURE OF MEDICAL SUPERINTENDENT

To : Treating Doctor

Purchase Office (with the Photocopy of receipt of payment)



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