

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH

Patient Stn



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Hospital
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BirthRight[™]
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SURGERY DETAILS

Date : 18/7/2026

Patient Name: Mudrakola Vishwa Date of Birth: 24-02-2026 Age: 4m.

Gender: Male Ward : P.O.T. UHID No: LBH-00129578

Date of Surgery: 18/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

ne of the Surgery : Meningocele repair

Time in : 10.00 Am

Time Out : 3 Pm

	NAME	AMOUNT
1. Surgeon	Dr. Praneeth / Dr. Srinantha	
2. Anaesthetist	Dr. Ravi	
3. Assistant Surgeon		
4. OT Technician	Shrisha	
5. Circulating Nurse	Thejas	
6. Assistant Nurse	Suman	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9409827 / 9709829

Order by: J. Praneeth

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH
[Barcode]


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SURGERY DETAILS

Date : 18/7/2026

Patient Name: Mudrakola Vishwa Date of Birth: 24-02-2026 Age: 4m 24D

Gender: male Ward: P.O.T UHID No.: LBH-00129578

Date of Surgery: 18/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Type of the Surgery: Laparotomy + Ladd's procedure

Time in : 10:Am

Time Out : 3pm

	NAME	AMOUNT
1. Surgeon	Dr. palak Singh	
2. Anaesthetist	Dr. Ravi	
3. Assistant Surgeon		
4. OT Technician	Shirisha	
5. Circulating Nurse	Thejas	
6. Assistant Nurse	Suman	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9709831

Order by: J. Ramasubramanian



myelomeningocele Repair And
Pathology of CNS Anatomy.

CONSUMABLES OF OT



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Circulating Staff : Technician : Date : 18/11/16 Time : 9.30 AM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
	Qty Issued	Qty Used		Qty Issued	Qty Used		Qty Issued	Qty Used
ET tube 3.3.5.4	111	01	Major Pack Drape	1	01	Inj Vit.K	1	—
LMA 1 1/2	01	—	Sutures Mexi 3-0-0	24	—	Cord Clamp Tissue 2ml	1	—
ECG leads : A / P / N	01	01	very 3.0.24.37.234.50.60	24	1	Suction Catheter	1	—
HME filter : A / P / N	01	01	napier 4.0. monogyn 4.0	24	1	Feeding Tube	2	1
Syringes : 10 cc	10	01	spend 6.0.20.3.0. pos 6.0	24	—	Vacuum Suction Set	1	—
05 cc	10	01	Gloves Rapid 5-0	24	1	Surgical Gloves	1	—
02 cc	10	01	6.6.1.2.7.1.1.2	24	1	Gauze Pack	1	—
01 cc	5	02	6.6.1.2.7.1.1.2	24	1	Syringe 1ml / 2ml	1	—
Cautery plate : A / P / N	01	01	Surgical blade	1	1	Surgical Blade # 20	1	1
IV set 18 blood set	111	110	NG tube	1	1	Koochies (S)	3	—
RL 10x10x10x10x10	111	111	Cautery pencil	1	1	NS sound	1	—
NS 10ml / 100ml / 500ml / 1000ml	512	101	Koochies	1	1	Transfix	1	—
NSU Spike	01	01	Ointments 0.25 Anakin	1	1	Tracheal Tube	1	—
Quon	03	03	Suction Catheter	2	2	Tracheal Tube	1	—
Fentanyl	01	01	Cap, Mask	1	1	Bonavent	1	—
Morphine			Gauze Pack	1	1	Tracheal Tube	1	—
Ketamine			Mop Pack	2	2	Tracheal Tube	1	—
Propofol	03	02	Steristrip	1	—	Tracheal Tube	1	—
Rocuronium	01	01	Underpad	1	2	Tracheal Tube	1	—
Glycopyrolate	01	01	Draw sheet	1	0	Tracheal Tube	1	—
Myopyrolate Neo	01	01	Abgel	1	1	Tracheal Tube	1	—
Ondansetron	01	01	Foleys catheter	1	2	Tracheal Tube	1	—
Pencan 25g/ Spinal Needle 22			Urobag	1	2	Tracheal Tube	1	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			Tracheal Tube	1	—
Bupivacaine 0.25% (Heavy)			Romodrain bag			Tracheal Tube	1	—
Antibiotics Taxim 500mg	01	—	Bandage			Tracheal Tube	1	—
Amikacin 250mg	01	—	Tegaderm	1	—	Tracheal Tube	1	—
Suppositories			Ioban	1	1	Tracheal Tube	1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Tracheal Tube	1	—
Supridol : 100mg			Vacuum Suction set	2	2	Tracheal Tube	1	—
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet	1	—	Tracheal Tube	1	—
Tab. Misoprost : 200mg			Betadine Solution	1	1	Tracheal Tube	1	—
Vacuum set	01	01	Microshield	1	2	Tracheal Tube	1	—
Dexa + Dormidol	111	110	Cotton Balls	1	1	Tracheal Tube	1	—
Tranexa + Tran	111	111	Latex Gloves	1	1	Tracheal Tube	1	—
Glovecel + Gloveon	511	—	Ramdone Scrub	1	1	Tracheal Tube	1	—
10cm + 20cm + 30cm	111	110	Saral			Tracheal Tube	1	—

Anaesthesiologist

Nurse

OT Technician

Order No. : 9709887

Ordered by :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHD No. : _____

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

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

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Dr. KOKKULA PRANEETH



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/7/26	10:30pm	ER	NICU	Abhishek
17/7/26	8:40 AM	ICU	OT	Aruna.
18/7	4:20pm	OT	ICU	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR:- panibhargavi	19/7/26	963784	
2	Dr. Harish gajran	18/7/26	9713942	
3	DR- Harish sa	20/7/26	981026	
4	DR- Harish sa	21/7/26	97312	
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Order No.

Signature

16/7

BHT

21484

Samshe

7/17

USG-kub

035542

Amc

17/12

upper GI

035561



17/7

2D Echo Screening

(Don't enter)

Aruna

1812

ECG

035725

Apr

De

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

1812

1872 infusion pump

5 pm

963784

82

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
16/7	Tr Placement	①	706679	} Samy
7	PAC Done on op Bays	—	—	
18/7	Calibration	①	9691	2

ANY OTHER INFORMATION

UPPER - 1

20 FOLIO - 1

EQ - 1

Date :

2/7/26

Time :

10:12

Prepared By :

K. San

Staff Nurse

K. Suman

Shift / Ward

GO-1
121

Billing Assistant

Billing Supervisor

**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 : IP5-00176487 Admit Date : 16-Jul-2026 Admit Time : 09:18 PM UHID : LBH-00129578

Patient Details :

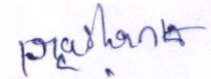
Patient Name	: Master MUDRAKOLA VISHWA	Age	: 0 Y 4 M 22 D
Guardian	: Mr MUDRAKOLA PRASHANTH KUMAR	DOB	: 24-02-2026 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 7-3-58, BHAGYA NAGAR Nirmal Adilabad Telangana INDIA 504106	Phone No	: 9121559633/ 7382386241
		E-mail	: THANNIRUPRANEETH3@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 121 Ward Name : 1F-GENERAL WARD I
Room No : GW 121 Admission Type : First Visit

Contact Details :

Name : Mr MUDRAKOLA PRASHANTH KUMAR Relationship : Father
Contact Address : H NO 7-3-58, BHAGYA NAGAR Nirmal Phone No : 9121559633
Adilabad Telangana INDIA 504106


Signature

Doctor Details :

Doctor Name : Dr. KOKKULA PRANEETH Specialisation : PEDIATRIC NEURO SURGERY
Referral Doctor : SELF Phone No :
Co-Consultant : Dr. SRIPARTHA KRISHNA YERRAMILLI

Payment Details :

Payment Mode : Cash Deposit Amount : 84929.25
Payor Name : SELFPAY



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	7			
7	Nursing plan of care and handover sheets	6			
8	Consultation sheet	2			
9	General consent for treatment	1			
10	Consent for Surgery				
11	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	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)	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			
28	Nurses clinical Presentation				
29	TPR & BP chart	6			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	2			
38	Braden Q Scale	2			
39	Bed side check list <i>Thromboplastin</i>	2			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
45	<i>Extra</i>	1			
Total No. of Pages					

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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MEDICATION RECONCILIATION FORM

g 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: ee

Shifted to: 121

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	<u>VIT D₃ drops</u>	<u>0.5ml</u>	<u>P/O</u>	<u>once daily</u>	<u>15/7/26</u>	☐ C ☐ DC
2	<u>Multivitamin syp</u>	<u>5ml</u>	<u>P/O</u>	<u>once</u>	<u>15/7/26</u>	☐ 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: Dr. Solich (Solich)

Date & Time: 16/7/26 9:30pm

se Name & Signature: Praneeth

& Time: 16/7/26 9:40pm



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PEDIATRIC IN-PATIENT MEDICAL RECORD

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH


Patient Name:

Vishwa

UHID ID:

Department:

Consultant:

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Dr. KOKKULA PRANEETH



Morgan History & Physical Examination

Name : Vishwa Age/Sex 4 mon / M

Information given by : _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

came for myelomeningocele repair

History of present illness :

H/O swelling in lower back since birth

↓
in size
Increasing since birth

H/O loose stools (+)

MRI spine : 10x9mm defect in upper sacral level ±
herniation of CSF filled sac containing neural elements
S/O spina bifida ± myelomeningocele.

Low lying cord ± tip of the cord extending upto the
level of defect at upper sacral levels.



Came for repair of myelomeningocele.

6/7/26 Hb - 9.9 / Tlc - 7920 / ~~WBC~~ AU - 4.3 lakh

PT - 14 / aPTT - 44 / INR - 1.0



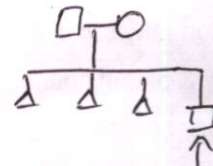
Pediatric Multiorgan History & Physical Examination

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

was admitted @ AGE (30/6 - 1/7)

Birth & Neonatal History:

FT/2.5kg / LSCS / No NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age

Immunization History :

up to date till 2.5 months age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 6.4 (Centile _____)

On Examination :

Temperature : 98.5°F Pulse Rate : 128/min B.P. 92/56 mm Hg SPO2 100% (RA)
Resp. rate and type of breathing : RR - 32/min

Rash _____
Lymphadenopathy _____
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : no distress
Air entry & breath sounds : B/L VBS, B/L AE +
Any addles sounds : _____
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of procordium : (N)
Heart Sounds : S₁S₂ +
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection (N)
Palpation : soft
Ausculation : IPS +
Spine : myelomeningocele External Genitalia : (N)
Relevant data from outside (CT, USG etc.,) _____

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Dr. KOKKULA PRANEETH

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : ✓ AVPU/GCS score : A

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

NAD.

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Myelomeningocele repair

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Complications of myelomeningocele

Desired goals of the treatment:

Hemodynamic stability.

Planned Labs:

Blood grouping

Planned Management

Reserve - 15ml/kg PRBC

15ml/kg FFP

NPO

iv fluid

from 4:30am

4:30am

tomorrow

USG - KUB & PVR tomorrow
at 9:30 am

NIB
Renal
16/7/26

Signature of the Doctor:

Somashree

Signature of the Consultant:

Dr. Praneeth

Name of the Doctor:

Name of the Consultant:

Dr. Praneeth

Date & Time:

16/7/26 8pm

Date & Time:

16/7/2026
DR

Patient Sticker

LBH-00129578
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Dr. KOKKULA PRANEETH



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NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/17/2028 8:20 am		NEG - KUB ↓ Shift to OT Financial Clearance John



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PROGRESS NOTES AND DOCTOR'S ORDER

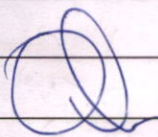
Date & Time	Progress Notes	Doctor's Order
17/7/26 8pm	C/S/B Neuroteam	
	Issues: nausea meningococci ↳ midgut malrotation	
	O/E: Child active Accepting feeds - (N) EOM - full B/L symmetrical Antigravity movements (+) Urine/Stool - (N) vitals - stable	Adv ① 2DECHO - (N) ② ECG as advised ③ w/f vitals
17/7/26 6pm	C/S/B Dr. palak	
18/7/26 6:10pm	POD-0 Ladd's procedure No episodes of force spiker / abd distension O/E - Afebrile vitals - stable P/A - soft Breath - intact	Adv ① NPO till further order ② NG aspiration 2nd hly + continuous drainage ③ NG aspirate to be replaced ml to ml R/L 6th hly ④ U/O monitor 4th hly

Date & Time	Progress Notes	Doctor's Order
18/7/26 6 pm	<u>C/S/B Neuroteam</u> K/C/O meningococci c tethered cord c midgut malrotation (without volvulus) s/p meningococci excision & repair laparotomy + Ladd's procedure	on 18/7/26
	<u>POD-0</u> → Issues: No fever spikes Ureter - Foley's in situ; Stool - not passed Child conscious B/L pupils NSRL EOM - full Tone - N B/L symmetrical antigravity movements (+)	<u>Adv</u> ① To decide on starting feeds after pediatric Surgeon opinion
	AF flat open	② If ↑↑↑ pain → plan Tramadol IV
	Surgical site: No discharge / leakage / bleeding	③ vitals monitoring

PHYSICIAN'S NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 9am	K/C/O meningococci tethered cord c midgut malrotation <u>S/p - meningococci excision & repair + laparotomy + Ladd's placed</u> 2 episodes of fever spikes yesterday night (104°F) Urine - passed Stools - did not pass yet	
	<u>O/E:</u> Child asleep Afebrile B/L pupils NSRL Tone - (N) EOM - full B/L symmetrical antigravity movements (+) vitals - stable	<u>Adv</u> 1) Foley's removal after pediatric surgery opinion 2) Dressing start to be done tomorrow 3) continue IV fluids till ORLs are started
		Dr. KOKKILA PRANEETH Reg. No: APMC/FMR/92741

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 10:15 AM	C/S / B Dr Nikhita	
	(POD-1) Meningocele repair + Ladd's pro Laparotomy + Ladd's procedure.	
	Episodes of febrile spikes. No episode of vomiting / abd. distension.	Adv ① NPO till further order ② NG aspirate 2nd hly + continuous drainage. ③ U/O monitoring 4th hly. ④ Continue IVF ⑤ Can remove Foley's catheter today from pediatric surgery side.
	O/E - Afebrile Vitals - stable P/A - soft. Dressings - intact - NG - 12.5 ml / 24h. (whitish)	
	did not pass stool. U/O - 100ml. U/O - 1.04 u/kg/h	
	 Dr. Nikhita 19/7/26 11:30 AM	

Date & Time	Progress Notes	Doctor's Order
20/7/26	cls/B Newsteam	
	<u>POD-3</u> K/clo	
	Issues: 2 episodes fever spikes (+) yesterday Started on liquid feeds (+)	
	O/E Child conscious B/L pupils NSR EDM - full Tone (+) B/L symmetrical	
	Plan o Allow oxyg - as per Peds & instructions o Dressing change o Review SCS	
		Abhishek

T. KORHOLA FRANCEETT



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Date & Time	Progress Notes	Doctor's Order
	<u>AB Newman</u>	
20 Feb 6:20 PM	No new issues. - taking orally. (1) Intermittent variable irritability. (2) Blood lactate + tds (3) dialysis - improving.	advise: - vitak inform SOS. - replace folic acid M

7. KOKKULA PRANEETH



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Date & Time	Progress Notes	Doctor's Order
21/7/26 8:50 AM	CLS/B Dr. Maliha POD - (3)	
	No fever spikes Vitals stable P/A - soft Dressing - removed	<u>Adv</u> 1) Full feeds. 2) Discharge today
 DR. HARISH JAYARAM Registration No: 66254 21/7/26 9:10 AM		Maliha Dr. Maliha 21/7/26 8:50 AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name: Dr. Harish Jayaram Date: 17/7/26 Time: 10:29 AM

Diagnosis:

Hospital:

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

C/S/B Dr. Harish Jayaram

Asymptomatic.

→ Incidentally detected
malrotation on
USG Abdomen (17/7/26)
(altered SMA/SMV axis)

Adv

1) Upper GI contrast
Study.



2) Plan - Laparotomy
+
Ladd's Procedure

3) PAC

4) Financial Clearance

Consultant :

Signature: Dr. Harish Jayaram Signature: [Signature] Date & Time: 17/7/26

Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 23 D
Dr. KOKKULA PRANEETH (M)



2D Echo

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CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

Referral for cardiac evaluation

CVS - S1, S2 (+)
NO murmur

ECHO

structural (+) heart
Lt. Arch
CBVF

Adv

1. ECG

Consultant :

Name :

Signature :

Date & Time :

17/7/26

LBH-00129578 IP5-00176487
 Master MUDRAKOLA VISHWA
 24-02-2025 0 Y 4 M 22 D (M)
 Dr. KOKKULA PRANEETH


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

Blood Group **B⁺**
 **BirthRight[™]**
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 Your Right to a Safe Delivery

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					

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 :

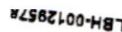
 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :



6 key

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.		

[illegible]



I.V. FLUIDS CHART

Weight. 6-4 kg Ward.

[illegible]

Signature

VERIFIED BY: Name

10.30 PM

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH



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DRUG CHART

Date of Admission: 16/7/26 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)

[illegible][illegible][illegible]



REGULAR PRESCRIPTIONS

Weight. 6kgs Ward.

DRUG : <u>END CEFOTAXIME</u>				Date Time	<u>18/7</u>	<u>19/7</u>	<u>20/7</u>													
Dose	Route	Frequency	Start Date																	
<u>300mg</u>	<u>IV</u>	<u>BD</u>	<u>18/07</u>		<u>10 AM</u>	<u>07:00</u>	<u>08:00</u>													
Name & Signature of the Doctor Starting the Drugs:				<u>Sripadhe</u> <u>10pm prani</u> <u>Simu</u> <u>Shankar</u> <u>Shankar</u> <u>Sushu</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>Dr. Sripadhe</u> <u>Dr. Sripadhe</u> <u>Dr. Sripadhe</u>																
DRUG : <u>END PARACETAMOL</u>				Date Time	<u>18/7</u>	<u>19/7</u>	<u>20/7</u>	<u>21/7</u>												
Dose	Route	Frequency	Start Date																	
<u>60mg</u>	<u>IV</u>	<u>TDS</u>	<u>18/07</u>		<u>6 AM</u>	<u>8 AM</u>	<u>10 AM</u>	<u>12 PM</u>	<u>2 PM</u>	<u>4 PM</u>	<u>6 PM</u>	<u>8 PM</u>	<u>10 PM</u>	<u>12 AM</u>	<u>2 AM</u>	<u>4 AM</u>	<u>6 AM</u>	<u>8 AM</u>	<u>10 AM</u>	<u>12 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Sripadhe</u> <u>10pm prani</u> <u>Simu</u> <u>Shankar</u> <u>Shankar</u> <u>Sushu</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>Dr. Sripadhe</u> <u>Dr. Sripadhe</u> <u>Dr. Sripadhe</u>																
DRUG : <u>PRO AC Satchet</u>				Date Time	<u>20/7</u>	<u>21/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1/2 satchet</u>	<u>PO</u>	<u>TID</u>	<u>20/7/26</u>		<u>6 AM</u>	<u>12 PM</u>	<u>6 PM</u>	<u>10 PM</u>	<u>12 AM</u>	<u>2 AM</u>	<u>4 AM</u>	<u>6 AM</u>	<u>8 AM</u>	<u>10 AM</u>	<u>12 PM</u>	<u>2 PM</u>	<u>4 PM</u>	<u>6 PM</u>	<u>8 PM</u>	<u>10 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Malika</u> <u>Dr. Malika</u> <u>10pm prani</u> <u>Simu</u> <u>Shankar</u> <u>Shankar</u> <u>Sushu</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>Dr. Malika</u> <u>Dr. Malika</u> <u>Dr. Malika</u>																
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 25 D (M)
Dr. KOKKULA PRANEETH



Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/2 Time: 12pm

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

98.9
99.1
98.3

Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

96/60
92/56

Heart Rate (Number)

179 bpm
120

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

70
60
50
40
30
20
10

Resp Rate (Number)

38 bpm
30 bpm

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

92% 98% 92%

Conscious Level Normal
Altered

GCS *

14/15 14/15 14/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1
0
08
1
0
02
1
0
05

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 /NICU fellow or PICU/NICU consultant to be informed

For a score of 3 or more, oxygen requirement is > 2L/min, then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
	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.
	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)

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026
Dr. KOKKULA PRANEETH
IP5-00176487
0 Y 4 M 23 D
(M)

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
Child
Hospital
It takes a lot to

BirthRight
RAINBOW HOSPITALS
Four Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/2/26

Doctor/Nurse/Family Concern? 2am 4:30am 6am 10am 1pm 6:30pm 8pm

Temperature (°F)	104	103	102	101	100	99	98	97	96	95	94
Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90
Blood Pressure (mmHg) *	130	120	110	100	90	80	70	60	50		
Resp. Rate (bpm) per 1 Minute *	70	60	50	40	30	20	10				
Receiving O ₂ (l/min)											
O ₂ Saturations (%)											
Conscious											
Level											
Normal											
Altered											
SCORE											
of shaded boxes											
Initials											

Temperature (°F) 99.6 100.6 98.9 98.5 98.9 99.8 99.3

Heart Rate (bpm) 130 bpm 136 bpm 132 bpm

Resp. Rate (bpm) 26 bpm 27 bpm 27 bpm

Receiving O₂ (l/min) 100% 99% 99%

O₂ Saturations (%) 100% 99% 99%

Conscious Level Normal

SCORE 0 1 1

Initials 0 0 0

- 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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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)



INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/2/2 Time:

Doctor/Nurse/Family Concern?

