zenoziva

Zenoziva Health
Hospital guidebook

Every desk, every journey, step by step: front desk, doctor, ward, casualty, theatre, lab, discharge and billing.

Edition 2, October 2026. Zenoziva ERP 16 with the hospital module and the phone apps.
Zenoziva Business Solutions Private Limited · zenoziva.com

About this guide

This guide walks through the hospital module of Zenoziva ERP the way a hospital uses it: a patient registers at the front desk, sees a doctor, is admitted, cared for on the ward, operated on, tested, discharged and billed. Each chapter is written for the people who do that part of the work, with the screen they will see beside each step.

Every screenshot was taken on a working copy of the software. The hospital, patients, doctors and amounts shown are fictional demo data, not real people or prices.

Menus, notes, checklists, wards, tariffs and print formats can all be set up to match your hospital. Chapter 11 shows where. For questions, training or changes to your set-up, contact your Zenoziva team through zenoziva.com.

Contents

1	Getting started	3
2	Front desk: registration and appointments	6
3	Doctor: consultation and orders	10
4	Admission and ward care	15
5	Casualty and emergency	22
6	Laboratory and imaging	27
7	Operation theatre	30
8	Discharge	33
9	Billing, insurance and TPA	35
10	Management reports	39
11	On the phone: Zenoziva Care and Zenoziva HR	41
12	Setting up your hospital	44
A	Roles and glossary	48

@@start@@

CHAPTER 1

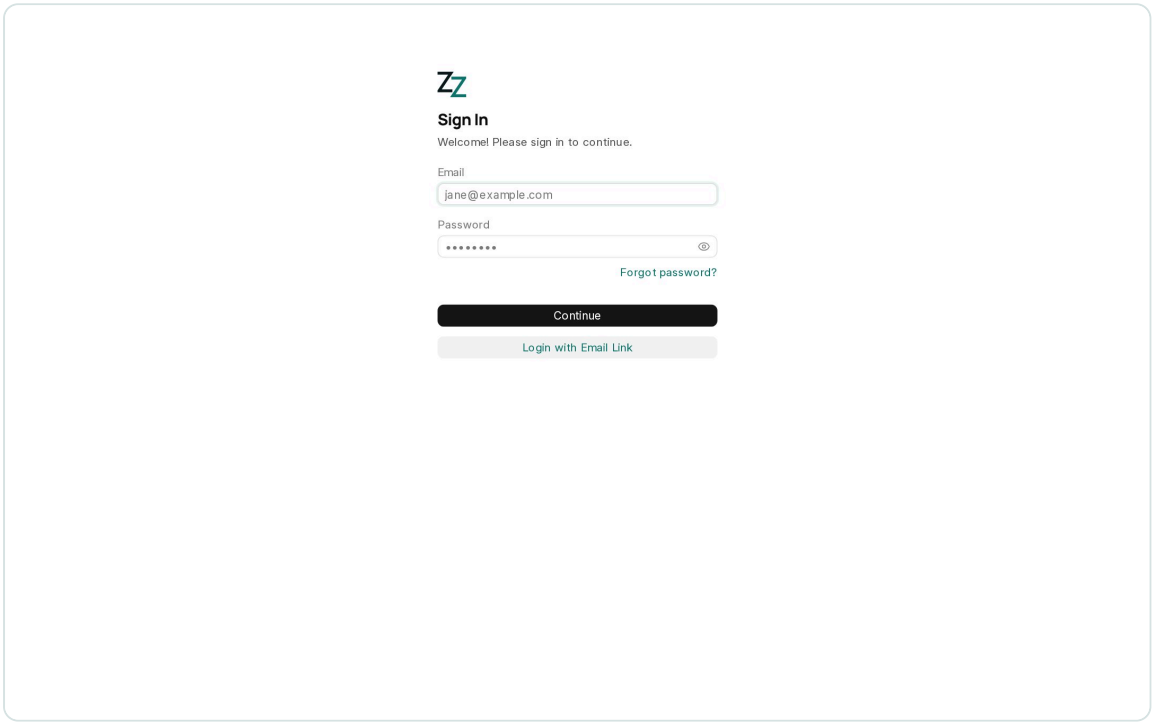
Getting started

For: Everyone

Each person signs in with their own login. What they see depends on their role: a nurse sees the Nursing, Casualty and OT menus; the front desk sees Front Desk and Billing; managers see everything.

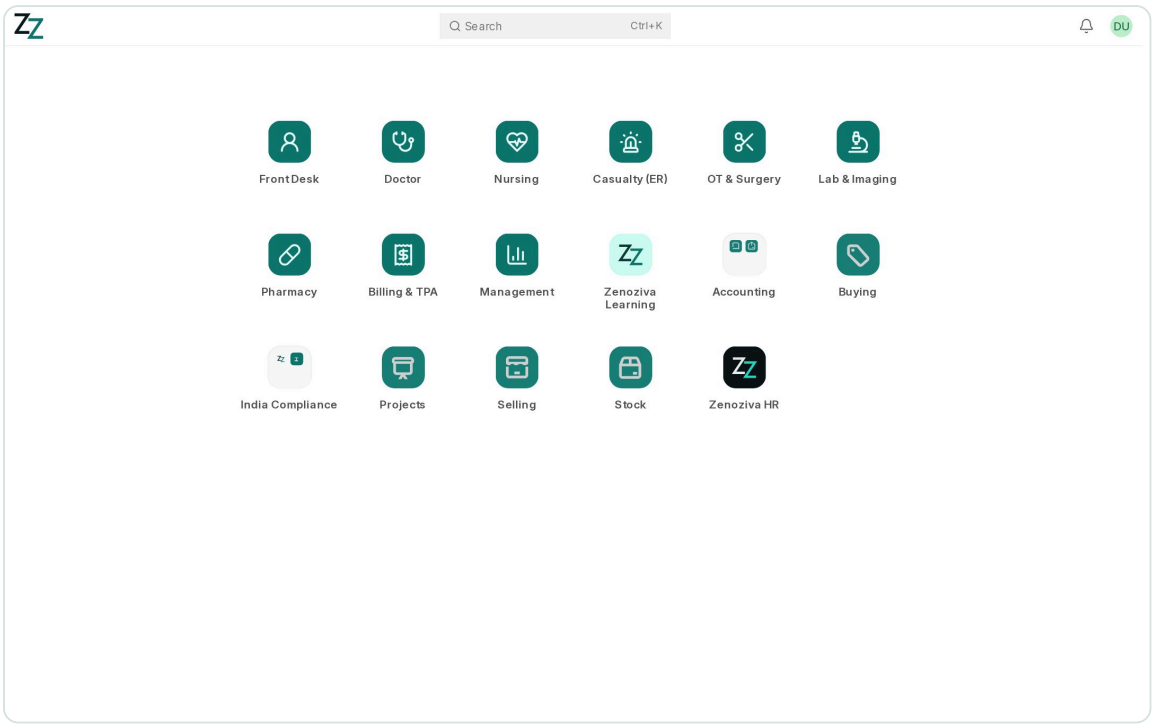
1.1 Sign in

Open your hospital's ERP address in a browser and sign in with your email and password. Ask your administrator for a login; never share one.



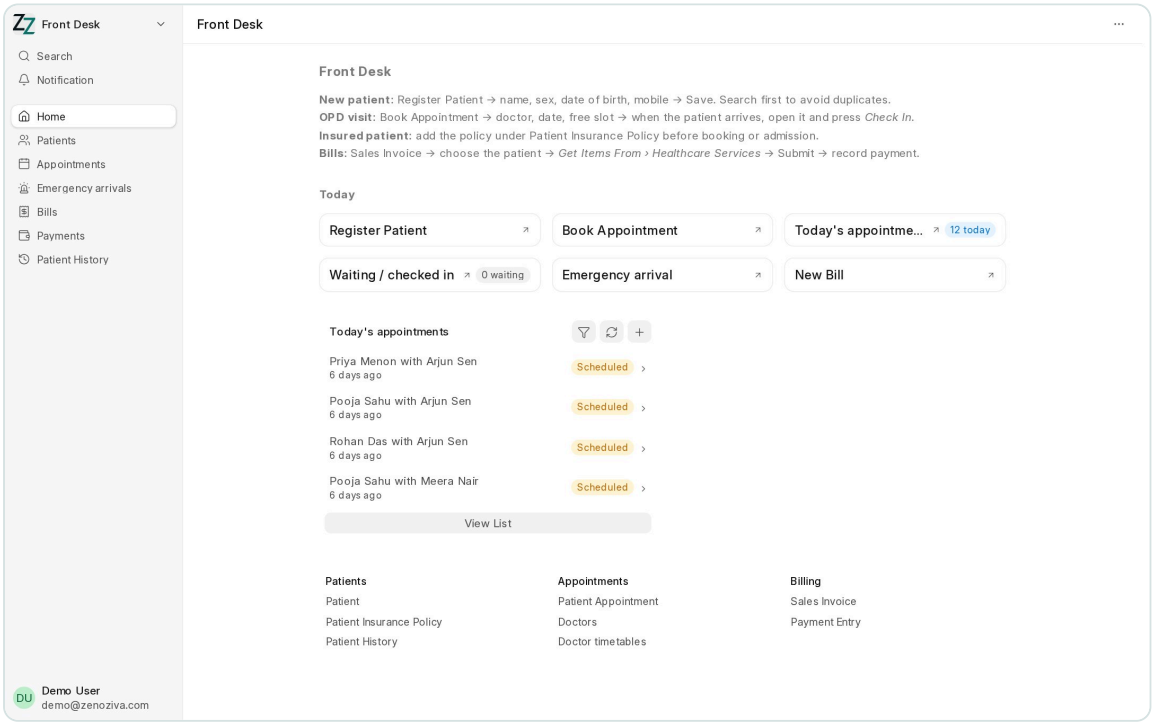
1.2 Your desktop

After signing in you see the desktop: one tile per menu you are allowed to use. The hospital menus come first: Front Desk, Doctor, Nursing, Casualty (ER), OT & Surgery, Lab & Imaging, Pharmacy, Billing & TPA and Management.



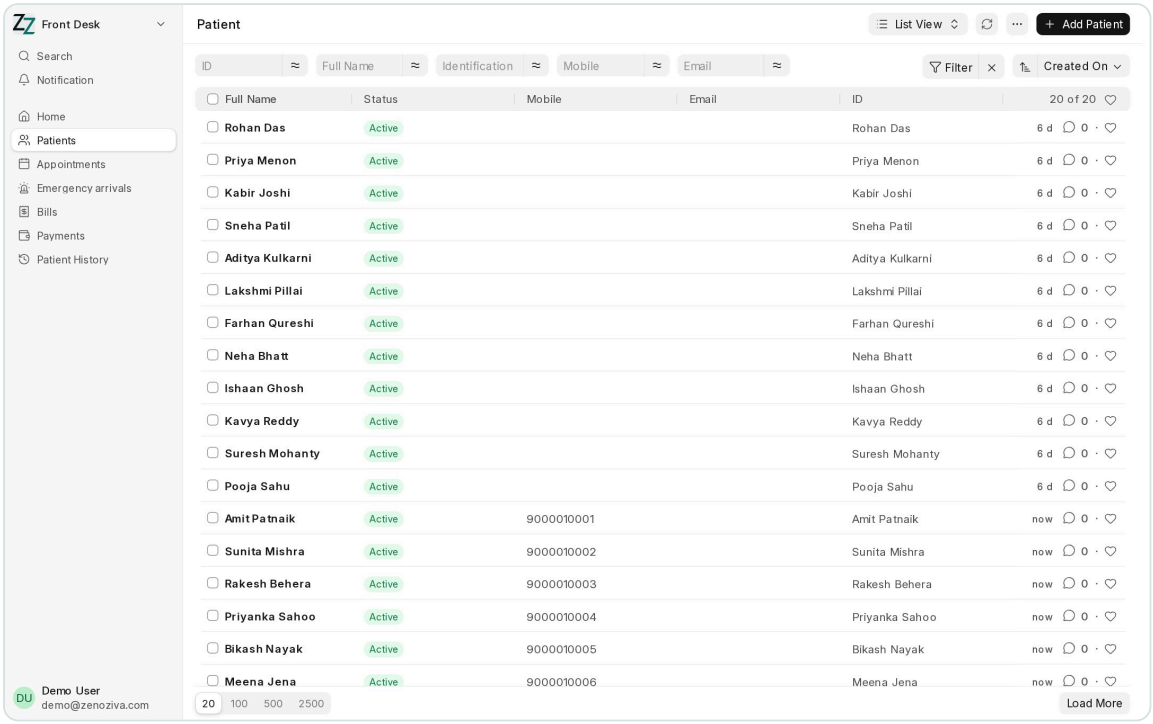
1.3 Inside a menu

Click a tile to open its menu. The left sidebar lists everything for that desk, grouped by task. The main area has shortcuts to the screens used most.



1.4 Lists and records

Every list can be searched, filtered and sorted. Click a row to open the record; use **+ Add** at the top right to create a new one. Records save with Ctrl+S.



CHAPTER 2

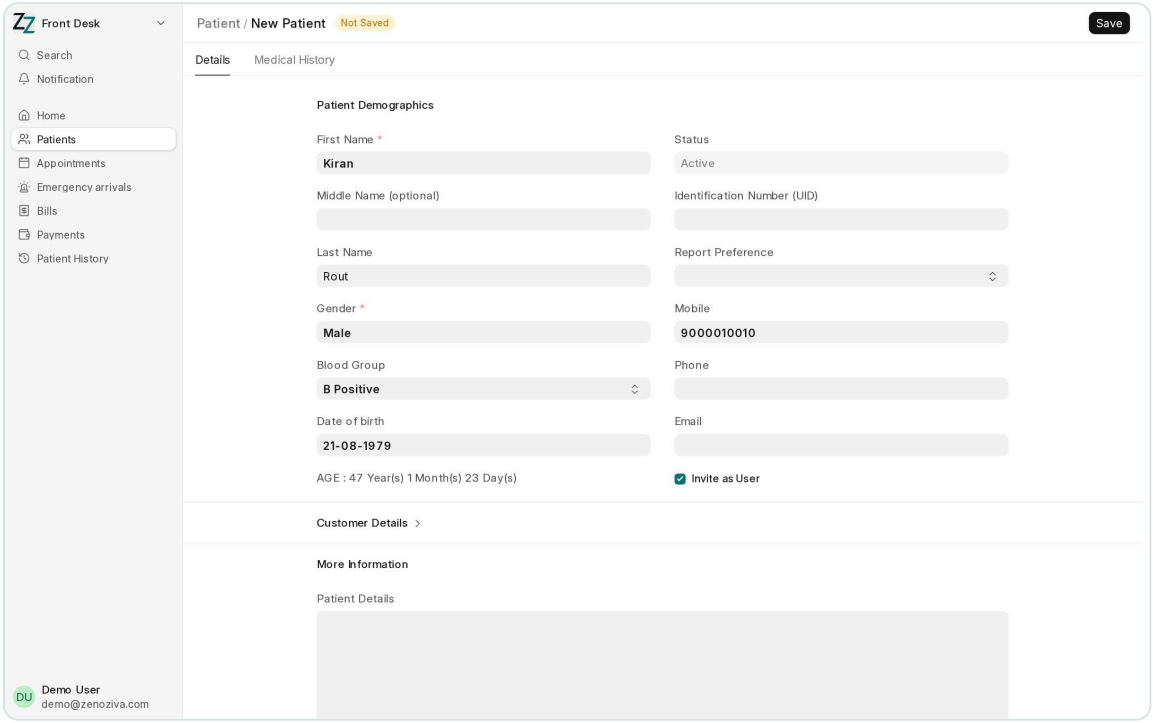
Front desk: registration and appointments

For: Front desk, reception

Our guide patient, Kiran Rout, walks in with fever and cough. The front desk registers him and books an outpatient (OPD) appointment with a physician.

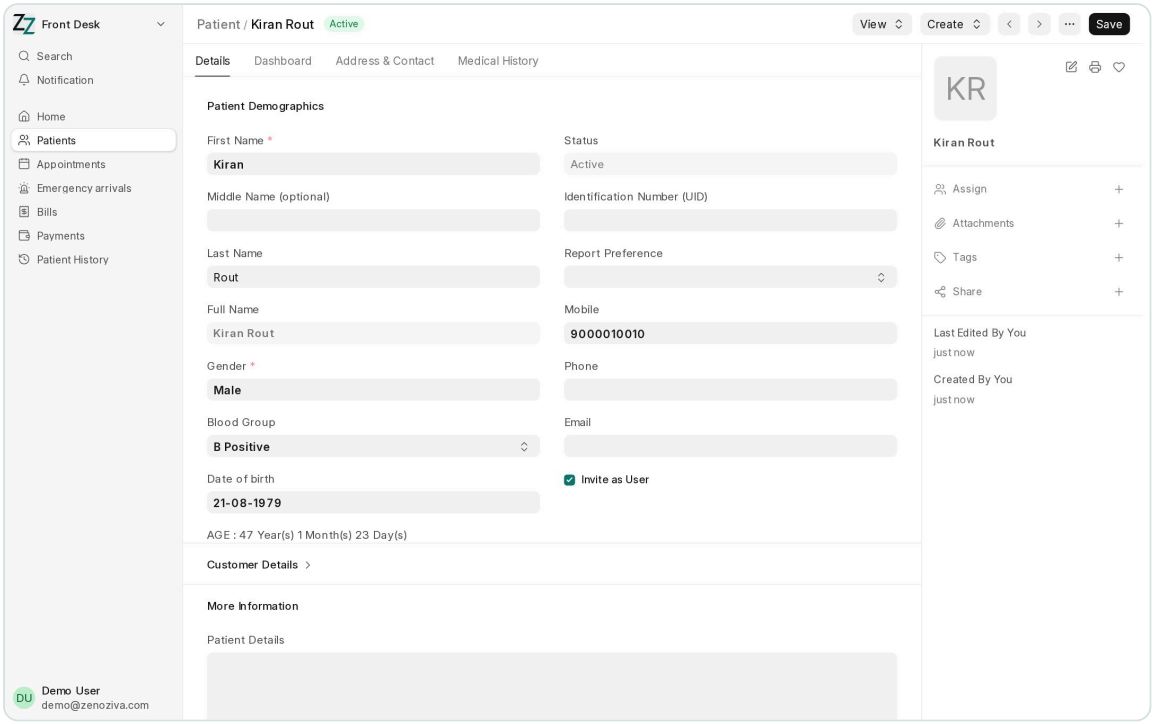
2.1 Register the patient

Front Desk › **Patients** › **+ Add Patient**. Enter name, sex, date of birth and mobile number. Blood group, address, ID numbers and emergency contact can be added now or later.



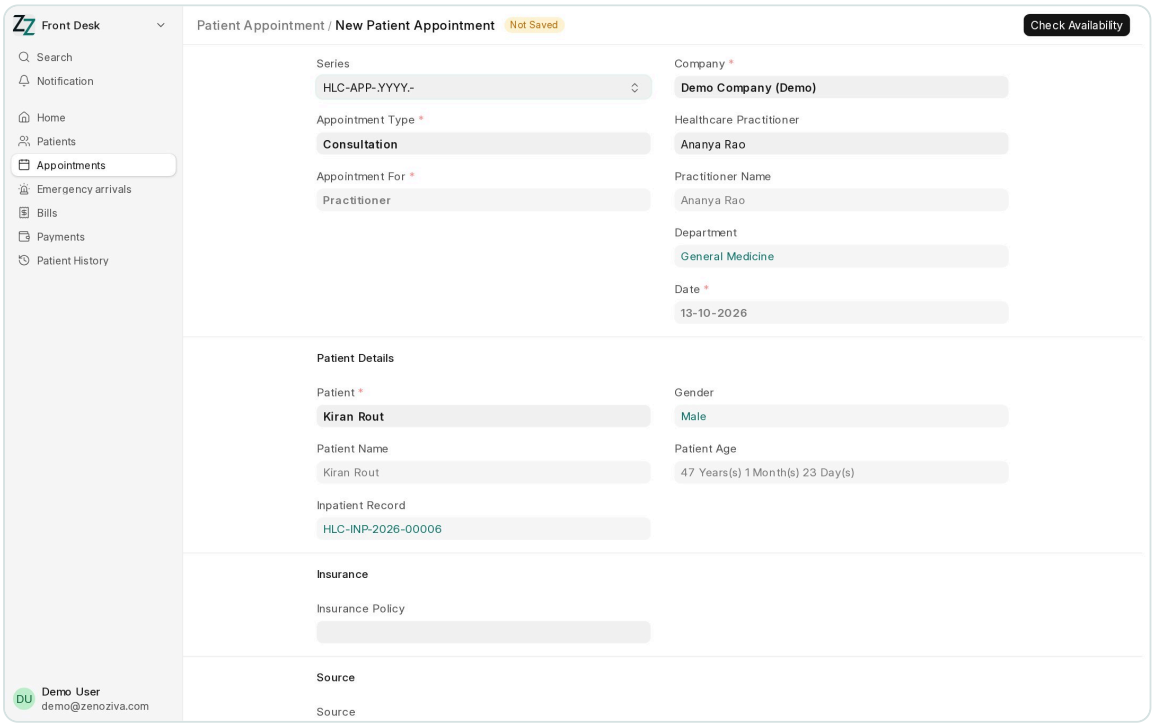
2.2 The patient record

Saving gives the patient a unique ID. The record is the patient's file for life: every visit, admission, test, note and bill links back to it.



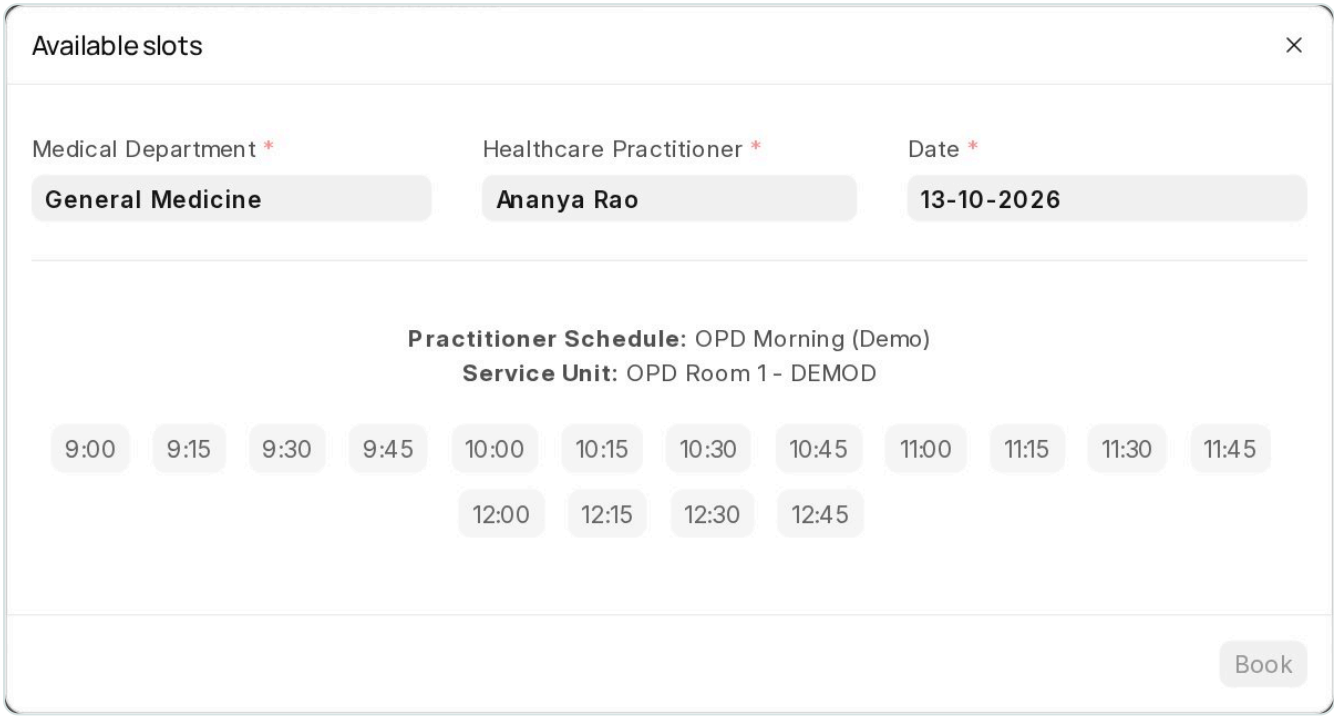
2.3 Book an appointment

Front Desk › **Appointments**, then add a new one. Choose the patient, the doctor and the date.



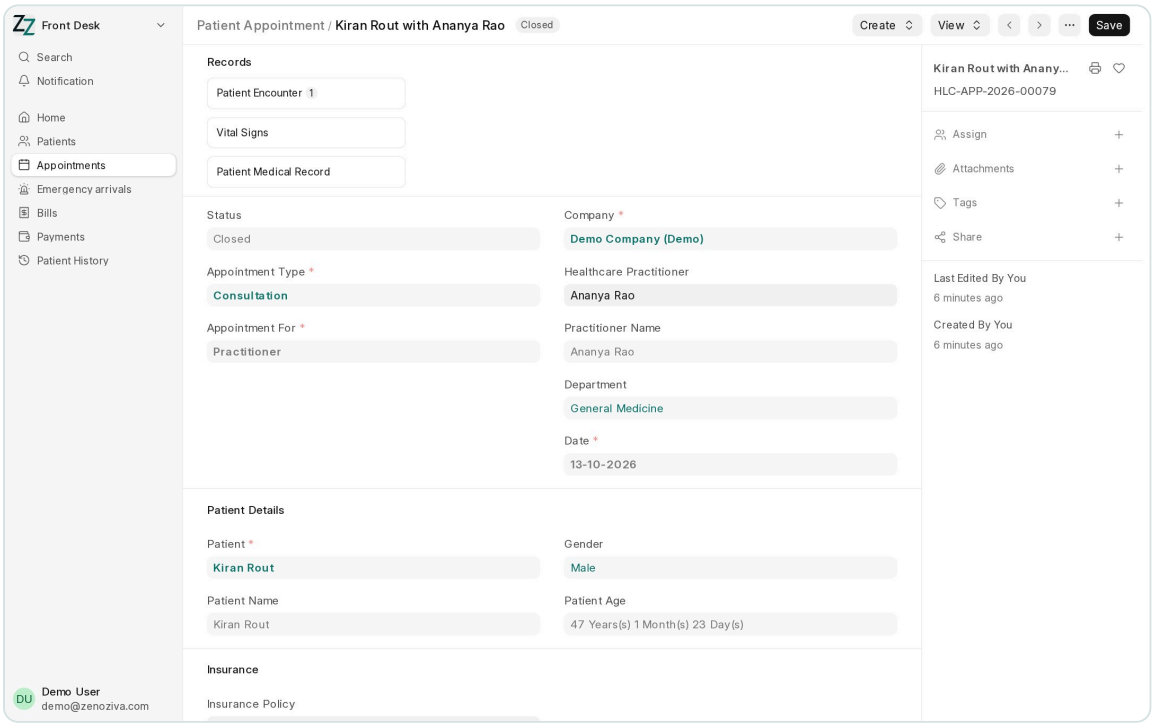
2.4 Pick a free slot

Check Availability shows the doctor's free slots for that day from their timetable. Click a slot to fill the time.



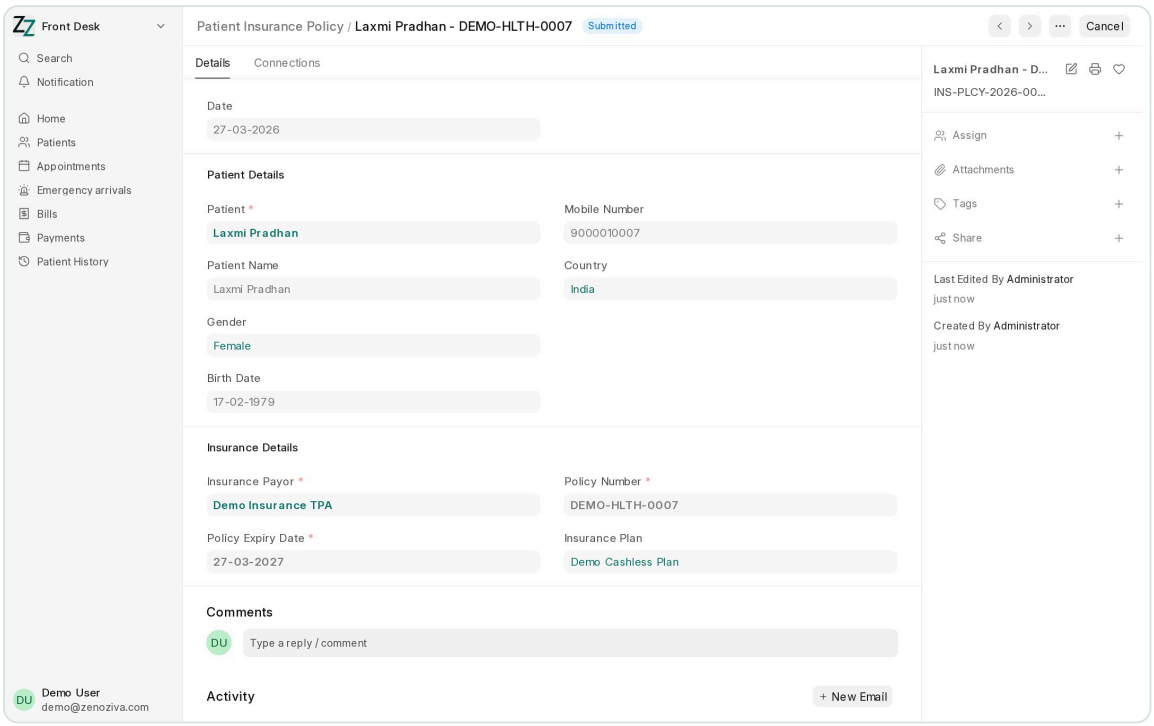
2.5 Appointment booked

Once saved, the appointment appears in the doctor's OPD list for that day. If the consultation fee is collected now, use Create Invoice; otherwise it is billed later.



2.6 Insured patients

For a patient with insurance or a TPA card, add a **Patient Insurance Policy**: insurer, plan, policy number and validity. Bills for this patient are then split between the patient and the insurer automatically (chapter 10).



CHAPTER 3

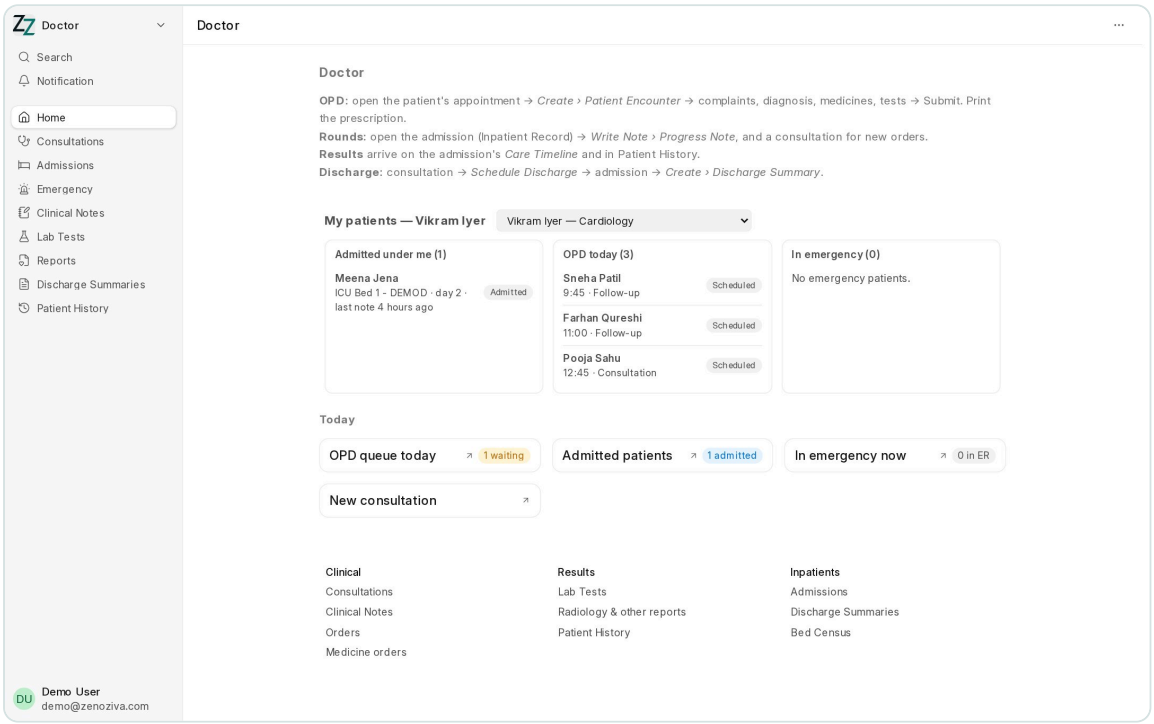
Doctor: consultation and orders

For: Doctors

The doctor sees Kiran in OPD, records the findings, orders tests and medicines, writes the initial assessment and decides to admit him.

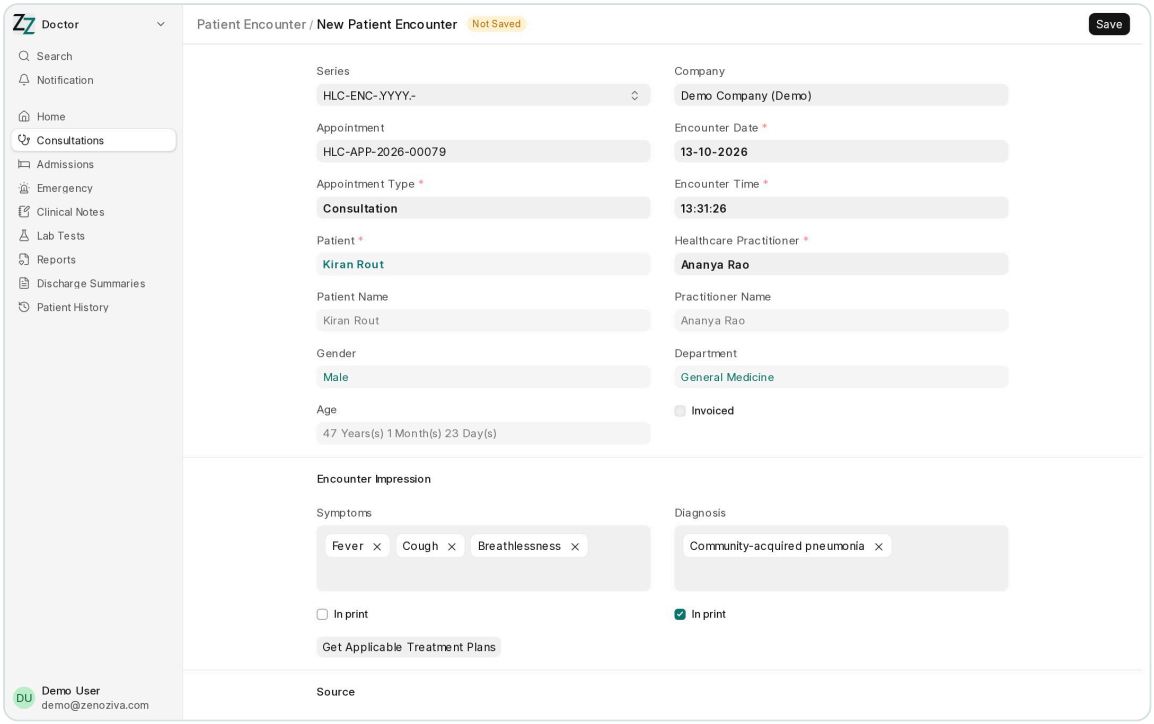
3.1 My patients

The Doctor menu opens on **My patients**: patients admitted under you (with bed, day of stay and when you last wrote a progress note), today's OPD list and emergency cases you are attending. Click a name to open it. Your login must be linked to your doctor record (chapter 11).



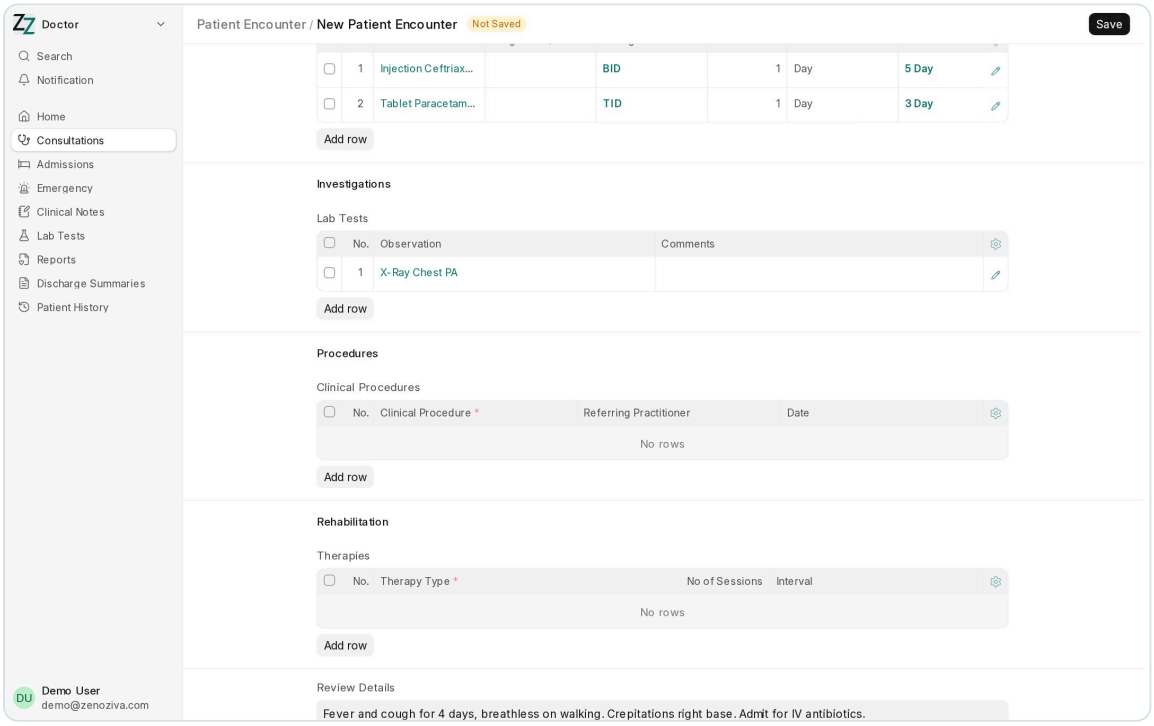
3.2 Start the consultation

Open the appointment and choose **Create** › **Patient Encounter**, or start one from Doctor › **Consultations**. Record complaints and diagnosis.



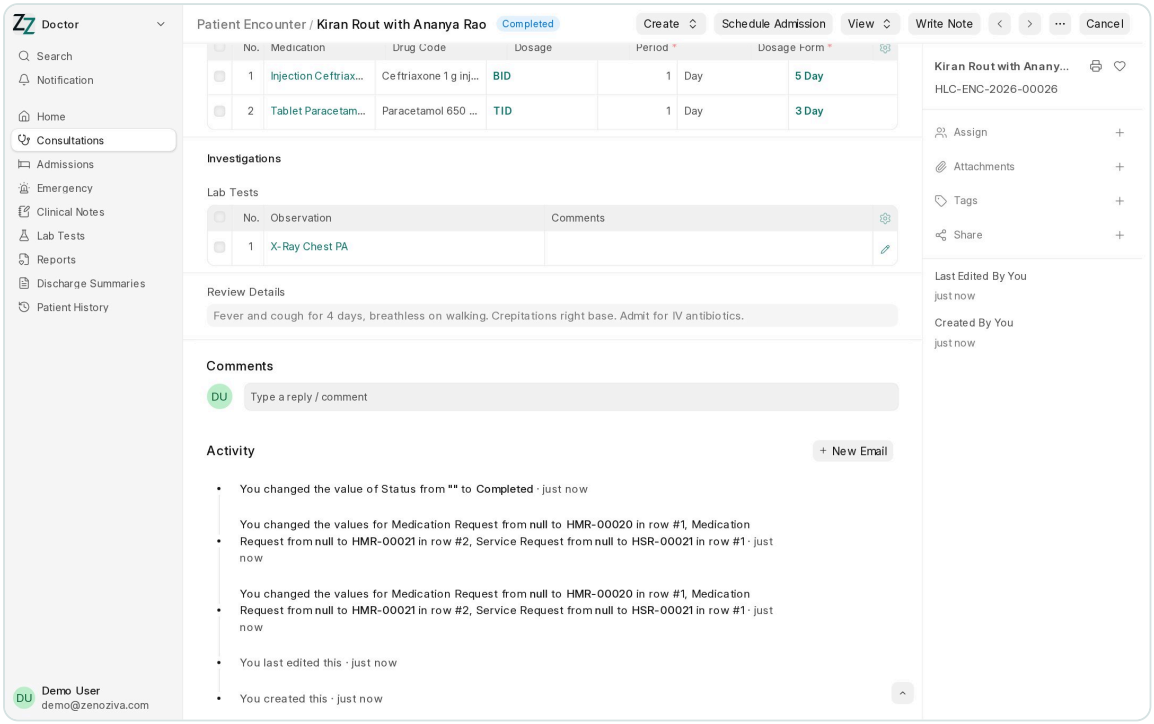
3.3 Order medicines and tests

Add medicines with dose and duration, and lab or imaging tests. The notes field holds the doctor's comment for this visit.



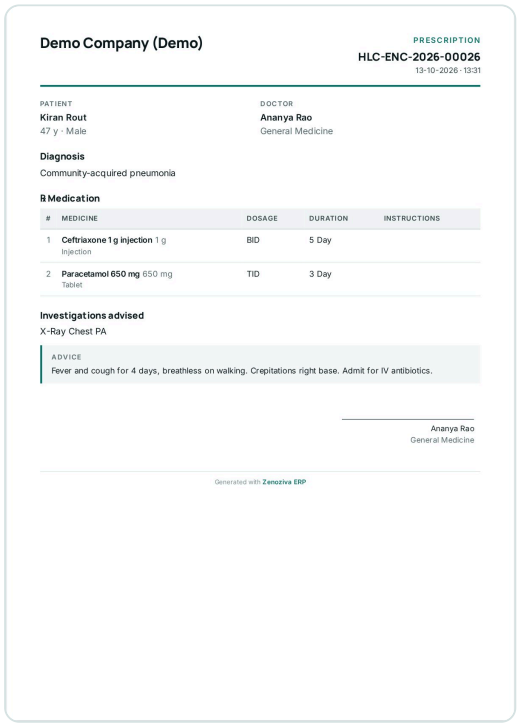
3.4 Submit

Submit the encounter when done. Orders go to the lab, imaging and pharmacy, and the visit is added to the patient's history.



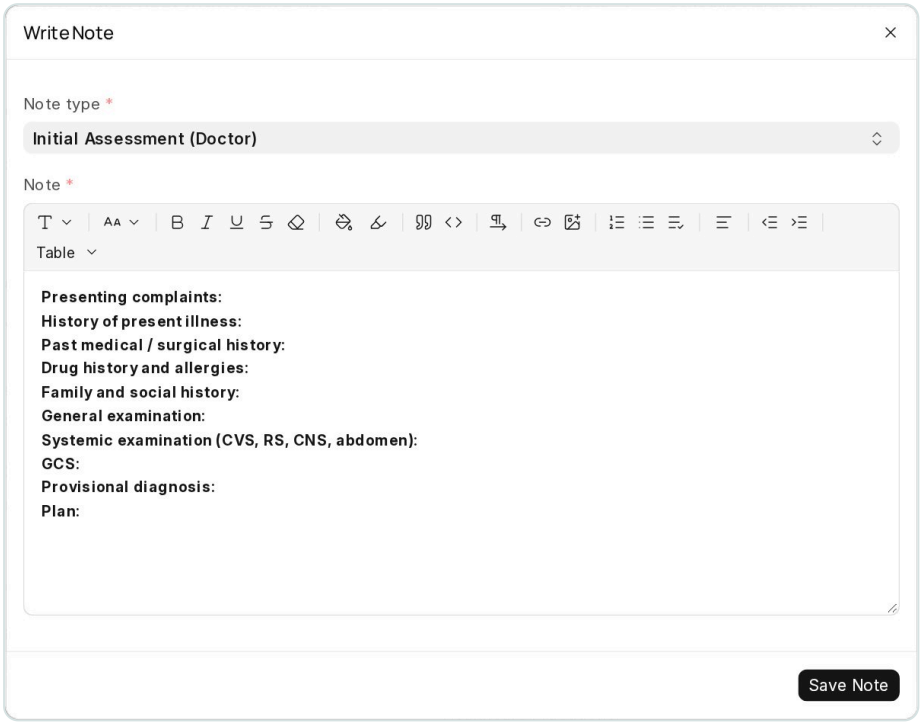
3.5 Print the prescription

Print gives the prescription in your hospital's format, ready to hand to the patient.



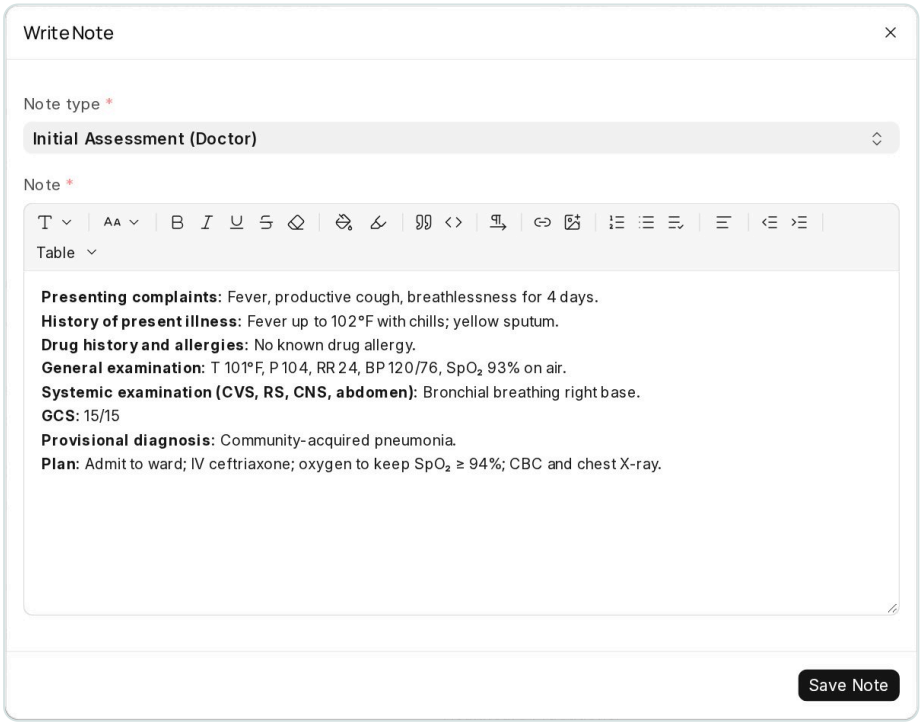
3.6 Write a clinical note

Write Note opens a note dialog. Choose the type of note and the template fills in the headings your hospital uses, here the doctor's initial assessment.



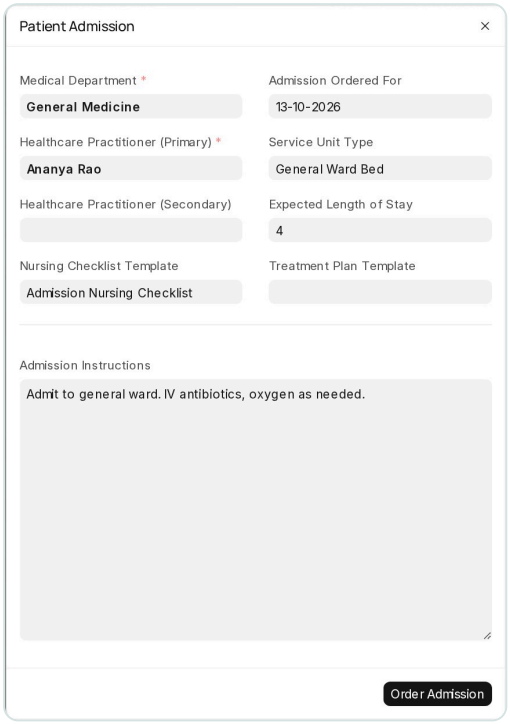
3.7 Fill in the headings

Type under each heading. A note cannot be saved empty or with the template untouched. The note is signed with your name, role and time, and appears in the care timeline.



3.8 Decide to admit

Schedule Admission sends the patient to admissions: choose the ward or bed type, expected length of stay, the admission nursing checklist and instructions for the ward.



CHAPTER 4

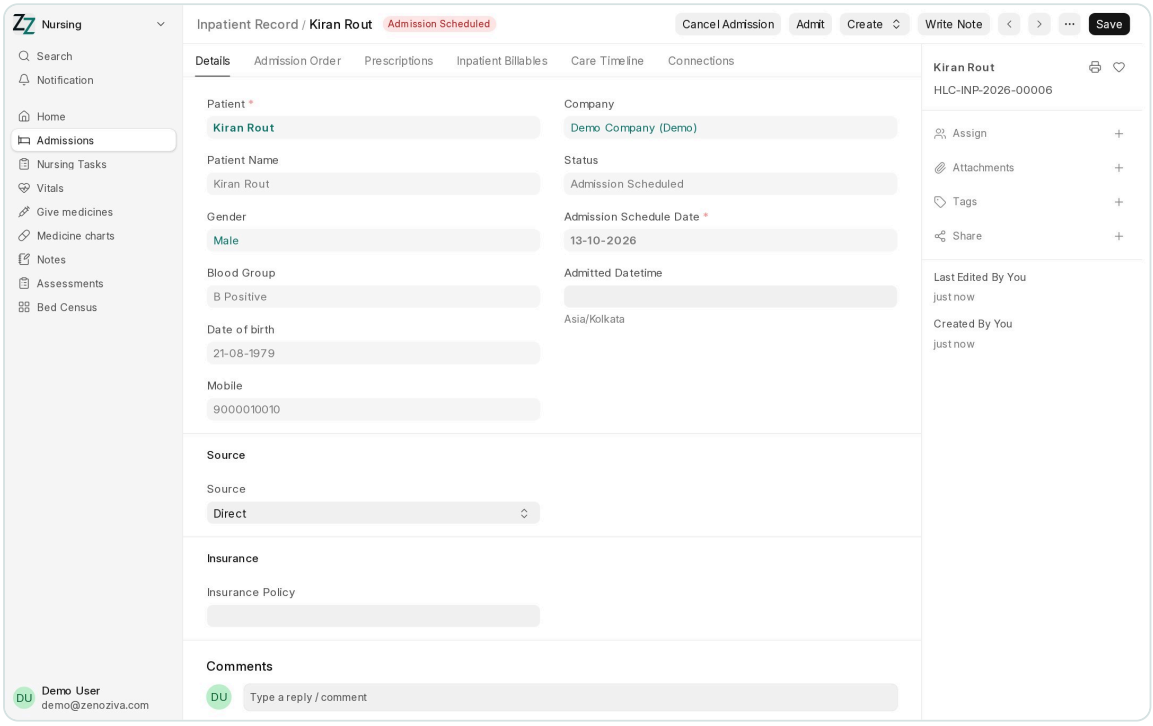
Admission and ward care

For: Admissions, nurses, doctors

Kiran's admission is waiting. The nurses complete the admission checklist, the bed is allotted, and the ward team record vitals, give medicines and write notes through his stay.

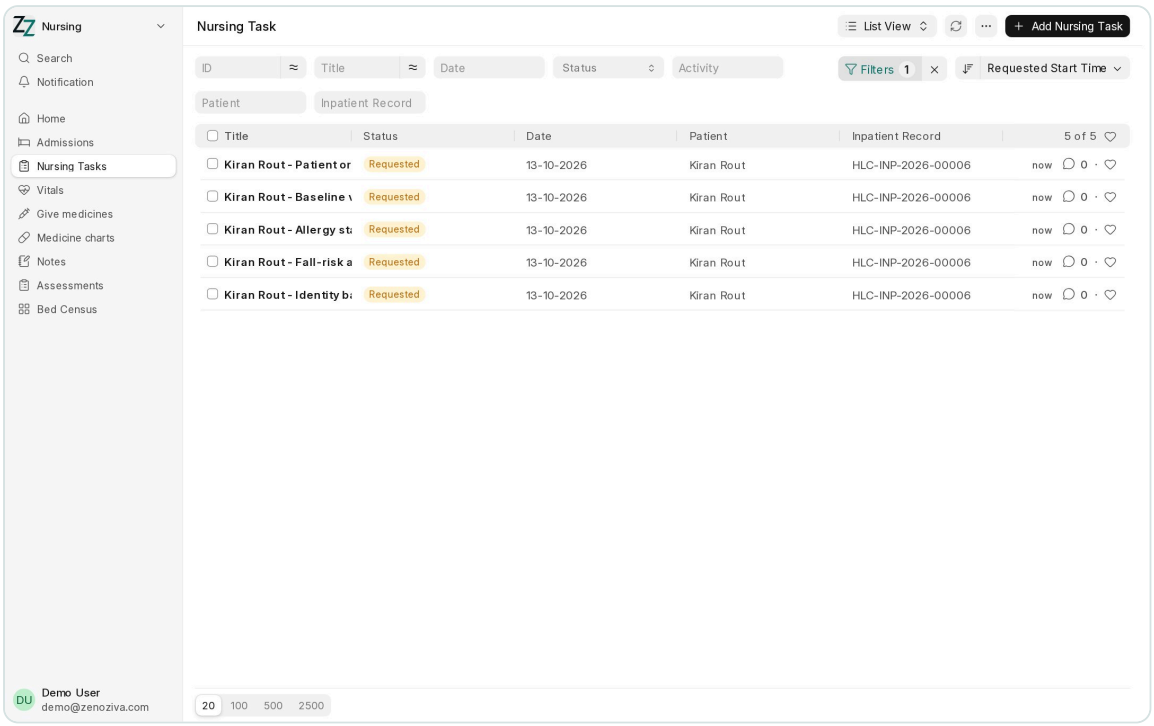
4.1 The inpatient record

Every admission has an **Inpatient Record**: the patient's file for this stay. It starts as Admission Scheduled.



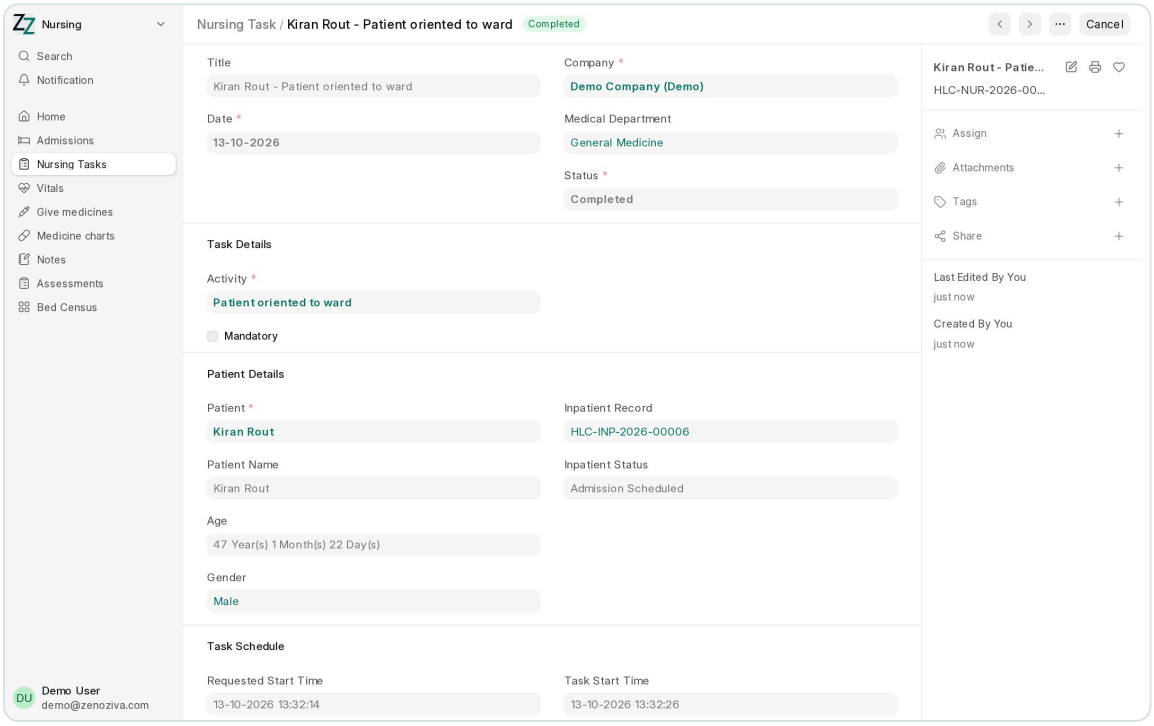
4.2 Admission checklist

Scheduling the admission creates the nursing checklist as tasks: identity band, allergy status, baseline vitals, orientation to the ward and fall-risk assessment (your hospital sets the list). Nurses open each task and mark it done.



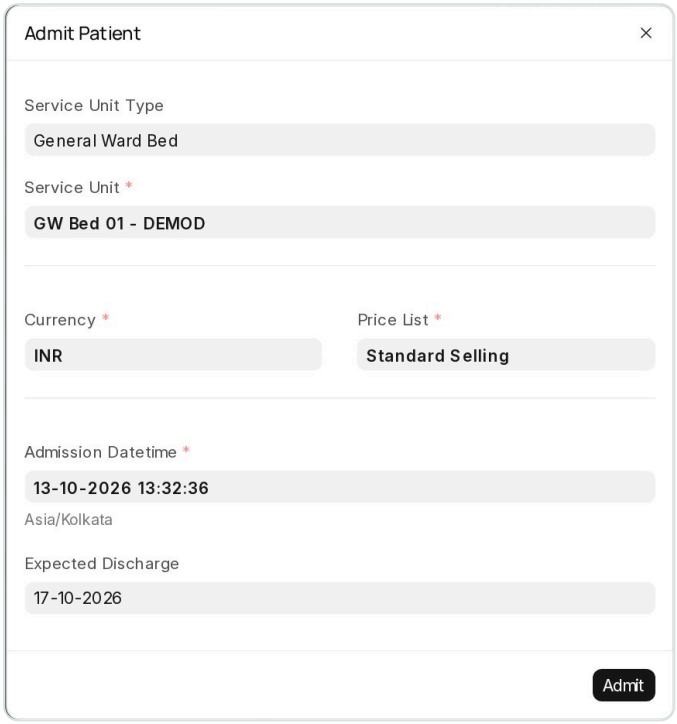
4.3 A nursing task

Each task records who did it and when. Open tasks also show in Nursing › **Nursing Tasks**.



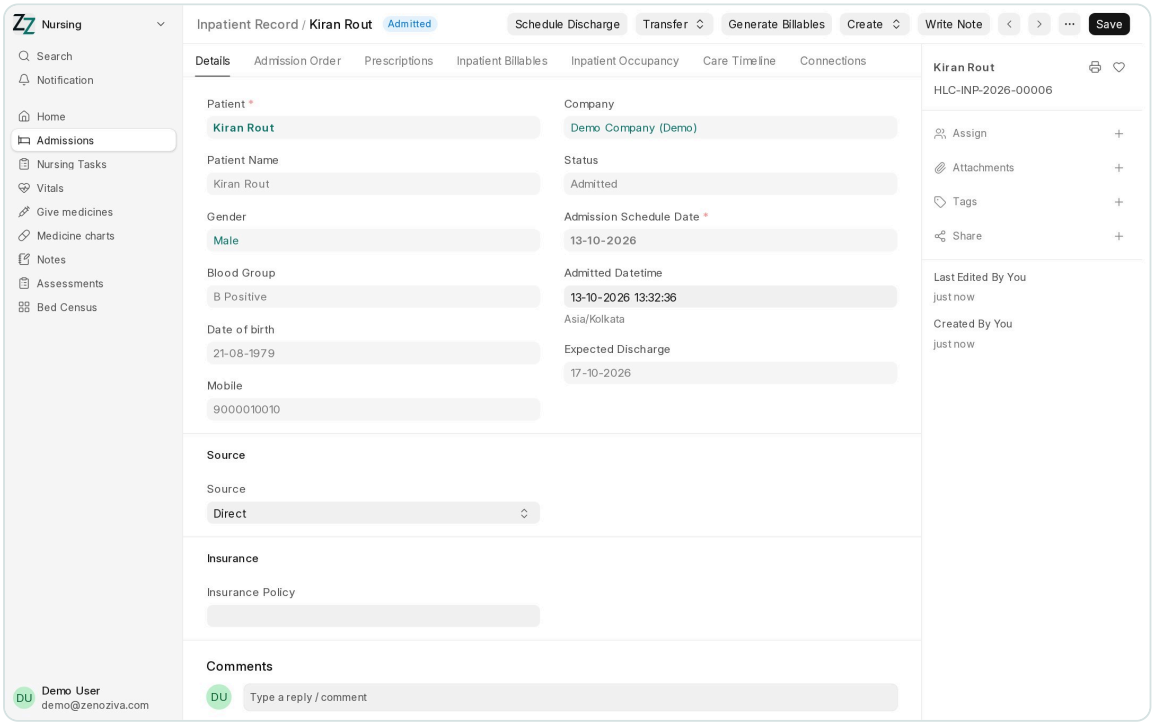
4.4 Allot a bed

On the inpatient record click **Admit**, choose the bed type and a free bed. Only vacant beds are offered.



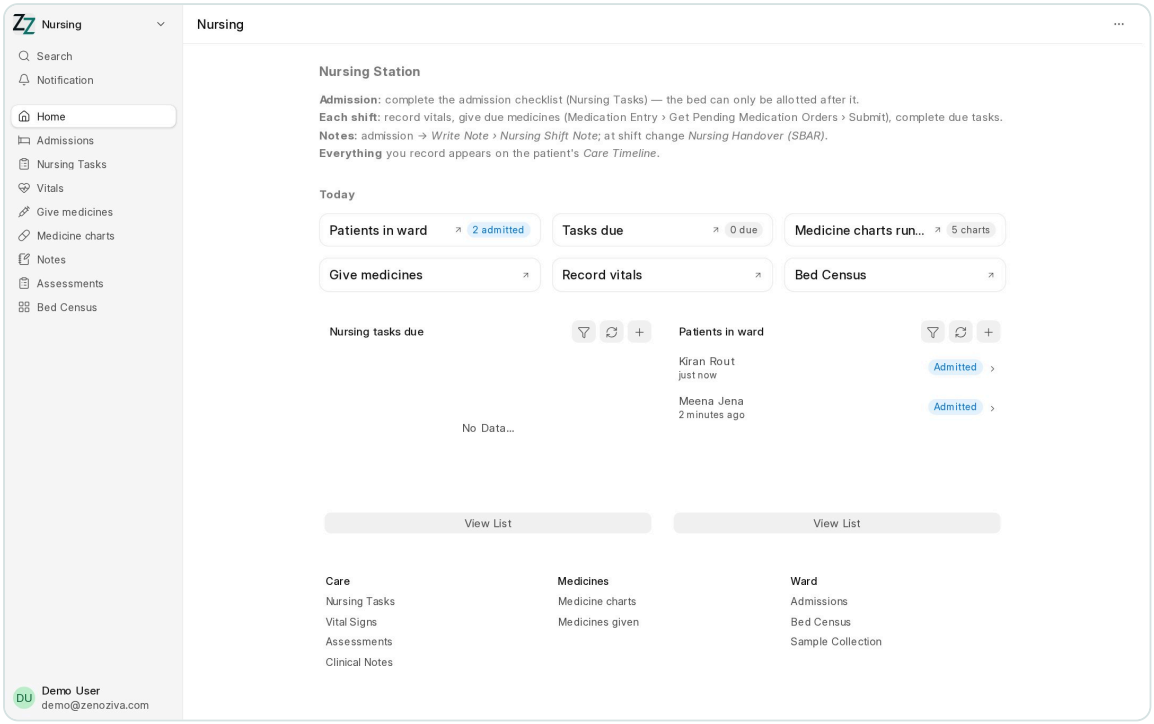
4.5 Admitted

The record is now Admitted, the bed is marked occupied and bed charges start from this time. Moving the patient uses **Transfer**, which keeps the full bed history for billing.



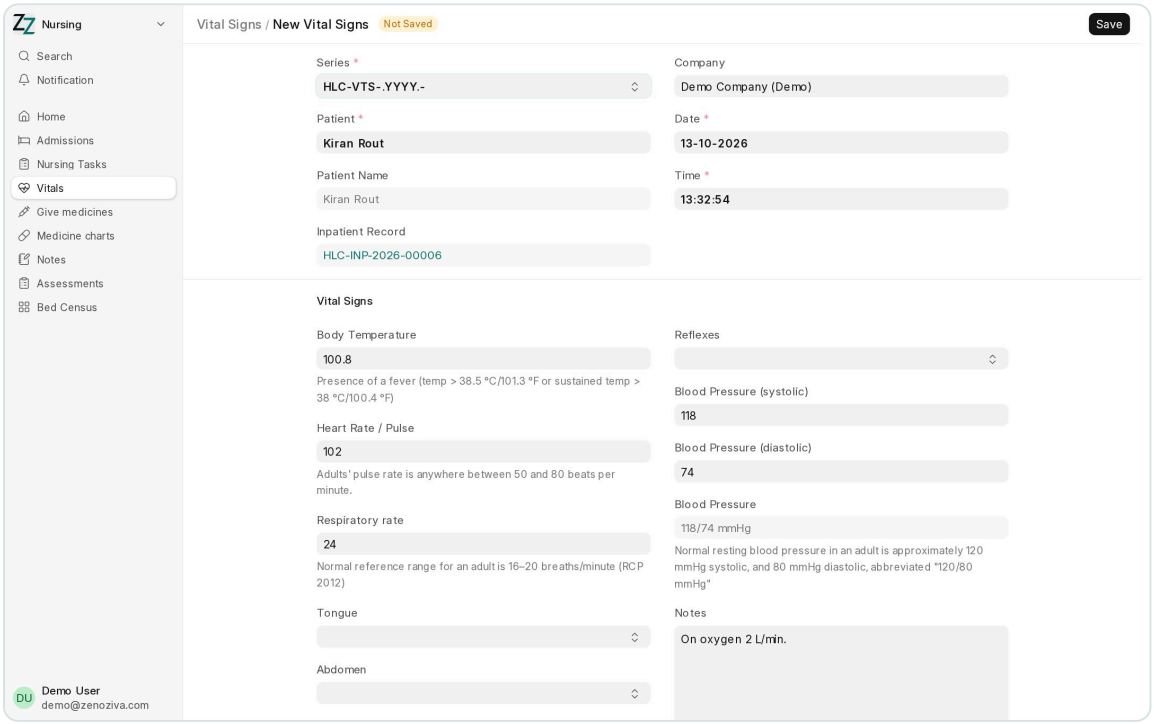
4.6 The nursing menu

Nurses work from the Nursing menu: patients in the ward, nursing tasks, vitals, the medicine round and notes.



