This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.



Doctor Name

MBBS ONCOLOGY Your Hospital Name, Street Name, Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

	m	yemailid@gmail.com
atient Name :		Date :
HID No. :	Age / Gender :	Mob.:
		Wt.:
		Ht.:
		BSA
		\triangle
		□ ER
		☐ PR
		☐ HER
		☐ AR
		☐ CEA
		☐ CA125
		☐ Mets
		☐ Chemo
		☐ Hormone
		Surgery
		☐ Radiation
		☐ DM
		☐ HT
		☐ Ki67
		☐ Allergy
		NEXT VISIT

\triangle	☐ AC
□ Early	☐ CAF
Recurrent	□ D
☐ Metastatic	☐ TC
	□н
	☐ TCF
	☐ FOLFOX
	Fulvetraz (250 mg)
	Fulvetraz (500 mg)

NEXT V/SIT



◆ Please Bring This Paper Every Visit ◆
 "Patients can take any Generic Medicine as per availability and patient choice"

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Doctor Name

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Patient Name :				Date :			
UHID No.	:	Age / Gende	r:		Mob.:		
Provisional	Diagnosis:				UHID No.:		
History:							
H/o Medica	tion:						
HTN	Diabetes	Thyroid Disorder					
Vital Signs:							
	Sys /	Dias Pulse (/min):	Temp(F):				

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Syste	mic Examination:		-	
Abdo	men:			
P/R:				
Treatm	ent Plan			

S. N.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days	Instructions
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
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							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food
							Before Food After Food

Next Visit	Next Visit
DD / MM / YYYY	DD / MM / YY



Doctor Name

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Patient Name :			UHID No :	
Date/Time :	Age/	Gender:	Mobile No.:	
LAB TESTS ADVISED:	VITAL SIGNS (As applicable	۵۱		
Test 1			_	(0=)
Test 2		Dias_ Pulse (/min):		
Test 3	Resp. Rate (/min):	Weight (kg)	: Height	: (cm):
Test 4				
Test 5	Allergic to:	Fall Risk Screening]:	
Test 6	Nutritional Screening:		Pain Sc	ore (0-10):
Test 7	CHIEF COMPLAINTS & HIS	TORY:		
Test 8				
Test 9				
Test 10				
Test 11				
Test 12				
Test 13				
Test 14				
Test 15				
Test 16	/ \		\ \ \ /	
Test 17		- (3)		Ovary
Test 18		Para- thyroid		
		> P		Testis
	F 7	0 0 Thyroid	Adrenal	
Other Lab Tests			~~	
IMAGING TESTS ADVISED:		IV V	(Lond)	
Test 1	UU	<i>,,</i> –		
Test 2	RELEVANT PAST MEDICAL	HISTORY:		
Test 3				
Test 4				
Test 5	FAMILY HISTORY:			
Test 7				
Test 7	OBSTETRICS / MENSTRUA	L HISTORY:		
Test 8				



Test 9	GENERAL EXAMINATION					Comments.	
Test 10	Clubbing	Pallor		Icterus		Cyanosis	
Test 11	Level Of Consciousness:						
Test 12	Pedal Oedema:		Lymp	hadenopathy:			
Test 13	SYSTEMIC EXAMINATION (System applicable):						
Test 14	CVS:						
Test 15	Respiratory System:						
Test 16	CNS:						
Test 17	Breast Exam.						
Test 18							
Test 19	Head & Neck						
Test 20	Abdomen						
Test 21	P/V						
Test 22	P/R						
Test 23	Supra. Lymph Nodes						
Test 24	Pulsation						
Test 25	Test 25						
Test 26 Allen's test							
Other Imaging Tests	PROVISIONAL DIAGNOS	913.					
Admission Advised: If yes							
Surgery Advised: If yes							
ourgery Advisou.	PF	RESCRIPTION					
Sr. MED No. (WRITE IN	ICINE I CAPITAL)	Dose	Route	Frequency	Days	Any Special Instructions	
					FOLLO	OW UP DATE	
Consultant S & Signatur					DD / MI	M / YYYY	



