GSTIN : 07AAACI2398N1Z4 **Day Care/OP Cash Bill - Bill of Supply** **Reference No :**

Indraprastha Apollo HOSPITALS TOUCHING LIVES

The Emergency Specialist DIAL 1066 Saving time. Saving lives

Name	: Master. AGAM MONGA	**Age :**	3Yr 1Mon, 12Days
Father Name	: ARUN MONGA	**Sex :**	Male
Address	: C-198 SAINIK NAGAR NEW DELHI WEST DELHI Other Delhi India110059, CellNo:91-9654414148		
Pan Number:	GQDPK0733H		

UHID: APD1.0012084572

OP Number: DEL1OPP6077599

Doctor's Name	: Dr. SAPNA MANOCHA	**Bill No**	: DEL-OCS-5058815
Speciality	: RADIATION ONCOLOGY	**Date**	: 4-Jul-26 **Time :** 14:57:22

Bill Amount: `. 75,080.00

FOR APOLLO HOSPITALS

Amount in words: ` Seventy-Five Thousand Eighty Only

S.No	Service Type/Service Name	Department	Quantity	Ref Tariff	Dis(%)	Amount (INR)
1	**Investigations (999311)**					
1	TOTAL BODY IRRADIATION (SINGLE SITTING)	Radiation Oncology	1	75,080.00	0.00	75,080.00
					Sub Total	75,080.00

Service Amount :	75,080.00
Total Bill Amount	75,080.00
Final Payment (Cash:0.00, NonCash:75,080.00)	75,080.00

No Tax is Payable on Reverse Charge Basis

Receipt Details: Received with thanks sum of `. 75,080.00 (CARD (BHIM))

` Seventy-Five Thousand Eighty Only From **Master. AGAM MONGA**

* Denotes Cancelled Services

(QR) Denotes Quick Registration

Authorized Signatory

Mr. ROBIN RANA

Cashier

GST rate reduction benefits passed on to the patients as applicable

Page 1 of 1

Keep the records carefully and bring them along during your next visit to our hospital

Accredited By Joint Commission International

For enquiry & appointments contact : **011-26925801 / 26925858**

Indraprastha Apollo hospital, Sarita Vihar, Delhi-Mathura Road, New Delhi 110076.
Phone : +91-11-26925801, 26925858, Fax : +91-11-26823629 Email: info@apollohospitals.com

DEAB - 152945 Estimate 1.5 Lakh

APD1.0012084572
MASTER. AGAM MONGA
Age: 3Year (s) Year(s)/Male
10 Jun 2026 2:10:42 PM

0012084572

Form # 1001

Indraprastha Apollo Hospitals

quest For Admission

	nga	Father's Husband's Name	Arun monga
		Date of Admission 11/6/26	Time of Admission 8:00am

(C) 7:52 AM 1 hrs

Payer Category - ☐ CASH ☐ CORP ☐ TPA ☐ INTL

Payment Details

Room Category Semi Private Under Dr BMT Team

Provisional Diagnosis

Allergies

Procedures and Treatment Contemplated: 2nd PTIS

MLC : Yes/No.

IF Yes : Inside MLC / Outside

Expected Length of Stay: 4 days

MLC No.:

T.P.A. Yes/No Auth. Letter Enclosed Yes/No

3503

INSTRUCTIONS FOR STAFF NURSE

Inform me and my Resident / Registrar / Dr.

Diet	NBM	Liquid	Repeated	Diabetic	Renal	Others
	Soft Solid	Normal	Cardiac	Salt free	Hepatic	

(B) Lab. Investigations | (D) Radiological Investigations | Medications

Special Instructions (if Any) | Pre-op Instructions (if applicable)

Att. Name ARUN MONGA
Relation FATHER
Phone No. 9654414148

Please tick: as appropriate: 9654414148

☐ Preventive ☐ Diagnostic ☐ Curative ☐ Palliative ☐ Rehabilitative

Name of Consultant/Authorised Signatory: BMT Team Signature:

Date & Time 10/6/26 1:20pm.

June 2023 /KE

PLEASE RETU
MEDICAL RECORDS DEPARTMENT (MRD)
Sarita Vihar, Delhi-Mathura Road, New Delhi-110076, Tel : 26925801, 26925858, Fax : 91-11-2

Lokesh Kumar

ADMISSION FORM

AF - I

UHID	DATE OF ADMN	TIME OF ADMN	WARD	Category/BedNo	IPNO
APD1.0012084572	11-Jun-2026	12:55:52 PM	5th Flr T2 Ward	3503 / SEMI PRIVATE	DELIP594655

NAME OF THE CONSULTANT: Dr.BMT TEAM

SPECIALITY: HEMATOLOGY,ONCOLOGY,IMMUNOLOGY,BMT

SECONDARY CONSULTANT:

SPECIALITY:

I HAVE CHECKED MY ADDRESS AND CERTIFY THAT IT IS CORRECT

Sign.....

