अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स), गुवाहाटी
All India Institute of Medical Sciences, Guwahati
स्वास्थ्य और परिवार कल्याण मंत्रालय,भारत सरकार के तत्वावधान में एक वैधानिक निकाय
(A statutory body under the aegis of Ministry of Health and Family Welfare, GoI)

Ref No.: 4-39/2022-23/AIIMS/GHY/PROC.-VE/II/2628 Date:21.12.2024

EXPRESSION OF INTEREST (EoI)

On behalf of Executive Director, AIIMS Guwahati EoI is hereby sought from Registered vendor for printing of necessary items which are summarised in the table below:-

DEPTT./ Section	SL.NO	ITEM with Specification	QNTY.	Attachment
CFM	1	AIIMS Guwahati News Letter	English- 20 Hindi- 20	Annexure-I
Diagnostic & Interventional Radiology	2	BMD Dxa Scan Requisition Form	1000 Nos.	Annexure-II
	3	Angiography consumable Form	1000 Nos.	Annexure-III
	4	MRI Consent Form	10000 Nos.	Annexure-IV
	5	USG Requisition Form	50000 Nos.	Annexure-V
	6	X-Ray Requisition Form	50000 Nos.	Annexure-VI
	7	MRI Requisition Form	50000 Nos.	Annexure-VII

Prospective vendors are encouraged to quote clearly indicating the price and GST applicable for each item as per table shown above on or before 30.12.2024. Partial quote by any party shall not be accepted for evaluation. Further to inform you that the printing should be made in good quality paper.

A sample copy of the above registers is placed as Attachment viz., Annexure-I to Annexure-VII. The vendors should prepare strictly according to the specifications mentioned in the corresponding Annexure. An expert team will evaluate the sample copies and if any discrepancies arise, the decision of the Competent Authority will be final.

The party quoting the L^1 price will be awarded to contract to supply the items of specific quantity. You are requested to submit quotes in the box, to be placed for the said purpose in the Admin. Section of AIIMS Guwahati in sealed envelope superscribing "Quotation for Printing Items of AIIMS Guwahati w.r.t., Ref. No..... dt....." Clearly mentioning the name and address of the bidder.

Sd/-

AAO, i/c
AIIMS, Guwahati

Copy to:

1. I/C Institute Website – for publishing on the Website.
2. Office Copy

अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स), गुवाहाटी
All India Institute of Medical Sciences, Guwahati
और परिवार कल्याण मंत्रालय,भारत सरकार के तत्वावधान में एक वैधानिक निकाय
(A statutory body under the aegis of Ministry of Health and Family Welfare, GoI)
Changsari, Guwahati-781101

PRINTING SPECIFICATIOON FORM OF AIIMS GUWAHATI

1. Name of the Item : 1) BMD DXA Scan Requisition Form (1000)
2) Angiography Consumable Form (1000)
3) MRI Consent Form (10,000, Ten thousand)
2. Quantity (with appropriate unit) 4) USG Requisition Form (50,000, Fifty thousand)
5) X-Ray Requisition Form (50,000, Fifty thousand)
3. Size : 6) MRI Requisition Form (50,000, Fifty thousand)

A4	A5	LEGAL	OTHERS*

* Plz. Specify

4. Printing : Single side / ~~both sides~~
5. Language :

English	Hindi	Assamese	Others*

(Tick on applicable one)

6. Font colour : Sample Enclosed
7. Paper Colour : Sample Enclosed.
8. Binding :

Staple	Pad	Hard	OTHERS*

* Plz. Specify

9. Whether Sl. No. to printed page wise : Yes No
(Tick on applicable one)
10. If yes, Sl. to be started from :

NB: A sample copy of the indented item (forms. Etc.) shall be presented to the Indenting Officer before the print out of the total quantity.

Name of the Indenting Faculty/ Officer : Kalyan Sarma.
Sign. with Seal of the Indenting Faculty/ Officer : Assistant Professor.
Department of D&I Radiology
Ph: 8257846764

Annexure – II

Qty: 1000
One Thousand only

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, ~~JODHPUR~~ GUWAHATI
DEPARTMENT OF ~~ENDOCRINOLOGY & METABOLISM~~ DIAGNOSTIC & INTERVENTIONAL RADIOLOGY
~~Endocrinology OPD, 1st floor 'C block', Room no - 150~~

BMD DXA SCAN REQUISITION FORM

Patient Name..... Age/Sex..... Address.....

Mob No..... Patient AIIMS ID..... Date of Birth.....

OPD/ IPD.....Ward/Bed No.....Ref. Physician.....Ref. Department.....

Diagnosis:.....

