BAH-00648965 IP5-0017
Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

Patie

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81048

SURGERY DETAILS

Date : 07-07-26

Patient Name: Master Devansh Date of Birth: 26-09-2021 Age: 4y

Gender: Male Ward : OT UHID No.: 648965

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

Name of the Surgery : Right Open Herniotomy

Time in : 11:50 Am Cord RVT Time Out : 12:50 pm

PAB-12

		NAME	AMOUNT
1.	Surgeon	Dr. Harish Jayaram	SP 45740
2.	Anaesthetist	Dr. Subhana	AF 13722
3.	Assistant Surgeon		OT - 36592
4.	OT Technician	Prashanth	CSSD - 1372
5.	Circulating Nurse	Sujata	
6.	Assistant Nurse	Bokhlai	

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

Signature of the Surgeon

Suja
Signature of Circulating Nurse

Order No: 969217 Order by: Sujata

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

BAH-[redacted]12965
Patient Sticker
Master-Chaterjee
Devansh 7Y/M
5232

Herniotomy Open

CONSUMABLES OF OT

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Circulating staff : .... Technician : .... Date : 7/7 .... Time : 12:30 PM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube (4.0 4.5 5.0)	1+1+1	—	Major Pack (Surgical pack)	1	1	Inj Vit.K		
LMA 2,	01	—	Sutures (9915)	2	1	Cord Clamp		
ECG leads : A / (P) / N	5	3	Vicryl 3-0, 4-0, 5-0	2+2+2	0	Suction Catheter		
HME filter : A / (P) / N	01	1	(2437)		1	Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	3	Gloves 6, (6 1/2), (7), 7 1/2	2+2+2	1+1	Surgical Gloves		
02 cc	10	3	PF 6, 6 1/2, 7, 7 1/2	2+2+2	—	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	1	Surgical blade 15	1	1	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil	1	1	NS 500ml	2	—
NS : (10ml) / (100ml) / (500ml) / 1000ml	5+1+1	1 0 0	Koochies			Transfix	1	—
Three way spike	01	0	Ointments XL	1	1	10 & 15	2+2	—
Valley set	01	1	Suction Catheter					
Fentanyl	01	1	Cap, Mask	5/5	10/10			
Morphine			Gauze Pack (R+M)	5/5	2			
Ketamine			Mop Pack					
Propofol	4	2	Steristrip					
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	—	Draw sheet	1	0			
Myopyrolate 1 Peo	02	—	Abgel					
Ondansetron	01	—	Foleys catheter					
Pencan 25g/ Spinal Needle (22)	0	1	Urobag			OA. (0)	1+1	+
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			NA. (18) 20	1+1	+
Bupivacaine 0.25%(Heavy)			Romodrain bag			Osmo (P)	01	—
Antibiotics			Bandage			ET Cuff Pres(P)	01	1
IV pcm	01	1	Tegaderm			Dexmed (100)	01	—
Suppositories			Ioban			Clonidine	01	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	—			
Justin : (12.5 mg) / 25mg / 100mg	01	1	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Bussy 10cm+100 Sm	1+1	—	Microshield	1	1			
Gauze + Blood (60)	5+2+1	1+1	Cotton Balls	01	1			
Dese + Fanke	1+1	—	Latex Gloves	10P	8P			
IV canula 22, 24	1+1	—	Ramdione Scrub					
Q. set 22, 11 3	1+1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 969846 Ordered by : ....

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

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10:55 Am

pre-Appt.

ESTIMATION SLIP

Date : 06/07/2026 UHID / IP No. : BAH-0064965 SI No. 81048

Name of Patient : Master Chandeddy Devansh Yadav Age: 4 Y. Gender: M.

Father's / Husband's Name : Mr. Srikanth. Corporate / Occupation : Business.

Address : _____ Phone : 9666582545 Email: _____

Procedure / Plan : Right Open Herniotomy.

MODE OF PAYMENT : ☐ SELF ☑ TPA : _____ ☐ GIPSA: _____ OTHERS

TARIFF INFORMATION :

Dr. H/J.

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges			X							
	Doctor's Fee				1 Day						
	L. Tax				Supply	N/A					

PARTICULARS			AMOUNT (₹)			
Surgeon's / Anesthetists's Fee / O.T. Charges			Supply.			
O.T. Consumables →			7506	Subject to approval by TPA / Insurance Company		
Instrument Charges				Not Covered by TPA / Insurance company		
Pharmacy, Consumables & Investigations			Cash.	As per actual - Not Included in Estimation		
Equipment Charges	Monitor :		Oxygen :		Infusion pump / Syringe pump :	
	Ventilator :	Conventional :		HFO-SLE 5000 :		HFO Sensormedix :
	Phototherapy :	Single Surface :		Double Surface :		Triple Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.			Cash	As per actual - Not Included in Estimation		
Package	Pkg. S-11		1,20,000			
Others						
Initial Minimum Deposit →			15,000 & Further as per clinical			

REMARKS:

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.**
3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
6. **For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.**
7. During Non-working hours of O.T (8:00 PM ot 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
8. Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I Mrs. Vaishnavi have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital

Signature of the Client | Mother. Signatory Relationship | Signature of the Financial Counselor

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Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176068 **Admit Date** : 07-Jul-2026 **Admit Time** : 10:49 AM **UHID** : BAH-00648965

Patient Details :

Patient Name	: Master CHENREDDY DEVANSH YADAV	**Age**	: 4 Y 9 M 11 D
Guardian	: Mr CHENREDDY SRIKANTH YADAV	**DOB**	: 26-09-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: HS NO 1-1-574/1, PADMANAGAR ROAD NO 1, Gurbabadi Nizamabad Telangana INDIA 503001	**Phone No**	: 9666524545/ 9951195585
		E-mail	: SRI.YADAV245@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 411 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 411 **Admission Type** : First Visit

Contact Details :

Name : Mr CHENREDDY SRIKANTH YADAV **Relationship** : Father

Contact Address : HS NO 1-1-574/1, PADMANAGAR ROAD NO 1, Gurbabadi Nizamabad Telangana INDIA 503001 **Phone No** : 9666524545

Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.10

Payor Name : ADITYA BIRLA HEALTH INSURANCE CO LTD

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Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	11:27am	ER	OT	Pooja
7/7/20	2.50pm	OT	339.	Thejas.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
07/07/26	CBP	67898	Ismail

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	iv placement PAC (OP Basis)	1	91567	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: CHENREDDY DEVANSH YADAV.

UHID ID:

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Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

4 o swelling right groin noticed ∴ 4 months
& irritability

History of present illness :

↓

O/E — Right reducible inguinal swelling (+)

Admitted for Right inguinal hernia.

No H/o Fever, cough, cold

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Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal neonatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

~~Not~~ Immunized till date

(P.T.O.)

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Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 18.9 kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 110/min B.P. 100/71 (76) SPO2 98% on RA

Resp.rate and type of breathing : 24/min

Rash –

Lymphadenopathy –

Oedema : –

Allergies (if any): –

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds :

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur :

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

Per Abdomen :

Inspection

Palpation :

Ausculation :

Spine : External Genitelia :

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

Soft

Right Reducible Inguinal Swelling (+)

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials:**

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic: Right inguinal hernia → Right open herniotomy done.

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Infection

Desired goals of the treatment : Surgical Resolution of Symptoms

Planned Labs:

W cannula – CBP

Planned Management

NPO continue
PAC – Done
INF – DNS
Sx – Right open hemitotomy plan

N/B. posted on 7/7/26 @ 10:55 am

Signature of the Doctor: .....
Name of the Doctor: N. Pearlin
Date & Time: 07/7/26, 10:20 am

Signature of the Consultant: DR HARISH JAYARAM Regis No: 66254
Name of the Consultant: Dr. Harish
Date & Time: 7/7/26 11.30AM

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OPERATION THEATER NOTES

Patient's Name : Master Chenreddy Devansh Age : 4y Gender ☑ Male ☒ Female

UHID No.: BAH-00648965 Weight : 17.7kgs Height : .....

Surgeon : Dr. Shreeja.		Asst. Surgeon : —
Anesthetist :	OT Nurse: Bithlai	OT Technician:

Pre-Operative Diagnosis: Right Inguinal Hernia

Surgical Procedure :

Right Open Herniotomy

Indications for Surgery :

Right Inguinal Hernia

Date : 07-07-26	Start Time : 12:05pm	End Time : 12:45pm

Pre Operative Preparations:

Post Operative Diagnosis: (R) Inguinal Hernia

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Rt thin hernia sac & no contents at time of surgery.
2) Vas and vessels normal

Procedure

1) Incision made over (R) lower groin crease
2) Subcutaneous tissue separated & external oblique aponeurosis opened.
3) Sac identified, lifted up, separated from cord structures and ligated at deep ring proximally & cut.

Amount of Blood Loss: ~1ml	Blood Transfused (in ML) —

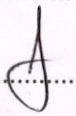
Name and Number of Surgical Specimen sent for examination:

—

Peri-Operative Complications: —

4) Distal Sac lay opened. Testis pulled back into scrotum
5) Wound closed in layers.

Name of the Surgeon: Dr. Harish Jayaram

Signature of the Surgeon: 

Date & Time: 7/7/26 12:55 pm

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POST-SURGICAL CARE PLAN FORM

Procedure Done: (R/P) Open Hemiotomy

Post-Surgical Diagnosis: (R) Inguinal Hernia

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour.

Wound Care:

Dressing

in /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

As early as possible

Special Referrals:

—

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

☐ Yes ☑ No

Any Other Post-Operative Care Needed including Required Follow Up

—

Treating Surgeon
(Signature & Stamp)

Date: 7/7/26 Time: 12:55 pm

Note: Plan of care will be readjusted if necessary.

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Dr. HARISH JAYARAM

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DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : 8/1/26.

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 3pm	C/S/B Dr. Shreyas	Advice
	POD-0 (R) Inguinal herniotomy.	- Full feeds
	afebrile -	- Ambulate the child
	vitals stable.	- Discharge tomorrow
	P/A - soft.	
	Dressing - NO soakage.	
7/7/26 6PM	DR. HARISH JAYARAM Registration No: 66254	Shrey 7/7/26 3pm Dr. Shreyas
	C/S/B Dr. Maliha	
8/7/26	POD - (1)	
	No fever spikes	Adv
	Vitals stable	1) Full feeds
	P/A - soft	2) Plan discharge today
	Dressing intact	
8/7/26 10.20 AM	DR. HARISH JAYARAM Registration No: 66254	Maliha 8/7/26 8:30 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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.,) : .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : M. Prathima - N-Rmo

Date & Time : 07/07/26, 10:25PM

Nurse Name & Signature: NN - Leo Smith

Date & Time : 07/7/26 @ 10:25am,

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Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 7/7/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name ..... Signatu

BAH-00648965 IP5-00176068
Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

REGULAR PRESCRIPTIONS

Weight. 18.98kg Ward. .....

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

DRUG : INJ · PARACETAMOL	Dose	Route	Frequency	Start Date	Date / Time 7/7 8/7
	285 mg	IV	TID	7/7/22	6AM Not given Pratti
Name & Signature of the Doctor Starting the Drugs: Dr. Shreeja					2pm 2pm OT
Additional Instructions:					10pm Pratti
Daily Doctor's Endorsement by a Sign					Nav Nav

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

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

26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

Weight. 18.98kg Ward. .....

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
7/7	12pm	INJ. PARACETAMOL	290MG	IV		
7/7	11:55pm	DICLOFENAC suppository	12.5MG	PR		
7/7	12:45pm	Inj GLYCOPYRROLATE	0.2mg	IV	X	

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

Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

IP5-0017608

I.V. FLUIDS CHART

18-98 kg
Weight. ..... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
07/7/26		DNS	IV	50	N.P		Not connected		

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

BAH-00648965 IP5-00176068
Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: SOB

Arrival Time: 11 am Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA

Body Weight: 18.9 Kg

Height: — cm

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

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

Family History: No history Significant

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

s please list, —

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

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

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

Observations: Weight: 18.9 Length: — Head Circumference (< 2 years): —

Temp.: 98.4°F HR: 88 b/m RR: 26 b/m BP: 90/50 mmHg

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

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

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

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

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: ..... (Date/Time): .....

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

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

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Father .....

Nurse Signature: .....

Nurse Name: ..... Teena .....

Date: ..... 7/7/22 .....

Time: ..... 11:37 am .....

BAH-00648965 IP5-00176068
Master CHENREDDY DEVANSH (M)
26-09-2021 4 Y 9 M 11 D
Dr. HARISH JAYARAM

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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.

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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FLUID CHART

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

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

1 Right open Hernotomy

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)
To close patent PPV to prevent bowel & omental Hernation	-Nil-

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, wound Infection, Scrotal swelling
b. Recurrence, ~~pain~~ pain

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: Sri
Name: Ch. Srikanth yadav
Relationship with patient: Father
Date & Time: 7/7/26 @ 11.40 AM

Witness:
Signature: Gyadav
Name: G. Gangadhar
Date & Time: 7/7/26 @ 11.42 AM

Doctor (who is taking consent):
Signature: ..... Name: Dr Vasee Desh Date 7/7/26 Time: 11:40 am

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Harish Jayaram
Asst. Surgeon : .....
Anaesthetist : Dr. Breenda
Scrub Nurse : Bakhlal

Patient Name : Master Chenreddy Age : 4 yr Gender : M
UHID No. : BAH-00648965 Surgery Name : Open Herniotomy
Date : 7/07/26 In-time : 11:45 Am Out-time : 12:50 pm

BAH-00648965
Master CHENREDDY
26-09-2021 4 Y
Dr. HARISH JAYARAM

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:40 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 : .....
Name : Dr K Sri Surya

Before Skin Incision ➤➤

TIME OUT Time: 12:04 pm

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 30 minutes ☑ 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 : Ratnakar

Before Patient Leaves Operating Room

SIGN OUT Time: 12:45 pm

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

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

Signature : .....
Name : DR HARISH JAYARAM

Patient Stick

BAH-00648965 IP5-00176068
Master CHENREDDY DEVANSH
26-09-2021 4 Y 9 M 11 D (M)
Dr. HARISH JAYARAM

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 7/07/26

To Be Filled In By Assigned Nurse :

Department : OT Duration of Procedure : 1hr

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 7/07/26

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 : —	Sufata
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	Sufata
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 : — Date & Time of antibiotic administration : — Date & Time procedure started : 07/07/26 @ 12:05pm	Sufata

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

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctors orders

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	YES
☐ Dressing	☑ Yes	☐ No	
☐ Toileting	☑ Yes	☐ No	

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: medication

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

☐ Patient ☑ Family Member ☐ Others: .....

Nurse Signature: .....

Nurse Name: .....

Date and Time: 7/4/26 @ 1.30 pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00648965 IP5-00176068 Master CHENREDDY DEVANSH 26-09-2021 4 Y 9 M 11 D (M) Dr. HARISH JAYARAM	7/7/26 @ 10.49	7/7/26 @ 9.57
	Transfer Ordered by Dr. Harish	Reason for Transfer Post-op Records
	From Unit OT	To Unit ICU
		Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 607	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ opt 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	Name of Person Ordered Transfer
	Dr. Harish

Patient & Clinical Records Received by : Satya

Date & Time of Patient Received : 7/6/26 @ 2.55pm

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

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

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Master cheriReddy Devansh Yadav. Age: 4yrs Sex: M UHID.No :

Date: 7/7/26 Time: 10:30Am Proposed Operation: Right- open Herniotomy

Diagnosis: Right Inguinal Hernia

B.P / CRT: H.R: Weight: 17.7kg ASA Physical Status: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: — Nil —

Medical History: CVS :

RESP :

CNS :

Renal :

Hepatic / GE : Nothing significant.

Others : — Nil —

Diabetes :

Birth H/o — Uneventful.

Physical Activity:

Immunised for age.

Past Anaesthetic History: — Nil —

Physical Exam:

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

Lungs : Cl. clear

Heart: S1 S2 .

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

10pm Solids.
10Am ORS

Signature: Name:

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

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ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No — Fasting Status: Confirmed

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

H.R: 88bpm | B.P / CRT: 90/60 | SpO2: 98% on RA | R.R: 18/min | Last Feed: > 6hrs

Pre-OP Diagnosis: Hernia ... Operation: (R) open herniotomy ... Date: 4/7/26

Surgeon: Dr. Harish ... Anaesthesiologist: Dr. K Sri Surya / Dr. Santha ... Technician: Vijay

TIME	11:50	12:00	12:50pm
N_2O / AIR / O_2 LPM	2 lit →	→	
HALO / SO / SEVO			
Drugs:			
Inj MIDAZOLAM	1mg		
Inj FENTANYL	40mcg		
Inj PROPOFOL	60mg + 30mg + 20mg		
PARACETAMOL	290mg IV		
INJ DEXMEDETOMIDINE	1mcg/kg/hr for 10min	F/b 0.4mcg/kg/hr	
FIO_2 / SaO_2	100%	100%	100%
$ETCO_2$	32	40	35
ECG	NSR	NSR	NSR
Temperature	36	—	36
Urine Output			
Fluids / Blood			

Antibiotic

Suppository: Supp DICLOFENAC 12.5mg

Blood Loss

NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (chart scale 0–240; systolic ~90–100, heart rate ~80, diastolic ~40–50 plotted)

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (Lt) UL
☐ Art Site: ...
☑ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☑ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☑ Hugger's ☐ Cotton Wool
☑ Other Blanket

Times:
Anaes Start: 11:50pm
OP Start: 12:10pm
OP End: ...
Leave OR: 12:50pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP: ...
☐ ART: ...
☑ IV: 22G (Rt) hand
☐ IV: ...
☐ IV: ...

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

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

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

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

Regional:
Extremity — Specify: ...
☐ Spinal ☐ Epidural ☑ Caudal
Others: ...
Position: (Lt) lateral decubitus
Site: Sacral hiatus
Needle Size: 22G ... Depth: ...
Parasthesia ☐ Yes ☐ No
Catheter at skin ... cm
Drug Name & Conc: 0.25% BUPIVACAINE
Bolus: 18ml
Infusion: ...
Block Level: ...
Comments: ...

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr K Sri Surya
Signature of the Doctor: [signature]

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Patient Sti

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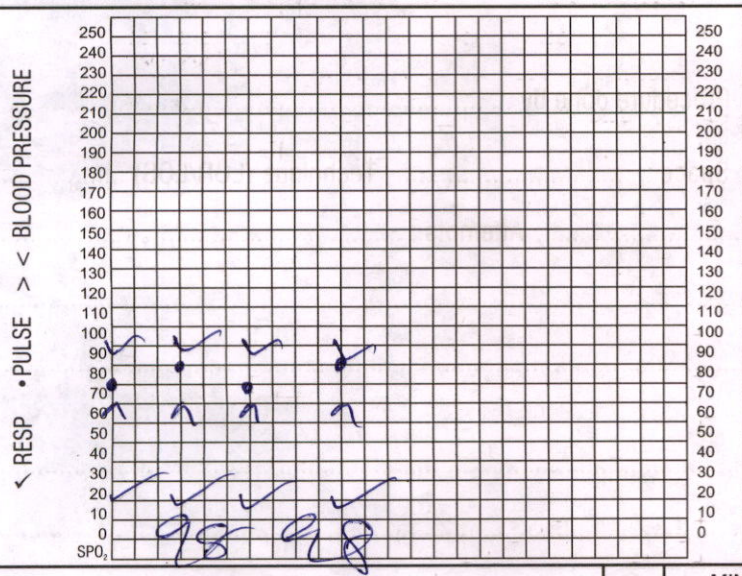
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Divya Time Received : 12:55pm Time Discharged : 2:30 pm



IV Cannula Site : RA

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

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

IV Fluids: NIL
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	1	1	2		2	A Minimum Total Score of 8 is Required for Discharge
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	2	2		2	Exceptions to this, are to be explained in the space below by the Discharging Physician:
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2	2	2		2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	1	1	2		2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2		2	
	TOTAL	8	8	10		10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
7/7	12:55pm	1/10	—	Divya

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

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

Anaesthesiologist Name : RAVI
Anaesthesiologist Signature: 07/7/26
Date & Time: 07/7/26 @ 2.30 pm

PACU Nurse Name : Divya
PACU Nurse Signature:
Date & Time: 7/7/26 @ 2.30 pm

Transferred to Unit by (PACU): Sujata
Date & Time: 7/7/26 @ 12.55pm

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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 : .....

Patient Sti

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Right open Hemiotomy

Anaesthesiologist: Dr. Smitha Surgeon: Dr. Harish Jayaram

Please read this before you consent for Anaesthesia

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

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

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

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☑ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

~~Patient~~ / Patient Attendant:
Signature: Sai
Name: Ch. Srikanth Yadav
Relationship with patient: Father
Date & Time: 7/7/26 10:30 Am

Witness:
Signature: Gayathri
Name: G. Gayathri
Date & Time: 7/7/26 10:30 Am

Doctor (who is taking consent):
Signature: Name: Dr. Smitha Date 7/7/26 Time: 10:30 Am

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

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

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00648965 IP5-00176068 Master CHENREDDY DEVANSH 26-09-2021 4 Y 9 M 11 D (M) Dr. HARISH JAYARAM	7/7/26 @ 10:49 am	7/7/26 @ 11:90 am
	Transfer Ordered by Dr. prathiba	Reason for Transfer Procedure
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films NA	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ? op files

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Gown (L)	(1)
2.	drapper ( )	(1)
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR. Sushmita	Dr. prathiba

Patient & Clinical Records Received by : Teena

Date & Time of Patient Received : 7/7/26 @ 11:30 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

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 2 D (M)
Dr. NABEEL ALAM QADRI

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Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 3pm

Weight: 18.98kgs Centile: >95th

Height: 95cm Centile: >95th

Inference: obese child

RDA: — Calories: 1950 kcal/D Protein: 23gm/D

Diet Recommendations: soft diet

Re-Assesment: avoid spicy, chilled and outside foods

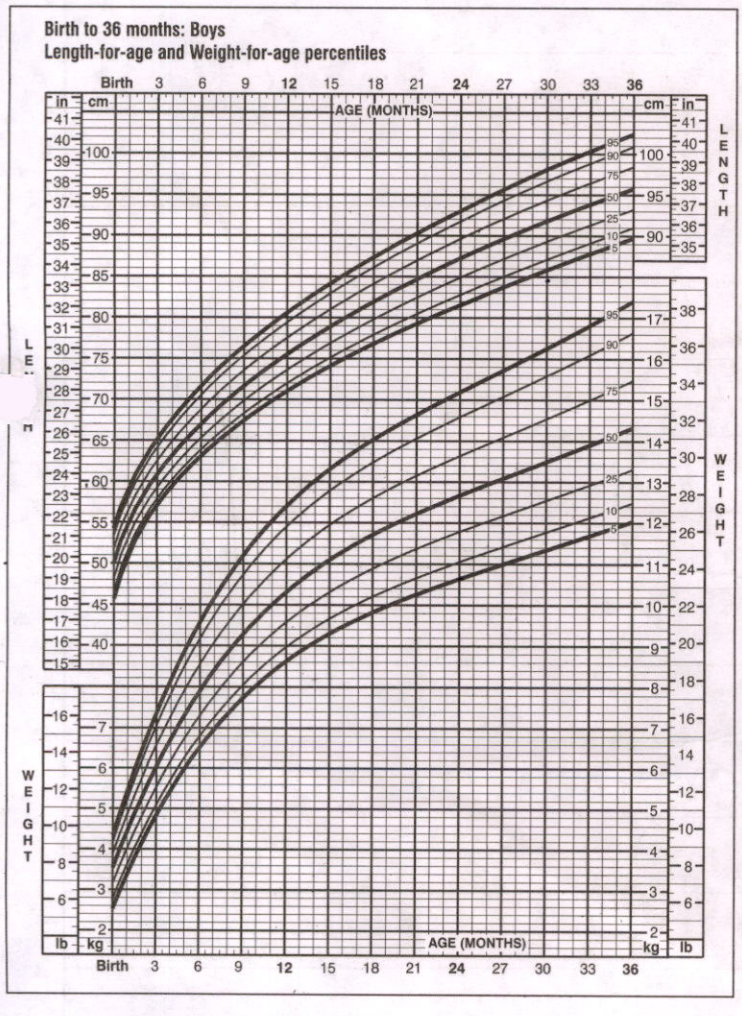
Food Allergies: No Veg/Non-veg ✓ Non-veg

