BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

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SURGERY DETAILS

Date : 07/07/26

Patient Name: Baby. Nakka charanya Reddy Date of Birth: ..... Age: 2y 2m 1D

Gender: Female Ward : P. OT - 1 UHID No. BAH-00659597

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

Name of the Surgery : EXCISION OF HEMANGIOMA

Time in : 9:40am Time Out : 11:40am

		NAME	AMOUNT
1.	Surgeon	: Dr. Harish Jayaram	.....
2.	Anaesthetist	: Dr. Sulpa	.....
3.	Assistant Surgeon	:	.....
4.	OT Technician	: Shivaleela	.....
5.	Circulating Nurse	: Swapna	.....
6.	Assistant Nurse	: Akhil	.....

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: 969175 Order by: .....

BAH-00659597 IP5-00176064
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HEMANGIOMA EXCISION OF TUMOR

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CONSUMABLES OF OT

Technician : Shirleety Date : 7/7 Time : 9am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube (4.0 4.5 5.0	1+1+1	—	Major Pack Surgical pack	1	0	Inj Vit.K		
LMA 2	01	1	Sutures 9915	1	1	Cord Clamp		
ECG leads : A / (P) / N	05	3	Vicryl 2-0, 3-0, (5-0)	2/2/2	1	Suction Catheter		
HME filter : A / (P) / N	01	1	Siprolin 3-0 (5-0)	2+2	1	Feeding Tube		
Syringes : 10 cc	20	2	Sutupak 2-0, 4-0	1+2		Vaccum Suction Set		
05 cc	20	2	Gloves 6, 6½, (7), (7½)	2+2	1+1	Surgical Gloves		
02 cc	20	2	PF 6, (6½), (7½), 7	2/2/2	1+0	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	1	Surgical blade 15	1+1	1	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil	1	0	NS 500ml	2	0
NS : (10ml) / (100ml) / (500ml) / 1000ml	5+1+1	—	Koochies			Framycetin	1	0
Mini spike	01	—	Ointments			(10G) 15G Jelly	2+2	0
Vacuum set	01	—	Suction Catheter					
Fentanyl	01	1	Cap, Mask	5/5	5/1	Skin marker	1	0
Morphine			Gauze Pack RM	5/5	4/5	Drain (No 8)	1	—
Ketamine			Mop Pack			Splint	1	1
Propofol	03	1	Steristrip			4" Roller Bandage	1	0
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	—	Draw sheet	1	0			
Myopyrolate 1 pco	02	—	Abgel					
Ondansetron	01	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22	01	1	Urobag			OA : 6.1	1+1	—
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			N.A : 1820	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Ozmoze (P)	01	—
Antibiotics			Bandage			Atropine + Adrenaline	1+1	—
IV PCM	01	—	Tegaderm			Midaz + Ephedrine	1+1	—
Suppositories			Ioban			Cox Jelly + Lox (cream)	1+1	—
Anamol : 80mg / (250mg) / 170 mg	1+1	1+1	Double J Stent			Dexmed (100)	01	—
Supridol : 100mg			Vaccum Suction set	1	—	Clonidine	1	
Justin : (12.5 mg) / 25mg / 100mg			Plastic Bed Sheet	1	0	NG + suction	2+2	—
Tab. Misoprost : 200mg	01	—	Betadine Solution	1	0	Soft roll 4/6	1+1	—
3 way 10cm + 100cm	1+1	—	Microshield	1	—	ET Co2 and Probe (1)	01	—
Gauze + Elloverol	5+1	—	Cotton Balls	1	0	Tegaderm	01	01
Dexa + Tranex	1+1	—	Latex Gloves	10p	6p	~~Diclofenac~~	*	
IV Canula 22, 24	1+1	—	Ramdione Scrub					
Q. site, splint 1, 3	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9691663 Ordered by :

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

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Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176064 **Admit Date** : 07-Jul-2026 **Admit Time** : 08:48 AM **UHID** : BAH-00659597

Patient Details :

Patient Name	: Baby NAKKA CHARANYA REDDY	**Age**	: 2 Y 2 M 1 D
Guardian	: Mr N SRIKANTH REDDY	**DOB**	: 06-05-2024
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 4-169, CHEVELLA MANDAL, GUNDALA VILLAGE Chevela Ranga Reddy Telangana INDIA 501503	**Phone No**	: 9701447545
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 404 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 404 **Admission Type** : First Visit

