

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION



Name: B/o Kavitha Rajput Age: 14 Sex: male UHID No: LBH 00118092

Date: 3/7/2020 Time: 5:48 PM Proposed Operation: CERT check-

Diagnosis: Taxonomical Segmentation

B.P/CRT: 138 H.R: Weight: 9.5Kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: w

Medical History: CVS :

Temp LSCS | 2.5kg | CIAB | No NICU admission

RESP : 

Diabetes :

CNS : E

Renal : 0

Hepatic / GE:

Physical Activity: *ach*

Others : ①

Past Anaesthetic History: 

Physical Exam: No obvious facial asymmetry

Airway: MP 1 2 3 4 **Mouth Opening:** **Mentohyoid Distance:** **Neck:** **Teeth:**

Lungs: chest clear

Heart: S, S, clear

CNS: GCS - Full

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site :

Spine Exam for regional: *not clear*

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 $\begin{cases} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{cases}$ _____
3. Informed Consent: ☒ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions: _____

stop Breast milk
of the before.

Cc, CBN

Signature: [Signature] Name: DR SHOBAN

[illegible]



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting : ☐ Yes ☐ No Drug: NG Tube : ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: Oral Feeds:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Reassessment Frequency:

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

Transferred to Unit by (PACU):

Date & Time:



EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

LBH-00118092 IP5-00176017
Baby Of KAVITHA RAJPUTH
20-06-2026 1 Y 0 M 18 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: CECT chest

Anaesthesiologist: Dr. SHABANA Surgeon: Dr. Naveen

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: Desaturation, Bronchospasm, Laryngospasm

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: J.V. Abhinav

Name: J.V. Abhinav

Relationship with patient: Father

Date & Time: 3/7/26, 5:52 PM

Witness:

Signature: R. Kavitha

Name: R. Kavitha

Date & Time: Mother 3/7/26 5:52

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Shalini

Date: 3/7/26 Time: 5:52 pm

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 అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ 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 నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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.
☐ లిజనల్ 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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్స్ బ్లాకులు, లిజనల్ 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 స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

ACTIVITY RECORD FOR BILLING

Name : B/o Kavitha

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Suggested Billable bed type : _____

LBH-00118092 IP5-00176017
Baby Of KAVITHA RAJPUTH
20-08-2025 1 Y 0 M 18 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	12pm	ER	ER	Abhishek

Cross Consultation Visit

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

[illegible]

6/07/26	CT Chest with Contrast
---------	------------------------

53441

Abhishek

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	iv placement	1	9916	[Signature]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Naveen Saradhi

Date : 6/7/26

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 10:45 am

Weight: 9.4 kg

Allergic History: _____

Chief Complaints: _____

? Anterior separation

Planned for CECT chest and abdomen

Pediatric Assessment Triangle

A Appearance - TICLS _____

B _____ C Circulation ☒ Normal ☐ Abnormal

Breathing
☐ ↑ WOB ☐ ↓ WOB ☒ Normal ☐ Gasping / Apnea
☐ 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: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment

Airway ☒ Open ☐ Maintainable ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No
If Yes _____

Breathing
Rate: 26/min SpO₂ on FiO₂ 96% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR
☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L A/E (+)
Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No
If Yes _____



Circulation

HR: 122/min

CFT ☐ Central
☐ PeripheralAny urgent interventions needed: ☐ Yes ☒ No

If Yes

BP: mmHg

Pulse Volume: ☐ Central
☐ PeripheralIf in Shock: ☐ Compensated
☐ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of
Heart Failure: ☐ Yes ☒ No

Disability

GCS: 15/15 AVPU:

Pupils: ☒ Responsive ☐ Non-Responsive ☐
Size ☐ Right
☐ LeftActive 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:

CBP on consultation

1 plain sample

Send creatinine now

Treatment Planned:

• NPO to continue

• IV fluids

• CECT chest under sedation

Need for Oxygen: ☐ Yes ☒ Noif yes Low Flow ☐High Flow ☐PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): 9 Antenatal sequestration

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: [Signature]

Date & Time: 6/21/26 : 10:50 am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. 9.4 kg Ward.

[illegible]

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

VARIABLE DOSE

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

[illegible]



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 : IP5-00176017

Admit Date : 06-Jul-2026

Admit Time : 10:45 AM UHID : LBH-00118092

Patient Details :

Patient Name : Baby Of KAVITHA RAJPUTH

Guardian : Mr J VINCENT ABHINAV

Gender : Male

Occupation :

Address (H) : 1-18-30, POLICE LINES GUN BAZAR, RASOOL
PURA Begumpet Police Lines Hyderabad
Telangana INDIA 500003

Age

: 1 Y 0 M 16 D

DOB

: 20-06-2025 08:26 PM

Religion

: Single

Marital Status

Phone No : 7981179860/

E-mail

: na@email.com

Admission Details :

Bed Type : DAY CARE

Room No : ER 05

Bed No : ER 05

Admission Type : First Visit

Ward Name : 1B-EMERGENCY

Contact Details :

Name : Mr J VINCENT ABHINAV

Contact Address : 1-18-30, POLICE LINES GUN BAZAR,
RASOOL PURA Begumpet Police Lines
Hyderabad Telangana INDIA 500003

Relationship : Father

Phone No : 7569539285

Signature

Doctor Details :

Doctor Name : Dr. PILLARISETTI NAVEEN SARADHI

Referral Doctor : SELF

Co-Consultant : Dr. JAPA AVINASH

Specialisation : PULMONOLOGY

Phone No

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 15000.00

Payor Name : SELF PAY



LBH-00118092
Baby Of KAVITHA RAJPUTH
20-06-2026 1 Y 0 M 18 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

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: ER Shifted to: ER

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

MEDICATION HISTORY RECORD

Doctor Name & Signature: Dr. Ran

Date & Time: 4:50am

Nurse Name & Signature: Abhishek

Date & Time: 6/7/26

Docu. No. : RCHBH/

* C- Continue, DC- Discontinue