Name of the Patient : **Master. AGAM MONGA**

Age : 3years 10months 20 Days Sex : **Male**

Address(Permanent) : **C-198 SAINIK NAGAR NEW DELHI WEST DELHI, Other,West Delhi, Delhi,India.**

Father/Spouse/Guardian: ARUN MONGA

Referred By : **SELF**

Phone/Mobile No : 91-9654414148

Email ID : NA@APOLLO.COM

Blood Group : **A +**

Nationality: India

Local Address :

Expected Length Of Stay: 4Day(s)

Local Contact No : 91-9654414148

Reason for admission/Diagnosis: 2ND PTIS

Name of next of Kin : ARUN MONGA Relationship : Father

Informed Ward :

MLC No : MLC Type :

Informed HK :

Mode of payment : Cash

INPATIENT HISTORY: Total IP Episodes : 4

IP NO	ADMITTING DOCTOR	LOS	Discharge Date&Time	IP NO	ADMITTING DOCTOR	LOS	Discharge Date&Time
DELIP591589	BMT TEAM	0d 7h	22/05/2026 05:20:01 PM	DELIP590368	BMT TEAM	4d 22h	18/05/2026 04:40:00 PM
DELIP589757	BMT TEAM	0d 10h	11/05/2026 06:10:00 PM	DELIP588083	BMT TEAM	1d 14h	01/05/2026 01:30:01 AM

Indraprastha Apollo HOSPITALS
TOUCHING LIVES

CONSENT FORM FOR CHEMOTHERAPY / IMMUNOTHERAPY / TARGETED THERAPY / HORMONAL THERAPY

INSTRUCTIONS: This consent form should be signed by patient if an adult (18 years or older); by a parent/ guardian if the patient is a minor; by the spouse or adult or children (above 18 yrs) or parents or adults' brothers/ sisters (above 18 yrs) or other family membe rs (In this order of priority). If the patient lacks the ability to make an informed decision. The physician or his designee doctors is responsible for obtaining informed consent.

The doctor has explained that I have the following medical condition:
TRANS FUSION DEPENDENT THALASSEMIA
and I have been explained and advised to undergo the following treatment (please tick as applicable)

Chemotherapy ☑

Immunotherapy ☐

Targeted therapy ☐

Hormonal therapy ☐

The drugs used during the treatment/ Regimen description are:
CYCLOPHOSPHAMIDE, FLUDARABINE

These drugs are usually administered through an intravenous line. This is done by inserting a new sterile disposable needle into a vein in the arm. A central line (used to give medicine, intravenous fluid, blood over a long period) may be used if you already have it. These drugs can be administered orally as well (in form of tablets/capsules), intramuscularly, intrathecally as well as subcutaneously. The doctor will decide the drugs and the route of administration based on your medical condition or diagnosis.

1. I / We have been advised of **the benefits and reason** for the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognize that the practice of medicine is as much as an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. **Some potential benefits of this procedure include:**
   - To give the best possible chance of being cured.
   - To control or shrink the tumor.
   - To improve the quality of life and survival.
   - Others, if any specify..... Immunosuppression

2. The **possible long and short-term complications** have been explained to me / us, like feeling of nausea, vomiting, taste changes, irritation of stomach lining and indigestion, loose motions (Diarrhoea), constipation, tiredness, sleeplessness, fever, sores in the mouth loss of hair(alopecia), nail changes, unstable blood sugars, liver, lung, heart, brain, bone marrow, nerves and kidney problems, low white cell counts, low red blood cell counts, low platelet counts and their associated

Form # 2028

Patient Label

Indraprastha Apollo HOSPITALS
TOUCHING LIVES

CENTRE FOR BONE MARROW TRANSPLANT AND CELLULAR THERAPY
CONSENT FOR ALLOGENIC STEM CELL TRANSPLANTATION FROM RELATED OR UNRELATED STEM CELL GRAFT

Patient Name: AGAM MONGA UHID No.:

Age/Sex: 4yea/Male Consultant Name: Dr. BMT team.

