P. D. HINDUJA HOSPITAL
& MEDICAL RESEARCH CENTRE

UNDERTAKING FORM FOR ADMISSION (3 pages document)+ 1 Consent form

I Mr./Mrs._____(Name of the patient),

Age_____Gender M/F (tick), is likely to undergo_____(Name of Treatment /Procedure / surgery) under Dr_____on_____(date)

Undertaking 1- Cash undertaking for payment.

I hereby declare that I am getting admitted

A) In..... **OR** .....billing class of my choice

The desired class of admission is_____however, due to unavailability of bed in desired class,

a. **Opting for Higher Billing Class** I ☐ patient or ☐ related to patient as_____is opting for bed in higher billing class..... The charges of higher billing class are explained to me and I am willing to pay the charges that may incur till the patient is shifted to the desired booked admission class.

OR

b. **Inconsistent Bed Allotment**- I ☐ patient or ☐ related to patient as_____is opting for bed in higher billing class..... I hereby agree to shift to my desired booked class once bed is available. If I or my patient do not agree to shift to my desired booked class from the upgraded class, I am agreeing to pay for higher billing class from the date of admission.

ICU direct admission – I hereby declare to be aware that if my patient is direct admission to ICU, then applicable billing class is "MEDIAN". In case if I opt for any higher bed class at the time of ICU transfer, all charges including ICU charges will be applicable of higher billing class from date of admission.

- I am aware that medical treatment may be extended beyond the expected time period on the judgement of the doctor.
- In the event of failure to pay the admission deposit of Rs._____in full, I undertake to pay the unpaid deposit within 24 hours of admission.
- I undertake to settle the interim bills within the stipulated timeline. In case of failure to do so, the hospital has the discretion to discharge/transfer the patient to another hospital on administrative grounds.
- I am fully aware of the charges of the hospital, and hereby undertake to make all payments
- I understand that certain categories of beds are equipped with continuous vital monitoring facility which is chargeable.

Contd.....

- I hereby understand that if my insurance company / TPA / Corporate does not have tie up with P.D.Hinduja Hospital, credit facility will not be available
- I have been explained/understood the charges that will be levied and the cost of implant may vary
- I hereby understand that after the admission process is over, I / my patient cannot leave the hospital premises unless approved in writing by the admitting consultant. The hospital will not be responsible for any incidence arising out of nonadherence to this requirement.

(Name & Signature of Patient / Relative)

Undertaking-2 Administration of High End Drugs

1. I understand that during course of treatment, high end drugs may be required for the patient.
2. I understand that multiple quantity of these vials may be used depending on the clinical requirement of the patient. This is also applicable for certain drug categories like sedatives and vasopressors.
3. I also understand that Brand Name and MRP of these drugs may vary from time to time as per date of purchase and based on manufacturer's directives:

I have gone through, below listed, a few commonly used drugs with MRP > Rs.3000 (MRP as on 5/12/2023/ or of last available stock)

Name of Item	Content	MRP
ELAXIM INJ 40 MG (RECOMBINANT TISSUE PLASMINOGEN ACTIVATOR) VIAL	TPA, TENECTEPLASE	50333
ACTEMRA 400MG INJ VIAL	Tocilizumab	40545
IMMUNOREL 5GM/100ML IV BOTL	IV IGG	20166
IMMUNOREL 10% (10GM/100ML) GLYCINE BASE IV BOTL	IV IGG	26514
ANDULFA 100MG INJ VIAL	ANIDULAFUNGIN	13700
AMBISOME INJ 50MG VIAL (HR)	Liposomal Fungisome	7814
ALBUMIN / ALBUREL I.V. 20% BOTL 100ML	Albumin	8057
GUFICAP INJ 50MG VIAL	CASPOFUNGIN	4791
COLYMONAS 4.5 MIU INJ	COLISTIMETHATE SODIUM	6808
ZAVICEFTA INJ 2GM/0.5GM VIAL	Ceftazidime + Avibactum	5008
FOSFOTAS 4GM INJ (WITH WATER FOR INJ 100ML)	Fosfomycin	4780
CIPREMI 100MG INJ VIAL	Remdesivir	3000
CASFUNG 50MG INJ(CASPOFUNGIN)	CAPSOFUNGIN	4795
GUFICAP 70MG INJ	CAPSOFUNGIN	5498
TYGACIL 50MG INJ VIAL (TIGECYCLINE)	TIGECYCLINE	4182
VORAZE TAB STR 4'S(VORICONAZOLE)	VORICONAZOLE	3432
ZAXTER KIT 1GM	MEROPENEM	1067
XYLISTIN FORTE PLUS 3 MILLION IU INJ	COLISTIMETHATE SODIUM	4101
RONAPREVE 120 MG/ML INJ 10ML VIALS	CASIRIVIMAB & IMDEVIMAB	119500
POSAONE IV 300MG	POSOCONAZOLE	9333

I authorize the clinical team to use drugs for my patient as and when required.

(Name & Signature of Patient / Relative)

Contd.....

UNDERTAKING-3 COVID WARD ADMISSION

(Applicable for Covid admission / Transfer post-detection during stay)

If patient is found to be COVID positive during admission, patient will be transferred to Single room

If patient is in Median A /Median class, or cannot be moved to a single room, the COVID positive patient will be shifted to S1 building 1st Floor west wing / designated area of the hospital.

(Name & Signature of Patient / Relative)

I/ WE hereby agree to have read and understood all the points mentioned in the Undertaking 1 to 3.
I/We have been given an opportunity to seek clarification on the above mentioned points.

Details Required	Patient details	Relative Details
Name		Name: Relation with patient:
Age		
Gender		
Occupation		
Religion		
Permanent Address		
Patient address at the time of admission / Temporary address(if applicable)		
Mobile Number	1. 2.	1. 2.
Email ID		
PAN Number		
Aadhar Number		
Signature		
We hereby confirm that the information given above is correct and we will inform the hospital in case of changes if any in the above.		

End of Page-3 document

Annexure to General Consent

I/my relative are aware of the current pandemic of COVID-19 including the nature of the infectious disease of COVID-19 and its associated risks, adverse effects and that there is neither a cure/remedy for the same nor a vaccine for the same currently. I am also aware that there could be asymptomatic carriers of this infection and that this infection could be transmitted to any person. I/my relative state that I/my relative have come to P.D.Hinduja Hospital & MRC out of my own free will and volition for administration of treatment.

Being aware that I/my relative could be asymptomatic carrier or an undiagnosed patient with COVID-19 and that I/my relative could possibly endanger the doctors/hospital staff, I/my relative agree that it is my/our responsibility to take appropriate precautions and follow the protocols prescribed by P.D.Hinduja Hospital & MRC.

I/my relative are also aware that I/my relative could get an infection from a doctor/hospital and despite taking all precautions for prevention of the same; I will not hold doctor/hospital accountable if such infection occurs to me/my relative.

For Pediatric cases only: I/We are aware that in the event my child becomes diagnosed with COVID-19, I/We agree for transfer of our child to another Facility

	Name	**Signature**
Patient:	_____	_____
Relative:	_____	_____
Date:	_____	Patient ID Details:_____

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