DISCHARGE SUMMARY

Name	Master MANVITH ETIKALA	UHID	KOH-00289088
Father/Guardian	Mr SRIDHAR	Age/Gender	7 Y 10 M 5 D/ Male
Address	GAYATRINAGAR, Borabanda, Hyderabad, Telangana, INDIA, 500018		
IP No	IP25-00020464	Admission Date	15-05-2026
Ref Doctor	Self		
Discharge Date	17-05-2026		

Consultant:
Dr. Kinnera Reddy S.V
MBBS, MS General surgery (Manipal university),
MCH Plastic & Reconstructive surgery (NIMS),
Fellowship in Aesthetic surgery (Barcelona, Spine).
Co- Consultant:
Dr. Y. Arvind
MBBS, MD Pediatrics, FEPM
Consultant Pediatrician & Pediatric Emergencies
Reg.No. 84564.

DIAGNOSIS
SOFT TISSUE INJURY OVER FOREHEAD (LACERATION)

Surgical procedure : Debridement + Local advancement flap done on 16.05.2026.

Name	Master MANVITH ETIKALA	UHID	KOH-00289088
IP No	IP25-00020464	Admission Date	15-05-2026

History: Master MANVITH ETIKALA, 7 Years, 10 Months, 5 Days, male presented with alleged history of fall over a grill after bumping into another child while playing. Child sustained injury over the forehead following that. For the above complaints he was admitted at Rainbow Children's Hospital, Financial District for surgical management.

Examination: He was afebrile, maintaining saturations at room air (98%). Heart rate was 110/min, Blood Pressure - 102/62mmHg and Respiratory rate - 20/min. Local examination : Deep laceration over forehead ~ 6x2 cm. No active bleed. Nose bleed +, stopped. 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: 22 kilo grams.

Investigations: Enclosed reports.

Indication for surgery : Full thickness defect on the forehead done on 16.05.2026.

Pre-Operative preparation :
- Parts painted & draped.

Surgery Notes:
- 5 x 2 cm deep laceration on forehead - frontal bone exposed.
- Full thickness defect over the forehead
- Margins debrided. Wash given.
- Hemostasis achieved.
- Wound closed with a local advancement flap in multiple layers with 5-0 rapid vicryl & 5-0 prolene.
- Dressing done.
- Procedure uneventful.

Post-Operative Notes: Post operative period was uneventful. He was initiated on oral feeds gradually which he tolerated well. He was seen by Dr. Kinnera Reddy (Fellowship in Aesthetic surgery (Barcelona, Spine).) who advised to continue conservative management. He remained hemodynamically stable during the hospital stay and operated site remained healthy. He is being discharged with the following advice.

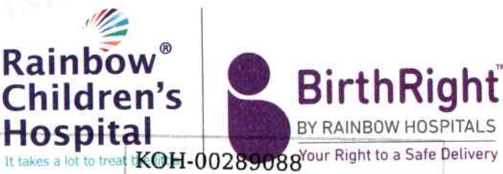
Advice:
* Syrup. Augmentin DDS (Amoxicillin - 400mg + Potassium clavulanate - 57mg/5ml) 5 ml thrice daily (1 hour before food or 2 hours after food) for 7 days (Should be kept in refrigerator after reconstitution, consume within 7-days)
* Tablet. Lanzol DT (Lansoprazole - 30 mg) 1 tablet once daily (1 hour before food) for 7 days

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SEELAPUR REDDY VENKATA KINNERA, 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 parenting, when and how to obtain emergency care etc also have been



Name	Master MANVITH ETIKALA	UHID	KOH-00289088
IP No	IP25-00020464	Admission Date	15-05-2026

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. Kinnera Reddy S.V
MBBS, MS General surgery (Manipal university),
MCH Plastic & Reconstructive surgery (NIMS),
Fellowship in Aesthetic surgery (Barcelona, Spine).
Co- Consultant:
Dr. Y. Arvind
MBBS, MD Pediatrics, FEPM
Consultant Pediatrician & Pediatric Emergencies
Reg.No. 84564.

Master. Manvith Etikala	UHID	ENCOUNTER NO
7 Y 10 M 3 D / Male	910000153004	912605151127
REFERRING PHYSICIAN DR.	REQUEST NO 91262006424	

REQUESTED DATE	COLLECTED DATE	RECEIVED DATE	REPORTED DATE
15 MAY 2026 23:11:48	16 MAY 2026 00:00:16	16 MAY 2026 00:09:00	16 May 2026 09:54:36

