

DISCHARGE SUMMARY

Name	Baby K LIKITHA	UHID	LBH-00064321
Father/Guardian	Mr RAMU	Age/Gender	9 Y 6 M 3 D/ Female
Address	H.NO 2-14/2,GUNJALLOOR,SURYAPET, Suryapet, Nalgonda, Telangana, INDIA, 508213		
IP No	IP25-00020466	Admission Date	16-05-2026
Ref Doctor	Self		
Discharge Date	17-05-2026		

Consultant:

Dr. MANCHUKONDA SANTHOSH KUMAR,
MBBS, DLO, DNB (ENT), Certified Training Program,
Fellowship in Implantation Otology,
Consultant Pediatric ENT & ENT surgeon

Co-Consultant:

Dr. Y. Arvind
MBBS, MD Pediatrics, FEPM
Consultant Pediatrician & Pediatric Emergencies
Reg.No. 84564.

DIAGNOSIS

CHRONIC ADENOTONSILLAR HYPERTROPHY

CHRONIC RHINOSINUSITIS

Procedure : Adenotonsillectomy with Coblation done on 16.05.2026



Name	Baby K LIKITHA	UHID	LBH-00064321
IP No	IP25-00020466	Admission Date	16-05-2026

History: Baby K LIKITHA, 9 Years, 6 Months, 3 Days female presented with history of intermittent cough, nose block since past 1 year prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital, Financial District for surgical management.

Examination: She was afebrile, maintaining saturations at room air (96%). Heart rate was 92/min, Blood Pressure - 96/60mmHg and Respiratory rate - 20/min. Tonsils were enlarged bilaterally. Bilateral hypertrophied inferior nasal turbinates present. Deviated nasal septum present. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 25.6 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 12.7 gm%, White Blood Cell count of 8.83 cells/cumm, platelet count of 3.65 lakhs/cumm

Indication for surgery : Right Inferior Turbinate Hypertrophy. Coblation Adenotonsillectomy Endoscopic sinus surgery right inferior Turbinoplasty done on 16.05.2026.

Surgery Notes:

- Grade 4 adenoid hypertrophy.
- Grade III tonsillar hypertrophy.
- Coblation adenotonsillectomy.
- Right middle meatal antrostomy.
- Right inferior turbinoplasty.

Post-Operative Notes: Post operative period was uneventful. She was initiated on oral feeds gradually which she tolerated well. She was seen by Dr.



Name	Baby K LIKITHA	UHID	LBH-00064321
IP No	IP25-00020466	Admission Date	16-05-2026

Manchukonda Santhosh Kumar, (Consultant Pediatric ENT& ENT surgeon) who advised to continue conservative management. She remained hemodynamically stable during the hospital stay and operated site remained healthy. She is being discharged with the following advice.

Advice:

- * Syrup. Augmentin DDS (Amoxicillin - 400mg + Potassium clavulanate - 57mg/5ml) 6.5 ml twice daily (1 hour before food or 2 hours after food) for 7 days (Should be kept in refrigerator after reconstitution, consume within 7-days)
- * Syrup. Crocin DS (Paracetamol - 5ml/240mg) 8 ml thrice daily after food for 3 days.
- *Syrup Alerid (Cetirizine 5mg/5ml) 5ml per oral twice daily 1 hour before food for 5 days
- * Gargle with Betadine thrice daily for 7 days.
- * Nasoclear nasal drops, 3 drops in each nostril thrice daily for 5 days.

Fever Management

- * Syrup. Crocin DS (Paracetamol - 5ml/240mg) 8 ml if temperature >100°F (maximum 4 doses per day with 6 hour interval)
- *Syrup Ibugesic 10ml per oral SOS (temperature > 101°F)
- * Tepid sponging if fever > 101 °F.

Review consultation with Dr. MANCHUKONDA SANTHOSH KUMAR, after 2 weeks in OPD at Financial District with prior appointment (**Review consultation will be charged**).

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe

Name	Baby K LIKITHA	UHID	LBH-00064321
IP No	IP25-00020466	Admission Date	16-05-2026

parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.



Parent/ Attender

In case of emergency contact 8121039503 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur** / **Kukatpally** / **Vikrampuri** / **LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website www.rainbowhospitals.in


Registrar/Resident/C.M.O

Consultant:

Dr. MANCHUKONDA SANTHOSH KUMAR,
MBBS, DLO, DNB (ENT), Certified Training Program,
Fellowship in Implantation Otology,
Consultant Pediatric ENT& ENT surgeon

Co-Consultant:

Dr. Y. Arvind
MBBS, MD Pediatrics, FEPM
Consultant Pediatrician & Pediatric Emergencies
Reg.No. 84564.



LBH-00064321 IP25-00020466
 Baby K LIKITHA
 14-11-2016 9 Y 6 M 2 D (F)
 Dr. MANCHUKONDA SANTHOSH



SURGERY DETAILS

Date : 16/05/26

Patient Name: Baby K Likitha Date of Birth: 14/11/2016 Age: 9Y

Gender: F Ward: OT UHID No.: LBH-00064321

Date of Surgery: 16/05/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Coblation Adenotomylabomy
 Endoscopic sinus surgery
 Inferior Turbinolectomy

Time in : 12:50 pm

Time Out : 3:40 pm

	NAME	AMOUNT
1. Surgeon	Dr. M Santhosh	
2. Anaesthetist	Dr. Aishwarya	
3. Assistant Surgeon	-	
4. OT Technician	Br. Suresh	
5. Circulating Nurse	Sr. Vaishali	
6. Assistant Nurse	Sr. Parvathi, Br. Buddha	

- Special Equipment:
- Laparoscopy
 - Bronchoscope
 - Harmonic
 - Morcelator
 - C-ARM
 - Cystoscopy
 - Versa Point
 - Liver Cusa
 - Neuro Cusa
 - Others: Debrider charges

[Signature]
Signature of the Surgeon

[Signature]
Signature of Circulating Nurse

Order No: 25-0000576125

Order by: Harimath Sr

76176

10/11/21

URGENT

10/11/21

10/11/21

10/11/21

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

URGENT

Adenotonsillectomy



CONSUMABLES OF OT

Circulating staff : Technician : Date : Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube + TRACOR + 55		01	Major Pack		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A/P/N		03				Suction Catheter		
HME filter : A/P/N		01				Feeding Tube No. 6		02
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves 6 1/2, 7		3+3	Surgical Gloves		
02 cc		03				Gauze Pack		
01 cc						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		01+03	Koochies					
3 Long C 100cm		01	Ointments					
P.C.M. 100cm		01	Suction Catheter					
Fentanyl			Cap, Mask					
Morphine			Gauze Pack		06			
Ketamine			Mop Pack		01	Sinus Blade		01
Propofol		01	Steristrip			Curved. 11cm		
Rocuronium		01	Underpad		02	4mm		
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron		01	Foleys catheter			E-Vac		01
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag			Saxalan		01
Antibiotics			Bandage					
O2 mask		01	Tegaderm			NS 1000ml		01
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		03			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
Dextora		01	Microshield					
Ignarexa		01	Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 576163,64 / 57618 / NSG

Ordered by : *[Signature]*

Doc. No. : RCH / FRM / GENERAL / 125

Handwritten text at the top center, possibly a title or date.

Handwritten text below the top center, possibly a subtitle or location.

Handwritten text in the upper right quadrant.

Handwritten text on the left side, possibly a date or page number.

Handwritten text in the middle of the page.

Handwritten text in the lower left quadrant.

Handwritten text in the lower left quadrant.

Handwritten text in the lower left quadrant.

Handwritten text in the upper right quadrant.

Handwritten text in the lower right quadrant.

Handwritten text in the lower right quadrant.

Handwritten text at the bottom left, possibly a signature.

Handwritten text at the bottom center, possibly a date.

Handwritten text at the bottom right, possibly a date.

ADMISSION SHEET



Registration Details :

Admission No : IP25-00020466 Admit Date : 16-May-2026 Admit Time : 08:52 AM UHID : LBH-00064321

Patient Details :

Patient Name : Baby K LIKITHA Age : 9 Y 6 M 2 D
Guardian : Mr RAMU DOB : 14-11-2016
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H.NO 2-14/2,GUNJALLOOR,SURYAPET Suryapet Phone No : 8309901536
Nalgonda Telangana INDIA 508213 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 RAMU Relationship : D/O
Contact Address : H.NO 2-14/2,GUNJALLOOR,SURYAPET Phone No : / 8309901536
Suryapet Nalgonda Telangana INDIA 508213

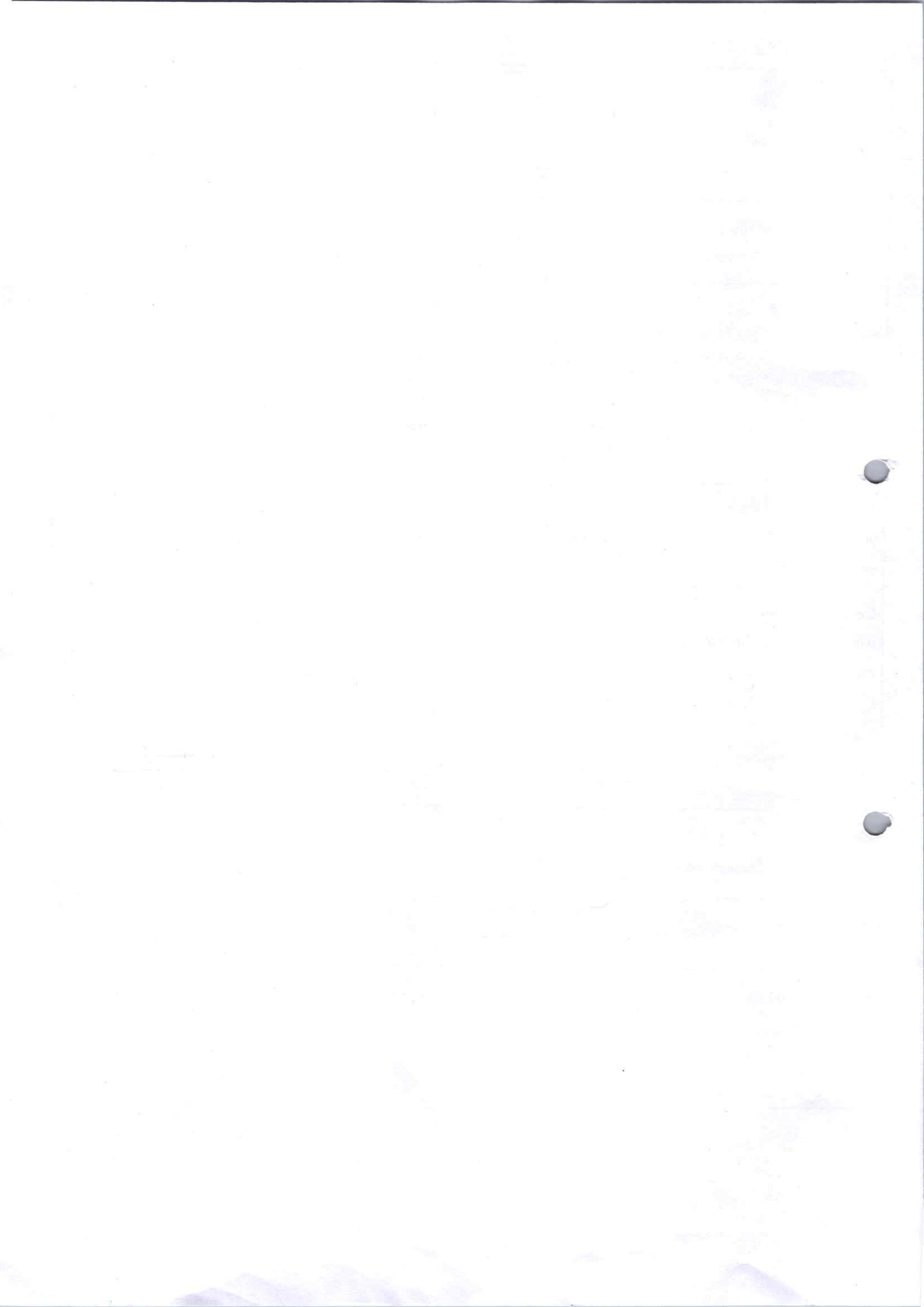
Signature

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



ACTIVITY REPORT LBH-00064321 **BILLING**
Baby K LIKITHA IP25-00020466

Name: ----- 9 Y 6 M 2 D (F)
Dr. MANCHUKONDA SANTHOSH

UHID No : ----- Consultant : ----- Dept : -----

Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/5/26	9:50am	R R	OT	Arjan
16/5/26	3:55pm	OT	post-op	Beja
16/5/26	6:25pm	OT	ward (307)	Beja
17/5/26		307	Billing	Kusuma

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
18/5/26	CSP	17405	
	CRBS- 28 my/dl	17404 17404	Arom
	by: ISAM		
	Crosschecked by [Signature]		
	17/05		
	@ 8:30pm		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
16/5/26	IV placement	①	576001	Arora
16/5/26	PAC OP Basis	①		Arora
<p>Crosschecked by SA repos @ 8:30 pm</p>				
17/5/26	NHA	1	6326	Kufner

ANY OTHER INFORMATION

Date: 16/5/26 Time: 9:50 am Prepared By: Arora

Staff Nurse Arora	Shift / Ward OT	Billing Assistant	Billing Supervisor
--------------------------	------------------------	-------------------	--------------------

Patient Sticker

Last food - 9 PM
Last liquid - 7 AM - milk



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby - Likitha Age: 9 y. Gender: Male Female
Date: 16/5/26 Time of Arrival: 8:43 AM

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: 98.6 PR: 112b/m BP: 96/60(72) RR: 26b/m SpO2: 100%

Chief Complaints: C/o pt came for Adenotonsillectomy.

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.

[Signature]
Signature of Parent / Guardian

Triage Completion Time : 8:57 AM

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 : Anan

Signature of Triage Nurse : [Signature]

Date & Time : 16/5/26 @ 8:46 AM

Handwritten notes at the top of the page, including the word "LITERATURE" and other illegible scribbles.

Handwritten notes in the middle section of the page, appearing as faint, scattered lines of text.

Handwritten notes in the lower middle section, with a small red mark visible on the left side.

Handwritten notes at the bottom of the page, including a large, illegible scribble in the lower right corner.

LBH-00064321
 Baby K LIKITHA 9 Y 6 M 2 D (F)
 14-11-2016
 Pat. MANCHUKONDA SANTHOSH



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/5/26 Time of arrival : 8:43 AM

Chief Complaints: Child came for Adenotonsillectomy.

Height : Weight : 25.64 kg Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 0/10 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

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 parent

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

Time of Initial assessment completed by ER Nurse : 8:47 AM

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

Time	Nursing Notes
8:43 AM	Assessed pt general condition monitoring vitals signs

Samples collected by:

Samples sent by:

Aman

Time: 8:55 AM

Time: 9:00 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
		MIL			

Condition of patient at time of shift - out :
 HR: 108b/m BP: 157/127(95) CFT: 128m
 RR: 20b/m SPO2 at FiO2: 100%
 GCS: 15 Temperature: 98.6
 Pain Score: 0/10
 Repeat RBS (if applicable):

Details of Shift - out
 Shift - out from ER to: OT
 Time of Shift - out: 9:50 AM
 Handover given to: Asijik
 (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): IV placement done

The Nurse: Aman Signature of the Nurse: [Signature]

Time: 10:15/20 @ 9:50 AM



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

LBH-00064321

IP25-00020466

Baby K LIKITHA

14-11-2016

9 Y 6 M 2 D

(F)

Dr. MANCHUKONDA SANTHOSH



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Intermittent ∴ 1 year
cough
Nose block

History of present illness :

A 9 years 6 month old female
was brought with c/o Intermittent
cough ∴ 1 year.

c/o Nose block & Snoring +
Mouth breathing +
Throat pain +

No H/o Fever, Ear pain, discharge

Pediatric Multiorgan History & Physical Examination

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

_____ DNS to left

_____ Gr - II Tonsillar hypertrophy

_____ High arched palate

_____ Malocclusion

Birth & Neonatal History:

_____ Term / LSCS

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)) 25.6 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 92 b/m B.P. 96/60(72) SPO2 96%

Resp. rate and type of breathing : 20/m

Rash _____

Lymphadenopathy _____ ⊖

Oedema : _____

Allergies (if any): _____

Respiratory System :

AEBE ⊕

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

S₁S₂ ⊕

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Soft

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

Relevant data from outside (CT, USG etc..) _____

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : GCS 15/15

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:

Adenotonsillar hypertrophy

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Hemodynamic instability
Sepsis

