[redacted] UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
r. MANCHUKONDA SANTHOSH

Master K. KRISHNA SRIHAN (8 Y 1 M 28 D/ M)
SWAB
CUV-00171083
NIN/00840
BA26050967017

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SURGERY DETAILS

Date : 19/05/26

Patient Name: MASTER. K. KRISHNA SRIHAN Date of Birth: 21/03/2018 Age: 8 Yrs

Gender: MALE Ward : UHID No.: CUV-00171083

Date of Surgery: 19/05/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : coblation Adenotonsillectomy Intracapsular

Time in : 3.10 Pm Time Out : 4.00 p.m.

		NAME	AMOUNT
1.	Surgeon	: DR. M. SANTHOSH	
2.	Anaesthetist	: DR. Sandhya	
3.	Assistant Surgeon	:	
4.	OT Technician	: NISHAND	
5.	Circulating Nurse	: AMOS	
6.	Assistant Nurse	: Thejas	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others coblator → 9616060

Signature of the Surgeon

Jyothi
Signature of Circulating Nurse

Order No: 9616059 Order by: Jyothi

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

Mst. Krishna SRIHAN

CV [redacted] 0047 1023 Patient Sticker
84/M 21.5kg
5091

Adeno

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CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : 19/5/26 Time : 12:30pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube oral 4.0/4.5/5.0	1+1+1	01	Major Pack Drape	1	1	Inj Vit.K		
LMA		—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	03				Suction Catheter		
HME filter : A / P / N	1	01				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	3	PF Gloves 6.5, 7, 7.5 2+2+2+2 → 1+1			Surgical Gloves		
02 cc	10	2	6, 6.5, 7, 7.5 2+2+2+2			Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	01	NG tube 6	2	2	Koochies (S)		
RL	1	01	Cautery pencil			NS 500ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	1+1	1+1	Koochies			Adrenalin	3	3
Minispike	1	01	Ointments			(OC) Sc 2+2	2	1
Oxymask (P)	1	—	Suction Catheter			Savlon	1	1
Fentanyl	1	01	Cap, Mask	8/8	8/8			
Morphine			Gauze Pack (N) FR	4+4	2			
Ketamine			Mop Pack	1				
Propofol	3	01	Steristrip					
Rocuronium	1	01	Underpad	1	1			
Glycopyrolate	1	01	Draw sheet	1	1			
Myopyrolate	1	—	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			Gauze	3	01
Bupivacaine 0.25%			Chest Drainage Catheter			Glassan	4	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dexamed	1	—
Antibiotics Aug 1020mg	1	01	Bandage			Dexa-Tranexa	1+1	1+1
I.V. pcm	1	01	Tegaderm			50C+pm line	1+1	—
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	2			
Justin : 12.5 mg / 25mg / 100mg	1+1	01	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	—	—			
Vacuum set	1	01	Microshield	1	0			
Oral airway 1/2	1+1	—	Cotton Balls	1	0			
Nasal airway 18/20	1+1	—	Latex Gloves	1op	1op			
3 way cocktail	1+1	01	Ramdione Scrub					
IV cannula 22/24	1+1	—	Saral					

Surgeon .... Anaesthesiologist .... Nurse Anns .... OT Technician

Order No. : 9615904 .... Ordered by : ....

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

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ACTIVITY RECORD FOR BILLING

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Name :___ _____

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
19/5/26	12:10pm	ER	OT	Abhishek
19/5/26	5:30 pm	OT	239	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. faisal B nandi	20/5/26	056/7043	Barnali
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/5	replacement	1	15425	[illegible]
	PAC OPD			
20/5/26	NHA	1	95617044	Bori

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP5-00174013 **Admit Date** : 19-May-2026 **Admit Time** : 10:59 AM **UHID** : CUV-00171083

Patient Details :

Patient Name	: Master K. KRISHNA SRIHAN	**Age**	: 8 Y 1 M 28 D
Guardian	: Mr RAGHAVENDER	**DOB**	: 21-03-2018
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: CARE OF POWER GRID COPRATION QUATER NOC-1 Nunna Krishna Andhra Pradesh INDIA 521212	**Phone No**	: 8527391638/ 9182941655
		E-mail	: SAHITYAANANTHULA@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 RAGHAVENDER **Relationship** : Father

Contact Address : CARE OF POWER GRID COPRATION QUATER NOC-1 Nunna Krishna Andhra Pradesh INDIA 521212 **Phone No** : 8527391638 / 9182941655

Signature

Doctor Details :

Doctor Name : Dr. MANCHUKONDA SANTHOSH KUMAR **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

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

Payor Name : POWER GRID CORPORATION OF INDIA

239.

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 29 D (M)
Dr. MANCHUKONDA SANTHOSH

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary				
3	Nursing Initial assessment	1			
4	Patient Transfer form	1+1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)	1+1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	2			
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra.	5+2			
	Billing	2			
	Total No. of Pages	36			

Signature and Date : R. Tejasri 20/05

Doc. No. : RCHBH/ FRM / GENERAL / 126 (P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o recurrent episodes of
cold, cough, noseblocke⊕
tonsillitis
Open mouth Breathing
Snoring Issues⊕

History of present illness :

As per informant, child apparently well then had recurrent episodes of cold, cough,
tonsillitis
Open mouth Breathing
Snoring Issues
Had Adenoid Hypertrophy⊕

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

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

Similar illness since 1 year

Birth & Neonatal History:

FTO

N perinatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information : middle.

