



CALCUTTA SCHOOL OF TROPICAL MEDICINE

GOVERNMENT OF WEST BENGAL

108 Chittaranjan Avenue, Kolkata - 700073

Phone : 033 2212 3695/96/97 Fax : 033 2212 3698

Website : stmkolkata.org

Memo No. STM/STORE/QUOTE/29/2020-21 QUOTATION NOTICE

Date : 24.09.2020

Sealed QUOTATIONS are invited from the Reputed Company/Direct Importers/Authorized distributor firms for supply of items as mentioned below at the Department of **Thalassaemia Control Unit, School of Tropical Medicine, Kolkata.**

The QUOTATION is to be submitted in the drop box which will be kept at the office chamber of the undersigned on all working days from **25.09.2020.**

The last date of submission of QUOTATION is **05.10.2020 up to 1 pm** and the same will be opened on the same date at 2 pm in presence of interested bidder , if any. The bidders will submit the QUOTATION in their own official pad along with the following essential documents :

- Valid Trade License / Enlistment
- PAN card of the Bidder /Bidder company
- GST Registration certificate
- IT Return of any two of last three financial year
- Valid P.Tax Certificate

Physical verification of samples and or physical demonstration may be done at the discretion of the hospital authority by a team of expert to adjudge the applicability or suitability of the product or products in the functional requirement of the patients since the items are life savings and the technical evaluation will be done accordingly in close observation of the product or products , technical brochures along with Test certificate produced and physical sampling thereof.

1. **Format A (Pcs) Size A4 Size Paper, 75 GSM,
No. Of Pages- 3, Black & White Printing**
2. **ID Card for Thalassaemia**
3. **Test Report Cards (Green)**
4. **4.Test Report Cards (red)**
5. **5. Test Report Cards (Yellow)**
6. **Case Report for Thalassaemia**

(As per Attachment)


24.09.2020

**Medical Superintendent cum Vice Principal
School of Tropical Medicine, Kolkata**

Medical Superintendent - Cum - Vice Principal
Germichael Hospital for Tropical Diseases
School of Tropical Medicine
Kolkata

The specification of printing of cards for Thalassaemia and Haemophilia patients under Haemoglobinopathies Control Programme-

Printing items	Specification
1. Format A	A4 page, 90 GSM, both side print
2. Format B	A4 page, 90 GSM, both side print
3. I card for Thalassaemia	Size - 12*14.5 cm, 230 GSM SS Board, 4 pages, maplitho paper,Both side multicolour printing Outer side lamination with 1 fold, CFC box delivery.
4. Test report cards (for Normal persons - green card, for Thalassamia patients - Red card and for Carriers - Yellow Card)	8.5*11 inch(in computer it is in-build size), Both side multicolour printing 130GSM M/L paper Loose card, CFC box delivery.
5. Case report card for Thalassaemia	File size A4, Sheet size 8.5''X11.75'', 19 Sheets, Combination of double punch transparent plastic file and inserted punched sheet,as an individual set. Printable sheet-1+18 : 1st sheet one side colour printing & 18 sheets one side 1 colour (black & white) printing,Paper-80 GSM M/L paper. Binding - Insertion of punched sheets in double punch transparent plastic file to make an individual set, delivery in CFC box.
6. I card for Haemophilia	Size - 12*14.5 cm, 230 GSM SS Board, 4 pages, maplitho paper,Both side multicolour printing Outer side lamination with 1 fold, CFC box delivery.
7. Case report card for Haemophilia	File size A4, Sheet size 8.5''X11'', 9 Sheets, Combination of double punch transparent plastic file and inserted punched sheet,as an individual set. Printable sheet-1+8 : 1st sheet one side colour printing & 8 sheets one side black n white printing,Paper-80 GSM M/L paper. Binding - Insertion of punched sheets in double punch transparent plastic file to make an individual set, delivery in CFC box.

Bash
8.6.2020

NATIONAL HEALTH MISSION
SCREENING FORMAT
HAEMOGLOBINOPATHIES CONTROL PROGRAMME

Screening Date: Screening No.(For Office use only)

Source Type : CAMP OPD **OTHER**

Title Mr Mrs Master Miss Ms :

NAME : SURNAME: GENDER:

Mobile number:

DOB: Age: Religion:

Caste: Educational Status: Literate/ Illiterate

Respondent Category : Antenatal mother Premarital group
Family member of Patient/Carrier Post marital Suspected
patient Other

If Respondent category Family Member

Screening/ Patient Number of affected Family member

Relation Type:

If Respondent Category Suspected Patient

Father's name: Mother's name:

Frequency of Blood Transfusion Total no of units Transfused

Date of Last Transfusion

JAUNDICE HEPATOMEGALY SPLENOMEGALY

Permanent address

State: District Area:
Urban/Rural

Block/Municipality Village/Ward

Address Line: Pin code:

Present address

State: District Area:

Urban/Rural

Block/Municipality

Village/Ward

Address Line:

Pin code:

Personal History

Parents are blood related: Yes/No

Weakness

Jaundice

History of Blood Transfusion (If yes)

Date of Last transfusion.....Total Unit Transfused.....

LMP:

Parity:

Gestational Age: WeekDays.....

Hematological Indices /HPLC/ Others

HPLC Test Date :

HPLC Test No. :

RBC Indices		HPLC	
RBC (x 10 ¹² /l)		HbA ₀ (%)	
WBC (10 ⁹ /L)		HbA ₂ (%)	
Hb (g/dl)		HbF(%)	
HCT (%)		HbA ₂ +E(%)	
MCV fl)		HbS(%)	
MCH (pg)		HbD(%)	
MCHC(g/dl)		Other(%)	
RDW (cv %)			
Platelets (x 10 ³ /μl)			

CONSENT FORM

I the undersigned give my consent to be screened for haemoglobinopathies by the examination of my blood sample. I have been explained about the condition of thalassaemia and the complication associated with it. The importance of thalassaemia carrier detection has been adequately explained to me. (information sheet provided and explained.)

আমি নিম্ন স্বাক্ষরকারী হিমোগ্লোবিনোপ্যাথিস - এর জন্য রক্ত পরীক্ষা করতে সম্মতি দিচ্ছি। আমাকে থালাসিমিয়া রোগ এবং এর অসুবিধা সমূহ বিস্তারিত ভাবে বলা হয়েছে। থালাসিমিয়া বাহক নির্ণয়ের উপযোগিতা সম্বন্ধেও আমাকে বিস্তারিত ভাবে জানানো হয়েছে।

मौ निम्न साक्षरकारी अपनी राय व्यक्त कर रहा हूं। हैमोग्लोबीनोपैथीस् के बारे में अपने रक्त परीक्षा के उपरान्त, मुझे थालासेमिया से संबंधित परिस्थितियो तथा उससे उत्पन्न होने वाली बुरे परिणामों से पुर्व अवगत कराया गया है एवं थालासेमिया वाहक परिक्षण का महात्व भी उपयुक्त तरिके से समझाया गया है।

অভিভাবকের স্বাক্ষর
(নাবালক/নাবালিকাদের ক্ষেত্রে)

Signature / L.T.I. / হস্তাক্ষর

Date :



আমি একজন থ্যালাসেমিয়া (Thalassaemia) রোগী।

আমাকে নিয়মিত রক্ত নিতে হয়। আমি
হঠাৎ অসুস্থ বা দুর্বল হয়ে পড়লে, আমাকে
সত্বর হাসপাতালে নিয়ে যান।



National Haemoglobinopathies Control Programme (NHM)
Department of Health & Family Welfare
Government of West Bengal

Name of the Care & Management Facility (TCU)

.....

Photograph to be attested by the
MO with date & seal

PHOTOGRAPH

নাম:

পিতা/অভিভাবকের নাম:

জন্মের তারিখ/ বয়স: Sex: পুরুষ/মহিলা/অন্যান্য

ঠিকানা:

.....

.....

ফোন নম্বর

অন্য আর একটি ফোন নম্বর:

রোগীর I.D. No:

কার্ড Issue-এর তারিখ:

রক্তের গ্রুপ:

রোগ নির্ণয়ের তারিখ:

থ্যালাসেমিয়ার ধরণ:

.....

.....

আসুন আমরা থ্যালাসেমিয়া মুক্ত রাজ্য গড়ে তুলি

- থ্যালাসেমিয়া একটি জন্মগত, বংশগত রক্তের রোগ, এটি সংক্রামক নয়।
- থ্যালাসেমিয়ার বাহক এই রোগের জিন বহন করে। যখন স্বামী-স্ত্রী দুজনেই থ্যালাসেমিয়ার বাহক হয় তখন একজন থ্যালাসেমিয়া শিশু জন্মানোর সম্ভাবনা থাকে।
- থ্যালাসেমিয়ার বাহক সম্পূর্ণ সুস্থ, বাহক নির্ণয়ে ভয় পাবেন না। আপনি থ্যালাসেমিয়ার বাহক না হলে নির্ভয়ে একজন বাহক কে বিয়ে করতে পারেন - এক্ষেত্রে থ্যালাসেমিয়া শিশু জন্মানোর কোনও সম্ভাবনা নেই।
- যদি একজন গর্ভবতী মহিলা বাহক হন, তাহলে গর্ভস্থ অবস্থায় শিশুর থ্যালাসেমিয়া আছে কি না পরীক্ষা করা যায়।
- বিয়ের আগে কোষ্ঠী বিচার নয়, রক্ত পরীক্ষা করে জেনে নিন আপনি থ্যালাসেমিয়ার বাহক কি না।
- পশ্চিমবঙ্গে লোকসংখ্যার ১০% বাহক।
- যদি আমরা থ্যালাসেমিয়া প্রতিরোধ করতে না পারি, তাহলে ভবিষ্যতে প্রতি ৫ জন শিশুর মধ্যে ১ জন থ্যালাসেমিয়া নিয়ে জন্মাবে।
- একজন থ্যালাসেমিয়া রোগী স্বাভাবিক লোককে রক্ত দিতে পারে।



HAEMOGLOBINOPATHIES CONTROL PROGRAMME
WEST BENGAL STATE HEALTH & FAMILY WELFARE SAMITY
GOVT. OF WEST BENGAL



Follow the advice given below:

❖ All family member should get tested for Thalassaemia carrier

Hemoglobin report	Advice	Precaution
Hemoglobin < 10 gm/dl	<p>Check Ferritin</p> <ul style="list-style-type: none"> • If < 30 ng / ml ➤ Iron syrup/Tablet- 3mg/kg/day in two divided doses half an hour before meal or one hour after meal ➤ After six months test blood for Se. Ferritin and Hemoglobin and visit doctor in any Hospital 	<ul style="list-style-type: none"> • Take medicine as advised • Drink plenty of water. • Wash hand before eating • Wear shoes/ Chappal • Take Anthelmintic medicine yearly • Eating plenty of green vegetables, Egg, Fish, meat, sprouted gram, banana flower, Moong dal, gourd, figs, Guava etc helps improving IRON level in blood. • Do not drink tea, coffee, Milk and calcium syrup or take calcium table within one hour of in taking IRON medicine
Hemoglobin < 8 gm/dl	Attend nearby hospital	



Eat green vegetables



Wash hand before eating



Wear shoes/Chappal



Use Sanitary Latrine



Take Anthelmintic medicine



Cut Nail and keep it clean



HAEMOGLOBINOPATHIES CONTROL PROGRAMME
WEST BENGAL STATE HEALTH & FAMILY WELFARE SAMITY
GOVT. OF WEST BENGAL



Follow the advice given below:

- ❖ Thalassaemia Screening of partner before marriage
- ❖ All family member should get tested for Thalassaemia carrier

Hemoglobin report	Advice	Precaution
Hemoglobin < 5 gm/dl ➤ Urgent hospitalization and blood transfusion if required	➤ Get registered in near by Thalassaemia Control Unit for regular follow up. ➤ Periodical Investigation as advised ➤ Intake Folic Acid , calcium regularly	<ul style="list-style-type: none"> • Take medicine as advised • Drink plenty of water. • Wash hand before eating • Wear shoes/ Chappal • Take Anthelmintic medicine yearly • Do not eat IRON rich food who is transfusion dependent.