Test Description	Value	Unit	Biological Ref Range	Methodology
		DEPARTMENT OF HEMATOLOGY		
CBP (CBC+PS+RDW) - WHOLE BLOOD				
HB ESTIMATION.	**10.6 [L]**	g/dL	11.5 - 15.5	Cyanide free SLS Haemoglobin
PCV (PACKED CELL VOLUME).	**33.7 [L]**	%	35.0 -45.0	Hydrodynamic focusing
RED CELL DISTRIBUTION WIDTH (RDW)	**15.0 [H]**	%	11.6 - 14.5	RDW-CV
RBC COUNT	4.49	x10^12/l	4.0 - 5.2	Hydrodynamic focusing
MCV	**75.1 [L]**	fL	77 - 95	Calculated
MCH	**23.6 [L]**	pg	25 - 33	Calculated
MCHC	31.5	g/dL	31.0 - 37.0	Calculated
TOTAL WBC COUNT.	12.20	x10^9/l	05-13	Fluroscence Flow cytometry
PLATELET COUNT.	392	x10^9/l	170 - 450	Hydrodynamic focusing and Microscopy
DIFFERENTIAL COUNT (DC)				
NEUTROPHILS	**65 [H]**	%	40 - 55	Fluorescence Flow cytometry and Microscopy
LYMPHOCYTES	30	%	20 - 38	Fluorescence Flow cytometry and Microscopy
MONOCYTES	04	%	4 - 8	Fluorescence Flow cytometry and Microscopy
EOSINOPHILS	**01 [L]**	%	2 - 8	Fluorescence Flow cytometry and Microscopy
BASOPHILS	0	%	0 - 1	Fluorescence Flow cytometry and Microscopy
OTHERS	0			
ABSOLUTE NEUTROPHIL COUNT	7.93	x10^9/l	02-08	Calculated
ABSOLUTE LYMPHOCYTE COUNT	3.66	x10^9/l	01-05	Calculated
ABSOLUTE MONOCYTE COUNT	0.49	x10^9/l	0.2 - 1.0	Calculated
ABSOLUTE EOSINOPHIL COUNT	0.12	x10^9/l	0.1 - 1.0	Calculated
ABSOLUTE BASOPHIL COUNT	**0 [L]**	x10^9/l	0.02 - 0.1	Calculated

[H] - HIGH [L] - LOW

[HC] - HIGH CRITICAL [LC] - LOW CRITICAL

HIMAYATHNAGAR Emergency : 040 - 48873000 | BANJARA HILLS (JCI, NABH & NABL Accredited) Emergency : 040 - 4466 5555, 91009 25516 | HYDERNAGAR (NABH Accredited) Emergency : 040 - 4246 2300 | KONDAPUR OUTPATIENT CLINIC (JCI Accredited-IVF) Emergency : 040 - 4246 2100 | SECUNDERABAD (NABH Accredited) Emergency : 040 - 4246 2200 | KONDAPUR Emergency : 040 - 4246 2400 | L B NAGAR (NABH Accredited) Emergency : 040 - 7111 1333 | NANAKRAMGUDA Emergency : 040-69313233

1800 2122 www.rainbowhospitals.in

SURGERY DETAILS

Date : 16/3/26

Patient Name: Master Manvith Etikala Date of Birth: .... Age: 7

Gender: Male Ward : .... UHID No.: ....

Date of Surgery: .... ☑ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Debridement + Local advancement flap over forehead.

Time in : 9:15 AM Time Out : 9:50 AM

		NAME	AMOUNT
1.	Surgeon	Dr S.V. Kinnera Reddy	35,000/-
2.	Anaesthetist	Dr. Aishwarya	
3.	Assistant Surgeon	—	
4.	OT Technician	Br. Ramsasy	
5.	Circulating Nurse	Br. Sushadeep	
6.	Assistant Nurse	~~Br [illegible]~~, ~~Sr. Parvathi~~, Br. Buddha	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator ☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa ☐ Neuro Cusa ☐ Others ....

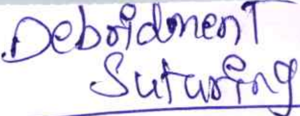
Kinnera
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 576022/23 Order by: Parvathi

Docu. No. : RCH/FRM/GENERAL/114

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSUMABLES OF OT

Circulating staff .... Technician : ANIL Date : 16/5/26 Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack Proto Bowl		02	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3	9915		01	Suction Catheter		
HME filter : A / P / N			Prolene (8899)		01	Feeding Tube		
Syringes : ~~10 cc~~		3				Vaccum Suction Set		
~~05 cc~~		3	Gloves 6½, 8		7	Surgical Gloves		
~~02 cc~~		3				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies					
O2-MASK (4)		1	Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask					
Morphine			Gauze Pack		03			
Ketamine			Mop Pack		03			
Propofol		2	Steristrip		01			
Rocuronium			Underpad			T-Bact ointment		01
Glycopyrolate			Draw sheet		04			
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
PCM		1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Dr. Kinnera Surgeon Dr. Usha Anaesthesiologist Nurse OT Technician

Order No. : 576035 (NSG) 576044 TECH Ordered by : Br. Buddhadel

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

Rainbow Children's Hospitals - Financial District

Survey No 74, Nanakramaguda village, Serilingampally(M) ,Hyderabad ,Telangana, INDIA ,500032.
TEL NO :040-44665555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP25-00020464 **Admit Date** : 15-May-2026 **Admit Time** : 09:58 PM **UHID** : KOH-00289088

Patient Details :

Patient Name	: Master MANVITH ETIKALA	**Age**	: 7 Y 10 M 4 D
Guardian	: Mr SRIDHAR	**DOB**	: 11-07-2018
Gender	: Male	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Single
Address (H)	: GAYATRINAGAR Borabanda Hyderabad Telangana INDIA 500018	**Phone No**	: 9948302422
		E-mail	: sridhar.etikala@gustosquad.com

Admission Details :

Bed Type : PRIVATE ROOM **Bed No** : PVT-303 **Ward Name** : 3F -PRIVATE ROOM

Room No : PVT-303 **Admission Type** : First Visit

Contact Details :

Name	: Mr SRIDHAR	**Relationship**	: S/O
Contact Address	: GAYATRINAGAR Borabanda Hyderabad Telangana INDIA 500018	**Phone No**	: / 9948302422

Signature

Doctor Details :

Doctor Name	: Dr. SEELAPUR REDDY VENKATA KINNERA	**Specialisation**	: PLASTIC SURGERY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	: Dr. Y ARVIND		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name: --

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

UHID No : --------------- IP No : -------------- ------------- Dept : -----------------

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/5/26	10:28	ER	303	[signature]
16/5/26	8:45 Am	3rd A (303)	OT	Miraj
16/5/26	2:40pm	OT	303	[signature]
17/5/26	9Am	303	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
15/05/26	CBP	17368	
	GRBS - 145 mg/dl	17367	Tapan
16/5/26	GRBS - 100 mg/dl	7390	Mirat

Cross checked by Kusuma 17/5/26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/5/26	Infusion pump	10:30 pm	16/5/26 @5pm	5911	Mirza
	Syringe pump		16/5/26 @10.30pm		

Cross checked by Kusuma 17/5/26

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/5/26	IV Cannulation	1	5908	[signature]
	PAC	1	5907	
16/5/26	NHA	01	6221	[signature]

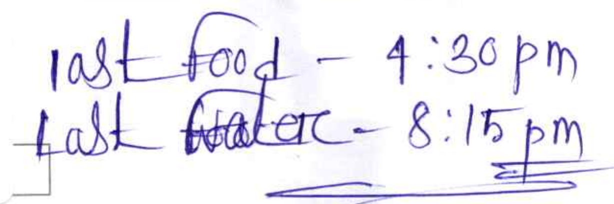
Cross checked by Kusuma 17/5/26

ANY OTHER INFORMATION

Date : 15/5/26 Time : 10 pm Prepared By : [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]	303		

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA



EMERGENCY ROOM TRIAGE FORM

Patient's Name : M. Manvith .... Age : 6 years Gender: ☑ Male ☐ Female

Date : 15/05/26 .... Time of Arrival : 8:45 pm

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: 97.7 F PR: 121 b/m BP: 121/82 (?) RR: 22 b/m SpO_2: 99%

Chief Complaints: Accidently fall down, Laceration over forehead (8 pm)

INITIAL PHYSIOLOGICAL CATEGORIZATION	**INITIAL PHYSIOLOGICAL STATUS**
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

Triage Classification	**CTAS**
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 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 : 8:50 pm

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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

1. 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: ....

2. 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 : Rupak .... Signature of Triage Nurse : [signature: Rupak]

Date & Time : 15/05/26 @ 8:47 pm

Docu. No. : RCH /FRM / CLINICAL / 085

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/05/26 Time of arrival : 8:45pm.

Chief Complaints: Deep Laceration over forehead. (8pm).

Height : .... Weight : 22.21 kgs. Head Circumference (<2 years) ....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: ....

If yes , identify ....

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 05/10. Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

☐ Character moderate ☐ Location forehead ☐ Frequency continous ☐ Duration ~ 40 min.

RISK FOR FALL:		**Functional Screening:** ☑ No Abnormalities Detected
If patient is < 6 years	☐ Yes ☑ No	☐ Mobility Problem
If **'Yes'** tick below fall risk intervention directly		☐ Walking Problem
If Patient is > 6 years		☐ Developmental Delay
If **'Yes'** Assess the below parameters		☐ Musculoskeletal Congenital Abnormality
History of Falling: within past 3 months	☐ Yes ☑ No	**Inform consultant for positive criteria**
Ambulatory Aids:		
• Wheelchair	☐ Yes ☑ No	
• Uses furniture for support	☐ Yes ☑ No	
Gait/Transferring:		
• Bedrest / immobile	☐ Yes ☑ No	
• Weak	☐ Yes ☑ No	**Nutritional Screening:** ☑ No Abnormalities Detected
• Impaired	☐ Yes ☑ No	☐ Underweight
Mental Status: Forgets limitations	☐ Yes ☑ No	☐ Overweight
		☐ Feeding Problem
IF YES FOR ANY CATEGORY = RISK FOR FALLING		☐ Special diet
Fall Risk Intervention:		☐ Special feeding method
☐ Escort while ambulating		**Inform consultant for positive criteria**
☐ Assist Patient		
☐ Educate patient and family on fall precautions/prevention		

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's'

Siblings in household ☑ Yes ☐ No (if yes How Many?) (1)

Time of Initial assessment completed by ER Nurse : 8:49pm

Docu. No. : RCHBH /FRM / CLINICAL / 120 (P.T.O.)