Chief Complaints:

SNo	Parameters	Response	Remarks
1	Previous Fractures (spontaneous/low trauma fracture)	Y/N	
2	Parent fractured hip	Y/N	
3	Current Smoking	Y/N	
4	Glucocorticoid use (≥5mg/d prednisolone or its equivalent for ≥3months)	Y/N	
5	Rheumatoid Arthritis	Y/N	
6	Secondary osteoporosis (disorders strongly associated with osteoporosis) a) Type 1 Diabetes b) Osteogenesis Imperfecta in adults c) Hyperthyroidism d) Hypogonadism e) Premature menopause (<45 years) f) Chronic malnutrition g) Malabsorption h) Chronic liver disease		
7	Alcohol ≥3units/day*	Y/N	

***1 glass wine(175ml) ~ 2 unit, 1 pint beer (568ml) ~ 3 unit, 50 ml port wine ~ 1 unit, 25 ml spirit ~ 1 unit**

Requesting Faculty/SR:..... Mobile No:.....

Date of Requisition:..... Signature:.....

Instructions before BMD/DXA

1) Avoid taking calcium tablets 24 hours prior to scan
2) Avoid wearing jewellery, belts etc on the day of scan
3) Scan cannot be done within 7-14 days of contrast given for CT scan/ MRI/ Barium studies
4) Patient should be accompanied by 1 attendant

Checked by (Endocrine SR) – **Date for test -**

Bill No -

Technician's Signature -

Annexure-III

(QTY:- 10,00) One thousand.

DIAGNOSTIC & INTERVENTIONAL RADIOLOGY,

DEPARTMENT OF ~~NEUROIMAGIN & INTERVENTOIN NEURO RADIOLOGY~~

~~N.S. CENTRE, AIIMS~~, GUWAHATI

PATIENT'NAME:_____ UHID:_____

OPD/WARD:_____ OPD/CR NO:_____

LIST OF COMMON CONSUMABLES ITEMS TO PROCURE FOR ANGLOGRAPHY/EMBOLIATION

▪ Injection Omnipaque 300mg/Iomeron 300mg	200ml
▪ Injection Omniscan 20ml	2 vails
▪ Three w2ay connector (BD)	6 pcs.
▪ ECG Electrodes	6 pcs.
▪ I.V. Infusion set (B.Braun)	3 sets.
▪ Normal saline(Polypack) 500ml	5 nos.
▪ Short connecting tube with three way	2 nos.
▪ Long connecting tube with three way	4 nos.
▪ Luer Lock syringes 10ml / 01ml	5 nos.
▪ Sterile Disposable gloves size7	10 nos.
▪ Medicut 18G/Puncture needle 18G	1 nos.
▪ Inj. Protamin	1 nos.
▪ Inj. NTG	1 amp
▪ Inj. Nimodipin	1 amp
▪ Exchange Guidewire (TERMO) 150 cm.35.38 Angled	1 nos.
▪ Neuro Intervention disposable KIT	1 pkt.
▪ Single Y connector (MERIT)	2 nos.
▪ Double large bore Y connecter (MERIT)	2 nos.
▪ Femoral sheath (Arrow) 6F/7F/8F/9F	½ nos.
▪ 200 ml luer lock syringe with quick fill tube	1 nos.
▪ 60" connecting tube with male/female lock	1 nos.
▪ Inflation Device (Encore)	1 nos.
▪ Picard 5 F	1 nos.

Annexure - IV

Qty (Ten thousand) (2nd)

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, GUWAHATI
DEPARTMENT OF DIAGNOSTIC & INTERVENTIONAL RADIOLOGY
Forms for Patients Screening and Consent Statement

दिनांक/Date _____ CR No. : _____

नाम/NAME _____

लिंग/SEX _____ आयु/AGE _____ चिकित्सक/PHYSICIAN _____

जन्म-तिथि/DATE OF BIRTH _____ वजन/WEIGHT _____

OUTPATIENT _____ INPATIENT _____

Have you ever had a surgical procedure or operation of any kind ? Yes / No

Type : _____

Are you pregnant or do you suspect that you are pregnant ? _____ Yes / No

Last Menstrual period : _____ Post Menopausal ? Yes / No

Have you ever injured by metallic foreign body (e.g., bullet, shrapnel) ? Yes / No

Where ? _____

Have you ever been injured in the eye by a metallic foreign body (e.g. metal silvers) ? _____ Yes / No

THE FOLLOWING ITEMS MAY BE POTENTIALLY HAZARDOUS OR CONTRAINDICATED AND MAY INTERFERE W THE MRI EXAMINATION BY PRODUCING AN ARTIFACT :

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING :

Cardiac pacemaker _____ Yes / No

Aneurysm clip (s) _____ Yes / No

Implanted insulin pump _____ Yes / No

Implanted drug infusion device _____ Yes / No

Bone growth stimulator _____ Yes / No

Neurostimulator (TENS-Unit) _____ Yes / No

Any type of biostimulator _____ Yes / No

Any type of internal electrode(s), including

Pacing wires _____ Yes / No

Internal hearing aid _____ Yes / No

Cochlear implant _____ Yes / No

Any type of intravascular coil, filter or stent _____ Yes / No

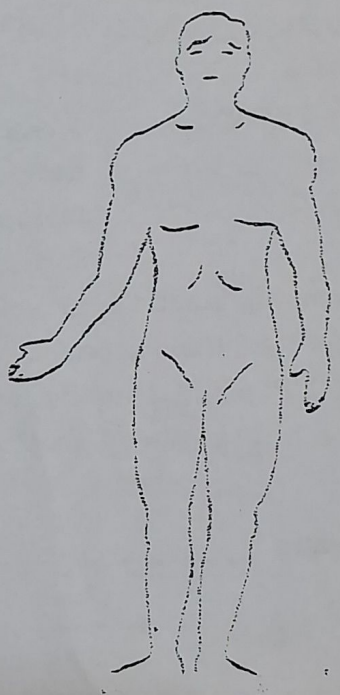
Any type of electronic mechanical or magnetic implant ____ Yes / No

Any metallic foreign body, shrapnel or bullet _____ Yes / No

Swan-Ganz catheter _____ Yes / No

Halo vest or metallic fixation device _____ Yes / No

Please mark on this drawing the locatic any metal inside your body



THE FOLLOWING ITEMS MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT
PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING :

Yes / No

Vascular clip (s) _____ Yes / No

Hemostatic clip (s) _____ Yes / No

Any type of surgical clip or staple (s) _____ Yes / No

Orbital / eye prosthesis _____ Yes / No

Wire suture (s) _____ Yes / No

Any type of implant held in place by a magnet _____ Yes / No

Any other implanted item _____ Yes / No

Type _____ Yes / No

Heart valve prosthesis _____ Yes / No

Any type of ear implant _____ Yes / No

Penile prosthesis _____ Yes / No

Tattooed eyeliner _____ Yes / No

Lens implant held in by metallic suture _____ Yes / No

Diaphragm _____ Yes / No

IUD _____ Yes / No

Renal shunt _____ Yes / No

Intraventricular shunt _____ Yes / No

Wire mesh _____ Yes / No

Artificial limb or joint _____ Yes / No

Any implanted orthopedic item(s) (i.e., pins, rods, screws, nails, clips, plates, wire)

_____

Dentures _____ Yes / No

Dental braces _____ Yes / No

Any type of removable dental item _____ Yes / No

Do you have any renal disorder/problem

Blood Urea / S. Creatinine.

PERTINENT PREVIOUS STUDIES

X-rays _____

Computed tomography _____

Ultrasound _____

Radionuclide study _____

I attest that the above information is correct to the best of my knowledge. I understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I am prepared to undergo MRI scan, if required with Contrast/Anaesthesia at my own risk, the consequences have been explained to me.

WITNESS Signature _____

Name _____

Date _____

_____

(Patient's Signature)

CONTACT No. : _____

Annexure - V

QTY - 50,000/- Fifty thousand. 240

DEPARTMENT OF DIAGNOSTIC & INTERVENTIONAL RADIOLOGY
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, GUWAHATI
USG REQUISITION FORM

नाम
Name_____ आयु Age लिंग Sex

USG No._____ तिथि Date_____ चिकित्सक विभाग Referring Unit_____

CR. No._____ वार्ड/ओ.पी.डी. Indoor/Outdoor____ रोगी स्थिति Ambulatory/Non_____

_____

जांच के लिए अंग
Examination Required_____

चिकित्सक की जांच रिर्पोट:
Clinical Information : **INCOMPLETE FORM SHALL NOT BE ACCEPTED**

किसी दवा का बुरा प्रभाव
Any History of Allergy_____

अन्तिम माहवारी तिथि
LMP_____

कोई पुराने एक्स-रे
Any Previous Relevant Investigation :

चिकित्सक के हस्ताक्षर
SIGNATURE OF MEDICAL OFFICER

पहचान चिन्ह Identification Mark
अंगूठा निशान Thump Impression

REMARKS :

एक्स रे-चिकित्सक
RADIOLOGIST

Your appointment is on :_____ Room No. :_____

Time Slot : 8:30 9:00 9:30 10:00 10:30 11:00 11:30 12:00 12:30

Annexure – VI

Qty - 50,000/-
Fifty thousand

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DEPARTMENT OF DIAGNOSTIC & INTERVENTIONAL RADIOLOGY
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, GUWAHATI
X-RAY REQUISITION FORM

नाम :
Name_____

आयु
Age

लिंग
Sex

एक्स-रे नम्बर
X-Ray No._____
CR. No._____
_____

तिथि
Date_____

वार्ड/ओ.पी.डी.
Indoor/Outdoor____

चिकित्सक विभाग
Referring Unit_____

रोगी स्थिति
Ambulatory/Non_____

एक्सरे जांच के लिए अंग
Examination Required_____

चिकित्सक की जांच रिपोर्ट:
Clinical Information : **INCOMPLETE FORM SHALL NOT BE ACCEPTED**

किसी दवा का बुरा प्रभाव
Any History of Allergy_____

अन्तिम माहवारी तिथि
LMP_____

कोई पुराने एक्स-रे
Any Previous X-Ray :

चिकित्सक के हस्ताक्षर
SIGNATURE OF MEDICAL OFFICER

रेडियोग्राफर के लिए
FOR RADIOGRAPHERS USE

पहचान चिन्ह Identification Mark
अंगूठा निशान Thump Impression

कमरा नं. Room No.	फिल्म साइज Size & No. of Films	के.वी. KV	एम.ए.एस. MAS
हस्ताक्षर/Signature			

REMARKS :

एक्स रे-चिकित्सक
RADIOLOGIST

Your appointment is on :_____ Room No. :_____

Time Slot : 8:30 9:00 9:30 10:00 10:30 11:00 11:30 12:00 12:30

Annexure - VII

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DEPARTMENT OF DIAGNOSTIC & INTERVENTIONAL RADIOLOGY

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, GUWAHATI

CLINICAL MRI REQUISITION FORM

1. **Clinical Dept. or Unit** .....

   C. R. No. ..... **Ward / Bed No.** .....

   MLC : Yes ☐ **No** ☐ **MLC No.** .....

2. रोगी का नाम /Patient's Name ..... आयु /Age ..... लिंग /Sex.....
   (साफ अक्षरों में / In Block letters)

   जन्म तिथि /Date of Birth : दिन /Day ..... माह /Month ..... वर्ष / Year ..... वजन /Weight ..... कि. ग्रा. /Kg.

3. General Patient Condition (Tick as appropriate)

   (i) Critical and with life support (ii) Ill but without life support (iii) Ambulatory

4. Clinical Details : History : (INCOMPLETE FORM SHALL NOT BE ACCEPTED)

   Examinations

   Relevant Investigations :

   Previous CT / MR / Other Reports / Studies
   (with numbers, if any)

5. Blood Urea / S Creatinine .....

6. Clinical Diagnosis : .....
   .....

7. Exact Anatomical site for MRI : .....
   .....

8. Special Instructions (Sedation, Allergy or other details which may facilitate a safe and informative study).

9. (a) Contrast Enhancement Required : Yes.....No.....

   (b) Allergic to any drugs :

   (c) Implant in Body (Tick as appropriate)

   Cardiac Pacemaker .....Aneurysmal clips.....Cardiac Valve/Prosthesis.....

   Metallic Implants.....Sharpnel/Pellet.....Others.....None.....

हस्ताक्षर / Signature .....
नाम / Name .....
(साफ अक्षरों में / In Block letters)
पदनाम / Designation.....

(Requisition may be signed by a Faculty Member/Sr. Resident)

Youe appointment is on : _____ Room No. : _____

Time Slot:	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30

Ph : 8257846764

(894) Annexure - I (237)

अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स), गुवाहाटी
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(A statutory body under the aegis of Ministry of Health and Family Welfare, GoI)
Changsari, Guwahati-781101

PRINTING SPECIFICATIOON FORM OF AIIMS GUWAHATI

1. Name of the Item : AIIMS GUWAHATI NEWSLETTER. (To be released on 12/1/2025)
2. Quantity (with appropriate unit) : 20- English ; 20- Hindi.
3. Size :

A4	A5	LEGAL	OTHERS*

* Plz. Specify

4. Printing : Single side/both sides
5. Language :

English	Hindi	Assamese	Others*
✓	✓		

Both English & Hindi.
(Tick on applicable one)

6. Font colour : Black.
7. Paper Colour : Coloured.
8. Binding :

Staple	Pad	Hard	OTHERS*
		✓	

* Plz. Specify

9. Whether Sl. No. to printed page wise (Tick on applicable one) : Yes No Hindi ~~No~~ version no. of pages:- 10
10. If yes, Sl. to be started from : English version no. of pages:- 25.

NB: A sample copy of the indented item (forms. Etc.) shall be presented to the Indenting Officer before the print out of the total quantity.

Name of the Indenting Faculty/ Officer : Dr. Himashree Bhattacharyya

Sign. with Seal of the Indenting Faculty/ Officer : 13/12/24