

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 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

SURGERY DETAILS

81064

Date : 9/7/26

Patient Name: Baby of yachika. Dhawan Date of Birth: 25-09-2021 Age: 4 Y 9 M

Gender: female Ward : P. OT UHID No.: BAH-00489775

Date of Surgery: 9/7/26 ☐ OT -1 ☐ OT -2 ☒ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Laparoscopic (R) hemiotomy

Time in : 11:15 AM

Time Out : 12:40 PM

	NAME	AMOUNT
1. Surgeon	Dr. Mainak	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Amaan / Wital	
5. Circulating Nurse	Gravani	
6. Assistant Nurse	Benjamin	

Special Equipment: ☒ Laparoscopy - 9694532 ☐ Bronchoscope ☐ Harmonic ☐ Morcelator

☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

☐ Neuro Cusa ☐ Others

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9694533

Order by: [Signature]

ESTIMATION SLIP

Date: 07/04/2023 UHID / IP No.: DAH-0068977 SI No. 81064 pt. 22
Name of Patient: Devi J. Yachika Dhanan Age: 44/9m Gender: Female
Father's / Husband's Name: M. Suresh Corporate / Occupation: NA
Address: 99 85702727 Phone: 99 85702727 Email: NA
Procedure / Plan: Right Laparoscopic Herniotomy - 1 Hr

MODE OF PAYMENT: ☐ SELF ☒ TPA: Nixa Bnyl ☐ GIPSA: 15/Mar/2023 OTHERS: Dr. Harish Jayaram

TARIFF INFORMATION:

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee										
L. Tax										
PARTICULARS			AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges			Rt: 39,930 + 14,630 + 10,000/h							
O.T. Consumables			Subject to approval by TPA / Insurance Company							
Instrument Charges			Not Covered by TPA / Insurance company							
Pharmacy, Consumables & Investigations			As per actual • Not Included in Estimation							
Equipment Charges	Monitor :		Oxygen :				Infusion pump / Syringe pump :			
	Ventilator :		HFO-SLE 5000 :				HFO Sensormedix :			
	Phototherapy :		Double Surface :				Triple Surface :			
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.			As per actual - Not Included in Estimation							
Package										
Others										
Initial Minimum Deposit			R. 10,000/-							

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HI / VBS, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
- Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

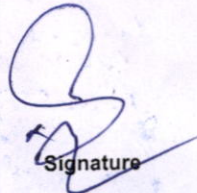
DECLARATION

I, Suresh have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client

Signature Relationship

Signature of the Financial Counselor

		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 : IP5-00176136 Admit Date : 09-Jul-2026 Admit Time : 09:36 AM UHID : BAH-00489775																										
Patient Details : <table border="0"> <tr> <td>Patient Name</td> <td>: Baby Of YACHIKA DHAWAN</td> <td>Age</td> <td>: 4 Y 9 M 14 D</td> </tr> <tr> <td>Guardian</td> <td>: Mr SWAROOP KANTH</td> <td>DOB</td> <td>: 25-09-2021</td> </tr> <tr> <td>Gender</td> <td>: Female</td> <td>Religion</td> <td>:</td> </tr> <tr> <td>Occupation</td> <td>:</td> <td>Martial Status</td> <td>: Single</td> </tr> <tr> <td>Address (H)</td> <td>: W1, SUN SHINE APT, MITHILA NAGAR, RD NO 12, Banjara Hills Hyderabad Telangana INDIA 500034</td> <td>Phone No</td> <td>: 9985702727</td> </tr> <tr> <td></td> <td></td> <td>E-mail</td> <td>: na123@gmail.com</td> </tr> </table>			Patient Name	: Baby Of YACHIKA DHAWAN	Age	: 4 Y 9 M 14 D	Guardian	: Mr SWAROOP KANTH	DOB	: 25-09-2021	Gender	: Female	Religion	:	Occupation	:	Martial Status	: Single	Address (H)	: W1, SUN SHINE APT, MITHILA NAGAR, RD NO 12, Banjara Hills Hyderabad Telangana INDIA 500034	Phone No	: 9985702727			E-mail	: na123@gmail.com
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Doctor Details : <table border="0"> <tr> <td>Doctor Name</td> <td>: Dr. MAINAK DEB</td> <td>Specialisation</td> <td>: PEDIATRIC SURGERY</td> </tr> <tr> <td>Referral Doctor</td> <td>: Self</td> <td>Phone No</td> <td>:</td> </tr> <tr> <td>Co-Consultant</td> <td>:</td> <td></td> <td></td> </tr> </table>			Doctor Name	: Dr. MAINAK DEB	Specialisation	: PEDIATRIC SURGERY	Referral Doctor	: Self	Phone No	:	Co-Consultant	:														
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Referral Doctor	: Self	Phone No	:																							
Co-Consultant	:																									
Payment Details : <table border="0"> <tr> <td>Payment Mode</td> <td>: Cash</td> <td>Deposit Amount</td> <td>: 0.00</td> </tr> <tr> <td></td> <td></td> <td>Payor Name</td> <td>: NIVA BUPA HEALTH INSURANCE COMPANY LTD</td> </tr> </table>			Payment Mode	: Cash	Deposit Amount	: 0.00			Payor Name	: NIVA BUPA HEALTH INSURANCE COMPANY LTD																
Payment Mode	: Cash	Deposit Amount	: 0.00																							
		Payor Name	: NIVA BUPA HEALTH INSURANCE COMPANY LTD																							

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP N _____ it: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DES



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	10:25 am	ER	OT	
9/7	1:30 pm	OT	236	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/26	Implacment	①	94264	df
9/7/26	PAC	①	94240	df
9/7/26	NHD	—	9695051	df

ANY OTHER INFORMATION

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Date : 10/7/26 Time : 8:30am Prepared By : df

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
df	—	—	—



OPERATION THEATER NOTES

Patient's Name : Baby of Yachika Dhawan Age : Gender : ☐ Male ☐ Female

UHID No.: Weight : Height :

Surgeon : Dr. Mainak Deb Asst. Surgeon : Dr. Shree

Anesthetist :

OT Nurse:

OT Technician:

Pre-Operative Diagnosis:

(R) Inguinal hernia.