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

Time	Nursing Notes
8:45 pm	Assessed pt Condition
	monitor vitals.
	Dressing Done c Stamstip
	T/M plan @ 8:15 A.

Samples collected by: Biswajit Time: 9:45 p

Samples sent by : Rupak Time: 10:15 p

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9:02 pm	Syp. Ibugesic (+)	orally	10 ml	[signature]	Tupak

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 111 bpm BP: 102/62 CFT: < 2 sec	Shift - out from ER to: 303
RR: 24 b/m SPO2 at FiO2: 98 %	Time of Shift - out: 10:25 p 10:25
GCS: 15 Temperature : 98.2 F	Handover given to: (Nurse's Name) Mira
Pain Score: —	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV Cannulation

Name of the Nurse : [signature] Signature of the Nurse : [signature]

Date & Time : 15/5/26 @ 10 am

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Forehead

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

UHID ID:

Department:

Consultant:

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

Pediatric Multiorgan History & Physical Examination

Name : ____________________ Age/Sex ________

Information given by: ____________________ Relationship ________

Chief Presenting Complaints & Duration (Chronologically)

A/H/O Laceration over Forehead
while playing x today evening

History of present illness :

Child was apparently alright till today evening
when he was playing in his society

he had accidently bumped onto another
child while playing (running) followed
by hit over grill beside it

leading to laceration over forehead

and nose bleed

NO H/O LOC / seizures / vomiting

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

Pediatric Multiorgan History & Physical Examination

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

Nothing significant

Birth & Neonatal History:

Smooth Transition

Birth & Socio Economic History:

About Father :

About Mother : No similar illness in

Any additional Information : family member.

Developmental History :

App. to age

Immunization History :

As per age immunized

(P.T.O.)

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms)______(Centile ______) Height (cms):______(Centile)______)

Weight (kgs))______(Centile ______)

On Examination :

Temperature : 97 F Pulse Rate : 110/min B.P. ______ SPO2 ______

Resp.rate and type of breathing : 20/min

Rash______

Lymphadenopathy______

Oedema :______

Allergies (if any):______

LE - Deep laceration over forehead ~6x2cm No active bleed
Nose bleed (+) - stopped

Respiratory System :

Inspection (any s/o distress) :______

Air entry & breath sounds :______

Any addes sounds :______

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

B/L AE (+) clear

Cardiovascular System :

Inspection of procordium :______

Heart Sounds :______

Any murmur :______

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : S_1S_2 (+)

Per Abdomen :

Inspection______

Palpation : Soft, No HSM

Ausculation :______

Spine :______ External Genitelia :______

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

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Cranial Nerves :

Motor System:

Nutriton :

Tone: Power

Co-ordinator : B/L PERL

Posture : 15/15

Involuntary Movements :

No meningeal signs

Reflexes :

No base of skull #

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Deep Laceration over Forehead
Planned for wound debridement
+ Suturing U GA

(P.T.O.)

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Sepsis

Desired goals of the treatment :

H. stability

Planned Labs:

CBP

PAC fitness

Noted. RV
15/5/26

Planned Management

1. NPO from 2 am
2. PNS
3. IV Panto / PCM / Augmentin
4. W/f seizure / LOC / vomiting
   (SOS) CT brain

Signature of the Doctor: [signature]

Name of the Doctor: Dr Mohith

Date & Time: 15/5/26

Signature of the Consultant: [signature]

Name of the Consultant: Dr Arvind

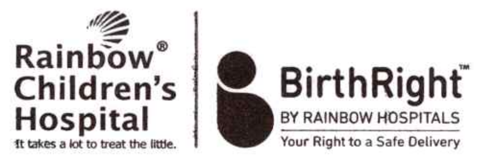
Date & Time: 15/5/26

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5 8 AM	O/S/B Dr. [illegible]	
	- No new issues over night	
	- No signs of raised ICP	
	- had one episode of vomitting - Non projectile subsided post [illegible] ondem	
	O/E	
	Alert/active	Plan
	C.B - ⓐ	① Shift to PreOP
	S/E - NAD.	② Rest CST.
	on NPO	
		[signature]

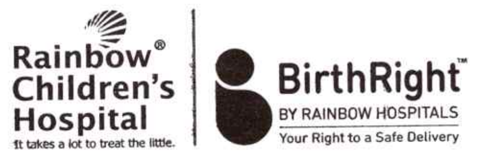
KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/2026 4pm	Y/B Dr. Sudha / Dr. Aravind.	
	S: Soft tissue Injury with Laceration over forehead	
	- POD - 0	
	- GC: stable	
	- No active bleed.	
	- alert, active.	
	- Had 2 vomitings ↓ tolerated feeding at 4pm No further vomiting.	
	~~Plan~~ Vitals	Plan
	HR: 90/min	continue IV fluids ~~until child tolerates feeds (x2)~~
	RR: 20/min	
	Afebrile	
	BP: 100/60 mmHg.	
		- Continue IV Augmentin
		- continue IV Paracetamol
		~~Noted by~~ Anjit on 16/5 @4pm
		(Dr. Y. Aravind)

