


ADMISSION NOTIFICATION SLIP

ADMISSION NOTIFICATION SLIP					
Name of Patient — Age — Sex	ARISHA KHATOON 20 M Female None Father's name : KHALILUR RAHAMAN			3608369	Marital Status-Hospital Reg. No.
Service Unit — Ward / Bed No.	Religion : Islam OLD (OB)-WARD 3 CAT-3			IP01554237 CAT-3	Head of Service — Income
Father / Husband Name					Name of Employee Institution
Address	PAEDIATRIC HEMATOLOGY, ONCOLOGY & BMT-Dr. A. 47 PURANI TAHSIL UATTRI KHALILABAD SANT KABIR NAGAR U.P.-272175 Dr. Anupam Sachdeva Dr. Manas Kalra				Admission Form
Tel. No.	7030731363 Pvt OPD	India			Room / Bed Charges
Occupation	28/11/2025	10:52			MRD No. & Re-Admission
Date & Time of Admission				(GAA5656)	Booking Adv. Rect. No. & Date
If Hospital Employee					Adv. Rect. No. & Dt.—PB.

If Hospital Employee or his/her Dependent Is Admitted, Please Complete the Statement Below		Adv. Rect. No. & Dt.—P
with Employee	Name of the Employee	

SHIFTING DETAILS

[illegible]



DATE OF CONSULTANTS VISIT & PROCEDURES DONE

[illegible]

For internal use only



Sir Ganga Ram Hospital
सर गंगा राम अस्पताल

Rajinder Nagar, New Delhi-110060. Ph.: 25750000, 42254000, 42251870
राजेंद्र नगर, नई दिल्ली-110060, फोन : 25750000, 42254000, 42251870

SGRH/PT.FAMILY/EDU/F-216

ARISHA KHATOON

20 M/Female CAT-3
3608369 IP01554237 CAT-3
Admit On : 28/11/2025 10:52AM

PAEDIATRIC HEMATOLOGY, ONCOLOGY

OLD (OB)-WARD 9

PATIENT AND FAMILY EDUCATION FORM

रोगी और परिवार शिक्षा फार्म

Date / दिनांक : 28/11/25

Diagnosis / Procedure / निदान/प्रक्रिया : Post HIDA c 2 Day Hiy

Sl. No./ क्रमांक सं.	Subject/ विषय	PROVIDED BY / द्वारा उपलब्ध कराया गया (Write Name/नाम लिखें)	Yes / No/ NA* हाँ / नहीं
1	Patient Rights & Responsibilities / रोगी अधिकार और उत्तरदायित्व	PCC / पी.सी.सी. :	
2	Voicing of complaint, Feedback/ Suggestions and Visitor's Policy / शिकायत की आवाज, प्रतिक्रिया/सुझाव और विजिटर की नीति	PCC / पी.सी.सी. :	
3	Infection Control Practices / संक्रमण नियंत्रण व्यवहार • Hand Hygiene/ हाथ स्वच्छता • Overcrowding near the Patient / रोगी के पास भीड़	Nursing Staff / परिचर्या कर्मचारी : No feedback	Yes
4	Pain Assessment/ दर्द आकलन	Nursing Staff / परिचर्या कर्मचारी : No feedback	Yes
5	Fall Prevention/ दर्द आकलन • Importance of bed-side railing/ बेड-साइड रेलिंग का महत्व	Nursing Staff / परिचर्या कर्मचारी : No feedback	Yes
6	Pressure Ulcer Prevention/ दबाव अल्सर की रोकथाम	Nursing Staff / परिचर्या कर्मचारी : No feedback	Yes
7	Medications/ Blood Donation / दवाएं/रक्तदान	Nursing Staff / परिचर्या कर्मचारी : No feedback	
8	Disease Specific Information/ रोग विशिष्ट जानकारी	Doctor/ डॉक्टर :	
9	Any special devices used/ Immunization/ Organ donation, if required / उपयोग किए जाने वाले किसी विशेष उपकरण/टीकाकरण /अंगदान, यदि आवश्यक हो तो	Doctor/ डॉक्टर :	
10	Nutrition Education Food / Drug interactions / पोषण शिक्षा खाद्य / दवा बातचीत	Dietician / आहार विशेषज्ञ :	