Developmental History :

Attained appropriate for age.

Immunization History :

Immunised till date

(P.T.O.)

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 6 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 20.7 Kg (Centile _____)

On Examination :

Temperature : 98.2°f Pulse Rate : 103/min B.P. 95/52 (59) mm Hg SPO2 99.1 RA

Resp.rate and type of breathing : 24/min
Regular

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : BAE (+), clear

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+) Heard

Any murmur :

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

Per Abdomen :

Inspection (N)

Palpation : Soft non tender

Ausculation : BS (+)

Spine : (N) External Genitelia : (N)

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

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert/Active

Cranial Nerves : Intact

Motor System:

Nutriton : Good

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements : Nil

Reflexes :

DTR **Superficials:**

Plantars (N)

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Coblation Adenotonsillectomy

(P.T.O.)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent Complications

Desired goals of the treatment : For Hemodynamic Stability

Planned Labs:

IV Cannula

Planned Management

1) Continue NPO
2) IV fluids DNS @ 50ml/hr
3) Shift to OT on call

Signature of the Doctor: JA
Name of the Doctor: Jaya Sri
Date & Time: 19/5/26

Signature of the Consultant: .....
Name of the Consultant: Dr. M. Santosh Kumar
Date & Time: .....

UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
l-03-2018 8 Y 1 M 28 D (M)
r. MANCHUKONDA SANTHOSH

SmithNephew
EVAC° 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2201074
2028-10-21

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OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender : ☐ Male ☐ Female

UHID No.: ..... Weight : ..... Height : .....

Surgeon :	Asst. Surgeon :	
Anesthetist : DR. SHINY	OT Nurse: Thejas	OT Technician: Nishad
Pre-Operative Diagnosis:		
Surgical Procedure : coblation Adenotonsillectomy		
Indications for Surgery :		
Date :	Start Time : 1:25pm	End Time : 2 pm
Pre Operative Preparations:		
Post Operative Diagnosis:		
Peri-Operative Complications:		
Operation Notes:		
- Grade III adenoid & tonsillar hypertrophy		
coblation Adenoidectomy & intracapsular Tonsillectomy		
- Pus & polypoidal mucosa in b/c OMC		
- Swab sent for CBS		

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

1. Inj. Augmentin 500mg IV BD

2. Inj. PCM 300mg IV TID

3. Inj. Tramadol 100mg IV BD

4. Nasoclear nld 3°-3°-3

5. Betadine mouth gargle 2 times daily

Name of the Surgeon: Dr. Santhosh

Signature of the Surgeon:

Date & Time: 19/5/26 @ 3 PM

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

8yr.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5 6:00pm	C/S/B Resident	
		Plan
	child doing well	
		(1) Inj Augmentin
	no fresh complaint	
		(2) Inj Pcm.
	Started oral soft food.	(3) Inj Tranexa 200mg.
	NO nasal bleed/ NO vomits	(4) Nasoclear N/d. (5) Betadine gargle
	Vitals : Stable	
		sohel (Dr. Sohel)
10/5/26. 8 Am.	Seen by Resident : Dr Saithri	
	S/P coblation adenotonsillectomy	
	No fresh issues	
	accepting orally	1. Plan D/C today
	O/E	
	child afebrile, active	Saithri
	hemodynamically stable.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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21-03-2018 8 Y 1 M 29 D (M)
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CROSS CONSULTATION FORM

Doctor Name : Dr faisal Date : 20/5/26 Time : .....

Diagnosis : .....

Hospital : RBH-BAT

.....

Referred for : ☑ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☑ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

chronic adenotonsillitis
S/P adenotonsillectomy POD-1.

No fever / vomiting / bleeding

Accepting orally

O/E
Child alert, afebrile
Hemodynamically stable.
Chest clear
Abdomen soft

Plan
1. can be discharged today
2. f/u c ENT surgeon.

Consultant :

Name : Dr. faisal Signature : DR. FAISAL B NAIK Registration No: 86449 Date & Time : 20/5/26

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
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						

D/C

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.,) : .....

CUV-00171083 IP5-00174013
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: GR Shifted to: 07

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sai

Date & Time : 19/5/26

Nurse Name & Signature: Abhishek

Date & Time : 19/5/26

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DRUG CHART

Date of Admission: 19/05/16 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 K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

REGULAR PRESCRIPTIONS

Weight. 20kg Ward. ....

