Government of West Bengal
Office of the Chief Medical Officer of Health, Jalpaiguri
District Health Administrative Building, 1st floor, Hospital Road, Jalpaiguri
Fax-03561-232001: Ph-03561-225394
E-mail – cmohofficejalpaiguri@gmail.com :: Pin – 735101

Memo No. CMOH/ 824 Dated, Jalpaiguri 22/02/ 2024

NOTICE INVITING QUOTATION

Sealed quotations are hereby invited from the reputed bonafide Firms or Agencies by the undersigned for supplying the following Printing IEC materials for Leprosy Section under the Chief Medical Officer of Health, Jalpaiguri. The rate should be quoted inclusive of all taxes and delivery charges. All bidders are requested to submit their up to date papers (Trade License, PAN No, GST Registration Certificate, P. Tax Certificate). The authority reserve the right to cancel or reject the whole quotation or party without assigning any reason thereof.

The quotation should reach to this office by registered post or by hand on or before 29/02/2024 upto 2:00 p.m. and Opening date of quotation is on 29/02/2024 at 4:00 p.m. in the office of the u/s in presence of the bidders.

Sl. No	Particulars	Quantity	Quoted Rate	Remarks
1	Flex (3/2 ft.)	400	Rates to be given in Total amount in Firm's/Agencies' Official letter Pad	
	U.L.F 01	100		as per attached **Annexure**

Chief Medical Officer of Health
Jalpaiguri 21/2/24

Memo No. CMOH/ 824/1(8) Dated, Jalpaiguri 22/02/ 2024

Copy forwarded for information & necessary action to:-

1) The Sabhadhipati Zilla Parishad, Jalpaiguri
2) The District Magistrate, Jalpaiguri
3) The Principal, Jalpaiguri Govt. MC&H, Jalpaiguri
4) The Dy. CMOH-I/II/III/IV/DMCHO/DTO, Jalpaiguri
5) The Station Master, Jalpaiguri Railway Station Jalpaiguri
6) The Post Master, Head Post Office Jalpaiguri
7) The DSM, with the direction to publish the matter in official website of CMOH Jalpaiguri
8) Office Notice Board
9) Office copy

Chief Medical Officer of Health
Jalpaiguri 21/2/24

Annexure - I

U.L.F 01

NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP), DISTRICT .....
PATIENT CARD

Sub-Centre		PHC :		Village :	
Block/CHC :	District :			State : West Bengal	
Belong to other State					
Registration Number			SC	ST	Others
Name			Age	Female	Male
Address (with Mobile No.)					
Duration of Signs/ symptom in months	Duration of disability if any				
Mode of detection	Voluntary / by WHU / referred by other / by contact survey / other mode				
Classification	PB	MB	New Case	Other Case (specify)	
Disability	Gr. - I	Gr. - II	EHF Score		
Date of First Dose					

AFTER ENTERING ABOVE INFORMATION IN THE CLINIC TREATMENT RECORD, THIS PATIENT CARD IS TO BE TRANSFERRED TO RELEVANT CENTRE FOR DELIVERY OF SUBSEQUENT DOSES	Signature of Medical Officer

Date of subsequent doses :

(PB Final) (MB Final)

2	3	4	5	6	7	8	9	10	11	12

Date of Discharge	Date :	RFT / Otherwise deleted (specify) :
End Status	EHF Score :	Follow up required (after RFT) for reaction, deformity, ulcer or eye care.

THIS CARD IS TO BE MAINTAINED AT TREATMENT CENTRE. AFTER EVERY DOSE UPDATE THE TREATMENT RECORD , AFTER ACHIEVING END STATUS, THE HW SHOULD SIGN THIS CARD AND RETAIN AT CENTER FOR FUTURE REFERENCE.	Signature of Medical Officer

CONTACT SURVEY IN PB/MB/CHILD CASE (Done on date .....)	No. Examined -	Cases detected MB - PB -

Record of Lepra Reaction / Neuritis

Type - I / II	**Neuritis - Yes / No**

Prednisolone doses issued with dates at MCH / SGH / Others

Date of MCR footwear if issued -

Date of Referral for RCS -

NB : This patient card is for use for the new cases as well as other cases. In urban situation this card can be uses by changing MCH / SGH / Others with appropriate health unit / area / region.

SPL

ANNEXURE - V

U.L.F.-04 (Page1)

SENSORY ASSESSMENT

DATE / ASSESSOR	Palm		Palm		Comments
	RIGHT	LEFT	RIGHT	LEFT	
					

Key : (Put these mark / icon on the site where lesion is seen)

- √ Sensation Present within 3cm
- x Anaesthesia
- Λ Clawing
- S Contracture
- Wound
- Crack
- Scar/Callus
- Shortening Level

ANNEXURE - V (continued)

U.L.F.-04 (Page2)

Assessment of Disability & Nerve Function

Name _____ Village _____ Block _____

S/O, W/O, D/O _____ Sub-Centre _____ Date of RFT _____

Age / Sex _____ Registration No. _____ Reffered by _____

Occupation _____ MB/PB _____ Date of Registration _____

RIGHT							LEFT					
						← Date →						
						Vision (0.2)						
						Light closure lid gap in mm						
						Blink present / Absent						
						Little Finger out						
						Thumb up						
						Wrist Extension						
						Foot up						
						Disability Grade hands						
						Disability Grade Feet						
						Disability Grade Eyes						
On Date												
Max. (WHO) Disability Grade												
EHF Score												
Signature of Assessor												

Muscle Power :
S = Strong,
W = Weak,
P = Paralysed

Score of vision : Counting fingers at 6 meters
0 = Normal,
2 = Unable to count finger

(This Form should be filled-in at time of registration and repeated after 3 months (Once in 2 weeks in case of neuritis / reaction)