

Patient

LBH-00005106 IP5-00176265
Master NALLANI CHAKRAVARTHULA
13-06-2017 9 Y 0 M 28 D (M)
Dr. P V L N MURTHY



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

URGERY DETAILS

Date : 11/7/26

Patient Name: Master N. CHAKRAVARTHULA Date of Birth: 13-06-2017 Age: 9Y

Gender: P Ward: PCP-OT UHID No.: LBH-00005106

Date of Surgery: 11/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: B/L myelogram + Cerebral

Time in : 7:10 PM

Time Out : 4:30 PM

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Gopi	
5. Circulating Nurse	Graci	
6. Assistant Nurse	Seema	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698210

Order by: Graci

Anaesthetics Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube	5-5, 6, 6.5	11	—	Major Pack	Surgical pack 1	—	—	Inj Vit. K			
LMA	2 1/2	01	—	Sutures				Cord Clamp			
ECG leads	A / P / N	05	03					Suction Catheter			
HME filter	A / P / N	01	01					Feeding Tube			
Syringes : 10 cc		10	02					Vacuum Suction Set			
05 cc		10	02	Gloves	6, 6 1/2 (2) 2 1/2 11			Surgical Gloves			
02 cc		10	02		6, 6 1/2 (2) 2 1/2 2			Gauze Pack			
01 cc		02	02					Syringe 1ml / 2ml			
Cautery plate	A / P / N	01	—	Surgical blade				Surgical Blade # 20			
IV set		01	01	NG tube	6	1	—	Koochies (S)			
RL		01	—	Cautery pencil				1500ml	2	1	
NS : 10ml / 100ml / 500ml / 1000ml	41-44/100	01	—	Koochies				Transil	1	1	
Mini spike	02	01	—	Ointments				Savlon	1	1	
02 mask	01	—	—	Suction Catheter				15 Adhione	3	5	
Fentanyl		01	01	Cap, Mask		5/5	5/5	10 (5) 10	2 1/2	1 1/2	
Morphine				Gauze Pack		5/5	1	Groomer	2	2	
Ketamine				Mop Pack		1	1	Ciplox	1	1	
Propofol		03	02	Steristrip				mask	2	2	
Rocuronium		01	—	Underpad		1	1	micro pore	1	1	
Glycopyrolate		01	—	Draw sheet		1	0				
Myopyrolate		01	—	Abgel							
Ondansetron		01	—	Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag				Gauze + gloves	4	4	
Bupivacaine 0.25%		01	—	Chest Drainage Catheter				Dexa + Dermid	1	—	
Bupivacaine 0.25% (Heavy)				Romodrain bag				50 cc Tpmaline	1	—	
Antibiotics	20 pen	01	01	Bandage				NG + Suction	1	—	
	Aug 1/2	01	—	Tegaderm				Tamoxifen	02	—	
Suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vacuum Suction set		1	1				
Justin : 12.5 mg / 25mg / 100mg		02	—	Plastic Bed Sheet		1	1				
Tab. Misoprost : 200mg				Betadine Solution							
Vaccums et	01	01		Microshield		1	1				
3ways 10 + 100cm	11	1	—	Cotton Balls							
O.A (2, 13)	11	—	—	Latex Gloves		10	10				
N.A (24, 26)	11	—	—	Ramdone Scrub							
Tr (Amo 6, T 22 + 20)	11	—	—	Saral							

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176265 Admit Date : 11-Jul-2026 Admit Time : 01:02 PM UHID : LBH-00005106

Patient Details :

Patient Name	: Master NALLANI CHAKRAVARTHULA VIBHAV	Age	: 9 Y 0 M 28 D
Guardian	: Mr VISHNU N C	DOB	: 13-06-2017
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: FLAT NO-504, , HIGH RISE PEARL APT, , ANUPAMA NAGAR, HASTINAPURAM, Hastinapuram Hyderabad Telangana INDIA 500074	Phone No	: 9949665426/ 8498929295
		E-mail	: vishnu.nallali@gmail.com

Admission Details :

Bed Type	: DAY CARE	Bed No	: POST OP 413	Ward Name	: 4F-OT COMPLEX
Room No	: POST OP 413	Admission Type	: First Visit		

Contact Details :

Name	: Mr VISHNU N C	Relationship	: Father
Contact Address	: FLAT NO-504, , HIGH RISE PEARL APT, , ANUPAMA NAGAR, HASTINAPURAM, Hastinapuram Hyderabad Telangana INDIA 500074	Phone No	: 9949665426

[Signature]
Signature

Doctor Details :

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

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELF PAY

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	2 pm	ER	OT	
11/7/26	5 pm	OT	Billine	

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
11/07	iv placement PAC on basis.	1	077951	[Signature]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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. B/C Myelotomy + Graft

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)
<u>Good healing</u>	

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. Ear Pain, discharge, Hearing loss

b. _____

I authorize Dr. Dr. P V L N MURTHY 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: N.C. VISHNU

Name: N.C. VISHNU

Relationship with patient: FATHER

Date & Time: 11/7/26 at 4:06pm

Witness:

Signature: Bhavya K

Name: BHAVYA KANDADA

Date & Time: 11/7/26 at 4:06pm

Doctor (who is taking consent):

Signature: Dr. P V L N MURTHY Name: Dr. P V L N MURTHY

Date: 11/7/26 Time: 4:05pm

శస్త్రచికిత్స / ప్రాసీజర్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- 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

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, 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 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 / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- 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:

SURGICAL SAFETY CHECKLIST

Surgeon : DR. PVLN Murthy
Asst. Surgeon :
Anaesthetist : DR. SLE.
Scrub Nurse :

Patient :
UHID :
Date :

LBH-00005106 IP5-00176265
Master NALLANI CHAKRAVARTHULA
13-08-2017 9 Y 0 M 28 D (M)
Dr. PVLN MURTHY



Age : Gender :
e :
Out-time :

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Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>11:05 PM</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>[Signature]</u>		
Name : <u>Dr. K. S. Somp</u>		

TIME OUT		Time: <u>4:14 PM</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?		
	☒ 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?		
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☒ Yes ☐ No	
Signature : <u>[Signature]</u>		
Name : <u>[Signature]</u>		

SIGN OUT		Time:
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>[Signature]</u>		
Name : <u>Dr. PVLN Murthy</u>		

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 11/7/26

To Be Filled In By Assigned Nurse :

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

Name of Surgeon : Dr. PVLN Murthy Date of Admission : 11/7/26

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 : Dns - Azeez	<i>[Signature]</i>
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☒ Operating Room ☐ Other : Nil Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	<i>[Signature]</i>
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<i>[Signature]</i>
4.	Name of doctor or staff administering the antibiotic : <i>[Signature]</i> Date & Time of antibiotic administration : 11/7/26 @ 4pm Date & Time procedure started : 11/7/26 @ 5pm	<i>[Signature]</i>

- 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

Docu. No. : RCHBH/ FRM / CLINICAL / 038

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Patient

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OPERATION THEATER NOTES

Patient's Name : Master N. CHAKRAVARTHULA Age : 9y Gender : ☒ Male ☐ Female

UHID No.: LBH-00005106 Weight : 33.6 kg Height :

Surgeon : Dr. PVLN Murthy

Asst. Surgeon :

Anesthetist : DR

OT Nurse:

OT Technician:

Pre-Operative Diagnosis: B/L OME

Surgical Procedure : B/L myelomectomy + Cerelectomy

Indications for Surgery :

Date :

Start Time : 4:10

End Time : 4:30pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: B/L myelomectomy + Cerelectomy



RAL /

**CONSENT
REGION.**

MONITORED ANESTHESIA CARE

Patient Name : VIBHAV. NC Age : 9 Gender : Male ☒ Female ☐

UHID NO: Surgeon Name: Dr. MURTHY PVLN

Anaesthesiologist : Dr. SUBRAMANIAM

Operative procedure planned : GRONCH TUBES INSERTION B/L

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics 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 mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease | | | |
| ☐ Others : | | | |

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient VIBHAV. NC the above mentioned operation / Diagnostic / Therapeutic procedures GRONCH TUBES INSERTION

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

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

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

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

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

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

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : N.C. Vishnu

Name : N.C. VISHNU

Relationship with Patient: FATHER

Date & Time : 10/7/26, 10:50 AM

Witness :

Signature : Bhavya K

Name : BHAVYA K

Date & Time : 10/7/26, 11:50 AM

Doctor (who is taking the consent) :

Signature : Dr. Jaya Chandra

Name : Dr. JAYA CHANDRA

Date & Time : 10/7/26, 11:50 AM

Depar
PRE-



JN

Name: VIBHAV N C Age: 9 Sex: M UHID.No:

Date: Time: Proposed Operation: GROMET INSERTION

Diagnosis: MIDDLE EAR FLUID COLLECTION

B.P / CRT: H.R: Weight: 33.5 kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>13.6</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: <u>290</u>	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: NIL

Medical History: CVS :

RESP :

Diabetes :

CNS :

NIL SIGNIFICANT

Renal :

Hepatic / GE :

Physical Activity:

Others :

Past Anaesthetic History: GROMET TUBE INSERTION in 25-VGA → u/c

Physical Exam:

Airway: MR 1 2 3 4 Mouth Opening: Adequate Mento-hyoid Distance: - Neck: N Teeth: INTACT

Lungs: AERB, CTA

Heart: S, S, M, P

CNS: Grossly Intact

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: VIS, BLB VEINS Spine Exam for regional: /

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

→ FLW CBC

Signature: [Signature] Name: Dr. Jaya Chandra

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



Fasting Status: *confirmed*

☒ Chart Reviewed

Surgeon: Dr. P.V.L.N. Murthy Anaesthesiologist: Dr. Tejaswini Technician: Srinidhi

NOTES

LBH-00005106 IP5-00176265
Master NALLANI CHAKRAVARTHULA
13-06-2017 9 Y 0 M 28 D (M)
Dr. P V L N MURTHY



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BirthRight™
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sain

Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>21</u>		☐ O ₂ 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)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1		2	2	2		
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	RESPIRATION	1	1	2		
Dyspnea or limited breathing	= 1		2	2	2		
Apneic	= 0						
BP ± 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2		
BP ± 20-50 of Pre Anaesthetic level	= 1						
BP ± 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	CONSCIOUSNESS	1	1	2		
Arousable on calling	= 1		2	2	2		
Not responding	= 0						
Pink	= 2	COLOR	1	1	2		
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2		
Cyanotic	= 0						
TOTAL			8	8	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7	@5PM	0/10	Nil	<u>[Signature]</u>

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

Anaesthesiologist Name : Dr. Terashwin

Anaesthesiologist Signature : Dr. Terashwin

Date & Time : 11/7/16 @ 5 PM

PACU Nurse Name : [Signature]

PACU Nurse Signature : [Signature]

Date & Time : 11/7/16 @ 5 PM

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): [Signature]

Date & Time : 11/7/16 @ 5 PM

EPIDURAL ANALGESIA RECORD

b)

Date and Time :

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00005106 IP5-00176265 Master NALLANI CHAKRAVARTHULA 13-06-2017 9 Y 0 M 28 D (M) Dr. P V L N MURTHY 		Date & Time of Admission 11/7/26 @ 1:02 pm	Date & Time of Transfer Order 11/7/26 @ 2 pm
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? optik	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name		Quantity
1.	Gown	← (17)	
2.	Kooche	← (17)	
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 :			
Date & Time of Patient Received :			

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

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



Vibhava NC

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. PVLN Murthy

Date: 11/07/2024

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 1:20 PM

Weight: 33.5 kg

Allergic History: NDA

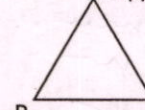
Chief Complaints:

No middle ear fluid collection

Now cause for myringotomy & Bk Grommet insertion

Pediatric Assessment Triangle

A Appearance - TICLS Normal



B

C Circulation

Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☒ Normal

☐ Abnormal

Pallor ☐

Cyanosis ☐

Mottling ☐

Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

Life Threatening ☐

Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

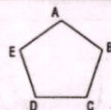
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway

☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing

Rate: 24 b/min SpO₂ on FiO₂ 100% LRA

Rhythm: Normal

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L A/E, clear

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 92bpm

CFT ☐ Central 3 sec ☐ Peripheral 3 sec

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

BP: 108/66 mmHg

Pulse Volume: ☐ Central good ☐ Peripheral good

If in Shock: ☐ Compensated ☐ Hypotensive

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☒ No



Disability

GCS: 15/15 AVPU: A

Pupils: ☐ Responsive ☒ Non-Responsive ☐
Size ☐ Right 3mm ☐ Left 3mm

Active Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure



Temp: 98.6°

Any Rash: ☐ Yes ☒ No

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status:

☐ Respiratory Distress

☐ Respiratory Failure

☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest

☒ Hemodynamically Stable

Secondary Assessment:

Head to toe examination with positive findings:

Normal

Labs Planned:

CBP

NIB

Sagan

W1126

Treatment Planned:

- NPO as advised

- IVF D5

NIB

Sagan

W1126

Need for Oxygen: ☐ Yes ☒ No

if yes Low Flow ☐

High Flow ☐

PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Middle ear fluid collection

Assessment done by

Name of the Doctor: Dr. Nanda

Signature: Dr. Nanda

Date & Time: 11/07/20, 1:30 PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



know NC

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: 11/07/2026, 1:20 PM

Nurse Name & Signature: Sagar

Date & Time: 11/7/26 @ 2pm



NC

DRUG CHART

Date of Admission: 11/07/2026 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:																			

Page: 2/4

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.	

[illegible]

Weight. 83.5 kg Ward.

[illegible]

LBH-00005106 IP5-00176265
 Master NALLANI CHAKRAVARTHULA
 13-08-2017 9 Y 0 M 28 D (M)
 Dr. P V L N MURTHY



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RESULT SHEET

Date	11/7/20				
Time					
Hb	13.6				
PCV	41.7				
RBC	5.27				
WBC	7.62				
N/L					
Platelets	290				
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					



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
11/2/26	02:00 pm	200	N	700								
	03:00 pm	DNB	7	700								
	04:00 pm		0									
	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												

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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
	Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output							



THE HUMPTY DUMPTY SCALE 11/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
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				
TOTAL			11				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	YES					
Call device within reach	YES					
Wheels Locked	YES					
Room free of clutter	YES					
Adequate Lighting	YES					
Wheel Chair Support	NO					
Other Intervention(s) Specify	NO					
Nurse's Name :	Sagan					
Signature :						
Date :	11/7					
Time :	2pm					



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. PVLN MURTHY Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	ER 2pm					
	Medical Condition (Any special condition to be noted):		Nil					
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:	98°F					
		Res:	24b/m					
		SpO ₂ :	100+					
		Pulse:	103b/m					
		BP:	95/52					
		Fall Risk Score:	11					
Pain Score:		0						
Recommendations	Safety Needs:		Yes					
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		Nil					
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		Nil					
Post Operative Procedure Special Orders:		Nil						
Handed Over By Name :		Sigan						
Signature :								
Date:		11/7/26						
Time:		2 pm						
Taken Over By Name :		Key						
Signature :								
Date:		11/7/26						
Time:		2:15 pm						

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/22	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

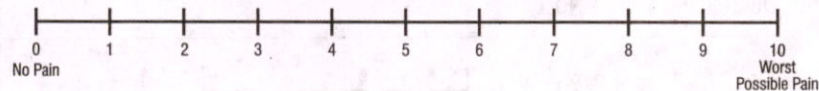
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain intervention.

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

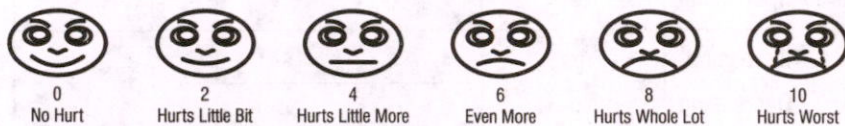
Numerical Pain Scale (Obstetric and Gynecology)



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 : 4/7			
				Time : 2 pm			
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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		
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		
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		
FRICITION-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		
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		
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		
				TOTAL SCORE	28		
				Evaluator's Name			

Low 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



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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		
11/7	2 pm	8.	Procedures	M	4	0	1	1	-	

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review																						

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/22 2pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	myingathmy with L-normet Insatation	H-Stability	Vitals monitosing		☐ Nursing ☐ Others:
11/7/22 2pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	myingathmy with L-normet Insatation	H-Stability	Vitals monitosing		☐ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others: