User Manual

of

Integrated Hospital Management System

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OVERVIEW

IHMS is a fully integrated and a comprehensive Hospital Management System. It can efficiently manage details of all the departments of a Hospital whether it be a single Hospital or a range of multiple Hospitals at city, District, State or National level. IHMS can help the management at Headquarters to monitor any particular Hospital at any moment of time.

IHMS streamlines and integrates operation processes and information flows in the hospital to synergies the resources namely men, material, money through information. It performs core hospital activities and increases customer service thereby augmenting the overall Hospital Image. IHMS bridges the information gap across the hospital. It automates activities of each and every department and generate MIS reports in few seconds. Patient records, clinical status, Human resources, Stock & Asset Maintenance, Accounts, Library, Dietary – all these can be very efficiently managed from our software. Hence IHMS software is a total solution for Complete Computerization of your healthcare institution.

The Software is designed intelligently in such a simple way, that a novice user or a person who has recently learnt how to use a computer can also operate this software easily. For users it seems an easy data entry software, but for management it is a effective tool which gives them statistical information in the form of registers and summary reports.

OBJECTIVE

- Helps in Efficient Management of the Hospital.
- Enhance Patient Care
- Improve work efficiency
- Improve Fiscal Control
- Eliminate the chances of any Pilferage
- Enable the Growth of the Hospital

FEATURES

- Multi level security with USB Lock, User name & Password for every staff. Further section wise access rights with customization to allow Saving/Modifying/Deleting/Printing records.
- Dual saving of data both on local server and also on Central server via synchronization.
- All the departments in IHMS are interlinked. So data from one department is easily available to other department for further process.
- Daily, Monthly, Annual Register reports and Summary reports can be generated at any moment of time.
- Proper Estimations and planning can be done by various departments for different activities
- Backup and Restore facility
- very easy to operate by any staff of the Hospital. The interface provided is consistent throughout all the sections of the software.
- Indept details capturing provision without the compulsion to type the data in all fields. Partly entered data can also be saved.

INSTALLATION PREREQUISITES

At Research Centres:

Server Machine: Quad core Pentium processor with 4 GB RAM & 500 GB HDD, 18 inch LCD Monitor

Client Machines: Pentium Dual Core processor or higher with 1 GB RAM & 150GB HDD, 15 Inch LCD Monitor

Printer: Any brand Laser Jet Printer

Network: 10mbps LAN network, 2 mbps Broadband Internet connectivity / VPN COnnectivity

Additional Software's: Windows 2003/2008 Server OS, Microsoft SQL Server 2000/2005/2008 Standard

At CCRH Headquarters:

Server Machine: Quad core Pentium processor with 4 GB RAM & 500 GB HDD, 18 inch LCD Monitor

Client Machines: Pentium Dual Core processor or higher with 1 GB RAM & 150GB HDD, 15 Inch LCD Monitor

Printer: Any brand Laser Jet Printer

Network: 10mbps LAN network, 2 mbps Broadband Internet connectivity / VPN COnnectivity

Additional Software's: Windows 2003/2008 Server OS, Microsoft SQL Server 2000/2005/2008 Standard

INSTALLATION INSTRUCTIONS

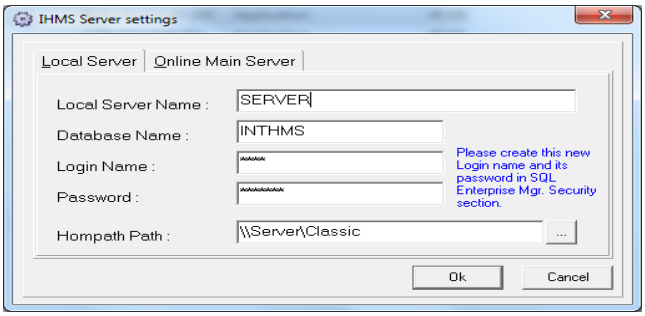
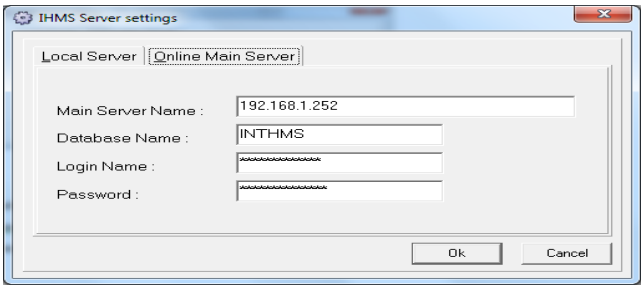
Server Installation steps:

1. Install Microsoft SQL Server licensed version which will create an SQL Instance on server.
2. Install Hompath Classic 8.5 Server setup and share the PATDATA folder to be accessible on network.
3. Install HASPUserSetup utility to install drivers for the security Lock working.
4. Install IHMS software.
5. Run the DBInstaller utility from UTILS folder of IHMS which will Create the database on SQL Instance.
6. Run the ServerSetting utility of IHMS to specify connection to the above database on SQL Instance.

Client machine Installation steps:

1. Install Hompath Classic 8.5 Client Setup and select the PATDATA folder shared on server.
2. Install IHMS Software.
3. Run the ServerSetting utility of IHMS to specify connection to the database hosted on SQL Instance on server.

Configuring Local and Main server in ServerSetting utility:

	Default Login name is ihms and password is ihms123
	Enter Login name and password provided by Administrator to enable synchronization to Headquarter server.

Default login credentials of IHMS:

Username : admin

Password: admin

MODULES INTRODUCTION

IHMS software is the integration of 8 different modules along with the Repertorisation tool as under,

ADMINISTRATION

Here Master data relating to all modules such as Human Resource, Patient Management, Stock Management, Accounts, Asset Management, Library Management and Dietary Management can be maintained here. Apart from this you can also configure users and allocate them access rights to various parts of the software and take regular backups. Synchronization of your institutes data to the central database of your headquarter can also be done from here.

HUMAN RESOURCE MANAGEMENT

Here all information relating to your Employees can be maintained. Further their Attendance, Performance, Salary, Loans & Advances details can be managed. Inward and Outward correspondence of your Hospital can be efficiently managed and any documents can be tracked immediately

PATIENT MANAGEMENT

Here all information relating to patients can be stored efficiently. OPD & IPD Registrations of patients along with their case records in detailed manner can be managed here. Patient transfer, Discharge, Bed maintenance, Lab Findings, Follow-ups, Video recording of patients are some of the best features.

STOCK MANAGEMENT

Here you can manage the stock of all items in your Hospital. Provision to prepare Indent, Store Quotations received, and Generate Purchase Order is given. Material is first received at Central location and thereafter it can be issued to various departments.

ASSET MANAGEMENT

Here you can manage maintenance details of all your Assets, Equipments, and Vehicles. Renew AMC on time for all based on MIS reports.

ACCOUNTS

Here you can manage daily Income & Expenses of your Hospital, plan budget for each financial year, generate MIS reports such as Receipt & Payment, Trial Balance, Profit & Loss Account, and Balance sheet at one click. Drill down facility up to voucher level is the interesting feature of this software.

LIBRARY MANAGEMENT

This is actually a kind of e-Library where soft copy data is managed efficiently. Members include Employees, Students, and Guests who may come to your Hospital. You can have any type of media and its unlimited copies configured in this software under various categories. Know instantly whether a particular Book or magazine is currently available and where it is kept or when it is due by other member. Generate reminders to members for media which is due.

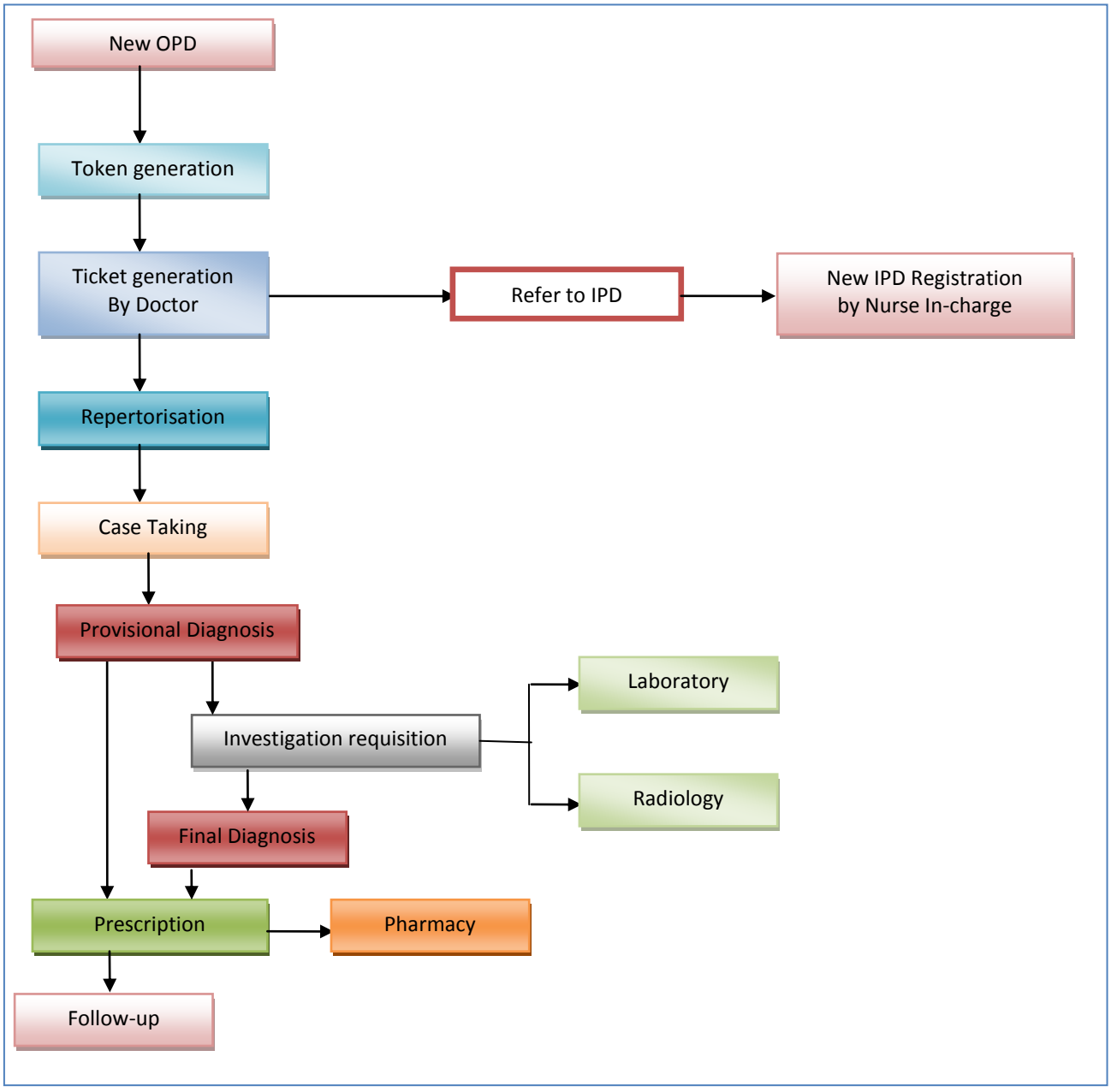
THIS MODULE IS NOT AVAILABLE FOR YOUR INSTITUTE AS PER INSTRUCTIONS OF CCRH HEADQUARTER

DIETARY MANAGEMENT

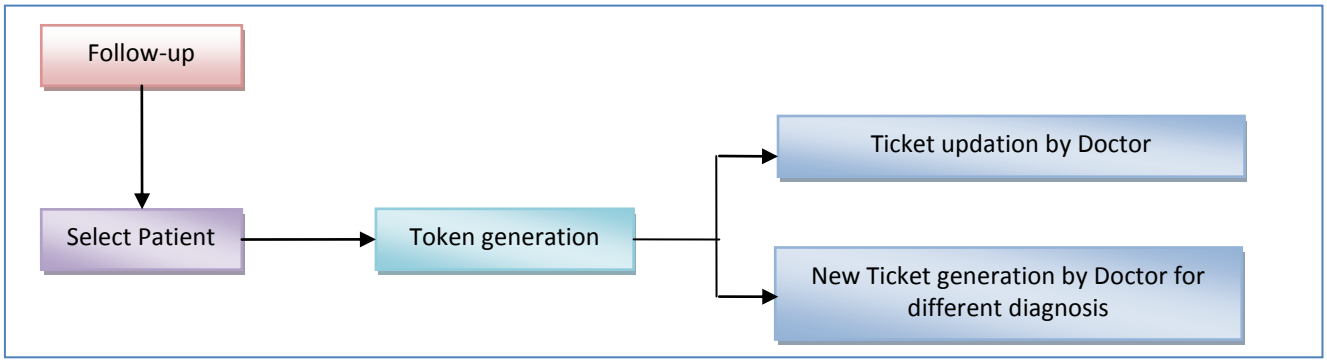
Here you can very efficiently plan weekly diet for all the IPD patients or Guests in your Hospital. Provision to configure Full & Half diet, Veg. & Non-Veg. diet is given in this software, so you can create a requisition and based on that consumption can be done. Stock of all the material including food grains, utensils, Fuel can be maintained efficiently and you can see the balance stock at any moment of time. Health tips section is also included in the software which will help your employees consume a proper diet and avoid health related complaints.

PATIENT MANAGEMENT FLOW

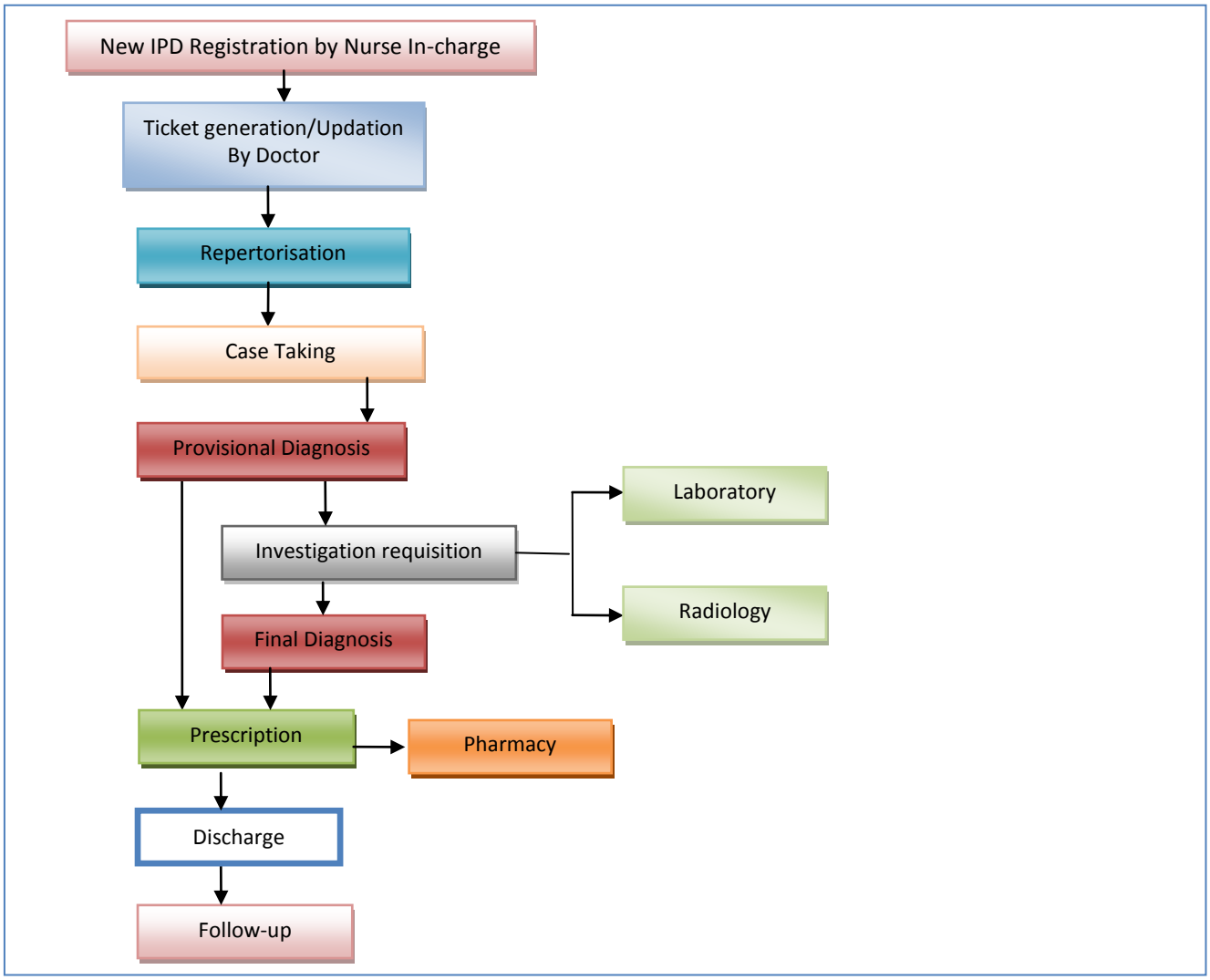
OPD Registration and Case Taking flow



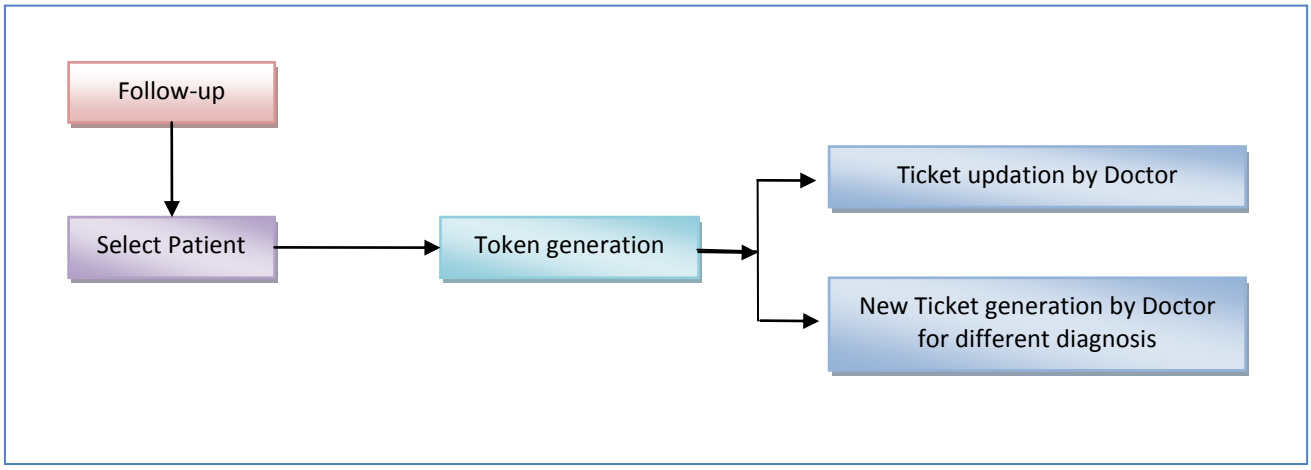
OPD Follow-up flow



IPD Registration and Case Taking flow



IPD Follow-up flow



PREPARING MASTER DATA

IHMS has provided you default master data in following masters –

Remedy Category (5)	State (35)
Remedy (2249)	Body Part Category (4)
Asset Category (3)	Body Part (34)
Department (8)	Item Category (16)
Grade (4)	Potency (7)
Designation (13)	Imaging Side (3)
Accounting Group (12)	Imaging View (6)
Account Ledger (7)	Requisition Type (12)
Despatch Mode (2)	Discharge Status (5)
Diet Events (3)	ICD10 Data Section (278)
Kitchen Item Category (4)	ICD10 Disease Category (1900)
Kitchen Items (29)	ICD10 Disease (87983)

After IHMS software is installed successfully, following data must be updated and created in Administration module for using the software on immediate basis:

- ✓ Institution – Fill all the details of your Hospital / Medical institution.
- ✓ Departments – Create further new departments of your institution.
- ✓ Sub-Department – Create Sub-Departments or Rooms under Department. These sub-departments will be helpful for selection when Token is created for a patient at reception.
- ✓ Designations – Create all designations that are allotted to employees in your institution.
- ✓ Shift – Create shifts in which your staff will be working.
- ✓ Allowances- Create allowances that you will be providing to your Staff.
- ✓ Wards- Create all the Wards that are in your Institution for admitting patients.
- ✓ Beds-Create Beds under each wards for allocating to the patients admitted.
- ✓ Potency- Create further potencies of medicines.
- ✓ Project- Create further Project details in which your institute is doing research.
- ✓ Diet Menu-Create details of Individual food items which are given to the admitted patients. E.g Rice, Dal, Idli, Sambar, Eggs, Chicken, Mutton, Veg Soup, Chicken soup etc.
- ✓ Diet Menu Dish- Create Menu dishes which is the combination of multiple food items. E.g: Dal Rice & Chicken Currey, Omlette Bread, Chapatti Mutton with Boiled Eggs etc.

After Master data is created, all staff details of your institution must be created in Human Resource Module and thereafter Login details for every employee must be created in Administration module. Each user can then be allotted access rights to use particular section / features of IHMS software which includes Adding, modifying, deletion & printing rights.

PROCESS WISE ENTRY INSTRUCTIONS

PMS MODULE INSTRUCTIONS

OPD REGISTRATION

1. **New Patient comes**
   - Reception will register patient details in OPD Registration form.
   - Thereafter New Token number will have to be generated for that patient.
   - The patients name will appear in the Patient Queue form of Doctor to call for consultation.
   - Thereafter New Patient Ticket will be prepared by the consulting Doctor. This Ticket itself will be a case paper in which complaints, diagnosis & prescription can be done.
   - Doctor can further enter Case record or request various types of investigations depending on disease diagnosed.

2. **Patient comes for Follow-up**
   - Reception will have to Select the Patient from 'Select Patient' form.
   - Thereafter New Token number will have to be generated for that patient.
   - The patients name will appear in the Patient Queue form of Doctor to call for consultation.
   - Thereafter the Doctor will open the Patient Ticket form and Click on New Follow-up button and specify follow-up details and even prescribe.
   - Doctor can further enter details in case record section and can also further request investigations.

3. **Existing Registered Patient comes for new complaints after some period of time**
   - Reception will directly select the Patient from 'Select Patient' form.
   - Thereafter New Token number will have to be generated for that patient.
   - The patients name will appear in the Patient Queue form of Doctor to call for consultation.
   - On selecting the patient from the queue, the existing Ticket opens. But since the patient has come after a long time for some other type of treatment and not for follow-up of previous treatment, the Doctor has to create a New Ticket by clicking New Ticket Button and specify complaints and other details and prescribe. Henceforth this new ticket will be considered for follow-up.
   - Doctor can further Enter Case records, request investigations or do Final Diagnosis.

IPD REGISTRATION

PATIENTS Referred to IPD from OPD

1. Receptionist will Register the Patient in OPD Registration form.
2. Thereafter New Token number will be generated for that patient.
3. The patients name will appear in the Patient Queue form of Doctor to call for consultation.
4. Thereafter New Patient Ticket will be prepared by the consulting Doctor and complaints and diagnosis details will be entered.

5. If the case found is a Chronic case and requires admission, the patient will be referred to IPD by tick marking the checkbox 'Refer to IPD' in Patient Ticket.
6. Nurse In-charge will get a list of referred patients in Pending Admissions form.
7. Nurse In-charge will select the Patient from 'Pending Admissions' form and admit that patient on a particular Bed in required ward. Date and time of admission along with required IPD number can be allotted to the patient.
8. The IPD doctor can then enter details in the same Ticket in which the patient is referred by first selecting the patient from 'Select Patient' form.
9. IPD Doctor can further Enter Case records, request investigations, do final diagnose & also prescribe.
10. Nurse In-charge can manage details of the patient along with Transfer or Discharge.

Direct IPD Admission

- Nurse Incharge will register patient details in IPD Registration form. Ward & Bed No will be allocated and the patient will be admitted.
- Thereafter New Patient Ticket will be prepared by the IPD consulting Doctor and complaints and diagnosis details will be entered.
- The Nurse In-charge can then prepare Visitor Card, maintain Temperature & Blood pressure records, Intake & Output records, Treatment details, Nurse report & manage Video recording of the patient in case records section. Further she can also manage transfer details & discharge details along with Bed management.
- IPD Doctor can further Enter Case records, request investigations, do final diagnose & also prescribe.

1. **Discharged Patient comes for Follow-up**
   - Follow-up will be given in OPD by the patients.
   - Reception will have to Select the Patient from 'Select Patient' form.
   - Thereafter New Token number will be generated for that patient.
   - The patients name will appear in the Patient Queue form of Doctor to call for consultation.
   - Thereafter the Doctor will open the Patient Ticket form and Click on New Follow-up button and specify follow-up details and even prescribe from there.
   - Doctor can further enter details in case record section and can also further request investigations if required.

2. **Existing Registered Patient comes for Admission with new complaints after few months**

   As the patient registration details already exist, there is no need to again register the patient.
   - If Patient comes to OPD then Reception will directly select the Patient from 'Select Patient' form and ten create Token. The consulting doctor will create new Ticket and will refer to IPD. If patient directly goes to IPD, then Nurse in-charge will select the Patient from 'Select Patient' form and do IPD Registration by allocating Bed. Then the IPD consulting doctor will create New Ticket for that patient.
   - The Doctor will examine the patient and further enter details in case record section and can also request investigations and prescribe.
   - Nurse In-charge will do Transfer or Discharge of Patient by selecting from 'Select Patient' form.

INTIMATION IN ADVANCE (POPUP REMINDERS)

IHMS software also displays a popup reminder for –

1. Laboratory staff, so they come to know in advance which patient will be coming to their department for getting Lab Tests done. This reminder is linked to the 'Lab requisition' which the doctor makes.
2. Radiology staff, so they come to know in advance which patient will be coming to their department for taking out X-Ray, ECG etc. This reminder is linked to the Imaging Investigation requisition which the doctor makes.
3. Pharmacy staff, so they come to know in advance which patient will be coming to their department for collecting the specified medicines. This reminder is linked to Prescription which the doctor makes.
4. Pharmacy staff, so they come to know in advance which balance stock of medicine is going to exhaust sooner depending on reorder level specified in Item Masters.

OTHER DATA ENTRY PROCESS

Laboratory Staff:

When doctor requests Lab investigations for patients. The names of patient will appear in the list of 'Pending Sample collection'. Double click on the patient name to display a popup for specifying list of sample collected from the patient. Select Requisition type from the drop down list which will generate a Sample number starting from 1 every day for each type of Requisition Type. Click on Add button and the sample details will be passed on to the senior Lab person who will actually perform test on the sample collected.

List of samples collected will appear in the Pending Lab Investigation form where double clicking on the patients name will display a popup and various investigations that are to be done on that patients samples collected. Again double clicking on the Sample Number in the list will open the respective Investigation screen for entering details. For e.g if the Biochemistry Test is to be done on sample collected, Biochemistry form will open when double clicked on the sample number. Accordingly if urine test is to be done on sample collected, then Urine form will open when double clicked on sample number.

Once a record is entered in various investigations forms, the pending list of tests will get cleared.

Radiology Staff:

When a doctor requests Imaging investigations for patients. The names of patient will appear in the list of 'Pending Imaging Investigation' form. Double clicking on the patient name will display a popup showing various types of imaging that are to be performed on the patient. Clicking on the Imaging Type listed will open the respective Investigation form for entering details. For e.f if the Investigation Type if X-Ray then X-Ray form will open. If the Investigation Type is CT-Scan or MRI accordingly those forms will open for entering investigation details.

Once record is entered in various investigation forms, the pending list of test will get cleared.

Pharmacy Staff:

When a Doctor prescribes medicines from Ticket or Prescription form, a list of patients will be displayed to the Pharmacy staff who will be coming to collect the medicines. Double clicking on the patients name in the list will display a popup in which list of medicines prescribed will be displayed along with instructions. The Pharmacy person will prepare the medicine accordingly and enter the Quantity and remarks, save the record and hand over the medicine to the patient. Once the record is saved, the patients name will be cleared from the pending list and will be marked as 'Medicine Issued'. Stock of that medicine will also get reduced from the Inventory.

FORM WISE ENTRY

PATIENT MANAGEMENT MODULE

SELECT PATIENT

This form will help you to select a registered patient so related things can be stored further for that patient. There are 10 search criteria's provided through which you can search a patient. They are by – First Name, Last Name, OPD Reg No., OPD Reg. Date, IPD Reg. No., IPD Reg. Date, Ticket Number, Patient Type, Department/camp wise, and Disease diagnosed wise. By default when this form is loaded, OPD Reg. date is set to current date which loads all the today's newly registered patient list automatically. Clicking on Search button will search and display patient list depending on the search criteria specified. Clicking on Show All button will display all the patient names that exist.

The search result displays details such as First Name, Last Name, Ticket Number, Ticket Date, OPD No., OPD Date, IPD No., IPD Date, Doctor In-charge, Discharged status, Discharged date.

CLOSE PATIENT

This will close all the open records of a patient.

PATIENT APPOINTMENT

Schedule appointments for new and existing patients. For existing patients just enter their OPD Registration number and all their details will be automatically retrieved. Specify the consulting Doctor, appointment time and complaints informed by the patient. Once an Appointment entry is saved, Appointment card can be printed and handed over to the patient when they come. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Patient Type, Patient first name, Consulting doctor.

OPD REGISTRATION

IHMS software can manage registration of patients done at your OPD or at the outdoor Camps conducted by your institution. Registration number will be automatically generated in the format of 'Incrementing number/Financial Year'. This number is editable and can be changed during registration process. Specify details such as gender, title, Age, address, contact numbers, Marital status, mother tongue, religion, Occupation, Education, Identification marks & Referring doctor. List of Referring doctor comes from doctors details created in Referred By master in Administration module. Once Patients details are registered, token will have to be created for the patient which will display the 'Patient Token' Screen.

