Annexure-C

AIDS AND APPLIANCES FORM

Regd. No._____ Date_____

Work Order No._____ Age/Sex_____

Religion_____

Name of the patient_____

Permanent Address_____

_____

Present Address_____

_____

Diagnosis_____

Aim of Treatment_____

Appls. Prescribed & delivered_____

Date of delivery_____

Cost of Aids / Appls_____

Monthly Income_____

Refered to_____

Signature of the Prefessional Specialist of Orth. / Audio / M.I. / Physio / O.T./ Psyche.

Undertaking form patient / Parent / Guardian

I Solemnly declare that, I have not obtained any aids / appls. form any other agency during last 3 years & I will keep it for bonafied use of my self / my son / my daughter. Further I declare that I have received this aids/ appls. in good condition & free of cost / 50% subside / full payment.

Approved by

Signature of patient / Parent / Guiardian