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CONSUMABLES OF OT

Date		Technician		Qty		Disposal	

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. **KOH-00276681** **IP5-00176270** Dept : _____
Baby AMEYAA MAITHANI
05-08-2015 **10 Y 11 M 6 D** (F)

Date of Admission: _____ **Dr. P V L N MURTHY** charge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	4:00	ER	OT	
11/7/26	6:30 PM	OT	322	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176270 Admit Date : 11-Jul-2026 Admit Time : 03:31 PM UHID : KOH-00276681

Patient Details :

Patient Name	: Baby AMEYAA MAITHANI	Age	: 10 Y 11 M 6 D
Guardian	: Mr SHISHIR MAITHANI	DOB	: 05-08-2015
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO-B-202,,APARNA CYBER COMMUNE,, NALLAGANDLA,,APARNA CYBER COMMUNE,, NALLAGANDLA, Serilingampally Hyderabad INDIA 500046	Phone No	: 8008022323/ 9000394077
		E-mail	: SHISHIR.MAITHANI@GMAIL.COM

Admission Details :

Bed Type	: DAY CARE	Bed No	: PRE OP 405	Ward Name	: 4F-OT COMPLEX
Room No	: PRE OP 405	Admission Type	: First Visit		

Contact Details :

Name	: Mr SHISHIR MAITHANI	Relationship	: Father
Contact Address	: FLAT NO-B-202,,APARNA CYBER COMMUNE,,NALLAGANDLA,,APARNA CYBER COMMUNE,,NALLAGANDLA, Serilingampally Hyderabad INDIA 500046	Phone No	: 8008022323

SHISHIR
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	: MEDI ASSIST INSURANCE TPA PVT LTD

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7/08	pac done in op basis	(1)	←	Antoine
11/7/08	in placement	(1)	8122	Antoine

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



CROSS CONSULTATION FORM

Doctor Name : Dr. Anapurna.T Date : 12/2/26 Time : 11:00 AM

Diagnosis : Chr. Adenotonsi

Hospital : RCH, BH

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

- Pediatric opinion.

Signature: _____

Findings and Recommendations :

Adenotonsillitis

S/P Adenotonsillectomy 100-1

- accepting feeds post surgery

O/G dietetic
vitals - stable

S/E - NAD

Plan:

→ Discharge as per ENT.

can be discharged
from pediatrics side.

Follow up ENT after

2 weeks.

Syp. Acetaminophen - 12ml

- F. Acetaminophen 500mg PO/50s

PO / 50s for pain.

Consultant :

Name : Dr. Anapurna.T Signature : [Signature] Date & Time : 11 AM 12/2/26



PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2016 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

Patient Name:

Ameyaa Maithani

UHID ID:

Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex 10y 11m 6d F

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Noisy breathing (2-4 days)

History of present illness :

Noisy breathing, sleep disturbances

NILH fever, cough, cold,

NPO - 1am - solid
3pm - liquid

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY



Pediatric multiorgan History & Physical Examination

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

nil

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

According to age

Immunization History :

Till date

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

no complications

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

Collect Arterial EDTA

NIB

Sagittal

11/7/26

4 pm

Planned Management

- NPO

- Evl DNS @ 7am/1hr

NIB

Sagittal

11/7/26

4 pm

Signature of the Doctor: *Dr. PVLN Murthy*

Name of the Doctor: Dr. PVLN Murthy

Date & Time: 11/7/26

Signature of the Consultant: *Dr. PVLN Murthy*

Name of the Consultant: Dr. PVLN Murthy

Date & Time: 11/7/26

DR. P V L N MURTHY
Registration No: 47267

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

Patient



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OPERATION THEATER NOTES

Patient's Name : Baby : Ameyaa Maithani Age : 10 Y Gender : ☐ Male ☒ Female

UHID No. : KOH-00276681 Weight : 46 kg Height :