Surgical Procedure :

Laparoscopic (R) Ingu herniotomy.

Indications for Surgery :

(R) Inguinal hernia.

Date :

9/7/26

Start Time :

11:15 AM

End Time :

12:40 PM

Pre Operative Preparations:

Post Operative Diagnosis:

(R) Inguinal hernia

Peri-Operative Complications:

Operation Notes:

Findings:

- (R) Patent ^{deep ring} Inguinal opening with round ligament as content.
- (R) (L) ~~ing~~ deep ring closed.

Procedure:

1. Umbilical port placed and pneumoperitoneum of 12 mm Hg @ 5 lit/min rate.
2. Above findings noted.
3. Another 3 mm working ports placed in (R) & (L) lumbar regions.
4. Peritoneum^{sac} around the deep ring excised and deep ring closed with 2.0 vicryl by purse string.

Amount of Blood Loss:

4 ml

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

5. Abdomen deflated and port sites closed.

Name of the Surgeon:

DR. MAINAK DEB
Registrar
MR/02413

Signature of the Surgeon:

[Signature]

Date & Time:

9/7/26 12:40pm



PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DEB



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Bleeding
Sepsis

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

LCBP
NIB
Sugar
10 am

Planned Management

- NPO as advised
- IVF. DNS
NIB
Sugar
10 am

Signature of the Doctor: Nalika
Name of the Doctor: Dr. Nandan
Date & Time: 09/07/2026, 9:40 AM

DR. MAINAK DEB
Registration No: TSMC/FMR/02413
Signature of the Consultant: [Signature]
Name of the Consultant: Dr. Mainak
Date & Time: 9/7/26 12 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 11:15pm	Dr. Nikhita POD-0 (R) Laparoscopic Herniotomy. Child active Accepting feeds O/E - Afebrile vitals - stable P/A - soft Did not pass urine Dressing - intact DR. MAINAK DEB Registration No. TSMC/FMR/02413	Adv ① Full feeds as tolerated
10/7/26 7:20am	Dr. Nikhita POD-1 (R) Laparoscopic Herniotomy Child c/o pain at operation site Child active, tolerating diet O/E - Afebrile vitals - stable P/A - soft, passed urine Dressing - Intact	Adv ① Full feeds as tolerated ② Plan d/c today

Dr. MAINAK DEB

[illegible]

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9/7/26 **RESULT SHEET**

Date						
Time	10:12 AM					
Hb	13.2					
PCV	38.2					
RBC	4.28					
WBC	9.53					
N/L	41/49					
Platelets	453					
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 :

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.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :

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25-09-2021 4 Y 9 M 14 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: Nalini, Dr. Nandan

Date & Time: 09/07/2026, 9:50 AM

Nurse Name & Signature: Sagar

Date & Time: 9/7/26 @ 10 am

BA4-00489775 IP5-00176136
Baby D'YACHI G. DHOLAN
25-09-2022 11 J.A. 14 D (F)
Dr. MAINAK DES



DRUG CHART

Date of Admission: 09/07/2022 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:				

Sign

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 18.2 kg Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : 150 - PARACETAMOL				Date Time 9/7/26
Dose 260mg	Route IV	Frequency TID	Start Date 9/7/26	6am - 10pm Nikita
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : 150 - ONDANSETRON				Date Time 9/7/26
Dose 2mg	Route IV	Frequency ONCE DAILY	Start Date 9/7/26	12:30pm Nikita
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



		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
9/10/2026	11:40AM	INT PARACTMOL	200mg	IV	[Signature]	[Signature]
9/10/2026	12:30PM	INT ONDANSATRON	1.8mg	IV	[Signature]	[Signature]
10/10/2026	8:18AM	DULCOLAX SUPPOSITORY	5mg	PR	Malika	[Signature]

Signature
VERIFIED BY : Name

11:45
12:35
8:20



I.V. FLUIDS CHART

Weight. 18.2 kg Ward.

[illegible]

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Dr. MAINAK DEB



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☐ Yes ☒ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/11/26	9:40 am	8.	Procedures	M	4	0	1	1	-	[Signature]
9/11/26	3pm	9	soft diet	M	1	0	1	1	-	[Signature]

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: LaparoScopi Herniotomy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26 9:40 am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Right inguinal hernia	Surgical Correction	Right Sided herniotomy (Lap'roscopic)	<u>Naik</u>	☒ Nursing ☐ Others:
9/7/26 9:40 am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Right inguinal hernia	H - stability	Vitals Monitoring	<u>[Signature]</u>	☒ Medical ☐ Others:
9/7/26 3pm	☐ Medical ☐ Nursing ☒ Others: <u>diets</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	(RT) inguinal hernia	soft diet	<u>RDP</u> E - 1350 kcal/d P - 23g/d	<u>Wishu</u>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN (F)
25-09-2021 4 Y 9 M 14 D
Dr. MAINAK DEB

8:0pm (solid)
9:15am (ORS)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby Trana (B/o Yachika Dhawan) Age: 9y 9m
Date: 9/7/21 Time of Arrival: 9:25am
Allergies: ☒ No ☐ Food ☐ Medications ☐ Other (Specify):
Source of Information: ☒ Ambulatory ☐ Parents ☐ Others (Specify):
Mode of Arrival: ☐ Wheelchair ☐ Stretcher ☐ Ambulance

Gender: ☐ Male ☐ Female

Triage Completion Time: 9:27am
☐ Not known any drug Allergies

INITIAL PHYSIOLOGICAL STATUS
☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life -Threatening

SIIOLOGICAL CATEGORIZATION
Work of Breathing
☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL VITAL SIGNS
Temp: 98.6 PR: 102 bpm SpO2: 98%
RR: 24 bpm

Chief Complaints: came for surgery
CTAS
☐ Immediate
☐ < 15 min
☐ 30 min
☐ 60 min
☒ 120 min

Triage Classification
☐ Level 1: Resuscitation
☐ Level 2: EMERGENT: Life or limb threatening
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
☐ Level 4: LESS URGENT: Significant illness but not life threatening
☐ Level 5: NON - URGENT: May receive care when convenient

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.
* CTAS - Canadian Triage and Acuity Scale

PART A. The following questions should be asked to all patients at the initial screening:
1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms:
☒ Not applicable ☐ Yes ☐ No
1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location: ☐ Yes ☒ No
2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening considered for any patient who meets one of the following criteria:
☐ Any patient with Fever / Rash / Vesicles / Discharge from eye and Cough
☐ Any patient with fever and respiratory symptoms when "YES" to any of the questions on epidemiologic risk in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)
☐ Patients should be immediately isolated in a negative room or a single room (as appropriate) for pending results
☐ The patient should be given a surgical mask immediately already wearing one.
☐ Both patient and triage staff should perform hand hygiene
☐ The staff should use PPE (as appropriate).

Signature of Parent / Guardian: Nachor

Name of Triage Nurse: Ramadevi
Date & Time: 9/7/21 at 9:27am

Docu. No.: RCHBH / FRM / CLINICAL / 085
Inform consultant for positive criteria.

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
10 AM	→ Assess the pt & continuous → Seen Dr. Nandan → Vitals checked & Record. → IV placement done.

Samples collected by: /

Time: /

Samples sent by: /

Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :

HR: 102 bpm BP: 94/54 CFT: 28 sec

RR: 24 b/m SPO₂: 100 %

GCS: 15/15 Temperature: 98°F

Pain Score: 0

Repeat RBS (if applicable): Nil

Details of Shift - out

Shift - out from ER to: OT

Time of Shift - out: 10:25 am

Handover given to: [Signature]
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done.

Name of the Nurse: Sagar

Signature of the Nurse: [Signature]

Date & Time: 9/7/26 @ 10:25 am

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DEB

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Lap. (R) herniotomy	
Post-Surgical Diagnosis: (R) Inguinal hernia.	
Post-Operative Monitoring Parameters /Frequency: TPR monitoring every 5m for 1st 1hr.	
Wound Care: Dressing	
Drain /Special Lines/Catheters: Nil	
Special Patient Positioning and Requirements: Nil	
Nutritional Instructions: Full feeds as tolerated	
When to Start Mobilization: As soon as possible.	
Special Referrals: Nil	
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 Nil	
Treating Surgeon (Signature & Stamp) DR. MAINAK DEB Registration No. TSMC/FMR/02413	Date: 9/10/2 Time: 12:40pm
Note: Plan of care will be readjusted if necessary.	

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. Right laparoscopic Herniotomy
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)
① Reduce the swelling in Right inguinal region ② Resolution of symptoms	Open Herniotomy

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. Infection, bleeding, need for redo surgery
- b. _____

1. I authorize Dr. Mainak Deb and his / her team to perform the procedural sedation upon the patient / myself.

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: YACHIKA DHAWAN

Relationship with patient: MOTHER

Date & Time: JULY 9, 10:47 @

Witness:

Signature: _____

Name: Swaroop

Date & Time: 9/7/26 @ 10:48 am

Doctor (who is taking consent):

Signature: _____ Name: Dr. Niketa

Date: 9/7/26 Time: 10:40 am

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

- 1
- 2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

- a.
- b.

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DEB



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10:30 am Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NKAH Body Weight: 15.2 Kg
Height: 100 cm

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Nothing Significant

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☒ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 15.2 kg Length: 100 cm Head Circumference (< 2 years): 32 cm
Temp.: 98.5 F HR: 90 bpm RR: 20 bpm BP: 90/50 mmHg

Pain Score: 0/10 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 21) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain: Location: Frequency: Duration:

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected
☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected
☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With *Paran*

Siblings in household ☐ Yes ☐ No (if yes How Many?)

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☐ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to *Mother*

Nurse's Name: *Deen* Date: *9/7/22* Time: *30 6am* *Dr* Signature



10/2/26

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10Am

Doctor / Nurse / Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94

98.5

Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Note:
 BP does not score
 in early
 warning scoring

100
81
60

Heart Rate (Number)

121B/m

Resp. Rate (bpm)
 (Over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

26B/m

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂(l/min)
 O₂Saturations (%)

RA
 99%

Conscious Normal
 Level Altered

GCS *

15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0
 0
 0

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.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

