

ADMISSION SHEET

Registration Details :



Admission No : IP25-00020684      Admit Date : 28-May-2026      Admit Time : 09:48 AM      UHID : CUV-00080347

Patient Details :

Patient Name : Baby KOTHAMASU SRISIYA      Age : 7 Y 0 M 26 D  
Guardian : Mr ANIL      DOB : 02-05-2019  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : Manikonda Hyderabad INDIA 500089      Phone No : 8885912728  
E-mail : na123@gmail.com

Admission Details :

Bed Type : MICU      Bed No : PRE-OP-01      Ward Name : 4F -OT  
Room No : PRE-OP-01      Admission Type : First Visit

Contact Details :

Name : Mr ANIL      Relationship : D/O  
Contact Address : Manikonda Hyderabad INDIA 500089      Phone No :

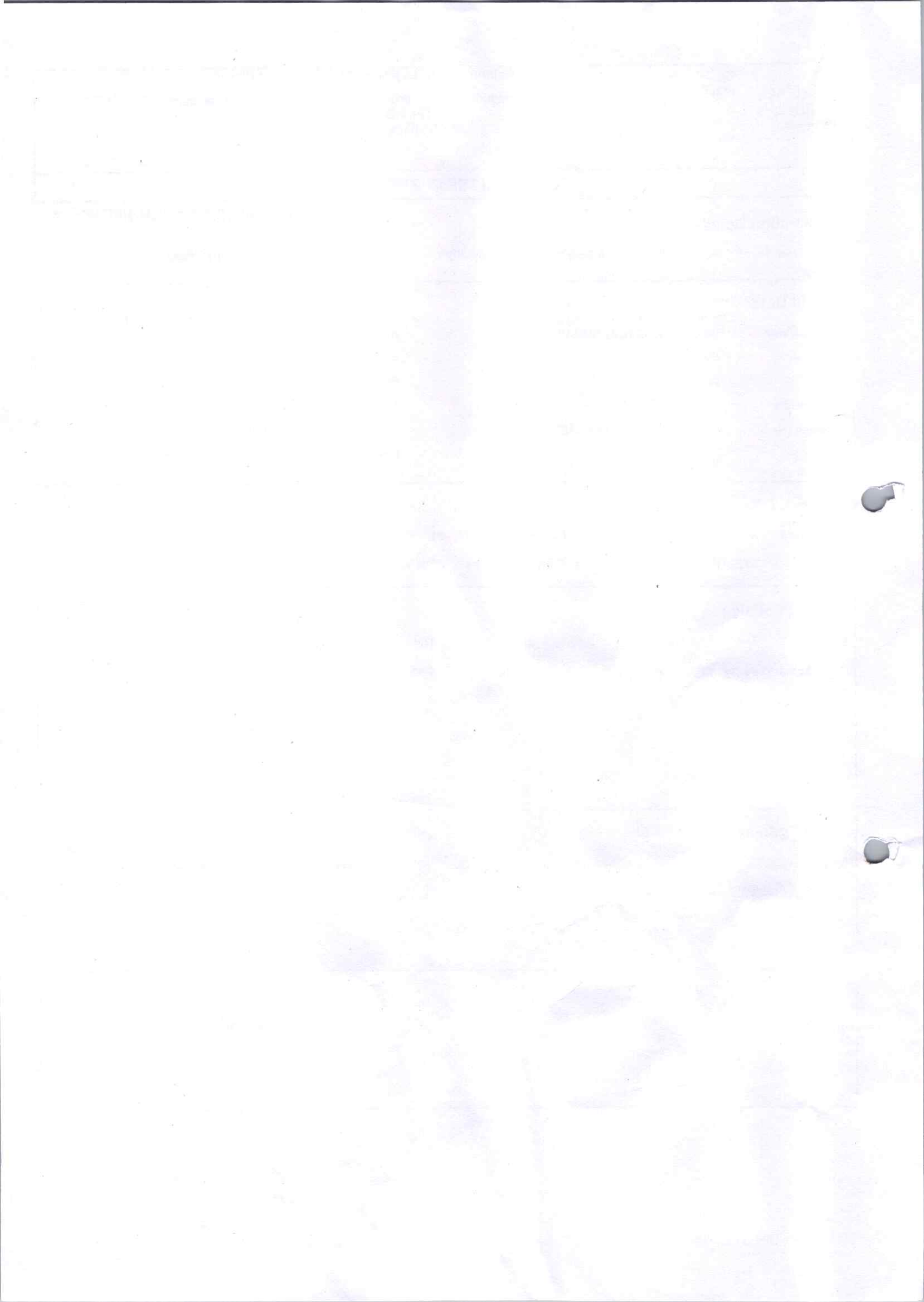
  
Signature

Doctor Details :

Doctor Name : Dr. MANCHUKONDA SANTHOSH KUMAR      Specialisation : EAR NOSE AND THROAT  
Referral Doctor : Self      Phone No :  
Co-Consultant : Dr. Y ARVIND

Payment Details :

Payment Mode : Cash      Deposit Amount : 0.00  
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



CUV-00080347 IP25-00020684  
 Baby KOTHAMASU SRISIYA  
 02-05-2019 7 Y 0 M 28 D (F)  
 Dr. MANCHUKONDA SANTHOSH



## SURGERY DETAILS

Date : 28/5/26

Patient Name: Baby Kothamash Srisiya Date of Birth: 21/5/2019 Age: 7 Year

Gender: female Ward : OT UHID No.: CUV-00080347

Date of Surgery: 28/5/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Coblation Adenoidectomy

Time in : 11:45 AM

Time Out : 12:45 PM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Santosh</u>	.....
2. Anaesthetist	<u>Dr. Mohan</u>	.....
3. Assistant Surgeon	<u>-</u>	.....
4. OT Technician	<u>Br. Suresh</u>	.....
5. Circulating Nurse	<u>Br. Subhadeep</u>	.....
6. Assistant Nurse	<u>Br. Buddha, sr. parvathi</u>	.....

- Special Equipment:  Laparoscopy  Bronchoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others Cobulator (581403)

[Signature]  
 Signature of the Surgeon

[Signature]  
 Signature of Circulating Nurse

Order No: 58140/58140/403  
 Docu. No. : RCH/FRM/GENERAL/114

Order by: [Signature]

SURGERY DETAILS

Handwritten notes and signatures in the upper section of the form, including patient information and surgeon details.

Handwritten notes and signatures in the middle section of the form, detailing the surgical procedure and anesthesia.

Handwritten notes and signatures in the lower section of the form, including post-operative instructions and administrative information.

Adenoidectomy

CONSUMABLES OF OT

Circulating staff : B. S. Suresh Technician : B. Suresh Date : 28/5/28 Time : .....

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>BAE</u>		01	Major Pack		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : <u>A/P/N</u>		04				Suction Catheter		
HME filter : A / P / N		01				Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves <u>6 1/2, 7</u>		2+2	Surgical Gloves		
02 cc		03				Gauze Pack		
01 cc		0				Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		02	Koochies					
<u>3 way 100ml</u>		01	Ointments			<u>EVAR</u>		01
<u>PCM 100ml</u>		01	Suction Catheter			<u>Feeding tube #6</u>		02
Fentanyl			Cap, Mask					
Morphine			Gauze Pack <u>(1x5)</u>		03	<u>Santon</u>		01
Ketamine			Mop Pack					
Propofol		01	Steristrip			<u>Adrenaline</u>		02
Rocuronium		01	Underpad		02	<u>10ml syringe</u>		02
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron		01	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics <u>DEXON</u>		01	Bandage					
<u>TOLANER</u>		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		03			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
<u>O<sub>2</sub> mask</u>		01	Microshield					
			Cotton Balls					
			Latex Gloves		20			
			Ramdione Scrub					
			Saral					

B. S. Suresh  
 Surgeon

Dr. Srinivas  
 Anaesthesiologist

Baby  
 Nurse

OT Technician

Order No. : 1392 / 581422-23

Ordered by : Anu

Doc. No. : RCH / FRM / GENERAL / 125 (2028)





POST - OPERATIVE ORDERS :

1. ~~Syp.~~ Augmentin ~~ADS~~  
5ml  $\rightarrow$  5ml  $\times$  7d

2. ~~Syp.~~ Jy. PCM 400mg  
IV BD

3. Jy. Tranexa 200mg IV BD

4. Nasoclear n/d 3<sup>o</sup> (B<sup>o</sup> / B<sup>o</sup>)

5. Syp. Allerid  
3ml BD

.....  
Consultant Surgeon's Name

.....  
Consultant Surgeon's Signature

Date : ..... Time : .....

### ACTIVITY RECORD FOR BILLING

Name: ----- CUV-00080347 IP25-00020684  
 Baby KOTHAMASU SRISIYA  
 02-05-2019 7 Y 0 M 26 D (F)  
 UHID No : ----- IP No Dr. MANCHUKONDA SANTHOSH t : ----- Dept : -----  
 Date of Admission : ----- of Discharge : ----- Time: -----  
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

CUV-00080347 IP25-00020684  
 Baby KOTHAMASU SRISIYA  
 02-05-2019 7 Y 0 M 26 D (F)  
 Dr. MANCHUKONDA SANTHOSH



### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26.	10 A.M.	ER.	OT.	A - Reef
28/5/25	3:50pm	OT	ward 309	Seena
		<i>309 to Billing</i>		

### Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				








# PATIENT TRANSFER FORM

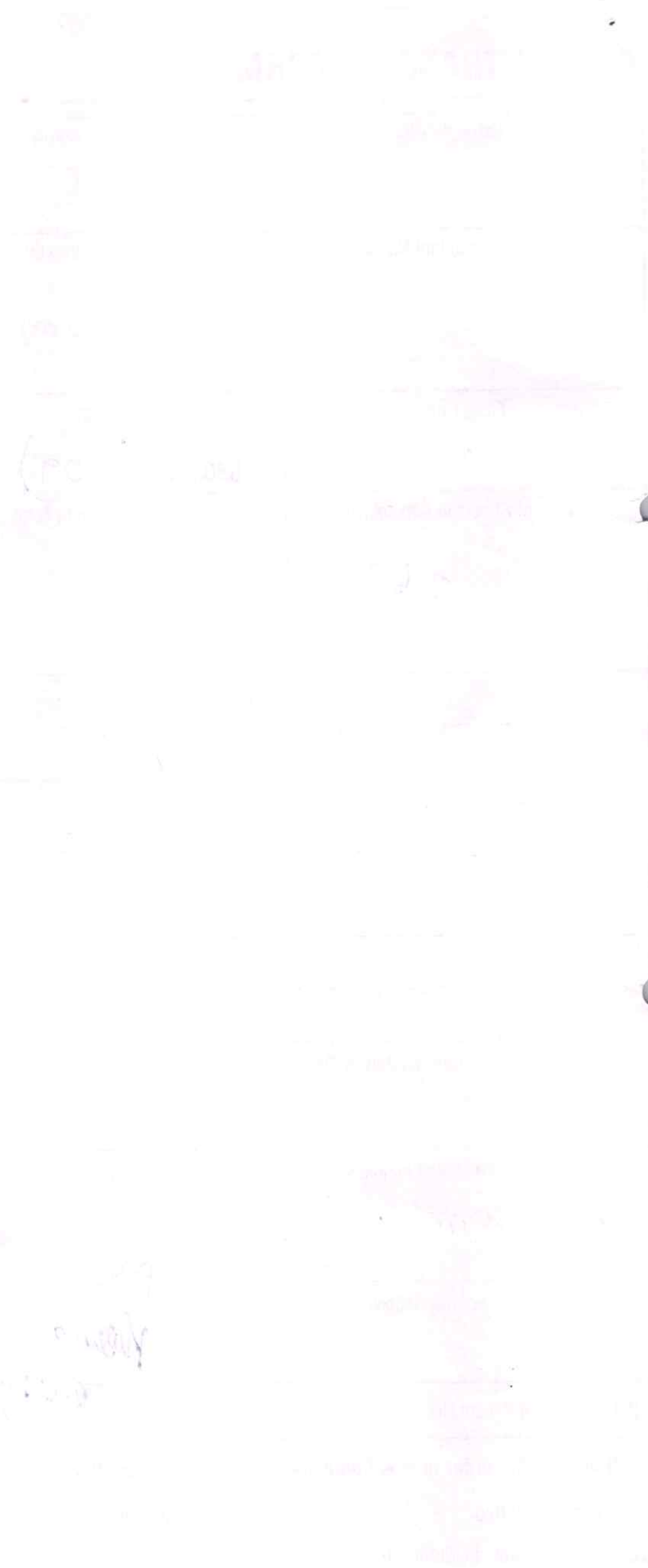
OT

Patient Name & UHID No. CUV-00080347 IP25-00020684 Baby KOTHAMASU SRISIYA 02-05-2019 7 Y O M 26 D (F) Dr. MANCHUKONDA SANTHOSH 		Date & Time of Admission 28/5/26 @ 1	Date & Time of Transfer Order 28/5/26 @ 3:50pm
		Transfer Ordered by Dr. Srinivas	Reason for Transfer post op care
From Unit OT	To Unit ward (309)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 26	Number of Imaging Films op file - 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Intrafee	01	
2.	DNS (500ml)	01	
3.	Proochi	01	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Br. Subhadeep @ 28/5/26 @ 3:50pm		Name of Person Ordered Transfer Dr. Srinivas.	
Patient & Clinical Records Received by : Kusuma 28/5/26 @ 3:50pm			
Date & Time of Patient Received : 28/5/26 @ 3:50pm			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- Unavailable Bed
  Nurse not Available
  Available Bed not ready


101



Handwritten notes in the bottom left corner, including the word "Area" and some illegible scribbles.

# PATIENT TRANSFER FORM



Patient Name & UHID No. CUV-00080347      IP25-00020684 Baby KOTHAMASU SRISIYA 02-05-2019      7 Y 0 M 26 D (F) Dr. MANCHUKONDA SANTHOSH 		Date & Time of Admission 28/5/26 @ 9.48 A.M.	Date & Time of Transfer Order 28/5/26 @ 10 A.M.
		Transfer Ordered by DR. Kashmina.	Reason for Transfer Admission.
From Unit ER.	To Unit OT.	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 16	Number of Imaging Films Nil.	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> OP If yes, what?      File given	
Medications / Consumables / Surgicals / Hand over      ✓ File			
Sl.No.	Item Name	Quantity	
1.	DNS	①	
2.	Intra file	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Anurash		Name of Person Ordered Transfer DR. Kashmina	
Patient & Clinical Records Received by : Subhadeep.			
Date & Time of Patient Received :      28/5/26			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- Unavailable Bed
- Nurse not Available
- Available Bed not ready

1911

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Last solid food - 8.A.M

Last Liquid - 8.30 A.M.



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Kothamasu Srisiya Age : 7y. Gender:  Male  Female

Date : 28/5/26 Time of Arrival : 9.15 A.M.

Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify):  Not known

Source of Information :  Parents  Others (Specify) \_\_\_\_\_

Mode of Arrival :  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 98°F PR: 100b/m BP: 94/6 (71) RR: 26b/m SpO<sub>2</sub>: 97%

Chief Complaints: Surgery of Adenoidectomy

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking	Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding	<input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening
Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

**NOTE :** All immunocompromised children and preterm babies to be considered Level 2.  
All Children less than 2 years age with high fever to be considered Level 3.

\* CTAS - Canadian Triage and Acuity Scale

[Signature]  
Signature of Parent / Guardian

Triage Completion Time : 9.20 A.M.

## Communicable Disease Triage Screening

**PART A. The following questions should be asked to all patients at the initial screening:**

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks  Yes  No

**PART B. For patients reporting fever and respiratory/rash symptoms:**  Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks?  Yes  No  
If yes, State Location: \_\_\_\_\_
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease?  Yes  No

**PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:**

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

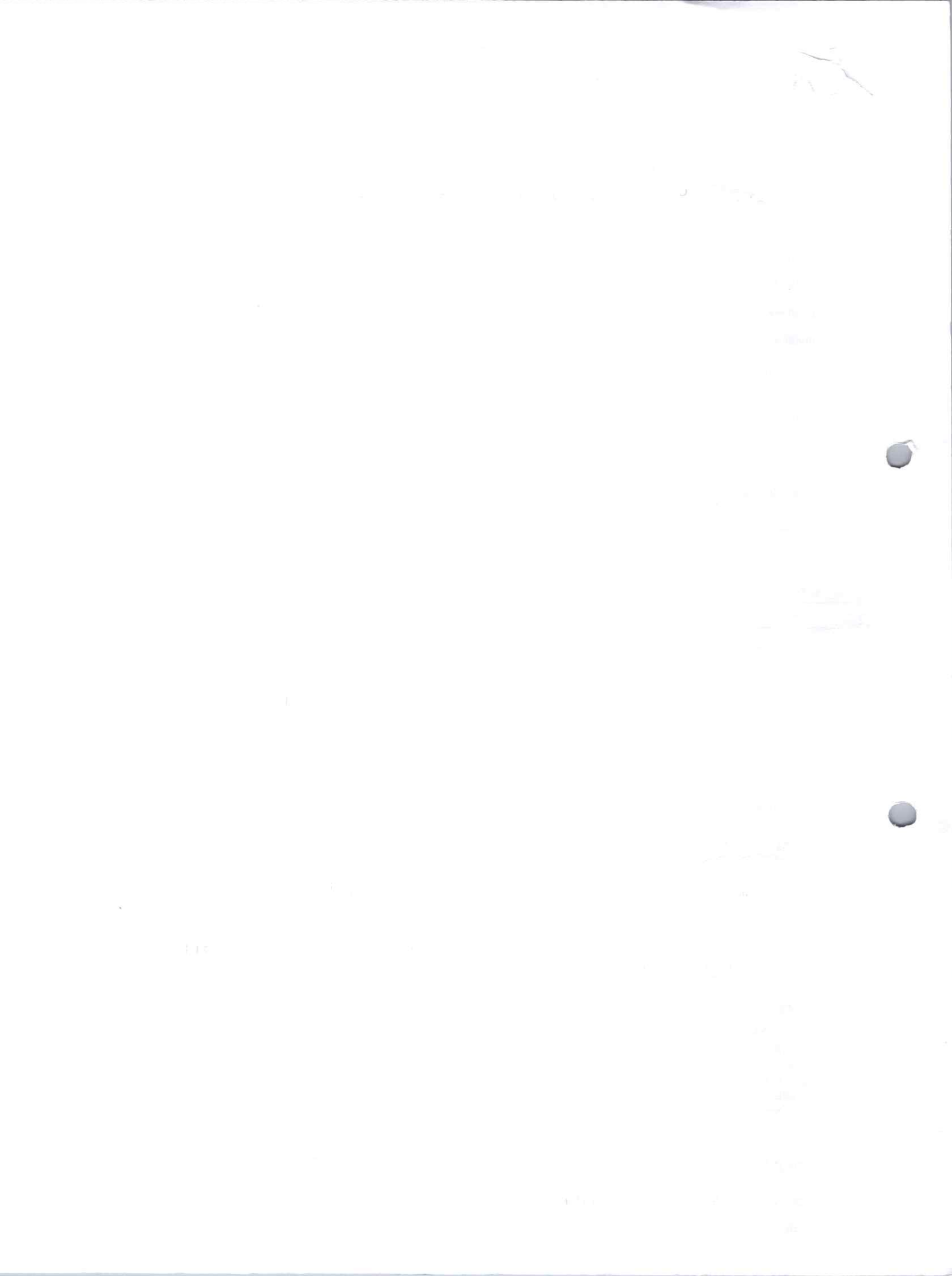
**PART D. ACTION / INTERVENTION:** (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Ankush

Signature of Triage Nurse : [Signature]

Date & Time : 28/5/26 @ 9.17 A.M.



080347 IP25-00020684

OTHAMASU SRISIYA

02-05-2019 7 Y 0 M 26 D (F)

Dr. MANCHUKONDA SANTHOSH



# NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/5/2019 Time of arrival : 9.15 A.M.

Chief Complaints : Surgery of Adenoideectomy

Height : Weight : 22.4 kgs. Head Circumference (<2 years)

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other:

If yes, identify

Pain Screening:  Yes  No If Yes, Pain Score: 02/10 Pain Tool Used:  N Pass  FLACC  Wong Baker

Character mild  Location throat  Frequency on and off  Duration 1 day

### RISK FOR FALL:

If patient is < 6 years  Yes  No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' Assess the below parameters

History of Falling: within past 3 months  Yes  No

### Ambulatory Aids:

• Wheelchair  Yes  No

• Uses furniture for support  Yes  No

### Gait/Transferring:

• Bedrest / immobile  Yes  No

• Weak  Yes  No

• Impaired  Yes  No

Mental Status: Forgets limitations  Yes  No

### IF YES FOR ANY CATEGORY = RISK FOR FALLING

#### Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

### Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

### Inform consultant for positive criteria

### Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

### Inform consultant for positive criteria

Psychological Screening:  No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parents

Siblings in household  Yes  No (if yes How Many?)

Time of Initial assessment completed by ER Nurse : 9.18 A.M.

**Nursing Care Plan (Including Labs / Medications / Other Care):**

Time	Nursing Notes
9.15 A.M	Assess the Baby Condition. vitals checked and Recorded. Informed to the Doctor.
9.17 A.M	Doctor Assess the Baby.

Samples collected by: / Iskanya Time: /  
 Samples sent by: / Iskanya Time: /

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
		N.I.			

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>98 b/m</u> BP: <u>90/65 (71)</u> CFT: <u>22cc PA</u> RR: <u>20 b/m</u> SPO2 at FiO2: <u>99.1</u> GCS: <u>15/15</u> Temperature: <u>98°F</u> Pain Score: <u>02/10</u> Repeat RBS (if applicable): <u>Not Applicable</u>	Shift - out from ER to: <u>OT</u> Time of Shift - out: <u>Subhadeep</u> Handover given to: <u>@ 10 AM</u> (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): IV Placement.

Name of the Nurse : Ankush Signature of the Nurse : A. Roy

Date & Time : 28/5/16 @

### Pediatric Multiorgan History & Physical Examination

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : \_\_\_\_\_

Cranial Nerves : Conscious, alert

**Motor System:**

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

**DTR**

**Superficials:**

Plantars \_\_\_\_\_

**Sensory System :**

**Bladder / Bowel :** \_\_\_\_\_

**Clinical Summary & Diagnostic:**

Adenoid hypertrophy  
Tonsillar hypertrophy

### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_  
Hemodynamic instability

Desired goals of the treatment : \_\_\_\_\_  
resolution of symptoms

**Planned Labs:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Planned Management**

\_\_\_\_\_  
- WF  
Plan - Adenotonsillectomy  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of the Doctor: Dr. Kasmeera  
Name of the Doctor: Dr. Kasmeera  
Date & Time: 28-05-2026

Signature of the Consultant: Amr  
Name of the Consultant: Dr. Y. Anwar  
Date & Time: 28/5/26 @ 8:30am

*Faint handwritten notes at the bottom of the page.*



# Rainbow<sup>®</sup> Children's Hospital

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00080347 IP25-00020684  
Baby KOTHAMASU SRISIYA  
02-05-2019 7 Y 0 M 26 D (F)  
Dr. MANCHUKONDA SANTHOSH



Patient Name: \_\_\_\_\_

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_

### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

c/o Recurrent  
cold ∴ 1 1/2 years

#### History of present illness :

A 7 year old female child  
was brought with c/o recurrent  
cold ∴ 1.5 years

c/o Nose block (+)

Mouth breathing (+)

No H/o Fever / Rash / Vomiting .

### Pediatric Multiorgan History & Physical Examination

**Past History :** (Including details of any previous investigation or treatment)

K/c/o Adenoid hypertrophy  
Grade - II Tonsillar Hypertrophy

**Birth & Neonatal History:**

smooth transit

**Birth & Socio Economic History:**

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

**Developmental History :**

no developmental delay

**Immunization History :**

vaccinated as per schedule

### Pediatric Multiorgan History & Physical Examination

**Anthropometry :**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) ) 22.4 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 98°F Pulse Rate : 100/m B.P. 94/61(71) SPO2 97%

Resp. rate and type of breathing : 26/m

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_ } ⊖

Oedema : \_\_\_\_\_

Allergies (if any): \_\_\_\_\_

**Respiratory System :**

AEBE ⊕

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : \_\_\_\_\_

Any adde sounds : \_\_\_\_\_

Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

**Cardiovascular System :**

S<sub>1</sub>S<sub>2</sub> ⊕

Inspection of procordium : \_\_\_\_\_

Heart Sounds : \_\_\_\_\_

Any murmur : \_\_\_\_\_

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : \_\_\_\_\_

**Per Abdomen :**

Soft, non tender

Inspection \_\_\_\_\_

Palpation : \_\_\_\_\_

Ausculation : \_\_\_\_\_

Spine : \_\_\_\_\_ External Genitelia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/2026	see B Dr. Aishwarya (D.N.Y. Anwar)	
4:30pm	Δ POD-0 of Colobation Adenoidectomy	
	No UO throat pain / fever	
	No bleeding	
	Oral intake ⊕	
	OIE: HR - 100/min	
	RR - 22/min	
	S/E: CUS: S/S ⊕, NO Mucus	
	RU: BU AE ⊕, NUBS	
	PIA: soft	
	CNS: WNL	
		Plan
		- Continue medications as charted
		- Wif feed / fever
		- ↑ oral intake
		Monitored by Kusuma 28/5/26
	Amind (D. Anwar)	
	Chowrey	

CUV-00080347 IP25-00020684

Baby KOTHAMASU SRISIYA

02-05-2019 7 Y 0 M 26 D (F)

Dr. MANCHUKONDA SANTHOSH



# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26		
9:10am	<p><u>CLS/B D-4, ANDS</u>            P&amp;D-I            ADRWDRDRCRM            No ISSUES</p>	
	<p><u>OK</u>            No Nasal BLEED            Active</p>	
		<p><u>Anti</u>            (1) D/C toy            CT and abkote            Paracetamol 500            F. (Anzal)            NASAL CLEAN S/S            ALB 20</p>
	<p><u>Amn</u>            (D-4. ANAND)</p>	

CUV-00080347 IP25-00020684

Baby KOTHAMASU SRISIYA

02-05-2019 7 Y 0 M 26 D (F)

Dr. MANCHUKONDA SANTHOSH



Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight 22.24 Ward '3A'

<b>DRUG :</b> <u>SYP. ALERID</u>				Date Time																	
Dose <u>3ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>28/5/20</u>																		
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>																					
Additional Instructions: <u>[Handwritten notes]</u>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

VERIFIED BY : Name ..... Signature .....

Patient Sticker



Sheet No: .....

## REGULAR PRESCRIPTIONS

Weight ..... Ward .....

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	↓																	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	↓																	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	↓																	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	↓																	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

VERIFIED BY : Name ..... Signature .....



# DRUG CHART

Date of Admission: ..... Drug Allergies: .....  Not known any Drug Allergies

**FOR THE SAFETY OF THE PATIENT**

- GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
  - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
  - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
  - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
  - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
  - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  - 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
  - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

**SOS / PRN (As Required Medication)**

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

nature  
VERIFIED BY : Name





Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Start Date	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :		Dose		Dose		Dose		Dose		
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		
Route	Start Date	Dose		Dose		Dose		Dose		
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		
Name & Signature of the Doctor		Dose		Dose		Dose		Dose		
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		
Additional Instructions:		Dose		Dose		Dose		Dose		
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5/26	11:50 AM	2x TRANEXAMIC ACID	300 mg	IV	<i>[Signature]</i>	<i>[Signature]</i>
28/5	11:50 AM	2x DEXAMETHASONE	2 mg	IV	<i>[Signature]</i>	<i>[Signature]</i>
28/5	12:00 PM	2x PARACETAMOL	300 mg	IV	<i>[Signature]</i>	<i>[Signature]</i>

VERIFIED BY SIGNATURE