*NA: Not Applicable / लागू नहीं है

I have been educated and informed of above in the language understood by me.
मेरे द्वारा समझा जाने वाली भाषा में मुझे ऊपर और शिक्षित किया गया है।

Name of Patient/ Attendant (Relationship) /
रोगी का नाम / उपस्थिति (रिश्ते)

Date/ दिनांक : 28/11/25



SGRH/DM/Dcl-Pt-Adm-HAI/F-386

DEMOGRAPHIC DETAILS Hospital: New Delhi



Name: ARISHA KHATOON

Gender: Female

Marital Status: Unmarried

Religion: Islam

Aadhaar Card No.:

Other name: KHALILUR RAHAMAN

Other name: SAMKA ARFIN

House Name:

Address: 47 PURANI TAHSIL UATTRI KHALILABAD SANT KABIR NAGAR U.P. - 2721

Uttar Pradesh, India

DOB: Mar 8, 2024

Occupation: None

Nationality: India

Contact No.:

Date: 28/11/25

Print Date: 28/11/2025 10:52AM

ON ADMISSION - DECLARATION BY PATIENT / RELATIVE ON INFECTION

I have been made to understand in a language that I know that I/my patient ✓
(Name) Samka Arfin age 28 sex F relationship Mother upon
admission in this hospital:-

(a) May be harboring an infection which being in the incubation period may manifest 48 hrs after admission.

(b) I / my patient may transmit my infection to attending healthcare workers/ other nearby patients during hospitalization.

(c) I / my patient may acquire an infection during hospitalization especially so in case of extremes of age, if there is a compromise of immunity due to chronic ailments like Diabetes, tuberculosis, cancer, HIV, fungal infection etc or in the event of any invasive procedure(s) performed despite all aseptic measures undertaken.

(d) Infection acquired by me during hospitalization may manifest during my hospital stay or 48 hrs after my discharge from the hospital.

(f) As it is an "Occupational hazard" for health care workers to acquire an infection while undertaking patient care in a hospital, I too may acquire an infection as a "Situational hazard" and will indemnify the hospital if such a situation arises.

Signature/Thumb Impression

Patient Name:

Mobile no:

Address:

Samka
Signature/Thumb Impression

Attendant Name: Samka Arfin

Mobile no:

Address: Samka



Sir Ganga Ram Hospital

ARISHA KHATOON

20 M/Female CAT-3
3608369 IP01554237 CAT-3
Admit On : 28/11/2025 10:52AM

PAEDIATRIC HEMATOLOGY, ONCOLOGY

OLD (OB)-WARD 9

Date and Time	Progress Notes and Investigation Orders	Medication orders in capital letters to prevent occurrence of medication errors with your patient			
		Name of drug Cap / tab / inj.	Dose	Route	Freq.
28/11/25	<u>S/B P40 team</u>				
	C/O AML post HDAC - 2 Day +15				
	fever spikes +nt				
	no cough / cold / no further loose stools				
	DE: bleeding				
	HR - 126/min				
	PR - 26/min				
	NG insert				
	DE: well				
		Adv			
		→ cef antibiotics			
		→ Inform fever spikes $\geq 101^{\circ}\text{F}$			
		→ strict vitals <u>min</u>			
		→ syp. 400g 2.5ml PO STAT			
		→ Lanoprog sachet 1/2 sachet			

→ 9m CBC 1-0-1

Plan of care

Goal of Treatment:
(Tick ✓ which is applicable)

Preventive:

Curative:

Rehabilitative:

Palliative:

Investigations Advised

8.8 kg

0.43 m²

Treatment Advised

send CBC &
Blood culture

Adv ① Inj. Magnex 4.5 mg IV

BD

② Inj. Pefalgan ~~850~~ 90 mg IV
SOS

③ Inj. Pantap 10 mg IV OD

④ Inj. Emust 2 mg IV SOS

⑤ IV DNS 700 ml (1100 hrs)
over 24 hours.

Handwritten signature

Diet Normal

Consistency:

Normal

Soft

Liquid

Tube feeds

Fasting

Type:

Normal

Diabetic

Low salt

Other:

Neutropenic

Procedure Planned

Preventive care, (e.g.)

References

Resident's Name & Signature

Date
Time

Handwritten signature
28/11/25.

Dr. Menes
Consultant's Name & Signature

Date 28/11/25
Time 11:00



SIR GANGA RAM HOSPITAL

Trust of Generations

Sgrh/Ad/F-101

Regno → 3608369

PRE-ADMISSION RECORD

Dated 28/11/25

MLC (Please tick): Yes ☐ No ☐

To be filled by the patient / attendant in capital letter

Please Tick - VEG /NON VEG

- Name of Patient ARISHA KHATOON Age/Gender 20 months / F
Date of Birth 08/03/2024 UHID
- Patient's occupation Religion Muslim
Nationality Indian Marital status
- Father's Name Khalid Rahman Spouse Name
- Mother's Name Sankha Akhila
- Address as per Aadhar 43, Purbani tahsil uatni, Khaliabad Dist: Sant Kabir Nagar UP-272175
Employee, GAA
- I.D. Proof submitted on Admission (Yes/No), Please specify:
PAN Card No with Photocopy Aadhar Card No. with Photocopy 861471931580
- E-mail
- Room category opted / entitled (Please tick):

E-Block			Premium Suite	Suite	Deluxe	Single Room	2-3 Bedded/ Multi-Sharing	4-6 Bedded/ Multi-Sharing	CRITICAL AREA
ES	ED	ETS	Cat-1A	Cat-1B	Cat-1C	Cat-1D	Cat-2	Cat-3	

9. Payment Mode (Please tick):

TPA / Insurance	Empanelled / Corporate	International	Employee/Dependant	Self Paying
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To be filled by the Admission Desk

Deptt. / Unit PHO Consultant

Ward / Bed No.	Room no. allotted.....	Room/Bed Charges
<u>1277 (Space)</u>	<u>Cat-3</u>	<u>MRD 870 + Rent - 4200 + PV - 1370 + 74</u> <u>Meel - 2 - cur + GST + RMO</u>

Source of Admission Casualty/Gen. OPD/Pri OPD Advance Paid / Receipt no. / Date 2K

FOR CHARITY / EWS PATIENTS

I.D. Proof / Document supporting EWS status

बैंस भुगतान शेष राशि की पूर्ति हम करेंगे।
I will pay Deficit in Insurance Payment

Signature of patient/Attendant with name

Mother
Sankha Akhila

आयकर अधिनियम 1961 के खण्ड 269 ST के अनुसार दिनांक 1/4/2017 से प्रत्येक दाखिल के लिये जाने वाले भुगतान में 2 लाख से अधिक राशि नकद नहीं की जा सकती है।

Signature of F.O. Exec with name

NURSING CLINICAL ASSESSMENT

Date / Time 28/11/24 at 11 AM

Vitals

Temperature 90.2 f Pulse: 120 bpm BP: 100/40 Respiration 24 bpm Height 114 cm Weight 8.8 kg

FALL RISK ASSESSMENT

Age: 20 months
 Previous fall: NO
 Bowel / Bladder Needs: NO
 Impaired Judgment: NO
 CVS / CNS Medication: NO
 Other: NO

Sensory Deficit: NO
 Muscular Weakness: NO

PAIN

Acute (< 6 wks. Duration)
None 0 Annoying 02
 Chronic (> 6 wks. Duration)
 Uncomfortable 04 Dreadful 06 Horrible 08 Agonizing 10

PSYCHOLOGICAL STATUS

CHILD

Anxious yes Depressed NO Angry NO
 Combative NO Sleep Disorder NO Other NO

PARENTS

Anxious yes Depressed NO Angry NO
 Combative NO Sleep Disorder NO Other NO

NURSING NEEDS

- Is there a language problem? Yes/No NO
- Any cultural /religious barriers? Yes/No NO
- Is the patient at risk for falls? Yes/No NO
- Can patient perform routine Personal activities independently? Yes/No NO
- Is the patient incontinent? Yes/No NO
- Does patient require oxygen therapy? Yes/No NO
- Is the patient on tracheostomy? Yes/No NO
- Any psychological problem? Yes/No NO
- Is the patient in pain? Yes/No NO
- Is the patient at risk for pressure ulcers? Yes/No NO
- Any special nutrition needs? Yes/No NO
- Does the patient has any artificial prosthesis? Yes/No NO
- Any other needs? Yes/No NO

patient received ward AT 11 AM
 Inform to doctor AT 11 AM
 Doctor seen the patient AT 11:30 AM
 form Completed by: N/A K K Date: 28/11/24 Time: 11:40 AM



Sir Ganga Ram Hospital

Rajinder Nagar, New Delhi - 110 060

Form # 01

CHECKED OK

ADMISSION / DISCHARGE RECORD

Name of Patient - Age - Sex	ARISHA KHATOON	3608369	Marital Status-Hospital Reg. No.
Service Unit - Ward & Bed No.	20 M Female None	IP01554237 CAT-3	Head of Service
Father / Husband Name	Father's name: KHALILUR RAHAMAN		Name of Employee Institution
Address	Religion: Islam OLD (OB)-WARD 9 CAT-3 47 PURANI TAHSIL UATTRI KHALILABAD SANT KABIR NAGAR U.P. - 272175	PAEDIATRIC HEMATOLOGY, ONCOLOGY & BMT (Dr. A. Dr. Anupam Sachdeva Dr. Manas Kaira	Admission Form
Tel. No.	7030731353		Room / Bed Charges
Religion	Pvt. OPD India		MRD No. & Re-Admission
Occupation	28/11/2025 10:52		Booking Adv. Rect. No. & Date
Nationality		(GAA5556)	Adv. Paid Rect. No. & Date
Date & Time of Admission			

Date of Discharge	Time	Total Days	Financial Arrangement
Provisional Diagnosis			International codes
FINAL DIAGNOSIS			
Write			
Principal Diagnosis			
First			
OPERATIVE SPECIAL PROCEDURES			
RESULT	CURED	RELIEVED	L.A.M.A. INVESTIGATION ONLY
Signature & Name Resident Dr.			D.O. EXPIRED
Signature of Senior Dr.			

AUTHORISATION FOR OPERATION / TREATMENT

Permission is hereby given for the performance of any diagnostic examination, biopsy, transfusion of blood & its products, operation and for the administration of any anaesthetic as may be deemed advisable in the course of this hospital admission. The risk of various procedure has been explained to me and I am willing to undertake the risk.

Whatever money and valuables I bring into the hospital with me will be kept at my own risk and the hospital will not any way be responsible for its loss / damage.

I fully understand that Sir Ganga Ram Hospital Does not grant any credit to patient unless a letter of authority from the agency or party responsible for payment is received before the time of patient leave of the hospital and I will be responsible for making full Payment at the time of discharge from the hospital.

All legal matters are subject to Delhi Jurisdiction only.

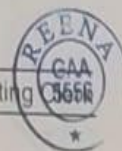
I have received _____ visitors pass, attendant pass, food pass and agree to abide by hospital rules and regulation.