Eat green vegetables



Wash hand before eating



Wear shoes/Chappal



Use Sanitary Latrine



Take Anthelmintic medicine



Cut Nail and keep it clean



HAEMOGLOBINOPATHIES CONTROL PROGRAMME
WEST BENGAL STATE HEALTH & FAMILY WELFARE SAMITY
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Hemoglobin < 8 gm/dl	Attend nearby hospital	



আয়রন যুক্ত খাবার

Eat green vegetables



Wash hand before eating



Wear shoes/Chappal



পরিষ্কর শৌচাগার সুস্থতার পরিচয়

Use Sanitary Latrine



Take Anthelmintic medicine



Cut Nail and keep it clean



Haemoglobinopathies Control Programme
Government of West Bengal



Thalassaemia Patient Case Card

Date of First Evaluation:

- Patient.ID. No.:
- Name:
- Type of Haemoglobinopathy :

OPD NO:

HPLC Report

	Respondent	Father	Mother	Brother 1	Brother 2	Sister 1	Sister 2
HbA							
HbF							
HbA2							
HbA2+ E							
Impression							

Extended Family screening

	Husband/ Wife	Son 1	Son 2	Daughter 1	Daughter 2
HbA					
HbF					
HbA2					
HbA2+ E					
Impression					

HbA					
HbF					

HbA2					
HbA2+ E					
Impression					

- **Mutation study Report:**

- **Age of Diagnosis:**

- **Age of presentation:**

- **Blood Transfusion History: Age of 1st Transfusion:**

No of Previous Transfusion:

Frequency of Transfusion:

- **RBC Phenotype:**

- **RBC antibody Panel:**

Splenectomy

Age of Splenectomy		
Date of Splenectomy		
Indication	<ol style="list-style-type: none"> 1. Increased Transfusion requirement. 2. Hypersplenism. 3. Huge Splenomegaly 4. Other 	
Pneumovaccination	Given/ Not given	Date
Haemophilus Influenzae b vaccination (Hib)	Given/ Not given	Date
Meningococcal Vaccination	Given/ Not given	Date

Penicillin Prophylaxis	
Malarial Prophylaxis	
Transfusion requirement after Splenectomy	

History of Hospitalization after splenectomy:

Date	Infection	Malaria	Other

Examination

Date	Height (cm)	Wt. (kg)	Liver (cm)	Spleen (cm)	Tanners stage	Icterus	Facial deformities	Others

Examination (contd.)

Date	Height (cm)	Wt. (kg)	Liver (cm)	Spleen (cm)	Tanners stage	Icterus	Facial deformities	Others

Biochemistry

LFT, Urea Creatinine

Date	T Bill	C bill	SGOT	SGPT	Urea	Creatinine	Total Protein	Alb	Calcium

Date	Sugar			GTT			Uric acid
	FBS	PPBS	HbA1 c	1 st hr	2 nd hr	3 rd hr	

Hormone Assay

Date	FT4	TSH	LH	FSH	Testosterone	Cortisol (8am , 4pm)	ACTH	GH	IGF-1	Serum PTH

Virology

Date	HIV	Anti HCV	HBsAg	Hep A	Hep B Vaccination

Imaging

Date	Cardiac Evaluation		USG		X-RAY	DEXA SCAN
	ECG	ECHO	Abdomen	Pelvic(F)		

1. Transfusion Record

Date	Pre Hb (gm %)	Volume transfused	Transfusion centre	Transfusion reaction	Remarks

Transfusion Record (contd.)

Date	Pre Hb (gm %)	Volume transfused	Transfusion centre	Transfusion reaction	Remarks

Chelation

Prechelation evaluation:

Date	Se Ferritin	SGPT/U/C	Hemogram (TC/N/PLT)	Audiometry (PTA)	Eye Examination (Fundoscopy)	Deferasirox	Deferiprone	Desferoxamine

CHELATION RECORD

Date	SGOT	SGPT	Creatinine	CH	Chelator Dose	Reaction

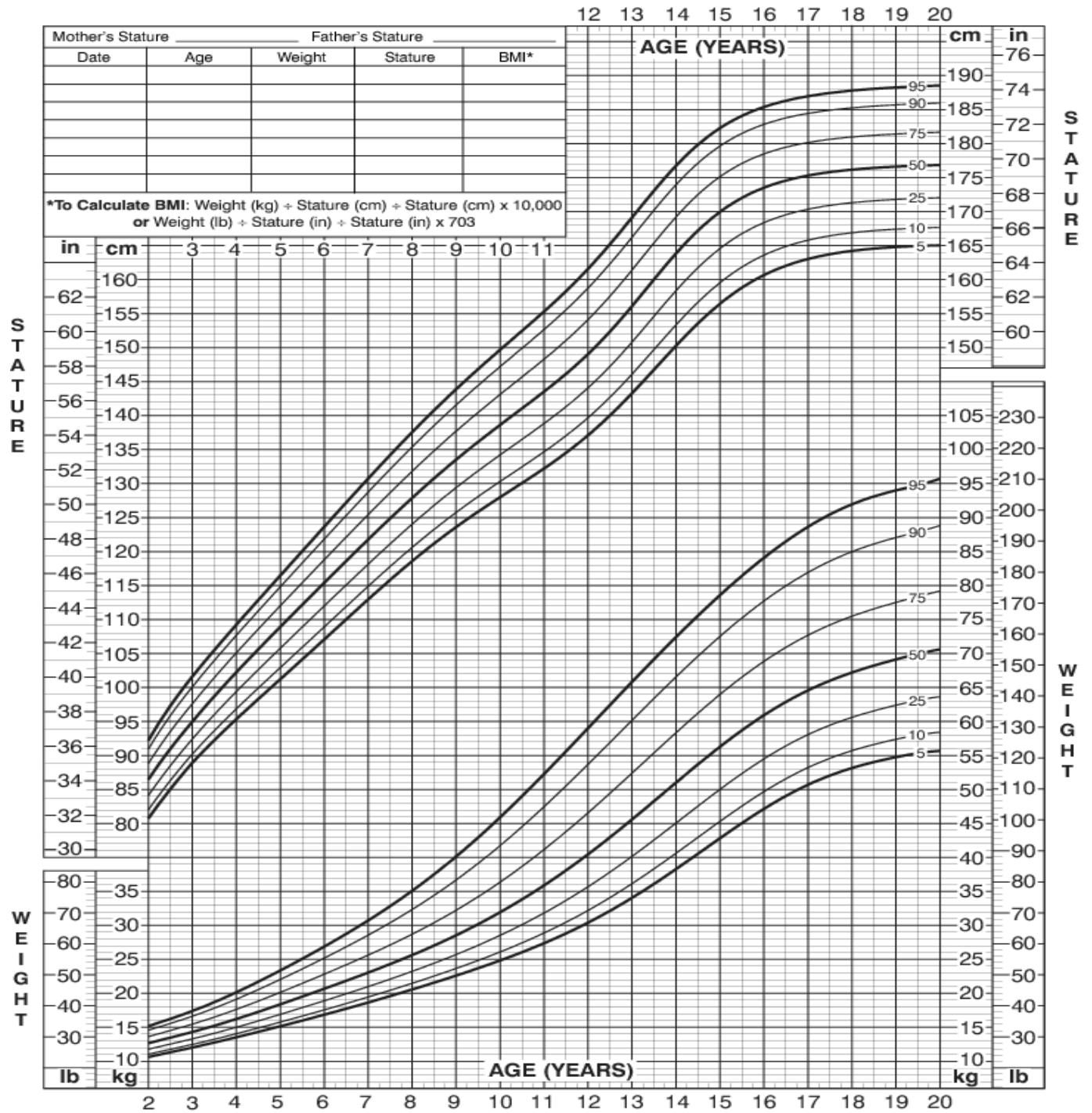
Special Treatment

Date	TLC/NEUT/PLT	Hydroxyurea	Endocrinological Therapy	Other

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 11/21/00).
 SOURCE: Developed by the National Center for Health Statistics in collaboration with
 the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>

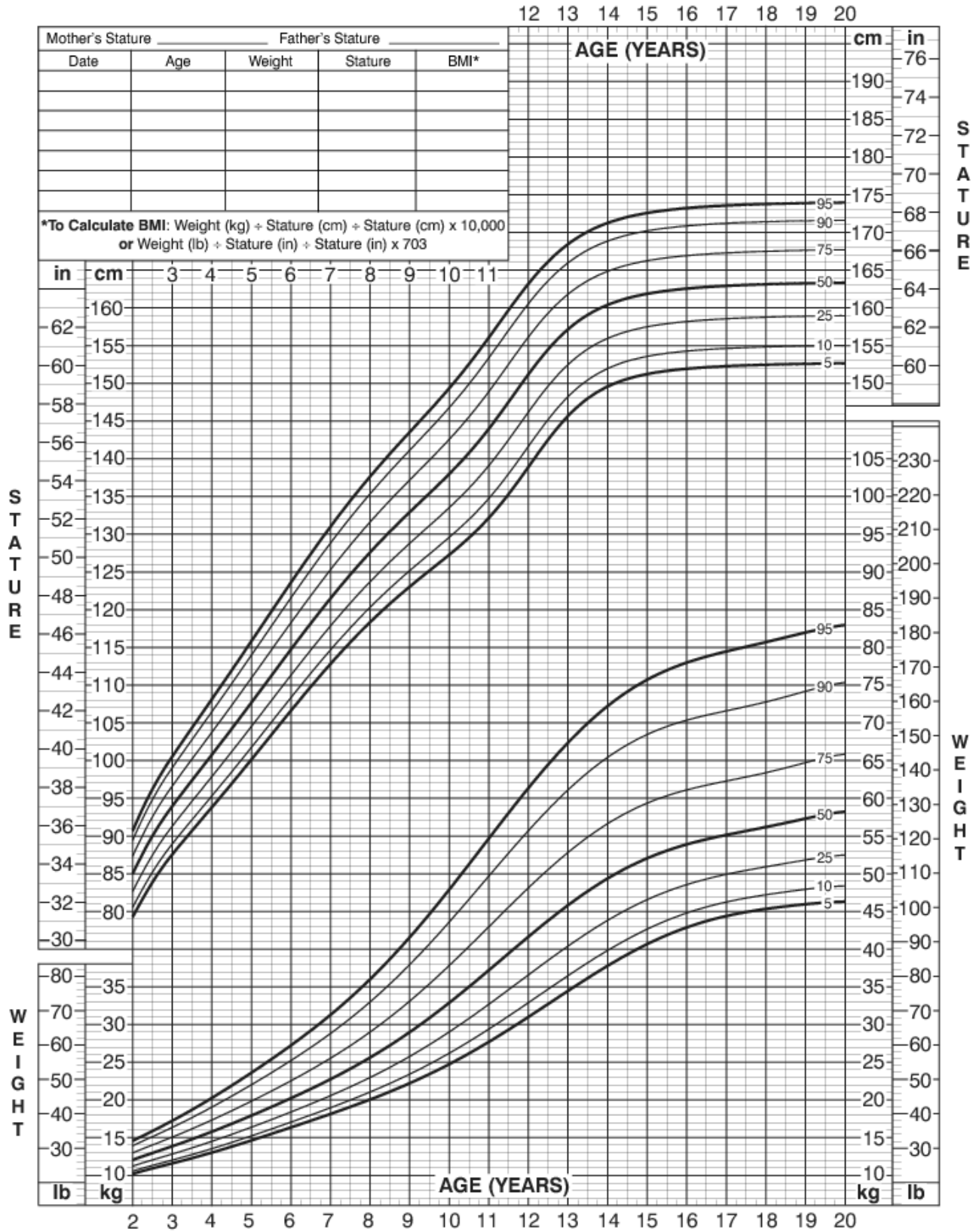


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2 to 20 years: Girls Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 11/21/00).

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