Desired goals of the treatment : resolution of symptoms

Planned Labs:

- CBP

Planned Management

- Adenotonsillectomy

Signature of the Doctor: Kasmeera A

Name of the Doctor: Dr Kasmeera

Date & Time: 16-05-2026

Signature of the Consultant: [Signature]

Name of the Consultant: D. Y. Aravind

Date & Time: 16/5/26

LBH-00064321 IP25-00020466

Baby K LIKITHA

14-11-2016

9 Y 6 M 2 D

(F)

Dr. MANCHUKONDA SANTHOSH



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/11/2016 7:45 am		CSFB or Urology / D.M. Anand
	A/S:- post-op Adenotonsillectomy.	
	mild to moderate pain (P).	
	the occasional blood tinged sputum	
	↳ no occult bleeding post op.	
	Started taking orally. → ↓ oral intake	
	due to pain.	
	Vitals were	
	hemodynamically stable	
	ofe:- Altered active hydration fair.	
	A/S:- (N) examination.	
		Plan
		Can A/S today if
		no setbacks after rounds
		continue PT as charted.
		Y/S
		(D.M. Anand)
		17/11/16 @ 10:30 am

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 10am	4/8/13 Dr. Asvink Dr. Snelke	
	4/17/20 Dr. Sambosh Post op Adenoidectomy	
	No new issues	
	<u>Vitals</u> HR: 90/min RR: 20/min SpO2: 98% RA BP: 100/60 mmHg	<u>plan</u> Discharge on oral: 1) Augmentin 2) Mucosolvan MD 3) Ibuprofen 4) Aleve syp. 5) Betadine gargle J.



RESULT SHEET

Patient Name : LBH-00064321 IP25-0002046
 Baby K LKITHA
 14-11-2016 9 Y 6 M 2 D ()
 Age : Ge Dr. MANCHUKONDA SANTHOSH
 I.D. No. : 

Date	16/5/26				
Time	12:55pm				
Hb	12.7 mg/dl				
PCV	39.5				
RBC	4.82				
WBC	8.82				
N/L	08/47				
Platelets	365				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					
Doctor's Signature					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Doctor's Signature						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

LBH-00064321
 Baby K LIKITHA 9 Y 6 M 2 D (F)
 14-11-2016
 Dr. MANCHUKONDA SANTHOSH

IP25-00020466



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)

DRUG :				Date Time															
Dose	Route	Frequency	Start Date	↓															
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date	↓															
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date	↓															
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 25.6 kg Ward. 3rd A

DRUG : Aug AUGMENTIN				Date Time	16/5	7/5															
Dose	Route	Frequency	Start Date																		
770mg	Oral	8 hourly	16/5/26	6pm	x	1800	Kala														
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>					9pm	x															
Additional instructions:					10pm	1800	Kala														
Daily Doctor's Endorsement by a Sign																					
DRUG : Aug PARACETAMOL				Date Time	16/5																
Dose	Route	Frequency	Start Date																		
325mg	Oral	12 hourly	16/5/26	9pm	x																
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>																					
Additional instructions:					9pm	1800	Kala														
Daily Doctor's Endorsement by a Sign																					
DRUG : Aug TRANEXA				Date Time	16/5																
Dose	Route	Frequency	Start Date																		
250mg	Oral	12 hourly	16/5/26	11pm	x																
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>																					
Additional instructions:					11pm	1800	Kala														
Daily Doctor's Endorsement by a Sign																					
DRUG : NASOLLEAR SALINE				Date Time	16/5	7/5															
Dose	Route	Frequency	Start Date																		
3°	PN	8 hourly	16/5/26	6pm	x	1800	Kala														
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>					9pm	x															
Additional instructions:					10pm	1800	Kala														
Daily Doctor's Endorsement by a Sign																					

Patient Sticker

Weight. Ward.

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.

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
16/5/26	1pm	Ij DEXAMETASONE	3mg	iv	Aidy	Beja Beja
16/5/26	1pm	Ij TRANEXAMIC ACID	375mg	iv	Aidy	Beja Beja
16/5/26	1:30pm	Ij PARACETAMOL	375mg	iv	Aidy	Beja Beja
16/5/26	12:55pm	Supp DICLOFENAC	25mg	PR	Aidy	Beja Beja
16/5/26	2:00pm	Ij AUGMENTIN	750mg	iv	Aidy	Beja Beja

VERIFIED Name Signature

LBH-00064321 IP25-0002046
 Baby K LKITHA 9 Y 6 M 2 D ()
 14-11-2016
 Dr. MANCHUKONDA SANTHOSH

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

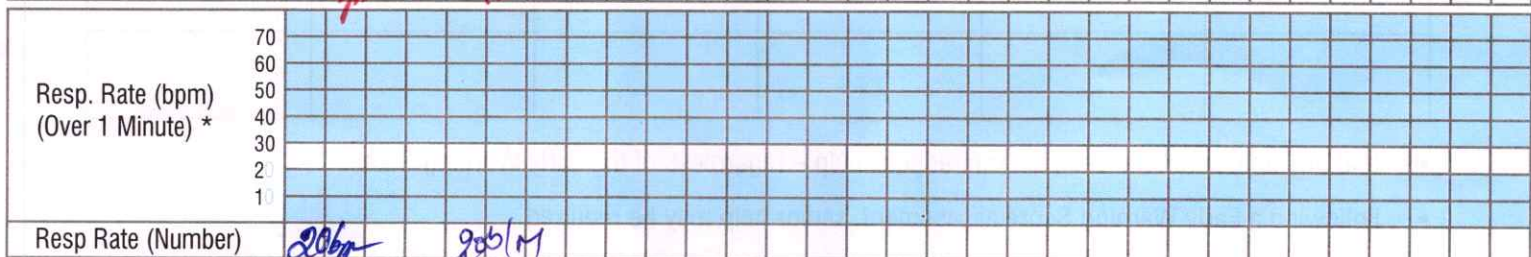
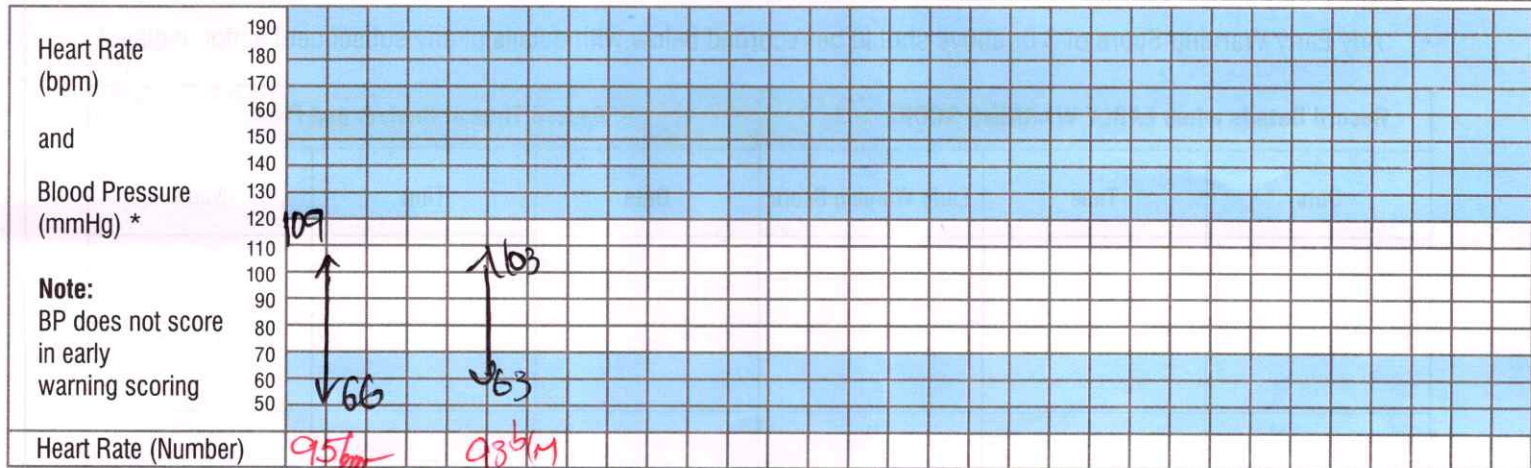
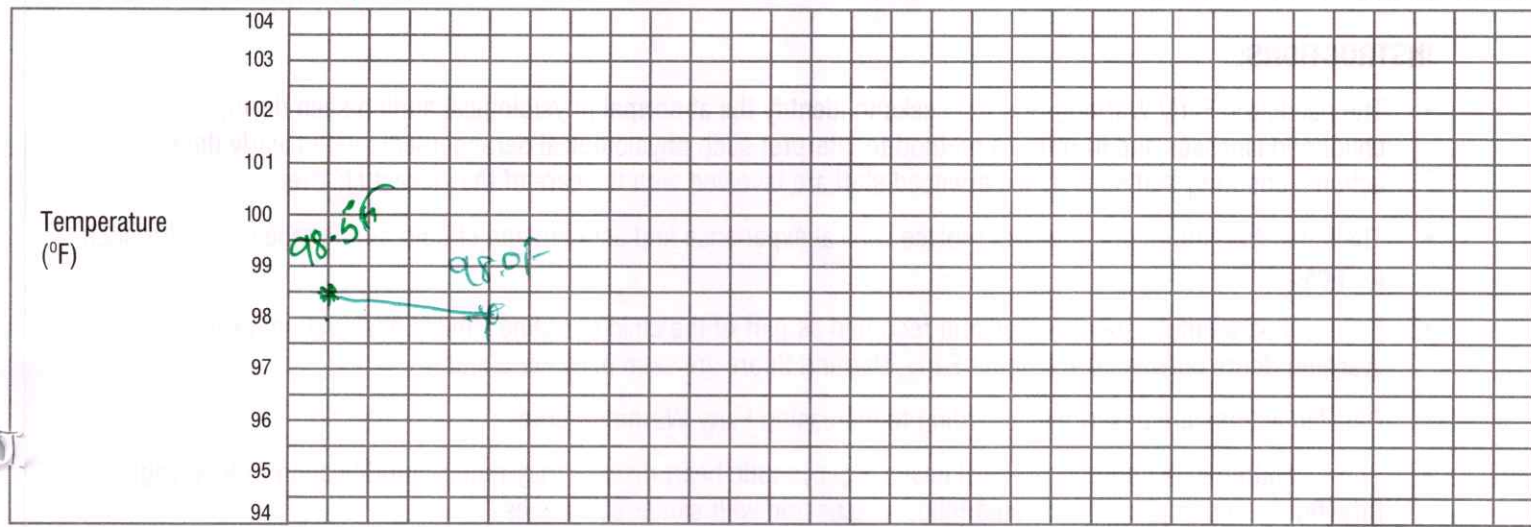


Doc. No. : RCHB/ FHM / CLINICAL / 126
 (16/5/26)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern? *EPH* *10PM*