Mandatory Fields: Department or Camp Name, OPD Reg. No, Gender, First Name, Age

PATIENT TOKEN

The Token feature in IHMS will help you to allot Tokens to your patients so that they can wait outside the respective OPD Rooms till their number is called. It also helps the patient know how much more time it will take for his turn for consultation considering the present patient inside the room. Every OPD Room configured in IHMS is linked to a doctor

in 'Doctors schedule' form whose name reflects here in Token screen when a Room No. is selected. The receptionist also comes to know How many tokens have been allotted to a particular doctor and how much is the queue left, so the receptionist can accordingly allot a patient to particular OPD room or can ask the patient which doctor they want to show. Token number will be generated from sr. No. 1 everyday for each doctor. A printout of the Token can also be handed over to the patient once token details are saved.

Mandatory fields: Department, Room No., Consulting Doctor

BILL RECEIPT

Available to all the patient related departments to raise and generate bill receipt for amount collected from patients. First select a patient from 'Select Patient' form whom you are charging. Select department & sub-department from the list. Right click on the Charges section which will display New & Delete option. Selecting New will insert a blank row undo charges where you can select the charges name & its amount will be automatically retrieved. Selecting delete will remove the charges from the list. Total amount will be calculated automatically if you add multiple charges in the list. Specify remarks & the collector name and save the record by clicking on 'Save' button and print the report by clicking 'Yes' when asked. Receipt can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Please note that charges are retrieved from the Charges Master which is in Administration module.

PENDING ADMISSIONS

This form will be accessible to Nurse in-charge. It will display list of patients who are referred from OPD for admission. Nurse In-charge will double click on the patients name which will open the IPD Registration form. On admitting the patient, the patients name will be removed from pending admissions form.

VIEW BED OCCUPANCY

This form will enable Nurse In-charge and IPD doctor to know the status of Beds in various Wards of your Institution. All the Patient Beds that are in your institution are listed here along with their status – Vacant, Occupied, On Maintenance. Vacant Beds are marked in Green color. On Maintenance Beds are marked in Red Color and Beds on which patients are admitted are marked with Light Blue Color along with Patients name. You can get a printout report of the Bed status at anytime by clicking on Preview Button.

IPD REGISTRATION

Nurse In-charge will have access to this form. It can be opened directly or can be opened by double clicking patient name in 'Pending Admissions' form. If opened from Pending Admissions, patient details will be loaded automatically and only Bed Allocation section has to be filled. If Chronic case patient is directly coming for admission then Nurse In-charge will enter all details of Patient and allocate Bed. All Patient Information fields are similar to the fields in OPD Registration form. In Bed Allocation section select Referring Doctor, Research Project under which the treatment is to be given, Department, Sub Department, Ward, Technical In-charge name, Bed Number, and Admission time. IPD Number will be auto generated in the format of 'Incrementing number/Financial year' which is also editable.

VISITOR CARD

Nurse In-charge will prepare Visitor Cards for people visiting IPD Patients. Visitor details such as Name, Gender, Age, Visiting time & validity period of the card can be specified and printed. When the card is handed over to the concerned person Card given check box has to be ticked. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Visitor Card report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Visitor Name, Gender, Visiting Time

BED MAINTENANCE

This form will be accessed by Nurse In-charge. Any Bed requiring maintenance can be managed from here. Initially all Ward numbers are listed. Tick marking a particular Ward number will list all the Beds available in it. The Bed which is required to be sent for maintenance will be ticked and details such as Date & time of sending and remarks need to be filled.

PATIENT TRANSFER

This form will be accessed by Nurse In-charge. Patients can be transferred from one bed to another in same ward or different ward. The patient who need to be transferred will be selected first from 'Select Patient' screen. Initially Present ward details of the patient will be displayed. New Ward details such as Department, sub-department, Ward Number, Bed Number, Treating Doctor, Transfer date & time needs to be entered for transfer process to complete. Once a patient is transferred to new bed, the existing Bed will become vacant.

PATIENT DISCHARGE

This form can be accessed by the IPD Doctor or Nurse In-charge for discharging the admitted patient. Brief details such as History, Examination , Investigations, Treatment, Results & Instructions need to be entered along with the Status, Discharging doctors name & Technical in-charge name. Discharge status can be set to Recovered, Unrecovered, Referred, Expired, LAMA (Left against medical advice). Once a patient is discharged, that bed will become vacant.

PATIENT QUEUE

This form will be accessed by the OPD doctors. Initially all the patients list will be listed along with token serial number who will be coming for consultation. Every OPD doctor will have their own queue differently depending on their logins and patients allocated to them by the receptionist while preparing Tokens. This list is actually the sequence in which the patients will be entering the OPD Room of respective doctors. Once the patient enters the Doctors room, the doctor will double click on the patient name which will get that patient selected and the 'Patient Ticket' Form will open.

PATIENT TICKET

This form will be available only to Doctors for managing OPD visits & subsequent follow-ups. This form can be opened from the Patient Queue by double clicking on the patient name or if the patient is selected from the 'Select Patient' form. When Ticket is being prepared for the first time, First Visit Tab will be displayed where doctor will enter Presenting complaints, History, Family history, specify generals, Go for repertorisation, enter treatment details, specify

provisional diagnosis disease details, prescribe medicine and can also refer the patient to IPD in case of chronic case. IHMS has ICD10 diagnosis list of diseases integrated into it properly under sections and categories which help the doctors to become familiar with the codes. The second Tab of photos enables the Doctor to add multiple photographs of Patients along with its description. After filling all the details click on save button and print the Ticket report by clicking on Preview button. Henceforth whenever the patient is coming for follow-up, follow-up details will be recorded against this Ticket number by clicking on New Follow-up button.

Only when that patient comes after a long period for different complaints, New Patient Ticket will have to be created and subsequent follow-ups will be recorded against that ticket number.

Any Ticket report can also be printed at later stage by double clicking the visit record in 'Case summary' section and then clicking on 'Preview' button.

REPERTORISE WITH HOMPATH

At any point of time while taking a case, the Doctor can go for Repertorisation from the 'Patient Ticket' form or from the 'Repertorise with Hompath' Menu. The patient currently selected in IHMS will automatically reflect in Repertorisation software and the Doctor can do Repertorisation by entering symptoms & applying filters etc.

REPERTORISATION FACTS

After repertorising the patient case, all details will be entered in repertorisation facts sheet where you can classify symptoms, enter miasmatic analysis & diagnosis details.

This form is divided into 4 sections. In first section of 'Classification of Symptoms', the doctor will enter Repertorisation date, Patients symptoms & disease symptoms. In second section of 'Miasmatic Analysis', you will select Section, subsection and enter Psora, Sycosis, Syphilis, & Pseudo-Psora/Tubercular details for it. Click on Add button and again select another Section & subsection and enter details for them. In this way multiple analysis details will be entered & added to list. If you want to remove any analysis details from the list created below, select the row and click on remove button. In third section of 'Miasmatic Diagnosis' you can specify Aeitology, Mental Generals, Physical generals, uncommon & particular diagnosis, common symptoms and Totality of symptoms. In continued fourth section of 'Miasmatic Diagnosis', you can specify which chapters, symptoms & rubrics you had taken during repertorisation. You can add these details by right clicking below chapter and selecting 'New' and typing in the respective cells. Enter further details in 'Repertorisation proper' and 'Repertorial Analysis' fields and save the record by clicking the 'Save' button and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields on this form but data in at least one field out of four sections is required in order to save the record.

IMAGING REQUISITION

This form is accessible to Doctors where they can request for Investigations of – X-Ray, USG, MRI, CT Scan, ECG and EEG. The Doctor will specify Requisition Type which will be retrieved from 'Requisition Type' master available in Administration module, then specify Body Part, Side, View and click on 'Add Button'. If another Type needs to be

added, it can be added similarly so that multiple investigations can be requested in one requisition. Previously requested investigations are displayed in below list on the form. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Requisition can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button. This requisition will immediately appear in the 'Pending Investigations' list of Radiologist and a popup will also be displayed there.

The status of this requisition can be known by the doctor in 'Requisition Status' form under Baseline Investigations section.

Mandatory fields: Requested By, Requisition Type, and Body Part.

LAB REQUISITION

This form is accessible to Doctors where they can request for Investigations of – Urine, Feaces, Elisa, Biochemistry, and Haematology. The Doctor will specify Requisition Type which will be retrieved from 'Requisition Type' master available in Administration module, then specify test count for each test as some test may require to be taken before and after lunch or early morning & after 3 hours & son on. Previously requested investigations are displayed in below list on the form. Once this current requisition is saved,Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Requisition can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button. This requisition will immediately appear in the 'Pending Lab Investigations' list of Laboratory staff and a popup will also be displayed there.

The status of this requisition can be known by the doctor in 'Requisition Status' form under Baseline Investigations section.

Mandatory fields: Requested By, Requisition Type, and Test Count.

FINAL DIAGNOSIS

This form is accessible to Doctors. They can do Final diagnosis of the patient during the first visit itself or during subsequent follow-up visits after consultation & investigation reports or after giving some medicines for few days and viewing its effect. Specify the Disease diagnosed by browsing ICD10 diagnosis list, then specify symptoms and Treatment. Click on 'Save' button to save the details and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button. You can get a final diagnosis register report in MIS Reports section depending on data entered on this form.

PATIENT MEDICINE ISSUE

This form will be accessed by the pharmacist where initially list of all the patients will be displayed who will be coming for collecting the medicines. This list will keep on generating whenever a Doctor prescribes a medicine to the patient. The Pharmacist has to double click on the patients name to get the list of medicines in a popup so those medicines could be prepared and given to the patient. Once the medicines are prepared and handed over to the patient the Pharmacist will tick mark the issued column and specify the quantity and click on save button.

Saving the record will deduct the stock of medicine and will remove that patient from the pending list of Pharmacist.

PRESENTING COMPLAINTS

This form will be accessed by the Doctor after selecting a Patient from 'Select Patient' form. This is the primary form for beginning in-dept case taking of a patient. Here details of Complaints with duration, Location & Extension of the complaint, Sensation character & Pathology details, Modalities & Ailments, and Concomitants will be fed by the doctor. Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field needs to be entered for saving the record.

COMPLAINTS ON FURTHER ENQUIRY

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is similar to 'Presenting complaints' form where details of Complaints with duration, Location & Extension of the complaint, Sensation character & Pathology details, Modalities & Ailments, and Concomitants will be fed by the doctor. Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field needs to be entered for saving the record.

HISTORY OF PRESENTING COMPLAINTS

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Here presenting complaints will be automatically retrieved from Complaints field of 'Presenting Complaints' form. Further the Doctor has to specify Duration, mode of onset, Course of illness, and Treatment adopted details after interrogating the patient. Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field, needs to be entered for saving the record.

HISTORY OF PAST ILLNESS

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Here information about illness or, injury inflicted or surgery that was conducted in past on the patient, Age during that time, details of treatment taken and it's results will be entered. Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field, needs to be entered for saving the record.

FAMILY HISTORY

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Details of relatives are preloaded and doctor has to further specify details such as Age, Dead or alive, any illness suffered by them in the past or are still suffering, cause of death if death has occurred. Click on 'save'

button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field, needs to be entered for saving the record.

PERSONAL HISTORY

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into four sections – Present history, Childhood history, Lifespace Investigations, Gynecological History, Obstetric history.

In 'Present History' section enter details such as Accommodation, Economic status, Diet & food habits, Habits & addiction, Hobbies, Sexual history, vaccinations, History of any regular treatment going on.

In 'Childhood history' section enter details about birth, milestones, teething, sitting, standing, walking, Urine control, Bed wetting, Eating indigestible, other problems, Growth & development details, Animal bite, Vaccinations inculcated, Drugs & Tonics, Blood Transfusions, and Allergies.

In 'Life space Investigation' section enter details such as behavior during childhood, Education, Adolescence & Psychosexual history, Occupational & Marital history, Present social and travel history.

If the selected patient is a female patient then only 'Gynecological History' section will be enabled. Enter details in this section related to menarche & its related complaints. Menstrual details are divided into five sub-sections such as Last Menstrual period, Changes, Climacteric, Abnormal discharges, and surgeries.

In 'Last Menstrual period details' sub-section details enter details such as Cycle, Quantity, consistency, Color & Stains, Odour, Character, Before menses, During menses, and after menses.

In 'Changes' sub-section enter details such as Early years, before marriage, after marriage, after pregnancy and Recent state

In 'Climacteric' sub-section enter details such as Age of menopause, associated complaints, and post menopausal complaints.

In 'Abnormal discharge' sub-section enter details such as Quantity & consistency, Color & Stains, Odour, Character, Relation with menses, modalities, and concomitants.

In 'Surgeries' sub-section whether undergone H/O gynecological surgeries, its reasons, contraceptive methods adopted and any complaints from use of those methods.

If the selected patient is a female patient then only 'Obstetric History' section will be enabled. Enter details in this section related to pregnancies, their number, any abortions, any still births, number of live births, number of childhood deaths, number of children presently surviving. Delivery details can be specified for each birth which includes Period of pregnancy, complaints & treatments in pregnancy, date & nature of labor, nature puerperium, weight of child at birth, whether alive or death, cause of death, lactation history.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button. This report can go up to five pages depending on quantity of data entered.

There are no mandatory fields but details in at least one field in any section, needs to be entered for saving the record.

GENERAL SYMPTOMS

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into three sections – Physical, Mental, and Mind.

In 'Physical' section you can specify details for Appearance, Appetite, Taste, Thirst, Craving, Aversion, Aggravation, Amelioration, Stool, Urine, Sweat, Sleep, Dreams, Perspiration, Thermal reactions, General modalities, Tendencies, / recurrent complaints, General sensation and complaints.

In 'Mental' section specify details about the mental state of the patient in detailed manner.

In 'Mind' section specify details such as Emotional, Subconscious & intellectual of the patient.

Click on 'save' button to save this record print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field in any section, needs to be entered for saving the record.

MENTAL CHARACTERISTICS

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into three sections – Appearance, Reaction, and Other features.

In 'Appearance' section, tick mark fields that are grouped into appearance and history of emotional upset.

In 'Reaction' section, tick mark fields applicable under Aversion, Desire, Intolerance, Aggravation, Amelloration.

In 'Other features' section tick mark fields applicable under Emotional, Perception, and Memory.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field in any section, needs to be ticked for saving the record.

CONSTITUTIONAL

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into three sections – Emotional, Physical, and Intellectual.

In Emotional section, enter details relating to patient such as Irritable, Vexation, Affectionate, Quarrelsome, Indignation, Attachment with any person, Abusive, Sad, Attachment with Objects, Violent, Indifference, Attachment with money, Rage, Quite, Attachment of Power, Suppressed, Brooding, Attachment with work, mortification, Self pitying, Attachment with career, Romantic, Revengeful, Timid, Egotism, Fault finding, Restless, Proud, Fearful, Mania, Jealous, Anxious, depression, suspicious, nervous, Cruel, and worried

In Physical section, enter details such as Appearance, facial expression, Ears, Height, Chin, Reaction to time, Skin complexion, Jaw, periodicity, Skin texture, Nose, Motion, Hair, Mouth, Lips, Position, Hair color, Shape of Hands, Temperature, Dandruff, Hand fingers, Weather, Nails, Hands & Palms, Season, Weather change, Temperature change, Season change, Air, Covering, Getting wet, Bath, food drinks, sex, sleep, Elimination, Sensory output, Relation to eating, Diathesis, Tendency, and any other remarks.

In Intellectual section, enter details such as perception, memory, thinking, decision, confidence, perfectionist, unreliable, goal oriented, person oriented, religious, Artistic, and any other remarks.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field in any section, needs to be ticked for saving the record.

DELIVERY & BIRTH RECORD

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into seven sections – History, Examination, Past History, Delivery Notes, New Born, Apgar Score, and Other.

In History section, enter details such as H/O Amenorrhea, Gravida, Para, Obstetric history, and Menstrual history.

In 'Examination' section, enter details such of all vital signs such as BP, Pulse, Temperature, R.R, Weight. Foetal examination details can also be entered in this section related to Height, Lie, Position, Presentation and FHS.

In 'Past History', enter details related to Hypertension, Toxaemias, A.P.H, Diabetes, Heart disease, Bleeding disorders, S.T.D's, and Anemia.

In 'Delivery Notes' section, specify whether the delivery was Nornal or Abnormal along with delivery date and time. Further details related to the delivery can be entered here such Type of Abnormal or Assisted delivery, Pain started details, Osdilation, Memb. Rupture, Labor prolonged, Obstructed, Liquor details and Placenta.

In 'New Born' section, enter details about the New born baby, whether it is a Male or female child, its weight, length, chest circumference, Occipito frontal circumference, cry, reflexes, its maturity details such as Pre, full, post term gestation, whether suffering from jaundice, Anaemia, Cyanosis, Birth trauma, caput, cephalhaematoma or any other. Futher details relating to Excessive salivation & frothing , respiratory distress, Imperforate Anus, Genitals, Femorals, Spinal lesions, Apex Beat, and Neurological examination details.

'Apgar Score' can be maintained for the new born under AP1, AP5, and AP10.

Any other Notes and Remarks can be maintained under 'Other' section.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields : Doctors name

No other fields are mandatory but at least one field in any section, needs to be specified for saving the record.

PHYSICAL EXAMINATION

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into three sections – General Examination, Systemic Examination, and Regional Examination.

In 'General Examination' section, enter details for Facies, Physical attitude, General build, Anemia, Jaundice, Cynosis, Oedema, Pigmentation, Lymphadenopathy, Clubbing, Nutrition, Neck veins, Blood Pressure, Pulse Rate, Temperature, Respiration rate, Height, and Weight.

In 'Systemic Examination' section, enter details for Respiratory syste, Cardiovascular system, Gastro Intestinal system, Genito Urinary system, Loco motor system, Nervous system, and any other examination details relating to system.

In 'Regional Examination' section, enter details for regional examination done.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field in any section, needs to be entered for saving the record.

MEDICAL MANAGEMENT

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form has only one field for specifying Medical details and it is compulsory.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Medical

GENERAL MANAGEMENT

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Enter details such as Diet and Auxiliary management and save the record by clicking on 'Save' button and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

There are no mandatory fields but details in at least one field needs to be entered for saving the record.

DOCTOR BOOK

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. The Doctor can enter here night report after observing the patient.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Doctor, Night Report.

TEMPERATURE AND BLOOD PRESSURE

This form will be accessed by Nurse In-charge and the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Nurse In-charge will make entries in this form and Doctor can view those entries at later stage whenever required. Details such as Pulse, Temperature, Systolic & Diastolic BP, Respiratory rate, Stools, Urine, Sputum, Weight, Bath, Height, Medicines given will be entered along with remarks by Nurse In-charge. Previous readings can also be seen below on the form which helps to know the health condition immediately.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Doctor, Night Report.

INTAKE & OUTPUT

This form will be accessed by Nurse In-charge and the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Nurse In-charge will make entries in this form and Doctor can view

those entries at later stage whenever required. This form is divided into two sections – Intake, and Output. Intake details such as IV Saline, Blood, Dextrose can be specified along with quantity at various intervals along with remarks. Output details from patient such as Urine, Vomit, and drainage can be entered and tracked at various intervals along with remarks.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Time, Intake, Output, Quantity & Nurse name.

TREATMENT BOOK

This form will be accessed by Nurse In-charge and the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Nurse In-charge will make entries of medicines given to the patient in this form and Doctor can view those entries at later stage whenever required. Select Medicine category based on which Medicines will be displayed in list. Select medicine and enter quantity that is given to the patient and click on 'Add' button. If second medicine is given, add it similarly. If you want to remove particular medicine, select it in the list of added medicines and click on 'Remove' button. Enter remarks and click on 'Save' button to save the record record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Nurse Name, at least one medicine added to list.

NURSE REPORT

This form will be accessed by Nurse In-charge and the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Nurse In-charge will make Morning, Evening, and Night report entries which Doctor can view those entries at later stage whenever required.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Nurse name, at least one field from Morning, evening or night section.

VIDEO RECORDING

This form will be accessed by Nurse In-charge and the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Nurse In-charge will do all minute observations of the patient and also Video record the behavior or improvement stages which help the doctor to know the progress of patient's treatment. To record the activities of the patient, a web camera must be attached to the system from which recording will be done. An inbuilt utility to capture images and photographs of patient is provided with IHMS. Connect the Web Camera and click on 'Start Web Cam' button. If you want to just take a photograph, click on 'Copy Image' menu in the Utility and then paste in Paint Program. If you want to do video recording, click on 'Start Recording' menu in the utility and it will start recording. By default the video file will be created on 'C' drive of the computer where it is being recorded. Once recording is done, click on 'Stop Recording'. Copy the recorded file to the servers shared folder which can be accessed from network. Browse the file path by clicking on 'Browse button' and selecting the video file. Specify remarks

and click on Add button. If you want to add another image or video, so it similarly as mentioned above and then browse the second file and click on 'Add' button.

Click on 'save' button to save this record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

DAILY ASSESSMENT

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Enter details such as assessment time, doctor name, sleep, appetite, thirst, bowel, bladder, personal caring details, Observations related to patients behavior, talk, mood, delusions, hallucinations, communication, prescription and remarks. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Assessment Time, Doctor name, sleep details

WEEKEND ASSESSMENT

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. This form is divided into four sections – General, Examination, Delusions, Treatment.

In 'General' section, enter details such as Sleep, appetite, Thirst, Bowel, Bladder, Menstrual function, sexual function, personal care, daily routine, duties, personal productivity, functions and observations.

In 'Examination' section, enter details such as Mental status, general appearance & behavior, PMA, IPR, EEC, Speech details, mood swing, affect, and Emotional reaction.

In 'Delusions' section, enter details such as persecution, Idea of reference, control, somatic, Infidelity, thought broadcasting, Halucinations, Orientation, attention, concentration, memory, grasp, and Insight

In 'Treatment' section, enter details such as Treatment and comments.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Doctor name, sleep.

PRESCRIPTION

This form will be accessed by the Doctor after a Patient has been selected. If a patient is not selected 'Select Patient' form will be displayed. Here the Doctor can prescribe medicines to the patients. First select Remedy category based on which Remedies will be filled in drop down list. Specify potency, size, Dosage and period along with instructions and click n 'Add' button. If you want to add another remedy select another and click on 'Add' button. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button. Once a prescription is made, its details will be available to the pharmacy department in the form of popup and in 'Pending Medicine Issue' form.

Mandatory fields : Doctor name and at least one remedy prescribed.

REQUISITION STATUS

This form will be accessed by the Doctor's which will help them to know the status of their Investigation requisitions made. All the requisitions will be listed date wise depending on the request date specified. This list displays whether the tests were performed or not. If the tests are performed, the doctor can double click on the row to get an instant report of the Investigation.

PENDING IMAGING INVESTIGATIONS

This form will be accessible to the Radiology department staff. This form lists the names of patients & the requisition made by a doctor. Once the patient comes to the radiology department with the requisition slip, the Radiologist can double click on the requisition number in this list which will display the types of imaging that are to be performed on the patient's body part with side and view details and remarks of the doctor. The Radiologist will have to double click on the imaging type list which will open the respective investigation form for entry of records. Saving the details in the investigation form will clear the patient from pending Imaging Investigations list.

X-RAY

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested X-Ray investigation or when the Radiologist selects the patient from the 'Select Patient' form and then opens this X-Ray form for entering record. This form is divided into two section – X-Ray details, and Image files.

In X-Ray details section, selecting the requisition number will fill the list of body parts whose X-Ray is to be done. The Radiologist will select the film size, specify film Quantity and film number for each body part that is requested. Further report details and remarks will be specified.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of X-Ray reports can be attached here by giving each one a particular identification number.

Record will be saved by clicking on 'Save' button and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Doctor name, Radiographer.

ABDOMEN & PELVIS USG

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested Abdomen & Pelvis USG investigation or when the staff selects the patient from the 'Select Patient' form and then opens this 'Abdomen & Pelvis USG' form for entering record. This form is divided into three section – USG of Abdomen, USG of Pelvis, and Image files.

In 'USG of Abdomen' section, enter details of Liver, Gall Bladder, Portal vein, CBD, Pancreas, Spleen, Right Kidney, Left Kidney, Urinary bladder, Prostate, and R.I Fossa.

In 'USG of Pelvis' section, enter details of Uterus dimensions, Endomentrial thickness, Adnexa, P.O.D, Ascites / Effusions, and Impression.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of USG reports can be attached here by giving each one a particular identification number.

Specify remarks, Radiologist name, prescribing doctors name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Radiologist, Test done by, Requesting doctor, and at least one field out of three sections.

OBSTETRIC USG

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested Obstetric USG investigation or when the staff selects the patient from the 'Select Patient' form and then opens this 'Obstetric USG' form for entering record. This form is divided into two section –Obstetric USG, and Image files.

In 'Obstetric USG' section, enter details for Gravida, Parity, Living children, Abortions, Last menstrual period, Expected date of delivery, Gestational Age, Weeks, and Indications. This section is further divided into four sub-sections – General measurement, foetal, liquor placenta, and others.

In General sub-section, enter details such as number of live foetus, presentation and lie details,

In measurement sub-section, enter details in mm for G.Sac, CRL, BPD, FL, AC, Gest. Age, F.Wt and number of weeks for each.

In Foetal sub-section, enter details of Head, spine, Abdomen, and Abnormality.

In Liquor placenta sub-section, enter details of liquor, liquor index, and placenta.

In others sub section, enter details of EDD, impression, and remarks.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of USG reports can be attached here by giving each one a particular identification number.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Radiologist, advising doctor, and at least one field out of two sections.

CT SCAN

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested CT Scan investigation or when the Staff selects the patient from the 'Select Patient' form and then opens this 'Obstetric USG' form for entering record. This form is divided into two section – CT Scan details, and Image files.

In 'CT Scan details' section, enter observations in report details and remarks fields. Specify the name of person doing test and advising doctor.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of CT Scan reports can be attached here by giving each one a particular identification number.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Test done by person, advising doctor, and Report details field.

MRI

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested MRI investigation or when the Staff selects the patient from the 'Select Patient' form and then opens this 'MRI' form for entering record. This form is divided into three sections – Brain MRI, Other MRI, and Image files.

In 'Brain MRI' section, enter details of Ventricles, Thalemia, Lateral Ventricles, Brain Parenchyma, Choroid Plexus, Posterior Fossa - cerebellum, 3rd ventricles, Cisterna Megna, 4th Ventricles, Space Occupying lesion, Falx and Cavum Septum, Intracranial Haemorrhage, Thalemia 2, and Midline shift.

In Other MRI section, enter report details and remarks according to observations.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of MRI scan reports can be attached here by giving each one a particular identification number.

Specify Remarks, MRI test conducting person, advisising doctor and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Test done by person, advising doctor, and at least one field on the form.

ECG

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested ECG investigation or when the Staff selects the patient from the 'Select Patient' form and then opens this 'ECG' form for entering record. This form is divided into two section – ECG details, and Image files.

In 'ECG details' section, enter observations in report details and remarks fields. Specify the name of person doing test and advising doctor.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of ECG reports can be attached here by giving each one a particular identification number.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Test done by person, advising doctor, and Report details field.

EEG

This form will be accessed by the Radiology department staff to enter investigation details. It can be accessed from Pending Imaging Investigations form where a particular patient has been requested EEG investigation or when the Staff selects the patient from the 'Select Patient' form and then opens this 'EEG' form for entering record. This form is divided into two section – EEG details, and Image files.

In 'EEG details' section, enter observations in report details and remarks fields. Specify the name of person doing test and advising doctor.

In 'Image Files' section, add the paths of scanned images which are stored on shared folder on server. All the soft copy of EEG reports can be attached here by giving each one a particular identification number.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Test done by person, advising doctor, and Report details field.

PENDING SAMPLE COLLECTION

This page will be accessible to the Laboratory staff. Initially this page will display a list of patients who had been prescribed Lab investigations and they will be coming to the LAB for giving samples for testing, When the patient comes and sample is taken, double click on the Patients name which will display a popup where requisition Type will have to be selected that will generate a sample number for that requisition. Every day, the sample number will start from one for each type of requisition.

After the sample number is generated, click on 'Add' button to add the sample number to the list and continue adding further sample number for other requisition types in this manner. Click the close button after generating the sample number. This sample number can be written on a piece of paper and stick on the sample bottle and sent to the Investigating staff.

PENDING LAB INVESTIGATION

This form will be accessed by the Laboratory staff who will be doing actual tests on samples collected. Initially this form will display a list of all patients whose sample has been collected and tests are pending. Double clicking on the patients name will display a popup with that patient's details and list of investigations that are to be performed along with sample numbers. Now that staff has to double click on the sample number which will display the respective investigation form for entering results of test conducted. For. E.g if Biochemistry is double clicked, then Biochemistry form will open. If Urine is double clicked, then Urine form will open and so on accordingly.

Once the test results are entered in the respective forms, that patients details will be cleared from this 'Pending Lab Investigation' form and the results will also be available to the Doctors.

URINE

This form will be accessed by the Laboratory staff for entering results of Urine test done on sample collected from patient. This form can be accessed in 2 ways – First by double clicking on the sample number in 'Pending Lab Investigation' form and secondly by selecting 'Urine' menu under 'Base Line Lab Investigations' after selecting a patient.

Macroscopic details such as Color & appearance, Reaction, SP. Gravity, Proteins, and sugar can be specified. Further Microscopic details such as RBC, WBC, Epithelial cells, Bacteria, and Cast, Crystals & special details can be specified. Select Lab technician, Assistant directors name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, Sample number, Lab technician, Assistant director, and at least on field under macroscopic or microscopic section.