DRUG : Inj AUGMENTIN				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date			
500mg	I.V	BID	19/5	6am	12:30pm 01	Nilai Kalai
Name & Signature of the Doctor Starting the Drugs: Sohil						
Additional Instructions:				6pm	10pm Kala Nilai	
Daily Doctor's Endorsement by a Sign						

DRUG : Inj TRANEXA				Date / Time	19/5	
Dose	Route	Frequency	Start Date			
200mg	I.V	BID	19/5	10am	01	
Name & Signature of the Doctor Starting the Drugs: Sohil				10pm	Kala Nilai	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG : INJ PARACETAMOL				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date			
300mg	I.V	TID	19/5	6am	X	Kala Nilai
Name & Signature of the Doctor Starting the Drugs: Sohil				2pm	Kala Nilai	
Additional Instructions:				10pm	Kala Nilai	
Daily Doctor's Endorsement by a Sign						

DRUG : NASOCLEAR DROPS				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date			
3°	N/D	TID	19/5	6am	X	Kala Nilai
Name & Signature of the Doctor Starting the Drugs: Sohil				2pm	X	
Additional Instructions:				10pm	Kala Nilai	
Daily Doctor's Endorsement by a Sign						

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Sheet No: ....

REGULAR PRESCRIPTIONS

Dept. .... Ward. ....

DRUG : BETADINE MOUTH GARGLE

Dose	Route	Frequency	Start Dt.
	P/O	TID	19/5

Name & Signature of the Doctor Starting the Drugs: Soheb

Additional Instructions: 5ml BETADINE IN 1Glass water

Daily Doctor's Endorsement by a Sign

Date/Time	19/5	20/5
6am	X	Kalp Vikas
2pm	X	
10pm	X	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Patient Sticker

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Sheet No: .... **REGULAR PRESCRIPTIONS** Dept. .... Ward. ....

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

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

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

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

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

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH (M)

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

	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
19/5	1:30pm	Inj PARACETAMOL	315mg	iv	[illegible]	[illegible] Pooja (1:36)
19/5	1:40pm	Inj TRANEXAMIC ACID	300mg	iv	[illegible]	[illegible] Pooja (1:45)
19/5	1:45pm	Inj DEXAMETHASONE	2mg	iv	[illegible]	[illegible] Pooja (1:50)
19/5	1:20pm	Inj. AUGMENTIN	630mg	IV	[illegible]	[illegible] Pooja (1:30)

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

21-03-2016
Dr. MANCHUKONDA SANTHOSH

I.V. FLUIDS CHART

Weight. 20.7 kg Ward. ....

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
19/5	8am	Ivf. DNS	IV	50ml/hr	Sai	Baonali Nitai	not connected		
19/5	1:15pm	RINGER LACTATE	IV	210ml/hr	[illegible]				

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

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others .....

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
19/5	11:30 AM	8	procedures	M	1	0	1	1	NA	Abhishek
20/5/24	9am	9	soft diet	F	1	0	1	1	—	Monica

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. Nope
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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Master K. KRISHNA SRIHAN
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Dr. MANCHUKONDA SANTHOSH

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
19/5 11:30 Am	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Chronic Adenotonsillitis	For Hemodynamic stability	Adenotonsillectomy with coblation	Jayasri	☑ Nursing ☐ Others:
19/5 11:30 Am	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Chronic Adenotonsillitis	Hemodynamic Stability	Adenotonsillectomy with coblation	Abhishek	☑ Medical ☐ Others:
21/5/26 9am	☐ Medical ☐ Nursing ☑ Others: Dietitian	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Adenotonsillitis	Soft diet	RDA E- 1550 kCal/d P- 29 g/d	Monica	☐ Medical ☐ Nursing ☑ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

CUV-00171083 IPS-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
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IPO — 8:30pm (Solid)
8:30 AM (Coconut water)

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Krishna. Srihan Age : 8 Y 1 M Gender: ☐ Male ☐ Female

Date : 19/05/26 Time of Arrival : 10:32 PM Triage Completion Time : 10:34 AM

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies

Source of Information : ☐ Parents ☐ Others (Specify) Nil

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☐ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☐ Stable
☐ Unstable :
☐ Not – Life - Threatening
☐ Life – Threatening

Initial Vital Signs: Temp: 98.2°F PR: 103 b/m BP: 95/50 (58) RR: 22 b/m SpO: 98% RA

Chief Complaints: Came for. Coblation Adeno Tonselectomy

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

K. Sathya
Signature of Parent / Guardian

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 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 : NR Subhra

Signature of Triage Nurse : S

Date & Time : 19/05/26 at 10:34 AM

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr MANCHUKONDA SANTHOSH

19/5/26

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	6pm	10pm	2AM	6am
Doctor / Nurse / Family Concern?				

