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24x7 HELPLINE: 0120-4504004

DISCHARGE SUMMARY

| | | | |
|--------------|--|--------------|----------------------|
| Name | BABY KHUSHBOO | Regn No. | VH0034745 |
| Patient Code | PN043737 | Sex | 7 Yrs. F |
| Guardian | ISO MR. MAJITHA LAL | Admitted On | 12-Nov-2018 04:43 PM |
| Address | VILL- CHAWARI, SECTOR 43 NOIDA | Discharge on | 20-Dec-2018 9:13 PM |
| Consultant | DR. PRAVEEN KUMAR (M.D.) PEDIATRICS | Source | CASUALTY |

FINAL DIAGNOSIS
POST BURN CONTRACTURE AND ULCER AT RIGHT KNEE JOINT
BILATERAL INGUINAL REGION AND LOWER ABDOMEN

HISTORY
Baby Khushboo, 7 years old female, had alleged history of burn injury over lower abdomen and inguinal region from hot water 1 year back. Admitted in Safdarjung Hospital for 2 months, brought to this hospital by her mother. Patient was admitted in this hospital with complaints from last 1 month, itching over burn area, rashes, mild fever on and off, generalised weakness, poor oral intake, and immobility of knee joint.


ON EXAMINATION
GC - Sick, afebrile, Pallor+ No icterus, No cyanosis, No clubbing, No oedema.
Pulse - 108/Min. R/S - B/L AI+ Temp - 98.7F.
CVS - S1S2 - CNS - NAD PA - Soft, B+ R/R - 20/Min.
SPO2 - 98% GCS - 15/15 Wt - 15 kg

INVESTIGATION
All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
Patient admitted in hospital through casualty on 12.11.18 under Dr. Praveen Kumar, with above mentioned complaints. After initial evaluation as per standardised protocol treatment initiated with IV fluids, IV antibiotics, Antipyretic, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Plastic Surgeon Dr. Mukesh was referred. Skin Grafting and debridement done. Regular dressing/garment GA in aseptic conditions done. Treatment optimized accordingly. Now patient condition is stable afebrile, pass urine and stool, taking orally well and is being discharged on following advice and medication.

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TREATMENT GIVEN

IV Fluids as advised
Syp. Augmentin Syp. Pantop
Syp. Omeprazole Tab. Dolo
Tab. Allegra Syp. Ferrob
Syp. Ibuprofen Syp. A to Z
Syp. Becasole Refresh tear eye drop
Mucicap KT eye drop Physiotherapy
And other supportive treatment

ADVICE ON DISCHARGE


Syp. A to Z - 5 ml Pw - Twice a day x 15 days
Syp. Omeprazole - 5 ml - twice a day x 15 days
Syp. Ferrob - 5ml - once a day x 15 days

FOLLOW UP

Review in Peds. OPD after 7 days or as and when required.

In case of any medical emergency please contact to emergency department of Vinayak Hospital or call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-450400-2444222-2444333.

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CONSULTANT / R.M.O.

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BABY KHUSHBOO



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DISCHARGE SUMMARY

| | | | |
|--------------|-----------------------|--------------|----------------------|
| Name | BABY MANVI KUMARI | Regn No. | VH0033845 |
| Patient Code | PN206445 | Sex | 2 Yrs. 5 Mon F |
| Guardian | DR. MR. LAXMAN JHA | Admitted On | 07-Aug-2018 10:58 AM |
| Address | DIST. MADHAWAN, BHAR | Discharge on | 12-Sep-2018 6:10 PM |
| Consultant | DR. SAURASH CHAUDHARY | Source | CASUALTY |

FINAL DIAGNOSIS
SMALL ULCER AT LEFT SHOULDER AND BURN CONTRACTURE LEFT AXILLA AND BURN SCAR AT LEFT SIDE OF FACE, SHOULDER AND ARM

HISTORY
Baby Manvi Kumari, 2.5 years, old female, patient was admitted in this hospital with complaints of burn contracture at left axilla, ulcer at left shoulder scar at left side of face and arm, penna loss (left)