FEACES

This form will be accessed by the Laboratory staff for entering results of Feaces test done on sample collected from patient. This form can be accessed in 2 ways – First by double clicking on the sample number in 'Pending Lab Investigation' form and secondly by selecting 'Feaces' menu under 'Base Line Lab Investigations' after selecting a patient. Macroscopic details such as Color, consistency, blood, mucus, Ocult blood can be specified. Further Microscopic details such as Ascaris, Hookworm, Threadworm, H.nana for OVA and E.histolitica, E.Coli, I.butscheli, G. Lambila, and Puss cells for CYTS can be specified. Select Lab technician, Assistant directors name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, sample number, Lab Technician, Asstt. Director and at least one field in Macroscopic or Microscopic findings.

ELISA

This form will be accessed by the Laboratory staff for entering results of Elisa test done on sample collected from patient. This form can be accessed in 2 ways – First by double clicking on the sample number in 'Pending Lab Investigation' form and secondly by selecting 'Elisa' menu under 'Base Line Lab Investigations' after selecting a patient. Enter details such as Requisition number, sample number, referring doctor name, Investigation done, result achieved, normal range and method adopted. Click on 'Add' Button to add it to the list and proceed for adding another to the list in same way. Enter Remarks, select Lab technician, Assistant directors name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, sample number, Lab Technician, Asstt. Director and at least one investigation findings added to list.

BIOCHEMISTRY

This form will be accessed by the Laboratory staff for entering results of Biochemistry test done on sample collected from patient. This form can be accessed in 2 ways – First by double clicking on the sample number in 'Pending Lab Investigation' form and secondly by selecting 'Biochemistry' menu under 'Base Line Lab Investigations' after selecting a patient. Enter details such as Requisition number, sample number, result values of different profiles, Lab Technician, and Asstt. Director. Click on 'Add' Button to add it to the list and proceed for adding another to the list in same way. Enter Remarks, select Lab technician, Assistant directors name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, sample number, Lab Technician, Asstt. Director and at least one result values in various profiles.

HAEMATOLOGY

This form will be accessed by the Laboratory staff for entering results of Haematology test done on sample collected from patient. This form can be accessed in 2 ways – First by double clicking on the sample number in 'Pending Lab Investigation' form and secondly by selecting 'Haematology' menu under 'Base Line Lab Investigations' after selecting a patient. Enter details such as Requisition number, sample number, result values of different profiles, Parasites, any other tests, Lab Technician name, and Asstt. Director. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Requisition number, sample number, Lab Technician, Asstt. Director and at least one value in the investigation list.

OT – COMPLAINTS

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Complaints' menu under Occupational Therapy. Enter details such as Onset of present illness, duration of present illness, course, predisposing factor, precepititating factor, and perpetuating and relieving factor. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: At least one field should be entered.

OT – PERSONAL HISTORY

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Personal History' menu under Occupational Therapy. This form is divided into 6 section such as – Childhood, Schooling & College, Occupational history, Social and substance abuse history, Psychosexual history, and Treatment & history.

In 'Childhood' section, enter details of birth history, Milestone, Infantile seizure, family relationship, illness of any type, and traumatic experience.

In 'Schooling & College' section, enter details of attitude to schooling, Grades in study, and relationship with classmate and teacher.

In 'Occupational History' section, enter details of Age when job started, Remuneration, Type of work, Frequency of job change, Interpersonal relationship, and Organizational behavior.

In 'Social & Substance Abuse History' section, enter details of relationship with friend's neighbors & community people, Hobbies and leisure time activities, substance abuse history.

In 'Psychosexual History' section, enter details of attitude towards sexual functions, premarital, marital & extra marital relationships, and sexual perversions.

In 'Treatment and History' section, enter details of any treatment undergone in past, family details such as structure or chart, socio economic situation, any psychic history in family, and details of past mental illness of the patient.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: At least one field should be entered out of all section fields.

OT – GENERAL DESCRIPTION

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'General Description' menu under Occupational Therapy. Enter details of Appearance and attitude towards the examiner, and further details relating to personality, speech, and perceptual disturbances.

Under 'Personality', you can specify details of Paranoid, schizoid, schizotypical, anti-social, borderline, histrionic, narcisists, avoidant, dependant, and obsessive compulsive.

Under 'Speech', you can specify details of pressured speech, poverty of speech, non spontaneous, stuttering, and muttering.

Under 'Perceptual disturbance', you can specify details of Hallucination, illusions, Thought form, and thought contents.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: At least one field should be entered out of all fields on the form.

OT – SENSORIUM & COGNITION

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Sensorium & Cognition' menu under Occupational Therapy. This form is divided into 4 sections such as – Alertness, Orientation, Memory, and others.

In 'Alertness or level of consciousness' section, enter details in Alert, drowsy, stuperus, and comatose fields.

In 'Orientation' section, enter details in Person, place, time, and situation fields.

In 'Memory' section, enter details in Immediate, recent, recent past, and remote fields.

In 'Others' section, enter details in concentration & attention, capacity & read & write, abstract thinking, information & intelligence, and safety & judgment fields.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: At least one field should be entered out of all section fields.

OT – SELFCARE PERSONAL HYGIENE

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Selfcare Personal Hygiene' menu under Occupational Therapy. This form specifically captures grooming details of patient. Enter details such as toileting, shaving, bathing, dressing, combing, and cleanliness. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: At least one field should be entered out of all fields on the form.

OT - DAY TIME ACTIVITIES

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Day Time Activities' menu under Occupational Therapy. Enter details of Social interaction, participation in household activities and further details related to marital relationship, parent care, and family attitude.

Under 'Marital relationship', enter details of communication with spouse, affection, and satisfactory physical and emotional gratification.

Under 'Parent care', enter details of Child care, and interest in children.

Under 'Family attitude', enter details of Regular, observes rules, and quality output.

Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: At least one field should be entered out of all fields on the form.

OT - PROBABLE DIAGNOSIS

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Probable Diagnosis' menu under Occupational Therapy. Browse the ICD10 disease code and select the disease name which is diagnosed for the patient and specify remarks. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Disease diagnosed.

OT MANAGEMENT

This form will be accessed by Occupational Therapist first by selecting the patient in 'Select Patient' form and then clicking on the 'Complaints' menu under Occupational Therapy. Here the therapist will enter details of case management in detailed manner. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: OT Management.

DOCTORS SCHEDULE

This form will be accessed by the Administrator to set the schedule of all the doctors. First Doctor's name will be selected, then, the time and sub-department in which they will be consulting will be specified. Note here that the sub-department specified here for the doctor is actually the Room number that is linked to the Patient Token form where the receptionist selects the Room and the doctor's name automatically retrieves there. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory field: Doctors name, and at least one weekday entry.

INTERNS SCHEDULE

This form will be accessed by the Administrator to set the schedule of all the interns. First Intern's name will be selected, then, the Date & time and department in which they will be working will be specified. Click on 'Save' button to save the record.

Mandatory field: Interns name, and at least one weekday entry.

MEDICAL CERTIFICATE

This form will be accessed by the Doctor for issuing medical certificates. If the patient is selected, then Patient name, Age, and address will be retrieved from registration info. Logged in doctors info will be automatically set in Doctors name, and Registration number from Employee registration info. Just specify the parent name and click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Doctor Name, Patient name, Suffering from disease name

UNDERTAKING

This form will be accessed by the doctor for entering details of patient, bystander, witness for undertaking the responsibility of the patient before being admitted. Enter details such as Bystander name, Bystander parents name, Bystander address, Witness name, Patients name, Age, Patients parents name & Address, Disease suffered by patient, relationship of parent specified with patient, Phone numbers, Police station name where patient lives, and also the name of Panchayat. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Bystander Name, Patient name, Suffering from disease name

PANCHAYAT CERTIFICATE

This form will be accessed by the doctor or Nurse-Incharge for entering details of the Patient and Panchayat before the patient is admitted. Enter details such as Panchayat Officer name, Panchayat name, Patient name & Age, Name of parent, Patients address, Disease suffered by patient, and designation of officer. Click on 'Save' button to save the record and print the report by clicking 'Yes' when asked. Report can also be printed at later stage by clicking the 'Edit' Button, selecting the required record and then clicking on 'Preview' button.

Mandatory fields: Panchayat Officer Name, Panchayat name, Patient name, Suffering from disease name

M.I.S REPORTS

This form will be accessible to Doctors & other Staff those who have been allotted access rights in Administration module to view reports. This form is divided into two sections. The left section displays the list of reports available and right section displays the filters or parameters based on report name selected on left. The user has to specify these parameters based on which details will be retrieved from the database and report will be displayed. Following are the reports that can be generated from this form-

1. Doctor Schedule – Click on 'Preview' button to display weekly schedule report of Doctors that is created from 'Doctors Schedule' form. No parameters are required to be specified.
2. Patient Appointment Register – Specify date range parameters and click on 'Preview' button to display Appointment Register report
3. OPD Register – OPD Register can be printed in 6 ways: Date wise, Department wise, Camp wise, Gender wise, Referring doctor wise, and Consulting Doctor wise. Selecting one option will display the necessary parameters for input. If Date wise is selected date range parameters will be displayed for selection. If Department wise is selected then Date range and department dropdown list will be displayed. Similarly for Camp, Gender, Referring doctor, and Consulting Doctor, the respective dropdown list will be available for selection along with date range parameters. Specify the parameter values and click on 'Preview' button to display the OPD Register.
4. IPD Register - IPD Register can be printed in 4 ways: Date wise, Gender wise, Research Project wise, and Ward wise. Selecting one option will display the necessary parameters for input. If Date wise is selected date range parameters will be displayed for selection. If Gender wise is selected then date range and gender drop down list will be displayed. Similarly for Research Project wise and Ward wise, the respective drop down list will be available for selection along with date range parameter. Specify the parameter values and click on 'Preview' button to display the IPD Register.
5. I.P.D Census – IPD Census report displays the day wise total number of male & female patients along with children admitted. It also displays the IPD number and discharge details on a particular day. Specify the date range parameter and click on 'Preview' button to display the IPD Census report.
6. Patient Ticket Register – Patient Ticket register will display details of Tickets prepared between a date range. It displays Presenting complaints & Disease diagnosed during the visit. Specify the date range parameter values and click on 'Preview' button to display the Patient Ticket Register.
7. Patient Ticket - Patient Ticket can also be printed from this form. OPD No., IPD No., and Ticket number parameters are displayed for selection. Type the OPD No. or IPD number based on which the Ticket number will be displayed in the drop down list. Select the Ticket number and click on 'Preview' button to display the Patient Ticket report.
8. Daily Patient Summary – This report displays figures of patients consulted gender wise and new & old cases. Specify the date range parameter values and click on 'Preview' button to display the Daily Patient Summary Report.
9. Monthly Patient Summary - This report also displays figures of patients consulted gender wise and new & old cases. Specify the month & year parameter values and click on 'Preview' button to display the Daily Patient Summary Report.
10. Annual Patient Summary - This report also displays figures of patients consulted gender wise and new & old cases. Specify the financial year parameter values and click on 'Preview' button to display the Daily Patient Summary Report.