Contact Details :

Name : Mr N SRIKANTH REDDY **Relationship** : Father

Contact Address : H NO 4-169, CHEVELLA MANDAL, GUNDALA VILLAGE Chevela Ranga Reddy Telangana INDIA 501503 **Phone No** : / 9701447545

N. Srikanth Reddy

Signature

Doctor Details :

Doctor Name : Dr. MAINAK DEB **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : ___ BAH-00859597 IP5-00176064 Baby NAKKA CHARANYA REDDY 06-05-2024 2 Y 2 M 1 D (F) Dr. MAINAK DEB ____Consultant: _____ Dept : _____

Date of Admissi ____Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	9:30a	ER	OT	Abhishek
7/7/26		OT	Billing.	Dutt

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
7/7/26	CBP, Blood grooping	7861	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
7/7/26	I V placement	1	1412	
	PAC.	op Basis		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Charanya Reddy

UHID ID:

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

Department:

Consultant:

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2Y2M1D (F)
Dr. MAINAK DEB

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Right arm swelling since birth.
gradually progressing in size.

History of present illness :

USG - s/o vascular malformation
Has had episode of bleeding - resolved with compression.
on T. Propranolol 10mg twice daily.
d/
Plan of Haemangioma Excision today

No H/o fever, cough, cold.

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal neonatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

No issues for age.

Immunization History :

Immunized till date -

(P.T.O.)

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
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Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.94 (Centile _____)

On Examination :

Temperature : 98.6°F Pulse Rate : NO/min B.P. _____ SPO2 98% on RA

Resp.rate and type of breathing : 26/min

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds :

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds :

Any murmur : RS2 ⊕

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

Per Abdomen :

Inspection

Palpation :

Ausculation :

Spine : External Genitelia : Soft

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

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

_____

_____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials:**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic: Haemangioma → Plan of Excision today.

_____

_____

_____

_____

(P.T.O.)

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Infection

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CBP
Blood grouping } on cannulation

Planned Management

Hemangioma Excision.

Signature of the Doctor: Ramya
Name of the Doctor: Dr. RAMYA
Date & Time: 7/7/26 ; 8:50 am

Signature of the Consultant:
Name of the Consultant: Dr. Ramesh
Date & Time: 7/7/26 11 AM

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06-05-2024 2 Y 2 M 1 D (F)
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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 : 7/7/26; 8:50am.

Nurse Name & Signature: Sreevidya

Date & Time : 7/7/26 @ 9:30 am

BAH-00659597 IP5-00176064
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06-05-2024 2 Y 2 M 1 D (F)
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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

REGULAR PRESCRIPTIONS

Weight. 11.94 Kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dr. MAINAK DEB (F)

Weight. 11.94 kg Ward. .....

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
7/7/26	9:35 AM	Inj. CEFAZOLIN	500mg 1 hour prior to OT	IV	N.Roy	Trina Swapna
07/07/26	11:35 AM	SUP DICLOFENAC	12.5mg	P/R	Roy	Bikki Divya
07/07/26	11:35 AM	SUP PARACETAMOL	250mg	P/R	Roy	Bikki Divya

Baby NARRA CHAKRAVARTHEE (F)
06-05-2024 2 Y 2 M 1 D
Dr. MAINAK DEB

BAH-00659502

I.V. FLUIDS CHART

Weight. 11.94kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
7/7/26.		DNS	IV	45	N.Pg.	Not Connected			
07/07/26	9:50am	RINGER LACTATE	IV	120 ml/hr	[illegible]	[illegible] D:2	7/7/26	[illegible]	[illegible]

Signature .....

VERIFIED BY : Name .....

BAH-00659597 IP5-00176064
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06-06-2024 2 Y 2 M 1 D (F)
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RESULT SHEET

Date	7/7/26					
Time						
Hb	9.0					
PCV	29.6					
RBC	4.29					
WBC	11.54					
N/L						
Platelets	442					
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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FLUID CHART

Sheet No. : 1

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
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm		H20			—	—	—	—	—	0	
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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Sheet No. : .....

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

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

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

Baby NAKKA CHARANYA REDDY
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CHECKLIST FOR THROMBOPHLEBITIS

7/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0								
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		—								
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		—								
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		—								
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		—								
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—								
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Docu. No. : RCHBH /FRM / CLINICAL / 137

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

NURSING CARE RECORD

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Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: Acute pain related to the procedure

Goals
- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☑ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☑ Improve Activity Tolerance
- ☑ Ensure Safety
- ☑ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☑ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
11.45 pm	* Assess the pt General Condition.	11.50 pm	* Assessed the pt General Condition.	* pt is Conscious & oriented
11.50 pm	* Relieve pain & Discomfort	11.55 pm	* Relieved pain & Discomfort	* vital stable
11.55 pm	* monitor vital signs	12.05 pm	* monitored vital signs	* no bleeding
12.00 pm	* monitor for bleeding	12.10	* monitored for bleeding	* maintained
12.05 pm	* maintain I/O chart	12.15 pm	* maintained I/O chart	* no Vomiting
12.10	* maintain npo status	12.20 pm	* NPO broken, water given	* shifted
12.15 pm	* Provide psychological support	12.25 pm	* provided psychological support	
12.20	* pt shift to the ward	12.30	* pt shifted to the ward	

Re-Assessment: Acute pain related to Surgical procedure has been decreased

Special Notes:

Nurse Signature: Nurse Name: Date & Time: 7/7/26 @ 1.15 pm

Patient Sticker

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

.....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment: .....

.....

Special Notes: .....

.....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY (F)
06-05-2024 2 Y 2 M 1 D
Dr. MAINAK DEB

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctors order

2. Destination Post Discharge: ☑ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☑ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

			Remarks
☐ Medication	☑ Yes	☐ No	
☐ Bathing	☑ Yes	☐ No	
☐ Eating	☑ Yes	☐ No	
☐ Walking	☑ Yes	☐ No	
☐ Dressing	☑ Yes	☐ No	
☐ Toileting	☑ Yes	☐ No	

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

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

Nurse Signature: .....

Nurse Name: .....

Date and Time: 7/17/2024 1:15pm

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

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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 EXCISION OF HEMANGIOMA ON RIGHT FOREARM.

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)
Removal of swelling	Nil

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

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

a. Bleeding, Infection
b. Recurrence, Contractures.

I authorize Dr. Mainak Deb. 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: .....
Name: N. Sai Harith Reddy
Relationship with patient: Father
Date & Time: 7/7/26, 9:30 AM

Witness:

Signature: N. Manisha.
Name: N. Manisha.
Date & Time: 7/7/26, 9:30 AM

Doctor (who is taking consent):

Signature: Maliha Name: Dr. Maliha Date 7/7/26 Time: 9:30 AM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

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OPERATION THEATER NOTES

Patient's Name : Baby Nakka Charanya Reddy Age : 2y Gender : ☐ Male ☑ Female

UHID No.: BAH-00659597 Weight : 12.9kg Height : .....

Surgeon : Dr-Harish Jayaram	Asst. Surgeon : Dr. Maliha	
Anesthetist : Dr. Gopa	OT Nurse: Akki/Swapna	OT Technician: Sivaleela

Pre-Operative Diagnosis: HEMANGIOMA (RT) ELBOW

Surgical Procedure :
EXCISION BIOPSY

Indications for Surgery :
HEMANGIOMA (RT) ELBOW

Date : 07/07/26	Start Time : 10:15am	End Time : 11:16am

Pre Operative Preparations:

Post Operative Diagnosis: HEMANGIOMA (RT) ELBOW

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Pedunculated swelling of 7x5x5cm on medial aspect of (RT) elbow.

Procedure:-

1) Incision made around the swelling (to circumscribe it)
2) Incision deepened upto subcutaneous tissues
3) Swelling excised
4) Wound ø closed in layers

Amount of Blood Loss: ~5ml | Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

1) Hemangioma for HPE

Peri-Operative Complications: —

- Subcutaneous tissues c vicryl 2-0
- Skin c prolene 5-0 simple sutures

Splint placed. Dressing done

DAYCARE

1) Syrup CEFIXIME (5ml=100mg) 3ml twice daily for 5 days
2) Syrup CROCIN DS (5ml=240mg) 4ml thrice daily for 3 days

Review in OT on Friday 10/7/26 at 8:30 am with Dr. Harish Jayaram.

Name of the Surgeon: Dr. Harish Jayaram

Signature of the Surgeon: [signature]

Date & Time: 7/7/26, 12:33pm.

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Baby NAKKA CHARANYA REDDY
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POST-SURGICAL CARE PLAN FORM

Procedure Done: EXCISION BIOPSY

Post-Surgical Diagnosis: HEMANGIOMA (RT) ELBOW

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

As early as possible

Special Referrals:

—

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

☐ Yes ☑ No

Any Other Post-Operative Care Needed including Required Follow Up

—

Treating Surgeon
(Signature & Stamp)

Date: 7/7/26 Time: 12:39 pm

Note: Plan of care will be readjusted if necessary.

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Hemangioma Excision

Anaesthesiologist: Dr. Sunidhara Surgeon: Dr Mainak Deb

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 Bleeding, laryngospasm

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: [signature]

Name: M. Srikanth Reddy

Relationship with patient: father

Date & Time: 4/7/26, 4pm.

Witness:

Signature: [signature]

Name: [illegible]

Date & Time: 4/7/26 @ 4pm

Doctor (who is taking consent):

Signature: [signature] Name: Dr. Bhanda Date 4/7/26 Time: 4pm

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

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

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby Nakka Charanya Reddy Age: 2y 1m Sex: f UHID.No : BAH-00659597

Date: 4/7/25 Time: 4pm Proposed Operation: Hemangioma Excision

Diagnosis: Right arm hemangioma.

B.P / CRT: 2 Secs H.R: 108 Weight: 12.3kgs ASA Physical Status: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 9.0	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC: 11,540	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 442	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 (5x5x5cm) FT, LSCS, BWt: 2.5kgs, UAB, No NICU admission

RESP : c/o Right arm since birth - gradually ↑ing in Siz (Elbow) Diabetes : Development - (N), Vaccinated till date

CNS :

Renal : H/o 1 Episode of bleeding - resolved with Compression. USG - S/p Vascular malformation.

Hepatic / GE : 1 Episode of fever yesterday night Physical Activity: Active child.

Others :

Past Anaesthetic History: Nil.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: Intact

Lungs : B/L AE (+) Clear

Heart: S1S2 (+)

CNS: NAD, Child is active

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 parents

CURRENT MEDICATIONS	DOSAGE
T- Propranolol	10mg BD since 3days
	5mg Used for 10 days

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours, Others 6 Hours ✓ Explained
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient parents
5. Other Instructions:
   - CBP after cannulation.
   - Check for blood availability

Signature: Name: Dr Ananda.

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

BAH-00659597 IP5-00176064
Baby NAKKA CHARANYA REDDY
06-05-2024 2 Y 2 M 1 D (F)
Dr. MAINAK DEB

ANAESTHESIA CHART

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

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

H.R: 78/43 | B.P / ~~CRT~~: 135 bpm | SpO_2: 100 % | R.R: 20 cpm | Last Feed: > 6hrs

Pre-OP Diagnosis: Right Arm hemangioma | Operation: Hemangioma excision (R) UL | Date: 07/07/24

Surgeon: Dr. Harish jayaram | Anaesthesiologist: DR. SHILPA / DR. SHINY | Technician: Shivaleela

TIME 9:45 10:45AM 11:45AM

N_2O / AIR / O_2 / PM 0.5 0.3 → → → →

HALO / ISO / SEVO MAC 1 → → →

Drugs:
Inj Midazolam 0.2mg IV
Inj Fentanyl 20mcg IV
Inj propofol 40mg + 30mg IV

Antibiotic: Amaan

Suppository: ~~Sup Ecoxicold~~ Sup Paracetamol 250mg P/R, Sup Diclofenac 12.5mg P/R

Blood Loss

FIO_2 / SaO_2: 100 100 100 100 100 100 100 100

$ETCO_2$: 36 37 37 39

ECG: SR SR SR SR SR SR SR SR

Temperature

Urine Output

NOTES

Fluids: RL → 120ml/hr

Blood

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: RUL
☐ Art Site:
☑ EKG Lead
☐ 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: 9:50 AM
OP Start:
OP End:
Leave OR: 11:40 AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☑ SGA LMA - 2
☐ 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: Supraclavicular brachial plexus + Musculocutaneous Block N.
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin ... cm
Drug Name & Conc: 0.25% Bupivacaine 10ml
Bolus:
Infusion:
Block Level:
Comments:

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

Name of the Doctor: DR SHINY
Signature of the Doctor: