BAH-00395673 IP5-00174691
Master ANAV KUMAR
30-01-2019 7 Y 4 M 4 D (M)
Dr. SRINIVAS NAMINENI

Patient Sticker

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SURGERY DETAILS

Date : 5/06/26

Patient Name: Mast ANAV KUMAR Date of Birth: 30-01-2019 Age: 7Y

Gender: M Ward : POT UHID No.: 0124691

Date of Surgery: 5/06/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPLEX HERNIA OKAE & BHAS

Time in : 1'10pm Time Out : 1'50pm

		NAME	AMOUNT
1.	Surgeon	SRINIVAS.N	
2.	Anaesthetist		
3.	Assistant Surgeon		
4.	OT Technician	Sisha	
5.	Circulating Nurse	Archi	
6.	Assistant Nurse	Roja	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 964/1046 Order by:

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Dental

CONSUMABLES OF OT

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Circulating ..... Technician : ..... Date : 3/6/26 Time : 12:30 Pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.5/5.0/5.5 Nasal	1+1	01	Major Pack	1	1	Inj Vit.K		
LMA 2½	1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	3				Suction Catheter		
HME filter : A / P / N	1	01				Feeding Tube		
Syringes : 10 cc	10	04				Vaccum Suction Set		
05 cc	10	04	Gloves 6/6½/7/7½ 2+2+2			Surgical Gloves		
02 cc	10	04	6/6½/7/7½ 2+2+2		H	Gauze Pack		
01 cc	2	2				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	01	NG tube			Koochies (S)		
RL	1	01	Cautery pencil			500ml NS	1	1
NS : 10ml / 100ml / 500ml / 1000ml	2+1	01	Koochies			Lace, See, See 2+2+2		
O2 mask (P)	1	0	Ointments			26G needle low	1	1
Airway 0.1	1+1	—	Suction Catheter			LOREADmonin	1	1
Fentanyl	2	01	Cap, Mask	5/5	5/5	Ribbone Gauze	1	1
Morphine			Gauze Pack 7×7	3+3	2			
Ketamine			Mop Pack	1P	1			
Propofol	2	02	Steristrip			IV cannula 22/24	1+1	1
Rocuronium	1	01	Underpad	1	1	Dexa	1	—
Glycopyrolate	1	—	Draw sheet	1	0	Tranexa	1	—
Myopyrolate	1	01	Abgel			Mfmispie	1	01
Ondansetron	1	—	Foleys catheter			NG-5.6.7.8.9.10		—
Pencan 25g/ Spinal Needle 22			Urobag			Midaz	1	—
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Nasal Airway 18.20	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Q Sit	01	01
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg	1+1	—	Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	1+1	01	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum set	1	—	Microshield	1	1			
Gauze	3	3	Cotton Balls	1	1			
Gloves cut	4	—	Latex Gloves	1 OP	1 OP			
IVP-cannula	1	01	Ramdione Scrub					
3-way 100A10cm	1+1	01	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9641045 Ordered by : .....

Doc. No. : RCH / FRM / 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 : IP5-00174691 **Admit Date** : 03-Jun-2026 **Admit Time** : 11:53 AM **UHID** : BAH-00395673

Patient Details :

Patient Name	: Master ANAV KUMAR	**Age**	: 7 Y 4 M 4 D
Guardian	: Mr ARVIND KUMAR	**DOB**	: 30-01-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FALT NO 202,BLOCK, 2 , PANCHAVATHI COMPLEX,, PRAGATHINAGAR, PANCHAVATHI COMPLEX,, PRAGATHINAGAR Quthbullapur Hyderabad INDIA 500090	**Phone No**	: 9951482000
		E-mail	: arvind2804@yahoo.co.in

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 ARVIND KUMAR **Relationship** : Father

Contact Address : FALT NO 202,BLOCK, 2 , PANCHAVATHI COMPLEX,, PRAGATHINAGAR, PANCHAVATHI COMPLEX,, PRAGATHINAGAR Quthbullapur Hyderabad INDIA 500090 **Phone No** : / 9951482000

Arvind Kumar

Signature

Doctor Details :

Doctor Name : Dr. SRINIVAS NAMINENI **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00395673 IP5-00174691 Master ANAV KUMAR 30-01-2019 7 Y 4 M 4 D (M) Dr. SRINIVAS NAMINENI sultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6	12:18pm	ER	OT	
3/6	4pm	OT	billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/6	PAC	(1)	40772	Sampal
3/6	replacement	(1)	1043	

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

PATIENT TRANSFER FORM

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Dr. SRINIVAS NAMINENI

	Date & Time of Admission	Date & Time of Transfer Order
Dr. Srinivas	3/6/2026 @ 11:53AM	3/6/26 12:18pm
	Transfer Ordered by	**Reason for Transfer**
	Dr. Ramya	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Personal belongings including clinical documents. If any handed over to attendant**	**Patient shifted with ID band:**
20	Yes ☑ No ☐ (Arvind Kumar)	Yes ☑ No ☐
Number of Imaging Films	If Yes, what? op files	If No: .....