11. Daily Patient Medicine Issued Summary – This report will display count of patients who have collected the medicines from Pharmacy which were prescribed to them. Specify the date range parameter values and click on 'Preview' button to display the Daily Patient Medicine Issued Summary Report.
12. Monthly Patient Medicine Issued Summary - This report will also display count of patients who have collected the medicines from Pharmacy which were prescribed to them. Specify the Month & Year parameter values and click on 'Preview' button to display the Monthly Patient Medicine Issued Summary Report.
13. Annual Patient Medicine Issued Summary - This report will also display count of patients who have collected the medicines from Pharmacy which were prescribed to them. Specify the financial Year parameter values and click on 'Preview' button to display the Annual Patient Medicine Issued Summary Report.
14. Bed Occupancy status – This report will help you to know the current Bed Occupancy status of your Institution. Ward wise all beds are displayed along with their status Vacant / Maintenance / Occupied. Occupied beds display patients name in it. Last page of the report will display the total of all these 3 status. click on 'Preview' button to display this report. No parameters are required to be specified.
15. Bed Maintenance Register – This report displays the details of Beds sent for maintenance and received back after maintenance is done. Specify the date range parameter values and click on 'Preview' button to display the Bed Maintenance Register report.
16. Visitor Card – This report will display the Card report to be given to visitors of patient admitted. It will display all the cards of people of a particular patient in separate page so the required page can only be printed. Specify the patient IPD No. and click on 'Preview' button to display the Visitor Card report.
17. Doctors Book Report – This report will display the Doctors book details of all the patients specified for a particular period. Specify the date range parameter values and click on 'Preview' button to display the Bed Doctors Book report.
18. Assessment Report – This report will display the Daily Assessment and Weekend assessment reports of a particular IPD patient. Specify the IPD number of the patient which will fill the Ticket number. Select the Ticket number and click on 'Preview' button to display the Assessment report.
19. Intake & Output Report – This report will display Intake & Output details of IPD patient monitored by Nurse In-charge. Select the date range parameter and also specify OPD No or IPD No. and click on 'Preview' button to display the Intake & Output report.
20. Treatment Book – This report will display the details of medicines given by Nurse in-charge along with her remarks. Select the date range parameter and click on 'Preview' button to display the Treatment Book report
21. Nurse Report – This report will display the Morning, Evening, and Night report details entered by the Nurse for all patients. Select the date range parameter and click on 'Preview' button to display the Nurse report.
22. GRAPHIC (T. P. R.) CHART – This report will display the Graphical Temperature chart of patient for a period of 7 days. Click on 'Preview' button to display the report.

23. Full Case Record – This report will display the Full Case Report of a patient selected. This report is divided into 23 sections and user can choose to print or hide a particular section in the report. Tick mark the required section details in the report and click on 'Preview' button to display the Full case report.
24. Full Investigation Report – This report will display details of all types of Investigations done on the selected patient. This report is divided into 12 sections in which results of investigations done are displayed. Specify OPD No or IPD No. and click on 'Preview' button to display the Full Investigation report.
25. Investigation Requisition – This report will display the details of requisitions made by Doctors to various patients between a particular date range. Select the date range parameter and click on 'Preview' button to display the Investigation Requisition report.
26. Investigations done register – This report will display the details of all Investigations done on patients between a particular date range. Select the date range parameter and click on 'Preview' button to display the Investigation Requisition report.
27. Prescription Register – This report will display the details of medicines prescribed to OPD & IPD patients between a particular date range. Select the date range parameter and click on 'Preview' button to display the Prescription Register report.
28. X-Ray Monthly Summary - This report will display the summary of X-Ray done for the month selected. The Body parts are listed along with the count of films consumed. Select the Month & Year parameter and click on 'Preview' button to display the X-Ray Monthly report.
29. X-Ray Annual Summary – Similar to the monthly X-Ray summary, this report will display a summary of 12 months. Select the Financial Year parameter and click on 'Preview' button to display the X-Ray Annual Summary report.
30. Category wise X-Ray Monthly Summary - - This report will display the summary of X-Ray done for the month selected. The Body parts Categories are listed along with the count of films consumed. Select the Month & Year parameter and click on 'Preview' button to display the Category wise X-Ray Monthly report.
31. Category wise X-Ray Annual Summary - Similar to the Category wise monthly X-Ray summary, this report will display a summary of 12 months. Select the Financial Year parameter and click on 'Preview' button to display the Category wise Annual X-Ray Summary report.
32. X-Ray Films Summary - This report will display the 12 month summary of films consumed of various sizes. Select the Financial Year parameter and click on 'Preview' button to display the X-Ray Films Summary report.
33. Provisional Diagnosis Register – This report will display the provisionally diagnosed disease register between a particular date range. . Select the date range parameter and click on 'Preview' button to display the Provisional Diagnosis Register report.
34. Final Diagnosis Register - This report will display the Final disease diagnosed register between a particular date range. . Select the date range parameter and click on 'Preview' button to display the Final Diagnosis Register report.

35. Disease Summary – This report will display the summary of finally diagnosed disease for the financial Period selected. Select the Financial Year parameter and click on 'Preview' button to display the Disease Summary report.
36. Daily Test Sheet – This report will display the summary of Tests done on daily basis. Count for each day is reflected in the report. Select the Month & Year parameter and click on 'Preview' button to display the Daily Test Sheet report.
37. Annual Test Sheet – Similar to Daily Test Sheet, this report will display the summary of Tests done on monthly basis for 12 months. Count for each month is reflected in the report. Select the financial period parameter and click on 'Preview' button to display the Annual Test Sheet report.
38. Occupational Therapy Case Report – This report will display Full case report for Occupational Therapist. This report is divided into 8 sections in which details were captured. Specify the OPD No or IPD No., based on which the Ticket number will be listed in drop down list. Select the Ticket no. and Tick mark the section details required in the report and click on 'Preview' button to display the OT Full case report.
39. Patient Transfer Register – This report will display the transfer details of IPD patients. Select the date range parameter and click on 'Preview' button to display the Patient Transfer Register report.
40. Patient Discharge Register – This report will display the details of Patients discharged between a particular date range specified. Select the date range parameter and click on 'Preview' button to display the Patient Discharge Register report.
41. Medicine Collection Report – This report will display the details of patients and medicines that were prescribed by the doctors and the collection status of medicine from Pharmacy. Patients who collect their medicines from the Pharmacy will be reflected first in the register report in green color and those who have not collected the medicines will be reflected later in red color. Select the date range parameter and click on 'Preview' button to display the Medicine collection report.

ADMINISTRATION MODULE

PREFERENCES

LOGIN DETAILS

ACCESS RIGHTS

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EMPLOYEE REGISTRATION

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MONTHLY PROGRESS

TRAINING PROGRAMME

TRAINING PROGRAMME FEEDBACK

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APPLICATION FOR CL/RH/CH LEAVES

APPLICATION FOR OTHER LEAVES

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FESTIVAL ADVANCE APPLICATION

PF WITHDRAWAL APPLICATION

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LOAN DETAILS

OTHER ADVANCE DETAILS

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CONTINGENT ADJUSTMENT

INCREMENT CERTIFICATE

PASSPORT NOC

MEDICAL CERTIFICATE

FITNESS CERTIFICATE

DOCUMENT TYPE

INWARD

OUTWARD

FORM PRINTING

M.I.S REPORTS

STOCK MANAGEMENT MODULE

INDENT

QUOTATION RECEIVED

PURCHASE ORDER

INVOICE DETAILS

CENTRAL RECEIPT

CENTRAL ISSUE

WRITE OFF

CENTRAL STOCK

CENTRE MEDICINE DISPATCH

HOSPITAL ARTICLES

DEPARTMENT RECEIPT

DEPARTMENT CONSUMPTION

STOCK ADJUSTMENT

DEPARTMENT STOCK

STOCK NEARING COMPLETION

LAUNDRY ISSUE

LAUNDRY RECEIPT

M.I.S REPORTS

ASSET MANAGEMENT MODULE

AMC NEARING RENEWAL

AMC RENEWAL

ASSET MAINTENANCE

EQUIPMENT MAINTENANCE

VEHICLE LOG BOOK

ASSET DISPOSAL

CONTRACTOR RATING

M.I.S REPORTS

ACCOUNTS MODULE

RECEIPT

PAYMENT

JOURNAL

BUDGET PLANNING

RECEIPT BOOK

PAYMENT BOOK

JOURNAL BOOK

LEDGER BOOK

BUDGET UTILIZATION

RECEIPT & PAYMENT

TRIAL BALANCE

PROFIT & LOSS A/C

BALANCE SHEET

DIETARY MANAGEMENT MODULE

DIET & NUTRITION

PLAN WEEKLY DIET MENU

DIET REQUISITION

KITCHEN CONSUMPTION

PATIENT CONSUMPTION

STOCK ADJUSTMENT

PURCHASE MATERIAL

ARTICLE STOCK REGISTER

CHECK BALANCE STOCK

M.I.S REPORTS