Patient Sticker

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN (M)
22-11-2020 5 Y 6 M 13 D
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 4/6/26

Patient Name: Master B. Gulshan nandan Date of Birth: 22-11-20 Age: 5Y

Gender: M Ward : P. OT UHID No.: 00209389

Date of Surgery: 4/6 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : DENTAL EXTRACTION (I) IV SEDATION

Time in : 10 Am Time Out : 10:20 Am

		NAME	AMOUNT
1.	Surgeon	DR NAMRATA	NPR00097 x 2 OPIP31489
2.	Anaesthetist	Dr. Sarita	
3.	Assistant Surgeon		
4.	OT Technician	Bapu	
5.	Circulating Nurse	Jyoti	
6.	Assistant Nurse	Divya	

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

Namrata
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 964245 Order by: Divya

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

Denied

CONSUMABLES OF OT

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Circulating staff : ..... Technician : ..... Date : ..... Time : 10 AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 5.5.5	1+1	—	Major Pack Gramon	1		Inj Vit.K		
LMA 2	01	—	Sutures			Cord Clamp		
ECG leads : A (P) / N	5	3				Suction Catheter		
HME filter : A / P / N	01	—				Feeding Tube		
Syringes : 10 cc	40	04				Vaccum Suction Set		
05 cc	40	04	Gloves (6) (6½) 7 7½	2+2+2+2	1+1	Surgical Gloves		
02 cc	40	04	6½ 7 7½	2+2+2	—	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			RLS 500	1	
NS : 10ml / (100ml) / 500ml / 1000ml	01	01	Koochies			10 cc	4	—
Mini spike	01	01	Ointments			Throat Pack	1	—
Gauze	03	02	Suction Catheter			Bi-lec Adrenaline	1	1
Fentanyl	01		Cap, Mask	5+5	5+5			
Morphine			Gauze Pack (N)	4	4			
Ketamine			Mop Pack	1	1	Nicdaz	01	—
Propofol	02	02	Steristrip			Nasal Airway		—
Rocuronium	01	—	Underpad	1	+	20122	1+1	—
Glycopyrolate	01	—	Draw sheet	1	+	Oral Airway		—
Myopyrolate +Neo	01+1	—	Abgel			011	1+1	—
Ondansetron	01	—	Foleys catheter			IV cannula 22/24	2+2	—
Pencan 25g/ Spinal Needle 22			Urobag			O2 mask (P)	01	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			EtCO2 Nasal prong	01	01
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
ET CO2 Nasal prongs (P)	01	—	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin (12.5) mg / 25mg / 100mg	01	—	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum Set	01	—	Microshield	1	—			
Dexa + Dexmide	1+1	—	Cotton Balls	1	1			
Tra... tpm	1+1	—	Latex Gloves	10	5+5			
... clonicon	5+1	—	Ramdione Scrub					
...00cm 3cc	1+1	—	Saral					

Anaesthesiologist Nurse OT Technician

9164385 Ordered by : .....

... / GENERAL / 125

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174725 **Admit Date** : 04-Jun-2026 **Admit Time** : 08:40 AM **UHID** : KUH-00209389

Patient Details :

Patient Name	: Master B GULSHAN NANDAN	**Age**	: 5 Y 6 M 13 D
Guardian	: Mr HARISH	**DOB**	: 22-11-2020
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO 777, NITHYA NIRMALA RESIDENCY, 102, HMT SWARNAPURI MIYAPUR Hyderabad Telangana INDIA 500049	**Phone No**	: 7013818659/
		E-mail	: no@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 403 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 403 **Admission Type** : First Visit

Contact Details :

Name : Mr HARISH **Relationship** : Father

Contact Address : **Phone No** : / 7013818659

Signature

Doctor Details :

Doctor Name : Dr. NAMRATA **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/6/26	IV Placement	1	2247	
	PAC (OP basis)			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Patient

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN (M)
22-11-2020 5 Y 6 M 13 D
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 DENTAL EXTRACTIONS (+ IV SEDATION)

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)
RELIEF OF PAIN AND INFECTION	

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. NO COMPLICATIONS.

b.

1. I authorize Dr. _____ 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: Lathasri

Name: Lathasri

Relationship with patient: Mother

Date & Time: 4/06/26, 7:21AM

Witness:

Signature: Dileep

Name: Dileep kumar

Date & Time: 4/06/26, 9:21AM

Doctor (who is taking consent):

Signature: Namrata Name: DR NAMRATA KOTHAPALLI Date 4/06/2026 Time: 9:20 AM

Patient Sticker

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో 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 భాషలో 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: .....

