

BAH-00658004 IP5-00174697
Master RISHI
21-05-2018 8 Y 0 M 13 D (M)
Dr. SIRISHA RANI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Scout Done

Date : 03/06/26

Patient Name: Master Rishi Date of Birth: 21-05-2018 Age: 8y

Gender: Male Ward: P. OT UHID No.: BAH-0058004

Date of Surgery: 03/06/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Femoral line placement

Time in : 2:10pm

Time Out : 2:30pm

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Swilthen</u>	
2. Anaesthetist	<u>Dr. Jaya chandra</u>	
3. Assistant Surgeon	<u>-</u>	
4. OT Technician	<u>Bapu</u>	
5. Circulating Nurse	<u>Alam</u>	
6. Assistant Nurse	<u>Jyoti</u>	

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

[Signature]
Signature of the Surgeon

[Signature]
Signature of Circulating Nurse

Order No: 9641149

Order by: [Signature]

Patient Sticker

M. V. P. Shi
8y 25kg
6332

Femoral Line Placement

CONSUMABLES OF OT



Circulating staff : Technician : Date : 3/4/26 Time : 2:30 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 4.5.5.0.5.5	11	1	Major Pack	1	1	Inj Vit.K		
LMA 2, 2 1/2	1	1	Sutures (5003)	2	1	Cord Clamp		
ECG leads : A (P) N	5	03				Suction Catheter		
HME filter : A (P) N	1	1				Feeding Tube		
Syringes : 10 cc	10	8				Vaccum Suction Set		
05 cc	10	4	Gloves 6, 6 1/2, 7, 7 1/2, 8, 8 1/2, 9			Surgical Gloves		
02 cc	10	0	PF (L) 6, 6 1/2, 7, 7 1/2, 8, 8 1/2, 9			Gauze Pack		
01 cc	2	1				Syringe 1ml / 2ml		
Cautery plate : A (P) N	1	1	Surgical blade (11)	1	1	Surgical Blade # 20		
IV set	1	01	NG tube			Koochies (S)		
RL	1	01	Cautery pencil			500ml NG	1	1
NS : 100ml / 100ml / 500ml / 1000ml	2	01	Koochies			Thaxobin	1	1
02 MASK (A)	1	1	Ointments			10cc, 5cc, 2cc, 1cc syringes		
Alprazolam 1-2	1	1	Suction Catheter			0.25% Anawin	1	1
Fentanyl			Cap, Mask	5/5	5/5	Tegaderm Foot Pad		
Morphine			Gauze Pack (2x2)	2	2	Small	2	2
Ketamine			Mop Pack	1	1	Dressing Pad Small	2	2
Propofol	2	02	Steristrip	1	1	INS HELOCK	2	02
Rocuronium	1	1	Underpad	1	1	Camera Cover	1	01
Glycopyrolate	1	1	Draw sheet	1	0			
Myopyrolate	1	1	Abgel			Turcanda 22, 24	1	1
Ondansetron	1	1	Foleys catheter			Dexa	1	1
Pencan 25g/ Spinal Needle 22			Urobag			Tramexy	1	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			Mimispi	1	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			Nasal Spray 18, 20, 22		
Antibiotics Augmentin 600	1	01	Bandage			Mida 2	1	01
			Tegaderm 8582	2	2			
Suppositories			Ioban			Tegaderm plain	01	01
Anamol : 80mg / 250mg / 170 mg	1	1	Double J Stent			Geli pad	01	01
Supridol : 100mg			Vaccum Suction set			CIVC 5cc, 2cc, 1cc	1	1
Justin : 12.5 mg / 25mg / 100mg	1	1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Vaccum set	1	01	Microshield	1	1			
Gauze	3	02	Cotton Balls	1	1			
Gloves and	4	02	Latex Gloves	10	08			
IV PCM	1	1	Ramdone Scrub	1	1			
3-way 100+10cm	4	1	Saral					

Surgeon : Anaesthesiologist : 9641140 Nurse : OT Technician : MS

Order No. : Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125

**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 : IP5-00174697 Admit Date : 03-Jun-2026 Admit Time : 12:55 PM UHID : BAH-00658004

Patient Details :

Patient Name : Master RISHI Age : 8 Y 0 M 13 D
Guardian : Mr VISLAVATH HARI KISHAN DOB : 21-05-2018
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 4-83/D, KARREMMMA CHELKA THANDA, Phone No : 9398575611
CHINNADHARPALLE, Hunwada E-mail : NA@GMAIL.COM
Mahabubnagar Telangana INDIA 509334

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 404 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 404 Admission Type : First Visit

Contact Details :

Name : Mr VISLAVATH HARI KISHAN Relationship : Father
Contact Address : H NO 4-83/D, KARREMMMA CHELKA THANDA, Phone No : / 9398575611
CHINNADHARPALLE, Hunwada Mahabubnagar
Telangana INDIA 509334

Handwritten signature

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Ti _____ Charge : _____ Time: _____

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

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Master RISHI
21-05-2018 8 Y 0 M 13 D (M)
Dr. BIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	1:30pm	ER	ICU	Abhishek
3/6		ER	ICU	
3/6	6:30pm	OT	ICU	Quip

Cross Consultation Visit

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



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

Rishi

UHID ID: _____

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Master RISHI
21-06-2018 8 Y 0 M 13 D (M)
Dr. SIRISHA RANI



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

According to age

Immunization History :

Immunized till date

(P.T.O.)

Clinical Summary & Diagnostic:

BMT donor
Come for femoral line.

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Master RISHI
21-05-2018 8 Y 0 M 13 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 26.3kg (Centile _____)

On Examination :

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21-05-2018 8 Y 0 M 13 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____
complication

Desired goals of the treatment : _____
hemodynamic stability

Planned Labs:

_____ CBP _____
_____ clot match _____

Planned Management

_____ Removal by _____

_____ NB to family _____
_____ 3/6 @ 1:30 PM _____

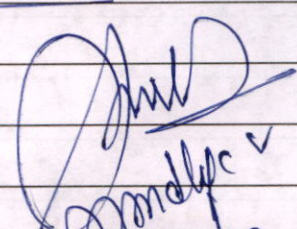
Signature of the Doctor: _____ Puf _____
Name of the Doctor: _____ Dr. Kamekshu _____
Date & Time: _____ 3/6/16 _____

Signature of the Consultant: _____ [Signature] _____
Name of the Consultant: _____ Dr. Sirisha Rani _____
Date & Time: _____ 3/6/16 @ 9:30 AM _____

BAH-00658004 IP5-00174697
 Master RISHI
 21-05-2016 8 Y 0 M 13 D (M)
 Dr. SIRISHA RANI

1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/14/26 9AM	stem cell donor for HCT	
	No fever No vomit	Plan
		1. stem cell collection today 2. Reserve unit PRBC. 3. CBP
		electrolytes calcium } T/m. on op band E/R/V DIC in every trans
		 Dr. Sandhya 4/18/26
		N/B Gayatri 9010544 @ 4pm 4/16/26

Blood Group - A+ve

1

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21-05-2013 8 Y 0 M 14 D (M)
Dr. SIRISHA RANI



RESULT SHEET



Date	3/6/26	4/6/26			
Time		9:53AM			
Hb	10.5	10.9			
PCV	33.6	34.7			
RBC	4.70	4.90			
WBC	25.22	35.66			
N/L	71/20	59.8/21.3			
Platelets	222	230			
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					

EAH-00658004 IP5-00174697
 Master RISHI
 21-05-2018 8 Y 0 M 13 D (M)
 Dr. SIRISHA RANI

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. Femoral line placement.
- 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)
Bone marrow aspiration (bone)	

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

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

- a. Bleeding.
- b. Infection.

1. I authorize Dr. Saitha 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: [Signature]
 Name: Mr. Hari Krishan
 Relationship with patient: Father
 Date & Time: 3/6/26 2pm

Witness:

Signature: [Signature]
 Name: Teena
 Date & Time: 3/6/26 2pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Saitha Date 3/6/26 Time: 2pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అబిండ్లెంట్

నేను, దిగువ సంతకం చేసిన ద్వారా, రోగి/నా పైన రైన్ఫోల్డ్ చిల్డ్రన్ 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 / 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

3. 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 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.	

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను 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 అబిండ్లెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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Master RISHI
21-05-2018 8 Y 0 M 13 D (M)
Dr. SIRISHA RANI



Patient

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION THEATER NOTES

Patient's Name : Master Rishi Age : 8yrs Gender : Male Female

UHID No. : BAH-00658004 Weight : 25kg Height :

Surgeon : Dr. Sathish (Sawitri) Asst. Surgeon : —

Anesthetist : Dr. Jaya chandra OT Nurse : Ms. Bobby Das OT Technician : Mr. Nishanth

Pre-Operative Diagnosis : Donor for BMT

Surgical Procedure : Femoral line placement

Indications for Surgery : BMT

Date : 3/6/26 Start Time : 2:10pm End Time : 2:30pm

Pre Operative Preparations : ↓ SAP Right groin cleaned and draped.

Post Operative Diagnosis : Donor for BMT

Peri-Operative Complications : — Nil —

Operation Notes : ↓ SAP Right femoral vein punctured

guide wire passed under usg guidance

Dilator passed over guide wire and sinus cutaneous

dilatation done. 5Fr double lumen 13cm

catheter passed over the guide wire. Then

guide wire removed. Both the lumens

checked for good back flow and

fixed with sutures.

Aseptic dressing done.

OPERATIVE NOTES

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

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications: nil

Name of the Surgeon: Dr. Sawittha

Signature of the Surgeon: [Signature]

Date & Time: 8/6/26 4:00 pm

BAH-00658004 IP5-00174697

Master RISHI

21-05-2018

8 Y 0 M 13 D

(M)

Dr. SIRISHA RANI



Patient Sticker



POST-SURGICAL CARE PLAN FORM

Procedure Done: Femoral line placement

Post-Surgical Diagnosis: Donor for BMT

Post-Operative Monitoring Parameters /Frequency: BP, PR, SpO2 @ 15mins

Wound Care: —

Drain /Special Lines/Catheters: right femoral. double lumen catheter in situ

Special Patient Positioning and Requirements: —

Nutritional Instructions: —

When to Start Mobilization: —

Special Referrals: —

The new order for all required medications documented in the doctor order/medication sheet:
 Yes No

Any Other Post-Operative Care Needed including Required Follow Up: —

Treating Surgeon (Signature & Stamp) Dr. Sirisha Rani Date: 3/6/26 Time: 2:50 pm

Note: Plan of care will be readjusted if necessary.

BAH-00658004
Master RISHI
21-05-2018
Dr. SIRISHA RANI



IP5-0017469 / 8 Y 0 M 13 D (M)



DRUG CHART

Date of Admission: 3/6 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Signature
VERIFIED BY : Name

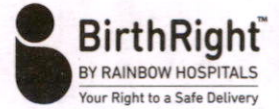
REGULAR PRESCRIPTIONS

Weight. 26.3kg Ward.



DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SUP CALUMAX P</u>				Date Time	<u>4/6</u>															
Dose	Route	Frequency	Start Date																	
<u>10ml</u>	<u>PO</u>	<u>Q24H</u>	<u>4/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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MEDICATION RECONCILIATION FORM

Drug Allergies: No 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: ICU 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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]