60r

11AM

2PM

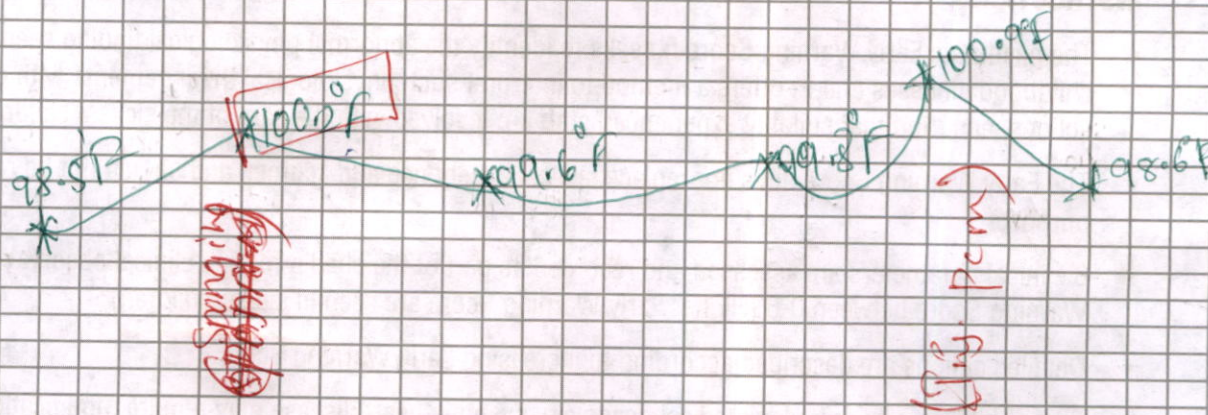
6pm

10pm

11pm

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

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

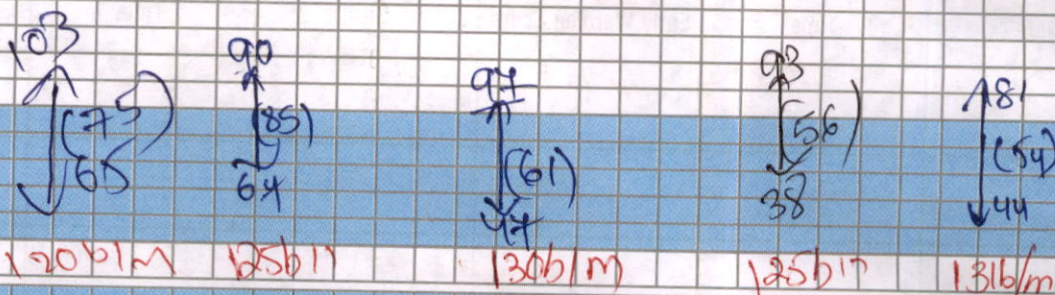
and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)



Resp. Rate (bpm)
Over 1 Minute) *

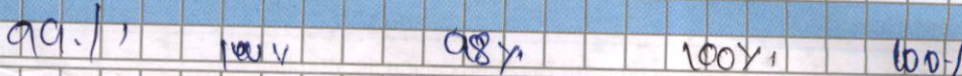
70
60
50
40
30
20
10

Resp Rate (Number)



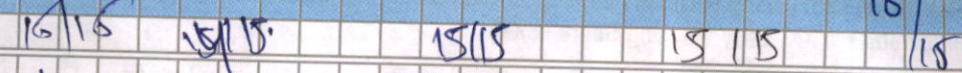
Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)



Conscious Level
Normal Altered

GCS *

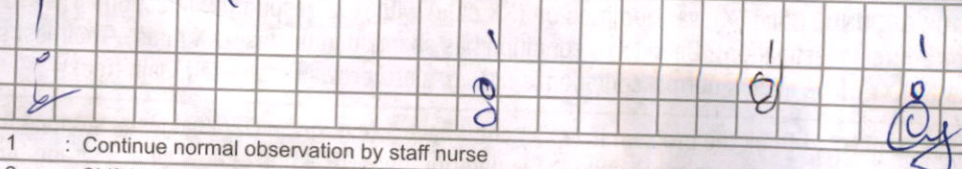


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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)

Patient Sticker

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 23 D (M)
Dr. KOKKULA PRANEETH

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
Children's
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

		5 PM	8 PM	10 PM	1:30 AM	3 AM
Temperature (°F)	103					
	102					
	101					
	100					
	99					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
Note: BP does not score in early warning scoring	80					
	70					
	60					
	50					
Heart Rate (Number)		130 bpm	110 bpm	28 bpm		
Resp. Rate (bpm) over 1 Minute *						
Resp Rate (Number)		28 bpm	28 bpm	28 bpm		
SpO2 Mod/ Severe stress None / Mild						
Receiving O2 (l/min)						
Saturations (%)		92%	92%	98%		
SpO2 Normal Altered		Normal	Normal	Normal		
SCORE		1	1	1		
of shaded boxes		0	0	0		
Initials		0	0	0		

- 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.
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- Score 5 & 6 : Shift in charge and PICU /NICU fellow or PICU/NICU consultant to be informed
- 2 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

**CHILDREN'S OBSERVATION
and EARLY WARNING SCORING TOOL**

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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.
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LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D
Dr. KOKKULA PRANEETH

RCH / FRM / CLINICAL / 124

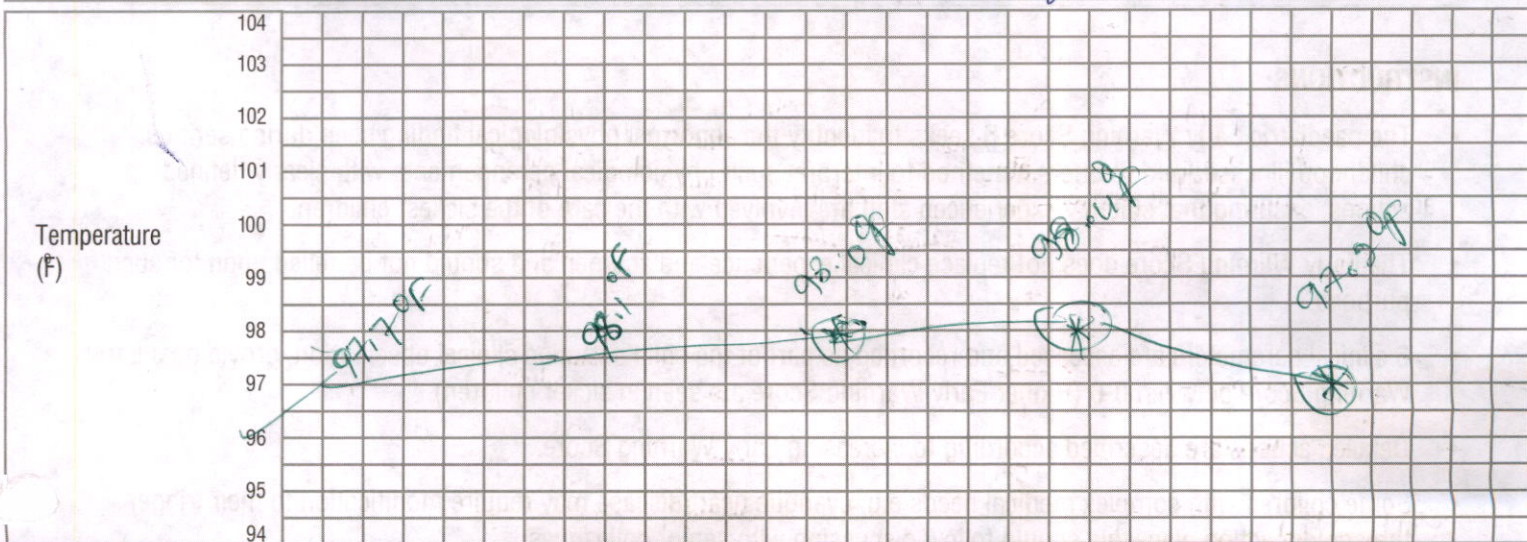
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/2/26
Doctor/Nurse/Family Concern? 12pm 9pm 10pm 18pm 6am



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *	102	108	118	120	130	140	150	160	170	180	190	200	210	220	230
Note: BP does not score in early warning scoring	(56)	(66)	(54)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)
Heart Rate (Number)	106b/m	118b/m	120b/m	130b/m	127b/m										

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	28b/m	28b/m	31b/m	32b/m	20b/m		

Resp Distress	Mod/ Severe None / Mild																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																</
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TOTAL SCORE					
Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials	O	O	O	O	O

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

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)



