

BAH-00655659 IP5-00173733
Ms V S GOUTHAMI
25-12-2006 19 Y 4 M 17 D (F)
Dr. P V L N MURTHY



SmithNephew
EVAC° 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2201068
2028-10-21

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

STERILIZED

Date : 12/5/26

Patient Name: V.S. Gouthami Date of Birth: 25/12/2006 Age: 19 Y 4 M

Gender: F Ward: P.OT UHID No.: 6.5.5.659

Date of Surgery: 12/5/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery: Septo plasty + Spue Excision done +
S/LC Tubeless plasty + Trans Uteromy Oclation

Time in : 5.30 pm Time Out : 7.20 pm

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist	Dr. Thejashini	
3. Assistant Surgeon		
4. OT Technician	Venket	
5. Circulating Nurse	P. Jayam	
6. Assistant Nurse	Arman, Bobi	

Special Equipment: Laparoscopy Broncoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others ... @lab used = 9605072

Signature of the Surgeon: *[Signature]*
 Signature of Circulating Nurse: *[Signature]*
 personal equipment used 10,000/-

Order No: 9605071 Order by: *[Signature]*



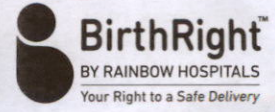
4 deno, lachinoplasty
 FESS, septoplasty

CONSUMABLES OF OT

Surgeon: Technician: Date: 12/5/20 Time: 5:30 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 6.0, 6.5, 7.0	11	1	Major Pack Dozepe	1	1	Inj Vit.K		
LMA 3.4	1	-	Sutures 2.004,	2	1	Cord Clamp		
ECG leads: A/P/N	5	3				Suction Catheter		
HME filter A/P/N	1	1				Feeding Tube		
Syringes : 10 cc	10	6				Vaccum Suction Set		
05 cc	10	4	Gloves 6, 16.5, 7.5 2-2-2-2			Surgical Gloves		
02 cc	10	2		3	3	Gauze Pack		
01 cc	3	-				Syringe 1ml / 2ml		
Cautery plate A/P/N	1	0	Surgical blade 15	1	1	Surgical Blade # 20		
IV set	1	1	NG tube 6	2	2	Koochies (S)		
RL	1	1	Cautery pencil					
NS: 10ml / 100ml / 500ml / 1000ml	4+1+1+2	1+1+1+1	Koochies			Ne 500ml	2	2
minipile	1	1	Ointments			ole	1	2
vaccum set	1	1	Suction Catheter			Transobix	1	0
Fentanyl	1	1	Cap, Mask			Bootoctet	1	1
Morphine			Gauze Pack (NTR)	3	3	carbon	1	1
Ketamine			Mop Pack	1	1	Adrenales	5	5
Propofol	3	2	Steristrip			Nasal pleent	1	1
Rocuronium	2	1	Underpad	1	1			
Glycopyrolate	1	1	Draw sheet	1	1			
Myopyrolate	1	1	Abgel					
Ondansetron	1	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22	1	-	Urobag			midazolam	1	1
Bupivacaine 0.25%	1	-	Chest Drainage Catheter			oval airway	1	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			(2,3)		
Antibiotics Aug (1.2gm)	1	1	Bandage			Nasal airway	1	1
iv pcm	1	1	Tegaderm			(26,128)		
Suppositories			loban			Dexmed(100mg)	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent			follet pmolin	1	1
Supridol : 100mg			Vaccum Suction set	2	2			
Justin : 42.5 mg / 25mg / 100mg	1	1	Plastic Bed Sheet	1	-			
Tab. Misoprost : 200mg			Betadine Solution	-	-			
3 way 100cm	1	1	Microshield	1	1			
9 glove all Gauze 44	-	-	Cotton Balls	-	-			
Tranexat Dexa 2	2	2	Latex Gloves	16	16			
Mask (A)	1	0	Ramdione Scrub					
iv cannula (8, 20)	1	1	Saral					

DAN-0055659 IP5-00173733
M & V S GOUTHAMI
25-12-2006 19 Y 4 M 17 D (F)
Dr. P V L N MURTHY



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

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

Signature: _____

Findings and Recommendations :

DNS ± spur + HIT + chronic tonsillitis
Sp endoscopic septoplasty + spur excision +
turbinoplasty + tonsillectomy = coblation

No fever / vomiting / bleeding
accepting orally

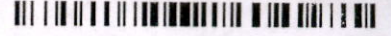
O/E
child afebrile
hemodynamically stable.

