




PATIENT APPLICATION FORM

PATIENT'S DETAILS




NAME:	RITURAJ
FATHER NAME:	RAJKISHORE MAHTO
DATE OF BIRTH / AGE:	7 YEARS
SEX:	MALE
ADDRESS:	Narkatiyaganj, West Champaran, Bihar-845451
DISEASE:	Hodgkin's Lymphoma
HOSPITAL DEPARTMENT TREATMENT ESTIMATE COST	AIIMS Mecical Oncology Autologous Stem Cell Transplant Rs. 5,00,000/-

For CANCER CARE TRUST


Authorized Signatory

Authorized Sign


Parent's Sign



डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B.R. Ambedkar Institute Rotary Cancer Hospital

अ.भा.आ.

बहिरंग

अस्पताल के अन्दर

एकक/Unit Prof. SB/DR-BP
विभाग/Dept. Med Onc

नाम/Name

RITURA

DR. B.R.A. IRCH, AIIMS, NEW DELHI

IRCH No. 290608

Clinic Paediatric Medical Oncology Clinic

Deptt. MEDICAL ONCOLOGY
General

नाम

Name RITURA

S/O- RAJ KISHOR

Reg. Date-16/02/2023

Clinic No. 6652/2023



UHID-106528415

/Date of Birth

Sex/Age M/7Y

Room 5 (Shift Morning)

Address VILLAGE SISAI, POST MLADI RAKHAHI WEST CHAMPARAN,
BIHAR, INDIA

निदान/Diagnosis

Primary refractory HL.

दिनांक/Date

उपचार/Treatment

08/03/23

C# 1 ICE.

① Cap. APRECAP 80mg D1-3

② Inj. EMETET 4mg IVP D1-3

③ Inj. DEXA 4mg IVP D1-3

④ Inj. PANTOP 20mg IVP D1-3

⑤ Inj. IFOSFAMIDE 1.5g/10NS/2 hours D1-3

⑥ Inj. MESNA 500mg IVP @ 0, 4, 8 hours D1-3

⑦ Inj. VP-16 75mg/1/2⁰ DS/2 hours D1-3

⑧ Inj. CARBOPLATIN 375mg/1/2⁰ DS/1 hr
D1 only

Post-chemo:

⑨ Tab. EMETET 4mg 1 tab SOS

⑩ Tab. PANTOP 20mg OD x 3 days.

⑪ Syp. LOOZ 1 tsp HS/SOS.

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE

O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

बाहर से आने वाले रोगियों के लिए धर्मशाला की सुविधा उपलब्ध है/Dharamshala facility is available for outstation patients

⑫ Plenty of oral fluids

P.T.O.

(13) Inj. G-CSF 100 mcg SC OD x 5 days
(from day 6 onwards)

(14) F/U 23/03/2023 U CBC/LFT/KFT

Sthi

SRM

D1
13/3/23

D2
4/3/23

D3
15/3

D4

16/3

D5
17/3

To
msro

Krudh issue

estimate certificate
of 5 lakhs.

Sthi

15/03/23

10 PRBC @
Daycare

2



23/3

C#2

Rpt. alone cycle + G-CSF
fr with CBC + LFT + KFT
+ CE CT N/C/A/P on 13/4/23
Lawrence Yalun

28/03/23

Syp. AUGMENTIN (5ml/228.8mg) 8 ml TDS x 5 days
Syp. PCM (5ml/250mg) 8 ml TDS.

Sthi
SRM

23-8097-9

208



डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B.R. Ambedkar Institute Rotary Cancer Hospital

अ.भा.अ
बहि
अस्पताल के अन्

BIOPSY NO -

OPR-6

एकक/Unit

विभाग/Dept.

नाम/Name

DR. B.R.A. IRCH, AIIMS, NEW DELHI

IRCH No. 290608

Clinic Paediatric Medical Oncology Clinic

Deptt. MEDICAL ONCOLOGY

General

Reg. Date-16/02/2023

Clinic No. 6652/2023



UHID-106528415

नाम

Name RITURA

S/O- RAJ KISHOR

Sex/Age M/7Y

Room 5 (Shift Morning)

Address VILLAGE SISAI, POST MLADI RAKHAHI WEST CHAMPARAN,
MIZORAM

R.No - 243

Riys, Riys

दिनांक/Date of Birth

निदान/Diagnosis

CHL

(Re failure / Relapse)

दिनांक/Date

उपचार/Treatment

Adv

5
02 MAR 2023

1) PET-CT

photocopy

2) CBC / LFT / RFT / U/M / LDH

3) Block Review at AIIMS

1085

4) Blood done at AIIMS

Main blood bank AIIMS
Case no - 1

Flu 01/03/23

R.No (3)

05 8:30am

Sharma

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE

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बाहर से आने वाले रोगियों के लिए धर्मशाला की सुविधा उपलब्ध है/Dharamshala facility is available for outstation patients

To

Pathology Dept
~~PGIMS~~ Rohatak

Kindly issue Biopsy Block for
① cervical LN done on 9/1/23
for Evaluation at AUMS

From 27/2

From 2/3

RADIOLOGY UNIT रेडियोलोजी एकक

डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल, अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली-110029
DR. BR Ambedkar Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, New Delhi-110029

APPOINTMENT FOR RADIOLOGICAL TEST रेडियोलोजी टेस्ट की तारीख

Name of the Patient : Rituraj

UHID No. 106528415

Age/Sex : 7/M

IRCH No.

Scheduled date तारीख 13/4/23 Room No. कमरा नं. 43/49/46/30

Please report at समय : 8.30 am.

Name of the Test / Procedure टेस्ट का नाम

Test	Type	Body part (s)
CT scan सीटी स्कैन	CECT, NCCT, HRCT Multiphase CT, CT angiography	Head, Orbit, Face, Neck, Chest, Abdomen, Pelvis, other.....
Ultrasound अल्ट्रासाउंड	Abdomen-Pelvis, KUB, Neck, Breast, Scrotum, TVS, TRUS, other.....	
Colour Doppler डॉपलर	Upper limb, Lower Limb, Other.....	
GI tract study बेरियम	Barium Swallow, Barium Follow Thru, Distal Cologram, Gastrograffin Study, other.....	
Urinary study आईवीपी	IVP, MCU, other.....	
Mammography मेमोग्राफी	Bilateral, Right, Left	
Othre अन्य		

Signature of booking clerk/officer [Signature]

Date given on: 23/3/23

Please read carefully and follow checked ✓ instructions चिन्हांकित ✓ सूचनाओं का पालन करें :

- Bring contrast injection lomeprol400mg/lohexol350mg/lobitridol350mg/other equivalent 40 ml यह दवा साथ लाएं.
- Fasting for 4 hours (only water or medicines are allowed) 4 घंटे खाली पेट रहें (पानी, दवाएं ले सकते हैं)
- Do not pass urine for 3-4 hours 3-4 घंटे पेशाब रोकें रहें.
- Bring 1 litre of drinking water for you पीने का पानी साथ लाएं.
- Bring on adult attendant with you एक वयस्क साथी साथ लाएं.
- Bring previous X-rays or other films, if any पुराने एक्सरे या फिल्मों साथ लाएं.
- Pay Rs. 200/300/750/1500/..... at Cash Counter no. 13 (each body part is charged separately) इतना शुल्क जमा करें.
- Special instruction विशेष सूचनाएं

सीटी स्कैन एवं मेमोग्राफी की रिपोर्ट कमरा सं. 45 से प्राप्त करें

General information सामान्य जानकारीयां :

- Contrast injection during CT scan can occasionally cause side effects ranging from mild allergy like itching to severe breathlessness, hypotension or shock, These cannot be predicted but chances are higher in those with history of asthma or allergy to medicine. So please inform if you have history of asthma or allergy to any medicine सीटी स्कैन में कंट्रास्ट दवा के इंजेक्शन से कभी कभी दुष्परिणाम (उल्टी, खुजली, शॉक इत्यादि) हो सकते हैं, यदि आपको दमा या कोई एलर्जी है तो पहले बताएं.
- Ladies if you could be pregnant, inform radiographer, nurse or doctor before the test महिलाएं यदि गर्भवती हैं तो पहले बताएं,
- Your test is likely to be over before 1 pm आपका टेस्ट 1 बजे के पहले पूरा हो सकता है.
- Report will be sent to OPD counter No. 9 or ward after two working days रिपोर्ट दो दिन के बाद काउंटर 9 या वार्ड में भेज दी जाएगी.

Consent of the Patient for contrast Injection कंट्रास्ट इंजेक्शन के लिए रोगी की सम्मति।

I have been explained the risks associated with iodinated contrast medium injection. I hereby give my consent for injection of contrast media to me by any route deemed necessary मुझे कंट्रास्ट इंजेक्शन के दुष्परिणाम की जानकारी दी गई है. मैं कंट्रास्ट इंजेक्शन के लिए अपनी सम्मति प्रदान करता हूँ/ करती हूँ.

Signature of Patient or attendant _____ Name _____

Date : _____ Relation with the Patient _____

रिपोर्ट नं०
- (13)

डॉ० बी० आर० अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B. R. AMBEDKAR INSTITUTE ROTARY CANCER HOSPITAL
 अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली-110029
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI-110029
 Radiology Requisition Form (Other than X-ray)

DR. B.R.A. IRCH, AIIMS, NEW DELHI
 UHID: 106528415
 IRCH No. 290608
 नाम
 Name RITURA
 S/O- RAJ KISHOR
 Sex/Age M/7Y

Patient Status
 Outdoor
 Indoor (Ward / Bed No.)
 General Condition of the Patient :
 Ambulatory
 Non-ambulatory
 Critical with life support
 Payment Status :
 Paying
 Exempted by (Sign & Stamp)
 EHS (No.)

Investigation Requested (Separate requisition is required for each type of investigation)

<p>CT</p> <p>Type</p> <input type="checkbox"/> CECT <input type="checkbox"/> NCCT <input type="checkbox"/> HRCT <input type="checkbox"/> Dual phase CT <input type="checkbox"/> Other (Specify) _____ <p>Body Part(s)</p> <input type="checkbox"/> Head <input type="checkbox"/> Orbit <input type="checkbox"/> PNS <input type="checkbox"/> Face / mandible <input checked="" type="checkbox"/> Neck <input checked="" type="checkbox"/> Chest <input checked="" type="checkbox"/> Abdomen <input checked="" type="checkbox"/> Pelvis <input type="checkbox"/> Other (specify) _____	<p>Ultrasound</p> <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Upper Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> KUB <input type="checkbox"/> Breast <input type="checkbox"/> Scrotum <input type="checkbox"/> Neck <input type="checkbox"/> TVUS <input type="checkbox"/> TRUS <input type="checkbox"/> Colour Doppler of _____ <input type="checkbox"/> Other (specify) _____	<p>Fluoroscopy & Special Radiography</p> <input type="checkbox"/> Barium Swallow <input type="checkbox"/> Barium Meal UGI <input type="checkbox"/> Barium Meal Follow Through <input type="checkbox"/> Gastrografin Study <input type="checkbox"/> Loopogram <input type="checkbox"/> Distal Cologram <input checked="" type="checkbox"/> Sinogram <input checked="" type="checkbox"/> IVP <input type="checkbox"/> Other (specify) _____	<p>Image Guided Interventions</p> <p>Procedure</p> <input type="checkbox"/> FNAC <input type="checkbox"/> Core Biopsy <input type="checkbox"/> Fluid Aspiration only <input type="checkbox"/> Fluid Aspiration for cytology <input type="checkbox"/> Catheter Drainage <input type="checkbox"/> Other (specify) _____ <p>of (organ/ lesion) _____</p> <p>As per the requirement, Please provide filled cytology/histopathology form</p>
	<p>Mammography</p> <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left	<p>Films Review</p> <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other _____	

Clinical Diagnosis :

*ClO primary Request
HL*

Clinical details :

Previous imaging :

- None
- At BRAIRCH (study/date)
- Outside (details)

For CT & IVP only:

Blood urea, creatinine
any history of allergy, asthma

Signature & Name of the Doctor

Date :

For the use of Radiology Department only	Study number/ Date :
Appointment on : <i>13/4/23</i>	Senior Resident/ Technologist :
Contrast Details : <i>1hr 8:30</i>	Comments :

Date : _____

Relation with the Patient _____



अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
NATIONAL CANCER INSTITUTE

UHID:	106528415	Sex :	Male
Patient Name :	Mr RITURA RITURA	Sample Received Date :	22/03/2023 04:34 PM
Age :	7 years 1 month 6 days	Department :	Medical Oncology
Unit Name :	Unit-I	Unit Incharge :	
Lab Name:	NCI CORE LAB	Lab Sub Centre:	
Reg Date :	16/02/2023 11:49 AM	Sample Collection Date:	22/03/2023 02:12 PM
Report Generated Date:	22/03/2023 07:52 pm	Dept / IRCH No:	290608
Recommended By:	Dr. Amlesh Seth	Lab Reference No:	836

Sample Details : S220323494

Report

Test Name	Result	Comment	Normal Range
LDH	330 U/L		• 120 - 246
<u>LFT</u>			
TOTAL BILIRUBIN	0.200 mg/dL		• 0.3 - 1.2 mg/dL
DIRECT BILIRUBIN	0.100 mg/dL		• < 0.3 mg/dL
INDIRECT BILIRUBIN	0.1 mg/dL		• < 0.9 mg/dL
SGPT/ALT	46 U/L		• 10 - 49 U/L
SGOT/AST	44 U/L		• < 34 U/L
TOTAL PROTEIN	6.900 g/dL		• 5.7 - 8.2 g/dL
ALKALINE PHOSPHATASE	249 I.U.		• 46 - 116 U/L
GLOBULIN	3.1		• 2.5 - 3.4 g/dL
A/G Ratio	1.22581 ratio		• 1.2 - 2.2 ratio
Albumin	3.800 g/dL		• 3.2 - 4.8 g/dL
Gamma-Glutamyl Transferase	37		• < 73 U/L
<u>RFT</u>			
UREA	12.800 mg/dL		• < 50 mg/dL
CREATININE	0.190 mg/dL		• 0.7 - 1.3 mg/dL
CALCIUM	8.400 mg/dL		• 8.7 - 10.4 mg/dL
PHOSPHOROUS	4.200 mg/dL		• 2.4 - 5.1 mg/dL
SODIUM (NA)	138 mmol/L		• 132 - 146 mmol/L
POTASSIUM (K)	4.500 mmol/L		• 3.5 - 5.5 mmol/L
CHLORIDE(CL-)	104 mmol/L		• 99 - 109 mmol/L
Uric Acid	2.200 mg/dL		• 3.7 - 9.2 mg/dL

Over All Comment :

Authorised Signatory

Verified By
ankitlabnci



DR. BRA INSTITUTE ROTARY CANCER HOSPITAL
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
ANSARI NAGAR, NEW DELHI-110029

Ref. No.F.1/IRCH/MR/2022-2023

Dated 1.3.MAR.2023

ESTIMATE CERTIFICATE

TO WHOM IT MAY CONCERN

This is to certify that Mr. Ritura, Age 07 years, Male, S/o Mr. Raj Kishor, (UHID-106528415 & IRCH No. 290608/23) is a known case of **Hodgkin's Lymphoma** and is under treatment with Medical Oncology at DR. BRA IRCH, AIIMS since 16.02.2023.

The approximate cost for his treatment would be Rs. 5,00,000/- (Rupees Five Lakhs Only).

The item-wise breakup of the expenditure is as under:-

S.No.	Name of Medicines with dosage/Consumables Required for treatment/operation	Duration of treatment	Approx. cost	Name of Procedure
1.	Autologous Stem Cell Transplant		Rs. 5,00,000/-	

The cheque/draft may be sent in favour of "DR. BRA IRCH, AIIMS, Ansari Nagar, New Delhi-29 (IRCH Patient Treatment Account)"

(NB: This estimate certificate is valid for six months from the date of issue)

Sameer Bakshi

(COUNTER SIGNED BY HOD)

Acting M.D. 10/3/23

Sameer Bakshi

(SIGNATURE BY CONSULTANT)

आचार्य समीर बखशी/Prof. SAMEER BAKHSHI
चिकित्सा अर्थाद्विज्ञान विभाग/Dept. of Medical Oncology
डॉ. भी.रा.अ., सं.रो.कें.अ., ज.भा.आ.सं., नई दिल्ली-29
Dr. B.R.A., IRCH, A.I.I.M.S., New Delhi-110029
डीमसी पंजीकृत सं/DMC Registration No. 18936

आचार्य समीर बखशी/Prof. SAMEER BAKHSHI
चिकित्सा अर्थाद्विज्ञान विभाग/Dept. of Medical Oncology
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Dr. B.R.A., IRCH, A.I.I.M.S., New Delhi-110029
डीमसी पंजीकृत सं/DMC Registration No. 18936

(COUNTER SIGNED BY M.S.)

चिकित्सा अधीक्षक/MEDICAL SUPERINTENDENT
ज.भा.आ.सं. अस्पताल/A.I.I.M.S. HOSPITAL
डॉ. भी.रा.अ., सं.रो.कें.अ./Dr. B.R.A., I.R.C.H.
नई दिल्ली-110029/New Delhi-110029