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

Anesthetist : Dr. Ravi OT Nurse : Thejas OT Technician : Srinivas

Pre-Operative Diagnosis: Ch. Adeno Carcinoma

Surgical Procedure : Adeno Carcinoma resection

Indications for Surgery :

Date : 11/7/26 Start Time : 9:00 AM End Time : 5:00 PM

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Adeno Carcinoma resection

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1 T. CEFODIM XP BID - 20kg	
2 T. XYZAL-M BID 20kg	
3 T. ZERODOL-P BID - 20kg	
4 T. TRANEX 500mg BID - 20kg	
5 Salt-water gargle TID - 20kg	

Name of the Surgeon: DR. P. V. MURTHY

Signature of the Surgeon: *[Signature]*

Date & Time: 11/2/20

Registration No: 47267

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY



Patient Sticker


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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters / Frequency:

Wound Care:

Drain / Special Lines / Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 11/7/20 Time: 2:00

Note: Plan of care will be readjusted if necessary.

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

KOH-00278681
Baby AMEYAA MAITHANI
05-08-2018 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: OT

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramekrishe

Date & Time : 11/6/26

Nurse Name & Signature: Sagar

Date & Time : 11/7/26 @ 4 pm



DRUG CHART

Date of Admission: 11/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES
 (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. 46 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 : <u>T. Cetopem xP</u>				Date <u>11/7</u> Time
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>11/7</u>	<u>10pm</u> X
Name & Signature of the Doctor Starting the Drugs: <u>Dhanubala</u>				
Additional Instructions:				<u>10pm</u> ✓
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. XYAL-M</u>				Date Time
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>11/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dhanubala</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. COMBIFAM</u>				Date <u>11/7</u> Time <u>12/7</u>
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>11/2</u>	<u>10AM</u> X <u>7AM</u> <u>date</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dhanubala</u>				
Additional Instructions:				<u>10pm</u> <u>12/7</u> <u>date</u>
Daily Doctor's Endorsement by a Sign				



DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.

VARIABLE DOSE

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Dose	Dose	Dose	Dose	Dose
Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/7/26	4:55pm	Inj DEXAMETHASONE	4mg	IV		
11/7/26	4:50pm	Inj TRANEXAMIC ACID	1g	IV		
11/7/26	5pm	Inj PARACETAMOL	1g	IV		
11/7/26	4:55pm	Inj AMOXICILIN CLAVULANATE	1.2g IV			

Weight. 46 kg Ward.

[illegible]

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2016 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : T. PANDIPRAWLE				Date Time
Dose	Route	Frequency	Start Dt.	
40mg	PO	OD	11/7	
Name & Signature of the Doctor Starting the Drugs: <i>Shankar</i>				<i>Cam Right to South</i>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : T. TRANCER				Date Time
Dose	Route	Frequency	Start Dt.	
500mg	PO	BD	11/7	11AM X
Name & Signature of the Doctor Starting the Drugs: <i>Shankar</i>				
Additional Instructions:				<i>11AM</i>
Daily Doctor's Endorsement by a Sign				

DRUG : T. MONTAIR LC				Date Time
Dose	Route	Frequency	Start Dt.	
1mb	PO	BD	11/7	10AM X
Name & Signature of the Doctor Starting the Drugs: <i>Shankar</i>				
Additional Instructions:				<i>10PM</i> <i>11:30</i> <i>South</i>
Daily Doctor's Endorsement by a Sign				

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

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 6.40 P Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction nil Body Weight: 46 kg Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
nil	nil	nil

Family History: No Significant

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

; 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: 46 kg Length: Head Circumference (< 2 years):

Temp.: 98.5 HR: 121 RR: 21 BP: 112/74

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 26) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 1 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 FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *father*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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *mother*Nurse Signature: *Graban*Nurse Name: *Graban*Date: *11/7/26*Time: *6:30pm*

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2016 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Hindi 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		
11/7/26	3 pm	8.	Procedures	M	4	0	1	1	-	
12/7/26	8 am	9	Soft diet	M/F	1	0	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:								
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			
Learning barrier/s:								
1. Reassurance & Support Family / Others	5. Respect values & beliefs		7. Other, Specify					
	6. Respect Cultural / Religion Preference							
	2. Demonstrate Understanding		3. Needs Review					



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

ADENOTONSITIS

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 3pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	MONITOR VITALS	H. STABLE	1cc fluids NPO		☒ Nursing ☐ Others:
11/7/26 3pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillectomy	H - stability	vitals monitoring		☐ Medical ☐ Others:
12/7/26 6am	☐ Medical ☐ Nursing ☒ Others: <i>breath</i>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Adenotonsillectomy	Sept dict	RDA E-1650 kcal/d p-29gmb		☐ 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:



NPD - 11am (Solid)
- 3pm (Liquid)

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Ameyaa Maithani Age : 10 Years Gender: ☐ Male ☒ Female
Date : 11/07/26 Time of Arrival : 3:06 pm Triage Completion Time : 3:08 pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): nil ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) _____
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

Work of Breathing

☒ Normal

☐ Increased

☐ Decreased

☐ Gasping / Apnea

Circulation / Colour

☒ Normal

☐ Abnormal

☐ Bleeding

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life - Threatening

Initial Vital Signs: Temp: 98.4 F PR: 98 bpm BP: 118/73 (83) RR: 22 bpm SpO₂: 100% RA

Chief Complaints: Came for Surgery - Adenotonsillectomy

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

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

Signature of Parent / Guardian: Sneha

Communicable Disease Triage Screening

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

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: _____
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 is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors 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 pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Neelima

Signature of Triage Nurse : [Signature]

Date & Time : 11/07/26 @ 3:08 pm

Docu. No. : RCHBH / FRM / CLINICAL / 085



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 11/7/26 Time of arrival: 3:08 pm
 Chief Complaints: Came for surgery Adenotonsillectomy RBS: /
 Height: 149 cm Weight: 46 kg BMI: Head Circumference (<2 years)
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: Nil
 If yes, identify Nil
 Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

RISK FOR FALL:

- ☐ If patient is < 6 years
 tick below fall risk intervention directly
☒ If Patient is > 6 years
 Assess the below parameters
- History of Falling: within past 3 months ☐ Yes ☐ No
- Ambulatory Aids:**
- Wheelchair ☐ Yes ☐ No
 - Uses furniture for support ☐ Yes ☐ No
- Gait/Transferring:**
- Bedrest / immobile ☐ Yes ☐ No
 - Weak ☐ Yes ☐ No
 - Impaired ☐ Yes ☐ No
- Mental Status:** Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
☒ Assist Patient
☒ Educate patient and family on fall precautions/prevention

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
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

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 Family

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

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse: 11/7/26

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

Time	Nursing Notes
3 pm	→ Assess the pt & conscious.
	→ Vitals checked & Record.
	→ Seen Dr. Ramakrishna
	→ 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 :	Details of Shift - out
HR: BP: 118/73 CFT: 225cc RR: 22b/m SPO ₂ : 100+ GCS: 15/15 Temperature: 98°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: OT Time of Shift - out: 4:15 pm Handover given to: _____ (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: _____

Date & Time: 11/7/26 @ 4:15 pm

KOH-00276681 IP5-00176270
 Baby AMEYAA MAITHANI
 05-08-2015 10 Y 11 M 6 D (F)
 Dr. P V L N MURTHY



RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years) Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10:00 AM	6:00 PM													
Doctor / Nurse / Family Concern?															
Temperature (F)	104	103	102	101	100	99	98	97	96	95	94				
Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	114	110	100	90	80	70	60	50	40	30	20	10	0	0	0
Resp. Rate (bpm) (Over 1 Minute) *	26	25	20	15	10	5	0	0	0	0	0	0	0	0	0
Receiving O ₂ (l/min)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
O ₂ Saturations (%)	97	98	95	90	85	80	75	70	65	60	55	50	45	40	35
Conscious Level	15/15	15/15	14/14	13/13	12/12	11/11	10/10	9/9	8/8	7/7	6/6	5/5	4/4	3/3	2/2
GCS *	15/15	15/15	14/14	13/13	12/12	11/11	10/10	9/9	8/8	7/7	6/6	5/5	4/4	3/3	2/2
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials															