INFANT (<1 year) **Children's Observation & Early Warning Scoring Chart**

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>16/2</u> Time: <u>11:17</u>	<u>11pm</u>	<u>11:17</u> <u>2am</u>	<u>6am</u>
Doctor/Nurse/Family Concern?			
Temperature (F)			
Heart Rate (bpm)			
Blood Pressure (mmHg) *			
Note: BP does not score in early warning scoring			
Heart Rate (Number)	<u>132b/m</u>	<u>130b/m</u>	<u>135b/m</u>
Resp. Rate (bpm) (Over 1 Minute) *			
Resp Rate (Number)	<u>30b/m</u>	<u>31b/m</u>	<u>30b/m</u>
Resp Distress			
Mod/ Severe			
None / Mild			
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	<u>97.1</u>	<u>98.1</u>	<u>99.1</u>
Conscious Level			
Normal			
Altered			
GCS *	<u>15/15</u>	<u>15/15</u>	<u>15/15</u>
TOTAL SCORE	<u>1</u>	<u>1</u>	<u>1</u>
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>P</u>	<u>P</u>	<u>P</u>

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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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)

Patient

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH



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Hospital
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Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 10

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm	MB										
	11:00 pm	RF										
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am	DRS	28ml									
	05:00 am		26ml									
	06:00 am		26ml									
	07:00 am		26ml									
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

Patient ID: IP5-00176487
LBH-00129578
Master MUDRAKOLA VISHWA
0 Y 4 M 22 D (M)
24-02-2025
Dr. KOKKULA PRANEETH

FLUID CHART

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Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

She: 2

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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
17/7	08:00 am	I	N	26ml		/			/		0	Amr	
	09:00 am	I	P	26ml		/			/		0		
	10:00 am	ONS	O	-		/	✓		/	-	0	Aruna	
	11:00 am	I	O	-		/			/		0		
	12:00 pm	I	Milk	26ml		/			/		0		
	01:00 pm	I	Milk	-		/			/		0		
Total Intake :						Total Output :							
17/7	02:00 pm	↑		26ml		/			/		0	Aruna	
	03:00 pm		Milk	26ml		/	✓		/	-	0		
	04:00 pm	DNS		-		/		✓	/		0	Aruna	
	05:00 pm			-		/		✓	/		0		
	06:00 pm			-		/		✓	/		0		
	07:00 pm	↓		-		/		✓	/		0		
Total Intake :						Total Output :							
17/7	08:00 pm			-		/			/		0	Aruna	
	09:00 pm	↑		-		/			/		0		
	10:00 pm	ONS		26ml		/	✓		/		0	Aruna	
	11:00 pm	I		26ml		/			/		0		
	12:00 am	I		26ml		/			/		0		
	01:00 am			-		/			/		0		
Total Intake :						Total Output :							
18/7	02:00 am		milk			/			/		0	Aruna	
	03:00 am	26	HPD	26ml		/			/		0		
	04:00 am	ONS		26ml		/			/		0	Aruna	
	05:00 am			26ml		/			/		0		
	06:00 am	I		26ml		/			/		0		
	07:00 am			26ml		/			/		0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : ③

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					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			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											
18/12	05:00 pm	DNS	p	26ml							0	
	06:00 pm		p	26ml							25ml	0
	07:00 pm		b		NIL							
Total Intake :						Total Output :						
	08:00 pm			26ml							0	
	09:00 pm			26ml							0	
18/12	10:00 pm	DNS	n	26ml	0ml						0	
	11:00 pm		p	26ml							0	
	12:00 am			26ml	2ml						0	
	01:00 am		0	26ml						45ml	0	
Total Intake :						Total Output :						
	02:00 am			26ml	nil						0	
	03:00 am			26ml							0	
19/12	04:00 am		n	26ml	0.5ml						0	
	05:00 am	DNS	p	26ml						30ml	0	
	06:00 am			26ml							0	
	07:00 am		0	26ml							0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

FLUID CHART

Sheet No. : 4

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G									
24/2	08:00 am			26ml	Nil					15ml	0			
	09:00 am			26ml	(white)						0	Sul		
	10:00 am	ONS	N	26ml	4ml						0	Sul		
	11:00 am		P		(white)						0	Sul		
	12:00 pm		O		1ml				10ml		0	Sul		
	01:00 pm			26ml							0	Sul		
Total Intake :					Total Output :									
24/2	02:00 pm			26ml	Nil						0			
	03:00 pm			26ml							0	Sul		
	04:00 pm	ONS	N	26ml	Nil						0	Sul		
	05:00 pm		P	26							0	Sul		
	06:00 pm		O		0.3ml						0	Sul		
	07:00 pm										0	Sul		
Total Intake :					Total Output :									
	08:00 pm										0	Ch		
	09:00 pm			26ml	Nil						0	Ch		
	10:00 pm	ONS	N	26ml							0	Ch		
	11:00 pm		P	26ml	Nil						0	Ch		
	12:00 am		O	26ml							0	Ch		
	01:00 am			26ml	Nil						0	Ch		
Total Intake :					Total Output :									
	02:00 am			26ml							0	Ch		
	03:00 am			26ml	Nil						0	Ch		
	04:00 am	ONS	N	26ml							0	Ch		
	05:00 am		P	26ml	0.5ml						0	Ch		
	06:00 am		O	26ml					55ml		0	Ch		
	07:00 am			26ml	4ml						0	Ch		
Total Intake : 90.8ml					Total Output : 80 ml									
Total 24 hrs. Intake					Total 24 hrs. Output									



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/2	08:00 am	Dropt KCL		RL 10ml						67ml	0	Anura	
	09:00 am		26ml	4ml						0			
	10:00 am		26ml							0			
	11:00 am		-						0				
	12:00 pm		26ml						0				
	01:00 pm		-						0				
Total Intake :						Total Output :							
20/2	02:00 pm	Dropt KCL		-								cannula changed	
	03:00 pm		-										
	04:00 pm		26ml							1			
	05:00 pm		26ml							0			
	06:00 pm		-						0				
	07:00 pm		-						0				
Total Intake :						Total Output :							
20/2	08:00 pm	NO IVP									0	Susha	
	09:00 pm									0			
	10:00 pm									0			
	11:00 pm								0				
	12:00 am								0				
	01:00 am								0				
Total Intake :						Total Output :							
21/2	02:00 am	NO IVP									0	Susha	
	03:00 am									0			
	04:00 am									0			
	05:00 am								6				
	06:00 am								0				
	07:00 am								0				
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

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

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Morning ☐ Afternoon ☐ Night ☒

Date: 16/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
11pm	→ Assess the Baby General Condition, monitor vitals & Record	12am	→ Assessed the Baby General Condition, monitored Vitals & Recorded	By Anu Meis done pg condition is improved
2am	→ plan to do Repair of myelomeningocele - 10:30am NPO from 4:30am	4am	→ planned to do Repair of myelomeningocele at 10:30am NPO from 4:30 am	
6am	→ plan to do USG KUB 8:30am	8am	→ planned to do USG KUB 8:30am	

Re-Assessment:

Special Notes:

USG T1m 8:30 am & Repair of myelomeningocele at 10:30am NPO from 4:30 am

Nurse Signature:

Nurse Name:

Aparajitha (20266)

Date & Time:

17/7/26 8:30

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH

NURSING CARE RECORD

Sh ☐ Night

Date: 17/11/26

Assessment: Baby having pain & discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the general condition of the baby	8AM	Assessed the general condition of the baby.	by done all these to improve baby condition.
9AM	Dr. Praneeth sir advis. USG KU B. & after shift to OT for melomen	9AM	Dr. Praneeth sir advised us to KU B. & after shifted to OT. for melomen	
	cl. Hold plane to upper GI constract study.		ingel Hold plane to upper GI constract study done. NPO Break.	
12PM	monitor vital: sings & record.	12PM	monitored vital sings & record.	
4PM	To Shift for 2nd echo	5PM	2nd echo done.	
6PM	Administer medication as per doctor's order.	6:5 PM	Administered medication as per doctor's order.	

Re-Assessment: Re-Assessment done by checking vitals.

Special Notes:

Nurse Signature: Anura.

Nurse Name: Anura

Date & Time: 17/11/26 8 PM

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 23 D
Dr. KOKKULA PRANEETH (M)

NURSING CARE RECORD

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BirthRight™
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: Baby 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
10pm	→ Assess the Baby General Condition, monitor vitals & Record	11pm	→ Assessed the Baby General Condition, monitored vitals & Recorded	By All this done pt condition is improved
12am	→ plan to do ECG now	1am	→ planned to do ECG now	
3am	→ plan to do myclomenin gels repair	3am	→ planned to do myclomenin gel repair	
6am	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes: myclomenin gels 71m - 8am
Capsoq 9am

Nurse Signature: By

Nurse Name: Aparajitha (001266)

Date & Time: 18/7/26 @ 8am

NURSING CARE RECORD

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 23 D (M)
Dr. KOKKULA PRANEETH

Shift

☐ Night

Date:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 15/7/26

Assessment:

Acute pain related to the procedure

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3:10 pm	Assess the pt General Condition.	3:15 pm	Assessed the pt General Condition.	pt is Conscious & oriented
3:20	Relieve pain & Discomfort	3:25	Relieved pain & Discomfort	pt is oriented
3:30	Monitor vital signs	3:35	Monitored vital signs	vital stable
3:40	Monitor for bleeding	3:45	Monitored for bleeding	no bleeding
3:50	Maintain I/O chart	3:55	Maintained I/O chart	maintained
4:00	NP broken, no water given	4:05	NP broken, water given	no vomiting
4:10 pm	pt shift to the ward	4:15 pm	provided psychological support	shifted
4:20 pm		4:25 pm	pt shifted to the ward	

Re-Assessment:

no ill further order

Special Notes:

NH Admission 2nd hour

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

18/7/26

[Signature]

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026
Dr. KOKKULA PRANEETH
IP5-00176487
0 Y 4 M 24 D (M)

NURSING CARE RECORD

Rainbow[®]
Children's
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BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/2/26

Assessment: Baby having dull activity.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the patient.	8pm	* assessed the general condition of the patient	By doing all the procedures the patient can be stable
10pm	* maintain personal hygiene.	10pm	* maintained personal hygiene.	
2am	* monitor urine output.	2am	* monitored urine output.	
4am	* NC Aspiration 2 nd mly.	6am	* monitored vitals.	
6am	* monitor vitals.			

Re-Assessment: NC Aspiration 2nd mly, urine output 4th mly.