ON EXAMINATION
GC - Sick, Irritability (+), (Apathetic), No Pallor, No icterus, No cyanosis, No clubbing, No oedema.
Pulse - 134/Min. R/S - B/L clear Temp - 98F.
CVS - NAD CNS - NAD PA - Soft, B+ R/R - 26/Min.
SPO2 - 96% GCS - 15/15 Wt - 8 kg

INVESTIGATION
All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
Patient was admitted with above mentioned complaints. After initial evaluation as per standardised protocol treatment initiated with IV fluids, IV antibiotics, Antipyretic, Analgesic, Antacid and other supportive treatment also given. After PAC clearance patient underwent surgery to Release contracture of left Axilla + Multiple Z Plastic and skin grafting done under GA on 9.08.2018. Post op surgery patient uneventful. Now patient condition is stable and is being discharged in satisfactory condition.

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TREATMENT GIVEN

IV Fluids as advised
Inj. Amoxiclav, Syp. Ibuprofen Plus,
Syp. Nalox Plus, Syp. Folicacid,
Syp. Augmentation Duo, Syp. A to Z
Sponge Bath
And other supportive treatment

ADVICE ON DISCHARGE

Dressing on Alternate day.
Keep dressing dry
Syp. Zincovit- 2.5 ml- Twice a day x 10 Days

FOLLOW UP

Review in OPD After 5 days or as and when required.

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Baby Manvi Kumari

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DISCHARGE SUMMARY

| | |
|-------------------------------------|------------------------------------|
| Name: BABY MANVI | Regn No: VH0034390 |
| Patient Code: PM041232 | Sex: 2Yrs. F |
| Guardian: D/O MR. Jitendra | Admitted On: 04-Oct-2018 11: AM |
| Address: Sector-13 SARAFABAD, NOIDA | Discharge on: 05-Nov-2018 02:00 PM |
| Consultant: DR VARUN KULSHRESTHA | Source: CASUALTY |

FINAL DIAGNOSIS
ACCIDENTAL BURN (M%)

HISTORY
Baby Manvi, 2 years old female patient was admitted in this hospital with complaints of pain. Present, blister present. AHO- accidental burn 25-30 % at home because she fell down on hot water at 8:00 pm on 3.10.2018 brought to casualty by her father at 11:00 AM on 4.10.2018.

ON EXAMINATION
GC - Sick, No Pallor, No Icterus, No cyanosis, No clubbing, No oedema.
Pulse - 120/Min RN - RT. clear Temp - 98.2F.
CVS - NAD CNS - NAD PA - Soft, Bv - R/R - 20/Min.
SPO2 - 89% GCS - 15/15 Wt. - 10 kg.

INVESTIGATION
All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
Patient admitted in hospital through casualty on 04.10.18 under Dr. Varun Kulshrestha with above mentioned complaints. After initial evaluation as per standardised protocol treatment initiated with IV fluids, IV antibiotics, Antipyretic, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Patient was monitored closely. After stabilisation, patient was shifted to ward. Regular dressing done. Paediatric referral (Dr. Surendra Anand) was done. Now patient is stable and being discharged following advice and medicines.

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TREATMENT GIVEN
IV Fluids as advised
Inj. Amoxycylav, Syp. Ibuprofen Plus,
Syp. Nubel Plus, Syp. Pediclor,
Syp. Augmentin Duo, Syp. A to Z,
Sponge Bath
And other supportive treatment.

ADVICE ON DISCHARGE
Dressing on Alternate day.
Keep dressing dry.
Syp. Zincovit- 2.5 ml- Twice a day x 10 Days

FOLLOW UP
Review in OPD After 5 days or as and when required.
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BABY MANVI

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DISCHARGE SUMMARY

| | |
|--|------------------------------------|
| Name: BABY PRANJALI | Regn No: VH0024115 |
| Patient Code: PM039091 | Sex: 6Yrs F |
| Guardian: D/O MR. RAHUL PATHAK | Admitted On: 09-Sep-2018 04:43 PM |
| Address: C-207 Swarn Nagar, G Noida | Discharge on: 27-Sep-2018: 8:55 PM |
| Consultant: DR PEEYUSH KUMAR, MBBS, MS | Source: CASUALTY |

FINAL DIAGNOSIS
3RD SECONDARY SUPERFICIAL AND DEEP BURN (SCALD INJURY)

HISTORY
Baby Pranjali, 6 years old female, patient was admitted in this hospital with complaints of burning sensation over burn area pain and burn site.

