

ESTIMATE LETTER ✓

OFFICE OF THE MEDICAL SUPERINTENDENT
GOVT. OF NATIONAL CAPITAL TERRITORY OF DELHI
G.B. 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 :- Ration Card/Voter

1. Card-OPD Card
2. Name of the Patient Renu yadav Date 8/1/2019
3. Address H.No. 324, Subhash Tapir, Badli, N.T.C. N.D-110044
4. Age 10/10/2008 Sex Female Dept. Cardiology
5. OPD/CRN No. 2044765 Treating Doctor/Consultant Dr. Sumod
6. Diagnosis of the Disease: Takayasu arteritis
7. Details of treatment/operation alongwith items required:-

@Rs. 23625 X 2 = Rs. 47250/- 2 coronary stent (Pronova)
Rs. 26050/- 1 balloon expandable aortic stent (Resortant)
Whether the patient pertains to (a) BPL Card Holder (b) Senior Citizen (c) DAN/PAN (d) Any other source of funding
(To be done free by hospital) (To be done by patient) (To be done by patient) (To be done by patient)
Note: The patient will be treated only for the condition mentioned on _____ as early as joining

Sumod Kaur
Professor
Department of Cardiology
GIPMER, New Delhi-02

Sign & Seal of Treating Doctor/Consultant

(To be filled by the Purchase Dept.): Amount + Vat :-

Rs. in words Seventy three thousand five hundred only. Signature: _____

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 department concerned. This certificate is issued only one time.

DECLARATION BY PATIENT

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

Signature of Patient/Relative,
Relation with patient: _____

Signature of Treating Doctor

Signature of Treating Doctor (With the Photocopy of the Estimate Form)

SIGNATURE OF MEDICAL SUPERINTENDENT

Signature of Medical Superintendent



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