Special Notes:

Nurse Signature: 

Nurse Name: Ranya

Date & Time: 19/2/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: Baby having pain discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the baby	8:5 am	Assessed the general condition of the baby	By doing all the procedures baby is Improved
10am	Monitor the vitals signs	10:15 am	Monitored the vitals signs	
1pm	provide comfortable position	2pm	provided comfortable position	
4pm	NG Aspiration to done	5pm	2nd hourly to be done	
6pm	Maintain I/O chart	6:30 pm	Maintained I/O chart	
8:30 pm	Administer medication as per doctor order	8pm	Administered medication as per doctor order	

Re-Assessment:

Special Notes:

continue NG Aspiration 2nd hourly

Nurse Signature:

Nurse Name:

Date & Time: 19/7/26 @ 8pm

NURSING CARE RECORD

Shift: _____

Date: 19/7/26

Assessment: _____

pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	By doing all the procedure pt is stable
10pm	→ Check the Vital signs	10:10pm	→ Checked the vital signs	
12am	→ Plan for Administration Medication	12:10am	→ providing medication as per doctor Order	
2am	→ Plan for Npo	2:10am	→ Continue Npo	
8am	→ Plan for NG Aspiration 2nd hrly	8:10am	→ NG Aspiration 2nd hrly	
	→ Plan for Continue IV fluids		→ Continue IV fluids	
			→ providing Comfortable position	

Re-Assessment: _____

Re-Assessment Every 2nd hrly (pt is stable)

Special Notes: _____

2nd hrly N.G. Aspiration

Nurse Signature: _____

Nurse Name: _____

Chandani

Date & Time: 20/7/26 2pm

20/7/26 2pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby having pain & discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the baby.	8am	Assessed the general condition of the baby	by done all these to improve baby condition
9am	Dr. Harish sir advis remove NGT allow only.	9am	Dr. Harish sir advised removed NGT allow only.	
11am	Dr. praneeth sir advis change dressing	11am	Dr. praneeth sir advised change dressing	
2pm	monitor vital sings & record.	2pm	monitored vital sings & record	
	IVF DNS + 5ml KCL 26ml/hr ongoing		IVF DNS + 5ml KCL 26ml/hr ongoing	
6pm	Administre medication as per doctor orders	6pm	Administred medication as per doctor orders.	

Re-Assessment:

Special Notes: plan for d/c + l/m.

Nurse Signature: *Anna*

Nurse Name: Anna

Date & Time: 20/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/2/26

Assessment: pt having pain in Lx site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	Assess the pt general condition	9PM	Assessed pt general condition	By done all implementation as per order
9PM	monitor vital sign	10PM	monitor vital sign	
10PM	maintain IO chart	11PM	maintained IO chart	
11PM	provide comfortable position	12AM	provided comfortable position	
12AM	Administer medication	6AM	Administered medication	

Re-Assessment:

Special Notes: wif fever

Nurse Signature:

Nurse Name: Sushma

Date & Time: 21/2/26 @ 2AM

Patient:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Praneeth Department: Neuro Date of Admission: 16/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area	10:20 AM 11:00 AM 12:00 PM 1:00 PM 2:00 PM 3:00 PM						
	Medical Condition (Any special condition to be noted):	NA NA NA 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:	98.6°	98.5°	98.4°	98.8°	98.6°	98.1°
		Res:	24b/m	20b/m	20b/m	21b/m	25b/m	29
		SpO ₂ :	100%	100%	99%	98%	97%	92
		Pulse:	162b/m	130b/m	126b/m	132b/m	116b/m	119
		BP:	92/56(mm)	90/58	81/54	89/57	80/47	98/6
		Fall Risk Score:	12	12	12	12	12	13
Pain Score:	0/10	0/10	0/10	0/10	1/10	1/10		
Recommendations	Safety Needs:	Side rails Side rails Side rails Side rails Side rails Side rails						
	Physiotherapy	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
	Others Specify:	NA NA NA NA NA NA						
	Special Diet:	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
Other Special Orders / Medications:		NA NA NA NA NA NA						
Post Operative Procedure Special Orders:		NA NA NA NA NA NA						
Handed Over By Name :		Renuka Apurva Apurva Apurva Swathi Swathi						
Signature :		Renuka Apurva Apurva Apurva Swathi Swathi						
Date:		16/7/26 17/7 17/7 18/7 18/7 18/7						
Time:		10:30 AM 8 PM 8 PM 8 AM 8 PM 8 PM						
Taken Over By Name :		Apurva Apurva Apurva Renuka Swathi Swathi						
Signature :		Apurva Apurva Apurva Renuka Swathi Swathi						
Date:		18/7 17/7 17/7 18/7 18/7 18/7						
Time:		10:30 AM 8 AM 8 PM 9 AM 6 PM 8 PM						

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kokkula Praneeth Department: 1st floor Date of Admission: 16/2/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known		If Yes Specify:		
BACKGROUND	Area	1st floor	2nd floor	3rd floor	4th floor	5th floor	6th floor	
	Shift Time	8p-8a	8a-8p	8p-8a	8a-8p	8p-8a	8a-8p	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.2F	97.8F	98.3F	98.0F	98.1F	
		Res:	28h	28	28h	28b/m	29	
		SpO ₂ :	98%	99	100%	99%	99%	
		Pulse:	110h	102	101h	112	114	
		BP:	99/62	100/64	98/60	99/59	99/56	
		Fall Risk Score:	10	10	10	10	10	
	Pain Score:	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA		
Handed Over By Name :		Ding	Swarna	Chandana	Aruna	Swarna		
Signature :								
Date:		19/2	19/2	20/2	20/2	21/2		
Time:		6am	8pm	2am	8pm	8am		
Taken Over By Name :		Swarna	Chandana	Aruna	Swarna			
Signature :								
Date:		19/2/26	19/2/26	20/2	20/2			
Time:		8am	2pm	8am	8pm			



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
TOTAL			12				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes				
Call device within reach		Yes				
Wheels Locked		Yes				
Room free of clutter		Yes				
Adequate Lighting		Yes				
Wheel Chair Support		No				
Other Intervention(s) Specify		No				
Nurse's Name :		Sush				
Signature :		Su				
Date :		2/2				
Time :		6AM				



THE HUMPTY DUMPTY SCALE

16/7 17/7 18/7 19/7 20/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	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	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	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	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	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	1	1	1
TOTAL			12	12	12	12	12

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes	yes
Call device within reach	yes	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no	no
Other Intervention(s) Specify	no	no	no	no	no
Nurse's Name :		kened	APY	APY	APY
Signature :		E	APY	APY	APY
Date :		16/7/20	17/7	18/7	19/7
Time :		6:30	6:00	6:00	6:00



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/2	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Aruna
20/2	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma
21/2	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ 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:

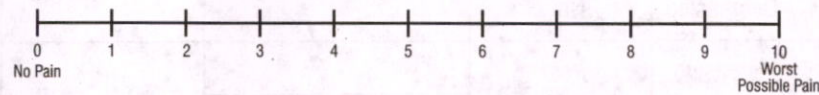
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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

Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	10:00 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Keneo
18/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
17/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Anuna
17/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
18/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
18/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surling
18/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shruti
18/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shruti
19/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani
20/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani

Re-assessment Frequency:

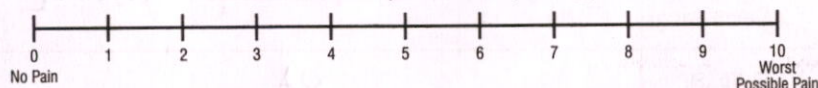
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date : 2/12			
					Time : 5:00			
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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			
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			
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			
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			
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
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			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	27		
Docu. No. : RCHB/FRM / CLINICAL / 119					Evaluator's Name	Sush		

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

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH



BRADEN 'Q' SCALE

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date :	18/2/16	19/2	20/2	19/2
				Time :	10:00am	6am	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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	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	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	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	4	4
FRICITION-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	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
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	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name			

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
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CHECKLIST FOR THROMBOPHLEBITIS

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 of Ward In Charge :

Signature : Name :

Signature : Name :

LBH-00129578 IP5-00176487
 Master MUDRAKOLA VISHWA
 24-02-2026 0 Y 4 M 22 D (M)
 Dr. KOKKULA PRANEETH



CHECKLIST FOR THROMBOPHLEBITIS

ACTION	STAGE / ACTION	SCORE	16/7 DAY-1			17/7 DAY-2			19 DAY-3			Remarks
			M	E	N	M	E	N	M	E	N	
1	IV site appears healthy No signs of phlebitis / Observe cannula	0			0	0	0	0	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 cord pyrexia Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse						Appu	Amu	Amu	Appu	Swab	Qy	

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 : Sourav

Signature of Ward In Charge :

Signature : Name : Neeraja Devi



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 18/12/26 Date of Removal: 19/12/26

Parameters	Date	Shift Time						
Need for the Catheter	<u>18/12</u>	<u>8:30 AM</u>	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			<u>[Signature]</u>	<u>[Signature]</u>				
Signature of the Nurse			<u>[Signature]</u>	<u>[Signature]</u>				

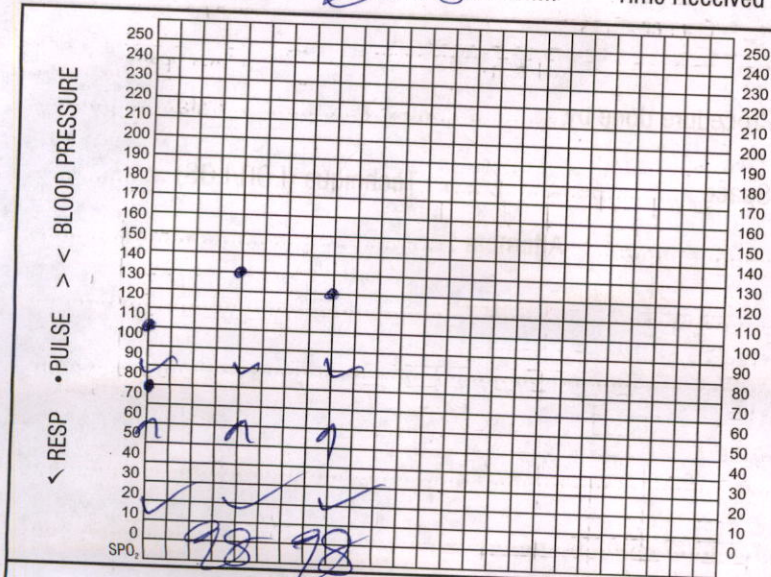


POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. S. S. S.

