

CODE 101 ✓

AUTOCLAVE REGISTER



PASTE USED STRIP HERE AFTER AUTOCLAVING OF THE PARTICULAR DRUM IS OVER	DATE & DRUM NO.		DRUM STARTED / SUPERVISED BY NAME	SIGNATURE
	DATE	DRUM NO.		

Mfd. by : **AJANTA PAPER CO.**, Neelkanth Apartment, Gokuldas Pasta Road, Behind Chitra Cinema, Dadar (E), Mumbai - 400 014.
Tel.: 2415 1816 / 2411 2348 • E-mail : ajantabook@gmail.com

AUTOCLAVE REGISTER



PASTE USED STRIP HERE AFTER AUTOCLAVING OF THE PARTICULAR DRUM IS OVER	DATE & DRUM NO.		DRUM STARTED / SUPERVISED BY NAME	SIGNATURE
	DATE	DRUM NO.		

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REGISTER

DELIVERY



Reg. No. Serial	Date & Time of Admission	Date & Time of Discharge	Name of the Patient & Address	Obstetrics History	Details of Child Birth			Type of Delivery & Indication of Intervention (if Any)	Birth Notifications To Municipal Authorities	Mother's Religion, Education, & Bl. Grp.
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				
	AM PM			Male - Female - Abortion -	Date - Sex - Time - Wt. - Kgs.					
	Husband's Full Name & Edu.		Age _____ Years		Day - O./E. - Apgar Score :	Child's Bl. Grp.				

FUMIGATION REGISTER



DATE	OT NO. FUMIGATION METHOD VAPOUR / CHEMICAL		STARTED BY - NAME, SIGNATURE & TIME	FINISHING TIME SUPERVISED BY - NAME, SIGNATURE	REMARK
	OT.NO.	METHOD			
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
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			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	

Mfd. by : **ASHITA PAPER CO.** Neelkumbh Apartment, Golukdas Pata Road, Behind Chitra Cinema, Dadar (E), Mumbai - 400 014.
Tel: 2415 1816 / 2411 2348 & E-mail : ajntabook@gmail.com

FUMIGATION REGISTER



DATE	OT NO. FUMIGATION METHOD VAPOUR / CHEMICAL		STARTED BY - NAME, SIGNATURE & TIME	FINISHING TIME SUPERVISED BY - NAME, SIGNATURE	REMARK
	OT.NO.	METHOD			
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	
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			NAME	NAME	
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			NAME	NAME	
			SIGN	SIGN	
			TIME	TIME	
			NAME	NAME	
			SIGN	SIGN	

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CODE No. 106

REGISTER

MTP

WITH 12 FORMS OF MONTHLY REPORT



Indications: A) Danger to life. B) Grave injury to physical health of pregnant woman. C) Grave injury to mental health of pregnant woman. D) Fertility caused by rape. E) Substantial risk that if the child was born, it would suffer from such physical or mental abnormality as to be seriously handicapped. F) Failure of contraceptives.

Yearly No.	Monthly No.	Name & Address of The Patient	Marital Status & Father's / Husband's Name	Duration of Pregnancy in wks	Dates	Indication of Termination	Name of Regd. Practitioner/s by whom the Opinion is formed	Dr. By Whom Termination is Performed	Remark
			<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Indication A / B / C / b / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.A.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.T.	Indication A / B / C / D / E / F			
		Age Yrs • Religion	<input type="checkbox"/> Unmarried / <input type="checkbox"/> Married Name - F / H		D.O.D.	Method - <input type="checkbox"/> D. & E. / <input type="checkbox"/> E.A. Instillation With - <input type="checkbox"/> Sterilisation / <input type="checkbox"/> I.U.C.D. Insertion			



OPERATION THEATER REGISTER

REGISTER

CODE NO. 109

Date

Serial No.	Date	Indoor / O.P.D. Reg. No.	Name of the patient	Type of Anaesthesia	Provisional Diagnosis	Title of the Surgery	Names				Remark
							Operating Surgeon	Anaesthetist	Assisting Doctors	Assisting Nurse/s	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	
			MALE / FEMALE AGE : YEARS	GA / SA / LA / EA Duration of Surgery am to pm						Material for H.P.E. <input type="checkbox"/> Yes / <input type="checkbox"/> No	



STERILISATION &

I.U.C.D. REGISTER

CODE NO. 112

Sr. No.	Name & Address With Prominent Landmark		Details of Couple		Patient's History		Sterilisation		Sterilisation		Remark
			Husband	Wife			Yearly No.	Monthly No.	Yearly No.	Monthly No.	
			Age	Yrs.	Yrs.	Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				
						Total Pregnancies	No.	No.	No.	No.	
			Education			Living M / F	<input type="checkbox"/> Abdominal / <input type="checkbox"/> Laparoscopic			L. M. P.	
			Occupation			Abortions	<input type="checkbox"/> Vasectomy				
			Monthly income			Age of Last Issue	Date of Operation			Date of I.U.C.D. Insertion	
			Caste			<input type="checkbox"/> M / <input type="checkbox"/> F	Type of Anaesthesia - GA / SA / LA / EA				



U. S. G. REGISTER

FORM F

Information of Referring Doctor / Center
Referral note to be attached with this page

Patient's Information

Name		
Age	Yrs. L.M.P.	Pregnancy in wks.
Husband's Name	Father's Name	
Add.:		
Number of Children	Male	Female
	Ph.	Ph.

History of genetic / medical disease in the family (Specify)

Basis of diagnosis : (a) Clinical (b) Bio-chemical (c) Cyo-genetic (d) Other (e.g.) Radiological, Ultrasonography-specify

Indication for pre-natal diagnosis

- A) Previous child/Children with (i) Chromosomal disorders (ii) Metabolic disorders (iii) Congenital anomaly (iv) Mental Retardation (v) Haemoglobinopathy (vi) Sex-linked disorder (vii) Single Gene Disorder (viii) Any other (specify)
- B) Advanced maternal age (>35 Years) (C) Mother/father/sibling has genetic disease (specify)
- D) Other (specify)

Procedures carried out (i) Ultrasound (ii) Amniocentesis (iii) Chorionic Villi aspiration (iv) Foetal diopsy (v) Cordocentesis

(vi) Any other (specify)

Name and Registration No. (of Gynaecologist / Radiologist/Registered Medical Practitioner) who performed it.

Name : _____ Reg. No. : _____

Any complication of procedure - please specify _____

Laboratory tests recommended :

- (i) Chromosomal studies (ii) Bio-Chemical studies (iii) Molecular studies (iv) Preimplantation genetic diagnosis

Result of pre-natal diagnostic procedure

Ultrasonography : Normal / Abnormal - Specify abnormality detected, if any.

Date (s) on which procedures carried out. _____ Date on which consent obtained _____ on _____

The results of pre-natal diagnostic procedure were conveyed to _____

Was M.T.P. advised / conducted • Date on which M.T.P. carried out _____

Gynaecologist Radiologist Registered Medical Practitioner.

Name :	Signature :
Registration No. :	Date :
	Place :

I, Ms./Mrs. _____ declare that by undergoing ultrasonography / image scanning, etc. I do not want to know the sex of my foetus	Signature / L.H. T. I.	Name & Signature	
		Name & Signature	

In case of invasive procedure, please take separate consent as prescribed in Form G

Covering almost all points of The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 & amended as of Jan. '03
Mtd. by : **ANANTA PAPER CO.**, Neelkanth Apartment, Goludas Pasa Road, Behind Chitra Cinema, Dadar (E), Mumbai - 400 014.
Tel.: 2415 1816 / 2411 2308 • E-mail : jgntabook@gmail.com

CODE NO- 113

FORM F

Information of Referring Doctor / Center
Referral note to be attached with this page

Patient's Information

Name		
Age	Yrs. L.M.P.	Pregnancy in wks.
Husband's Name	Father's Name	
Add.:		
Number of Children	Male	Female
	Ph.	Ph.

History of genetic / medical disease in the family (Specify)

Basis of diagnosis : (a) Clinical (b) Bio-chemical (c) Cyo-genetic (d) Other (e.g.) Radiological, Ultrasonography-specify

Indication for pre-natal diagnosis

- A) Previous child/Children with (i) Chromosomal disorders (ii) Metabolic disorders (iii) Congenital anomaly (iv) Mental Retardation (v) Haemoglobinopathy (vi) Sex-linked disorder (vii) Single Gene Disorder (viii) Any other (specify)
- B) Advanced maternal age (>35 Years) (C) Mother/father/sibling has genetic disease (specify)
- D) Other (specify)

Procedures carried out (i) Ultrasound (ii) Amniocentesis (iii) Chorionic Villi aspiration (iv) Foetal diopsy (v) Cordocentesis

(vi) Any other (specify)

Name and Registration No. (of Gynaecologist / Radiologist/Registered Medical Practitioner) who performed it.

Name : _____ Reg. No. : _____

Any complication of procedure - please specify _____

Laboratory tests recommended :

- (i) Chromosomal studies (ii) Bio-Chemical studies (iii) Molecular studies (iv) Preimplantation genetic diagnosis

Result of pre-natal diagnostic procedure

Ultrasonography : Normal / Abnormal - Specify abnormality detected, if any.

Date (s) on which procedures carried out. _____ Date on which consent obtained _____ on _____

The results of pre-natal diagnostic procedure were conveyed to _____

Was M.T.P. advised / conducted • Date on which M.T.P. carried out _____

Gynaecologist Radiologist Registered Medical Practitioner.

Name :	Signature :
Registration No. :	Date :
	Place :

I, Ms./Mrs. _____ declare that by undergoing ultrasonography / image scanning, etc. I do not want to know the sex of my foetus	Signature / L.H. T. I.	Name & Signature	
		Name & Signature	

In case of invasive procedure, please take separate consent as prescribed in Form G

Covering almost all points of The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 & amended as of Jan. '03
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