Heart Rate (Number)	<i>95 bpm</i>	<i>93 bpm</i>
Resp Rate (Number)	<i>20 bpm</i>	<i>20 bpm</i>
Resp Mod/ Severe Distress None / Mild	<i>N</i>	<i>N</i>
Receiving O ₂ (l/min) O ₂ Saturations (%)	<i>0.9%</i>	<i>98%</i>
Conscious Level Normal / Altered	<i>N</i>	<i>N</i>
GCS *	<i>15</i>	<i>15</i>

TOTAL SCORE		
Number of shaded boxes	<i>0</i>	<i>0</i>
Pain Score	<i>0</i>	<i>0</i>
Observer's Initials	<i>EPH</i>	<i>EPH</i>

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
 - Score 2 : Shift in charge nurse to be informed and continue hourly observations
 - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 - Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.
- NB: Scores 3 should be recorded overleaf

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

FLUID CHART

Sheet No. : 01

(16/5/26)

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	NOMF	orally	NOMF	NO	NO			NO	0		OT
	07:00 pm	orally	orally	NOMF	NO	NO			NO	0		OT
Total Intake : 150ml						Total Output : M-0 0-0						
	08:00 pm	No Int	orally	No Int	No	No			No	No	0	OT
	09:00 pm	No Int	orally	No Int	No	No			No	No	0	OT
	10:00 pm	No		No	No	No			No	No	0	OT
	11:00 pm	No		No	No	No			No	No	0	OT
	12:00 am	orally	orally	No	No	No			No	No	0	OT
	01:00 am	orally	orally	No	No	No			No	No	0	OT
Total Intake : 80 + 80ml						Total Output : M-0 0-1						
	02:00 am	No Int		No	No	No			No	No	0	OT
	03:00 am	No Int		No	No	No			No	No	0	OT
	04:00 am	No Int		No	No	No			No	No	0	OT
	05:00 am	No Int		No	No	No			No	No	0	OT
	06:00 am	-	orally	-	No	No			No	No	0	OT
	07:00 am	-	orally	-	No	No			No	No	0	OT
Total Intake : 100ml						Total Output : M-0 0-2						
Total 24 hrs. Intake		410										
Total 24 hrs. Output		M-0 0-3										

Patient Sticker



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Ciketha Age: 9y 3m Sex: Female UHID.No:

Date: 14/5/26 Time: 12:30pm Proposed Operation: Adenotonsillectomy

Diagnosis: Adenotonsillar Hypertrophy Endoscopic sinus surgery

B.P / CRT: Low H.R: Weight: ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl -:	SGOT/SGPT:		

Allergies: NKA

Medical History: CVS: -

RESP: H/O cough on & off Diabetes: -

CNS: Nothing significant

Renal: Nothing significant

Hepatic / GE: Nothing significant Physical Activity: DANCE

Others: Term, ces, non admission, no developmental delay

Past Anaesthetic History: -

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: (N) Mentohyoid Distance: (N) Neck: (N) Teeth: No loose tooth

Lungs: BAD (+)

Heart: SIS (+)

CNS: NAD

Pregnant: Yes No NA Venous Access Site: (+) Spine Exam for regional: (N)

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

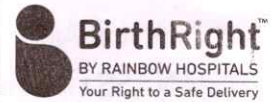
Pre-Operative Instructions:

- DVT Prophylaxis: -
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions: check weight
CBP during consultation

Signature: Ciketha Name: KESHA

Patient Sticker

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: Confirmed

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R.: _____ B.P / CRT: _____ SpO₂: 100-f R.R.: _____ Last Feed: 7:30 hrs

Pre-OP Diagnosis: _____ Operation: Adenotonsillectomy Date: 16/5/26

Surgeon: Dr. Santosh Anaesthesiologist: Dr. Abh Technician: ANIK

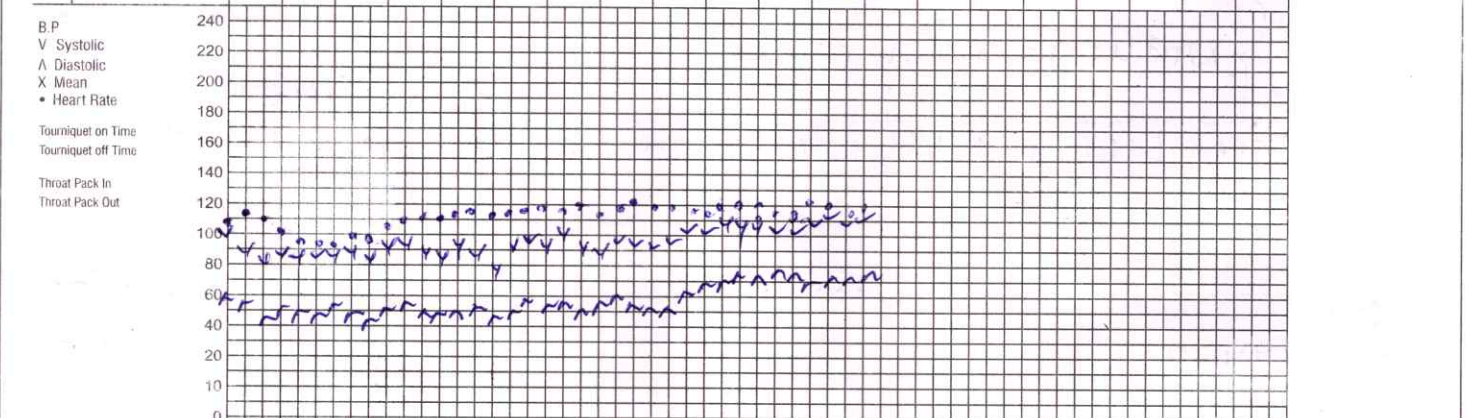
TIME	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	
N.O. / AB / O LPM	50																							
HALO / SO / REVO INAC																								
Drugs:																								
MIDAZOLAM	1mg																							
FENTANYL	50mcg																							
PROPOFOL	100																							
ROCURONIUM	20 + 20																							
TRANEXAMIC ACID	375																							
DEXAMETHASONE	3mg																							
PARACETAMOL	375																							
M.V. / P.Y. / R. / U.A. / G.																								
FiO ₂ / SaO ₂	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	
ETCO ₂	38	40	48	42	40	40	40	38	40	42	40	40	40	40	40	40	40	40	40	40	40	40	40	
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Temperature	36.4	36.4	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	36.3	
Urine Output																								
Fluids																								
Blood																								
		250ml/h																						