Consultant :

Name : Signature : Date & Time :

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173733 Admit Date : 12-May-2026 Admit Time : 03:23 PM UHID : BAH-00655659

Patient Details :

Patient Name : Ms V S GOUTHAMI Age : 19 Y 4 M 17 D
Guardian : Mr V S A RAJU DOB : 25-12-2006
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 1-12-159/A, SANJEEVAIAH COLONY,
CHINNA THOKATTA New Bowenpally Phone No : 9000349987/ 9666543336
Hyderabad Telangana INDIA 500011 E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 402 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 402 Admission Type : First Visit

Contact Details :

Name : Mr V S A RAJU Relationship : Father
Contact Address : H NO 1-12-159/A, SANJEEVAIAH COLONY,
CHINNA THOKATTA New Bowenpally Phone No : 9000349987
Hyderabad Telangana INDIA 500011

Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. NIVEDITHA CHALMEDA

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

BAH-00655659 IPS-00173733
Mr V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
Dr. P V L N MURTHY



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/5/2006	4:00pm	GR	OT	R
12/5	9pm	OT	304	R

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

BAH-00655659 IP5-00173733
Ms V S GOUTHAMI
25-12-2006 19 Y 4 M 17 D (F)
Dr. PVLN MURTHY



Patient Name:

Ms V.S. Gauthami 19yr Female

UHID ID:

Department:

ENT

Consultant:

Dr. PVLN Murthy



Pediatric Multiorgan History & Physical Examination

Name : Ms. V. S. GAUTHAMI Age/Sex 19y / F
Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

cp Nasal blockage
recurrent cold
sneezing
headache } 2 yrs.

History of present illness :

cp Nasal blockage with difficulty
in breathing and disturbed sleep
and mouth breathing

a/w recurrent URTI → cold, cough once in
2 weeks : 6 months.

cold & cough → watery nasal discharge
with continuous sneezing
and dry/non productive
mild cough.

a/w headache → more on the frontal
part
→ increased by evening,
relieved with medication



Pediatric Multiorgan History & Physical Examination

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

Similar to recurrent
UTI since past 2 yrs.
requiring frequent medication
usage.

Birth & Neonatal History:

Normal perinatal and
Antenatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} middle

Developmental History :

Attained all milestones adequately
as per age

Immunization History :

Immunized till date as per
age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs) : 6.5 kg (Centile _____)

On Examination :

Temperature : 98.0 °F Pulse Rate : 92/min B.P. 117/77 SPO2 99% @ RA

Resp. rate and type of breathing : 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : Normal, moving symmetrically with

Air entry & breath sounds : BAE (+), airway clear respiration

Any added sounds : Nil

Relevant data from outside (Chest X-Ray, ABG, etc.,) X ray Naso px → Adenoids (+)

X PNS → DNS

Cardiovascular System :

Inspection of precordium : Normal

Heart Sounds : S1 (+)

Any murmur : Nil

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

Per Abdomen :

Inspection : Normal, All quadrants moving in coordination with respiration

Palpation : soft, non tender

Auscultation : Bowel sounds (+)

Spine : (N) External Genitalia : (N)

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



Pediatric Multiorgan history & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : Intact

Motor System:

Nutrition : Normal

Tone : Adequate Power 4/5

Co-ordinator : well coordinated

Posture : Normal

Involuntary Movements : Nil

Reflexes :

DTR +++ Superficials: +++

Plantars elicited

Sensory System :

Intact

Bladder / Bowel : adequate 8/0 & w/o

Clinical Summary & Diagnostic:

Chronic ~~allergic~~ tonsillitis + chronic
sinusitis & DNS.