Signature of Patient or Representative

Signatory Relationship

Signatory of Admitting

For internal use only for hospital





Sgrh/IA/Paed/F-064

Sir Ganga Ram Hospital

Rajinder Nagar, New Delhi-110060

INITIAL ASSESSMENT SHEET (Paediatrics)

Name of Patient Arisha
Ward/Bed ward 9 Reg No. 3608369
Date/Time 28/11/25 Resident: _____
Vulnerable - ☒ Yes / ☐ No
Restraint - ☒ Yes / ☐ No Informant Mother

ARISHA KHATOON

20 M/Female CAT-3
3608369 IP01554237 CAT-3
Admit On : 28/11/2025 10:52AM

PAEDIATRIC HEMATOLOGY, ONCOLOGY

OLD (OB)-WARD 9

Allergy

If patient has bleeding disorder, metal implant, pacemaker,
HbsAg or any viral marker positive, write them in the ALERTS box below

Write generic name (e.g. paracetamol)

Allergy
Reaction

Alert

Anaphylaxis, Urticaria, Bronchospasm, 'Diarrhoea', etc.

Presenting complaints

1.	<u>40- AML</u>
2.	
3.	<u>Post HIOAC 2-day + 14.</u>
4.	
5.	<u>admitted with fever since morning</u> <u>acute onset, high grade, 101°F.</u>

Treatment History

1.	<u>asso. with keeping dull</u>
2.	
3.	
4.	
5.	

Past History

1.	
2.	
3.	
4.	
5.	



NO Insurance

SGRH/DM/IPT-TPA/F-334

Sir Ganga Ram Hospital

Declaration For Taking Indoor Treatment With Insurance Cover

1.

I 3608369



DEMOGRAPHIC DETAILS

Name: ARISHA KHATOON

Sex: Female

Marital Status: Unmarried

Religion: Islam

Aadhaar Card No.:

Father name: KHALILUR RAHAMAN

Mother name: SAMKA ARFIN

Spouse Name:

Address: 47 PURANI TAHSIL UATTRI KHALILABAD SANT KABIR NAGAR U.P. - 272175
Uttar Pradesh, India

DOB: Mar 8, 2024

Occupation: None

Nationality: India

Contact No.:

my relative _____ (relationship)

_____ am / is getting admitted under

Print Date : 28/11/2025 10:52AM

ATE policy (tick -s/ as appropriate)

(iv) The Name of Beneficiary recorded in the policy is _____

(v) Sum insured is _____

(vi) Sum consumed in previous admission of individual / family is _____

(vii) Remaining sum in the medical policy is _____

(viii) Co-payment / percentage that the beneficiary has to pay is _____ percent as per policy.

(ix) Room rent capping is for Rs. _____

(b) Copy of my Insurance policy is attached () / not attached ()

2. I have been given a written financial counselling for admission to a Premium suite / Suite / Deluxe Room / Single room / Twin sharing room / Three / more sharing room / for DAYCARE as per my entitlement / or a room chosen by me outside my entitlement as per my Medical insurance policy with an approximate financial estimate for treatment for Rs. _____. It has been intimated that at discharge this may be higher.

I further declare that :-

(a) I have read and understood the terms and conditions of the medical policy

(b) The mandatory 2 year observation period is not over () / over () (tick 3 as appropriate)

(c) I / family have () / have not () (tick 3) taken inpatient treatment for any ailment under this policy earlier this year in this () / other hospital () (tick 3 as appropriate)

(d) I understand outcomes of treatment depend upon response of body to treatment given.

(e) I understand that my final bill may be less, equal to, or exceed the approximate financial estimate given in anticipation, before admission.

(f) Denial of cashless claim if any, will be as per terms and condition of the policy. I understand that in case of denial, I can avail re-imburement from the Insurance company.

(g) In case, hospital bill exceeds the amount cleared by the TPA/ insurance company/ there is denial of cashless facility, I will pay the hospital dues. before discharge from this hospital.