Antibiotic: Fi Augmentin 250mg

Suppository: Supp. DICLOFENAC 25mg

Blood Loss: 25ml

NOTES:



LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP

Cuff Site: _____

Art Site: _____

EKG Lead: 3

Temp Site: skin

FiO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: Supine

Pressure Points Checked

Eye Care:

Oint

Tape

Padding

Awake

Temp:

HME Fluid Warmer

Cling Film OH Warmer

Hugger's Cotton Wool

Other

Times:

Anaes Start: 12:50 pm

OP Start: 2:10 pm

OP End: _____

Leave OR: 3:40 pm

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP: _____

ART: _____

IV: _____

IV: 22G @ ul

IV: _____

Induction

IV Inhal

Pre O₂ RSI

Others

Mask SGA

Airway Oral Nasal

ETT# 6 at 18 cm

Oral Nasal Cuff

Tracheostomy Topical

Drug: Rocuronium

Awake Direct Vision

Video Laryngoscopy Stylette / Bougie

Fiberoptic

Blade# 2 Attempts: 1

Difficulty Why? _____

Regional:

Extremity Specify: _____

Spinal Epidural Caudal

Others: _____

Position: _____

Site: _____

Needle Size: _____ Depth: _____

Parasthesia Yes No

Catheter at skin _____ cm

Drug Name & Conc: _____

Bolus: _____

Infusion: _____

Block Level: _____

Comments: _____

Transportation to

PACU ICU Other

Relaxant Reversed Yes No NA

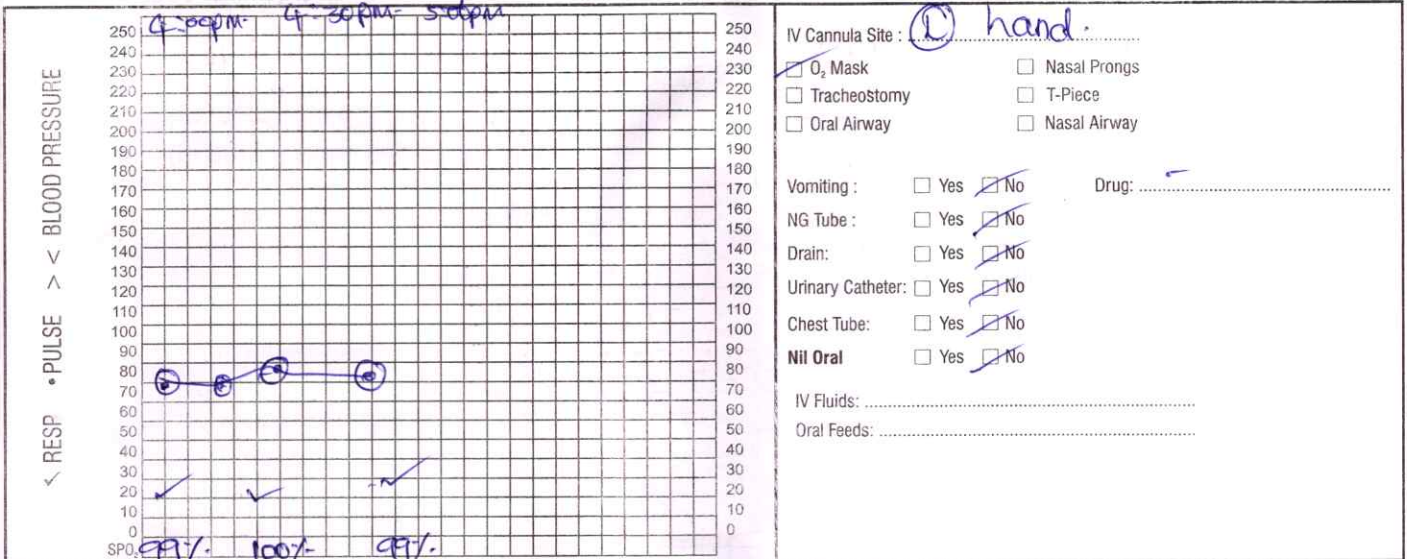
Name of the Doctor: Dr. Ashwary

Signature of the Doctor: Abh

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sr. Sreeja Time Received : 3:55 pm Time Discharged :



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	01	02	02		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	02	02	02		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	02	02	02		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	01	02	02		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	02	02	02		
TOTAL		08	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
16/5/26			AS per ASCON	Sreeja

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr. S. Seethan

Anaesthesiologist Signature: [Signature]

Date & Time: 16/5/26 @ 5:25pm

PACU Nurse Name : Sr. Sreeja

PACU Nurse Signature: [Signature]

Date & Time: 16/5/26 @ 5:25pm

Transferred to Unit by (PACU): Sr. Sreeja

Date & Time: 16/5/26 @ 6:25pm

OPERATION THEATER NOTES

Patient's Name : Baby K Likhitha Age : 09 Gender : F
UHID : LBH-00064321 I.P.No. 25-00020468 Weight :

Surgeon : <u>Dr. M Santhosh</u>	Asst. Surgeon : <u>-</u>
Anesthetist : <u>Dr. Usha</u>	OT Nurse : <u>Sr. parvathi f Dr. Buddha</u>
Surgical Procedure : <u>Chronic Adenotonsillar Hypertrophy</u> <u>Chronic Rhinosinusitis</u>	
Indications for Surgery : <u>Rt - Inferior Turbinate Hypertrophy</u> <u>sp - Coblation Adenotonsillectomy</u> <u>Endoscopic sinus surgery Rt - Inferior Turbinoplasty</u>	
Date : <u>16/5/26</u>	Start Time : <u>12:50pm</u> End Time : <u>3:40pm.</u>

PRE-OPERATIVE PREPARATION :

.....

.....

.....

OPERATION NOTES:

.....

- Grade 4 adenoid hypertrophy
- Grade III tonsillar hypertrophy
- coblation Adenotonsillectomy
- Right middle meatal Antrastomy
- ~~Rt~~ ^{Right} Inferior Turbinoplasty

.....

.....

POST - OPERATIVE ORDERS :

1. IV Augmentin 600mg
IV BD

2. IV PCN 500mg IV BD

3. IV Tranexa 250mg IV BD

4. Betadine mouth gargle
2 times daily

5. Nasodec n/d 3^o / 3^o / 3^o

.....
Consultant Surgeon's Name

.....
Consultant Surgeon's Signature

Date : Time :

(07)

PATIENT TRANSFER FORM



Patient Name & UHID No. <i>Baby K Likitha</i>	Date & Time of Admission <i>16/05/26 @ 8:52 AM</i>	Date & Time of Transfer Order <i>16/5/26 @ 6:25 PM</i>
Treating Consultant Name <i>Dr. M. Santhosh</i>	Transfer Ordered by <i>Dr. Usha.</i>	Reason for Transfer <i>post-op-care</i>
From Unit <i>OT</i>	To Unit <i>ward - 307</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>26</i>	Number of Imaging Films <i>op file - 1</i>	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.	/	/
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Dr. B. Madhul</i> <i>16/5/26 @ 6:25 PM</i>	Name of Person Ordered Transfer <i>Dr. Usha.</i>
--	---

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

10/10/10




10/10/10



PATIENT TRANSFER FORM



Patient Name & UHID No. LBH-00064321 IP25-00020466 Baby K LIKITHA 9 Y 6 M 2 D (F) 14-11-2016 Dr. MANCHUKONDA SANTHOSH 		Date & Time of Admission 16/5/26 @ 8:52 AM	Date & Time of Transfer Order 16/5/26 @ 10:09 AM
		Transfer Ordered by DR. Kashmira	Reason for Transfer Admission
From Unit BR	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 13	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what? <i>RTD</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Aran</i>		Name of Person Ordered Transfer DR. Kashmira	
Patient & Clinical Records Received by : <i>Pr. Subhadevi</i>			
Date & Time of Patient Received : 16/5/26 @ 10:20 AM			

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

1. Introduction

2. Methodology

3. Results

4. Discussion

5. Conclusion

6. References

7. Appendix

0.T

**NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)**

5759907

Patient Name: BABY. K. LIKITHA		Age: 9Y	Gender: FEMALE
UHID No: LRH-CV064321	IP No: 25-00020466	Date: 16/05/26	Time: 09:09AM
Diagnosis: ADENOIDS HYPERTROPHY			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML ✓	100MCG	-
2.	Morphine Sulphate Inj. 15mg/ML	-	-
3.	Remifentanyl Hydrochloride Inj. 2MG	-	-
4.	Remifentanyl Hydrochloride inj. 1MG	-	-
Doctor Name: Dr. AISHWARYA		Doctor Registration No: 15MC / 1 MR / 24434	
Signature: <i>Aishwarya</i>			

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: **25-00020466** Date: **16/05/2026**
Aadhaar No. of the Patient (Optional):

1.	Name : BABY. K. LIKITHA	Remarks		
2.	Complete postal address (with contact number, if any)	11-NO:2-14/2, GUNTLOOR, SUMAPET NALLANDUR, TELANGANA, INDIA-505213		
3.	Brief description of the illness	ADENOIDS HYPERTROPHY.		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	-		
5.	Details of essential Narcotic drug dispensed	FENTANYL CITRATE		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
16/5/26	FENTANYL CITRATE	ONE	K. mamatha	-
-	-	-	-	-

Dispensed by (Name & ID No.): **K. PRASANTHI (1016027)** Signature: *K. Prasanthi*
Received by (Name & ID No.): **M. PRASANTHI (010444)** Signature: *M. Prasanthi*
Time: **09:10AM**

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name: ARYA K. KUMAR Age: 11 Gender: Female
 UHID No: 1111111111 IP No: 1111111111 Date: 11/11/11
 Diagnosis: 1111111111
 PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj. 50mcg/ml		
2	Morphine Sulphate Inj. 15mg/ml		
3	Propofol 1% Inj. 250mg		
4	Propofol 1% Inj. 100mg		

 Doctor Name: A. K. K. K. Date: 11/11/11
 Signature: _____
 Reg. No: _____

NARCOTIC DISPENSING FORM APPENDIX A - FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 1111111111 Date: 11/11/11
 Hospital No. of the Patient (Optional): _____

S.No	Name of the Patient (Optional)	Complete postal address (with contact number, if any)	Name of the Patient	Signature (Thumb impression of the patient)	Quantity	Name of the Essential Narcotic Drugs	Date
1	<u>ARYA K. KUMAR</u>						
2							
3							
4							
5							

Dispensed by (Name & ID No.): A. K. K. K.
 Received by (Name & ID No.): M. P. P. P.