KOH-00289088 IP25-00020461
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 6 D (M)
Dr. SEELAPUR REDDY VENKATA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26	C/S/B Dr. Aswini / Dr. Gnaha	
	Δ: Soft tissue injury c̄ laceration over forehead	
	POD - 1	
	· GC: stable	
	· taking orally, tolerating	
	· No new issues	
	Vitals	
	HR: 90/min	Plan
	RR: 22/min	Discharge on:-
	BP: 100/70mmHg	
	Afebrile	1) Syp. AUGMENTIN
		2) Syp. CROCINDS.
		[signature]
	[signature] (DrM.A. IND)	
	12/5/26	
	@10:20pm	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Docu. No. : RCH /FRM / CLINICAL / 088

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

RESULT SHEET

Date	15/5/26					
Time	orally					
Hb	10.6					
PCV	33.7					
RBC	4.49					
WBC	12.20					
N/L	65/30					
Platelets	392					
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						

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

Culture and Sensitivities : ....

....

....

....

Radiology: USG : ....

X-Ray:..

ECHO: ....

CT: ....

MRI ....

Others (ECG, Contrast Studies etc.,) : ....

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

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 / 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

Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

REGULAR PRESCRIPTIONS

Weight. 22kg Ward. 3rd

DRUG : INJ. AUGMENTIN				Date ▸ / Time ▾	15/5	16/5	17/5
Dose	Route	Frequency	Start Date				
660mg	IV	BD	15/5	7AM	X	6:20AM	
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions: 10PM – 7AM				10pm	11PM		
Daily Doctor's Endorsement by a Sign							

DRUG : INJ. PANTOPRAZOLE				Date ▸ / Time ▾	16/5	17/5
Dose	Route	Frequency	Start Date			
20mg	IV	OD	15/5			
Name & Signature of the Doctor Starting the Drugs:				6AM	12PM	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG : INJ. PARACETAMOL				Date ▸ / Time ▾	16/5	17/5
Dose	Route	Frequency	Start Date			
300mg	IV	8H	16/5	3AM		
Name & Signature of the Doctor Starting the Drugs:					9:30pm given	
Additional Instructions: (Post Sx)				11AM	OT	
				7pm		
Daily Doctor's Endorsement by a Sign						

DRUG :				Date ▸ / Time ▾	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VERIFIED

VERIFIED

Patient Sticker

Weight. 22 kg....... Ward. 3rd A.................

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	4 AM	Inj ONDEM	3 mg	IV	[signature]	Poornima
16/5	9.30 AM	INJ PARACETAMOL	300 mg	IV	[signature]	[signature]

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

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA

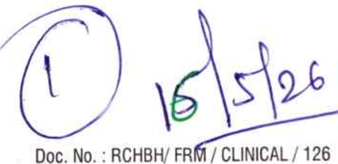
I.V. FLUIDS CHART

Weight. 22 Ward. 5th D

		...tion of I.V. Fluid (...n ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/5	10pm	DNS	IV	60 ↓ [illegible]	[signature]	[signature] [signature]	16/5/25	[signature]	[signature] [signature]

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

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 4 D (M)
Dr. SEELAPUR REDDY VENKATA



Doc. No. : RCHBH/ FRM / CLINICAL / 126

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	12 Am	3 Am	6:20 Am	Shifted to O.T	2:50 pm	7pm	11 pm
Doctor / Nurse / Family Concern?							
Temperature (°F) (scale 94–104)	97.4°F	97.1°F	97.1°F		98.6°F	98.8°F	97.9°
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring	101/68		120/70		99/69	99/73	110/69 (79)
Heart Rate (Number)	94 b/m	93 b/m	112 b/m		106 bpm	108 bpm	99 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)							
Resp Rate (Number)	21 b/m	19 b/m	22 b/m		23 bpm	21 bpm	22 b/m
Resp Distress: Mod/ Severe / None / Mild	N	N	N		N	N	N
Receiving O_2 (l/min) / O_2 Saturations (%)	98%	99%	98%		99%	98%	99%
Conscious Level: Normal / Altered	N	N	N		N	N	N
GCS *	15	15	15		15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0		0	0	0
Pain Score	3	3	3		2	2	2
Observer's Initials	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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: 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.

Patient Sticker

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 02/ 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)

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA

17/5/26

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	Obs 1	Obs 2
Date : .... Time:	3 AM	7 AM
Doctor / Nurse / Family Concern?		
Temperature (°F) (104–94)	97.5°	97.3°
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	96/69 (70)	105/70 (79)
Note: BP does not score in early warning scoring		
Heart Rate (Number)	103b/m	99b/m
Resp. Rate (bpm) (Over 1 Minute) * (70–1)		
Resp Rate (Number)	21b/m	22b/m
Resp Distress — Mod/ Severe / None / Mild	N	N
Receiving O_2(l/min) / O_2Saturations (%)	99%	98%
Conscious Level — Normal / Altered	N	N
GCS *	15	15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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: 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.