BAH-00655659 IP5-00173733
 M. V. S. GOUTHAM
 25-12-2008 19 Y 4 M 17 D (F)
 Dr. P. V. L. N. MURTHY



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: LRTI, Sleep Apnea.

Desired goals of the treatment: Resolution through Surgical management

Planned Labs:
TV Cannula

Planned Management
 ① IWF DNS @ 20ml/hr
 (1/3 maintenance)
 ② NPO
 ③ Shift to O.T
 FESS + Septoplasty +
 Turbinoplasty +
 Tonsillectomy with
 CO ablation
 NIB
 Renuka
 12/5/26

Signature of the Doctor: JM
 Name of the Doctor: Jayashri
 Date & Time: 12/5/26 @ 3:20 PM

Signature of the Consultant: [Signature]
 Name of the Consultant: DR. P. V. L. N. MURTHY
 Registration No: 47267
 Date & Time: 12/5/26

BAH-00655659 IP5-00173733
Ms V S GOUTHAMI
25-12-2006 19 Y 4 M 17 D (F)
Dr. P V L N MURTHY



OPERATION THEATER NOTES

Patient's Name : Ms. V-S GOUTHAMI Age : 19y Gender : Male Female

UHID No. : BAH-00655659 Weight : Height :

Surgeon : P V L N Murthy Asst. Surgeon :

Anesthetist : Dr. Surya OT Nurse : Bi Babu OT Technician : Venkat

Pre-Operative Diagnosis : DAS E Spue + HIT + che Tomility

Surgical Procedure : Endoscopic septoplasty + Spue excision + turbinate plasty + Tomillectomy + Coblation

Indications for Surgery :

Date : 12/5/26

Start Time :

End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Endoscopic septoplasty + Septal Spue excision + B/L Turbinate plasty + Tomillectomy + Coblation

BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26	C/S/B Resident	
11:20 PM	Asst - Drs i spor + HIT + Chronic Tonsillitis	
	S/p - Endoscopic septoplasty + spur excision + Turbinoplasty + Tonsillectomy i Coblation	
	No fever, vomiting, nasal bleeding	Adv - - Continue medication as per chart
	Child hemodynamically stable	- w/f fever, vomiting, nasal bleeding - Monitor vitals and Inform sos
		Bharath
		noted by Durga (607539)
12/5/26 8:25 am	C/S/B Resident	
	no fever / vomiting / bleed	Adv. (D) today
	O/E: alert vitals stable chest clear throat healthy.	F/up i ENT surgeon Akhila

BAH-00655659
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY

IPS-00173733

Patient



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					

BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY

m. V.S. Gauthami
 1 year Female



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						<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

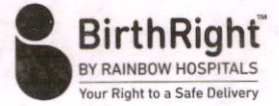
Doctor Name & Signature: Jayabharathi (J.M.)

Date & Time: 12/5/20 & 3:15 pm

Nurse Name & Signature: Penuke

Date & Time: 12/5/20 & 3:20 pm

BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2008 19 Y 4 M 18 D (F)
 Dr. P V L N MURTHY



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : BOTROLLOT SOLUTION				Date Time	12/5	13/5															
Dose	Route	Frequency	Start Dt.																		
	Nasal	TID	12/5	6AM	X	10PM	X														
Name & Signature of the Doctor Starting the Drugs: Bhargava				2PM		10PM															
Additional Instructions: - 2° in each nostril																					
Daily Doctor's Endorsement by a Sign																					

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

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

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

Signature
Name

Patient Sticker



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

Signature
Name



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
12/5	5 ²⁰ pm	INJ. AMOXICILIN + CLAVULANATE	1-2 g	IV	[Signature]	Smen VETAY
12/5	5 ²⁰ pm	INJ. DEXAMETHASONE	6mg	IV	[Signature]	Smen VETAY
12/5	5 ²⁰ pm	INJ. TRANEXAMIC ACID	1g	IV	[Signature]	Smen VETAY
12/5	5 ²⁰ pm	INJ. PARACETAMOL	1g	IV	[Signature]	Smen VETAY
12/5	5 ²⁰ pm	INJ. DEXMEDETOMEDINE	100 mg in 50ml NS	IV once	[Signature]	Smen VETAY
12/5	5 ²⁰ pm	INJ. DICLOFENAC	75mg	IV slow	[Signature]	Smen VETAY

Signature

VERIFIED BY : Name

BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



12/5/26

IC. No. : RCHB/ FRM / CLINICAL / 127

TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 9:30 AM 6 AM

Doctor / Nurse / Family Concern?

Temperature (°F)	104		
	103		
	102		
	101		
	100		
	99		
	98		
	97	96.6 F	97.3 F
	96	*	*
	94		

Heart Rate (bpm)	190		
	180		
and Blood Pressure (mmHg) *	160		
	150		
Note: BP does not score in early warning scoring	140		
	130		
Heart Rate (Number)	120	93	99
	110	62	83
	100		
	90		
	80		
	70		
	60		
	50		

Resp. Rate (bpm) (Over 1 Minute)	70		
	60		
Resp Rate (Number)	50	28	28
	40		
	30		
	20		
	10		

Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O ₂ (l/min)			
O ₂ Saturations (%)		99%	100%

Conscious Level	Normal		
	Altered		
GCS *		8/15	15/15

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

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

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

BAH-00655659 IP5-00173733
 M & V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



No. : RCHBH/ FRM / CLINICAL / 127

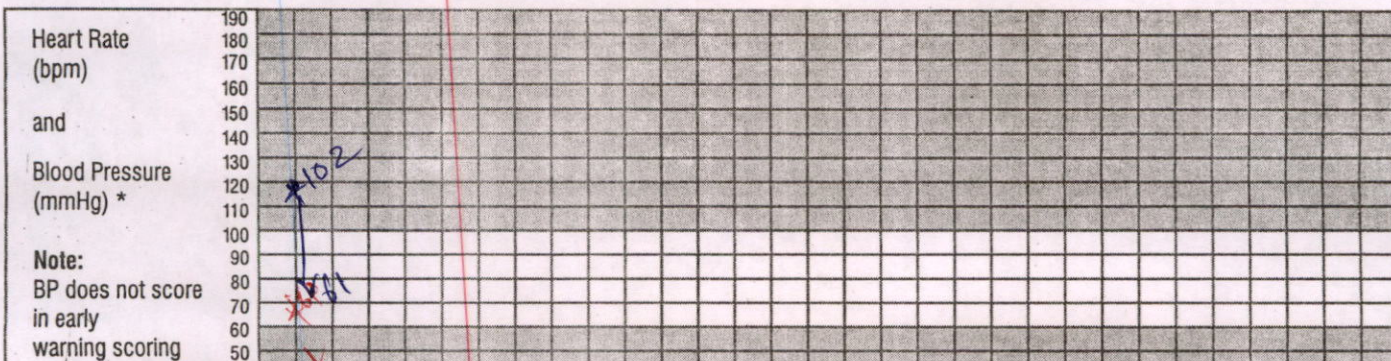
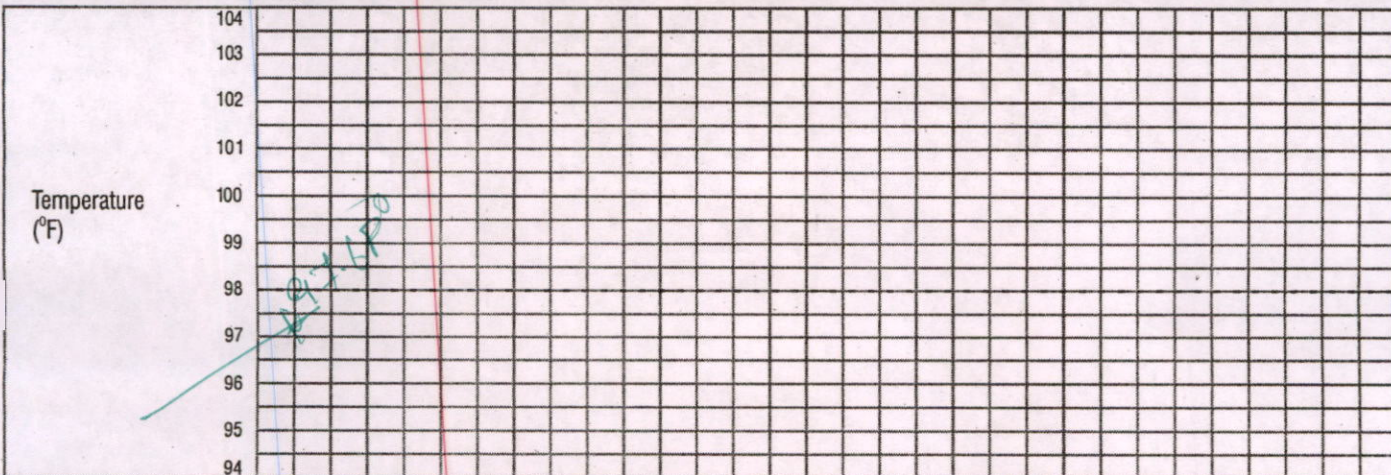
TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart



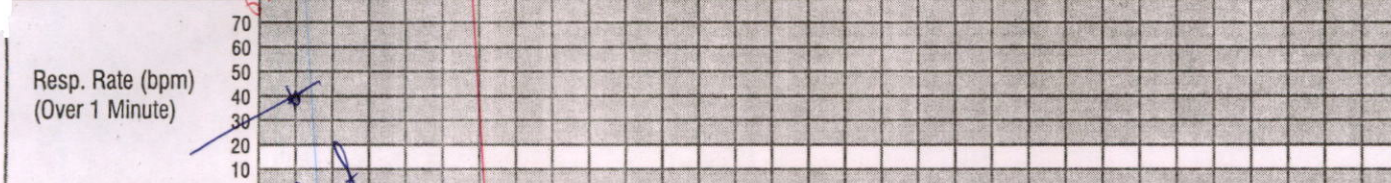
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern? *gsm*



Heart Rate (Number) *102*



Resp Rate (Number) *32 bpm*

Resp Distress | Mod/ Severe | None / Mild

Receiving O₂ (l/min) | O₂ Saturations (%) *0.8l*

Conscious Level | Normal | Altered *(15/15)*

GCS *

TOTAL SCORE
 Number of shaded boxes: *0*
 Pain Score: *0*
 Observer's Initials: *gsm*

- 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.

Patient St

BAH-00655659
 Me V S GOUTHAMI
 25-12-2008 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY

IP5-00173733



FLUID CHART

Sheet No. : (1)

12/5/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am		0										
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm		N										
	03:00 pm												
	04:00 pm												
	05:00 pm	RL	0	100ml									
	06:00 pm			100ml									
	07:00 pm			100ml									
Total Intake :						Total Output :							
	08:00 pm									0			Uici
	09:00 pm		H2O							0			Uici
	10:00 pm									0			Uici
	11:00 pm	NA								0			Uici
	12:00 am		H2O							0			Uici
	01:00 am									0			Uici
Total Intake :						Total Output :						U: 2	m: 0
	02:00 am									0			Uici
	03:00 am		H2O							0			Uici
	04:00 am									0			Uici
	05:00 am									0			Uici
	06:00 am		H2O							0			Uici
	07:00 am									0			Uici
Total Intake :						Total Output :						U: 2	m: 0
Total 24 hrs. Intake			Total 24 hrs. Output									U: 2	m: 0

BAH-00855659 IP5-00173733
 Me V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



FLUID CHART



Sheet No. : 2

13/5/26

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.

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

BAH-00655659
M V S GOUTHAMI
25-12-2006 19 Y 4 M 17 D (F)
Dr. P V L N MURTHY



CONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: Endoscopic septoplasty, Turbinate Plasty - IFESS

Anaesthesiologist: Dr. P. V. L. N. Murthy Surgeon: Dr. P. V. L. N. Murthy

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 Laryngospasm, Bradycardia, post procedure or supine

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: Gouthami

Name: Gouthami

Relationship with patient:

Date & Time: 11/5/26 @ 3:30pm

Witness:

Signature: T. S. S. S.

Name: Sevanthi

Date & Time: 11/5/26 @ 3:30pm

Doctor (who is taking consent):

Signature: Amr Name: Dr. Amrleen Date: 11/5/26 Time: 3:30pm

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.

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

స్పెసిఫిక్ హై రిస్క్:

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

హృదయ వ్యాధి రక్తపోటు మధుమేహం మూత్రపిండాల వైఫల్యం బహుళ అవయవ వైఫల్యం

కాలేయ సమస్యలు షాక్ ఊబకాయం దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



Name: Ms. Gouthami Age: 19y Sex: F UHID.No: B.AH 058.166.P.

Date: 11/07/26 Time: 3pm Proposed Operation: Endoscopic septoplasty

Diagnosis: DN - Deviated nasal septum / Sinusitis / turbinate hypertrophy + IPSS

B.P / CRT: 115/70 H.R: 88 Weight: 65kgs ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 10.0 Glucose: Protein: HIV: X-Ray:
 PCV: Urea: Alb: HBS Ag: NR ECG:
 WBC: 6.180 Creat: Total Bill: HCV: 2D Echo:
 Plate: 346 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:

RESP: No H/o fever / cold / cough Diabetes:

CNS: H/o sore throat

Renal:

Hepatic / GE: Physical Activity: Active

Others:

Past Anaesthetic History:

Physical Exam: apex

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

Lungs: clear enlarged tonsils

Heart: NAD

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:

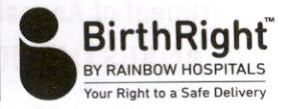
- DVT Prophylaxis:
- NIL ORAL Water / ORS 2 Hours Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: Am Name: Dr Anveen

BAH-00655659 IP5-00173733
 Ms V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: confirm

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 88bpm B.P / CRT: 110/70 SpO₂: 100% R.R: 12/mt Last Feed: >6hr

Pre-OP Diagnosis: DNSeptrum, Tonsillitis, Sinusitis Operation: Septoplasty, Tonsillectomy Date: 12/5/16

Surgeon: Dr. Murethy Anaesthesiologist: Dr. Sundhara Technician: Vijay

TIME	FiO ₂ / SaO ₂	ETCO ₂	ECG	Temperature	Urine Output
5:30	100	30	NR	33.9	
6:00	100	32	NR	34.2	
6:30	100	30	NR	34.3	
7:00	100	32	NR	34.8	

Drugs: MIDAZOLAM 2mg, FENTANYL 100ug, PROPOFOL 100mg, ROCURONIUM 50mg, DESAMETHASONE 6mg, PARACETAMOL 1g, TRAMADOL 1g, DICLOFENAC 75mg, DERMOLLET MEDICINE 0.1mg/kg, DERMOLLET 0.1mg/kg.