Signature _____

Name of policy holder _____

Date _____

Signature _____

(TPA Desk staff as witness)

Date _____

**SIR GANGA RAM HOSPITAL****PATIENT / ATTENDANT DECLARATION AT ADMISSION**

I (Name) Samka Arfin hereby declare that to the best of my knowledge I/my minor / unconscious relative (relation) _____ (Patient Name) Arisha Khatoon age 20 months / F is suffering from / has suffered from the following in the past:-

Ser No	Ailment / Condition	Yes	No	Don't Know	If No Confirm No	If yes, duration
1	Alcohol ABUSE		<input checked="" type="checkbox"/>			
2	Arthritis - Rheumatoid / Osteo		<input checked="" type="checkbox"/>			
3	Asthma/ Bronchitis		<input checked="" type="checkbox"/>			
4	Cancer/Tumor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
5	Congenital/ Inborn conditions		<input checked="" type="checkbox"/>			
6	Diabetes / Blood Sugar disease		<input checked="" type="checkbox"/>			
7	Drug ABUSE		<input checked="" type="checkbox"/>			
8	High Blood fat / High Cholesterol		<input checked="" type="checkbox"/>			
9	High Blood Pressure / High BP		<input checked="" type="checkbox"/>			
10	Heart Attack / Disease		<input checked="" type="checkbox"/>			
11	Kidney Disease		<input checked="" type="checkbox"/>			
12	Liver Disease		<input checked="" type="checkbox"/>			
13	Stroke /Paralysis/ Convulsions		<input checked="" type="checkbox"/>			
14	Mental illness		<input checked="" type="checkbox"/>			
15	HIV/Sexually Transmitted Disease		<input checked="" type="checkbox"/>			
16	Tobacco Abuse - Smoke/smokeless		<input checked="" type="checkbox"/>			
17	Tuberculosis / TB		<input checked="" type="checkbox"/>			
18						
19						
20						

I / my patient (Name) _____ was EARLIER admitted in hospital for

Following condition(s)/Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____

3608369

**DEMOGRAPHIC DETAILS**

Name: ARISHA KHATOON

Sex: Female

Marital Status: Unmarried

Religion: Islam

Aadhaar Card No.:

Father name: KHALILUR RAHAMAN

Mother name: SAMKA ARFIN

Spouse Name:

Address: 47 PURANI TAHSIL UATTRI KHALILABAD SANT KABIR NAGAR U.P. - 272175, Uttar Pradesh, India

DOB: Mar 8, 2024

Occupation: None

Nationality: India

Contact No.:

Print Date : 28/11/2025 10:52AM

Signature Samka Name Samka Arfin Adhar No _____

Relationship with patient Mother Mobile No _____ Date 28/11/25



SIR GANGA RAM HOSPITAL

EWS PATIENT & FINANCIAL STATUS VERIFICATION ON ADMISSION

As per paras 70, 71 of order of Honible High Court of Delhi dated 22 Mar 2007 and Para A (v) of Fresh Guidelines for Free treatment of ELIGIBLE EWS patients in Private Hospitals

1. Patient Details:

(a) Name Arisha khatoon Age 80 months Sex F

(b) Adhaar No. 861471931580 (Attach copy)

(c) PAN No. _____ (Attach copy)

(d) Bank 3000300 DEMOGRAPHIC DETAILS Current page of updated Pass Book

(e) Ration Card 3000300 (Attach copy)

(f) Relation S Sec: Female DD: Mar 8, 2024

(g) Date of ac Martial Status: Unmarried Occupation: Name

(h) Ward/ Ro Religion: Muslim Nationality: India

(i) Category d Adhaar Card No: Contact No: _____

Palmer name: KHALILUR RAHAMAN

Mother name: SAMKA ARFIN

Spouse Name:

Akateon: E1 PURANI TAHEIL UATTNI KHALILABAD SANY KABIR NAGAR U.P. - 272173

Upar Pradesh, India

Print Date: 28/11/2025 10:00AM

2. It is certified that the patient's. Please tick (✓) as applicable :-

- ☐ Self/total family income from all sources is Less than Rs. 1,85,904/- (1 Yr. bank statement)
- ☐ Belongs to Economically Weaker Section (EWS) of the society.
- ☐ Has Govt. Ration Card (PRS/PR Card) No. _____ (attach copy)
- ☒ Has Govt. Ration Card (PRS/PR Card) No. _____ (attach copy)
- ☐ Has a medical insurance of _____ (attach policy)/ ☐ has NO medical insurance
- ☐ Wants treatment in the GENERAL WARD ☐ free of cost/ ☐ on subsidy/ Charity
- ☒ Wants treatment in PRIVATE WARD on payment of hospital bills timely. Samka

3. All statements made above are true.

Signature Samka Arfin

Name Samka Arfin

Adhaar No. _____

Relation with patient Mother

Mobile No. _____

Date 28/11/25

Witness

Signature _____

Name _____

Mobile No. _____

Adhaar No. _____

Date _____



ARISHA KHATOON
20 NI Female CAT-3
3088309 IP01834257 CAT-3
Admit On : 29/11/2025 10:32AM
PAEDIATRIC HEMATOLOGY ONCOLOGY
OLD (OB)-WARD 9

11

Sir Ganga Ram Hospital

Rajinder Nagar, New Delhi - 110060

Tel.: 25868671, 52251252, 52251389, Helpline : 9312943734

ADMISSION ASSESMENT (PAEDIATRICS NURSING)

VULNERABLE : yes Explained
RESTRAINT No to
Mother.

ADMISSION THROUGH :

CASUALTY ☐

ELECTIVE ☒

Provisional Diagnosis:

POST H1D Aes- Day +14

Emergency Contact No.:

Patient Orientation to Environment

- Nurse Call Bell..... ☒ Medicines Reconciliation : yes
- Side Rails ☒ * TAB VORICONAZOLE (200mg) 1/2 - 1/4
XBSP/O
- Visiting Time ☒ * Byp. SEPTAN (240mg) 5ml BDP/O
(M/W/F)
- Telephone Facilities..... ☒
- Information Booklets ☒ -1 Corded Mouth Paint 2 days XBSP/O
- Pharmacy Policy ☒ inform to DR. Pivinkle
- Cafeteria Services ☒

I Have been explained about the above facilities provided in the room.

Explained about white, yellow metal and
Laptop & Mobile etc.

Patient's / Attendant
Signature

Staff Nurse
Signature



Muskurata Bachpan Trust

Ref no. 12

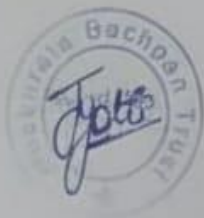
Date 29/11/2025

श्रीवा में,
महोदय जी,
गुरुकुला बचपन ट्रस्ट
ठाहो सराय, महाराजी - 110030
महोदय,



मैं समका अफरीन, मेरी बेटी अरीखा जो सर गंगा राम हॉस्पिटल में दिनांक 28/11/2025 से भर्ती हैं जिसे डाक्टरों ने कैन्सर बताया है जिसके लिए मेरी बेटी का बोन मैरो ट्रांसप्लांट होना है। मेरी बेटी उम्र मात्र 1.5 साल है जो इतनी कम उम्र में कैन्सर जैसी ज़ंभरे बीमारी को झेल रही है। बीमारी के इलाज के लिए हमने 10 से 12 लाख अपना सब इकट्ठा करके लगा दिया है लेकिन अभी भी इतने ही पैसे भी जरूरत हैं। हम आपकी संस्था से जुड़े सभी डानरों और संस्था में कार्यरत सभी वोलिंटेयरों से अनुरोध है कि आप हमारी मदद करें। हम जीवन भर आपके अभारी रहेंगे और हमारे वच्चे को आपकी वजह से दूसरा जीवन मिलेगा।

धन्यवाद,



प्राणी. समका अफरीन



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