BAH-00660615 IP5-00176039
Baby C BHAVISHYA
08-05-2015 11 Y 1 M 28 D (F)
Dr. Prashant Sachina

Patient Sti

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SURGERY DETAILS

Date : 06/07/26

Patient Name: Baby. Bavishya Date of Birth: 08-05-2015 Age: 11yrs

Gender: Female Ward : P. OT - III UHID No.: BAH - 0066615

Date of Surgery: 06/07/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Colonoscopy & Biopsy

Time in : 4:00pm Time Out : 5:30PM

	NAME	AMOUNT
1. Surgeon	: Dr Alisha	
2. Anaesthetist	: Dr. Surya	
3. Assistant Surgeon	:	
4. OT Technician	: Aman	
5. Circulating Nurse	: Swapna	
6. Assistant Nurse	: Sravani	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others Colonoscope 28cm :> 9690625

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9690625 Order by: J. Ramadevi

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Colono Scopy

CONSUMABLES OF OT

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Circulating Staff ..... Technician : ..... Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 6.6½ ~~7.0~~	1+1	—	Major Pack			Inj Vit.K		
LMA ✓			Sutures			Cord Clamp		
ECG leads : A / P / N	5	03				Suction Catheter		
HME filter : A / P / N	1	—				Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	05	Gloves 6, 6½, 7, 7.		—	Surgical Gloves		
02 cc	10	03	6, 7	2+2	2+1	Gauze Pack		
01 cc		—				Syringe 1ml / 2ml		
Cautery plate : A / P / N		—	Surgical blade			Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL ✓	1	—	Cautery pencil			500ml NS	2	2
NS : 10ml / 100ml / 500ml / 1000ml	1	01	Koochies ~~All Adult~~	1	1	Mansoflin	1	1
Air way 2,3	1+1	—	Ointments			Soft	1	1
O2 Nasal Prongs ET(A)	1	01	Suction Catheter			50cc, 10cc	1+1	1+1
Fentanyl	1	01	Cap, Mask	5/5	10/10	Plastic apron	2	~~3~~
Morphine			Gauze Pack N	2	2			
Ketamine			Mop Pack	1	1			
Propofol	6	04	Steristrip					
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	—	Draw sheet					
Myopyrolate	1	—	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet	1	0			
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum Sheh		01	Microshield					
Buscopan		01	Cotton Balls					
Dexmed 100mcg		01	Latex Gloves	16P	16P			
50cc + pmo line		1+1	Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9690631 Ordered by : .....

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

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Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176039 **Admit Date** : 06-Jul-2026 **Admit Time** : 02:54 PM **UHID** : BAH-00660615

Patient Details :

Patient Name	: Baby C BHAVISHYA	**Age**	: 11 Y 1 M 28 D
Guardian	: Mr C BALAKRISHNA	**DOB**	: 08-05-2015
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: 12-2-686/1 Gudimalkapur Hyderabad Telangana INDIA 500028	**Phone No**	: 9550436498
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 401 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 401 **Admission Type** : First Visit

Contact Details :

Name : Mr C BALAKRISHNA **Relationship** : Father

Contact Address : 12-2-686/1 Gudimalkapur Hyderabad Telangana INDIA 500028 **Phone No** : / 9550436498

Signature

Doctor Details :

Doctor Name : Dr. Prashant Bachina **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. M N V POUSHYA SAI

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP 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
6/7/26	3:20pm	ER	OT	
6/7/26	6pm	OT	Billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
06/07	CBP, CRP, ESR, Albumin	(op Basis)	Tenuf

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	Tx placement	1	690351	Tuf
6/7	PAC	1		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 Colonoscopy ± Biopsy

2 .....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Evaluation and diagnosis	Nill

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a. Bleeding
b. Perforation

1. I authorize Dr. Prashant B and his / her team to perform the procedural sedation upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:
Signature: Savitha
Name: Savitha
Relationship with patient: Mother
Date & Time: 6/7/26, 3:45 pm

