1. Face sheet

The first page of the file. Every time on it must match the discharge summary and the bill to the minute.

Hospital

Hospital name · registration no. (Clinical Establishments Act)	
Admitting consultant · qualification · registration no. (with state code)	
Referred by (doctor / hospital)	

Patient

UHID · IP registration no.	
Name in full (surname, first, middle), as on the policy and ID	
Age (years / months) · date of birth · sex	
Address · mobile · relative's name and mobile	
Photo ID seen (type, last 4 digits) · verified by	

Admission and discharge

Date and time of admission (dd-mm-yyyy, HH:MM)	
Type: emergency / planned / day care / maternity	
Medico-legal case: Y / N · MLC no. · police station · FIR no.	
Date and time of discharge (dd-mm-yyyy, HH:MM)	
Status at discharge: home / referred to another hospital / LAMA / DAMA / death	
Final diagnosis (with ICD-10 if used)	

Insurance

Insurer · TPA · policy / card no.	
Cashless or reimbursement · pre-auth no. and date-time approved	
Scheme (PM-JAY / state scheme / CGHS / corporate) · beneficiary ID	

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2. Admission note (doctor)

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Written at admission by the admitting doctor. Every complaint needs a duration; every chronic illness needs a 'since'. These are the boxes on the pre-authorisation form.

Complaints

Chief complaint	Duration (days / months)	Onset (sudden / gradual)

History

History of present illness	
Date of first consultation for this illness · where	
Treatment taken before admission	
Past surgery / hospitalisation (year, what)	
Menstrual / obstetric history (LMP, G P L A, EDD), for women	
Family history	
Allergies (drug, food) · or 'no known allergy'	
Current medicines (name, dose, since)	

Past history of chronic illness

Ask every patient and write the answer, including 'No'. A blank is read as 'not asked'.

Condition	Yes / No	Since (month / year)	On treatment (what)
Diabetes			
Hypertension			
Heart disease			
Hyperlipidaemia			
Asthma / COPD / bronchitis			
Thyroid disorder			
Osteoarthritis			
Cancer			
HIV / STD related ailment			
Other			

Personal history

Alcohol: never / past / current · quantity · last intake (as stated by patient)	
Tobacco / smoking: type · quantity · since	
Other substance use (as stated)	

Examination

Temp · pulse · BP · resp. rate · SpO2 · weight	
General examination	
Systemic examination (CVS, RS, CNS, P/A, local)	

Assessment and plan

Provisional diagnosis (ICD-10 if used)	
Why admission is needed (why this cannot be treated as OPD)	
Plan: medical / surgical / ICU / investigation · proposed procedure	
Expected length of stay · ICU days	
Doctor's name · signature · date · time	

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3. Nursing admission assessment and consents

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. NABH asks for a nursing assessment at admission and for the initial assessment to be countersigned by the clinician in charge within 24 hours.

Nursing assessment

Date · time received in ward	
Temp · pulse · BP · resp. rate · SpO2 · pain score (0 to 10)	
Consciousness · mobility · diet	
Fall risk · pressure-sore risk	
Allergies (confirmed with patient)	
Valuables handed to (name, relation)	
Nurse's name · signature	
Countersigned by clinician (name, date, time)	

Consents on file

One line per consent. The signed forms stay in the file; this page shows the TPA they exist.

Consent	Form / ref. no.	Date and time signed	Signed by (patient / relative, relation)	Explained by	Witness
General consent for admission and treatment					
Procedure / surgery					
Anaesthesia					
Blood transfusion					
High-risk consent					
Audio-video consent (where the scheme requires it)					
Other					

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4. Doctor's progress notes and orders

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. At least one note on every calendar day of the stay, by the doctor who saw the patient, signed with the time. Write what changed and why. Use as many pages as needed.

Progress notes

Note: complaints today · vitals · findings · reports reviewed · assessment · plan. Orders: new, changed or stopped medicines and investigations.

Date and time	Note	Orders	Doctor (name, signature)

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5. Drug administration chart

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Generic name, strength, dose, route and frequency for every order. Each dose given gets a time and the nurse's initials. If a drug is not on the chart, an assessor will treat it as not given.

Orders and doses given

In the day columns write the time each dose was given and initials, e.g. 08:00 RS. Write 'held' or 'refused' with the reason in remarks.

Drug (generic) · strength	Dose · route · frequency	Started (date, time) · ordered by	Stopped (date, time)	Day 1	Day 2	Day 3	Day 4	Day 5	Remarks

IV fluids and blood

Date	Fluid / blood product	Volume	Rate	Started (time, by)	Completed (time)	Reaction (Y/N)

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6. TPR, BP and intake-output chart

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. At the frequency the doctor orders, and at least once every shift.

Vitals

Date	Time	Temp	Pulse	Resp.	BP	SpO2	Pain (0 to 10)	Intake (ml)	Output (ml)	Recorded by

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7. Nursing notes

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Every shift, in the nurse's own hand and signature. Notes written later by one person in one sitting are what assessors look for.

Notes

Date	Shift	Time	Observation	Action taken · doctor informed (name, time)	Nurse (name, signature)

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8. Investigation log

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Every test ordered, by whom and when, and the result that changed the plan. Reports are filed behind this page.

Investigations

Test	Ordered (date, time, by)	Done on	Reported on	Key result	Report filed (Y/N)

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9. Procedure / OT note

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Summary page for each procedure. The full operation and anaesthesia notes are filed with it. The indication is the line most often missing.

Procedure

Date · start time · end time	
Procedure performed	
Indication (why it was needed, with the finding that decided it)	
Surgeon · assistant · anaesthetist	
Anaesthesia type	
Findings	
Implants / devices (stick the sticker or write make, batch, serial)	
Specimen sent for histopathology (Y/N, to which lab)	
Complications · blood loss	
Post-operative orders	
Surgeon's signature · date · time	

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10. Discharge, transfer, LAMA or death note

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. The last entry in the file. Times here must match the face sheet, the discharge summary and the bill.

Discharge

Date and time of discharge / transfer / death	
Final diagnosis	
Condition at discharge (vitals, wound, mobility)	
Discharge summary signed and copy given (Y/N) · given to	
Advice on discharge · follow-up date	
Doctor's name · signature	

If transferred or referred

Referred to (hospital, doctor) · reason	
Condition at transfer · accompanied by	

If leaving against medical advice (LAMA / DAMA)

Risks explained (in the patient's language) by · date · time	
Reason given by patient / relative	
Signature of patient or relative (relation) · witness	
Discharge summary given (NABH expects one for LAMA too)	

If death

Date and time of death · declared by	
Cause of death certificate (MCCD) issued (Y/N) · copy in file	

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11. ICP completeness check

Patient: _____ · UHID: _____ · IP no.: _____ · Page ____ of ____. Run this before the discharge authorisation request goes to the TPA and before copies are made. Our checklist, built from what insurers and Ombudsman awards have queried.

Checklist

Check	Done (Y/N)	Checked by
Every page carries patient name, UHID and IP no., and is numbered		
Name and age are the same on the ICP, the ID, the policy and every report		
Admission note: every complaint has a duration		
Admission note: every chronic illness answered Yes / No with 'since'		
Admission note: why admission is needed is written		
Alcohol and tobacco history written as stated, not left blank		
A doctor's progress note exists for every day of the stay		
Every note and order is signed, dated and timed		
Entries are by the person who made them (no one rewrote the file)		
Every drug billed appears on the drug chart with doses given		
IV fluids and blood are charted with times		
Vitals recorded every shift		
Every investigation billed was ordered in the notes and its report is filed		
Procedure indication is written in the notes		
Admission and discharge times match the face sheet, discharge summary and bill		
Consents are signed, dated, timed and witnessed		
Discharge summary signed, copy in file		

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12. Request for copies of indoor case papers

Filled by the patient or authorised attendant. The IMC (Professional Conduct, Etiquette and Ethics) Regulations, 2002, regulation 1.3.2: records requested by a patient, authorised attendant or legal authority are to be issued within 72 hours.

Request

Patient name · UHID · IP no. · dates of admission and discharge	
Requested by (name) · relation to patient	
ID shown (type, last 4 digits)	
Purpose: insurance claim / second opinion / legal / other	
Insurer · TPA · claim no. (if for a claim)	
Pages requested: all indoor case papers / specific pages	
Attested copy required (Y/N)	
Date and time of request	

Consent

I request copies of the indoor case papers named above and consent to their release to me, and to the insurer or TPA named above for processing my claim.

Signature of patient / authorised attendant: _____ Date: _____

For the medical records department

Pages issued (count) · attested by (name, designation, stamp)	
Date and time issued · issued to	
Fee (if any) · receipt no.	

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How to use this set

Using it

Print pages 1, 2, 3, 9 and 10 once per admission, and pages 4 to 8 as many times as the stay needs. Keep them in this order in one file.
Write as you go. A note written at the time, by the person who did the work, is worth more than a neat file written at discharge.
Dates as dd-mm-yyyy and times as 24-hour HH:MM. Never leave a box blank: write NA or No.
Correct mistakes with a single line, initials and time. Do not overwrite or use whitener.
Put your letterhead and Clinical Establishments registration number on page 1.

Where the fields come from

Page	Based on
1 Face sheet	IRDAI standard claim form Part B (hospital details, admission and discharge date and time, type of admission, status at discharge)
2 Admission note	Pre-authorisation form: presenting complaints, duration of ailment, date of first consultation, chronic illness 'since', alcohol or substance use. NABH IMS.4: reasons for admission, diagnosis and care plan
3 Nursing assessment	NABH AAC.4: nursing assessment at admission, countersigned within 24 hours
4 Progress notes	NABH AAC.5 and IMS.3: re-assessment as progress notes; entries signed, dated and timed. Gujarat CE Rules Annexure-12: a detailed daily statement of the patient's health and condition
5 Drug chart	NABH MOM.5 and MOM.7: orders with medicine, route, strength and frequency; administration documented
8 Investigations	NABH IMS.4: results of investigations in the record
9 Procedure note	NABH IMS.4: procedures performed are incorporated; claim form procedure details
10 Discharge note	NABH AAC.12 and AAC.13: discharge, LAMA, discharge summary
12 Release request	IMC Regulations 2002, reg. 1.3.2: copies within 72 hours

Keeping the file

Gujarat: IPD records at least five years (Rule 15(3)); medico-legal, court and consumer forum cases until final disposal; for a maternity case, a full record of the pregnancy for at least ten years (Annexure-12).
Nationally, the IMC Regulations 2002 require indoor records for three years.

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