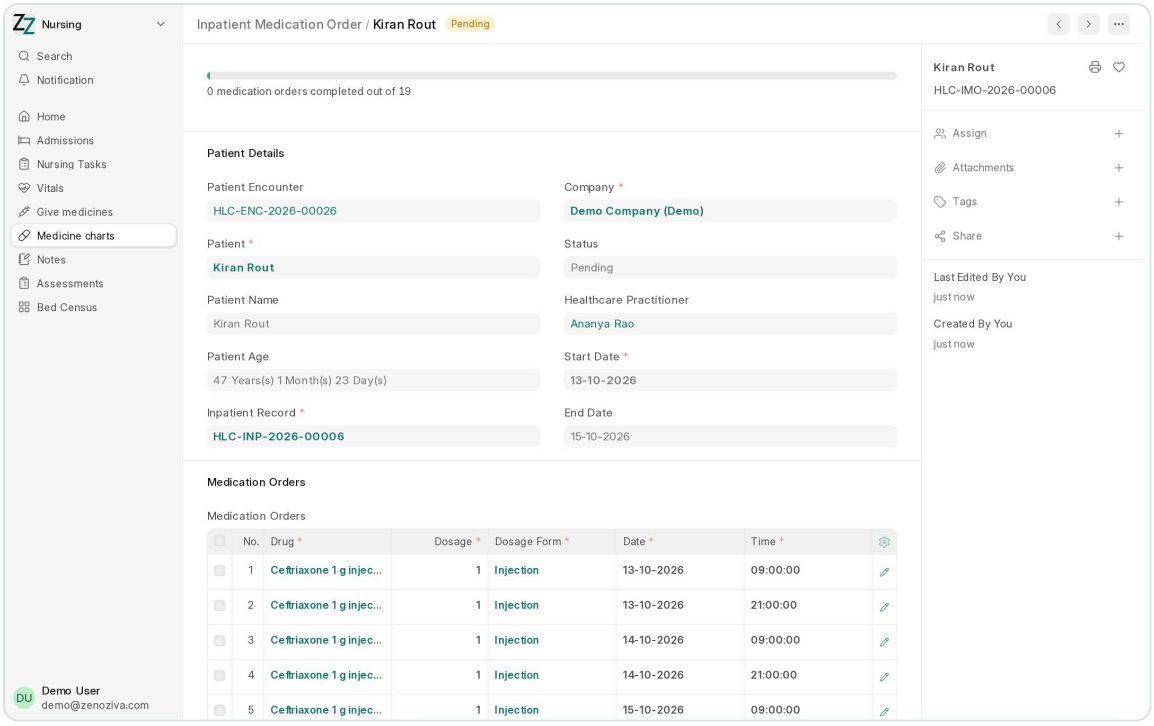
4.7 Record vitals

Nursing › **Vitals**, then add a new one: temperature, pulse, respiration, blood pressure and remarks, linked to the admission.



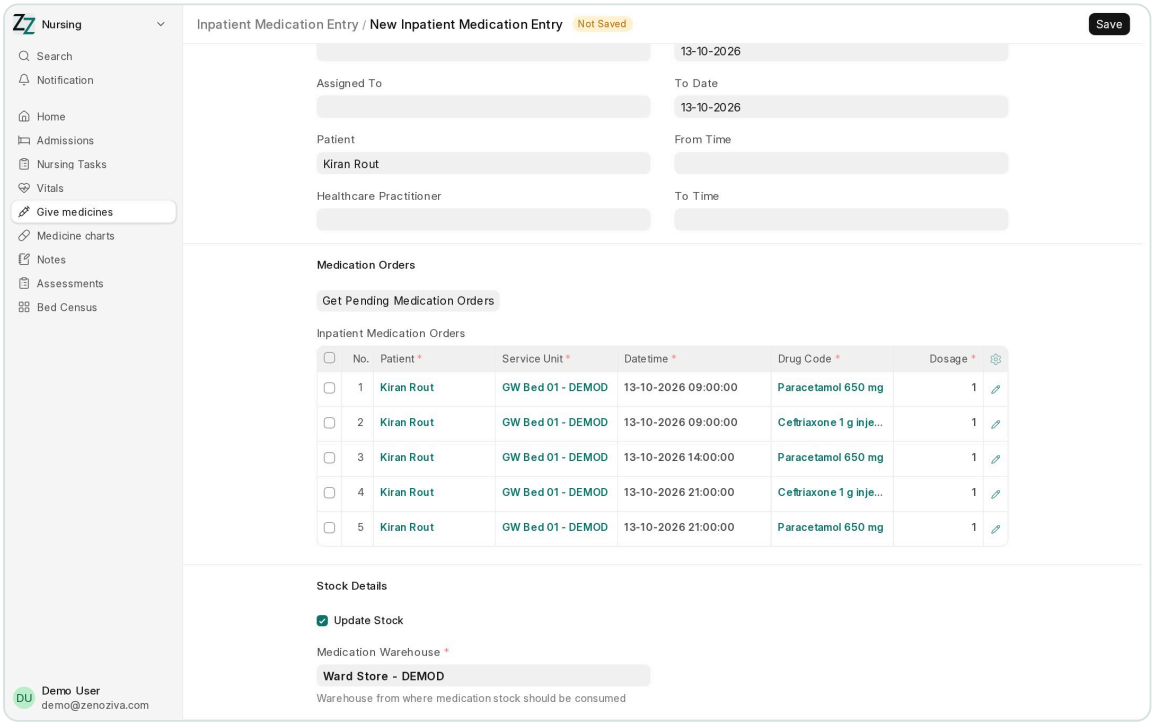
4.8 The medicine chart

Medicines the doctor orders for an inpatient become an **Inpatient Medication Order**: the chart, with each dose scheduled by date and time.



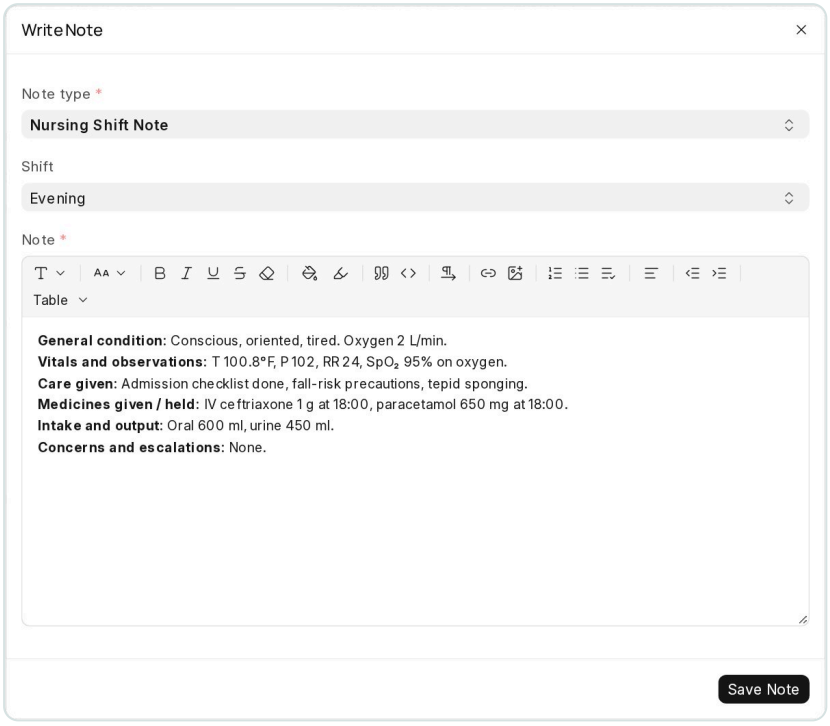
4.9 The medicine round

Nursing › **Give medicines** (Inpatient Medication Entry): pick the ward store and **Get Pending Medication Orders**. Tick the doses given and submit; stock is issued from the ward store and the doses are charged to the patient.



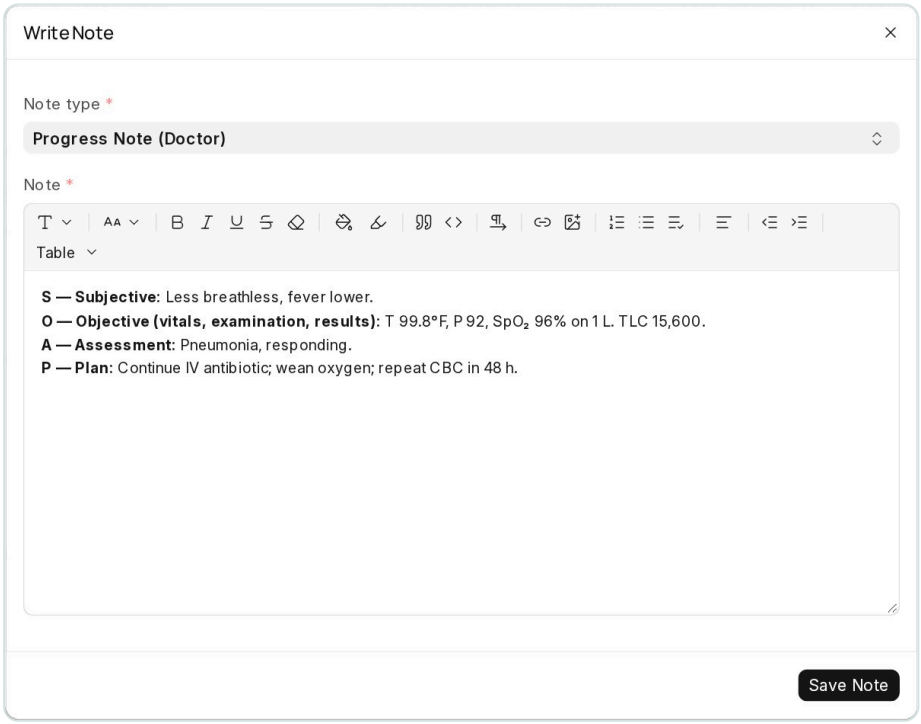
4.10 Nursing shift note

Write Note › Nursing Shift Note, with the shift. The template covers condition, observations, care given, medicines, intake and output, and concerns.



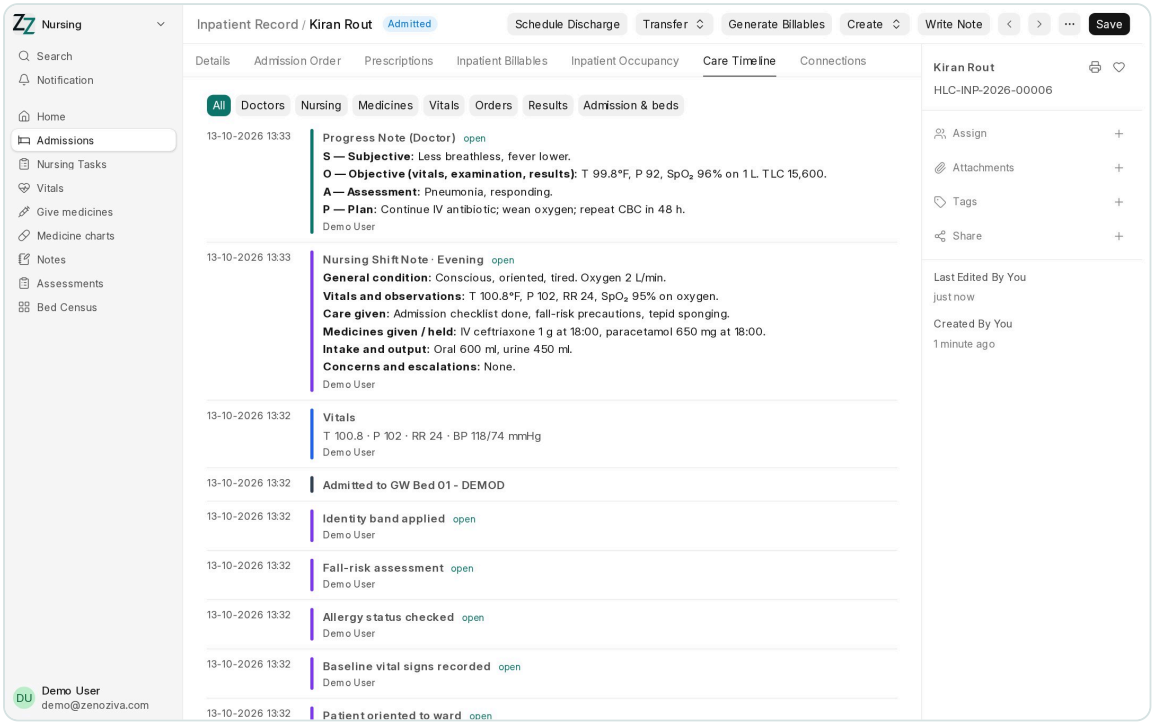
4.11 Doctor’s progress note

Doctors write a daily Progress Note (Doctor) in SOAP form from the same button. My patients warns when an admitted patient has no progress note yet.



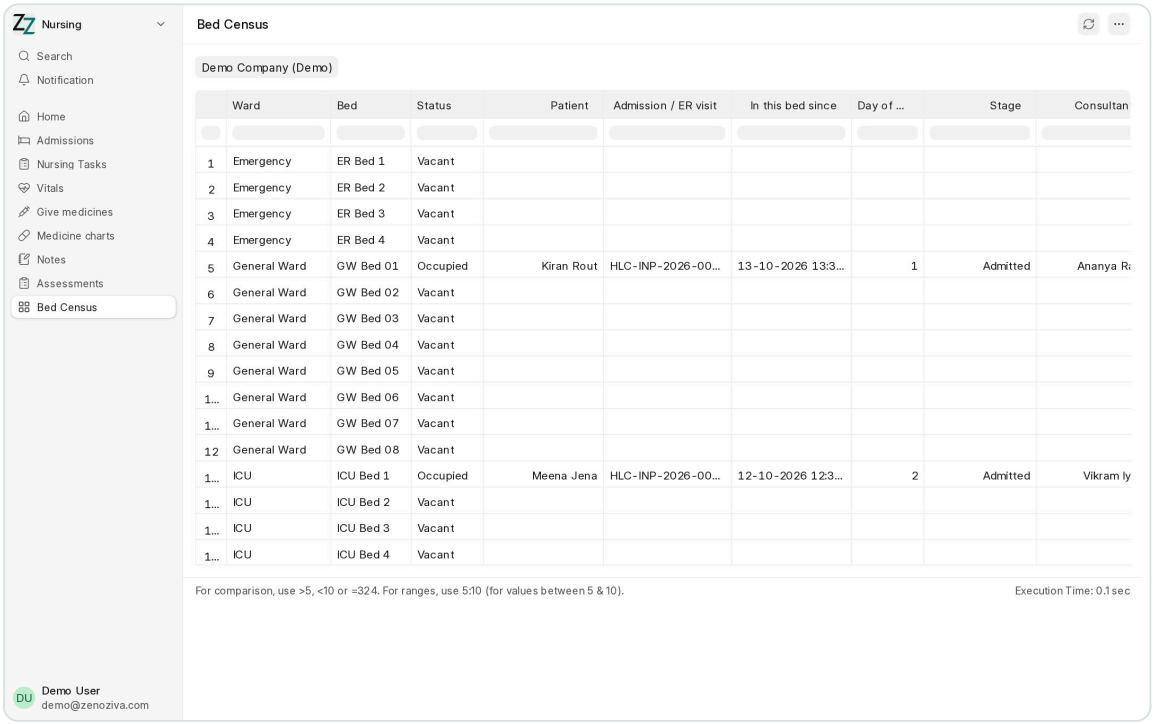
4.12 Care timeline

The **Care Timeline** tab shows everything that happened in this stay, newest first: notes, vitals, medicines given, nursing tasks, tests and transfers, each with who and when.



4.13 Bed census

Nursing › **Bed Census** lists every ward and bed with its patient, so the ward in-charge and admissions see occupancy at a glance.



CHAPTER 5

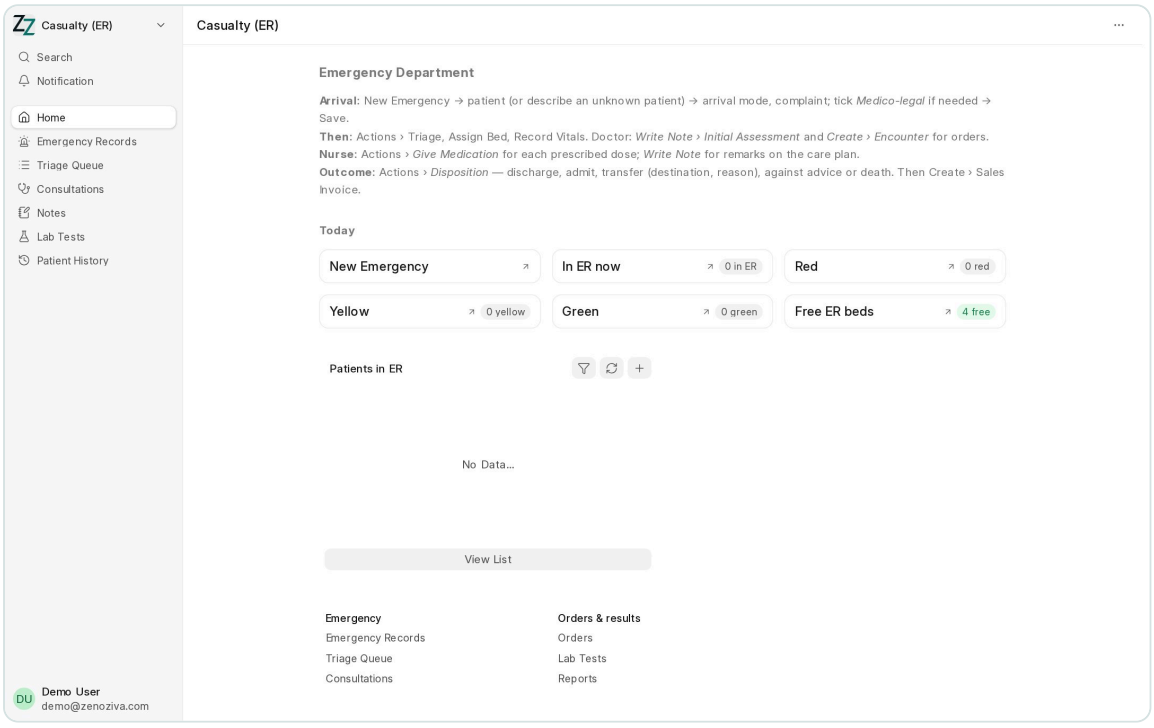
Casualty and emergency

For: Emergency doctors and nurses

Mohan Das arrives by ambulance with chest pain. Casualty registers him, triages him, records vitals, treats him and transfers him to a cardiac centre. Every step is logged.

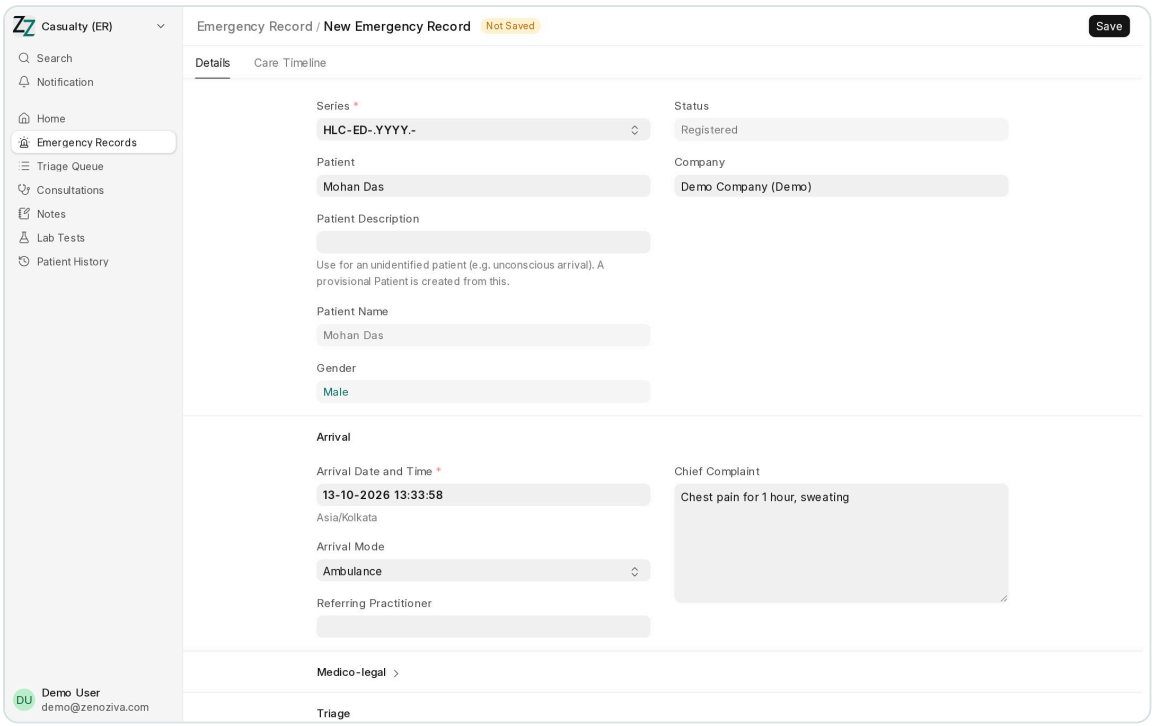
5.1 The Casualty menu

Casualty (ER) lists patients in emergency now, with triage level and time since arrival.



5.2 Register the arrival

Casualty (ER) › **Emergency Records**, then add a new one: the patient (register a new one if needed), how they arrived, who brought them and the chief complaint. Tick medico-legal case if it applies and fill the police details.



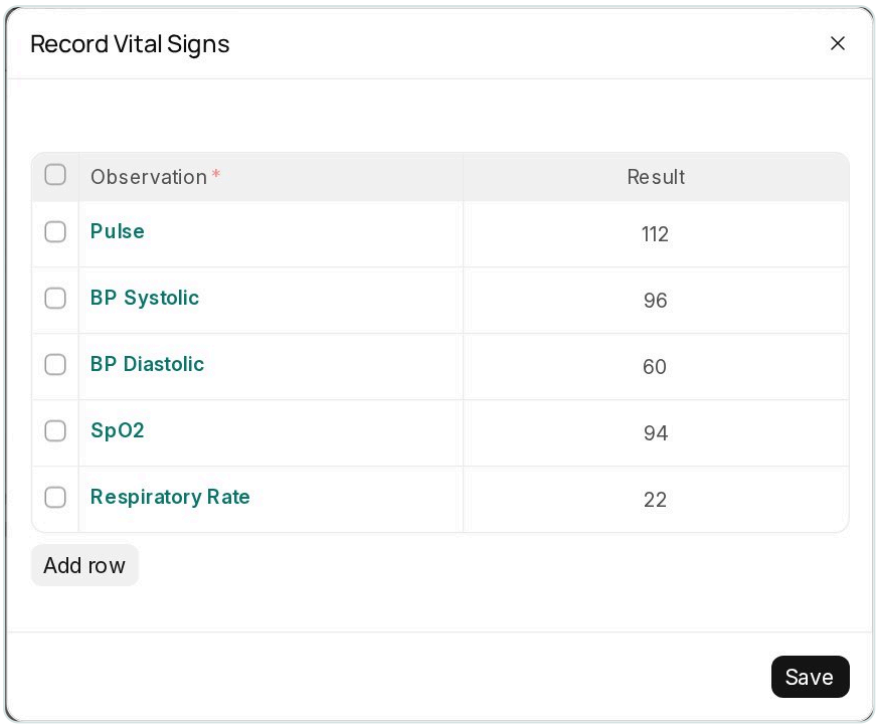
5.3 Triage

Triage sets the triage level. The level shows on the Casualty list so the most urgent patients are seen first.



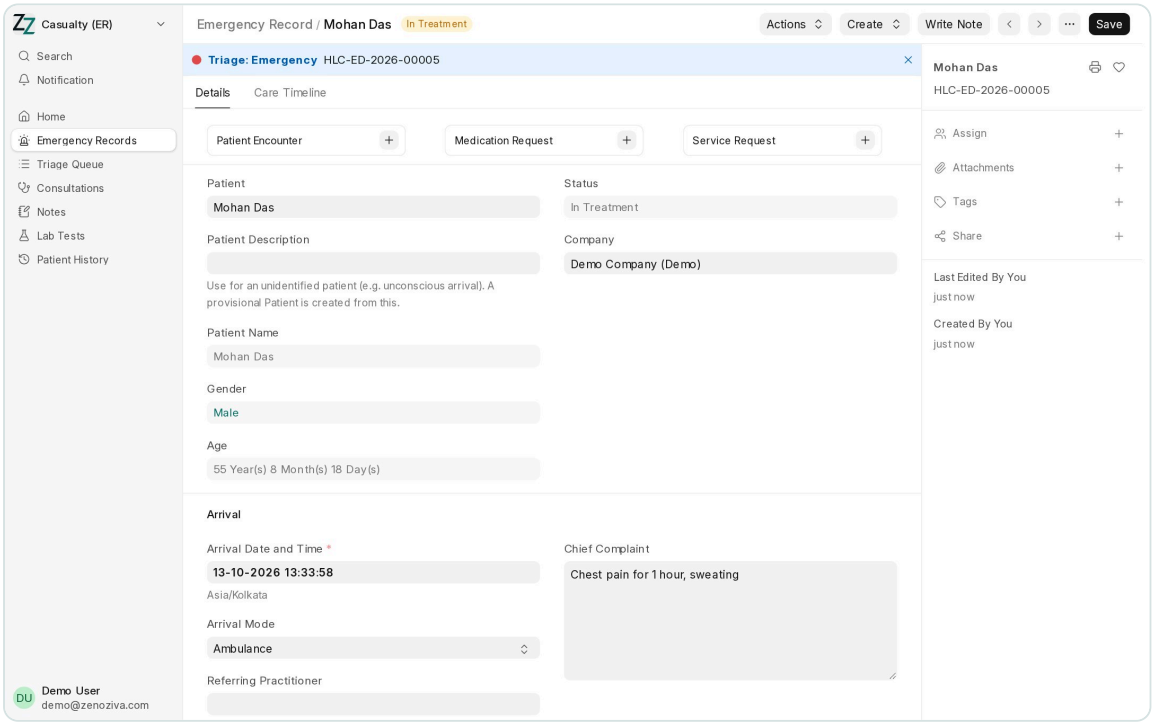
5.4 Vitals

Record Vitals adds a set of readings with the time; repeat as often as needed. **Assign Bed** places the patient on a casualty bed.



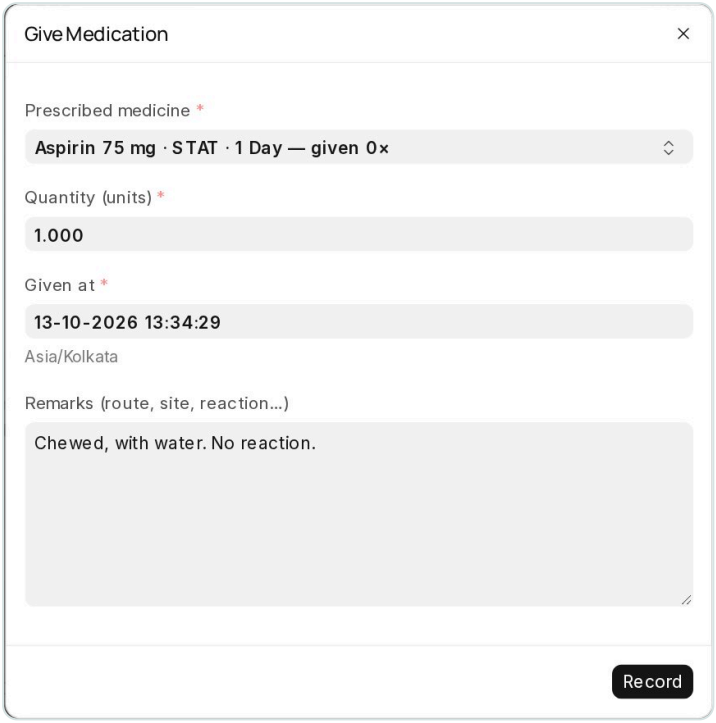
5.5 In treatment

The record now shows triage, bed and vitals. The doctor examines the patient and writes the initial assessment with **Write Note**.



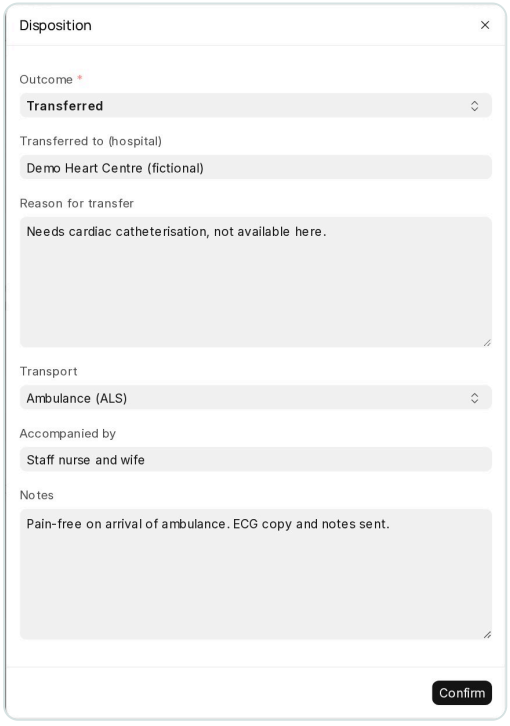
5.6 Give ordered medicines

Medicines the emergency doctor orders appear under **Give Medication**. The nurse picks the dose given and adds remarks; it is recorded as a completed nursing task, stock is issued and the dose is billed.



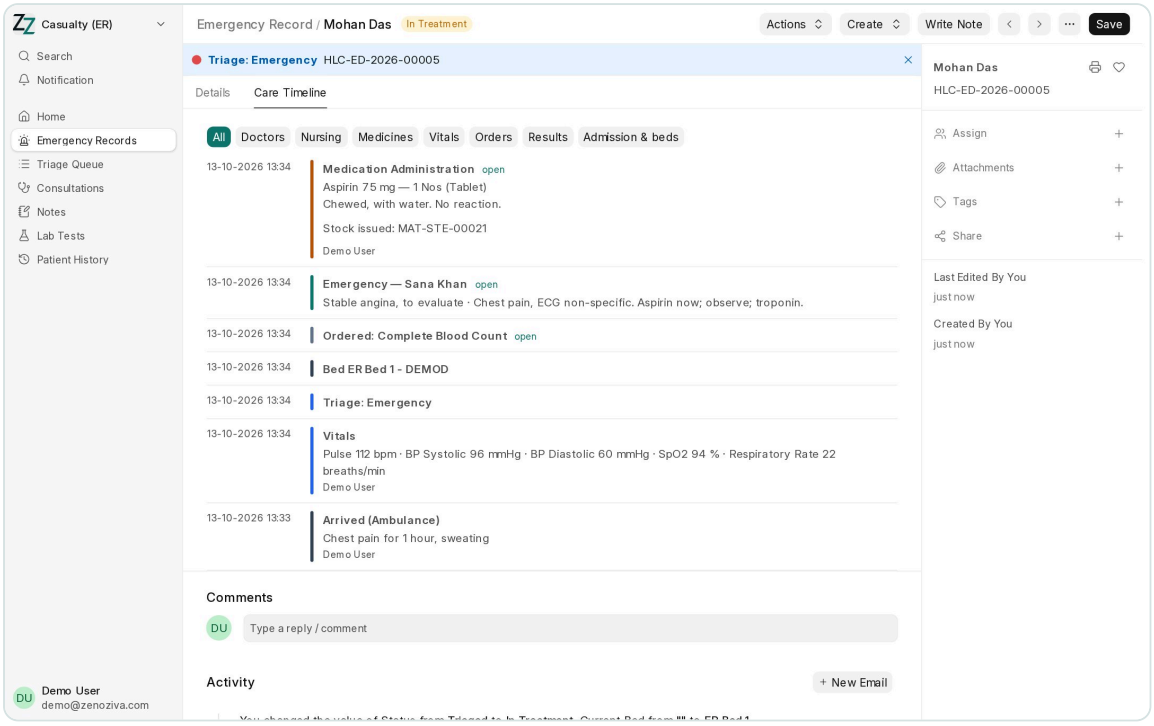
5.7 Outcome

Disposition closes the emergency visit: Admitted, Discharged, Transferred, Left Against Medical Advice or Death. A transfer asks where to, why, how and who accompanied the patient; admission opens an inpatient record.



5.8 Emergency timeline

The **Care Timeline** of the emergency record shows arrival, triage, vitals, notes, orders, medicines and the outcome, with who did each and when.



CHAPTER 6

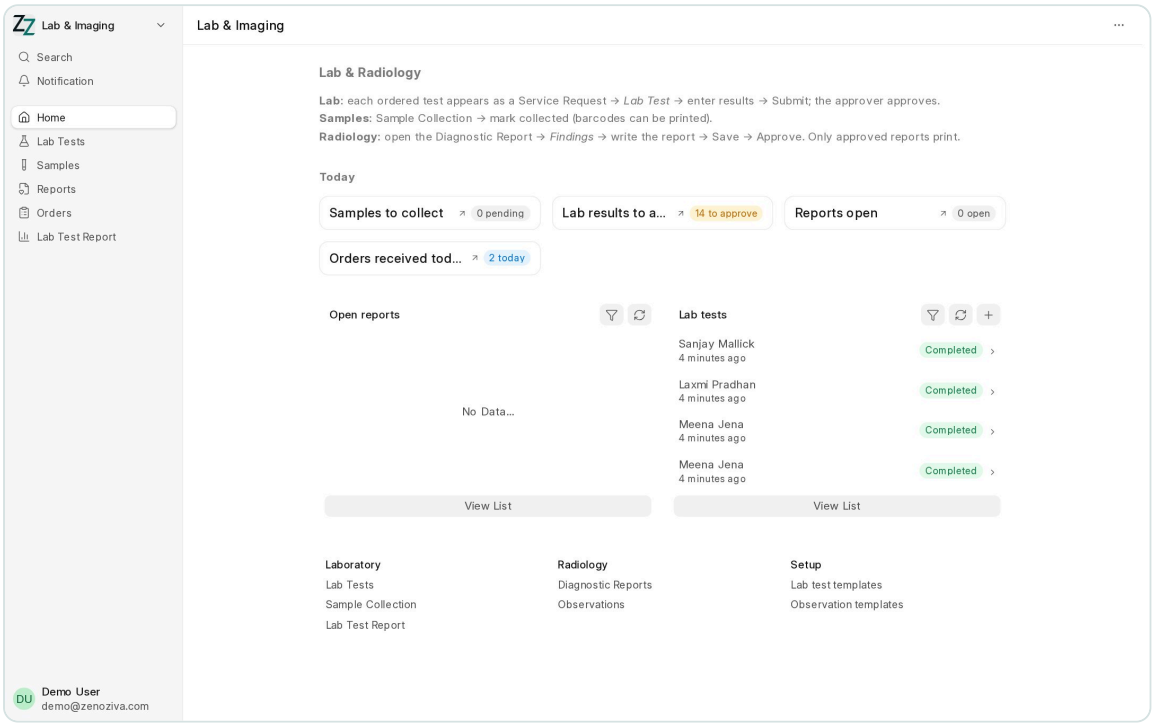
Laboratory and imaging

For: Lab technicians, radiologists

Tests ordered by doctors arrive in Lab & Imaging. Results are entered against the order, approved, and printed on the hospital's report format.

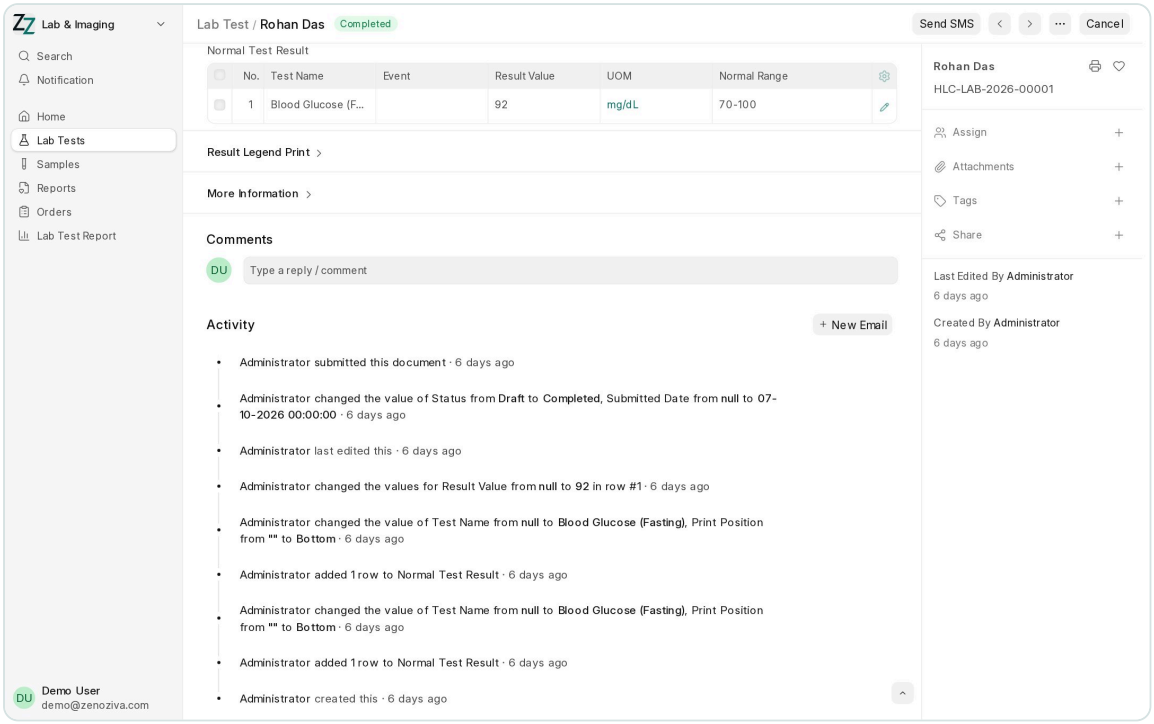
6.1 The Lab & Imaging menu

Pending samples and tests, results to approve, and imaging reports.



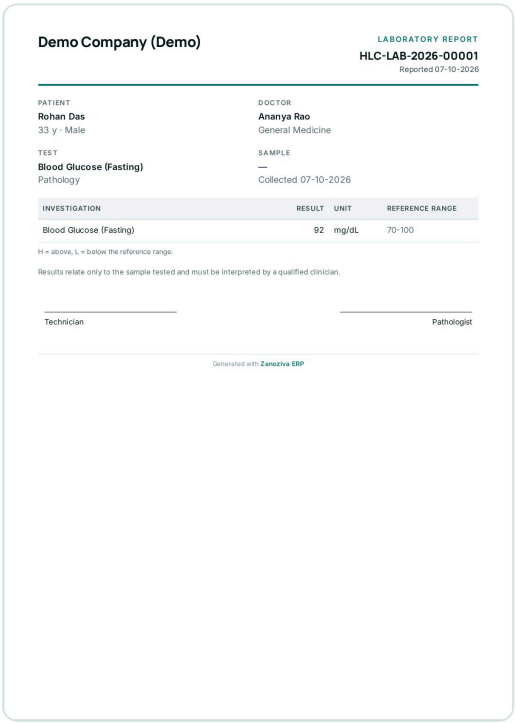
6.2 Enter results

Open the **Lab Test**, enter each result; normal ranges are shown beside the value. Submit to finalise.



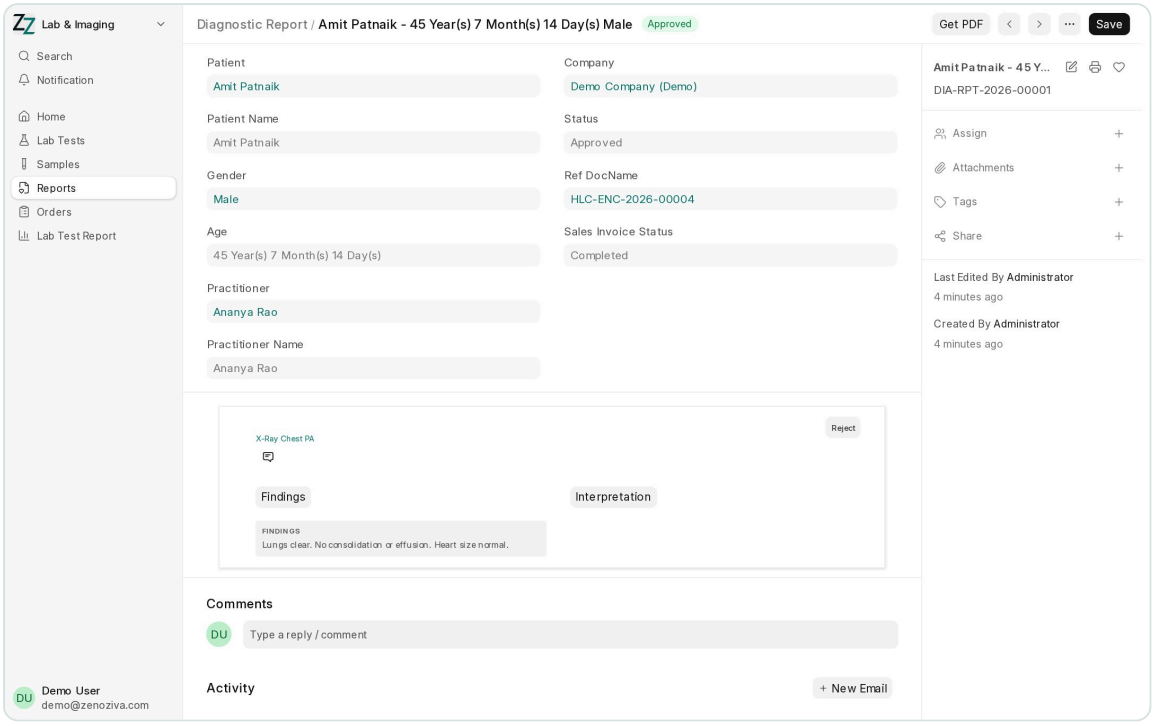
6.3 Lab report

The printed lab report carries the patient, the ordering doctor, the sample, results with reference ranges, and signature lines for the technician and pathologist.



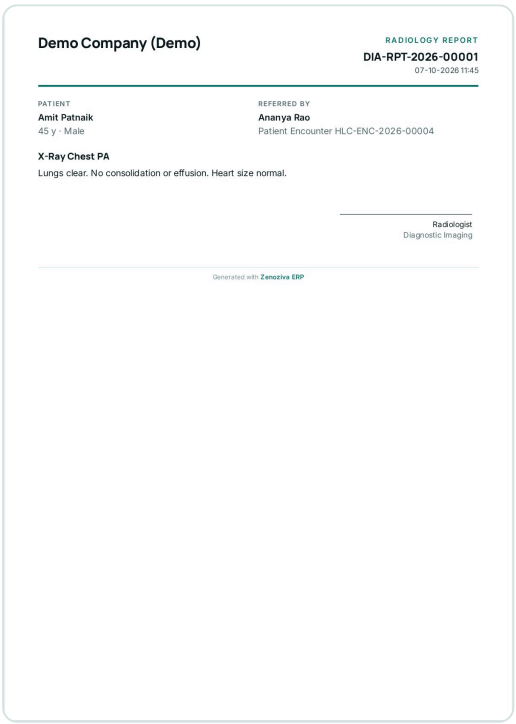
6.4 Imaging report

For X-ray, ultrasound and CT the radiologist writes the findings and impression in a **Diagnostic Report** and approves it.



6.5 Printed imaging report

The approved report prints on the hospital's format.



CHAPTER 7

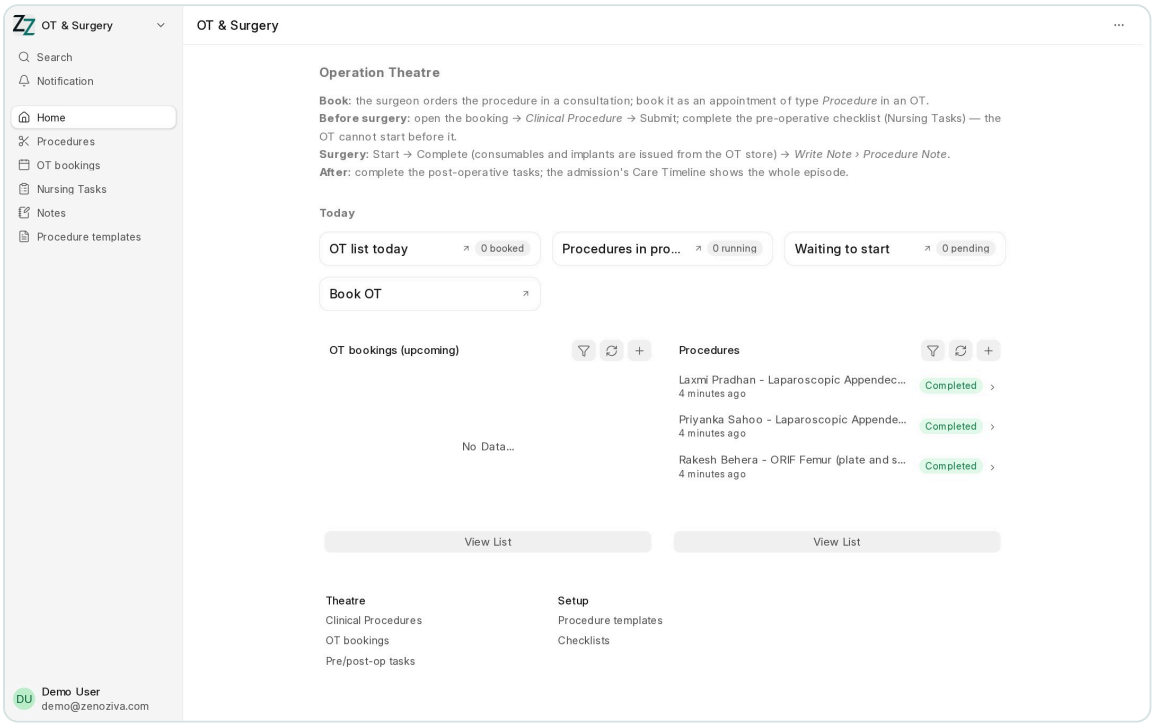
Operation theatre

For: Surgeons, OT nurses, anaesthetists

A planned operation is booked as a procedure, the OT checklist is completed, the procedure is recorded and the surgeon writes the operation note.

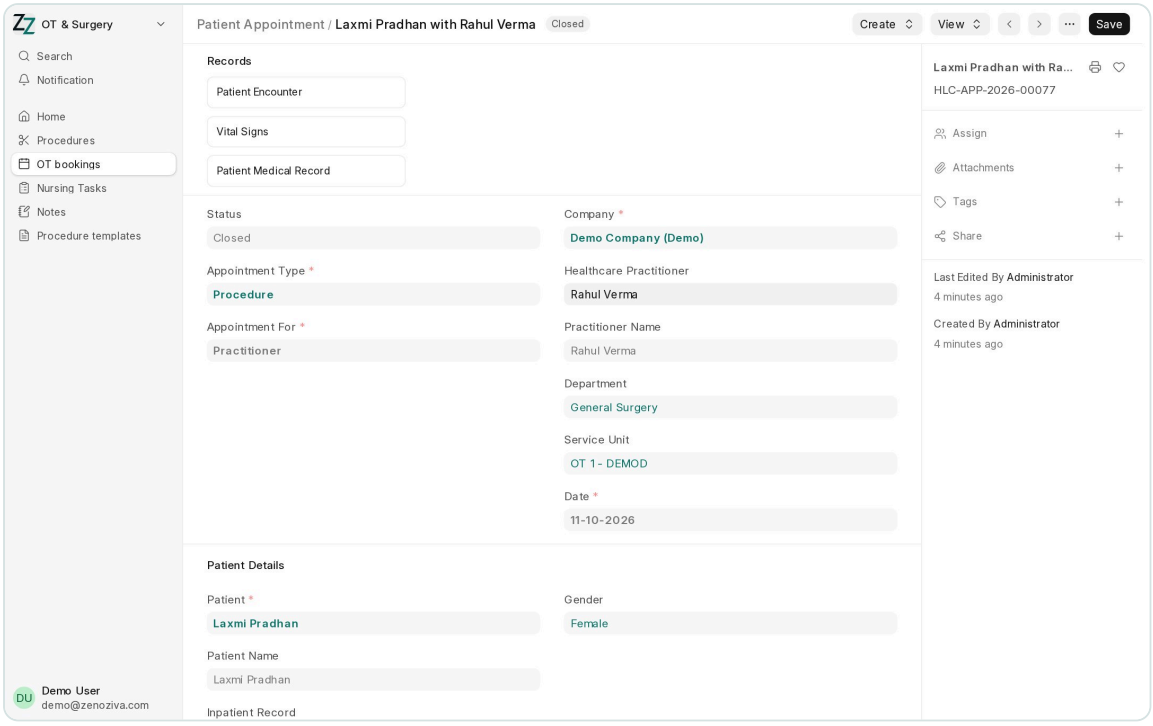
7.1 The OT & Surgery menu

OT bookings for the day, procedures in progress, checklists and procedure notes.



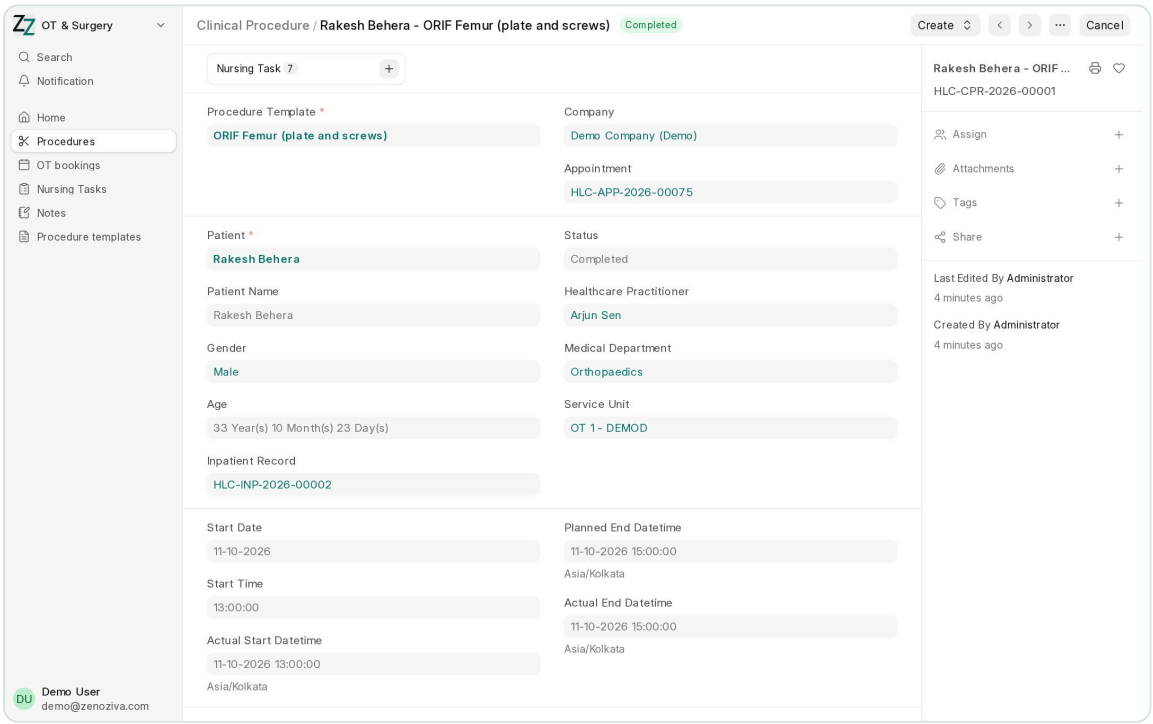
7.2 Book the theatre

A procedure appointment books the theatre, surgeon and time.



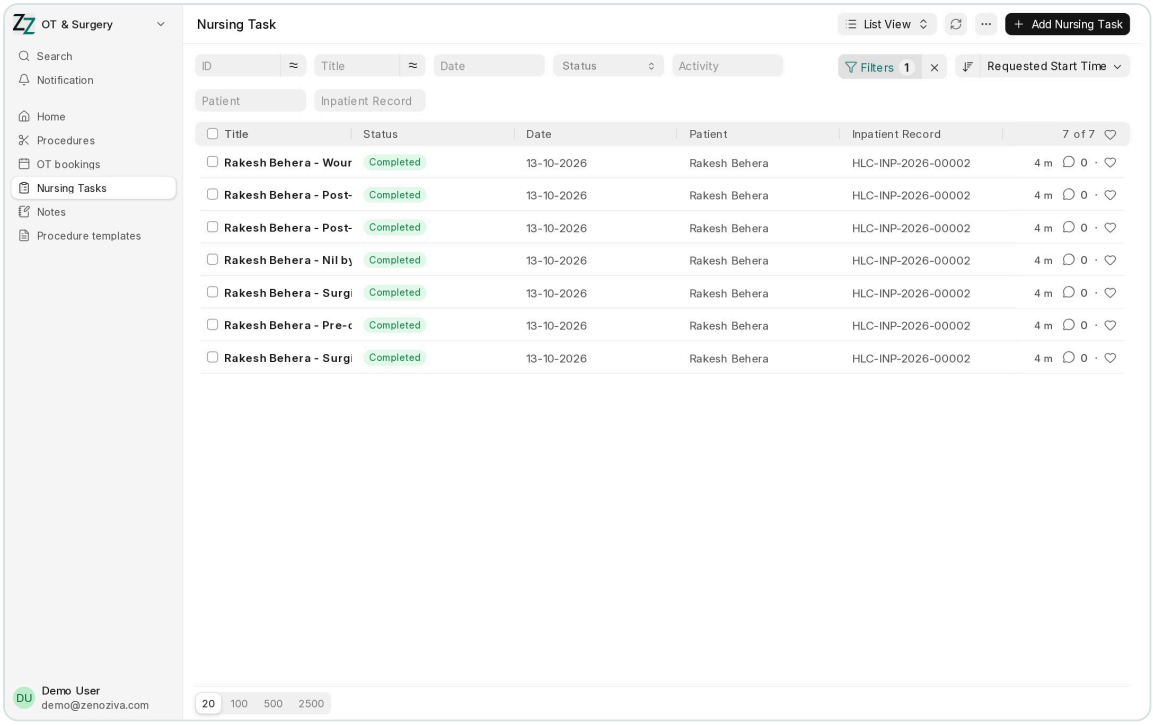
7.3 The procedure record

The **Clinical Procedure** records the operation: team, start and end times, and consumables used, which are issued from stock and billed.



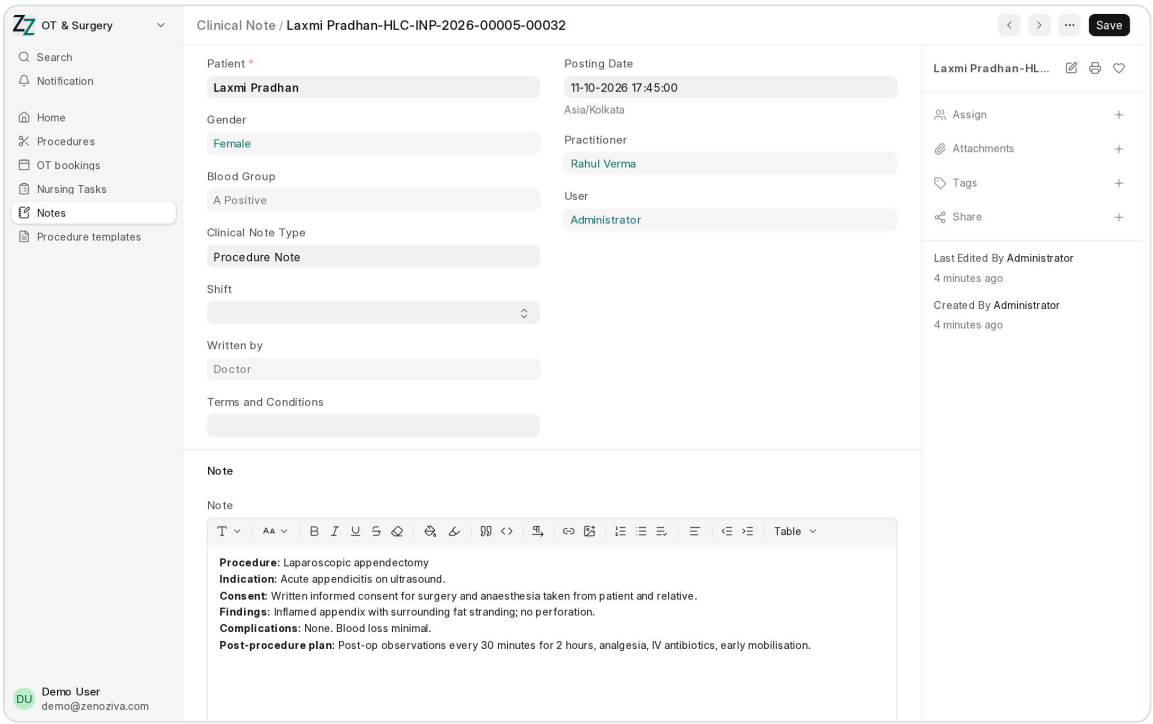
7.4 OT checklist

The pre-operative and safety checklist comes up as nursing tasks for the OT team.



7.5 Operation note

The surgeon writes the **Procedure Note** from **Write Note**: procedure, findings, steps, implants, blood loss and post-operative orders.



@@discharge@@

CHAPTER 8

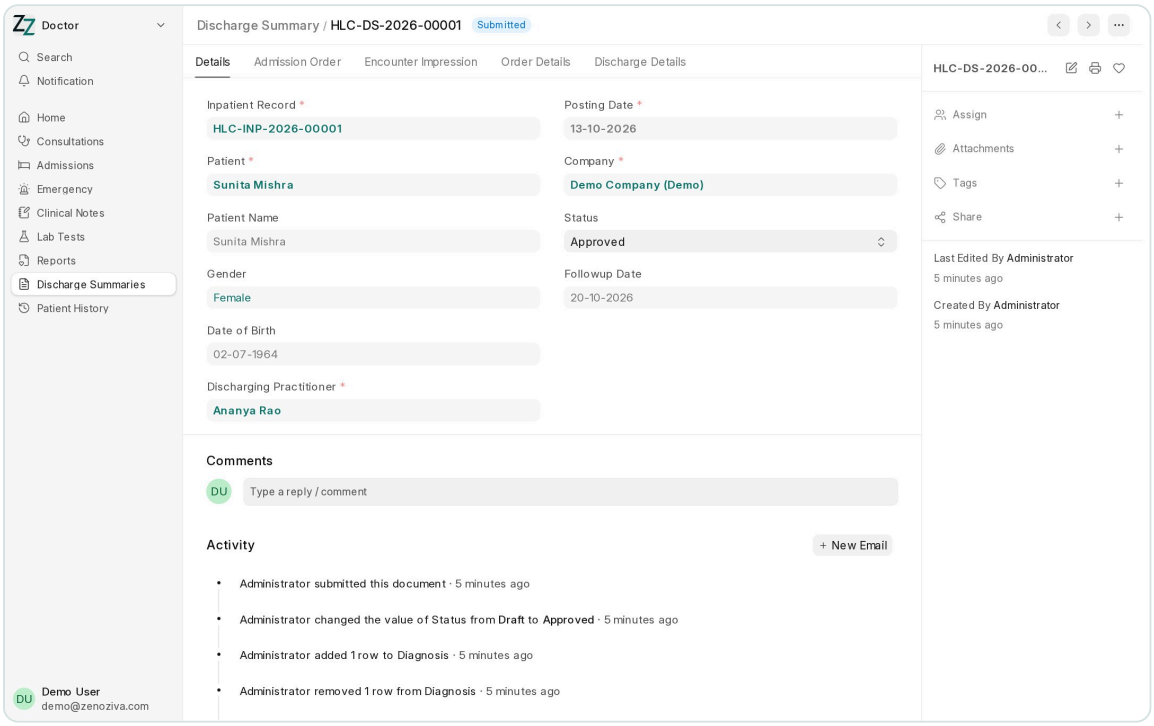
Discharge

For: Doctors, nurses, billing

When the patient is ready to go home the doctor schedules the discharge and writes the discharge summary; billing settles the account and the bed is released.

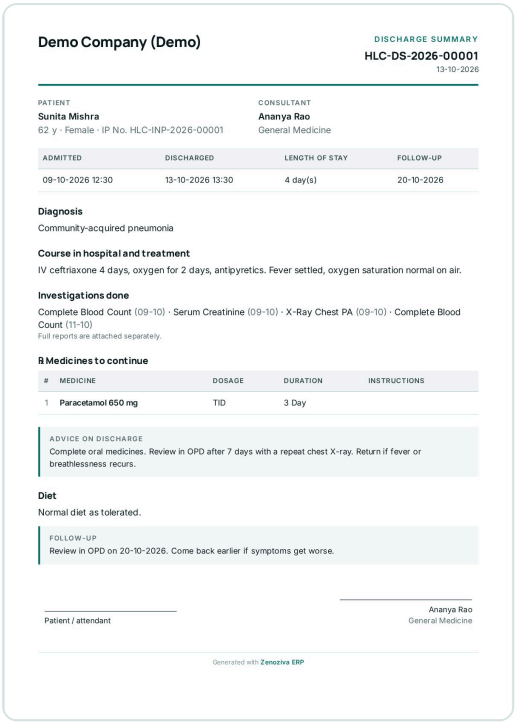
8.1 Discharge summary

The doctor fills the **Discharge Summary**: diagnosis, course in hospital, procedures, condition at discharge, medicines and follow-up advice.



8.2 Printed summary

The summary prints on the hospital's format to hand to the patient, with the type of discharge.



Demo Company (Demo)

DISCHARGE SUMMARY
HLC-DS-2026-00001
13-10-2026

PATIENT
Sunita Mishra
62 y · Female · IP No. HLC-INP-2026-00001

CONSULTANT
Ananya Rao
General Medicine

ADMITTED	DISCHARGED	LENGTH OF STAY	FOLLOW-UP
09-10-2026 12:30	13-10-2026 13:30	4 day(s)	20-10-2026

Diagnosis
Community-acquired pneumonia

Course in hospital and treatment
IV ceftriaxone 4 days, oxygen for 2 days, antipyretics. Fever settled, oxygen saturation normal on air.

Investigations done
Complete Blood Count (09-10) · Serum Creatinine (09-10) · X-Ray Chest PA (09-10) · Complete Blood Count (11-10)
Full reports are attached separately.

℞ Medicines to continue

#	MEDICINE	DOSAGE	DURATION	INSTRUCTIONS
1	Paracetamol 650 mg	TID	3 Day	

ADVICE ON DISCHARGE
Complete oral medicines. Review in OPD after 7 days with a repeat chest X-ray. Return if fever or breathlessness recurs.

Diet
Normal diet as tolerated.

FOLLOW-UP
Review in OPD on 20-10-2026. Come back earlier if symptoms get worse.

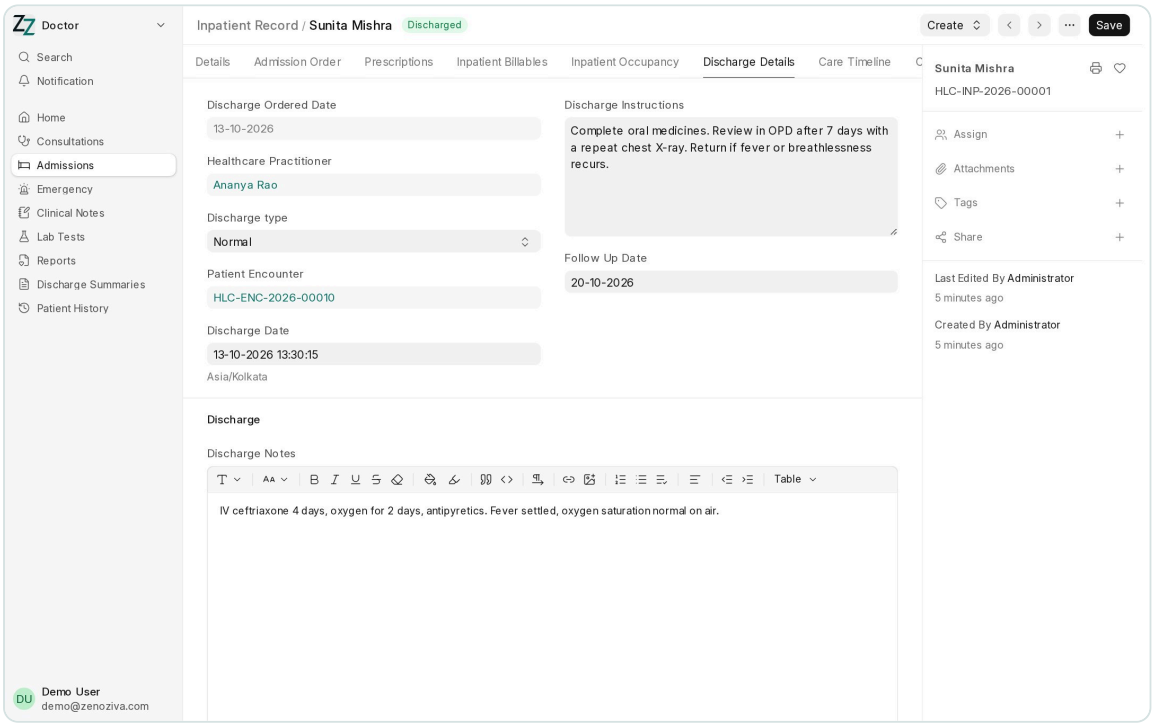
Patient / attendant

Ananya Rao
General Medicine

Generated with Zenoziva ERP

8.3 Discharge complete

Once the bill is settled, **Discharge** on the inpatient record releases the bed. Discharge type (normal, on request, against medical advice, referred, death) is recorded with its details.



@@billing@@

CHAPTER 9

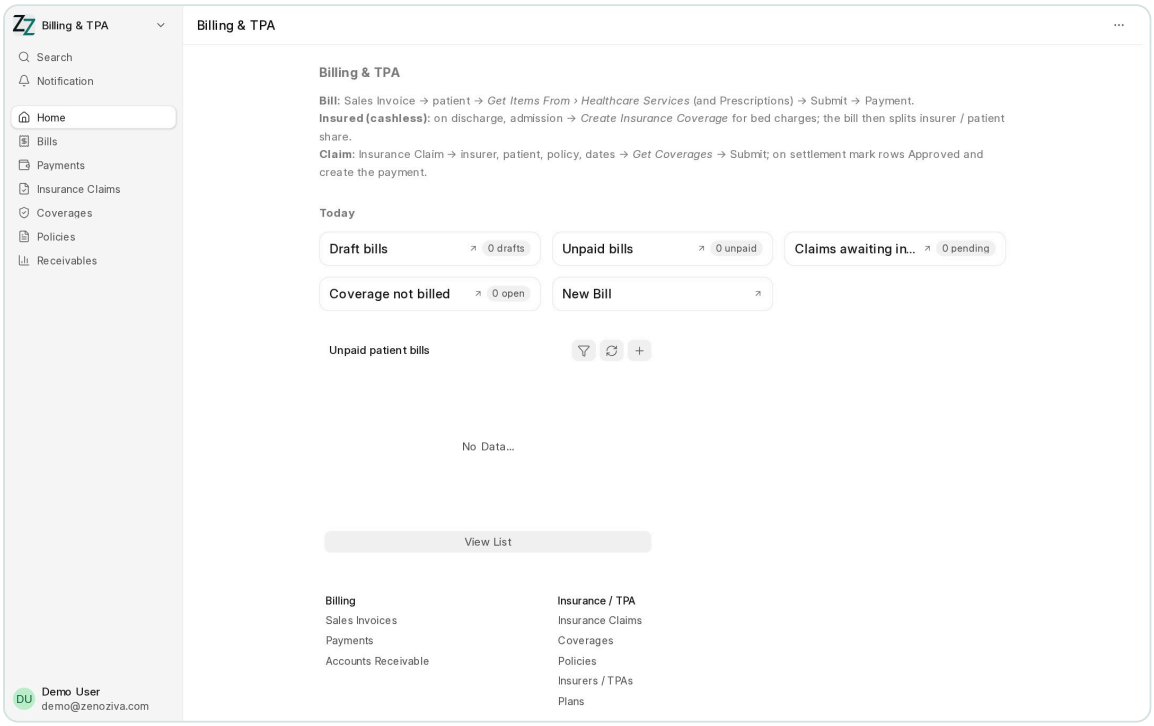
Billing, insurance and TPA

For: Billing, accounts, TPA desk

Charges collect on the patient as care is given: consultations, bed days, medicines, tests and procedures. Billing pulls them into one invoice; for insured patients the insurer's share is split out and claimed.

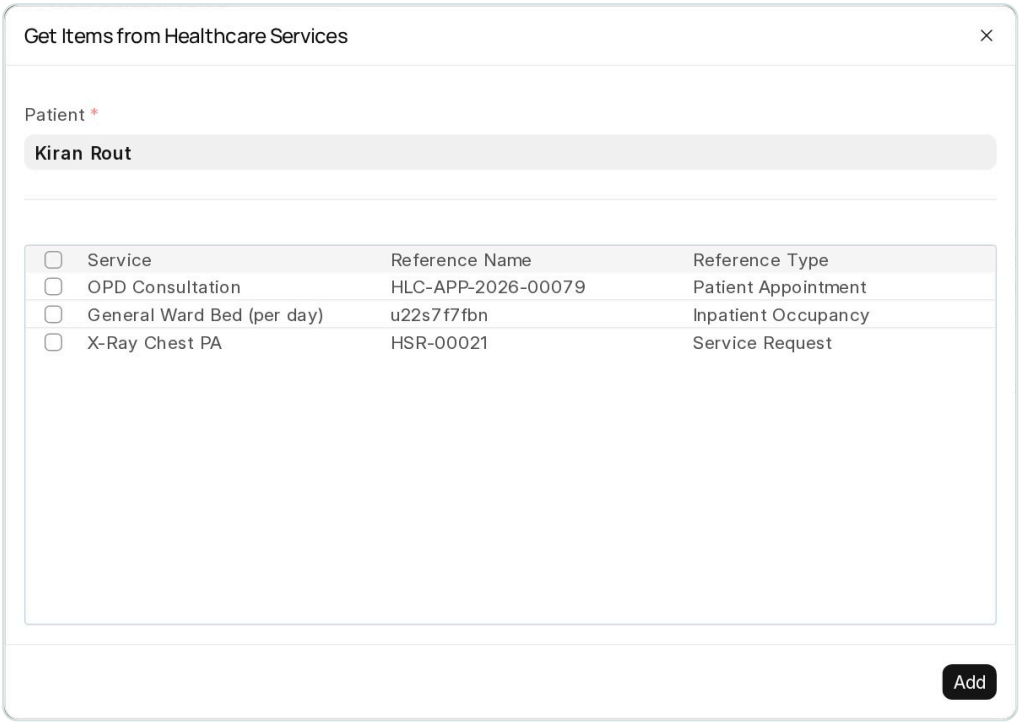
9.1 The Billing & TPA menu

Invoices, payments, unbilled services, insurance policies, coverage approvals and claims.



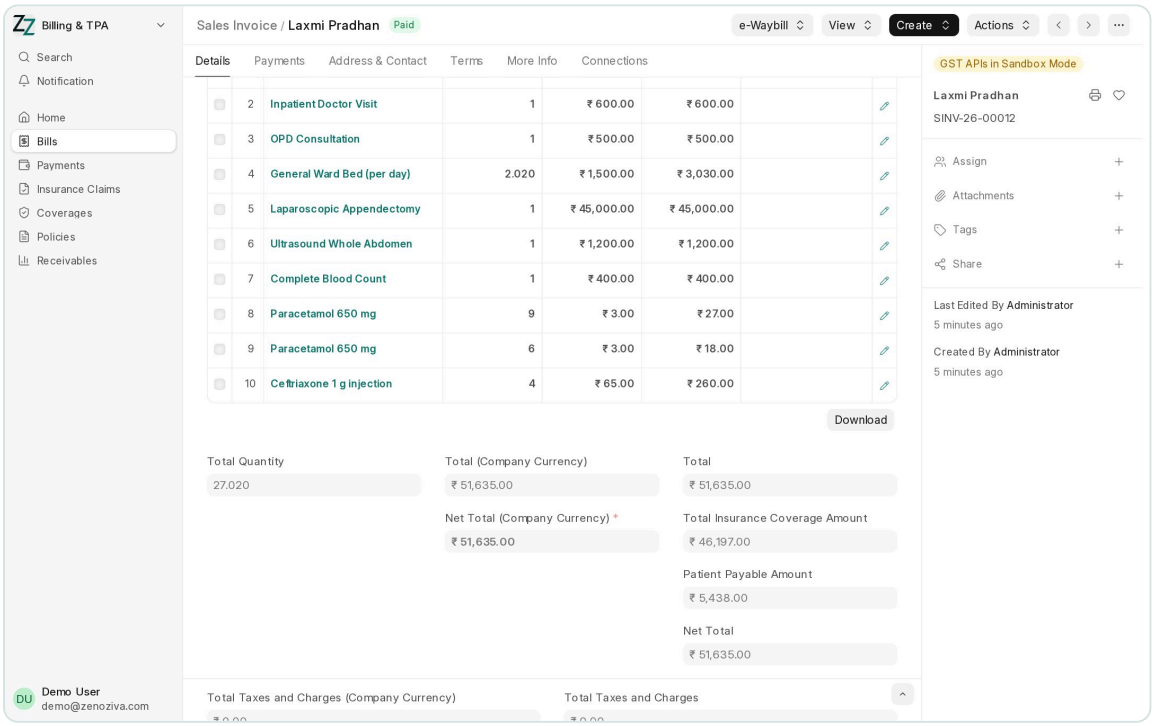
9.2 Collect unbilled services

New **Sales Invoice** for the patient, then **Get Items From** › **Healthcare Services** lists everything not yet billed. Tick what to bill.



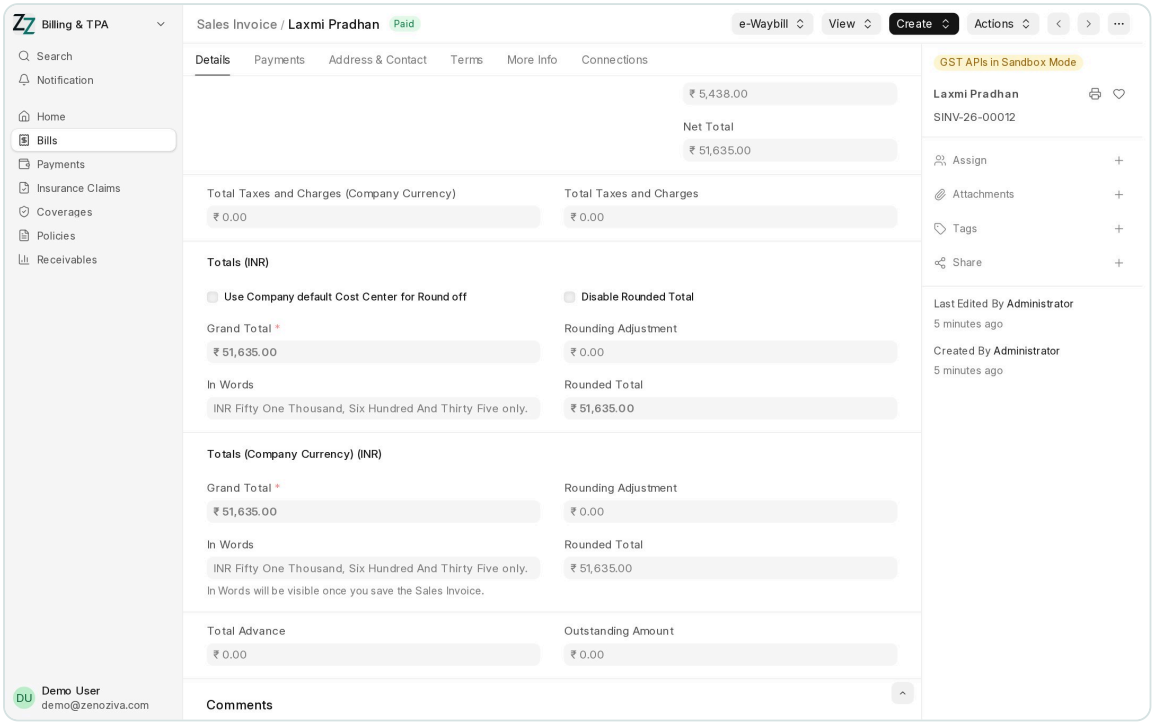
9.3 The invoice

Each line shows the service, quantity and rate from the hospital's tariff.



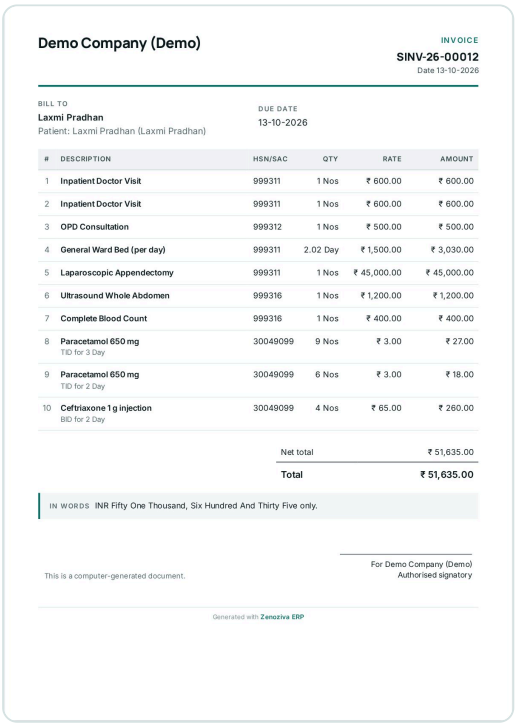
9.4 Insurer’s share

For an insured patient the covered amount is shown separately: the patient pays their share and the rest is due from the insurer.



9.5 Printed bill

The bill prints with the patient's and insurer's shares.



Demo Company (Demo)

INVOICE
SINV-26-00012
Date 13-10-2026

BILL TO
Laxmi Pradhan
Patient: Laxmi Pradhan (Laxmi Pradhan)

DUE DATE
13-10-2026

#	DESCRIPTION	HSN/SAC	QTY	RATE	AMOUNT
1	Inpatient Doctor Visit	999311	1 Nos	₹ 600.00	₹ 600.00
2	Inpatient Doctor Visit	999311	1 Nos	₹ 600.00	₹ 600.00
3	OPD Consultation	999312	1 Nos	₹ 500.00	₹ 500.00
4	General Ward Bed (per day)	999311	2.02 Day	₹ 1,500.00	₹ 3,030.00
5	Laparoscopic Appendectomy	999311	1 Nos	₹ 45,000.00	₹ 45,000.00
6	Ultrasound Whole Abdomen	999316	1 Nos	₹ 1,200.00	₹ 1,200.00
7	Complete Blood Count	999316	1 Nos	₹ 400.00	₹ 400.00
8	Paracetamol 650 mg TID for 3 Day	30049099	9 Nos	₹ 3.00	₹ 27.00
9	Paracetamol 650 mg TID for 2 Day	30049099	6 Nos	₹ 3.00	₹ 18.00
10	Ceftriaxone 1 g injection BID for 2 Day	30049099	4 Nos	₹ 65.00	₹ 260.00

Net total ₹ 51,635.00
Total ₹ 51,635.00

IN WORDS INR Fifty One Thousand, Six Hundred And Thirty Five only.

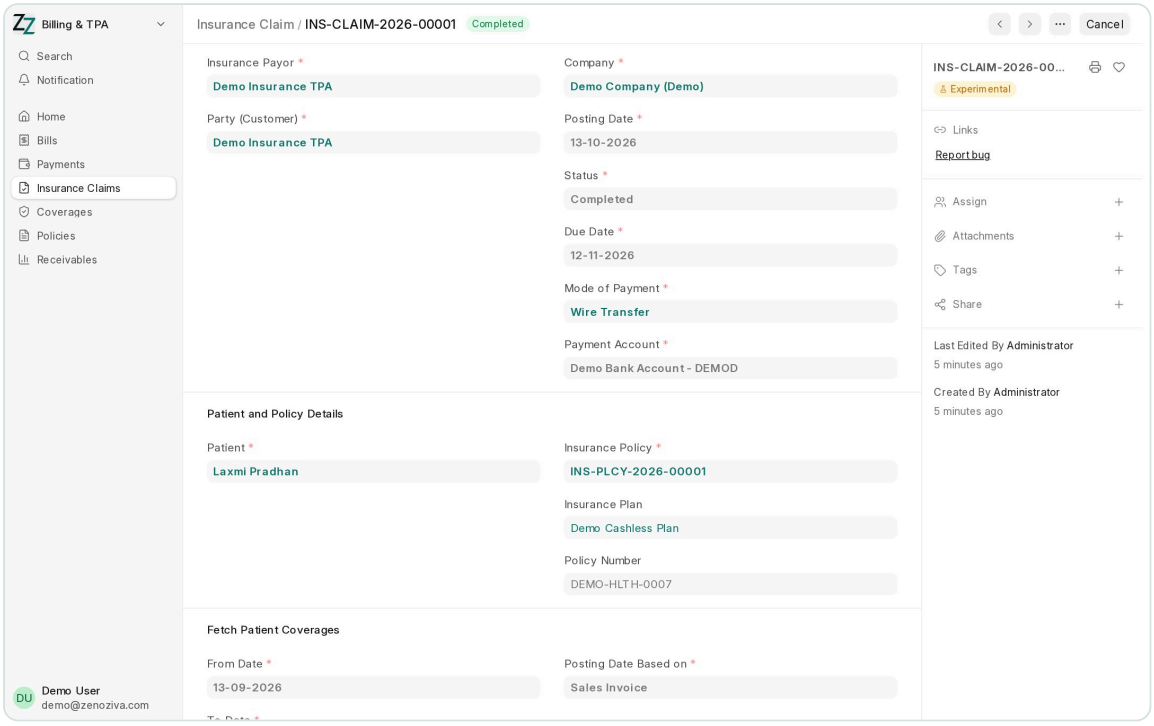
This is a computer-generated document.

For Demo Company (Demo)
Authorised signatory

Generated with Zenoziva ERP

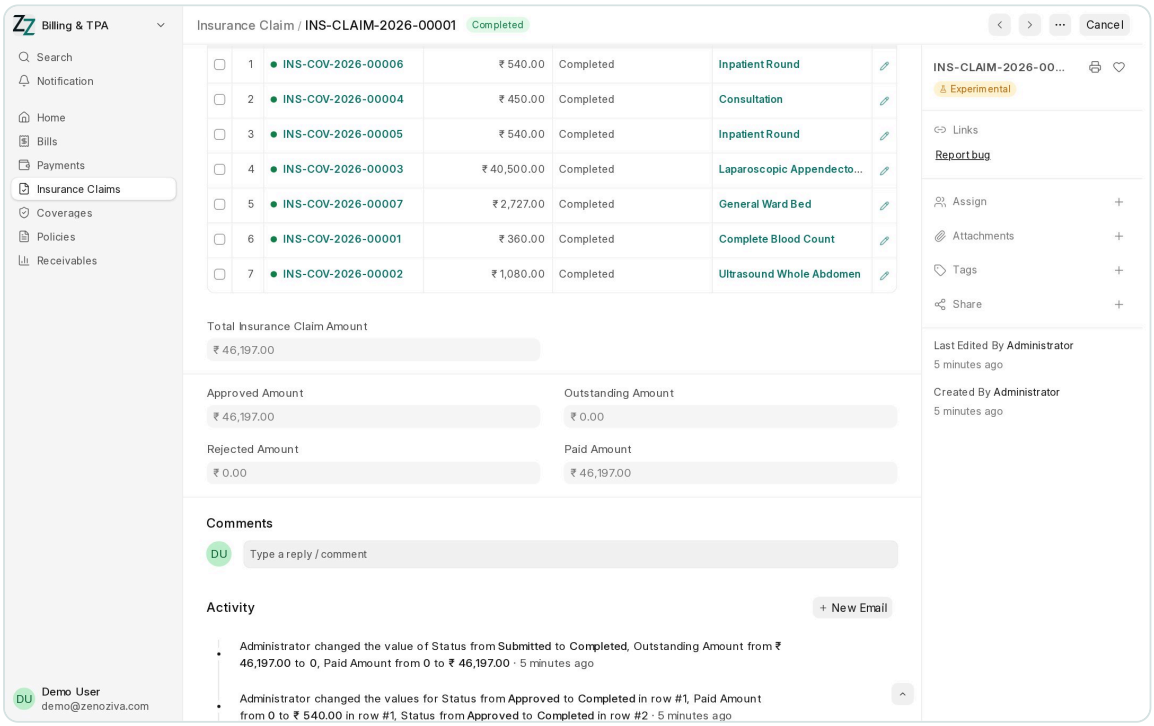
9.6 Insurance claim

An **Insurance Claim** gathers the covered amounts for the insurer, tracks approval and records the settlement when it is received.



9.7 Claim lines

Each covered service on the claim, with the amount claimed and approved.



CHAPTER 10

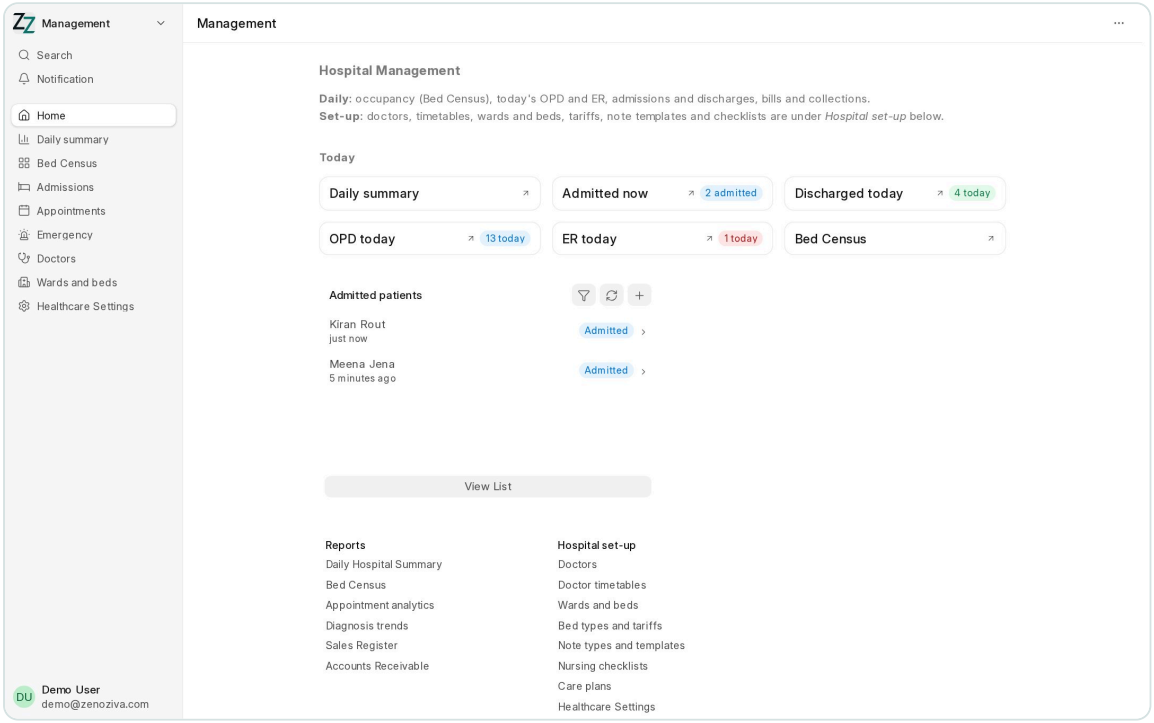
Management reports

For: Management, medical superintendent

Management sees the whole hospital: patients, beds, clinical work and money.

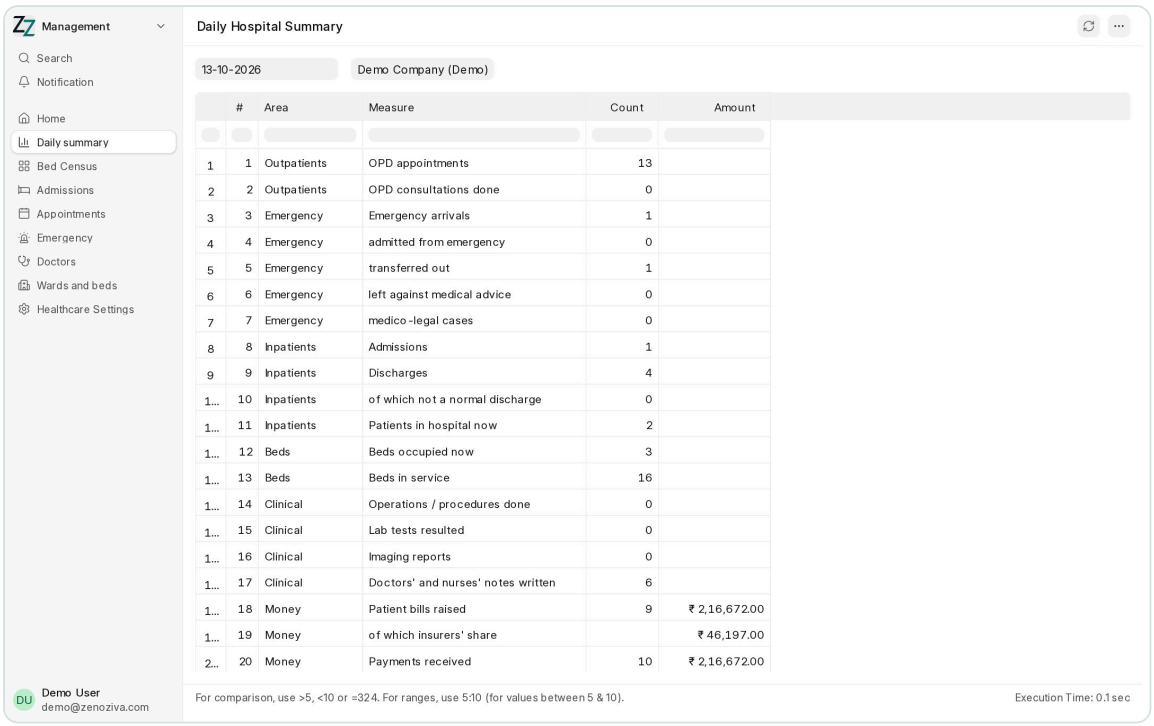
10.1 The Management menu

Today's numbers at the top, then reports (daily summary, bed census, appointment analytics, diagnosis trends, sales register, receivables) and the hospital set-up screens.



10.2 Daily hospital summary

One page for any date: OPD, emergency arrivals and outcomes, admissions and discharges, beds occupied, operations, tests, notes written, bills raised, insurers' share, payments received and unpaid bills.



@@phone@@

CHAPTER 11

On the phone: Zenoziva Care and Zenoziva HR

For: Doctors, nurses, every employee

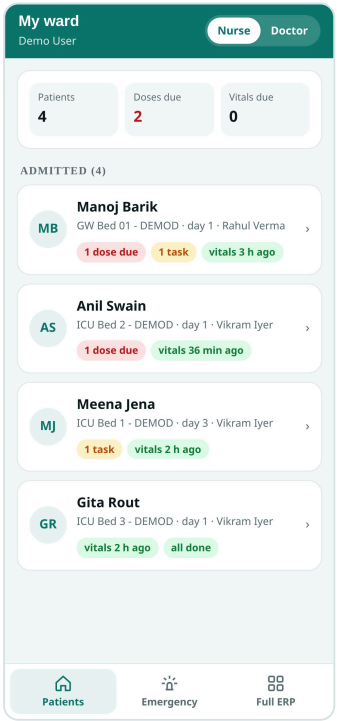
Two phone apps work with the same logins and permissions as the desk. **Zenoziva Care** (your ERP address followed by /care) is for doctors and nurses at the bedside; **Zenoziva HR** (/hrms) is for every employee. Both install from the browser; no app store is needed. The full ERP installs to the home screen as well.

11.1 Install

Open the address on the phone and sign in. On Android: menu › **Install app**; on iPhone: Share › **Add to Home Screen**. The app then opens full-screen from its own icon.

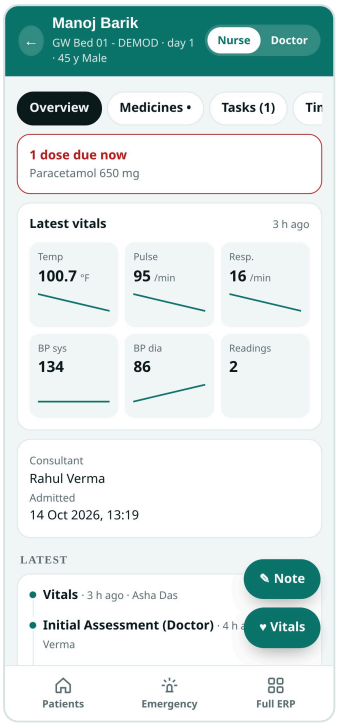
11.2 My ward (nurses)

Every admitted patient with bed, day of stay and consultant, flagged with doses due, vitals overdue (none in the last 6 hours) and open tasks. Totals at the top. **Emergency** lists the patients in casualty now.



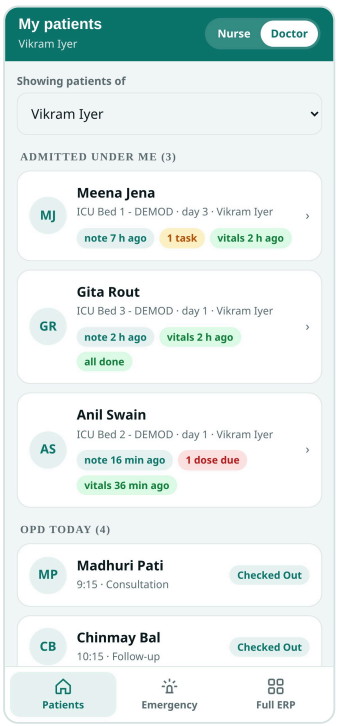
11.3 A patient

Overview: latest vitals with trend lines, consultant and admission. Medicines: today's doses; Give records the dose and issues it from the ward store, as on the desk. Tasks: mark nursing tasks Done. Timeline: the whole admission. Vitals and Note add a reading or a note (shift note for nurses, progress note for doctors, from your hospital's templates).



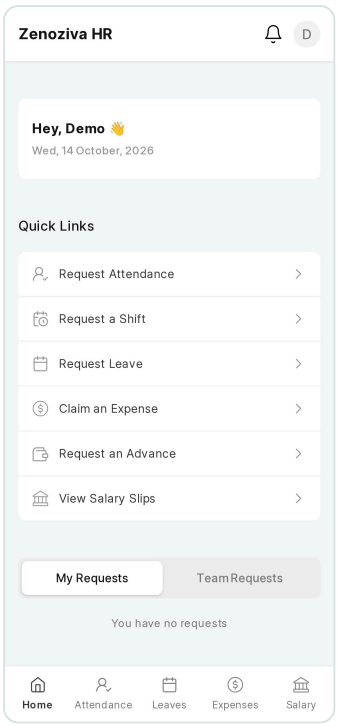
11.4 My patients (doctors)

Switch to Doctor at the top: the doctor's admitted patients with their latest note and vitals, today's OPD and anyone in emergency. Administrators can pick any doctor.



11.5 Zenoziva HR

Each employee checks in and out, requests leave, attendance corrections and shifts, claims expenses and advances, and opens their salary slips. Managers approve their team's requests under **Team Requests**.



CHAPTER 12

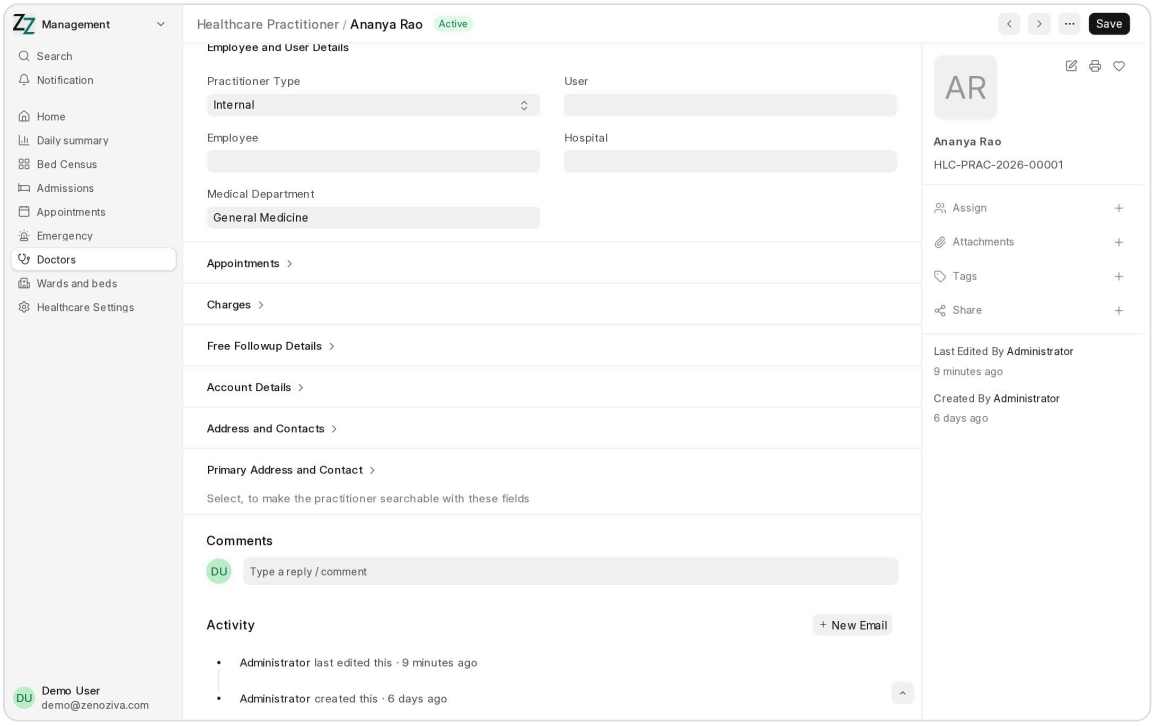
Setting up your hospital

For: Hospital administrator

Zenoziva sets up the module with your hospital's departments, doctors, wards, tariffs and forms. The administrator can change most of it later, from Management › Hospital set-up.

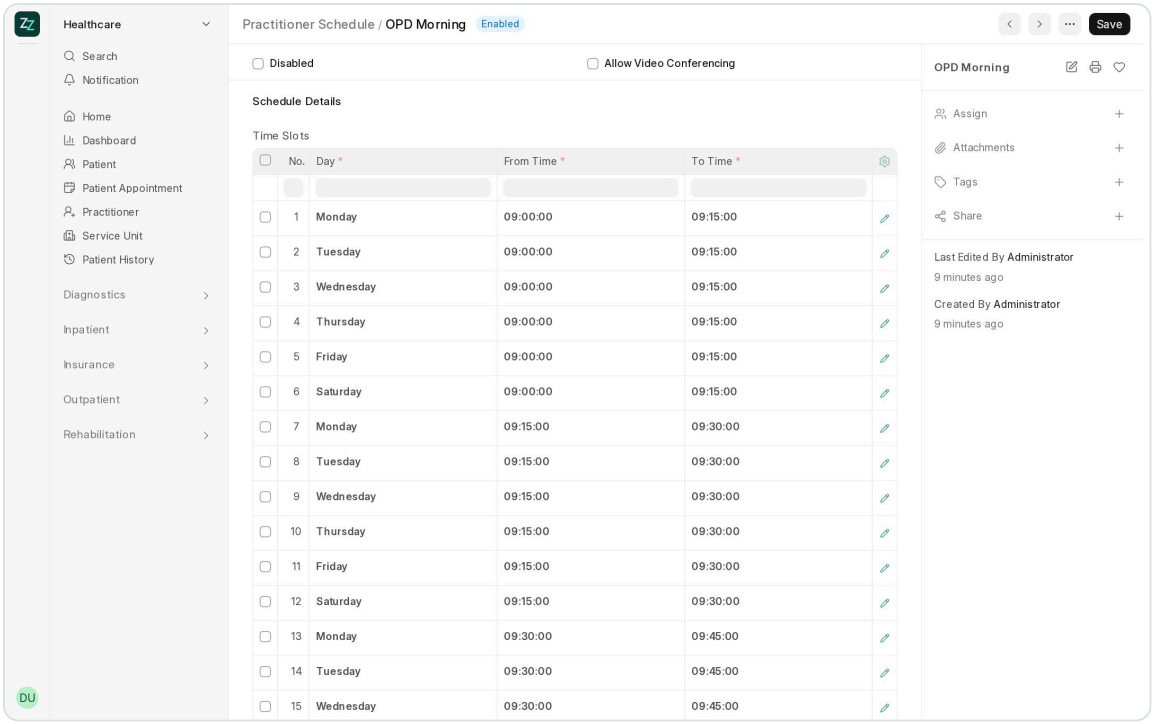
12.1 Doctors

Each doctor has a **Healthcare Practitioner** record: department, consultation fees and timetable. Set **User** to the doctor's login so My patients shows their own patients.



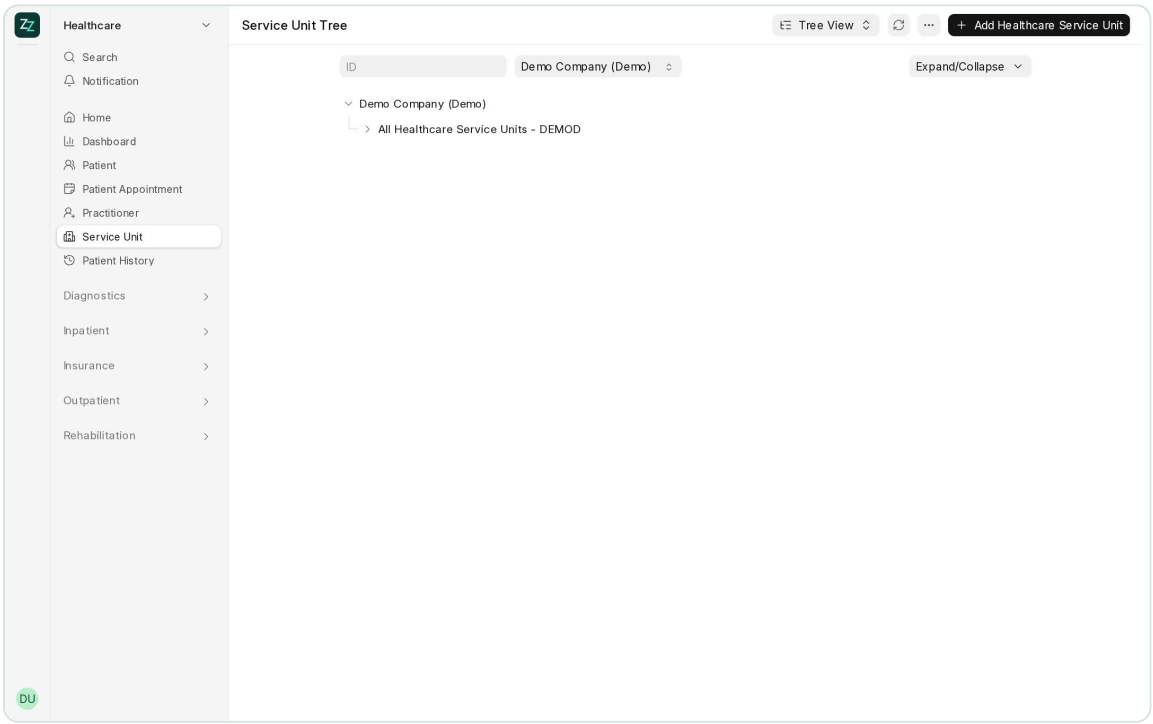
12.2 Doctor timetables

A **Practitioner Schedule** sets OPD days, times and slot length. Appointments are offered only in these slots.



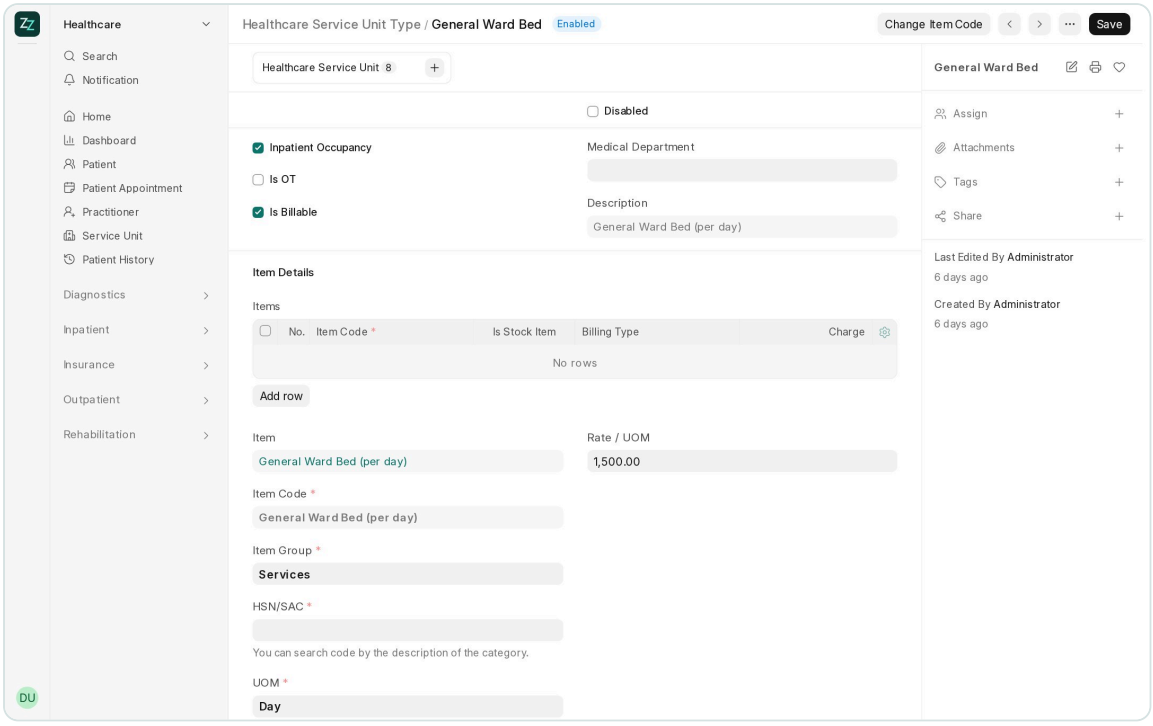
12.3 Wards and beds

Healthcare Service Unit is a tree: hospital › floor › ward › bed. Add, rename or close beds here.



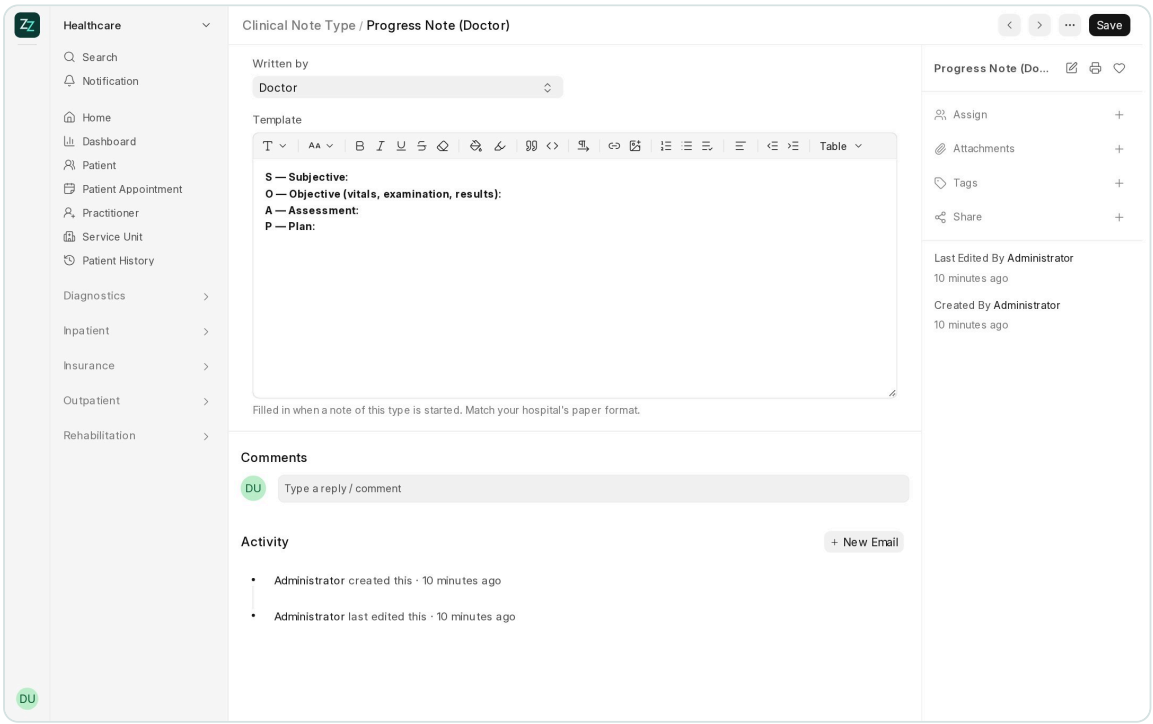
12.4 Bed types and tariffs

Each bed type (general ward, private room, ICU) has its daily charge and billing item.



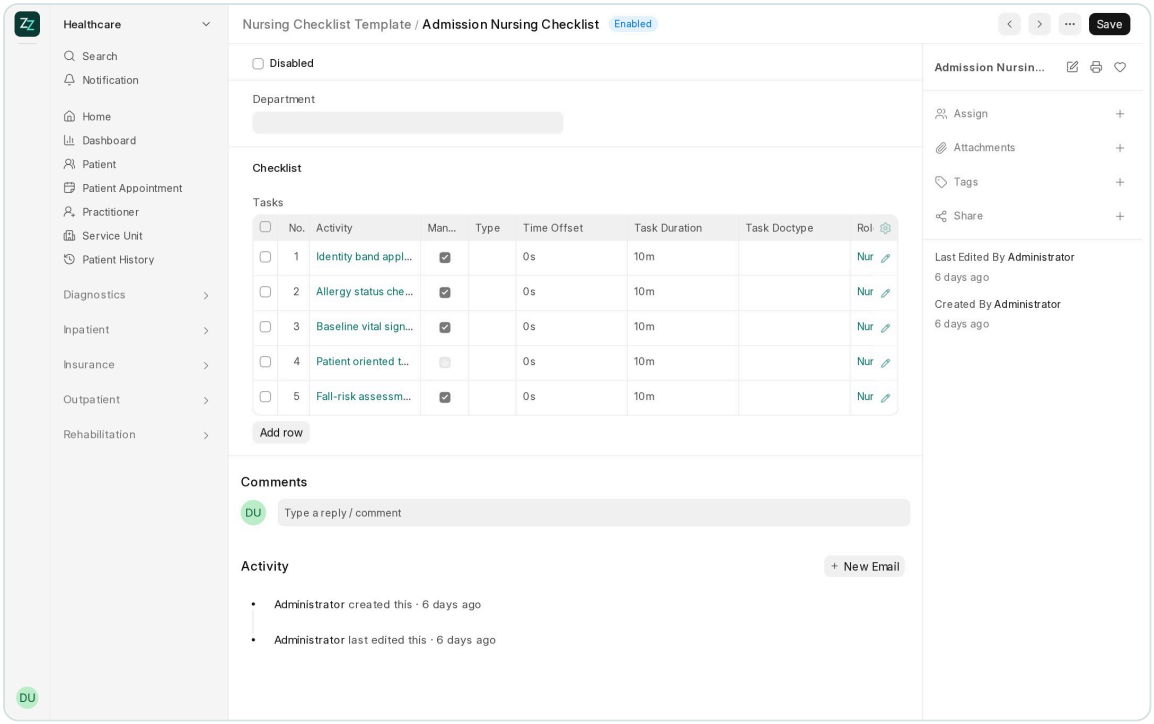
12.5 Note templates

Clinical Note Type holds each kind of note, who writes it (doctor or nurse) and its template. Change the headings to match your hospital's forms.



12.6 Nursing checklists

Nursing Checklist Template lists the tasks created on admission, before surgery and at discharge.



12.7 Logins and roles

Each staff login gets roles (Physician, Nursing User, Front Desk, Pharmacist, Laboratory User, Accounts User and so on). Roles decide the menus and records they can open. Logins are managed by your system administrator under Users.

Appendix: roles and glossary

Roles and the menus they open

Role	Menus	Work
Front Desk	Front Desk, Billing & TPA	Registration, appointments, insurance details, OPD bills
Physician	Doctor, Casualty (ER), OT & Surgery	Consultations, orders, notes, admission and discharge
Nursing User	Nursing, Casualty (ER), OT & Surgery	Vitals, medicine rounds, checklists, nursing notes
Laboratory User	Lab & Imaging	Samples, results, imaging reports
Pharmacist	Pharmacy	Dispensing and stock of medicines
Accounts User	Billing & TPA	Invoices, payments, claims
Healthcare Administrator	All hospital menus and Management	Set-up and reports

Glossary

OPD	Outpatient department: patients seen without admission.
IPD / inpatient	A patient admitted to a bed.
Encounter	One consultation: the doctor's findings, diagnosis and orders.
Inpatient Record	The file for one admission, from admission to discharge.
Emergency Record	The file for one visit to casualty, from arrival to outcome.
Triage	Sorting emergency patients by how urgently they need care.
Disposition	The outcome of an emergency visit: admitted, discharged, transferred, left or died.
MLC	Medico-legal case: injuries or cases that must be reported to the police.
LAMA	Left against medical advice.
TPA	Third-party administrator that handles insurance claims for the insurer.
Care Timeline	The tab listing every note, vital, medicine, task and test in an admission or emergency visit.