Time Received : 3:50 pm

Time Discharged :



IV Cannula Site : 225 (R)

☐ O₂ 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 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	1	1	1			A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	2	2	2			
BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0	2	2	2			
Fully awake = 2 Arousable on calling = 1 Not responding = 0	1	2	2			
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	2	2	2			
TOTAL	8	8	9			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
18/7	3:50 pm	1/10	—	<u>Dr. S. S. S.</u>

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

Anaesthesiologist Name : Dr. S. S. S.

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 18/7/2026 4 pm

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: 18/7/2026 4 pm

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)

[illegible]

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 :

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH

Name: Master mudrakola vishwa Age: 4m Sex: male UHID.No: LBH-00129578
Date: 16/7/26 Time: 5:45pm Proposed Operation: myelomeningocele
Diagnosis: Repair of myelomeningocele
B.P / CRT: 2sec H.R: 110 Weight: 6kgs ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 9.9
PCV: 29.9
WBC: 9920
Plate: 4.3
PT: 14
PTT: 44
INR: 1.0

Glucose: 110 Protein: 5.1
Urea: 10 Alb: 3.8
Creat: 0.8 Total Bill: 1.2
Na: 138 Dir. Bill: 1.2
K: 4.0 LDH: 120
Ca++: 1.0 Alk phos: 120
Mg++: 0.8 Amylase: 120
Cl-: 100 SGOT/SGPT: 120

HIV: 120
HBS Ag: 120
HCV: 120
Blood group: 120
T3: 120
T4: 120
TSH: 120

X-Ray: USG - midgut malrotation
ECG: study
2D Echo: study
Stress/Angio: study
Other: study

Allergies:

NKDA

Medical History: CVS: -

RESP: -

Diabetes: -

CNS: H/O swelling in the lower back since birth

Renal: -

Hepatic / GE: H/O Acute gastroenteritis 15 to 20 days ago; H/O loose stools. birth

Others: USG - midgut malrotation

Past Anaesthetic History: SLD

Physical Exam: (N)

Airway: MP 1 2 3 4

Mouth Opening: 1.5

Mentohyoid Distance: 4.5

Lungs: BAE (+) clear

Heart: S1S2 (+)

CNS: HMF (+)

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: accessible

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: Water / ORS 2 Hours
- NIL ORAL: Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: Reckul 15ml/kg PRBC

Signature: [Signature] Name: Dr. Pejani Blood grouping: B+

LBH-00129578

IP5-00176487

Master MUDRAKOLA VISHWA

24-02-2026 0 Y 4 M 24 D (M)

Dr. KOKKULA PRANEETH



NIBP SBP DBP MAP MABL - $\frac{9.9-8}{9.9} \times 80 \times 6 \text{ kg}$

95th 102-104 65-68 78-80

50th 80-88 50-54 62-65

25th 78-80 45-48 56-58

5th 70-72 38-40 48-50

ANAESTHESIA CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status:

Adequate

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R: 138 bpm

B.P/CRT: <3sec

SpO₂: 98% on R.A

R.R: ~30/min

Last Feed: 2 Gms

Pre-OP Diagnosis:

Operation:

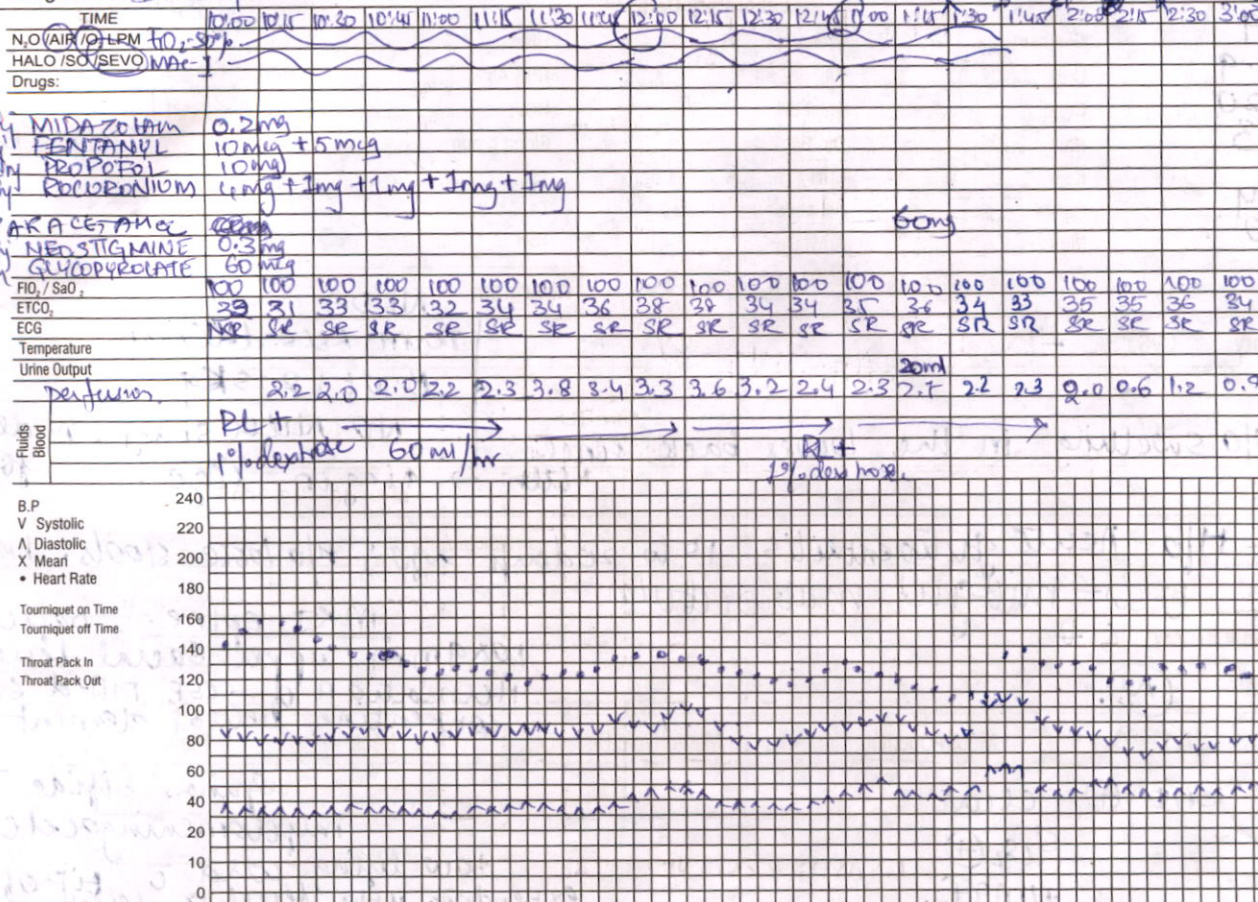
Repair of myelomeningocele

Date: 18/11/26

Surgeon: Dr. Sripa

Anaesthesiologist: Dr. Rav

Technician: Smita



Antibiotic

Suppository

Blood Loss

NOTES

Tr NG
(feeding)
tube passed

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site: Left CC

☐ Art Site:

☒ EKG Lead

☒ Temp Site

☒ FIO₂ Monitor

☒ Agent Monitor

☒ Pulse Oximeter

☒ Capnograph

☒ Ventilator

☐ Nerve Stimulator

☒ Position: Prone -> Supine

☒ Pressure Points Checked

Eye Care:

☐ Oint

☒ Tape

☒ Padding

☐ Awake

Temp:

☒ HME

☐ Cling Film

☒ Hugger's

☐ Other

☐ Fluid Warmer

☐ OH Warmer

☐ Cotton Wool

☐ Other

Times:

Anaes Start: 10:00 AM

OP Start: 3 PM

OP End: 3 PM

Leave OR: 3 PM

Anaesthesia:

☒ GA

☒ Monitored Anaesthesia Care

☐ Regional

Line (Size & Location)

☐ CVP:

☒ ART: 24 G

☒ IV: 22 G

☐ IV:

Induction

☒ IV

☒ Pre O₂
☐ Others

☒ Mask

☐ Airway

☐ Oral

☐ Nasal

☐ Cuff

☒ Tracheostomy

☐ Topical

☒ Drug: Rocuronium

☐ Awake

☒ Direct Vision

☐ Video Laryngoscopy

☐ Stylette / Bougie

☐ Fiberoptic

Blade # 1

Attempts: 2

Difficulty Why?

☒ Bilat = BS

☐ Semi-Closed Circle

☒ Closed Circle

☐ Other

Regional:

Extremity

☐ Spinal

☐ Epidural

☐ Caudal

Others:

Position:

Site:

Needle Size:

Depth:

Parasthesia

☐ Yes ☐ No

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU ☐ ICU ☐ Other

Relaxant Reversed

☒ Yes ☐ No ☐ NA

Name of the Doctor: Dr. K. S. S. S.

Signature of the Doctor:

CONSENT FORM FOR ANAESTHESIA

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

Dr. KOKKULA PRANEETH



Patient Name : master mudrakola vishwa Age : 4m Gender : Male ☒ Female ☐
UHID NO : LBH - 00129578 Surgeon Name : Dr. Praneeth
Anaesthesiologist : Dr. Tejaswini Operative procedure planned : Repair of myelomeningocele

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 without numbness can be achieved by infusing weak solutions of local anesthetics 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 mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : Desaturation; bleeding, blood transfusion
• Doctor to document in medical record also if necessary (Cross-out if not applicable) ICU stay post OP VENTILATION

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☒ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : Prashant
Name : Prashant
Relationship with Patient : Father
Date & Time : 16/7/26 7:10pm

Witness :

Signature : Veena
Name : Veena
Date & Time : 16/7/26 7:10pm

Doctor (who is taking the consent) :

Signature : Dr. Tejaswini

Name : Dr. Tejaswini



UNITED STATES DEPARTMENT OF JUSTICE

DR. JOSEPHINE
10-1-00 10-1-00
DR. JOSEPHINE
10-1-00 10-1-00

10-1-00 10-1-00
10-1-00 10-1-00

10-1-00 10-1-00
10-1-00 10-1-00

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH
IP5-00176487

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)

LAPAROTOMY + LADD'S PROCEDURE

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)
To restore bowel anatomy to prevent volvulus.	