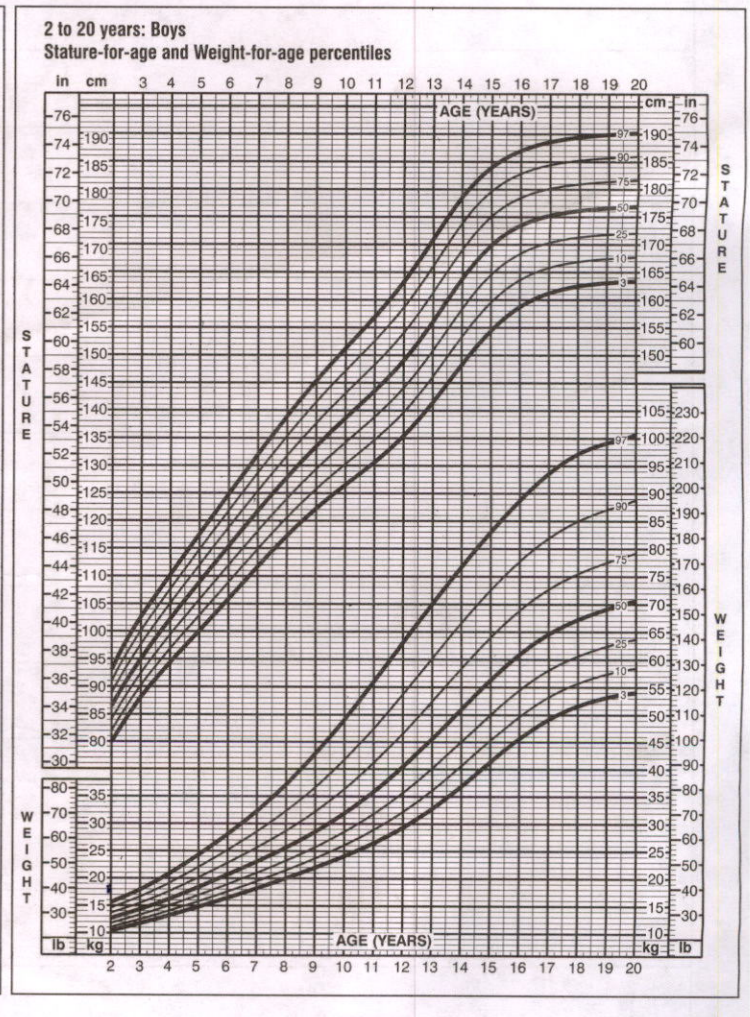
Diagnosis: (Rt) Inguinal Herniatomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Vaid

GROWTH CHART (BOYS)





Dietician's Name Saima

Dietician's Signature Saima

Daily Notes:

8/7/26
9:40 am

child is stable, oral intake is better
continue soft diet

Saima