Temperature (F) — 104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94

98.2°F (6pm) · 98.3°F (10pm) · 96.2°F (2AM) · 94.2°F (6am)

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

	6pm	10pm	2AM	6am
BP	106 (67) 58	103 (70) 60	101 (65) 56	96 (59) 63
Heart Rate (Number)	118 b/m	102 B/m	112 B/m	106 B/m

Resp. Rate (bpm) (Over 1 Minute) *

70 / 60 / 50 / 40 / 30 / 20 / 10

	6pm	10pm	2AM	6am
Resp Rate (Number)	26 b/m	24 B/m	28 B/m	24 B/m
Resp Distress (Mod/ Severe / None / Mild)				
Receiving O_2 (l/min)	1L		RA	RA
O_2 Saturations (%)	100 %	100 %	99 %	
Conscious Level (Normal / Altered)				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

ACTIONS NB: Scores 3 should be recorded overleaf	
	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

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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)

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
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FLUID CHART

Sheet No. : 19/5/26

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: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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	↑		–							0	Dipanwita
19/5	06:00 pm	No IVF	Jelly Date	–			NP			✓	0	Dipanwita
	07:00 pm	↓		–							0	Dipanwita
Total Intake :								**Total Output :** M - 0 U - 1				
	08:00 pm		Ice cream	–							0	Swathi
	09:00 pm			–						✓	0	Swathi
	10:00 pm	NO		–							0	Swathi
	11:00 pm	IVF		–			NP			✓	0	Swathi
	12:00 am			–							0	Swathi
	01:00 am			–							0	Swathi
Total Intake :								**Total Output :** M - U - 2				
	02:00 am			–							0	Swathi
	03:00 am			–						✓	0	Swathi
	04:00 am	NO		–							0	Swathi
	05:00 am	IVF		–			NP			✓	0	Swathi
	06:00 am			–							0	Swathi
	07:00 am		Milk	–						✓	0	Swathi
Total Intake :			Good					**Total Output :**		M -	U - 5	

Total 24 hrs. Intake		Total 24 hrs. Output	M - 0 U - 5

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21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

FLUID CHART

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Sheet No. : .....

20/5/26

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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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											
	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**	

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☐ Patient Attendant

Operative Procedure: ADENO-TONSILLECTOMY & COBLATION

Anaesthesiologist: Dr. Ayesha Surgeon: Dr. SANTHOSH KUMAR

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and *does not feel* pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Laryngospasm, Bronchospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- 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: K. Sahithya
Name: K. Sahithya
Relationship with patient: Mother
Date & Time: 18/5/26, 12:55pm

Witness:
Signature:
Name:
Date & Time: 18/5/26 @ 12:55 pm

Doctor (who is taking consent):
Signature: Name: Dr. Sk. Ayesha Date 18/5/26 Time: 12:55pm

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ లీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

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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 Coblation Adenoidectomy & Tonsillectomy (Intracapsular)

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)
Nose block M-breathing	

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.

b.

1. I authorize Dr. M. Santhosh Kum 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: .....

Name: K. Sahithi

Relationship with patient: Mother

Date & Time: 19/5/26, 12:54pm

Witness:

Signature: .....

Name: A. Sangeeth

Date & Time: 19/5/26, 12:54 pm

Doctor (who is taking consent):

Signature: ..... Name: Dr M. Santhosh Date 19/5/26 Time: 12:30 pm

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనోస్ 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 శస్త్రచికిత్స / 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: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
. MANCHUKONDA SANTHOSH

SURGICAL SAFETY C

Patient Name : Mst. K Krishna Srihan Age : 8y Gender : M

UHID No. : ..... Surgery Name : .....

Date : ..... In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12:40 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. N.K. [illegible]

Before Skin Incision ➤➤

TIME OUT Time: 1:23 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, 1hr Anticipated Blood Loss? ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews: Laryngospasm, Bronchos
- 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 : Teeven

Before Patient Leaves Operating Room

SIGN OUT Time: 2:35 pm

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 : .....

Name : DR. M. Santhosh

Patient St... UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN (M)
1-03-2018 8 Y 1 M 28 D
r. MANCHUKONDA SANTHOSH

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 19/5/26

To Be Filled In By Assigned Nurse :

Department : P. OT Duration of Procedure : 1 hr

Name of Surgeon : DR. M. Santhosh Date of Admission : 19/5/26

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 : Inj. Augmentin	
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 : Aman Date & Time of antibiotic administration : 19/5/26 @ 1 pm Date & Time procedure started : 19/5/26 @ 1.20 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

Patient UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
1-03-2018 8 Y 1 M 28 D (M)
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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

Treating Surgeon
(Signature & Stamp)

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

Note: Plan of care will be readjusted if necessary.

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
21-03-2018 8 Y 1 M 29 D
Dr. MANCHUKONDA SANTHOSH

