

Ananta Hospital – Departmental Service Details Form

(To be filled by all Department Heads and submitted to the Medical Superintendent)

Section A: Department Information

1. Department Name: _____
2. Head of Department (HOD): _____
3. Designation: _____
4. Contact Number & Email: _____

Section B: Clinical & Medical Services

1. Core Specializations / Treatments Offered
- (List the main diseases, conditions, or procedures treated in your department)

2. Types of Services Provided
 - OPD Consultations
 - Emergency Services
 - In-Patient Services (IPD)
 - Surgeries/Procedures
 - Critical Care/ICU Support
 - Rehabilitation / Physiotherapy
 - Counseling / Supportive Care
 - Others: _____
3. Key Medical Facilities & Equipment Available
- (Example: MRI, Cath Lab, Linear Accelerator, Arthroscopy Unit, etc.)

4. Special Clinics / Programs Conducted
- (Example: Stroke Clinic, Cardiac Rehab, Pain Clinic, Cancer Screening Camps, etc.)

Section C: Patient Care & Support

1. Patient Education / Awareness Programs
- (Health camps, workshops, awareness days, etc.)

2. Average Monthly Patient Load
 - OPD: _____
 - IPD: _____
 - Surgeries/Procedures: _____
3. Multidisciplinary Collaborations
- (Eg. Joint cases with ICU, Oncology, Neurology, etc.)

Section D: Team & Staff

1. Doctors (Consultants, Residents) – Number: _____

2. Nursing Staff – Number: _____

3. Technicians / Paramedics – Number: _____

4. Other Support Staff – Number: _____

Key services offered:

Section E: Additional Notes / Suggestions

(Any new service planned, challenges faced, or requirements for better patient care)

Declaration by HOD

I hereby confirm that the above details are true and complete to the best of my knowledge.

Signature & Stamp of HOD: _____

Date: _____