A. CONSENT FOR ALLOGENIC STEM CELL TRANSPLANT

1. I authorize Apollo Hospital & its Bone Marrow Transplant Team BMT team to perform an Allogenic Stem Cell Transplant using the conditioning regimen Thio/Flu/cyclo/TBI/ATG
2. I understand my / my patient's diagnosis to be: TDT (Transfusion dependent thalassemia)
3. I understand that my / my patient's doctor may need to perform other urgent procedures on me that may be unanticipated. I consent to the performance of any additional procedures determined during my / my patient original procedure to be in my / my patient's interests and where delay might cause additional harm.
4. I / my patient has been told about and understand the risks and benefits of undergoing a stem cell transplant procedure. These risks can be serious and life threatening. They are outlined in the information below. I fully understand the risks and benefits and have been able to ask questions that have been answered by my / my patient transplant physician.
5. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during my recuperation. I know that results cannot be guaranteed. The details of these are discussed in detail below and I / my patient have had opportunity to ask questions and have them answered to my full understanding (In the language which I understand) or in the presence of interpreter.
6. I have been told that the transplant has its own complications like fever, mucositis, hair loss, loose stools, relapse, failure to engraft and GVHD (Graft Versus Host Disease).
7. I have been told that that during or after the transplant the condition is likely to worsen with decrease in blood counts resulting in bleeding and infections which may be fatal.
8. I have been explained that the success rate of Allogenic/haploidentical/Matched Unrelated Donor HSCT (hematopoietic stem cell transplant) for TDT (Diagnosis) is up to 85-90 %.
9. There is also a 10-15 % mortality risk during this procedure. This may even occur during the course of transplant.
10. I understand that during the course of the treatment I/my patient will need transfusion of blood products. I also understand that although the blood products to be administered have been prepared and tested in accordance with strict scientific rules established by the Drug Controller of India, yet adverse events may rarely occur
11. I understand that due to some unknown biomedical aberrations, unpredictable, idiosyncratic reactions can occur and may prove difficult to diagnose and/ or treat.
12. I understand the alternatives to the proposed procedure and the related risks to be:
    - Standard chemotherapy
    - Immunotherapy
    - Supportive measures
    - No therapy to treat disease
    - Comfort care

B. INFORMED CONSENT

Before I am able to decide if I / my patient want to have a stem cell transplant, it is important to know the risks and benefits, what will happen during the pre-transplant, pre-transplant and post-transplant phase. This process is known as informed consent. I am expected to read this Informed Consent Form carefully. It contains information about the stem cell transplant process. If there is anything I am/ my patient do not understand or if I need more information, I am / my patient free to ask my transplant doctor. I am / my patient aware that I can also discuss the stem cell transplant process with friends, relatives, and my own doctor if I wish. If I decide that I / my patient want to have a stem cell transplant I will sign the consent statement attached to this Informed Consent Form.

C. PURPOSE

I/my patient have/has a blood cancer or disorder of bone marrow TDT (Transfusion dependent thalassemia). that has low chance of being cured by chemotherapy, radiotherapy, immunotherapy or other non- transplant approach. Because of this, it has been recommended that I/my patient should undergo stem cell transplantation (bone marrow transplantation) as a possible cure for this disease.

D. SOURCE OF STEM CELLS

Donors for allogenic stem cell transplant are selected on the basis of HLA (Human leukocyte antigen) report which has an important role in immune function. The closer the match between donor and recipient, lesser will the complications such as graft rejection and graft versus host disease (GVHD). If you chose to have an allogenic stem cell transplant, you will need to

Patient Label

Form # 2005

Indraprastha Apollo HOSPITALS
TOUCHING LIVES

HIGH RISK INFORMED CONSENT AND REQUEST FOR STARTING CHEMOTHERAPY

I/We have been informed that Mr. / Ms. MASTER AGAM MONGA . TDT (Transfusion dependent thalassemia) and the ~~cancer is in early~~ / ~~locally advanced~~ /, supportive stage. We have also been informed that Radiation therapy / Surgery / Chemotherapy / Immunotherapy / Hormonal therapy / target therapy or any combination of these are necessary as discussed. AS CONDITIONING .

The possible long and short term complications have been explained to me / us in my / our language, like feeling of Nausea, vomiting, taste changes, irritation of stomach lining and indigestion, loose motions (Diarrhoea), constipation, tiredness, sleeplessness, fever, sores in the mouth, loss of hair (Alopecia), nail changes, unstable blood sugars, liver, lung, heart, brain, bone marrow, nerves and kidney problems, low white cell counts, low red blood cell counts, low platelet counts and their associated complications including life threatening infections (Septicemia) and bleeding from any site, possibility of drug allergy, early menopause and infertility.

I understand that extravasation of drug (infiltration of drug into the subcutaneous tissue or subdermal tissues surrounding the administration site)is possible with any intravenous injection however accidental extravasation of chemotherapy may result in significant erythematous reactions to skin sloughing and necrosis. The onset of symptoms may occur immediately or several days to weeks after administration.

I understand that I could have side effects from my chemotherapy that are not listed on this form. Each patient can respond differently to chemotherapy, and could have side effects that have not been reported by others.

The treatment is designed with a clear understanding that adequate appropriate supportive measures including growth factor support, blood components support, radiation therapy protectors, chemotherapy protectors, nutritional support, vascular access, antibacterial, antiviral and antifungal therapy etc. may be required for acceptable/minimal toxicity.