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 Is 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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
11/7/26	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	170										
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm	140										
	11:00 pm	200										
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am	120										
	05:00 am	200										
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	170 + 140 + 120 + 200 = 630
-----------------------------	-----------------------------

Total 24 hrs. Output	140 + 200 = 340
-----------------------------	-----------------



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.

		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								
12/7/26	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							

KOH-00276681 IP5-00176270
 Baby AMEYAA MAITHANI
 05-08-2015 10 Y 11 M 6 D (F)
 Dr. P V L N MURTHY

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: 11/7/26 @ 7m

Assessment: pain

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 patient general condition	2pm	* Assessed the patient's general condition.	
3pm	* Maintain I/O chart	3pm		
4pm		4pm	* Monitoring the vital signs	* No other issues.
5pm	* Monitoring the vital signs.	5pm		
6pm		6pm	* Maintained the I/O chart.	
7pm	* Administering the medications AS per orders	7pm	* Administering the medications AS per orders	
8pm		8pm		

Re-Assessment: NO Assess.

Special Notes:

Nurse Signature: 

Nurse Name: Shree

Date & Time: 11/7/26 @ 7m

KOH-00276681 IP5-00176270
 Baby AMEYAA MAITHANI
 05-08-2015 10 Y 11 M 6 D (F)
 Dr. P V L N MURTHY



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: 11/7/26

Assessment: patient having pain

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
8pm	Assess the patient General condition	8:30 PM	Assessed the patient General condition on bed	⇒ patient is stable
10pm	TO monitor vitals	10:20 PM	monitored patient vitals	
12am	TO monitor I/O chart	12am 30	monitored patient I/O chart	
2am	TO Administer medication	2:30 am	Administered medication	
4am	TO provide comfortable position	4:30 am	provided patient comfortable position	
6am	TO maintain personal Hygiene	6:30 am	maintain patient personal Hygiene	

Re-Assessment: given patient comfortable position

Special Notes: NA

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 12/7/26 @ 8:00 am

NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	<u>Adenostomy</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>ER</u> <u>4:15 pm</u>	<u>OT</u> <u>2pm</u>	<u>3rd floor</u> <u>8pm</u>			
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>nil</u>	<u>nil</u>			
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:	<u>98°F</u>	<u>98.8°</u>	<u>98.0</u>			
		Res:	<u>24 b/m</u>	<u>24 b/m</u>	<u>20 b/m</u>			
		SpO ₂ :	<u>100 %</u>	<u>100 %</u>	<u>100</u>			
		Pulse:	<u>82 b/m</u>	<u>82 b/m</u>	<u>90 b/m</u>			
		BP:	<u>114/68</u>	<u>114/62</u>	<u>100/70</u>			
		Fall Risk Score:	<u>2</u>	<u>2</u>	<u>2</u>			
Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>				
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>Nil</u>	<u>nil</u>	<u>NA</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>Nil</u>	<u>nil</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>nil</u>	<u>NA</u>				
Handed Over By Name :		<u>Sagan</u>	<u>Shui</u>	<u>Annam</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>11/7/26</u>	<u>11/7/26</u>	<u>12/7</u>				
Time:		<u>4:15pm</u>	<u>8:00am</u>	<u>8am</u>				
Taken Over By Name :		<u>Shui</u>	<u>Annam</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>11/7/26</u>	<u>11/7</u>					
Time:		<u>8:00am</u>	<u>8pm</u>					

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	☐ 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:							

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/26	3 pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
12/7/26	10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Annamma
12/7/26	11 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Annamma
12/7/26	11:30 AM	1	S/S	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab-combifam given	Soubhama
12/7/26	12:30 pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Soubhama
				☐ 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		
				☐ 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:

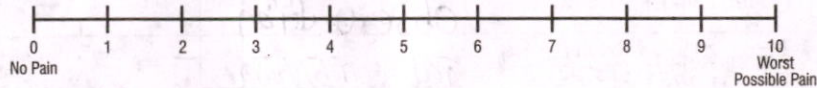
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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)



Wong - Baker (Pediatrics) Above 7 Years



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

BRADEN 'Q' SCALE

					Date : 11/7/16 12/7		
					Time : 3pm 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 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	
FRICTION-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 of 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	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23							
					TOTAL SCORE	28	28
					Evaluator's Name	8	10

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

11/7 12/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	1				
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	1				
	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				
	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	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	1			
TOTAL			9	9			

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 :	Sagar				
Signature :	[Signature]				
Date :	11/7	12/7			
Time :	3:20 PM	8:00 AM			



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	NA	pi	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				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							

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 : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
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

DISCHARGE PLANNING FORM

Nationality: Indn

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

1. Anticipated Date of Discharge: 11/2/16

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

Reli

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:

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Sue

Date and Time: 11/2/16 12:00 PM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

Name: Ameeyaa Maithani Age: 10Y Sex: F UHID.No :
Date: 10/12/20 Time: 8:00Pm Proposed Operation: Adenotonsillectomy
Diagnosis: Cerebral Adenoids
B.P / CRT: H.R: Weight: 46.7kg 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: NKA

Medical History: CVS: no smoking PT/CCS/4legs/CLAB/ No NICU stay
RESP: Normal Breathing Diabetes: - Developmental (N)
CNS: Nothing significant Immunised till date
Renal:
Hepatic / GE: Physical Activity: Active
Others: (N)

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: (N) Mento-hyoid Distance: (N) Neck: (N) Teeth: (N)
Lungs: BAG
Heart: S/S
CNS: NAD
Pregnant: ☐ Yes ☒ No ☐ NA Venous Access Site: UL Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis :
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL 209 explained
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Vinod Kumar

[illegible]



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sarai

Time Received : 8pm

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>20</u>	☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway	☐ Nasal Prongs ☐ T-Piece ☐ 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 :	Drug :	

POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT	SCORING INTERPRETATION
		IN	30	60	90	
Able to move 4 extremities voluntary or on command	= 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					
Able to move 0 extremities voluntary or on command	= 0					
Able to deep breathe & cough freely	= 2					
Dyspnea or limited breathing	= 1					
Apneic	= 0					
BP $\pm$ 20 of Pre Anaesthetic level	= 2					
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1					
BP $\pm$ 50 of Pre Anaesthetic level	= 0					
Fully awake	= 2					
Arousable on calling	= 1					
Not responding	= 0					
Pink	= 2					
Pale, dusky, blotchy, jaundiced, other	= 1					
Cyanotic	= 0					
TOTAL			8	8	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/9/16	@ 5PM	0/10	Nil	

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

Anaesthesiologist Name : Dr. K. Sri. Surya

Anaesthesiologist Signature:

Date & Time: 11/9/16 6:40pm

PACU Nurse Name : Sarai

PACU Nurse Signature:

Date & Time: 11/9/16

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): 322

Date & Time: 11/9/16 @ 5P

Date and Time :

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

Patient Name : Baby Ameeyaa Maithani Age : 10Y Gender : Male ☐ Female ☒
UHID NO: Surgeon Name: Dr. PVLN Murthy
Anaesthesiologist : Dr. Subeemanyam
Operative procedure planned : Adenotonsillectomy

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 : Bronchospasm, laryngospasm.

- 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 Baby Ameeyaa Maithani the above mentioned operation / Diagnostic / Therapeutic procedures Adenotonsillectomy

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

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

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

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

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

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

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Bijlwan

Name : DIUYA BISLWAN

Relationship with Patient: MOTHER

Date & Time : 10/7/26 8:15 pm

Witness :

Signature : Shishir

Name : SHISHIR MAITHANI

Date & Time : 10/7/26, 8:16 pm

Doctor (who is taking the consent) :

Signature : Dr. Vinod

Name : Dr. Vinod

Date & Time : 10/7/26, 8:10 pm



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. Adeno tonsillectomy & Tonsillectomy
2. _____

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- 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 breathing</u>	

- 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:

- Bleeding, Change in voice, vocal regurgitation
- Sec. of Adenoid

- I authorize Dr. Dr. PVLN MURTHY 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.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]

Name: SHISHIR MAITHANI

Relationship with patient: FATHER

Date & Time: 11/7/26 at 4.25pm

Witness:

Signature: [Signature]

Name: DIVYA BILWAN

Date & Time: 11/7/26 at 4.30pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. PVLN MURTHY Date: 11/7/26 Time: 4.25pm

శస్త్రచికిత్స / ప్రాసీజర్ కు 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 భాళి 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 / 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

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రాంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ ను 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.

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ క్లియరంటే ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భావ 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. TEJASWINI
Scrub Nurse : MAYAG

Patient Name : Baby. Ameyamaisham Age : 10Y Gender : F
UHID No. : KOM-00296681 Surgery Name : Adenotomectomy
Date : 11/2 In-time : 4:50PM Out-time : 5:50PM

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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>4:45pm</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. Tejaswini</u>		

Before Skin Incision >>

TIME OUT		Time: <u>4:50pm</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>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>5:50pm</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>[Signature]</u>		
Name : <u>PVLN MURTHY</u>		

DR. PVLN MURTHY
Registration No: 47267

Patient Sticker

KCH-002
Baby AMEYAA
05-08-2015
Dr. P V L N MURTHY



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/7

Department : O.T. Duration of Procedure : 2 hrs

Name of Surgeon : Dr. P V L N MURTHY Date of Admission : 11/7

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 : INS	
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : 11/7/20 @ 4u Date & Time procedure started : 11/7/20 @ 5u	

- 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

PATIENT TRANSFER FORM

Patient Name & UHID No. KOH-00276681 IP5-00176270 Baby AMEYAA MAITHANI 05-08-2016 10 Y 11 M 6 D (F) Dr. P V L N MURTHY 		Date & Time of Admission 11/7/26 @ 3:31 pm	Date & Time of Transfer Order 11/7/26 @ 4:15 pm
		Transfer Ordered by Dr. Rama Krishna	Reason for Transfer Admission
From Unit ER	To Unit OT OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File — 20 —	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ? Sneha of 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 ☐ Dr. Rama Krishna			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Ramakrishna	
Patient & Clinical Records Received by : Sagar 11/7/26			
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

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 7 D (F)
Dr. P V L N MURTHY



41m

322

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 12/7/26 Time: 8am

Weight: 46kg Centile: 79th

Height: 160cm Centile: 79th

Inference: underweight child

RDA: - Calories: 1650kcal/d Protein: 29g/d

Diet Recommendations: soft diet

Re-Assessment: Acid Spicy, & outside foods

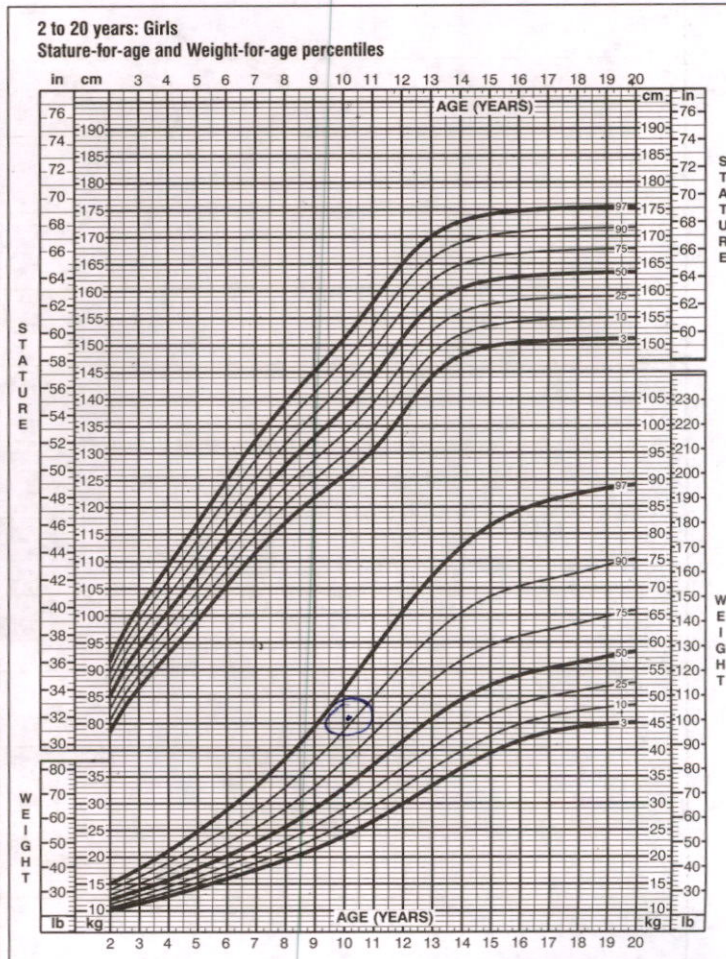
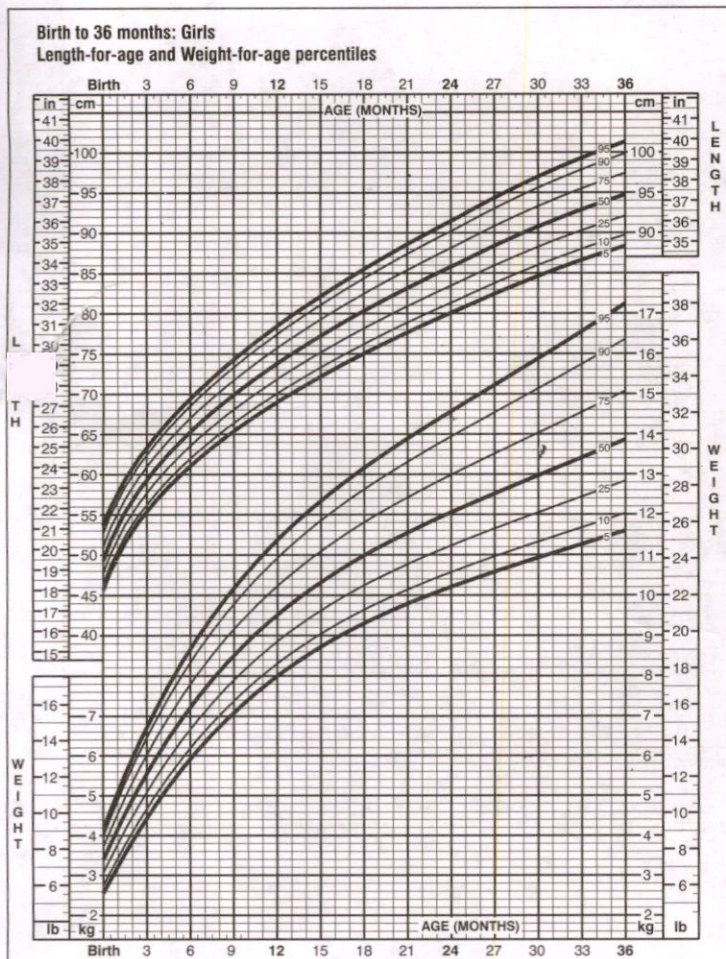
Food Allergies: NO Veg/Non-veg Veg

Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Enisura

GROWTH CHART (GIRLS)



Dietician's Name: Laina

Dietician's Signature: Laina

Daily Notes:

[illegible]

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
		11/7/26 @ 2pm	11/7/26 @ 7m
		Transfer Ordered by	Reason for Transfer
		Dr. Murthy	Post op
From Unit	To Unit	Information to Attendant	
OT	322	Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
20	Nil	Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nil		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
Saini		Dr. Murthy.	
Patient & Clinical Records Received by :			
		Kalyani 11/7/26 at 7pm	
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

KOH-00276681 IP5-00176270
Baby AMEYAA MAITHANI
05-08-2015 10 Y 11 M 6 D (F)
Dr. P V L N MURTHY

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SURGERY DETAILS

Date : 11/7
Patient Name: Baby. Ameeyaa Maithani Date of Birth: 5/8/2015 Age: 10y
Gender: F Ward: O.T. UHID No: KOH-00276681
Date of Surgery: 11/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Adenotomyllectomy & Coblation

Time in : 4:50pm

Time Out : 5:50pm

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Sirisha	
5. Circulating Nurse	Ramadevi	
6. Assistant Nurse	Theraja	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Coblation used: 9698346

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698345

Order by: Y. Ramadevi

Baby: Ameyaa
Mother: [Name]
Patient sticker

Adeno

CONSUMABLES OF OT

Circulating staff : Technician : Date : 11/7 Time :

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube	5.5 / 6.5	10	01	Major Pack	Supraglottic	1	1	Inj Vit.K			
LMA		01	—	Sutures				Cord Clamp			
ECG leads: A / P / N		10	03					Suction Catheter			
HME filter: A / P / N		10	01					Feeding Tube			
Syringes : 10 cc		10	02					Vaccum Suction Set			
05 cc		10	02	Gloves	6.6 / 2 / 2	2	2	Surgical Gloves			
02 cc		10	02	PF 6.6 / 2 / 2	2	2	2	Gauze Pack			
01 cc		05	—					Syringe 1ml / 2ml			
Cautery plate: A / P / N		01	—	Surgical blade				Surgical Blade # 20			
IV set		01	01	NG tube	6	2	2	Koochies (S)			
RL		01	01	Cautery pencil				Ascorbic	2	1	
NS: 10ml / 100ml / 500ml / 1000ml		4	1	Koochies				Transderm	1	1	
Mini spike		01	01	Ointments				10 / 1 / 50	2	2	1
02 Malt		01	—	Suction Catheter				Paracetamol	1	1	
Fentanyl		01	01	Cap, Mask		5/5	5/5	Adrenaline	2	3	
Morphine				Gauze Pack	(R+M)	5/5	1				
Ketamine				Mop Pack		1	—				
Propofol		03	02	Steristrip							
Rocuronium		01	01	Underpad		1	1				
Glycopyrolate		01	01	Draw sheet		1	1				
Myopyrolate		01	01	Abgel							
Ondansetron		01	01	Foleys catheter							
Pencan 25g/ Spinal Needle 22		01	—	Urobag							
Bupivacaine 0.25%		01	—	Chest Drainage Catheter				gauze + gloves	9	3	0
Bupivacaine 0.25%(Heavy)				Romodrain bag				Dexamethasone	1	0	0
Antibiotics	Trp	01	01	Bandage				Transderm	01	0	2
Aug (1.2)		01	01	Tegaderm				Soft + prolon	1	—	
Suppositories				Ioban				diclofenac	01	01	
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set		1	1				
Justin : 12.5 mg / 25mg / 100mg		02	—	Plastic Bed Sheet		1	—				
Tab. Misoprost : 200mg				Betadine Solution		1	—				
Vaccum set		01	—	Microshield		1	—				
2 ways 10 + 100 cm		1	0	Cotton Balls							
O.A (2,3)		1	—	Latex Gloves		10	5				
N.A (28,26)		1	—	Ramdone Scrub							
Tr Camle (22,20)		1	—	Saral							

Surgeon : Anaesthesiologist : Nurse : OT Technician :
 Order No. : Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125