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	op file	1
2.	growz	1
3.	kcul	1
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anvesh Jaiswal	Dr. Ramya

Patient & Clinical Records Received by : Teena

Date & Time of Patient Received : 3/6/26 @ 12:20pm

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

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

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Srinivas Naminemi Date : 3/6/26

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

Start Time of Assessment: 12pm Weight: 25.2kg

Allergic History: .....

Chief Complaints:
Decayed teeth
↓
Planned for pulpotherapy 7y followed by crown insertion in GA

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 ☐

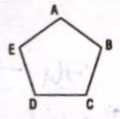
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

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_2 100% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BILATERAL
Palpation Findings (If necessary) .....

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

Circulation

HR: 86/min CFT: Central ..... Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 97/55(66) 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.: 98.1 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.

Treatment Planned:

- Pulp therapy FU → fly. Crown insertion & IV sedation @ Rep 12:30pm
- NPO to continue
- IV Fluids

NB

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Dental Caries.

Assessment done by

Name of the Doctor: Dr. Ramya

Signature:

Date & Time: 3/6/26 ; 12 pm.

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT.

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. RAMYA

Date & Time : 3/6/26 ; 12 pm

Nurse Name & Signature: Lavanya

Date & Time : 3/6/26 @ 12:10pm

Patient Sticker

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BirthRi
BY RAIN

శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనోస్ 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.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

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

1 PULSE THRAPY W.S.A

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)
AVOID 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.

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: Arvind Kumar

Name: ARVIND KUMAR

Relationship with patient: father

Date & Time: 3/6/26 @ 12.59 pm

Witness:

Signature: Deepa Kumari

Name: Deepa Kumari

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

Doctor (who is taking consent):

Signature: ..... Name: SRINIVAS Date 3/6/26 Time: 12.59 pm

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30-01-2019 7 Y 4 M 4 D (M)
Dr. SRINIVAS NAMINENI

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OPERATION THEATER NOTES

Patient's Name : MASTER ANAV KUMAR Age : 7Y Gender : ☑ Male ☐ Female

UHID No.: 0174691 Weight : Height :

Surgeon : DR. SRINIVAS	Asst. Surgeon :	
Anesthetist : DR. Thejaswini	OT Nurse: [illegible]	OT Technician: [illegible]

Pre-Operative Diagnosis:

Surgical Procedure :
COMPREHENSIVE OPAR REHAB.

Indications for Surgery :
INFECTED MOLAR.

Date : 31/08/24	Start Time : 1:20pm	End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:
d/d GA WITH NTT-
RUCTOMY N 7# FOLLOWED
BY CROWN INSERTION
DONE.

SOFT DIET

SYRUP IBUGESIC PLUS
5ml 1-1-1 x 3DAYS.

RAVIGEN IN 3DAYS

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: SB IRVIN ABD

Signature of the Surgeon: .....

Date & Time: .....

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POST-SURGICAL CARE PLAN FORM

Procedure Done: COMPREHENSIVE ORAC & REHAB.

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

—

Wound Care:

—

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

Treating Surgeon
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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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:				

VERIFIED BY : Name ..... Sig ..... re

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REGULAR PRESCRIPTIONS

Weight. 25.2kg. Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

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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Weight. 25.2 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
3/6/26	3:15pm	DICLOFENAC SUPP.	25mg	PR		
3/6/26	1:25pm.	Inj PARACETAMOL	375mg	IV		

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

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I.V. FLUIDS CHART

Weight. 25.2kg Ward. .....

		Composition of I.V. Fluid (In, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
3/6/26		IVF – DNS (2/3rd maintainence)	IV	45 ml/hr			not (cancelled)		
3/6/26	1:15pm	RINGER LACTATE	IV	250			3/6/26.		

Signature .....

VERIFIED BY : Name .....

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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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3/6

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FLUID CHART

Sheet No. : 0

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: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
3/6	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am					1						
	12:00 pm											
	01:00 pm			0 1								
Total Intake :						**Total Output :**						
	02:00 pm		200									
3/6	03:00 pm		1019									
	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	

Patient Sticker

FLUID CHART

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Sheet No. : .....

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

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

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

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Anav kumar Age: 7y Sex: M UHID.No : BAH-00395673

Date: 1/8/26 Time: 6:10pm. Proposed Operation: Pulpotherapy 74 followed by Crown insertion.

Diagnosis: Childhood Dental Caries.

B.P / CRT: <3sec H.R: 90/55 mmHg Weight: 25kg. 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: Allergic to dust.

Medical History: CVS : • NVD / Term / 3.8kg / No NICU admission

RESP : Diabetes :

CNS : Earpain (+) • Vaccinated upto date

Renal : • Milestones achieved as per age

Hepatic / GE : Physical Activity: Active

Others :

Past Anaesthetic History: –

Physical Exam: –

Airway: MP 1 (2) 3 4 Mouth Opening: adequate Mentohyoid Distance: Neck (N) Teeth: Artificial cap @ 2nd primary in (L) upper jaw

Lungs : BAE (+), clear

Heart: S1S2 (+)

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 : } Explained.
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient / Attender
5. Other Instructions:
   • CBP on IV cannulation.

Signature: Name: Dr. K. Sirisha.

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Confirmed
Physical Status:	☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 120/min | B.P / CRT: 88/55 mmHg | SpO_2: 100% | R.R: 20/min | Last Feed: >6 hrs.

Pre-OP Diagnosis: Dental caries | Operation: Pulp therapy + crown insertion | Date: 3/6/26

Surgeon: Dr. Srinivas | Anaesthesiologist: Dr. Savithri / Dr. B.T | Technician: Sirisha

TIME	1pm	1:30	2pm
N_2O /AIR /O_2 LPM	0.7L/min		
HALO /SO /SEVO	4%	3%	3%
Drugs:			
MIDAZOLAM SPRAY			
FENTANYL	50mcg		
ROCURONIUM	10mg		
PARACETAMOL	375mg		
NEOSTIGMINE		2mg	
GLYCOPYRROLATE		0.5mg	
FIO_2 / SaO_2	100	100	100
$ETCO_2$	43	42	42
ECG	SR	SR	SR
Temperature	32.9	33	34.5
Urine Output			

Antibiotic

Suppository: DICLOFENAC 25mg PR

Blood Loss

NOTES

Fluids / Blood: RINGER LACTATE 250ml/hr

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

Tourniquet on Time
Tourniquet off Time
Throat Pack In 3:18pm
Throat Pack Out 3:31pm

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: (L) UL
☐ Art Site:
☑ EKG Lead 3 leads
☑ Temp Site skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 1:10pm.
OP Start: 1:15pm
OP End: 1:40pm
Leave OR: 1:50pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 4.5 at NORTH POLE cm
☑ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☑ Drug: ROCURONIUM RATE.

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 1
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. Tejaswini
Signature of the Doctor:

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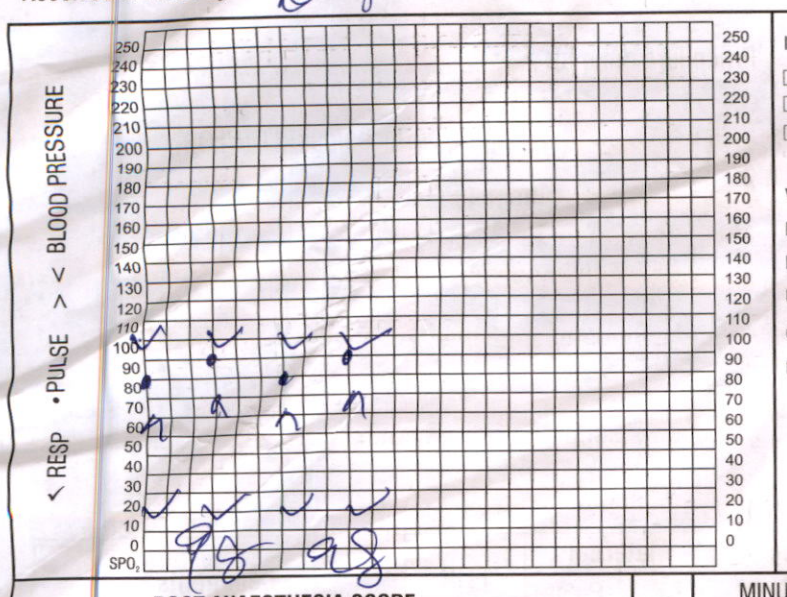
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 1:55pm Time Discharged : .....



IV Cannula Site : RT

- ☐ 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
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	ACTIVITY	1	1	1	2	
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	1	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
	TOTAL	8	8	9	10	

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6	1:55pm	4/10	—	

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

Anaesthesiologist Name : Dr. Vijaychandra
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 3/6/26 @ 3pm

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): billing
Date & Time: 3/6/26 @ 3pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal		FHR	Comments
				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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Master ANAV KUMAR
30-01-2019 7 Y 4 M 4 D (M)
Dr. SRINIVAS NAMINENI

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Patient Name : Anav Kumar Age : 7y Gender : Male ☑ Female ☐

UHID NO: BAH-00395673 Surgeon Name: Dr. Srinivas.

Anaesthesiologist : Dr K. Sri Surya

Operative procedure planned : Pulpotherapy 7E followed by Crown Insertion.

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 Anav Kumar the above mentioned operation / Diagnostic / Therapeutic procedures Pulpotherapy 7E followed by crown insertion.

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 : Deepa Kumari

Name : Deepa Kumari

Relationship with Patient: Mother

Date & Time : 1/6/26 - 6:20 pm

Witness :

Signature : Arvind Kumar

Name : ARVIND KUMAR

Date & Time : 1/6/26 6:20pm

Doctor (who is taking the consent) :

Signature : S. Sunya

Name : Dr K. Sri Sunya

Date & Time : 1/6/26 6:20pm