I/We have also been explained the precautions to be taken in daily life during treatment time to minimize chances of such complications and report to the hospital when any problem arises. The cost survival benefit, cancer control benefit, likely outcome and cost effectiveness have also been explained.

It has also been explained to me / us that cancer may not respond or may come back after initial response with adequate treatment in some cases. If there is any progressive disease or non-tolerable side effects or patient desires to discontinue or patient will benefit from change in treatment plan, it will be undertaken accordingly. The treatment scheme is reevaluated after 2 to 3 cycles as per international guidelines and continued if desired results and acceptable toxicity are achieved.

I/We hereby request you to start the above-explained treatment after fully understanding the nature of the disease (What will happen if no treatment is taken) and the benefits, alternatives and risks associated with the proposed treatment plan. I / We, am / are ready to support myself / the patient financially during the treatment and willing to accept associated benefits and risks.

Patient _____ Date _____ Time _____ Name _____

Witness _____ Date _____ Time _____ Name _____

Doctor _____ Date _____ Time _____ Name _____

Interpreter (if applicable) _____ Date _____ Time _____ Name _____

PATIENT REPRESENTATIVE / SURROGATE :

The patient is unable of consent because: Patient is MINOR . and I, _____ (name / relationship to the patient), therefore consent for the patient. I acknowledge that I have had an opportunity to discuss this procedure as stated above, with my physician or his/ her designee and hereby consent to this procedure.

Patient Representative _____ (ARUN MONGA . Date _____ Time _____

Witness _____ Date _____ Time _____ Name _____

Doctor Nikhil Gupta Date 10/7/25 Time 3pm Name DR-NIKHIL GUPTA .

Interpreter (if applicable) _____ Date _____ Time _____ Name _____

Jan 18 / SP

Patient Label

Form # 2001

Indraprastha Apollo HOSPITALS
TOUCHING LIVES

CONSENT FORM FOR TRANSFUSION OF BLOOD / BLOOD COMPONENTS

A blood transfusion is a life - saving medical procedure by a physician. Blood can be given " whole" but more often a component or combination of components or apheresis component is transfused. Among the most common component are

~~Red~~ cells	for bleeding or low haemoglobin
~~Platelets~~	for bleeding or low platelet count
~~Plasma~~	for restoring blood volume or providing factors
~~Cryo~~precipitate	for special clotting factors.
~~Granulocyte~~	for neutropenia

I acknowledge that the doctors have explained:

1. My medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me/my patient.
2. Other relevant procedure/treatment options and their associated risk.
3. My prognosis and the risks of not having the procedure.
4. I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks and treatment options. My questions and concerns have been discussed and answered satisfactorily.
5. I accept that medicine is not an exact science and understand that no guarantees can be given to the results and understand these limitations.
6. I agree to the administration of blood and/or components in the interest of proper medical care.
7. I have been informed of the transfusion options available which may include banked blood (allogenic) provided by voluntary replacement (relatives) donors.
8. I have been informed that despite careful screening in accordance with national regulations, there are instances of transmissions life threatening infections such as Acquired Immune Deficiency Syndrome, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risks. I also understand that unpredictable reactions may occur which include but are not limited to fever, rash and shortness of breath, shock and in rare occasions, death.
9. Expected benefits of the transfusion may include minimizing shock, brain and other organ damage, hastening recovery and limiting blood loss. However, I understand that there are no guarantees offered as to the expected benefits.
10. I have had the opportunity to ask questions about transfusions, alternate forms of treatment, risk of non-treatment, the procedures to be used, and the relative risk and hazards involved and I believe that I have sufficient knowledge to make an informed decision about getting transfusions of blood/blood components.
11. I have read the form and / or the contents have been explained to me in the language that I understand.

AUTHORISATION OF PATIENT

Patient Signature _____ Name _____
Witness Signature _____ Name _____
Doctor Signature _____ Name _____
Interpreter Signature (If required) _____ Name _____
Date _____ Time _____

PATIENT REPRESENTATIVE/ SURROGATE:

The patient is unable of consent because: Patient U MINOR And I _____ (name/ relationship to the patient), therefore consent for the patient. I acknowledge that I have had an opportunity to discuss this procedure as stated above with my physicians or physician's designee and hereby consent for this procedure. The consent and its contents have explained in a language understood by me/us.

Patient Representative Signature _____ Name (ARUN MONGA,
Witness Signature _____ Name _____
Doctor Signature _____ Name DR-NIKHIL GUPTA .
Interpreter Signature ~~(If required)~~ _____ Name _____
Date 10/7/25 Time 3pm.

IAH/2001/MEDICAL/VERSION1/MARH 2024

_____ Date _____ Time _____ Name _____

Jan 18 / SP