Patient Sticker

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)

15/5/26

FLUID CHART

Sheet No. : 1

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 Thrombo-phlebitis 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											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	—	Idly & H2O	—	No	No		No	No		0	
	12:00 am	—		—	No	No		No	No		0	
	01:00 am	DM		60	No	No		No	No	✓	0	
Total Intake : 60m						**Total Output :** M				U 21		
	02:00 am				No	No		No	No		0	
	03:00 am	~~DM~~ (struck out)	NPO	—	No	No		No	No		0	
	04:00 am	DM		60	No	No		~~No~~ (struck out)	No		0	
	05:00 am	DM		60	No	No		~~No~~ (struck out)	No	✓	0	
	06:00 am	DM	NPO	60	No	No		No	No		0	
	07:00 am	DM		60	No	No		No	No		0	
Total Intake : 240 m						**Total Output :**				U 21		

No Admission

Total 24 hrs. Intake	300ml

Total 24 hrs. Output	M U 22

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA

FLUID CHART

16/05/26

Sheet No. : 02

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.

		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am					Shifted from OT						
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
F.	02:40 pm	DNS	Juice + Daily + H2O	60ml	NO	NO			NO		0	[signature]
	03:00 pm	"		60ml	NO	NO			NO		0	[signature]
	04:00 pm	"		60ml	NO	NO			NO	✓	0	[signature]
	05:00 pm	NOIVF		NOIVF	NO	NO			NO		0	[signature]
	06:00 pm	"		"	NO	NO			NO		0	[signature]
	07:00 pm	"		"	NO	NO			NO		0	[signature]
Total Intake :		180ml + 60ml + 60ml				Total Output : M → 0 U → 1						
16/5	08:00 pm	NO		NO	NO	NO			NO		0	[signature]
	09:00 pm	I		I	NO	NO			NO	✓	0	[signature]
	10:00 pm		Dinner		NO	NO			NO		0	[signature]
	11:00 pm	V	x	V	NO	NO			NO		0	[signature]
	12:00 am	F	H2O	F	NO	NO			NO		0	[signature]
	01:00 am				NO	NO			NO	✓	0	[signature]
Total Intake :		I - 300ml				Total Output : M - 0 U - 2						
16/5	02:00 am	NO		NO	NO	NO			NO		0	[signature]
	03:00 am	I			NO	NO			NO	✓	0	[signature]
	04:00 am			I	NO	NO			NO		0	[signature]
	05:00 am	V		V	NO	NO			NO		0	[signature]
	06:00 am				NO	NO			NO		0	[signature]
	07:00 am	F		F	NO	NO			NO	✓	0	[signature]
Total Intake :		I -				Total Output : M - 0 U - 2						

Total 24 hrs. Intake	I - 600ml

Total 24 hrs. Output	M - 0 U - 5

Docu. No. : RCH /FRM / CLINICAL / 092

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10:25pm Mode of Arrival: walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: No

Body Weight: 22 kg Kg

Height: .... cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) ....

Past Medical History	Past Surgical History	Previous Hospital Admission
No	No	No

Family History: No

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☐ No

If yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: ....

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: .... Length: .... Head Circumference (< 2 years): ....

Temp.: 97.9°F HR: 101 RR: 24 BP: 101/65

Pain Score: 01 Specify Site: .... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 10/12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 01 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

Character of Pain .... Location .... Frequency .... Duration ....

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 ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

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 ....

Siblings in household ☑ ~~Yes~~ ☐ No (if yes How Many?) ....

All Information Obtained From ☐ Patient ☑ ~~Mother~~ ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No   Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No   Hand hygiene Explained: ☐ ~~Yes~~ ☐ ~~No~~   ☐ ~~Others~~

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ....Mother..

Nurse's Name: ....Miraj........................ Date: ......15/5/26........ Time: 10:45pm Signature

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

UHID.No : ....

Name: ... Master Mankith ... Age: ... 6 yr ... Sex: ... Male ...

Proposed Operation: ... SUTURING OVER FOREHEAD

Date: ... 15/05/26 ... Time: ...

Diagnosis: ... Laceration over forehead

ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

B.P / CRT: 121/82 mmHg H.R: 121 bpm Weight: 22.2 kg

RR = 22 cpm SPO2 = 99%, Temp = 97.7 F

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	
		SGOT/SGPT:		

Allergies: —

Patient Sticker

ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Conditi...

B.P / CRT: 104/76 ... Consent Present

Pre-OP Diagnosis: Laceration

SpO₂: 99-RA

✓ Chart Reviewed

R.R: 96/min

Surgeon: Dr Kenneera

Operation: Suturing

Last Feed: 8/5

Anaesthesiologist: Dr [illegible] / Dr [illegible]

Date: 16/5/24

Technician: [illegible]

TIME	9.15AM	9.45	10.15AM
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO	O_2 supplem via mask @ 6L/min		
Drugs:			
Inj Midazolam	1mg		
Inj Fentanyl	45μg		
Inj Propofol	50mg + 50mg + 30mg		
FIO_2 / SaO_2	100	100	
$ETCO_2$			
ECG 3 leads	SR	SR	
Temperature			
Urine Output			

Antibiotic

Suppository

Blood Loss

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Master Manvith Age: 6 Yr Sex: Male UHID.No :