Antibiotic: Avromen 7ml x 2 Suppository

Fluids: 1L

B.P: 110/70

Heart Rate: 60bpm

Throat Pack In: 6pm

Throat Pack Out: 6:46pm

LAB Values: ARB, GRBS, Others

Equipment Checked and Functional

BP: 110/70

Cuff Site: br

Art Site: br

EKG Lead: sin

Temp Site: sin

Position: supine

Pressure Points Checked:

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

Times: Anaes Start: 5pm OP Start: 7:20pm OP End: 7:20pm Leave OR: 7:20pm

Anaesthesia: GA Monitored Anaesthesia Care Regional

Line (Size & Location): CVP ART IV: 20g br IV IV

Induction: IV Inhal Pre O₂ RSI Others

Mask: Mask SGA Airway Oral Nasal

ETT# 7.0 at 20 cm

Oral: Oral Nasal Cuff Tracheostomy Topical

Drug: Awake Direct Vision Video Laryngoscopy Stylette / Bougie Fiberoptic

Blade# 3 Attempts: 1

Difficulty Why? —

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

Regional: Extremity Specify: Spinal Epidural Caudal

Position: supine

Site: br

Needle Size: 20 Depth: 20

Parasthesia: Yes No

Catheter at skin: 20 cm

Drug Name & Conc: —

Bolus: —

Infusion: —

Block Level: —

Comments: —

Transportation to: PACU ICU Other

Relaxant Reversed: Yes No NA

Name of the Doctor: Sundhara

Signature of the Doctor: Sundhara



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Neelini Time Received: 7:20pm Time Discharged:

BLOOD PRESSURE < > PULSE < > RESP SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <u>right hand</u> <input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Nasal Prongs <input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece <input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drug:, NG Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Urinary Catheter: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Chest Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Nil Oral <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IV Fluids:, Oral Feeds:,

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command = 2	Able to move 2 extremities voluntary or on command = 1	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 move 0 extremities voluntary or on command = 0	ACTIVITY	2	2				
Able to deep breathe & cough freely = 2	RESPIRATION	2	2				
Dyspnea or limited breathing = 1							
Apneic = 0							
BP ± 20 of Pre Anaesthetic level = 2	CIRCULATION	2	2				
BP ± 20-50 of Pre Anaesthetic level = 1							
BP ± 50 of Pre Anaesthetic level = 0							
Fully awake = 2	CONSCIOUSNESS	1	1				
Arousable on calling = 1							
Not responding = 0							
Pink = 2	COLOR	2	2				
Pale, dusky, blotchy, jaundiced, other = 1							
Cyanotic = 0							
	TOTAL	8	9				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
12/5	7:20pm	0		Neelini

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Neelini

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: Neelini

PACU Nurse Signature: [Signature]

Date & Time: 12/5/26 at 7:20

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): 304

Date & Time: 12/5/26

BAH-00655659 IP5-00173733
 M & V S GOUTHAMI
 25-12-2006 19 Y 4 M 17 D (F)
 Dr. P V L N MURTHY

304

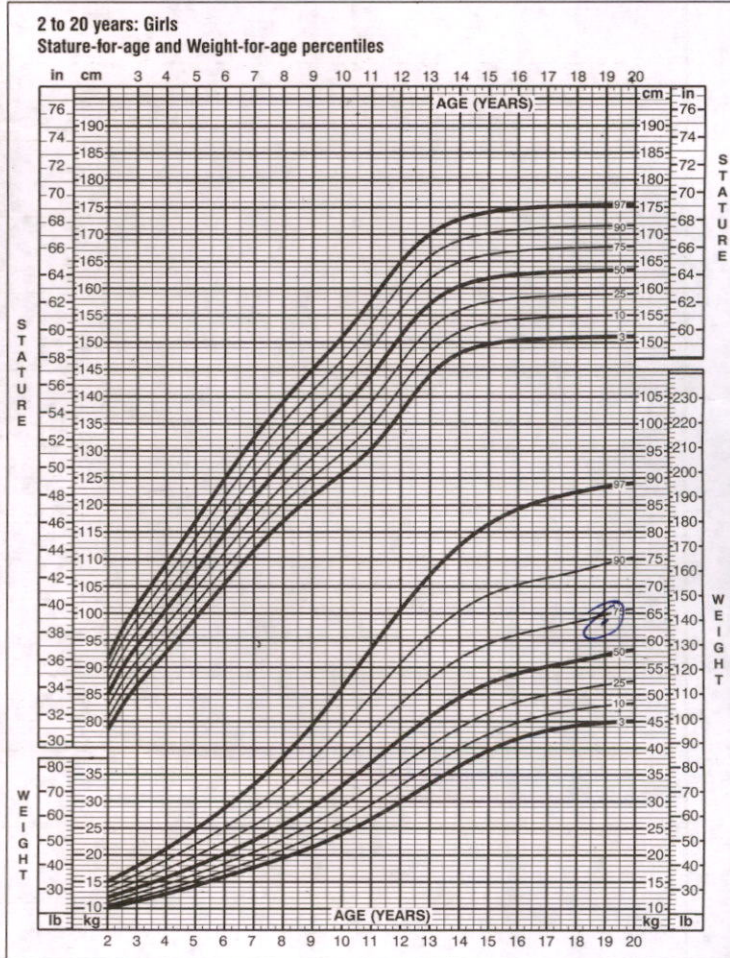
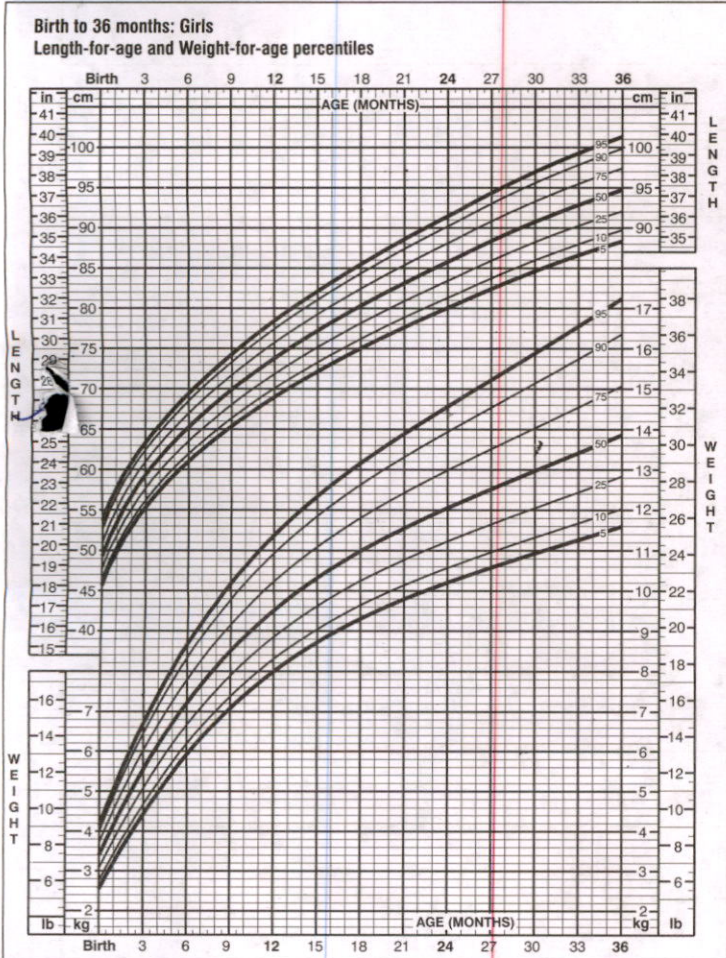


NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 13/5/26 Time: 8 AM

Weight: 64 kg Centile: 77th
 Height: 140 cm Centile: 77th
 Inference: well child
 RDA: — Calories: 2100 kcal/d Protein: 37 gm/d
 Diet Recommendations: soft rice
 Re-Assessment: Avoid Spicy & outside foods
 Food Allergies: NO Veg/Non-veg: NON-veg
 Diagnosis: Adenotonsillectomy
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: *T. S. Rao*

GROWTH CHART (GIRLS)



Dietician's Name: *Saina*

Dietician's Signature: *Saina*