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/5/26 Time: 9:00am

Weight: 20.7kg Centile: 5th

Height: 120 cm Centile: 75th

Inference: Under weight Child

RDA: — Calories: 1550 kcal/d Protein: 27g/d

Diet Recommendations: Soft diet

Re-Assesment: Avoid spicy, outside Foods

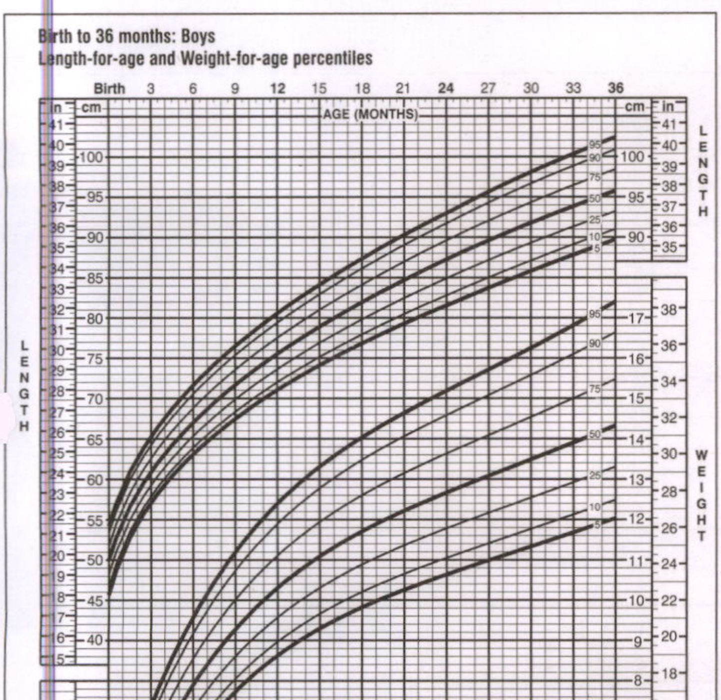
Food Allergies: NO Veg/Non-veg Non-veg.

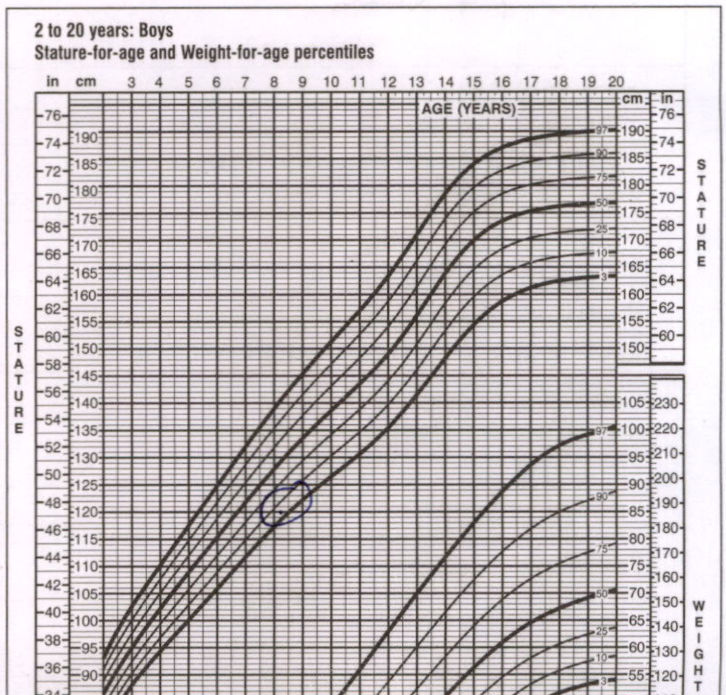
Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (BOYS)





Dietician's Name: Mounica Dietician's Signature: Mounica

Daily Notes:

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
K. K CUV-00171083 IPS-00174013 Master K. KRISHNA SRIHAN 21-03-2018 8 Y 1 M 28 D (M) Dr. MANCHUKONDA SANTHOSH	15/26 at 10:59Am	19/5/26 at 12:10pm
Treatin	Transfer Ordered by Dr. Jayasri	Reason for Transfer Surgery
	From Unit ER	To Unit OT
		Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 25	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what? Op File	Patient shifted with ID band: Yes ☐ No ☐ If No: .....
Number of Imaging Films		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	EVAC	1
2.	Gown	1
3.	Kochue	1
4.		
5.		

ting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Ns. Abhishikta	Dr. Jayasri

Patient & Clinical Records Received by :

Date & Time of Patient Received : 19/05/26 3:30pm.

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/05/26 Time of arrival : 10:36Am

Chief Complaints: Come for Adenotonsillectomy & Coblation RBS: Nil

Height : ..... Weight : 20.7kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify ..... Nil .....

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

☐ Character Nil ☐ Location Nil ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☑ If Patient is > 6 years
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: Nil (Date/Time): Nil

Social History: Lives With family

Siblings in household ☑ Yes ☐ No (if yes How Many?) One younger brother.

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 10:38Am

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

Time	Nursing Notes
	Dr. Anirudh sir seen the child
	IV placement done
	vitals monitored
	pt shifted to OT

Samples collected by: NA Time:

Samples sent by : NA Time: NA

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 103 bpm BP: ..... CFT: < 2sec	Shift - out from ER to: OT
RR: 24 b/m SPO_2 : 98%	Time of Shift - out: 12:10pm
GCS: 15/15 Temperature : 98.2°F	Handover given to: Sandhya
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): NA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement

Name of the Nurse : Nr. Abhishek Signature of the Nurse : Abhi

Date & Time : 19/5/26 @ 10:30Am

CUV-00171083 IP5-00174013
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Santosh kumar Date : 19/5/26

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: 20.7 kg

Allergic History: .....

Chief Complaints: .....
- Recurrent URTI
- Oral breathing } since 1 year
- Snoring

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☐ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

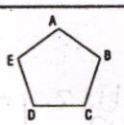
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: Similar illness since 1 year

Medication History: .....

Relevant Investigations: Grade II Adenoids
Tonsillar hypertrophy

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing

Rate: 34/min SpO₂ on FiO₂ 99% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BAE (+)
Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 102/min CFT [Central ..... / Peripheral .....] <3sec

BP: 102/59 (59) mmHg

Pulse Volume: [Central ..... / Peripheral Good]

If in Shock: [Compensated ..... / Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

Murmurs: ☐ Yes ☒ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☒ No

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Disability

GCS: 15/15 AVPU: .....

Pupils: [Responsive ☐ Non-Responsive ☐ / Size [Right ..... / Left .....]]

Active Seizures: ☐ Yes ☐ No Sugars: .....

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: 98.2°F

Any Rash: ☐ Yes ☒ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: .....

.....

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

1) NPO since 8:30pm solid
8:30 Am Coconut water

2) Inf. DNS @ 50ml/hr

3) Shift to OT

4) Coblation assisted Adenotonsillectomy

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Chronic Adenotonsillitis

Assessment done by

Name of the Doctor: Dr. Lai

Signature: Ly

Date & Time: 19/5/26

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

442

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.	Inj. Fentanyl Citrate 100 mcg / 2 ml	100MCG	SOS
2.	Fentanyl Citrate 25 mcg patch		-
3.	Inj. Morphine 15 mg / ml	-	-

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:** .....

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

1.	**Name :**	**Remarks**
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
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	

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 : .....

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. SANTHOSH Department: ER Date of Admission: 19/5/26

SITUATION

Diagnosis: Coblution Adenotonsillectomy

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND Area / Shift Time	ER 12:10pm		HD unit 5:30pm-8pm	HDU not 8pm-8am	ITU	
Medical Condition (Any special condition to be noted):	NA		NA	NA		
ASSESSMENT Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.2°F		98.2°F	98.3°F		
Res:	20b/m		24b/m	25b/m		
SpO_2:	98%		98%	99%		
Pulse:	103b/m		102b/m	109b/m		
BP:	95/54(59)		98/58	100/60mm		
Fall Risk Score:	10		10	10		
Pain Score:	0/10		0/10	0/10		
Recommendations Safety Needs:	Yes		Yes	Yes		
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	NA		NA	NA		
Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA		NA	NA		
Post Operative Procedure Special Orders:	NA		NA	NA		
Handed Over By Name :	Abhishek		Dipanjita	Rakesh		
Signature :	Abhi		Dipu	Rk		
Date:	19/5/26		19/5/26	20/5/26		
Time:	12:10pm		@ 8pm	@ 8AM		
Taken Over By Name :	Dipanjita		Kalavathi	Kalavathi		
Signature :	Dipu		Rk	Kavi		
Date:	19/5/26		19/5/26	19/5/26		
Time:	@12:10pm		@8pm	8AM		

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
r. MANCHUKONDA SANTHOSH

NURSING CARE RECORD

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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 19/05

Assessment: .....

.....

Goals

- ☑ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2:00 pm	→ Assess the patient general condition.	2:05 pm	→ Assessed the patient general condition.	patient is conscious
2:30 pm	→ maintain airway oxygenation.	2:35 pm	→ maintained airway oxygenation.	
3:00 pm	→ Monitor vitals	3:05 pm	→ monitor vitals	
	→ maintain I/O chart			
3:30 pm	→ ensure safety	3:35 pm	→ ensure safety	
4:00 pm	→ patient shift to the ward as per Doctor Orders	4:05 pm	→ patient shift the ward as per doctor order.	

Re-Assessment: ..... was done.

Special Notes: .....

.....

Nurse Signature: Divya Nurse Name: R Date & Time: 19/05/16 3:45pm

Docu. No: RCHBH /FRM / CLINICAL / 148

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 19/5/2026

Assessment: Patient having pain

Goals

- ☐ Maintain Airway and Oxygenation
- ☑ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☑ Any Others. Specify.....
- ☑ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	✓ Assess the pt General condition	8:10AM	✓ Assessed the pt General condition	Patient all plans are completed
10AM	✓ Monitor vital signs	10:10AM	✓ Monitored vital signs	
2AM	✓ Maintain fluid balance	2:10AM	✓ Maintained fluid balance	
4AM	✓ Ensure safety	4:10AM	✓ provided side rails	
8AM	✓ Administer medication as per doctor orders	8:10AM	✓ Administered medication as per doctor orders	

Re-Assessment: Re-Assessment was done. pt are completed.

Special Notes: NA

Nurse Signature: ..... Nurse Name: Soattie Date & Time: 20/5/26 @ 8pm

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 19/5	DATE 20/5	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	F			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	TOTAL		10	10			

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate Lighting		✓	✓			
	Wheel Chair Support		✓	✗			
	Other Intervention(s) Specify		✓	✗			
Nurse's Name :			Abhishek	Swati			
Signature :			Abhi				
Date :			19/5	20/5			
Time :			11:10pm	GAP			

CUV-00171083 IP5-00174013
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PAIN ASSESSMENT FORM

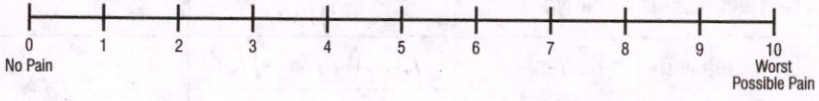
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/5/26	11:30 AM	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	— NA —	Abhishek
19/5/26	6pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
19/5	10pm	1/10	surgical site	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Inj. Paracetamol given	[signature]
19/5	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Reduce the pain	[signature]
20/5	1AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
20/5	3AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
20/5	6AM	1/10	surgical site	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Inj. Paracetamol given	[signature]
20/5	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Reduce the pain	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2016 8 Y 1 M 28 D (M)
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BRADEN 'Q' SCALE

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					Date : 19/5/26 20/5			
					Time : 11:30AM 6AM			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4.		
				TOTAL SCORE	28	27		
				Evaluator's Name	Abhishek	Swathi		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

UV-00171083 IP5-00174013
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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/2 DAY-1			20/5/ DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	NB	0	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—	—	—	—						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	—	—	—	—						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—	—	—	—						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—	—	—	—						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	—	—	—						
			Signature of the Nurse										

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
			Signature of the Nurse										

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

UV-00171083 IP5-00174013
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-03-2018 8 Y 1 M 28 D (M)
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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 19/05/26

2. Destination Post Discharge: ☐ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

			Remarks
☐ Medication	☐ Yes	☐ No	.....
☐ Bathing	☐ Yes	☐ No	.....
☐ Eating	☐ Yes	☐ No	.....
☐ Walking	☐ Yes	☐ No	.....
☐ Dressing	☐ Yes	☐ No	.....
☐ Toileting	☐ Yes	☐ No	.....

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: .....
   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: .....

Nurse Name: D. VYA

Date and Time: 19/05/26 @ 5:30pm

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2PM Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA Body Weight: 21.5 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Nothing Significant

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: 21.5 Length: — Head Circumference (< 2 years): —

Temp.: 98.4°F HR: 82 b/m RR: 26 b/m BP: 90/50

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 20) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 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): .....

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify ..... Inform consultant for positive criteria.

Social History: Lives With ..... Parents .....

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 Signature: .....

Nurse Name: ..... Reena .....

Date: ..... 19/5/26 .....

Time: ..... 2 p.m .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
CUV-00171083 IP5-00174013 Master K. KRISHNA SRIHAN 21-03-2018 8 Y 1 M 28 D (M) Dr. MANCHUKONDA SANTHOSH	19/05/26 11.00 pm	19/05/26 @5.30pm
	Transfer Ordered by	Reason for Transfer
	DR! SANTHOSH	Surgery
From Unit	To Unit	Information to Attendant
OT	2-3A	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
22	NIL.	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.	NIL	NIL.
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	DR! SANTHOSH.

Patient & Clinical Records Received by : Dipanwita 19/5/26 @5.40 pm

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

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

PF

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Date : 19/05/26

Patient's Name : Master K. Krishna Srihan Age : 8 yrs Gender : ☑ M ☐ F

Blood Group : ..... UHID : CUV-00171083

Planned Surgery: Cobblation Adenotonsillectomy Surgeon : Dr. Santosh Kumar

Anesthetist : Dr. Shubhangini Date & Time of Operation : 19/05/26 12:30 pm

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

S.No.	INSTRUCTIONS	ER/Ward,Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1	Weight checked recorded ? 21.5	✓			✓		
2	Is the patient fasting for over 6 hours Pre-Operatively ?	✓			✓		
3	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screning, CXR etc) Available before starting the procedure			✓			✓
4	Enema given / Bowel Preparation		✓			✓	
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	✓			✓		
6	Sterile Gown Given	✓			✓		
7	Is Blood arranged as required ?		✓			✓	
8	If Blood has been ordered - is Blood bag ready ?		✓			✓	
9	IV Cannula to be placed / IV fluids if Indicated	✓			✓		
10	Pre Anesthetic consultation with anesthesiologist	✓			✓		
11	Pre Medications Given ? (Sedatives / etc)		✓			✓	
12	Skin Preparation		✓			✓	
13	Site is marked		✓			✓	
14	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)		✓			✓	
	Implants are available		✓			✓	
16	Equipment is available (Aware)		✓			✓	
17	Antibiotic Prophylaxis is given within the last 60 minutes		✓			✓	
18	Other (if any)		✓			✓	

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : ..... OT Nurse Name : ..... ER/Ward Nurse Name : .....

Billing Executive Signature : ..... Signature of OT Nurse : ..... Signature of ER/Ward Nurse .....

Date & Time : ..... Date & Time : 19/05/26 2:00 p.m. Date & Time : 19/05/26 18:30 hrs

Doc. No. : RCHBH/ FRM / CLINICAL / 107

CUV-00171083 IPS-00174013
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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATIO

Name: Master. K. KRISHNA SRIHAN Age: 8y Sex: Male UHID.No : CUV-00171083

Date: 18/5/26 Time: 12:45pm Proposed Operation: ADENOTONSILLECTOMY c COBLATION

Diagnosis: Grade-3 Adenotonsillar Hypertrophy

B.P / CRT: ..... H.R: ..... Weight: 21.5kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

15/5/26

Laboratory Data:

Hgb: 11.9	Glucose:	Protein:	HIV:	X-Ray:
PCV: 35.9	Urea:	Alb:	HBS Ag:	ECG:
WBC: 9500	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4.91akh	Na:	Dir. Bill:	Blood group: AB Negative	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: packed foods

Medical History: CVS : —

RESP : Nose block Diabetes :

CNS : — FT/LSCS/MCh/3.0kg/CHAB

Renal : — -Immunisation

Hepatic / GE : — Physical Activity:

Others : Mouth breathing (+)

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: Missing 2 | 2 / 2

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA Peripheral (+) Venous Access Site : Spine Exam for regional : Midline

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

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

CURRENT MEDICATIONS	DOSAGE

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:

Signature: Name: Dr. SK Ayesha

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status: 6 hrs	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 118	B.P / CRT: 105/68	SpO_2: 100%	R.R: 16	Last Feed: 7 AM

Pre-OP Diagnosis: Mouth Breathing Operation: Adenotonsillectomy Date: 19/5/26

Surgeon: Dr Santosh Anaesthesiologist: M Subramanyam Technician: Amal

TIME 1530 @ 2:30pm

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:
Midazolam 0.8 mg
Fentanyl 40 mcg
Propofol 70 mg
Rocuronium 7 mg
TRANEXAMIC ACID 300mg IV

FIO_2 / SaO_2 50% 100% 100% 100%

$ETCO_2$ 37 30

ECG NSR NSR

Temperature

Urine Output

Fluids Blood RL 200ml/hr

Antibiotic —

Suppository Diclofenac 25 mg

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: RLL
- ☐ Art Site:
- ☑ EKG Lead 3 Lead
- ☑ Temp Site Axilla
- ☑ 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: 1.15 PM
OP Start: 1.25 PM
OP End:
Leave OR: 2.30 p.m

Anaesthesia:
- ☑ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP:
- ☐ ART:
- ☑ IV: 22g RUL
- ☐ IV:
- ☐ IV:

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

- ☑ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# 5.0 at 16 cm
- ☑ Oral ☐ Nasal ☐ Cuff RAE
- ☐ Tracheostomy ☐ Topical
- ☐ Drug:

- ☐ Awake ☐ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade# 2 Attempts: 1

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: M Subramanyam
Signature of the Doctor:

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

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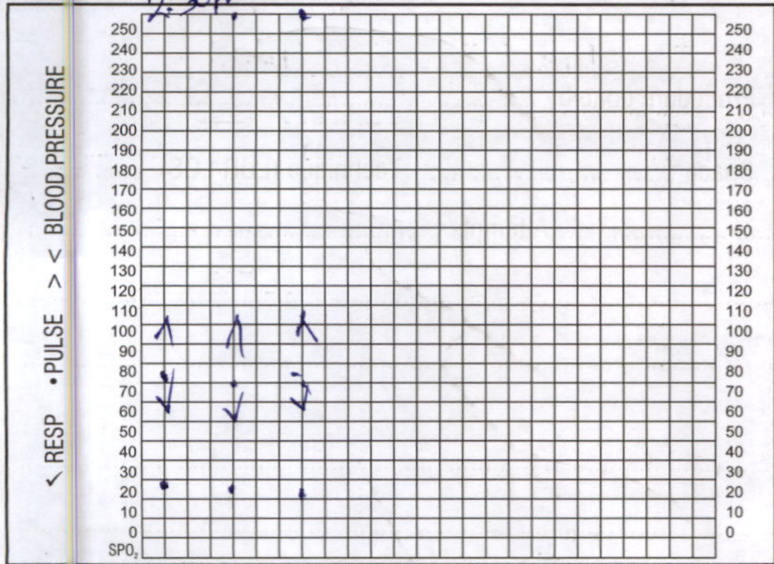
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : .... Time Received : 04:05pm 2:35 pm Time Discharged : 20/05/26



IV Cannula Site : 22g Right hand.

- ☑ O₂Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

Vomiting :	☐ Yes	☑ No	Drug: Nil.
NG Tube :	☐ Yes	☑ No	
Drain:	☐ Yes	☑ No	
Urinary Catheter:	☐ Yes	☑ No	
Chest Tube:	☐ Yes	☑ No	
Nil Oral	☐ Yes	☐ No	

IV Fluids: NO
Oral Feeds: Oral.

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT
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		2	2	2	~
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0		RESPIRATION		1	2	2	
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0		CIRCULATION		2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS		0	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0		COLOR		2	2	2	
		TOTAL		7	10	10	

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
19/05	4:00pm	0/10	Nil	[signature]

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

Anaesthesiologist Name : Dr. SK. Ayesha

Anaesthesiologist Signature: [signature]

Date & Time: ....

PACU Nurse Name : Ganapathy

PACU Nurse Signature: Ganapathy

Date & Time: 19/05/26 @ 3:35pm

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): Ortho

Date & Time: 19/05/26 @ 3:30 pm

Patient Sticker

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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		Maternal		FHR	Comments
			Left	Right	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 : .....