Witness:
Signature:
Name: Suman
Date & Time: 6/7/26 at 3:45 pm

Doctor (who is taking consent):
Signature: Name: Dr. Hema Tulsi Date 6/7/26 Time: 3:40 pm

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్‌బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.
b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికి _ / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
   ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేర్లు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Abha
Asst. Surgeon : Dr. Kunal
Anaesthetist : Dr. Surya
Scrub Nurse : Sravathi

Patient Name : Baby. Bhavishya Age : 11y Gender : F
UHID No. : BAH-00660615 Surgery Name : Colonoscopy + Biopsy
Date : 06/07/26 In-time : 3:55 pm Out-time :

BAH-00660615 IP5-00
Baby C BHAVISHYA
08-05-2015 11 Y 1 M
Dr. Prashant Bachina

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 3:48 pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☐ Yes ☐ No ☑ NA

Signature :
Name : Dr. K Sri Surya

Before Skin Incision ➤➤

TIME OUT Time: 4:05 pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Voluntary 30 mins Nil ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☑ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☑ No

Signature :
Name : Swapna

Before Patient Leaves Operating Room

SIGN OUT Time:

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : Dr Kunal
Name : Dr. Kunal.

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 06/04/26

To Be Filled In By Assigned Nurse :

Department : P.OT-III Duration of Procedure : 1 hrs

Name of Surgeon : Dr. Alisha Date of Admission : 06/04/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : NA	
2.	Hair Removal ☐ Yes ☑ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : —— Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : NA Date & Time of antibiotic administration : NA Date & Time procedure started : 06/04/26 @ 4:05 pm	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

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OPERATION THEATER NOTES

Patient's Name : Bhavishya Age 11y 1m 28D Gender : ☐ Male ☑ Female

UHID No.: BAH-00660615 Weight : 41.43 kg Height : —

Surgeon :	Asst. Surgeon :	
Anesthetist : Dr. Surya	OT Nurse: Sravani	OT Technician: Aman
Pre-Operative Diagnosis:		
Surgical Procedure: Colonoscopy (+) Biopsy		
Indications for Surgery : GI bleed (+) weight loss		
Date : 06/07/26	Start Time : 4:05pm	End Time : 5:30pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Colonoscopy (+) Biopsy

Patulous anal opening (+).

anal canal & terminal rectum -
- ulcers (+) exudates (+)
- LOV (+).

ulcers (+) are medium, non serpiginous, rigid.

Rest of the colon & rectum (N)

Seen till 50 cm of Ileum

- Exaggerated Ileal nodularity (++).

Amount of Blood Loss: ×

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

(4) (1) Ileum (2) Caecum + As. colon (3) Colon (4) disease area (Rectum)

Peri-Operative Complications:

×

Name of the Surgeon: Dr Alisha

Signature of the Surgeon:

Date & Time: 6/9/26

Patient Stick

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Colonoscopy

Post-Surgical Diagnosis: ? IBD

Post-Operative Monitoring Parameters /Frequency:

x

Wound Care:

x

Drain /Special Lines/Catheters:

x

Special Patient Positioning and Requirements:

x

Nutritional Instructions:

x

When to Start Mobilization:

immediate

Special Referrals:

x

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No ✓

Any Other Post-Operative Care Needed including Required Follow Up

Vitals monitory

Treating Surgeon
(Signature & Stamp)

Date: 6/7/16 Time: 5pm

Note: Plan of care will be readjusted if necessary.

BAH-00660615 IP5-00176039
Baby C BHAVISHYA
08-05-2015 11 Y 1 M 28 D (F)
Dr. Prashant Bachina

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 8/7/20 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:				

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 41.43kg Ward. OT

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				

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				

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				

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				

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Weight. ch1..6.3.kg Ward. .....O.T.....

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

Signature .....

VERIFIED BY : Name .....

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IP5-00176039 BAH-00660615

I.V. FLUIDS CHART

Weight. 41.434kg Ward. OT

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
6/7/15		DNS (Full maint) (During NPO)	IV	80					

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