Date: 15/05/26 Time: 9:20pm Proposed Operation: SUTURING OVER FOREHEAD

Diagnosis: Laceration over forehead

B.P / CRT: 121/82 mmHg H.R: 121 bpm Weight: 22.2 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

RR = 22 cpm SPO2 = 99%, Temp = 97.7 F

Laboratory Data:

Hgb: PCV: WBC: Plate: PT: PTT: INR:

Glucose: Urea: Creat: Na: K: Ca++: Mg++: Cl -:

Protein: Alb: Total Bill: Dir. Bill: LDH: Alk phos: Amylase: SGOT/SGPT:

HIV: HBS Ag: HCV: Blood group: T3 T4 TSH

X-Ray: ECG: 2D Echo: Stress/Anglo: Other:

Allergies: –

Medical History: CVS: A/H/o Accidental fall down at 8:00pm
C/o Bleed over B/L Nostril
No Ear Bleed
No LOC (+)
Dizziness (+), Blood loss 20-30 ml Noted

FT/LSCS/ Bwt = 2.7kg / CIAB / No NIC Sta...

RESP:

Diabetes: –

CNS: - Development as per age

Renal: - Immunization till date

Hepatic / GE:

Physical Activity: Active

Others:

Past Anaesthetic History: –

Physical Exam: Accurate

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: ++++ / (+)+++ ✓ loose teeth

Lungs : B/L AE (+)

Heart: S1 S2 (+)

CNS: Conscious, oriented

Pregnant: ☐ Yes ☐ No ☑ NA

Venous Access Site : Accessible Spine Exam for regional :

Anaesthetic Plan: ☑ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
Syrup Ibugesic	10 ml

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours } Explained
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions: CBP

Signature: [signature] Name: DR SHINY

Docu. No. : RCH /FRM / CLINICAL / 044

Patient Sticker

ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No — Fasting Status: >6 hrs

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 96/min B.P / CRT: 104/76 SpO_2: 99% RA R.R: 26/min Last Feed: 8 hrs

Pre-OP Diagnosis: Laceration Operation: Suturing Date: 16/5/24

Surgeon: Dr Kennela Anaesthesiologist: Dr Rishi / Dr Aishwarya Technician: Ravi

TIME	9.15AM	9.45	10.15AM
N_2O /AIR /O_2 LPM			
HALO /ISO /SEVO			

O_2 supplement via mask @ 6L/min

Drugs:
- Inj Midazolam 1mg
- Inj Fentanyl 45µg
- Inj Propofol 50mg + 50mg + 30mg

FIO_2 / SaO_2	100	100
$ETCO_2$		
ECG 3 leads	SR	SR
Temperature		
Urine Output		
Fluids		
Blood		

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: LUL
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☐ FIO_2 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: 9.15AM
OP Start:
OP End: 9.50 AM
Leave OR:

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV: RUL
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .... Attempts: ....
Difficulty Why?

☐ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☑ Other

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: Kosha
Signature of the Doctor: [signature]

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Br. Subhadeep Time Received : 9:55 AM Time Discharged : -

✓ RESP •PULSE > < BLOOD PRESSURE (chart 0–250, SpO2): 145/145/145; 45 46 48; 98%, 99%

IV Cannula Site : (R) Hand

☐ O$_2$ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: -
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No
IV Fluids: DNS
Oral Feeds: -

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		1	1	2		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 Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		1	1	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		1	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		7	8	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
16/8/26	9:55 AM		A8 per Axorn	[signature]

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Kesha
Anaesthesiologist Signature: [signature]
Date & Time: 16/5/26 @ 2:40 pm

PACU Nurse Name : Br. Subhadeep
PACU Nurse Signature: [signature]
Date & Time: 16/5/26 @ 2:40 pm

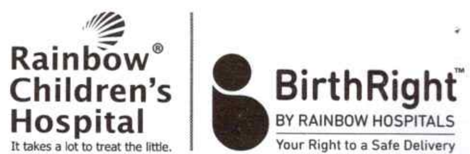
Reassessment Frequency:

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

Transferred to Unit by (PACU): ....

Date & Time: ....

Patient Sticker



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: .... Time: .... Procedure done by ....

CSE /Spinal /Epidural Position : .... Space :................................ Technique (LOR/LOS) ....

Depth: .... Catheter at Skin: .... Attempts : ....

Parasthesia : Yes/No if yes details : ....

Solution Composition : ....

Any other issues :

a) ....

b) ....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal		FHR	Comments
				BP	Pulse		

Delivery Details : Time : .... APGAR: .... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

OPERATION THEATER NOTES

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA

Patient's Name .... Age : .... Gender : ....

UHID.: .... I.P.No. : .... Weight : 22.21kgs

Surgeon : Dr S. V. Kinnera Reddy	Asst. Surgeon : —
Anesthetist : Dr. Aishwarya	OT Nurse : Br. Buddha

Surgical Procedure : Debridement + Local advancement flap.

Indications for Surgery : Full thickness defect on the forehead.

Date : 16/5/26	Start Time : 9:15 AM	End Time : 9:50 AM

PRE-OPERATIVE PREPARATION :

parts painted & draped.