ON EXAMINATION
GC - Sick, Irritability, Anhydrosis, No Pallor, No Icterus, No cyanosis, No clubbing, No oedema.
Pulse - 80/Min RN - RT. clear Temp - 101.8F.
CVS - NAD CNS - NAD PA - Soft, Bv - R/R - 20/Min.
SPO2 - 96% GCS - 15/15 Wt. - 16 kg.

INVESTIGATION
All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
Patient admitted in hospital through casualty on 09.09.2018 under Dr. Peeyush with above mentioned complaints. First AID treatment of patient was done at Kailash Hospital and the patient came to Vinayak Hospital and was admitted with MLC NO-3054. After initial evaluation as per standardised protocol treatments initiated with IV antibiotics, IV PPR, analgesic and other supportive treatment. Patient was shifted to ICU for monitoring. Paediatrician referral was done by Dr. Parveen and surgical referral was done by Dr. Varun. Physiotherapy as also done. Now patient is being discharged on following medications.

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TREATMENT GIVEN
IV Fluids as advised
Inj. Monocel - Inj. Amikacin
Syp. Pedicloryl - Syp. Crocin
Syp. Foliclor - Syp. Aloe
Syp. Hemozinik - Syp. Kamtar
Syp. Ibuprofen Plus - Syp. Augmentin
Electrol Powder - Protinax powder junior
And other supportive treatment

ADVICE ON DISCHARGE
Syp. A to Z - 5 ML - twice a day x 5 days
Syp. Arithra - 5 ML - Once a day x 5 days
Syp. Hemozinik - 5ml - Twice a day x 5 days
Liquid Paraffin (heavy) local applications
On dressing maintain asepsis of wound
Plenty of water intake.

FOLLOW UP
Review for dressing with Dr. Varun Kulshrestha Alternate day or as and when required.
In-case of any medical emergency please contact to emergency department of Vinayak Hospital or call call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-4504000-2444222-2444333.
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BABY PRANJALI

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DISCHARGE SUMMARY

| | | |
|--|---------------|----------------------|
| Name: BABY UNNATI | Regn No.: | VH0034378 |
| Patient Code: PNC41171 | Sex: | 3Yrs F |
| Guardian: D/O MR. AJAY VERMA | Admitted On: | 03-OCT-2018 02:42 PM |
| Address: 35 Top Floor, Krishna Nagar | Discharge on: | 17-Oct-2018 2:48 PM |
| Consultant: DR. MUNESH KUMAR - MDD, M.Ch (Plastic Surgeon) | Source: | CASUALTY |

FINAL DIAGNOSIS
FUC OF SCALD BURN LEFT HAND AND BACK

HISTORY
 Baby Unnati, 3 years, old female, patient was admitted in this hospital with alleged history of accidental scald burn at home on 10.02.2018 treatment taken from LALUP hospital new Delhi with complaints of contracture left elbow with axilla, limiting movement of left elbow.

ON EXAMINATION
 vit - SCL, Irritability -, (dehydration), No Pallor, No icterus, No cyanosis, No clubbing, No oedema.
 Pulse - 112/Min R/S - B/L clear Temp - 98.2F
 CVS - S1S2 Audible CNS - NAD PA - SCL, B/L R/R - 20/Min
 SPO2 - 96% on RA GCS - 15/15 Wt - 14 kg

INVESTIGATION
 All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
 Patient admitted in hospital through casualty on 03.10.18 under Dr. Varun Kulkarni with above mentioned complaints. After initial evaluation as per standardised protocol treatment initiated with IV fluids, IV antibiotics, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. After consent and PAC, clearance patient taken up for surgery. Debridement skin grafting and multiple Z-plasty left axilla done on 07.10.2018. Post operative patient was shifted to ICU for close monitoring. Alternate day dressing done. Patient condition has improved. Patient is being discharged with following advice and oral treatment.

