HEALTH MINISTER CANCER PATIENT FUND
RASHTRIYA AROGYA NIDHI (RAN)
GOVERNMENT OF INDIA

Name of Hospital : REGIONAL CANCER CENTRE, TRIVANDRUM

Hospital No.....**Clinic**..... **RAN No:**.....

Date of Registration..... Date:.....

Name of Patient : .....

Address : .....
.....

Family Income : Annual/Monthly : .....

No.of Members in the Family ..... Income .....

Income certificate issued by .....

Others :

Calculated per capita per months Rs.....

Diagnosis : .....

Finance required for INVESTIGATIONS/SURGERY/RADIOTHERAPY/ CHEMO THERAPY/ HOSPTIAL STAY/ OTHERS .....: .....

Approximate Treatment Period :.....

Remarks of the Committee :

Dr.K.Ramadas,MD,DMRT,DNB
Medical Supdt, Chairman

Dr. Francis V James,
Addl. Professor, Member

Dr.P.T.Latha
Welfare Officer, Member

Approved by :

DIRECTOR

Initial Treatment Completed on : .....

Bill No._____ Date:_____

Amount Used So far : Rs. _____

Investigations	:	Rs.
Chemotherapy Drug	:	Rs.
Radiotherapy	:	Rs.
Surgery	:	Rs.
Blood Products	:	Rs.
Other expenses	:	Rs.
Total l	**:**	**Rs.**