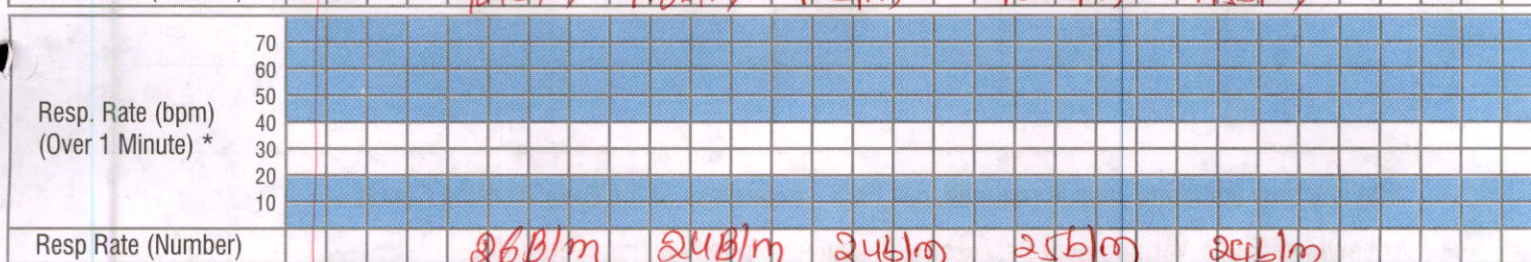
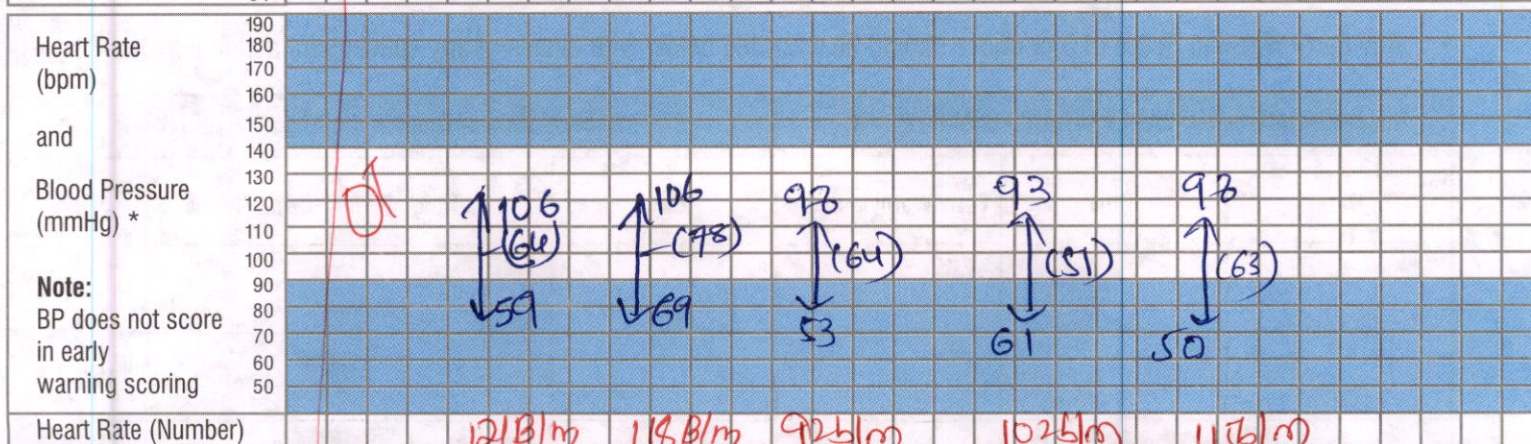
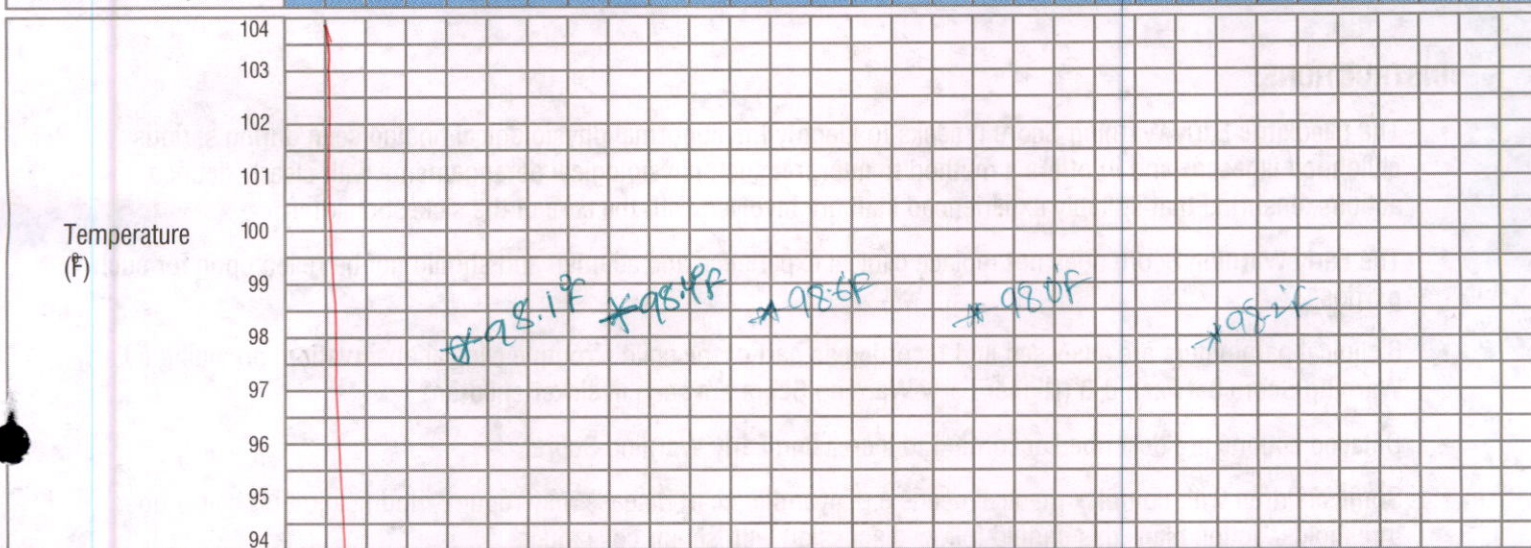
9/7/28

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

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 1:40pm 2pm 5pm 10pm 2am 6am
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe				
	None / Mild				
Receiving O ₂ (l/min)		RA	RA	RA	RA
O ₂ Saturations (%)		99%	100%	100%	99%
Conscious Level	Normal				
	Altered				
GCS *		15/15	15/15	15/15	15/15

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

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
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
9/7	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
9/7	02:00 pm	↑									0	Rosny	
	03:00 pm										0	Rosny	
	04:00 pm	NO									0	Rosny	
	05:00 pm	IVF									0	Rosny	
	06:00 pm	↓									0	Rosny	
	07:00 pm										0	Rosny	
Total Intake :						Total Output : N-0 U-0							
9/7	08:00 pm	↓									0	Hanika	
	09:00 pm	↓									0	Hanika	
	10:00 pm	NO									0	Hanika	
	11:00 pm	IVF									0	Hanika	
	12:00 am	↑									0	Hanika	
	01:00 am	↑									0	Hanika	
Total Intake :						Total Output : m-0 u-							
	02:00 am	↓									0	Hanika	
	03:00 am	↓									0	Hanika	
	04:00 am	NO									0	Hanika	
	05:00 am	IVF									0	Hanika	
	06:00 am	↑									0	Hanika	
	07:00 am	↑									0	Hanika	
Total Intake :						Total Output : m-0 u-1							
Total 24 hrs. Intake		Crood											
Total 24 hrs. Output		m-0 u-2											



FLUID CHART

Sheet No. :

10/09/26.

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	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	
-----------------------------	--



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Mainak Des Department: ER Date of Admission: 9/7/26

SITUATION	Diagnosis: <u>Right laparoscopic Herniotomy</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	ER 10:25 am	OT 8am-4:30 pm	HD unit 2pm-8pm	HD unit 8pm-8am
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ASSESSMENT	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98°F</u> Res: <u>24 bpm</u> SpO ₂ : <u>100%</u> Pulse: <u>82 bpm</u> BP: <u>80/52</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.6°F</u> Res: <u>25 bpm</u> SpO ₂ : <u>100%</u> Pulse: <u>84 bpm</u> BP: <u>96/52</u> Fall Risk Score: <u>10</u> Pain Score: <u>1/10</u>	Temp: <u>98.3°F</u> Res: <u>26 bpm</u> SpO ₂ : <u>99%</u> Pulse: <u>106 bpm</u> BP: <u>99/64</u> Fall Risk Score: <u>10</u> Pain Score: <u>0/10</u>	Temp: <u>98.6°F</u> Res: <u>25 bpm</u> SpO ₂ : <u>100%</u> Pulse: <u>117 bpm</u> BP: <u>102/67</u> Fall Risk Score: <u>10</u> Pain Score: <u>0/10</u>
Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>Siderally</u>	<u>Siderally</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Recommendations	Others Specify:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Recommendations	Other Special Orders / Medications:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Recommendations	Handed Over By Name :		<u>Sagan</u>	<u>Quig</u>	<u>Rosmar</u>	<u>Hanka</u>
	Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Recommendations	Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>
	Time:		<u>10:25am</u>	<u>11:40am</u>	<u>@ 8pm</u>	<u>@ 8am</u>
Recommendations	Taken Over By Name :		<u>Reena</u>	<u>Mouni</u>	<u>Hanka</u>	<u>Rosmar</u>
	Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Recommendations	Date:		<u>9/7</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>
	Time:		<u>10:25am</u>	<u>@ 11:40am</u>	<u>@ 8pm</u>	<u>@ 8am</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:							
	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
12:50	Assess the pt General Condition.	12:55	Assessed the pt General Condition.	pt is Conscious & oriented
1:00	Relieve pain & Discomfort	1:15	Relieved pain & Discomfort	pt vital Rechecked
1:10	Monitor vital signs	1:15	monitored vital signs	no bleeding
1:20	Monitor for bleeding	1:28	monitored for bleeding	maintained
	maintain I/O chart		maintained I/O chart	no vomiting
	maintain NPO status		NPO broken, water given	shifted
1:30	pt shift to the ward	1:35	pt shifted to the ward	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00489775

IP5-00176136

Baby Of YACHIKA DHAWAN

25-09-2021

4 Y 9 M 14 D

(F)

Dr. MAINAK DEB



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26.

Assessment: Baby having pain at Surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby General condition	2:15pm	Assessed the baby General condition.	Baby vital stable.
4pm	provide comfortable position	4:10pm	provided comfortable position	
5pm	Maintain personal Hygiene.	5:15pm	Explained about Hand Hygiene.	
6pm	Ensure baby Safety	6:20pm	Explained about Siderals.	
7pm	Administer All medication as per doctor Advice	7:30pm	Administered Medication as per presc. chd.	

Re-Assessment: Reduced the pain

Special Notes: W / P fever spikes.

Nurse Signature: Rosary

Nurse Name: Rosary

Date & Time: 9/7/26 @ 8pm

BAH-00489775 IP5-00176136
 Baby Of YACHIKA DHAWAN
 25-09-2021 4 Y 9 M 14 D (F)
 Dr. MAINAK DEB

NURSING CARE RECORD

Shi

☒ Night

Date: 10/7/26

Assessment: patient having Dull activity.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3pm ↓ 10pm ↓ 2am ↓ 8am	Assess the patient general condition. Monitor the vital signs. Maintain Ilo chart. Administer the medication as per doctor order. provided comfortable position.	8:10pm ↓ 10:30pm ↓ 2:20am ↓ 8am	Assessed the patient general condition. Monitored the vital signs. Maintained Ilo chart. Administered the medication as per doctor order. provided comfortable position	All plans are Implemented as per doctor order.

Re-Assessment: Re-Assessment was done.

Special Notes: w/f fever spikes

Nurse Signature: [Signature]

Nurse Name: Harika

Date & Time: 10/7/26 @ 3am

BAH-00489775 IP5-00175136
 Baby Of YACHIKA DHAWAN
 25-09-2021 4 Y 9 M 14 D (F)
 Dr. MAINAK DEB



NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

CHECKLIST FOR THROMBOPHLEBITIS

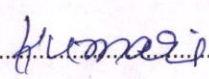
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	☒	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first 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 : 



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	9:40 am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
9/7	12:50 PM	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	
9/7/26	6 PM	2/10	Surgical Site	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inj. paracetamol given	Rosna
9/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Re-assessment done Reduc pain	Rosna
10/7/26	1 AM	1/10	Surgical Site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj. pcm given	Hemika
10/7/26	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Re-assessment done pain reduced	Hemika
10/7/26	6 AM	0/10	Surgical Site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj. pcm given	Hemika
10/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Re-assessment done pain reduced	Hemika
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

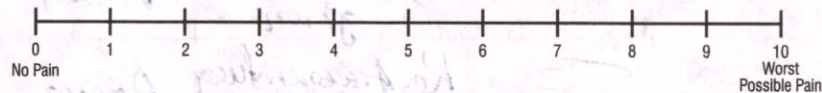
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

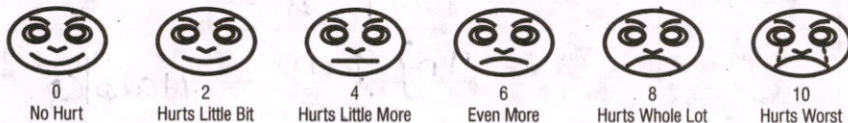
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date : 9/7/26 10:17		
					Time : 8:40am 6am		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
					TOTAL SCORE	28	28
					Evaluator's Name	8	4/4

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



THE HUMPTY DUMPTY SCALE 9/7 10/12

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	5			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			10	16			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes			
Call device within reach	yes	yes			
Wheels Locked	yes	yes			
Room free of clutter	yes	yes			
Adequate Lighting	yes	yes			
Wheel Chair Support	No	No			
Other Intervention(s) Specify	No	No			
Nurse's Name :	Suman	Hewitt			
Signature :	[Signature]	[Signature]			
Date :	9/7	10/12			
Time :	9:40 am	6am			

SURGICAL SAFETY CHECKLIST

Surgeon: Dr. Mainak deb
Asst. Surgeon: _____
Anaesthetist: Dr. Ramya
Scrub Nurse: _____

Patient Name: Babyol Yachika Age: 4Y Gender: F
UHID No.: 489775 Surgery Name: lap. pyloroplasty
Date: 9/7/26 In-time: 11:15 AM Out-time: 12:14 PM

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DEB


Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>11:05 AM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☒ NA	
Blood Units Reserved	☐ Yes ☐ No ☒ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature: <u>G. Ramya</u>		
Name: <u>Ramya</u>		

TIME OUT		Time: <u>11:10 AM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>Nil</u> <u>1 hour 5 min</u> ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☒ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature: <u>Dr. Mainak</u>		
Name: <u>Dr. Mainak</u>		

SIGN OUT		Time: <u>12:14 PM</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☒ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature: <u>Dr. Mainak</u>		
Name: <u>Dr. Mainak</u>		



Patient :

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 9/7/20

Department : P.O.T. Duration of Procedure : 1 hour

Name of Surgeon : Dr. Mainak Deb Date of Admission : 9/7/20

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic : Nil	
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : N/A Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Nil Date & Time of antibiotic administration : Nil Date & Time procedure started : Nil	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

BAH-00489775
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 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

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctor orders

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

yes

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: [Signature]

Nurse Name: [Signature]

Date and Time: 27/7/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00489775 IP5-00176136 Baby Of YACHIKA DHAWAN 25-09-2021 4 Y 9 M 14 D (F) Dr. MAINAK DEB 		Date & Time of Admission 9/7/26 @ 9:30 PM	Date & Time of Transfer Order 9/7/26 @ 1:30 PM
		Transfer Ordered by Dr. Mainak	Reason for Transfer Post-op
From Unit OT	To Unit 236	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 92	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.	no of file	1	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Mainak	
Patient & Clinical Records Received by : Roshara.			
Date & Time of Patient Received : 9/7/26 @ 1:50 PM			

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



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure:

(2) Laparoscopic Herniotomy

Anaesthesiologist:

Dr. SUBRAHMANYAN

Surgeon:

Dr. HARINA

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi-Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☒ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature:

Yachika

Name:

YACHIKA DHAWAN

Relationship with patient:

MOTHER

Date & Time:

JULY 7, 2026 6:00pm

Witness:

Signature:

Dr. Ravi

Name:

Dr. Ravi

Date & Time:

9/7/26 6:10pm

Doctor (who is taking consent):

Signature:

Ravi

Name:

RAVI

Date

9/7/26

Time:

6:10pm

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.

రిజనల్ 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 నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

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.
☐ రిజనల్ 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 సింట్రిల్ వెనెస్ యాక్సెస్, అర్థిలియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ 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:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: BABY IVANA Age: 4y 9m Sex: (F) UHID.No:
Date: 01/7/28 Time: 6:00pm Proposed Operation: (R) Laproscopic Herniotomy on 09/7/28
Diagnosis: (R) INGUINAL HERNIA
B.P / CRT: 2 sec H.R: Weight: 18.2kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: Creat: Total Bill: HCV: 2D Echo:
Plate: Na: Dir. Bill: Blood group: Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies:

XXX

Medical History: CVS:

RESP:

CNS:

Renal:

Hepatic / GE:

Others:

(N) DELIVERY / Vaccinated to date

Diabetes:

Physical Activity: ✓

Past Anaesthetic History:

Physical Exam:

Active / Afebrile

Airway:

MR 1 2 3 4

Mouth Opening:

Mentohyoid Distance:

Neck: NAD

Teeth: Intact

Lungs:

Adequate

2 finger knuckle

Heart:

clinically NAD

CNS:

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site:

Adequate

Spine Exam for regional: NAD

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

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

After last meal! 8:30
21/7/28 Clear liquids 9:00

Signature: [Signature] Name: RAU

- CBB plus IV calculation



ANAESTHESIA CHART

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

BirthRightTM
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Physical Status:

☒ Patient Identified

Fasting Status:

6hr

☒ Consent Present

☒ Chart Reviewed

H.R:

114

B.P / CRT: 90/60

SpO₂:

99.1

R.R:

20

Pre-OP Diagnosis:

Ingrown toenail

Operation:

Clap. Toenail

Surgeon:

Dr. R. R. R.

Last Feed:

6hr

Anaesthesiologist:

Dr. R. R. R.

Date:

11/11/11

Drugs:

INT MIDAZOLAM - 0.9 mg

INT Fentanyl - 10 mcg

INT Propofol - 10 mg

INT Rocuronium - 9 mg

INT PARACETAMOL - 10 mg

FiO₂ / SaO₂

ETCO₂

ECG

Temperature

Urine Output

Fluids

Blood

B.P

V Systolic

A Diastolic

X Mean

Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

Temp:

☐ HME ☐ Fluid Warmer
☐ Ciling Film ☐ OH Warmer
☒ Hugger's ☐ Cotton Wool
☐ Other

Times:

Anaes Start: 11:15 AM

OP Start: 1

OP End: 12:40 PM

Leave OR: 12:40 PM

Anaesthesia:

☒ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)

CVP

ART

ET

Induction

☒ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT # 4.5 at 18 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☒ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic

Blade # Attempts: 1
Difficulty Why?

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

Regional:

Extremity Specify:
☐ Spinal ☐ Epidural ☒ Caudal

Others: (1) lateral decubitus

Position: (1) lateral decubitus

Site:

Needle Size: 22 Depth:

Parasthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc: 0.5% Bupivacaine

Bolus: 2 cc

Infusion:

Block Level:

Comments:

Transportation to PACU ☐ ICU ☐ Other

Relaxant Reversed ☒ Yes ☐ No ☐ NA

Name of the Doctor: Dr. R. R. R.

Signature of the Doctor:

BAH-00489775 IP5-00176136
Baby Of YACHIKA DHAWAN
25-09-2021 4 Y 9 M 14 D (F)
Dr. MAINAK DEB



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

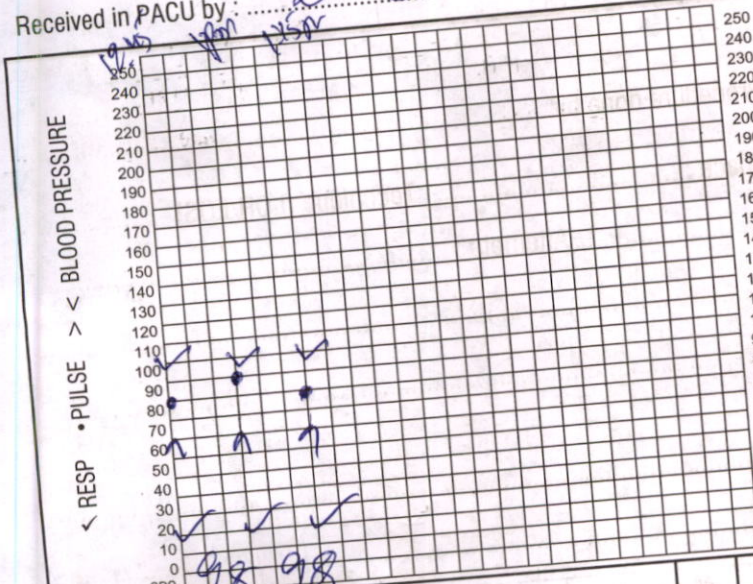
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: *Diya*

Time Received: *12:45 PM*

Time Discharged: *1:30 PM*



IV Cannula Site: *986*
☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting: ☐ Yes ☒ No
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)		MINUTES			OUT
		IN	30	60	90
Able to move 4 extremities voluntary or on command	= 2	1	1	1	2
Able to move 2 extremities voluntary or on command	= 1				
Able to move 0 extremities voluntary or on command	= 0				
Able to deep breathe & cough freely	= 2	2	2	2	2
Dyspnea or limited breathing	= 1				
Apneic	= 0				
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2	2
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1				
BP $\pm$ 50 of Pre Anaesthetic level	= 0				
Fully awake	= 2	1	1	2	2
Arousable on calling	= 1				
Not responding	= 0				
Pink	= 2	2	2	2	2
Pale, dusky, blotchy, jaundiced, other	= 1				
Cyanotic	= 0				
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
9/7	12:45 PM	1/10	—	<i>Diya</i>

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

Anaesthesiologist Name: *Anvi*

Anaesthesiologist Signature: *Anvi*

Date & Time: *09/7/21 1:30 PM*

PACU Nurse Name: *Diya*

PACU Nurse Signature: *Diya*

Date & Time: *9/7/21 @ 1:45 PM*

Reassessment Frequency:

- Every 1 hour for all hospitalized patients.
- For 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

Transfer Unit by (PACU): *Perioperative*

Date: *9/7/21*

Patient Sticker



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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge / Shifting Ordered by

Signature

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00489775 IP5-00176136 Baby Of YACHIKA DHAWAN 4 Y 9 M 14 D (F) 25-09-2021 Dr. MAINAK DEB		Date & Time of Admission 9/7/26 @ 9:35 am	Date & Time of Transfer Order 9/7/26 @ 10:25 am
Transfer Ordered by Dr. Nandan		Reason for Transfer Admission	
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op file	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Gown	①	
2.	Kooche	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Teeva			
Date & Time of Patient Received : 9/7/26 @ 10:30 am			

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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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 9/7/26 Time: 3pm

Weight: 18.06 kgs Centile: >50th

Height: 108 cms Centile: >50th

Inference: well child

RDA: - Calories: 1350 kcal/d Protein: 23g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled, outside foods

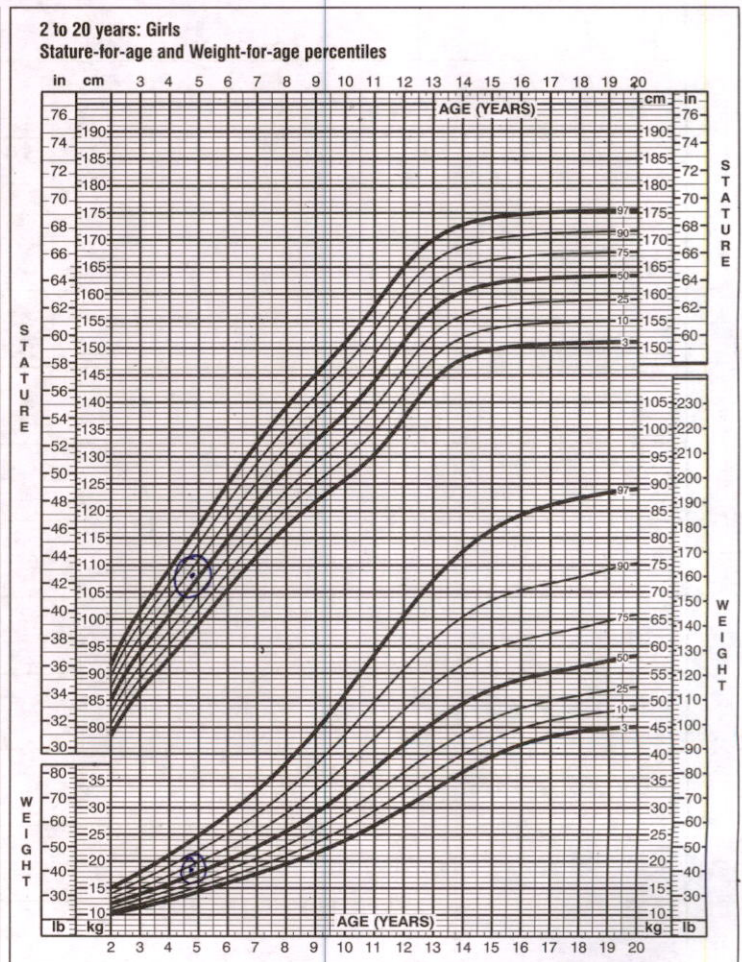
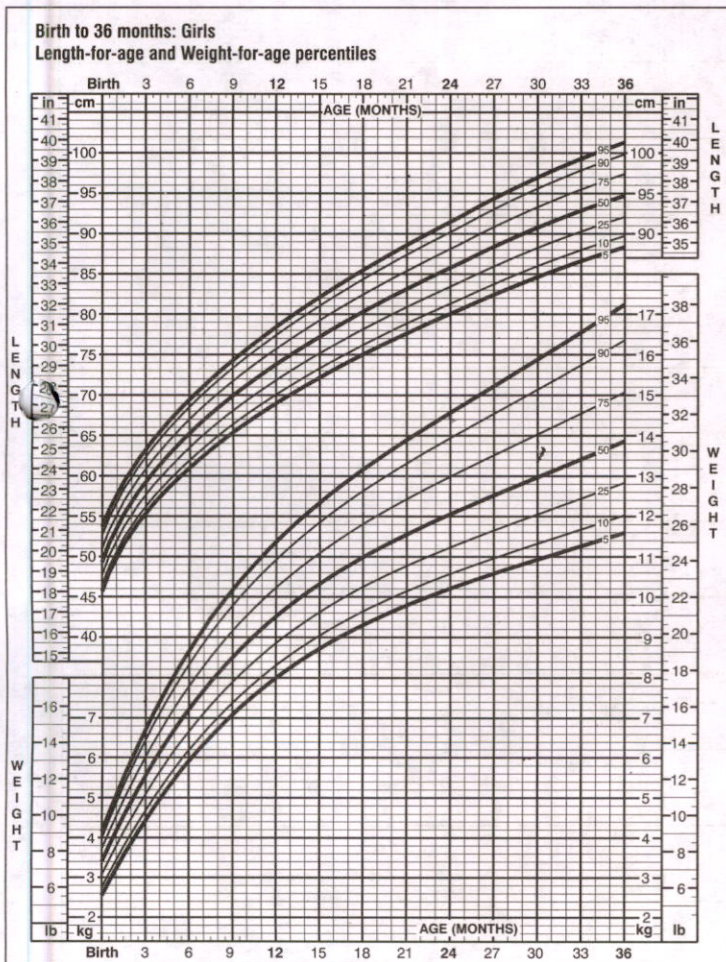
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: (H) Inguinal hernia

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha Dietician's Signature: [Signature]

Daily Notes:

10/1/26
8am

Child is stable. Intake is fair

continue to soft diet

NRH