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TREATMENT GIVEN
 IV Fluids as advised
 Inj. Augmentin
 Inj. Dynapar
 Inj. Pan 40
 And other supportive treatment

ADVICE ON DISCHARGE
 Syp. Augmentin duo - 5ml - Thrice a day x 5 days
 Syp. Digesic + Dolo - 5 ml - SOS
 Next Dressing After 5 days

FOLLOW UP
 Review in surgery. OPD with Dr. Munesh Kumar after 5 days or so and when required.
 In-case of any medical emergency please contact to emergency department of Vinayak Hospital or can call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-4504400-244222-244133

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BABY UNNATI

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DISCHARGE SUMMARY

| | | |
|---|---------------|----------------------|
| Name: Baby Vanshika | Regn No.: | VH0034822 |
| Patient Code: PNC41517 | Sex: | 9 Months F |
| Guardian: D/O MR. MUNNA SINGH | Admitted On: | 11-Oct-2018 07:01 PM |
| Address: L-71A, Jahangir Puri, Delhi | Discharge on: | 12-Nov-2018 4:20 PM |
| Consultant: DR. MANUJ MEHRA (Plastic Surgeon) | Source: | CASUALTY |

FINAL DIAGNOSIS
BURN- 25.5 OVER ABDOMEN AND BILATERAL LOWER LIMBS

HISTORY
 Baby Vanshika, 9 months old female patient was brought to casualty at 6:30 PM by her parents with complaints of burn over abdomen, burn over bilateral thighs, and burn over genital region.
 AKVO- Burn at 2:00 PM today at home with hot milk.

ON EXAMINATION
 vit - SCL, Anxious, No Pallor, No icterus, No cyanosis, No clubbing, No oedema.
 Pulse - 130/Min R/S - B/L A1 - Temp - 98.1F
 CVS - NAD PA - SCL, B/L R/R - 42/Min
 SPO2 - 96% GCS - 15/15 Wt - 5.5 kg

INVESTIGATION
 All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
 Patient admitted in hospital through casualty on 11.10.18 under Dr. Manoj Mehra with above mentioned complaints. After initial evaluation as per standardised protocol treatment initiated with IV fluids, IV antibiotics, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Patient was shifted to ward on 14.10.2018 after stabilisation. Pediculicidal referral (Dr. Phaveen) was done. Now the patient condition is stable and being discharged with following advice and oral medicines.

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TREATMENT GIVEN
 IV Fluids as advised
 Inj. Augmentin Inj. Amikacin
 Inj. Pan 40 Inj. Morphine
 Syp. Digesic Inj. Rantac
 And other supportive treatment

ADVICE ON DISCHARGE
 Syp. Zinovit - 5 ml - Once a day x 5 days

FOLLOW UP
 Review in OPD with Dr. Manoj Kumar after 7 days or so and when required.
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BABY VANSHIKA

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DISCHARGE SUMMARY

| | | | |
|--------------|----------------------------|--------------|----------------------|
| Name | Master DEV VERMA | Regn No. | VH0034984 |
| Patient Code | PN045658 | Sex | 1 Yrs. M |
| Guardian | S/O MR. DEEPU VERMA | Admitted On | 19-Dec-2018 12:30 PM |
| Address | VILL-BHANGEL SEC-102 NOIDA | Discharge on | 09-Jan-2019 2:48 PM |
| Consultant | DR VARUN KULSHRESTHA | Source | CASUALTY |
| MLC No. | 3098 | | |

FINAL DIAGNOSIS
 IT* 15% DEEP BURN

HISTORY
 Mast. Dev Verma, 1 years, old male, patient was admitted in this hospital with history of scald by hot milk both legs and left palm on December 17th 2018 (12:00 midnight at home, bhangel, sec-102, Noida, bought by father in casualty.

ON EXAMINATION
 GC - Sick, Irritability +, „dehydration“, No Pallor, No Icterus, No cyanosis, No clubbing, No oedema.
 Pulse - 108/Min R/S - B/L clear Temp - 98.0^o.
 CVS - NAD CNS - NAD PA - Soft, B+ R/R - 28/Min.
 SPO2 - 96% OCS - 15/15 Wt - 11 kg.
 L/E : Blisters present at left hand and left palm.
 Deep burn posterior medial aspect of left leg + Right leg in posterior medial aspect.

INVESTIGATION
 All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
 Patient admitted in hospital through casualty on 19.12.18 under Dr. Varun Kulshrestha with above mentioned complaints. After initial evaluation as per standardized protocol treatment initiated with IV fluids, IV antibiotics, Antipyretic, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Patient managed conservatively + Multiple antiseptic dressing under GA was done. Podiatric referrals (Dr. Sunder Anand) were done. Treatment optimized accordingly. Now patient condition is stable afebrile, pass urine and stool, taking orally well and is being discharged on following advice and medication.

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 Tel. No. 0120-404000 (99 Lines), 2444222, 2444333
 Website: www.vinayakhospital.in
 24x7 HELPLINE: 0120-4040000

TREATMENT GIVEN

IV Fluids as advised
 Inj. Moxifloxacin - Inj. Amikacin
 Syp. Pedicoryl - Syp. Crcein
 Syp. Potklor - Syp. Arce
 Syp. Hemozink - Syp. Rantar
 Syp. Hugesic Plus - Syp. Augmentin
 Electro Powder - Protinex powder junior
 And other supportive treatment

ADVICE ON DISCHARGE

Syp. Azithra - (100mg/5ml/5ml) - Once a day x 5 days.
 Syp. Hemozink - 3ml - Twice a day x 7 days

FOLLOW UP
 Review for dressing with Dr. Varun Kulshrestha Alternate day or as and when required.
 In-case of any medical emergency please contact to emergency department of Vinayak Hospital or call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-404000-2444222-2444333.
 We wish you a speedy and pleasant recovery. Thank you.

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MASTER DEV VERMA

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DISCHARGE SUMMARY

| | | | |
|--------------|--|--------------|----------------------|
| Name | Master SHOEBAB | Regn No. | VH0022054 |
| Patient Code | PN037118 | Sex | 8 Yrs. M |
| Guardian | S/O SAJID HOSSAIN SURAJPUR, G.N | Admitted On | 21-Aug-2018 03:18 PM |
| Address | | Discharge on | 29-Sep-2018 05:19 PM |
| Consultant | DR VARUN KULSHRESTHA/ Dr. Prasenjit Kumar (MD) | Source | CASUALTY |

FINAL DIAGNOSIS
 ELECTRIC BURN INJURY- RIGHT HAND AND FOREARMS, 3rd BURN NECROSIS OF FINGERS OF RIGHT HAND

HISTORY
 Mast. Shoebab, 8 years old male patient was alleged history of electric burn at 2:00 PM on 20.08.2018 near sunapur, G. Noida. While victim was playing there. Brought to casualty by his brother (Mr. Anand) 2:25 PM. Now complaints of burn injury on left hand, right hand and in umbilical region, stiffness right hand fingers, pain
 No. H/O No ENT Bleeding, No seizure

ON EXAMINATION
 GC - Sick, Irritability +, „dehydration“, No Pallor, No Icterus, No cyanosis, No clubbing, No oedema.
 Pulse - 100/MaR/120/74 rest/ly R/S - B/L clear Temp - 98.0^o.
 CVS - NAD CNS - NAD PA - Soft, B+ R/R - 28/Min.
 SPO2 - 99% OCS - 15/15 Wt - 15 kg.

INVESTIGATION
 All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
 Patient admitted in hospital through casualty on 21.09.18 under Dr. Varun Kulshrestha with above mentioned complaints. After initial evaluation as per standardized protocol treatment initiated with IV fluids, IV antibiotics, Antipyretic, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Patient managed conservatively + Multiple antiseptic dressing under GA was done. Podiatric referrals (Dr. Sunder Anand) were done. Debridement was done. Bilateral fasciectomy also done. During hospital patient was having fever managed conservatively. 2 Unit PRBC was transfused. Patient developed gangrene 2nd - 5th distal end of finger. After consent and PAC clearance amputation of 2,3,4,5 finger of right hand was done. Grain flap for right wrist and forearm on 18.09.2018. Still right hand and forearm status is poor, all deep muscles of forearm necrosis, grain flap detached earlier. So patient is referred to higher Burn centre Subhartaj Hospital for further management.