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

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

- a. Bleeding, Infection, Recurrence
- b. Adhesive Intestinal obstruction

1. I authorize Dr. Harish Jayaram 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: Prashanth
Name: Prashanth
Relationship with patient: Father
Date & Time: 18/7/26, 9:28 AM

Witness:

Signature: Veena
Name: Veena (Mother)
Date & Time: 18/7/26, 9:28 AM

Doctor (who is taking consent):

Signature: Maliha Name: Dr. Maliha
Docu. No.: RCHB/FRM CLINICAL / 027 (26)

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబ్సెండ్

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

1.
 2.

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:

శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, 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.

4. డాక్టర్ / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను. గాలిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాల అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

సాక్షి:

సంతకం:

నేను:

తేదీ & సమయం:

తేదీ & సమయం:

(P.T.O)

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Nivedita
 Asst. Surgeon : Dr. Nikita
 Anaesthetist : Dr. Ravi
 Scrub Nurse : Suman, Theja

DR. KOKKULA PRANEETH



Age : 4m Gender : m
 Surgery Name : Laparotomy + Ladd's procedure
 Date : 18/12/26 In-time : 10:AM Out-time :

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN

Time: 09:45 AM

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 : Ravi

Name : RAVI

Before Skin Incision >>

TIME OUT

Time: 1:45 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? 10-15ml ☒ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☒ Yes ☐ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No

Signature : Suman

Name : Suman

Before Patient Leaves Operating Room

SIGN OUT

Time: 2:10 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 : Dr. Nikita

Name : Dr. Nikita
18/12/26
2:10 PM

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
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 :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☐ Yes ☐ No	
Correct Site	☐ Yes ☐ No	
Correct Procedure	☐ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?		☐ Yes ☐ No ☐ NA
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?		☐ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?		☐ Yes ☐ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.		☐ Yes ☐ No
Signature :		
Name :		

Before Patient Leave

SIGN		
Nurse Verbally Confirms with		
The Name of the Procedure R.....		
That Instrument, Sponge and Counts are Correct (or Not Ap.....)		
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 :		

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 18/7/26

Department : P.O.T. Duration of Procedure : 1 hour

Name of Surgeon : Dr. Nabeel Alan Date of Admission : 18/7/26

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. cefotaxim 300mg	Thijas
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	Thijas
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Teena Date & Time of antibiotic administration : 18/7/26 @ 10 AM Date & Time procedure started : 18/7/26 @	Thijas

- 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

Procedure :-

- ① Right supraumbilical incision made
- ② ^{Abdomen} ~~wound~~ opened in layers.
- ③ Findings noted
- ④ Ladd's bands released . ⑤ Kocherization done & duodenum straightened . ⑥ Mesenteric adhesions released & base of mesentery broadened . ⑦ Bowel walk done - normal
- ⑧ Small bowel placed in right side of abdomen & colon placed in left side of abdomen .
- ⑨ Appendectomy NOT done .

Amount of Blood Loss: ~ 1ml

Blood Transfused (in ML) - Nil

Name and Number of Surgical Specimen sent for examination:

- Nil -

Peri-Operative Complications: - Nil -

Name of the Surgeon: A. Palak Singh

Signature of the Surgeon: [Signature]

Date & Time: 18/7/24
3.10 PM



OPERATION THEATER NOTES

Patient's Name : mudrakala Vishwa Age : 4m 24d Gender : ☒ Male ☐ Female
UHID No. : LBH-00129578 Weight : 6 Kg Height : 7

Surgeon :		Asst. Surgeon :	
Anesthetist : <u>Dr. Ravi</u>	OT Nurse : <u>Suman</u>	OT Technician : <u>Shrinsha</u>	
Pre-Operative Diagnosis : <u>Malrotation of gut</u>			
Surgical Procedure : <u>LAPAROTOMY + LADD'S PROCEDURE</u>			
Indications for Surgery :			

Date : <u>18/7/26</u>	Start Time : <u>01:46 PM</u>	End Time :
-----------------------	------------------------------	------------

Pre Operative Preparations:
<u>post-prep : 57-betadine</u>

Post Operative Diagnosis:
<u>Malrotation of gut</u>
Peri-Operative Complications:
<u>-Nil-</u>

Operation Notes:
<u>Findings</u>
<u>- Malrotation of gut noted without volvulus .</u>
<u>- IC junction noted in (R) hypochondrium</u>
<u>- DJ junction noted just right to mid line .</u>
<u>- Bowel walk done - healthy .</u>
<u>- Ladd's bands noted running from caecum over duodenum till lateral peritoneum .</u>

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH



POST-SURGICAL CARE PLAN FORM

Procedure Done: *Laparotomy + Ladd's procedure*

Post-Surgical Diagnosis: *Malrotation of gut*

Post-Operative Monitoring Parameters /Frequency:

TPR monitoring every 15 mi for 1st hr.

Wound Care:

Dressing

Drain /Special Lines/Catheters:

NG tube in situ - 2nd bdy aspiration + continuous drainage

Special Patient Positioning and Requirements:

- Nil -

Nutritional Instructions:

- NPO till further orders

When to Start Mobilization:

- Nil -

Special Referrals:

- Nil -

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

- Nil -

Treating Surgeon
(Signature & Stamp)

Dr. palak Singh

Date: *18/7/20* Time: *3:10pm*

Note: Plan of care will be readjusted if necessary.

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 23 D
Dr. KOKKULA PRANEETH
IP5-00176487
(M)

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. Meningocele repair and detethering of cord
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)
<u>Detethering of cord</u>	—

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. wound infection, CSF leak, ~~meningitis~~ meningitis, wound dehiscence
- b. Neurogenic bladder, Neurogenic bowel, lower limb weakness, Retel

I authorize Dr. Praneeth upon the patient / myself.

2. I recognize that the practice of medicine is as much an art as a science and there 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: Praneeth

Name: Praneeth

Relationship with patient: Father

Date & Time: 16/7/2026 @ 8 PM

Witness:

Signature: _____

Name: _____

Date & Time: _____

Doctor (who is taking consent):

Signature: Praneeth

Name: D. Praneeth

☐ రోగి ☐ రోగి అబ్బందెంట్
 వాను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/

2.....భూమి పై నీటి పారుదలను నియంత్రించే పరికరం (కానీ)

1. జినికల్ ఫలోవోలను అంగీకరిస్తున్నాను.

2. சுருதி உபநிஷத்.

సప్రసిక్త / ప్రాసీజర్ ప్రయోజనాలు:

யலாயு.

புயல்பெயர்வது

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ಅಯ್ಯರವಿಜ್ಞಾನಿಯು:

9

గారిని మరియు వారి బృందాన్ని, రోగి/నాస్తి ఈ శస్త్రచికిత్స

செய்து

నాకు బుద్ధి నావిరాళినీ
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రగా ఇస్తున్నాను భువికలస్తున్నాను.

५५

ନିଉଜିଲାଣ୍ଡ:



ప్రతి & సమయం:

ತೊಟ್ಟಿಲಿ ಸುಯ್ಯಾರಂ:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Praneeth/Dr. Partha
Asst. Surgeon :
Anaesthetist : Dr. Ravil/Dr. Suri
Scrub Nurse : Suman

Patient Name : Mudrakola Vishwa Age : 4m Gender : M
UHID No. : CEH-00129578 Surgery Name : opening of cecum repair
Date : 18/1/26 In-time : Out-time :

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH


Before Induction of Anaesthesia >>

SIGN IN

Time: 9:50 AM

Has Confirmed ☒ 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 : [Signature]

Name : Dr. S. S. Suri

Before Skin Incision >>

TIME OUT

Time: 11:02 AM

Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

Correct Patient (Check ID Band) ☒ Yes ☐ No
Correct Site ☒ Yes ☐ No
Correct Procedure ☒ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 1hr. 20ml ☒ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA

Is Essential Imaging Displayed?

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No

Signature : [Signature]

Name : Thyos

Before Patient Leaves Operating Room

SIGN OUT

Time:

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No

Signature : [Signature]

Name : Dr. Praneeth



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 18/7/2022

To Be Filled In By Assigned Nurse :

Department : P.O.T. Duration of Procedure : 1 hour

Name of Surgeon : Dr. Sripartha Date of Admission :

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. cefotaxim 300 mg	Thijas
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	Thijas.
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Teena Date & Time of antibiotic administration : 18/7/26 @ 10 PM Date & Time procedure started : 18/7/26 @ 11:03 AM	Thijas.

- 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

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled in By Assigned Nurse

Duration of Procedure

Use of Antibiotics

Name of Surgeon

Bundle Care Checklist (Checklist)

Item	Yes	No
1. Hand hygiene performed by all staff before and after patient contact	☒	☐
2. Patient's skin is intact and free of infection at the time of surgery	☒	☐
3. Patient's skin is prepared with antiseptic solution	☒	☐
4. Patient's skin is covered with sterile drape	☒	☐
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LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH



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BirthRight
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OPERATION THEATER NOTES

Patient's Name : Master Mudrakola Vishwa Age : 4m Gender : ☒ Male ☐ Female
UHID No. : LBH-00129578 Weight : 6 Kg Height :

Surgeon : Dr. Surya, Dr. Ravi Asst. Surgeon : OT Technician : Shrisha

Anesthetist : Dr. Surya, Dr. Ravi OT Nurse : Suman

Pre-Operative Diagnosis: MENINGOCELE WITH TETHERED CORD

Surgical Procedure : MENINGOCELE EXCISION AND REPAIR

Indications for Surgery : TETHERED CORD

Date : 18/07/2026 Start Time : 11.03 Am End Time :

Pre Operative Preparations:

3x BETADINE

Post Operative Diagnosis: MENINGOCELE WITH TETHERED CORD

Peri-Operative Complications: NONE

- Operation Notes:
- 1) Patient laid prone under GA. Pressure points padded.
 - 2) Meningocele sac opened, CSF released, dysplastic neural tissue noted.
 - 3) Tethered cord noted with fatty filum terminale.
 - 4) Filum terminale dissected and sectioned.
 - 5) Dura dissected and detached from surrounding fascial defect.
 - 6) Dura closed in watertight fashion with 4-0 PDS.
 - 7) Thoracolumbar fascia mobilised and raised as flap and closed over fascial defect.
 - 8) Redundant dysplastic skin excised and closed in layers