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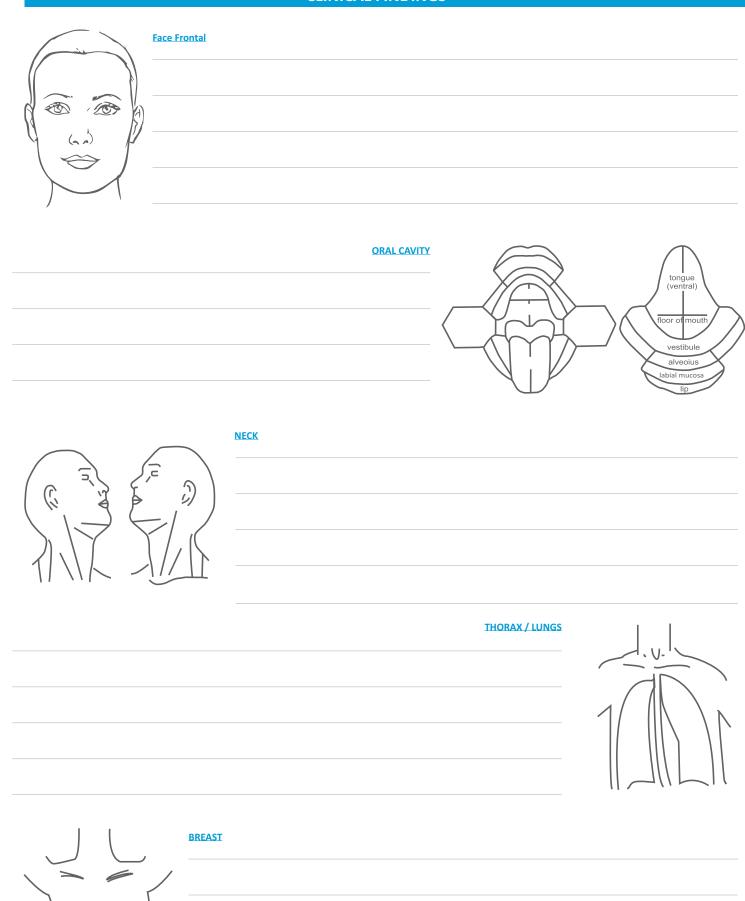
Patient Name :		UHID No :
Date/Time :	Age/Gender:	Mobile No. :
LAB TESTS ADVISED: Test 1	Consult. Start Time: Allergic to	o: Temp (°C):
Test 2	Fall Risk Screening:	Pain Score (0-10):
Test 3	Nutritional Screening : Well Nourished	Malnourished Mild Moderate Severe Obese
Test 4	VITAL SIGNS (As applicable)	Severe Obese
Test 5	BP (mm/Hg): Sys / Dias Pulse (/min)): Height (cms):
Test 6	Weight (kg): Resp. Rate (/min):	Head Circum-pediatric (cms):
Test 8		
Test 9	PROVISIONAL DIAGNOSIS:	
Test 10		
Test 11	CHIEF COMPLAINTS & HISTORY:	
Test 12		
Test 13		
Test 14		
Test 15		
Test 16		
Test 17		
Test 18		
Other Lab Tests	RELEVANT PAST MEDICAL HISTORY:	
IMAGING TESTS ADVISED:		
Test 1		
Test 2		
Test 3		
Test 4		
Test 5		
Test 6		
Test 7		
Test 8		



	Test 9						
	Test 10						
	Test 11						
	Test 12						
	Test 13						
	Test 14						
	Test 15						
	Test 16						
	Test 17						
	Test 18						
	Test 19						
	Test 20						
	Test 21						
	Test 22						
	Other Imaging Tests	STAGE:					
		STAGE:					
Admis	sion Advised: If yes						
Surger	y Advised:						
Chemo	otherapy: If yes						
			PRESCRIPTION				
Sr. No.	MEDICIN (WRITE IN CAI	E PITAL)	Dose	Morn	Noon	Night	Days
						FOLLOW U	IP DATE
Do	octor's Seal & Signature					FOLLOW U	DP DATE



CLIN		DINGS





(T)		SKIN / BONE & SOFT TISSUE	
	Tul I lust		
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			Anthropidal Indianal Maller
æ	FEM	ALE REPRODUCTIVE SYSTEM	
			Labia Majora
		ABDON	MEN
	MAL	E REPRODUCTIVE SYSTEM	
	_		

Doctor's Seal & Signature

DD / MM / YYYY