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TREATMENT GIVEN

IV Fluids as advised
 Inj. Amoxycilin, Syp. Hugesic Plus,
 Syp. Nobel Plus, Syp. Pedicor,
 Syp. Augmentin Duo, Syp. A to Z,
 Sponge Bath
 And other supportive treatment

ADVICE ON DISCHARGE

Dressing on Alternate day.
 keep dressing dry
 Syp. Zimoviv-2.5 ml- Twice a day x 10 Days

FOLLOW UP
 Review in OPD After 3-days or as and when required.
 In-case of any medical emergency please contact to emergency department of Vinayak Hospital or call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-404000-2444222-2444333.
 We wish you a speedy and pleasant recovery. Thank you.

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MASTER SHOEBAB

SUCCESSFUL TREATMENTS

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24x7 HELPLINE: 0120-4104100

DISCHARGE SUMMARY

| | | | |
|--------------|----------------------|--------------|----------------------|
| Name | Ms Baby Ritu | Regn No. | VH0035045 |
| Patient Code | PH049287 | Sex | 17Yr. 5 mon F |
| Guardian | S/O SURESH KUMAR | Admitted On | 28-Dec-2018 11:24 PM |
| Address | PREM VIHAR, KHODIA | Discharge on | 23-Jan-2019 6:42 PM |
| Consultant | DR VARUN KULSHRESTHA | Source | CASUALTY |

FINAL DIAGNOSIS
2ND, II AND III DEGREE BURN NECK, RIGHT ARM, FOREARM, CHEST AND ABDOMEN

HISTORY
Baby Ritu, 18 months old female patient was admitted in this hospital with H/o hot tea falling on chest and right arm - 12 days back, treated by a private practitioner, not brought any medical documents. Place of burn - at home on 18 Dec 2018. On exam dressing intact Burn approx - 15-20%

ON EXAMINATION
GC - Sick, No Pallor, No Icterus, No cyanosis, No clubbing, No edema.
Pulse - 130/Min. RR - 30, A.I.P. Temp - 99°F.
CVS - S1S2. Lungs - S1S2. PA - S1S2, Rr - 32/Min.
SPO2 - 98%

INVESTIGATION
All the Investigation Reports are attached with Discharge Summary.

COURSE IN HOSPITAL
Patient admitted in hospital through casualty on 28.12.18 under Dr. Varun Kulshrestha with above mentioned complaints. After initial evaluation as per standardized protocol treatment initiated with IV fluids, IV antibiotics, Analgesic, Antacid and other supportive treatment also given. All necessary investigations were done. Patient managed conservatively. Multiple antiseptic dressing under was done. Paediatric referral (Dr. Suminder Arora, Dr. Praveen, Dr. Naveen) was done. Patient managed conservatively. Doctor advised for skin grafting but attendant refused. Now patient condition is stable and getting discharged with following medication and advice.

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TREATMENT GIVEN

IV Fluids as advised
Iaj. Monocel - Iaj. Amikacin
Syp. Piptaz - Syp. Cefcin
Syp. A to Z - Syp. Temoferon
Syp. Hemorik - Syp. Ranstar
Syp. Haggic Plus - Syp. Augmentin
ORS Powder

And other supportive treatment

ADVICE ON DISCHARGE

Syp. Azithromycin 100 mg- 3 ml - once in a day x 5 days
Syp. Bogeic Plus - 3 ml - thrice a day x 5 days
High Protein diet
Dressing on alternate day of discharge.

FOLLOW UP

Review for dressing with Dr. Varun Kulshrestha Alternate day or as and when required

In case of any medical emergency please contact to emergency department of Vinayak Hospital or can call to your Consultant Doctor or Ambulance by Calling emergency No. 0120-4504100-244222-244333.

We wish you a speedy and pleasant recovery. Thank you.

CONSULTANT (M.O.)

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MS. BABY RITU

We thank you from the bottom of our hearts for the beings a part of our family and helping us successfully bring smiles to many!!!!

You are a very Valuable Member of our family and without your presence....Everthing else is just an Effort!!!! ❤️