00209389 IP5-00174725
...ter B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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 : ..... Age : ..... Gender : ☐ Male ☐ Female

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

Surgeon :		Asst. Surgeon :
Anesthetist :	OT Nurse:	OT Technician:
Pre-Operative Diagnosis:		
Surgical Procedure : DENTAL EXTRACTION .		
Indications for Surgery : DENTAL CARIES .		
Date :	Start Time :	End Time :
Pre Operative Preparations:		
Post Operative Diagnosis:		
Peri-Operative Complications:		
Operation Notes: (↓) IV SEDATION .		
1. ~~EXT~~ EXTRACTION OF 54, 64 .		
2. SDF APPLICATION ON 55, 75, 85 .		
SOFT FOOD FOR 3 DAYS		
GENTLE BRUSHING FOR 3 DAYS .		
REVIEW AFTER 3 DAYS .		

℞

Syrup. IBUGESIC (5ml) × 3 days.
(1 — 1 — 1)

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: Dr. Namrata K

Signature of the Surgeon: Namrata

Date & Time: 04/06/26 10:22AM.

Patient

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: DENTAL EXTRACTIONS.

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:
BLEEDING EVERY 15 MINS.

Drain /Special Lines/Catheters:
—

Special Patient Positioning and Requirements:
—

Nutritional Instructions:
—

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Namrata

Treating Surgeon
(Signature & Stamp)

Date: 04/06/26 Time: 10:22 AM

Note: Plan of care will be readjusted if necessary.

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

Pat

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Namrata Date : 4/6/26

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

Start Time of Assessment: ..... Weight: 20 Kg.

Allergic History: .....

Chief Complaints:
Abscess on 54, 64 – Dental caries on 75, 85.
Came for Extraction of 54, 64. SDF application of 75, 85

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

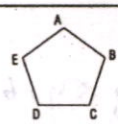
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 24/min SpO_2 on FiO_2 98% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BILAE (+)
Palpation Findings (If necessary).....

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

Circulation

HR: 116/min

CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 93/53(69) mmHg

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

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

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

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

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 98 F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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

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

Labs Planned: .....

CBP on cannulation.

N/B Abwishlll

Treatment Planned: .....

• Extraction @ 54, 64, SDF application @ 75, 85

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Dental rehabilitation

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: .....

Date & Time: 4/6/26 ;

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 9/6/26 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:				

Signature

VERIFIED BY : Name .....

[illegible] IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

REGULAR PRESCRIPTIONS

Weight. 20 kg 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 : | 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

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

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

Weight. 20 kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

I.V. FLUIDS CHART

Weight. 20kg Ward. .....

Date		Composition of I.V. Fluid (Solution ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/6/26		DNS (2/3rd maintainance)	IV	42	[signature]		not	Compl	

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

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 : Dr. RAMYA

Date & Time : 4/6/26 ; 8:40am

Nurse Name & Signature: Sagar

Date & Time : 4/6/26 @ 9:10 am

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	4/6/26					
Time	8:51					
Hb	11.7					
PCV	34.1					
RBC	4.24					
WBC	7.41					
N/L	33.4/60.3					
Platelets	396					
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.,) : .....

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		Total 24 hrs. Output	

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

FLUID CHART

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

Birth
BY RAIN
Your Rig to a Safe Delivery

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**	

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

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : B. Gulshan Nandan Age : 5y6m Gender : Male ☑ Female ☐

UHID NO: KUH-00209389 Surgeon Name: Dr. Namrata Kamalakar Rao

Anaesthesiologist : Dr K. Sri Surya

Operative procedure planned : Extraction of 54, 64, SDF application on 7.5.25

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

Comments : post Op O2 support.

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient B. Gulshan Nandan the above mentioned operation / Diagnostic / Therapeutic procedures Extraction of 54, 64, SDF application on 7.5.25

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

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

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

- Pregnant : ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / ~~Monitored~~ Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : Lathasri

Name : Lathasri

Relationship with Patient: Mother

Date & Time : 3/6/26 1:03 PM

Witness :

Signature : Dilip kumar

Name : Dilip kumar

Date & Time : 3/6/26 1:04 PM

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr K. Sri Surya

Date & Time : 3/6/26 1:00 pm

KUH-00209389 IP5-00174725
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: B. Gulshan Nandan Age: 5y 6m Sex: M UHID.No : KUH-00209389

Date: 3/6/26 Time: 12:50 pm. Proposed Operation: Extraction of 54, 64. & DF Application of 74, 85

Diagnosis: Abscess on 54, 64. Dental caries on 75, 85

B.P / CRT: ..... H.R: ..... Weight: 20kg 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: NKDA

Medical History: CVS : • C-Section / Term / 3.5kg / No NICU

RESP : Diabetes :

CNS : Autistic Child. • Vaccinated upto date

Renal : • Speech delayed.

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: N Neck: N Teeth: All teeth intact

Lungs : BAE (+), clear

Heart: $S_1 S_2$ (+)

CNS: Grossly Intact.

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis : Coconut water.
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 on IV cannulation.

Signature: Name: Dr. K. Srisurya.

ANAESTHESIA CHART

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Adequate	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed
H.R: 104	B.P / CRT: 90/60	SpO_2: 98%	R.R: 22
Pre-OP Diagnosis: Dental caries		Operation: Dental extractions	Last Feed: 6hr
Surgeon: Dr-Nanavati		Anaesthesiologist: Dr Sarita / Dr-AK	Date: 16.6.26
			Technician: Prashanth

TIME	10:00	10:30
N_2O /AIR /O_2 LPM	VIA NP	
HALO /SO /SEVO		
Drugs:		
Inj-MIDAZOLAM 1mg		
Inj PROPOFOL 60mg+40+20		
Inj FENTANYL 40mcg		
FIO_2 / SaO_2	99 100	
ETCO		
ECG	SR	
Temperature		
Urine Output		
Fluids / Blood		

Antibiotic –

Suppository –

Blood Loss –

NOTES –

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

ABG

GRBS

Others

- ☑ Equipment Checked and Functional
- ☑ BP
- ☑ Cuff Site: (N) VL
- ☐ 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

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

Times:
Anaes Start: 10:00AM
OP Start:
OP End:
Leave OR: 10:20AM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: (R) VL 22G
☐ IV:
☐ IV:

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

☐ Mask ☐ SGA
☐ 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:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

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

Name of the Doctor: Dr Ashish-K
Signature of the Doctor:

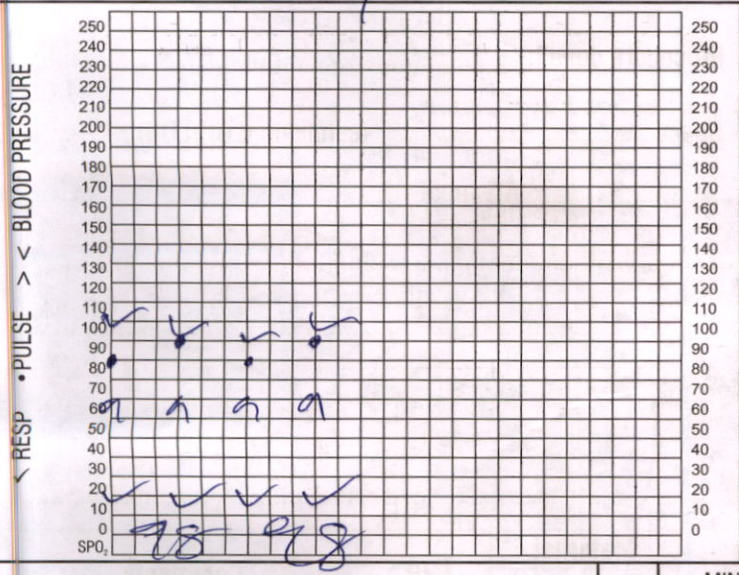
KUH-00209389
Master B GULSHAN NANDAN
22-11-2020 5 Y 6 M 13 D (M)
Dr. NAMRATA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dlvg Time Received : 10:35Am Time Discharged : 1pm



IV Cannula Site : 22G

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

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

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

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 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 Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	2	2	2		
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	2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2		
	TOTAL	8	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/6	10:35Am	1/10	—	

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

Anaesthesiologist Name : RAVI
Anaesthesiologist Signature: Ravi
Date & Time: 04/6/20

PACU Nurse Name : Dlvg
PACU Nurse Signature: Dlvg
Date & Time: 4/6/20 @ 1pm

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

Transferred to Unit by (PACU): Dlvg
Date & Time: 4/6/20 @ 1pm

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

nt Sticker

of Anaesthesiology

AL ANALGESIA RECORD

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

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

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

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

mposition : .....

issues :

.....

.....

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

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....