OPERATION NOTES: 5 X 2 cm deep laceration on forehead - frontal bone exposed.

margins debrided. wash given
hemostasis achieved.

wound closed with a Local advancement flap in multiple layers using 5-0 rapid vicryl + 5-0 prolene

- dressing done

- procedure uneventful

Dr Kinnera Reddy

POST - OPERATIVE ORDERS :

Rx

1) NBM for 2hrs.

2) Inj Augmentin } as per pediatrician advice

3) Inj PCM }

Dr. S. V. Ammera Reddy

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 16/5/26 Time : 10:30AM

OT

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
master. Manit	16/5/26 @9:58pm	16/8/24 @2:40pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Kinner	Dr. Aishwarya	post op care
From Unit	**To Unit**	**Information to Attendant**
OT	~~NICU~~	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
27	—	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS (500ml)	01
2.	IV set	02
3.	T-Bacta	01
4.	Steristrip	01
5.	Under Pad	01

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Br. Subhadip (signature) @2:40pm	Dr. Aishwarya

Patient & Clinical Records Received by : Arijit (signature)

Date & Time of Patient Received : 16/5/26 @ 2:40pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
KOH-00289088 IP25-00020464 Master MANVITH ETIKALA 11-07-2018 7 Y 10 M 4 D (M) Dr. SEELAPUR REDDY VENKATA	15/5/26 at 9:50pm	16/5/26 at 8:45AM
	Transfer Ordered by	**Reason for Transfer**
	Dr. Mohit	Laceration
From Unit	**To Unit**	**Information to Attendant**
303	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
14	PAC - ①	~~Yes~~ ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS	
2.	Intrafix	
3.	Hight Pressure -	
4.	Thermometer.	
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Mirai	DR. Mohit.

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 16/8/26 @ 8:45AM

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

Docu. No. : RCH /FRM / CLINICAL / 102

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
KOH-00289088 IP25-00020464 Master MANVITH ETIKALA 11-07-2018 7 Y 10 M 4 D (M) Dr. SEELAPUR REDDY VENKATA	15/5/26 @ 9:58 pm	15/5/26 @ 10:25 p
	Transfer Ordered by DR. Mohith	**Reason for Transfer** Admission
From Unit ER	**To Unit** 303	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 14	**Number of Imaging Films** PAC — 1	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☑ No ☐ If yes, what ? 10 OP file

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS	1
2.	Intrafix	1
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature]	DR. Mohith

Patient & Clinical Records Received by : Miraj

Date & Time of Patient Received : 15/5/26 at 10:25 Pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

KOH-00289088 IP25-00020464
Master MANVITH ETIKALA
11-07-2018 7 Y 10 M 5 D (M)
Dr. SEELAPUR REDDY VENKATA

303

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 16-05-26 Time: 4:30PM

Weight: 22.21Kgs Centile: 25th Centile

Height: — Centile: —

Inference: Well Nourished Child

RDA: 1660Kcal - 1700KCAL Calories: 1700KCAL Protein: 19.0gms

Diet Recommendations: Advised moderate carbohydrates c̄ Adequate protein

Re-Assesment: —

Food Allergies: Nil ~~Veg~~/Non-veg

Diagnosis: Laceratio over forehead

Nutritional Intervention ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

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

Dietician's Name: Ashiya

Dietician's Signature: [signature]

Daily Notes:

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MASTER. MANVITH ETIKALA	Age: 7 Y	Gender: MALE
UHID No: KOH - [illegible] IP No: [illegible]	Date: 16/05/2026	Time: 06:39 AM.
Diagnosis: LACERATION OVER FOREHEAD.		

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.	Remifentanil Hydrochloride Inj. 2MG	–	
4.	Remifentanil Hydrochloride inj. 1MG	–	

Doctor Name: DR SHINY

Doctor Registration No: KMC 173328

Signature: [signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: [illegible]

Date: 16/05/2026

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	**Name :** MASTER. MANVITH ETIKALA	
2.	Complete postal address (with contact number, if any)	GAYATRI NAGAR. BORABANDA. HYDERABAD TELANGANA [illegible]
3.	Brief description of the illness	SUTURING.
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
16/05/2026	FENTANYL	ONE	[signature]	

Dispensed by (Name & ID No.): Bhaskar 015754 Signature: [signature]

Received by (Name & ID No.): [illegible] Signature: [signature]

Time: 6. AM

Docu. No: RCH / FRM / CLINICAL / 133

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:		Age:	Gender:
UHID No:	IP No:	Date:	Time:
Diagnosis:			

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	Remifentanil Hydrochloride Inj. 2MG		
4	Remifentanil Hydrochloride Inj. 1MG		

Doctor Name: Doctor Registration No:

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: .... Date: ....

Aadhar No. of the Patient (Optional) ....

		Remarks
1.	Name:	
2.	Complete postal address (with contact number, if any):	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recognized)	
5.	Details of essential Narcotic drug dispensed:	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.): .... Signature: ....

Received by (Name & ID No.): .... Signature: ....

Time: ....