Date & Time: 3/6/26 @ 1:30 PM

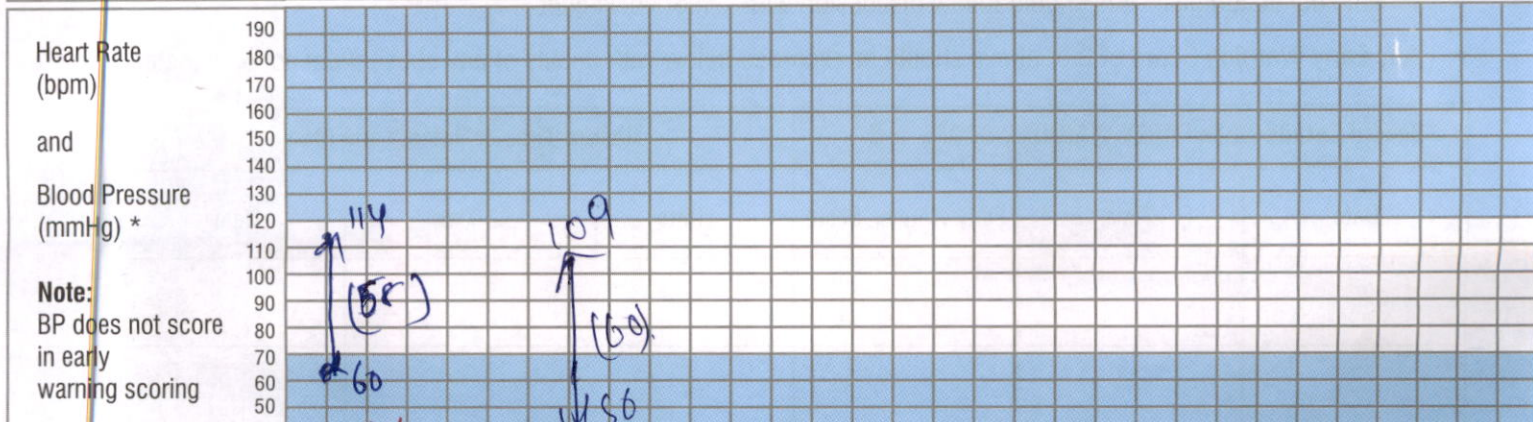
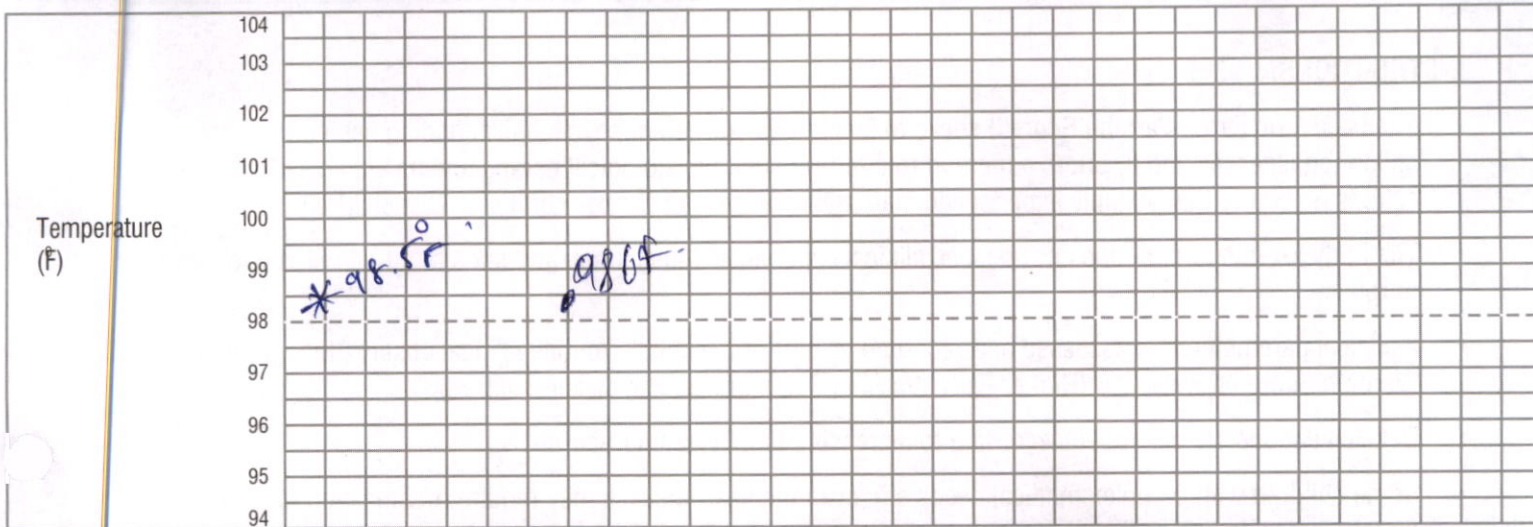
Nurse Name & Signature: [Signature]

Date & Time: 3/6/26 @ 1:35 PM

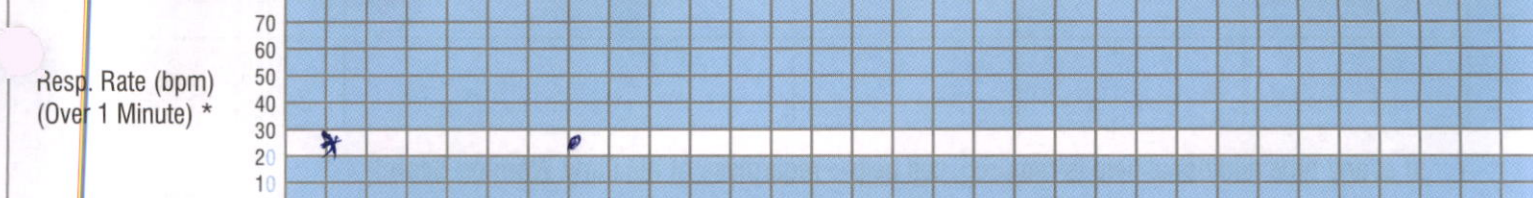
2

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/6 Time: 9 am 1 pm
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 103b/m 109b/m



Resp Rate (Number) 26b/m 20b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 98% 99%

Conscious Level Normal Altered C C

GCS * 15/5 15/15

TOTAL SCORE Number of shaded boxes 0 0
 Pain Score 0 0
 Observer's Initials RA S

- 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 in charge AND PICU fellow or PICU consultant to be informed.
- NB: Scores 3 should be recorded overleaf

* 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)

①

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/5/20 Time: 10 PM 3 PM 6 AM
 Doctor / Nurse / Family Concern?

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	<u>98.0° F</u>	<u>98.0° F</u>	<u>98.2° F</u>
	97			
	96			
	95			
	94			

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100	<u>90</u>	<u>100</u>	<u>101</u>
	90	<u>(81)</u>	<u>(80)</u>	<u>(88)</u>
80				
70				
60	<u>80</u>	<u>60</u>	<u>59</u>	
50				

Heart Rate (Number)	<u>100b/m</u>	<u>94b/m</u>	<u>98b/m</u>
---------------------	---------------	--------------	--------------

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	0			
	0			
	0			

Resp Rate (Number)	<u>24br/m</u>	<u>22br/m</u>	<u>24br/m</u>
--------------------	---------------	---------------	---------------

Resp Distress	Mod/ Severe	None / Mild	
---------------	-------------	-------------	--

Receiving O ₂ (l/min)			
O ₂ Saturations (%)	<u>99%</u>	<u>99%</u>	<u>100%</u>

Conscious Level	Normal	Altered	
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GCS *	<u>15/15</u>	<u>15/15</u>	<u>15/15</u>
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TOTAL SCORE			
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>✓</u>	<u>✓</u>	<u>✓</u>

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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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)

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 Dr. SRISHA RANI

3/6/ab-



FLUID CHART

Sheet No. : 1

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output. (28 kg)

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									280 ml			
	09:00 pm	100 ml								200 ml			
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am									200 ml			
Total Intake : 300 ml						Total Output : 450 ml							
	02:00 am												
	03:00 am												
	04:00 am									200 ml			
	05:00 am												
	06:00 am												
	07:00 am									200 ml			
Total Intake : 200 ml						Total Output : 400 ml							

Total 24 hrs. Intake 500 ml $\frac{1}{10}$ ml/kg

Total 24 hrs. Output 850 ml $\frac{1}{6}$ ml/kg/h



FLUID CHART



Sheet No. : 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							
4/6	08:00 am								100ml		0	Debut
	09:00 am	Soda	100ml	1ml							0	
	10:00 am			1ml							0	
	11:00 am	H ₂ O		50ml					200ml		0	
	12:00 pm			50ml							0	
	01:00 pm			50ml							0	
Total Intake : 252ml					Total Output : 300ml							
	02:00 pm										0	Debut
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm										0	
	06:00 pm										0	
	07:00 pm										0	
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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 Dr. SIRISHA RANI



CONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: Femoral line placement ->

Anaesthesiologist: Dr. Saithe Surgeon: Dr. Subrahmanyam

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:
 Name: (Hasi Kishan)
 Relationship with patient: Father
 Date & Time: 3/6/26 12:30pm

Witness:

Signature:
 Name:
 Date & Time: 3/6/26 12:30pm

Doctor (who is taking consent):

Signature: Name: Dr. Saithe Date 3/6/26 Time: 12:30pm

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 శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

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

స్పెసిఫిక్ హై రిస్క్స్:

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

హృదయ వ్యాధి రక్తపోటు మధుమేహం మూత్రపిండాల వైఫల్యం బహుళ అవయవ వైఫల్యం

కాలేయ సమస్యలు షాక్ ఊబకాయం దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Master Rishi Age: 8y Sex: M UHID.No:

Date: 3/6/26 Time: 12:30pm Proposed Operation:

Diagnosis:

B.P / CRT: H.R: Weight: 22kg 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/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS:

RESP: Diabetes:

CNS:

Renal:

Hepatic / GE: Physical Activity:

Others:

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:

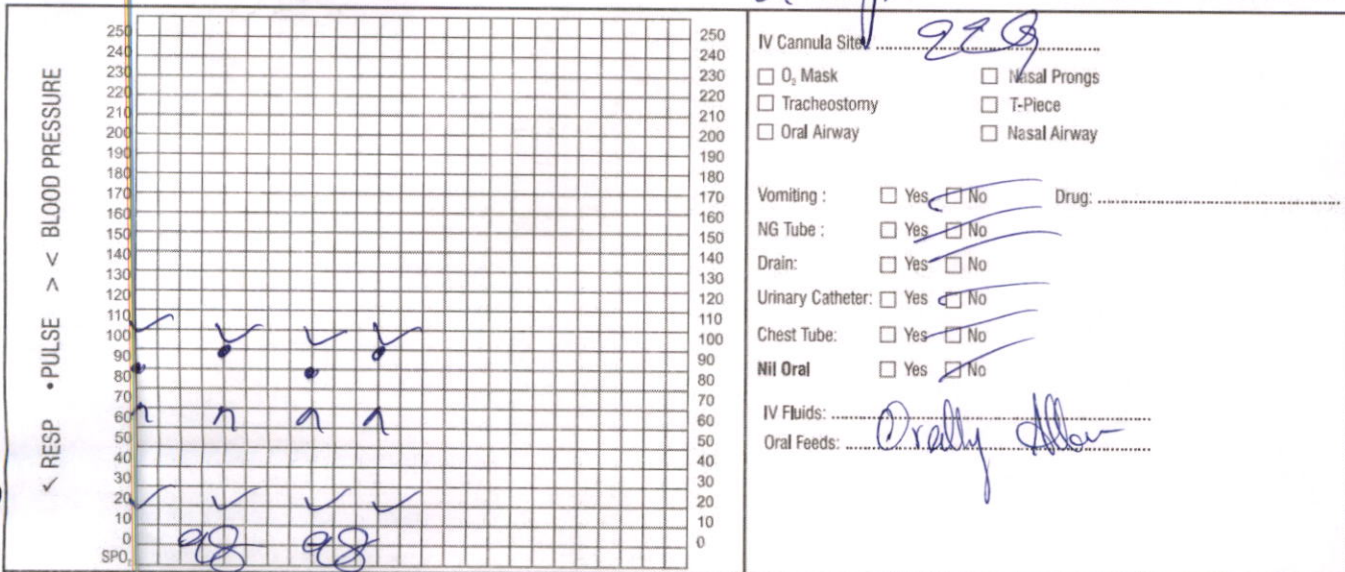
- DVT Prophylaxis:
- NIL ORAL
 → Water / ORS 2 Hours
 → Others 6 Hours
7 AM - solids.
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Sanjiv



POST-RECORD

Received in PACU by : Durg Time Received : 2:35pm Time Discharged :



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	2	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	2		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	2	2	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	1	1	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	2	2	2	2		
TOTAL	8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6	2:35pm	1/10	—	<u>Durg</u>

Pain Tool Used: N PASS FLACC Wong-Baker NPS

Anaesthesiologist Name : Durg

Anaesthesiologist Signature: Durg

Date & Time: 3/6/20 08

PACU Nurse Name : Durg

PACU Nurse Signature: Durg

Date & Time: 3/6/20 @ 4pm

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): 116

Date & Time: 3/6/20 @ 4pm



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 4/6/26 Time: 1 PM

Weight: 26.3 kgs Centile: 50th

Height: 126 cm Centile: 72.5th

Inference: well child

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

Diet Recommendations: Normal high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods.

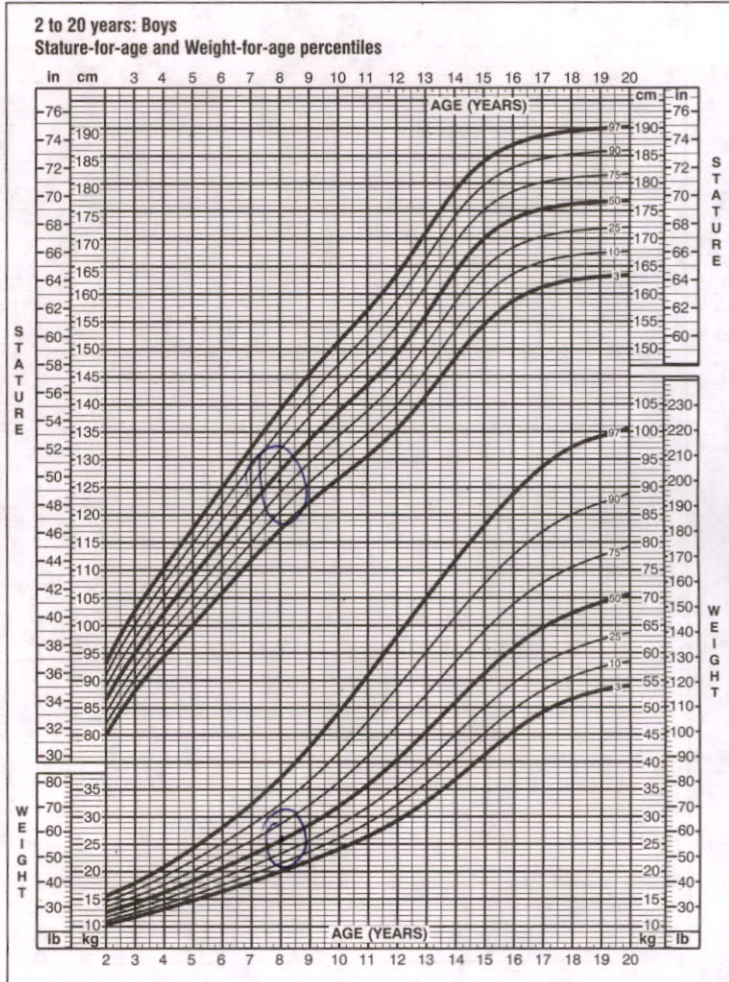
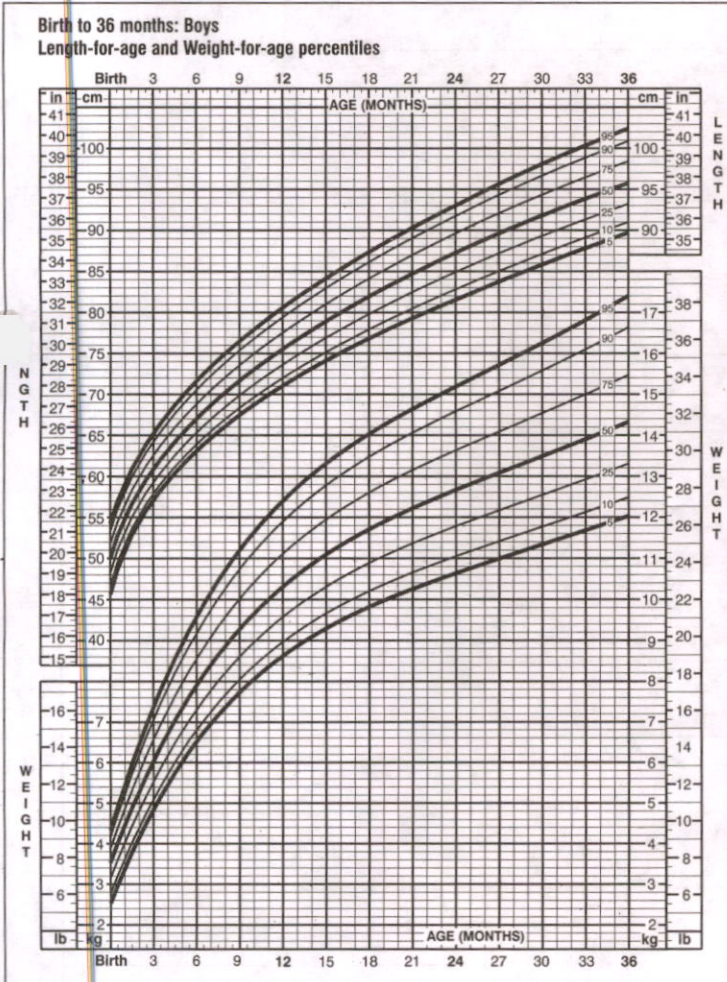
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: BMT done 2 weeks ago for Femoral line.

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: parent's don't need dietitian. don't charge for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: MOUNICA