Amount of Blood Loss: 20ml

Blood Transfused (in ML) 1

Name and Number of Surgical Specimen sent for examination: —

Peri-Operative Complications:

None

of the Surgeon: Dr. Shyam

Apr

LBH-00129578
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 24 D (M)
Dr. KOKKULA PRANEETH
IPS-00176487

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Meningocele repair
MME

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

GIS, vitals

Wound Care:

—

Drain /Special Lines/Catheters:

Foley's catheter

Special Patient Positioning and Requirements:

lateral

Nutritional Instructions:

~~Oral~~ Orally as per ped Sx

When to Start Mobilization:

—

Special Referrals:

—

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

☒ Yes ☐ No

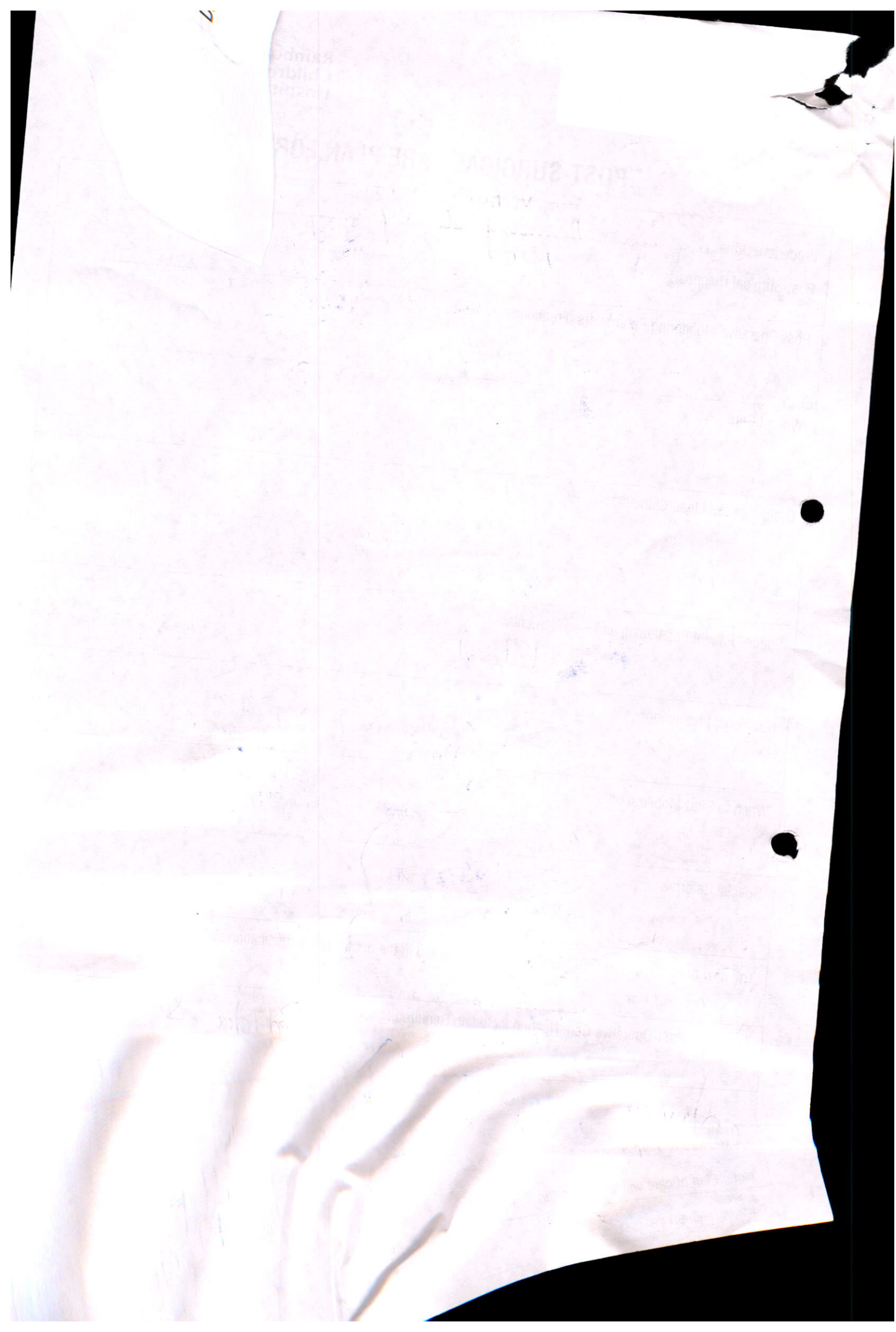
Any Other Post-Operative Care Needed including Required Follow Up

Pediatric &

Treating Surgeon
(Signature & Stamp)

Note: Plan of care will be readjusted if necessary.

Date: 18/2/2026 Time: 12:00 PM



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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 | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 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		
18/2/26	10:00pm	8	procedure	M	4	0	1	1	-	Praneeth

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

LBH-00129578 IP5-00176487
Master MUDRAKOLA VISHWA
24-02-2026 0 Y 4 M 22 D (M)
Dr. KOKKULA PRANEETH



Diagnosis: _____

Date Time	Discipline	Type	Issues / Problem List	Goal	Plan / Intervention	Signature	Team Verification
16/7/26 9:30 AM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	menigo myelocoele	H. Stability	Sx Repair	Solu	☐ Nursing ☐ Others: Doctor
16/7/26 9:50 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	menigo myelocoele repair	H. Stability	IV fluid & NPO	Kendrick	☒ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctor order

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:

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

Remarks

Explain to parents

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: Personal Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Apuragiri

Date and Time: 14/02/2026 08:00 PM



Patient Sticker

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o veena (vishwa) Age : 4M Gender: ☒ Male ☐ Female
Date : 16/2/26 Time of Arrival : 7:35pm Triage Completion Time : 7:37pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify): NA
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

Circulation / Colour

☒ Normal

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life - Threatening

Initial Vital Signs: Temp: 98.5°F PR: 128b/m BP: 92/56 (16) RR: 26b/m SpO₂: 100% RA

Chief Complaints: came for surgery Repair of Myelomeningocele.

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: prashanth

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 : Mr. Rachel

Signature of Triage Nurse : [Signature]

Date & Time : 16/2/26 @ 7:37pm



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctor order

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

Explained to parents

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: Personal Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Apurajitha

Date and Time: 16/7/26 @ 10:30pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/7/26 Time of arrival : 7:39 pm
Chief Complaints: came for surgery repair of myelomeningocele RBS: NA
Height : Weight : 6.4 kg BMI : Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify NO
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: NA Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

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: NA (Date/Time): NA

Social History: Lives With family

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

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

Time of Initial assessment completed by ER Nurse : 7:42 pm

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

Time	Nursing Notes
9:20pm	→ Assess the child condition.
	→ Seeing Dr. Sohela.
	→ vitals are recorded.
	→ IV placement Done.
	→ Samples collected and send to lab.
	→ T/m surgery at 10:30 Am.
	→ shifted to ward

Samples collected by: Shambhu
 Samples sent by :

Time: 9:20pm

Time: 9:30pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>128b/m</u> BP: <u>92/56 (95)</u> CFT: <u>4.2cc</u> RR: <u>26 b/m</u> SPO ₂ : <u>100%</u> GCS: <u>15/15</u> Temperature: <u>98.1°F</u> Pain Score: <u>0/10</u> Repeat RBS (if applicable): <u>NA</u>	Shift - out from ER to: <u>ICU</u> Time of Shift - out: <u>10:25 PM</u> Handover given to: <u>Aparajitha</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: Renuka

Signature of the Nurse: [Signature]

Date & Time: 16/7/2022 7:45 PM

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00129578 IP5-00176487 Master MUDRAKOLA VISHWA 24-02-2026 0 Y 4 M 24 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 16/7/26 @ 9:15 PM	Date & Time of Transfer Order 18/7/26 @ 11:20 AM
		Transfer Ordered by Dr. Praneeth	Reason for Transfer Post-Op
From Unit OT	To Unit 181	Information to Attendant Yes ☐ No ☐	
Number of Sheets in Clinical File 22	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	op file - ①		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Praneeth	
Patient & Clinical Records Received by : Sushma			
Date & Time of Patient Received : 18/7/26 @ 5 PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00129578 IP5-00176487 Master MUDRAKOLA VISHWA 24-02-2026 0 Y 4 M 23 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 16/7/26 @ 9:18pm	Date & Time of Transfer Order 18/7/26 @ 9:30pm
		Transfer Ordered by Dr. praneeth sir	Reason for Transfer myelomeningocele & detethering of cord + Laparotomy & Hadd's procedure
From Unit 121	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	USG kub - ①		
2.	Upper - GI - ①		
3.	ECG - ①		
4.	Received with ID Band and		
5.	(Left hand) Cerebral dots and		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐ time			
Name & Signature of Person who is Transferring [Signature]		Name of Person Ordered Transfer Dr. K. praneeth	
Patient & Clinical Records Received by : [Signature]			
Date & Time of Patient Received : 18/7/26 @ 9:30 am			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00129578 IP5-00176487 Master MUDRAKOLA VISHWA 24-02-2026 0 Y 4 M 22 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 16/7/26 @ 9:18pm	Date & Time of Transfer Order 17/7/26 @ 10:30am
		Transfer Ordered by Dr. praneeth.	Reason for Transfer myelomeningocele
From Unit 121	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films USG-100B-①	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Aruna		Name of Person Ordered Transfer Dr. praneeth	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00129578 IP5-00176487 Master MUDRAKOLA VISHWA 24-02-2026 0 Y 4 M 22 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 16/2/26 @ 9:18 PM	Date & Time of Transfer Order 16/2/26 @ 10:30 PM
		Transfer Ordered by Dr. Soheela	Reason for Transfer Admission.
From Unit ER	To Unit ICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films NO	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? optikey	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR - Praneeth		Name of Person Ordered Transfer Dr. Soheela	
Patient & Clinical Records Received by : Aparajitha			
Date & Time of Patient Received : 16/2/26 @ 10:30 PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready