

BAH-00570966 IP5-00175994
Baby GILLALA NAINIKA
19-12-2023 2 Y 6 M 16 D (F)
Dr. RAVI CHANDER RAO



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Go online

FC not Done

Date : 5/7/20

Patient Name: Baby Gillala Nainika Date of Birth: 19/12/2023 Age: 2 y 1 m

Gender: Female Ward: P-OT UHID No: BAH-00570966

Date of Surgery: 5/7/20 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Debridement & nail bed repair & suturing

Time in : 11:05 pm

Time Out : 11:45 pm

	NAME	AMOUNT
1. Surgeon	Dr. Ravi Chander Rao	
2. Anaesthetist	Dr. Thejaswini	
3. Assistant Surgeon		
4. OT Technician	Prashanth Mangali	
5. Circulating Nurse	Benjamin	
6. Assistant Nurse		

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9689437/A

Order by: Benjamin

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ t: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/1/26	8:45 pm	ER	105	Rubian,
5/1/26	10:30 AM	105	OT	Srinath
6/1/26	1 AM	OT	105	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Ojwale	6/1/26	9689745	
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Date

Investigations

Order No.

Signature

5/2/24

CBP

7539

Rafan.

[illegible]

[illegible][illegible]

Prepared By :

Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175994 Admit Date : 05-Jul-2026 Admit Time : 08:21 PM UHID : BAH-00570966

Patient Details :

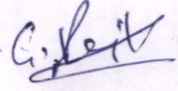
Patient Name	: Baby GILLALA NAINIKA	Age	: 2 Y 6 M 16 D
Guardian	: Mr GILLALARAJ KIRAN	DOB	: 19-12-2023
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO. S 4 2ND FLOOR, , SWARNA APARTMENTS, OPP A.G COLONY LAXMI NAGAR Ameerpet Hyderabad Telangana INDIA 500038	Phone No	: 8121418733/ 8106815748
		E-mail	: na123@rainbowhospitals.in

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 103 Ward Name : 1F-VIBGYOR
Room No : SPVT 103 Admission Type : First Visit

Contact Details :

Name	: Mr GILLALARAJ KIRAN	Relationship	: Father
Contact Address	: FLAT NO. S 4 2ND FLOOR, , SWARNA APARTMENTS, OPP A.G COLONY LAXMI NAGAR Ameerpet Hyderabad Telangana INDIA 500038	Phone No	: 8121418733 / 8106815748


Signature

Doctor Details :

Doctor Name	: Dr. RAVI CHANDER RAO	Specialisation	: PLASTIC SURGERY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. NITASHA BAGGA		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: MEDI ASSIST INSURANCE TPA PVT LTD

BAH-00570966 IP5-00175994

Baby GILLALA NAINIKA

19-12-2023 2 Y 6 M 16 D (F)

Dr. RAVI CHANDER RAO



suburging CONSUMABLES OF OT

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Cir

Technician :

Prasanna

Date :

Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 8.8.5.14	14/14	—	Major Pack			Inj Vit.K		
LMA 1 1/2	1	—	Sutures			Cord Clamp		
ECG leads : A/P/N	5	3	9915	1	—	Suction Catheter		
HME filter : A/P/N	1	—	pps 60	1	1	Feeding Tube		
Syringes : 10 cc	10	8				Vaccum Suction Set		
05 cc	10	5	Gloves 7.5	14/1	2	Surgical Gloves		
02 cc	10	5				Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade 11.5	1+1	1	Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL	1	—	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml	1	1	Koochies			Ns 500 ml	1	1
minipilce	1	1	Ointments			Transdex	1	1
osmotic (P)	1	—	Suction Catheter			Jelly	1	—
Fentanyl	1	1	Cap, Mask	5/5	5/5	10cc 5cc	2+2	1
Morphine			Gauze Pack (N)	3	2	26 Needle	1	1
Ketamine			Mop Pack			10x2 Adrenalin	1	—
Propofol	3	2	Steristrip					
Rocuronium	1	—	Underpad	1	1	Urolog Ag/silver	1	1
Glycopyrolate	1	—	Draw sheet	1	1	8 Plint 3	1	1
Myopyrolate 1/20	2	—	Abgel			6inch Bandage	1	1
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter			Gauze	3	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			Glosson	4	—
Antibiotics			Bandage			padding	1	—
Supern	1	—	Tegaderm			dead frame	14/1	—
Suppositories			Ioban			500ml saline	14/1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			nasal prongs (10x2)	1	1
Supridol 100mg			Vaccum Suction set					
Justin 12.5 mg / 25mg / 100mg	14/1	1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
vaccum set	1	—	Microshield	1	—			
oral air way 011	14/1	—	Cotton Balls					
paralaminway 1614	14/1	—	Latex Gloves	10P	10P			
supraproton hood	14/1	—	Ramdione Scrub					
Low cannula 22/24	14/1	—	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. :

Ordered by :

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



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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Crush injury of left hand little finger
at 6pm at home.
~~when~~

History of present illness :

crush injury of left hand little finger
at 6pm at home
while playing - place at door hinge



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Immunization History :



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 12.5 kg (Centile _____)

On Examination :

Temperature : 98.2° F Pulse Rate : 103/min B.P. _____ SP02 100% Room air
Resp. rate and type of breathing : 26/min

Rash _____

Lymphadenopathy _____ Dr. Good

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bilateral air entry present

Any adduc sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Crush injury left little finger
for suturing



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

complications

Desired goals of the treatment: _____

hemodynamic stability

Planned Labs:

CBP

1 plan

Noted by
Lachel

Planned Management

1) PAC

2) NPO

3) IV fluids

4) Mgt to or on call

Noted by
Lachel.

Signature of the Doctor: _____

Madhu

Name of the Doctor: _____

Madhu

Date & Time: _____

5/12/23

Y25087

Signature of the Consultant: _____

Name of the Consultant: _____

Dr. Ravi Chander Rao

Date & Time: _____

5/12/23

2:30 PM

Dr. RAVI CHANDER RAO



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Date & Time	Progress Notes	Doctor's Order
6/7/26. 8 PM.	seen by Resident	
	ASis - ① finger crush injury. S/P debridement + repair + suturing pain under control accepting orally DE child alert, afebrile hemodynamically stable chest clear abdomen soft.	Plan 1. Cont plan D/C today after discussing w plastic surgeon <u>J. Sahithi</u>

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date	5/7/26				
Time	10PM				
Hb	10				
PCV	31.4				
RBC	4.16				
WBC	10,970				
N/L	45.3/40.4				
Platelets	8.69				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ 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:

Date & Time:

Nurse Name & Signature:

Date & Time:

DRUG CHART

Date of Admission: 12/12/2023 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 Signature



REGULAR PRESCRIPTIONS

Weight. 13.5kg Ward.

DRUG : <u>Syrup. AUGMENTIN DUO</u>				Date Time	<u>6/7</u>
Dose <u>6.5ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>5/12/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Madhwa</u>				<u>6am sona</u>	
Additional Instructions: <u>(5ml/200mg)</u>				<u>6pm</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Tab. CARIZOL</u>				Date Time	<u>6/7</u>
Dose <u>15mg</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>5/12/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Madhwa</u>				<u>6am sona</u>	
Additional Instructions: <u>Tab - 15mg</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syrup. CONSPIRAM</u>				Date Time	<u>6/7</u>
Dose <u>3ml</u>	Route <u>PO</u>	Frequency <u>TBD</u>	Start Date <u>5/12/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Madhwa</u>				<u>6am sona</u>	
Additional Instructions: <u>TID. Once a Day</u>				<u>2pm</u>	
Daily Doctor's Endorsement by a Sign					
DRUG :				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VARIADLE DOGS

Nurse Sig.

Nurse Sig

Nurse Sig.

Nurse Sig.

Dose	
------	--

Dose

Dose

Dose

Start Date

Dose

Dose

Dose

	Dose
--	------

Dose	
------	--

	Dose
--	------

Dose	100 mg
------	--------

Dose

Dose	
------	--

	Dose
--	------

Dose

Dose

Nurse Sig

Nurse Sig

Nurse Sig

Nurse Sig.

Dose	100 mg
------	--------

Dose

Dose

Dose

Start Date

	Dose
--	------

	Dose
--	------

Dose	
------	--

Dose	
------	--

	Dose
--	------

	Dose
--	------

	Dose
--	------

	Dose
--	------

Dose	
------	--

	Dose
--	------

Dose	
------	--

Dose	100 mg
------	--------

Nurses

Diagram
praktik

Weight. 135 lbs Ward.

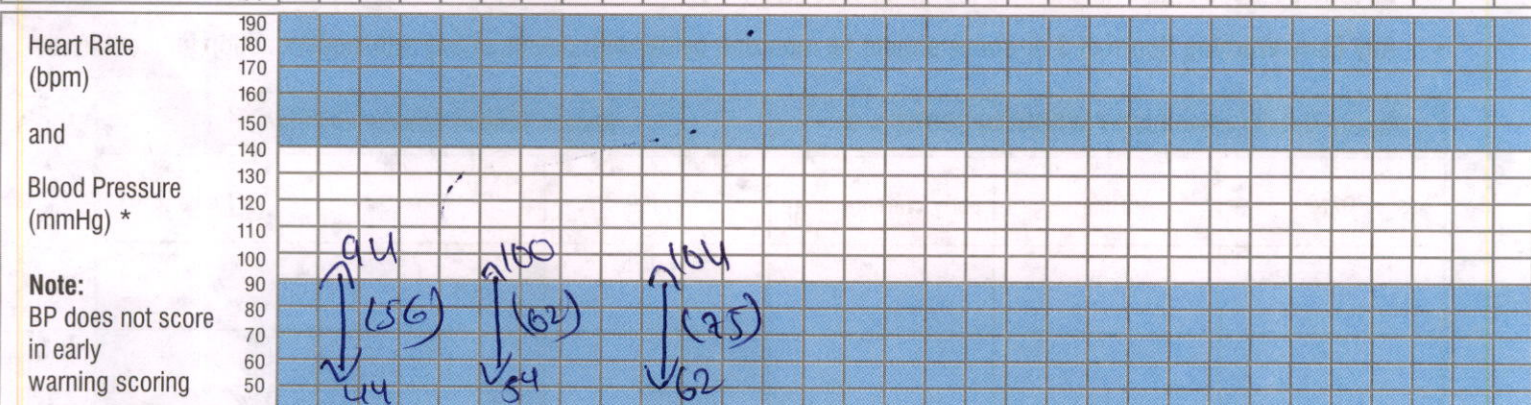
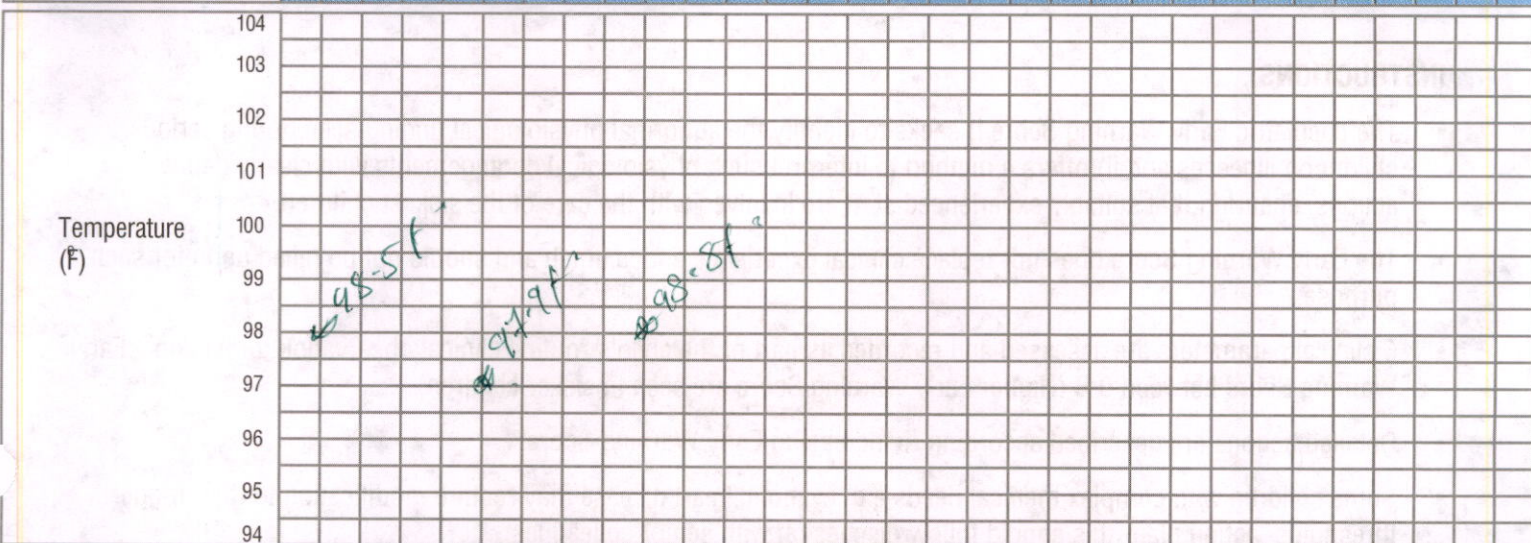


PRESCHOOL (1-5 years)
**Children's Observation &
 Early Warning Scoring Chart**

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/2 Time: 10PM 8AM 6AM

Doctor / Nurse / Family Concern?



Heart Rate (Number) 105b/m 105b/m 100b/m



Resp Rate (Number) 28b/m 28b/m 28b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 100%

Conscious Level Normal Altered 5/5 5/5 5/5

GCS *

TOTAL SCORE
 Number of shaded boxes 1 1 1
 Pain Score 0 0 0
 Observer's Initials S S S

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.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	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												
5/1/20	12:00 am	Fasti water								0	0		
	01:00 am												
Total Intake :						Total Output :							
6/17/20	02:00 am	Ne cron								0	0	mouth	
	03:00 am									0	0	mouth	
	04:00 am	DNS								0	0	mouth	
	05:00 am									0	0	mouth	
	06:00 am									0	0	mouth	
	07:00 am									0	0	mouth	
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.

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

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Pain & Discomfort

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
11:50 PM	Assess the PT Condition	11:55 PM	Assessed the PT Condition	After the plan of care PT Condition was improved
12 AM	Vital monitor	12:30 AM	Vitals monitored & green.	
12:30 AM	Do Chart	2:35 AM	Do Chart maintained & green.	
1:30 AM	NPO Status of the patient	4 AM	NPO Breasted & no vomiting,	
4 AM	Position.	6 AM	Comfortable position given.	
6 AM	Side rails.		Side rails applied to prevent from fall	
6 AM	Photo in		Photo to ward as per order	

Re-Assessment: Pain & Discomfort has reduce

Special Notes:

Nurse Signature: Benjamin

Nurse Name: Benjamin

Date & Time: 5/7/26 @ 6 AM

NURSING CARE RECORD



Date:

Assessment:

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

Time	Plan of Care	Time	Implementation	Evaluation
			12/10	

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

BAH-00570966 IP5-00175994
Baby GILLALA NAJNIKA
19-12-2023 2 Y 6 M 16 D (F)
Dr. RAVI CHANDER RAO

Patie



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4/12				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	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				
Cognitive Impairments	Not Aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own Ability	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			13				

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 :	Raf/Am				
Signature :	Raf/Am				
Date :	8/12				
Time :	8:30 pm				



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ravi Chander Rao Department: Surgery Date of Admission: 31/12

SITUATION	Diagnosis: <u>Crush Injury</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area						
BACKGROUND	Shift Time	<u>CR</u> <u>8pm-12am</u>	<u>12am-2pm</u>	<u>2pm-6pm</u>	<u>6pm-10pm</u>	<u>10pm-8am</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2</u>	<u>98.1</u>	<u>98.1</u>	<u>98.1</u>	
		Res:	<u>24b/m</u>	<u>28b/m</u>	<u>24</u>	<u>28b/m</u>	
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	
		Pulse:	<u>112b/m</u>	<u>105b/m</u>	<u>108</u>	<u>105b/m</u>	
		BP:	<u>98/50</u>	<u>98/51</u>	<u>97/61</u>	<u>95/59</u>	
		Fall Risk Score:	<u>18</u>	<u>13</u>	<u>13</u>	<u>13</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>1/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Rafiq</u>	<u>Saravathi</u>	<u>Deepam</u>	<u>Saravathi</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>31/12</u>	<u>31/12</u>	<u>31/12</u>	<u>31/12</u>		
Time:		<u>8:30pm</u>	<u>10:30pm</u>	<u>1pm</u>	<u>6:30pm</u>		
Taken Over By Name :		<u>Saravathi</u>	<u>[Signature]</u>	<u>Saravathi</u>	<u>[Signature]</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>31/12</u>	<u>31/12</u>	<u>31/12</u>	<u>31/12</u>		
Time:		<u>9pm</u>	<u>10:30pm</u>	<u>1pm</u>	<u>8pm</u>		

BAH-00570966 IP5-00175994
 Baby GILLALA NAINIKA
 19-12-2023 2 Y 6 M 16 D (F)
 Dr. RAVI CHANDER RAO



BRADEN 'Q' SCALE

					Date : 08/12/23			
					Time : 8:30pm			
Mobility	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			
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		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Ravi Chander Rao		

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/2	8pm	0/10	✓	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	✓	<i>[Signature]</i>
6/1/2	12Am	0/10	✓	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		<i>[Signature]</i>
6/7	8Am	0/10	✓	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	✓	<i>[Signature]</i>
				☐ 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		
				☐ 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:

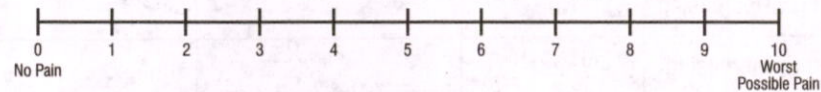
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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)



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



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : _____ Name : _____

Signature of Ward In Charge :

Signature : _____ Name : _____

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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		
5/12	8:30 pm	3	Pain Management	Am	1	0	1	1	Nil	Rafan
6/12/26	9am	9	soft diet	m	1	0	1	1	-	mounica

Part - III: CODES

Who was taught: PT: Patient ☒ F: Father ☐ M: Mother ☐ S: Spouse ☐ Sn: Son ☐ D: Daughter ☐ C: Caregiver ☐ O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio ☐ D: Demonstration ☐ V: Video ☐ O: Oral ☒ P: Printed ☐

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding ☒ 2. Demonstrates Understanding ☐ 3. Needs Review ☐

BAH-00570066
Baby GILLALA NAINIKA
19-12-2023 2 Y 6 M 18 D
Dr. RAVI CHANDER RAO (F)

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis:

laceration / crush injury.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5/12/23	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	laceration	st. stability	NPO Debridement wound	Handen	☒ Nursing ☐ Others:
5/12/23 8pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	laceration over ② 2nd finger.	st. stability	Safe surgery	Rafael	☒ Medical ☐ Others:
6/12/23 9am	☐ Medical ☐ Nursing ☐ Others: Dickhan	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	laceration crush injury left little finger suturing	soft diet	ROAZ C:- 1250ccallyd P:- 2191g	mounica	☐ 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:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctors order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

Explain to
nurses

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal hygiene

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

☐ Patient

☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Shravanthi

Date and Time: 5/12/23 10AM

SENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Debridement + Suturing

Anaesthesiologist: Dr. Tejaswini Surgeon: Dr. Ravi chander

Please read this before you consent for Anaesthesia

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

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others: Desaturation, Laryngospasm, Bronchospasm

Declaration by Patient Attendant

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

Patient / Patient Attendant:

Signature: [Signature]

Name: G. JYOTHI DAS

Relationship with patient: Mother

Date & Time: 5/1/26 10:40 Pm

Witness:

Signature: [Signature]

Name: G. RAJ KIRAN

Date & Time: 5/1/26 10:40pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Tejaswini Date: 5/1/26 Time: 10:38 Pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00570966 IP5-00175994
Baby GILLALA NAINIKA (F)
19-12-2023 2 Y 6 M 16 D
Dr. RAVI CHANDER RAO



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. Left Little finger - Debridement + Suture / v-y plasty
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>Faster healing</u>	<u>suture</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. _____

b. _____

and his / her team to perform the procedural sedation

1. I authorize Dr. _____ upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: _____

Name: G. JYOTHI DAS

Relationship with patient: Mother

Date & Time: 5/7/26 10:40 AM

Doctor (who is taking consent):

Signature: _____

Name: Dr. Ravi Chander

Date: 5/7/26

Time: 10:40 AM

Docu. No.: RCHBH/FRM CLINICAL / 027 (26)

Witness:

Signature: _____

Name: G. RAJ KIRAN

Date & Time: 5/7/26 10:40 PM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబ్సెంటే

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 / 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 రోగాగానే, 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 / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను. అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b.

1. 4. డాక్టర్

/ ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.

గాలిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స

- 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 అబ్సెంటే:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

పేరు: తేదీ & సమయం:

Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

Name: Baby G. Nainika Date: 5/1/2006
 Age: 87 cm Sex: Female Time: 10:35 pm
 Proposed Operation: left little finger sut
 ASA Physical Status: 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
 B.P / CRT: 13/5 H.R: 135 Weight: 13.5 kg
 Diagnosis: crash injury left little finger

Laboratory Data:

Hgb: 10.5 Glucose: 100 Protein: 6.5
 PCV: 35 Urea: 10 Alb: 4.5
 WBC: 12000 Creat: 1.2 Dir. Bill: 1.2
 Plate: 250000 Na: 135 LDH: 100
 PT: 12 Ca++: 10 Alk phos: 100
 PTT: 25 Mg++: 1.5 SGOT/SGPT: 10
 INR: 1.2 Cl-: 100

Allergies: None

HIV: + HBS Ag: + Blood group: A+
 HCV: + Stress/Angio: + Other: +
 ECG: + 2D Echo: + X-Ray: +
 T4: + T3: + TSH: +

Medical History:

CNS: Normal
 RE SP: Normal
 CVS: Normal

Past Anaesthetic History:

CNS: Normal
 Renal: Normal
 Hepatic / GE: Normal
 Others: Normal

Physical Exam:

MP 1 2 3 4
 Airway: Normal
 Lungs: Normal
 Heart: Normal
 CNS: Normal

Normal

Venous Access Site: Right Arm
 Spine Exam for regional: Normal

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA
 Pregnant: ☐ Yes ☐ No ☐ NA

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

Pre-Operative Instructions:

1. DVT Prophylaxis: ☒ Water / ORS 2 Hours ☐ Others 6 Hours
2. NIL ORAL ☒ Standard ☐ High Risk
3. Informed Consent: ☒ Discussed with Patient
4. Post Operative Pain Management: ☒ Discussed with Patient
5. Other Instructions:

CURRENT MEDICATIONS	DOSAGE

Signature: Dr. Nainika Name: Dr. Nainika

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

Patient Sticker

EPIDURAL ANALGESIA RECORD



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CSE /Spinal /Epidural

Position : Space : Technique (LOR/LOS) :
Catheter at Skin: Attempts :

Catheter at Skin: Technique (LOR/LOS)
 Attempts:

Any other issues :

b)

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

Patient Satisfaction :

Discharge / Shifting ordered by

Signature:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Ravi Chandra
Asst. Surgeon : Dr. Thejaswini
Anaesthetist : Dr. Thejaswini
Scrub Nurse : Benam

BAH-00570906 IP5-00175994
Baby GILLALA NAINIKA
19-12-2023 2 Y 6 M 16 D (F)
Dr. RAVI CHANDER RAO



Age : Gender :
y Name : Suturing
Date : 5/7/26 In-time : 11:05 PM Out-time : 11:45 PM

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

BirthRight®
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN

Time: 11:00 PM

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 : Dr. Thejaswini

Name :

TIME OUT

Time: 11:10 PM

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? 25 min
3 ml ☐ Yes ☒ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA

Is Essential Imaging Displayed?

☒ Yes ☐ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No

Signature : Benam

Name :

SIGN OUT

Time: 11:45 PM

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 : Dr. Ravi Chandra

Name :

BAH-00570966 IP5-00175994
Baby GILLALA NAINIKA
19-12-2023 2 Y 6 M 16 D (F)
Pa Dr. RAVI CHANDER RAO



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 5/7/26

Department : P.O.T. Duration of Procedure : 30 min.

Name of Surgeon : Dr. Ravi Chandra Date of Admission : 5/7/26

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 :	
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) 37 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 5/7/26 @ 11:10 AM	

- 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

15

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OPERATION THEATER NOTES

Patient's Name : Age : 2 years Gender : ☐ Male ☒ Female

UHID No.: Weight : 13.5 kg Height :

Surgeon : Dr. Ravi Chander		Asst. Surgeon :	
Anesthetist : Dr. Thyashu	OT Nurse: Benjamin	OT Technician: Prashant	
Pre-Operative Diagnosis:			
Surgical Procedure : (R) Little finger near total amputation			
Indications for Surgery : Debridement + nail bed repair + suturing			
Date : 5/7/24	Start Time : 11.10.	End Time : 11.40 pm	
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: L4A Debridement of the wound along			
Tip intact on small ulnar lateral aspect.			
capillary fill present			
Nail bed repaired & skin sutured.			
Dressing & Splint given			

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Patient


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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

ast to use the dressing

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

en 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: 5/7/26 Time: 11-50P

Note: Plan of care will be readjusted if necessary.

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/12/23 Time of arrival : 6:29 PM
Chief Complaints : 1st crush injury @ Hand 1st & 2nd finger 30 mins back RBS : NA
Height : NA Weight : 13.5 kg BMI : NA Head Circumference (<2 years) : NA
Allergies : ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other : NA
If yes, identify : NA
Pain Screening : ☒ Yes ☐ No If Yes, Pain Score : 02/10 Pain Tool Used : ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character : Sharp ☐ Location : @ Hand 1st & 2nd finger ☐ Frequency : Sute ☐ Duration : continuous

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 : NA (Date/Time): NA

Social History: Lives With : family

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

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

Time of Initial assessment completed by ER Nurse : 6:31 PM

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

Time	Nursing Notes
	* Assessed the condition
	* Sw placement done
	* sample sent.
9pm	* shifted to ward.

Samples collected by: / NA
Samples sent by : / NA

Time: / NA
Time: / NA

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
6:54pm 5/2	SYP-IBUGESIC-PLUS	PO	6ml	Neel	Shavani

Condition of patient at time of shift - out :	Details of Shift - out
HR: 108bpm BP: 98/64mmHg CFT: 22sec RR: 24b/min SPO ₂ : 99% RA GCS: 15/15 Temperature : 98.2°F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: 105 Time of Shift - out: 8:45pm Handover given to: Sravanthi (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):
Sw placement done

Name of the Nurse : Mr Lachel Signature of the Nurse :
Date & Time : 5/1/26 @ 8:45pm

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 5/2/26 Time: 9am

Weight: 13.5 kgs Centile: 250th

Height: 91 cms Centile: 750th

Inference: well child

RDA: - Calories: 1250 kcal/d Protein: 21 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled & outside foods

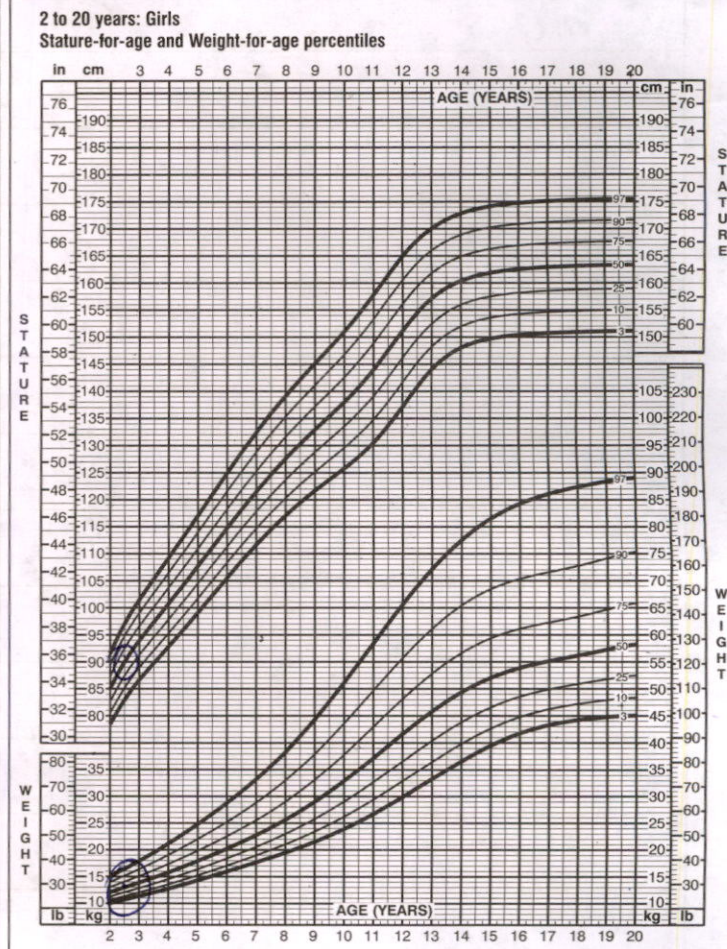
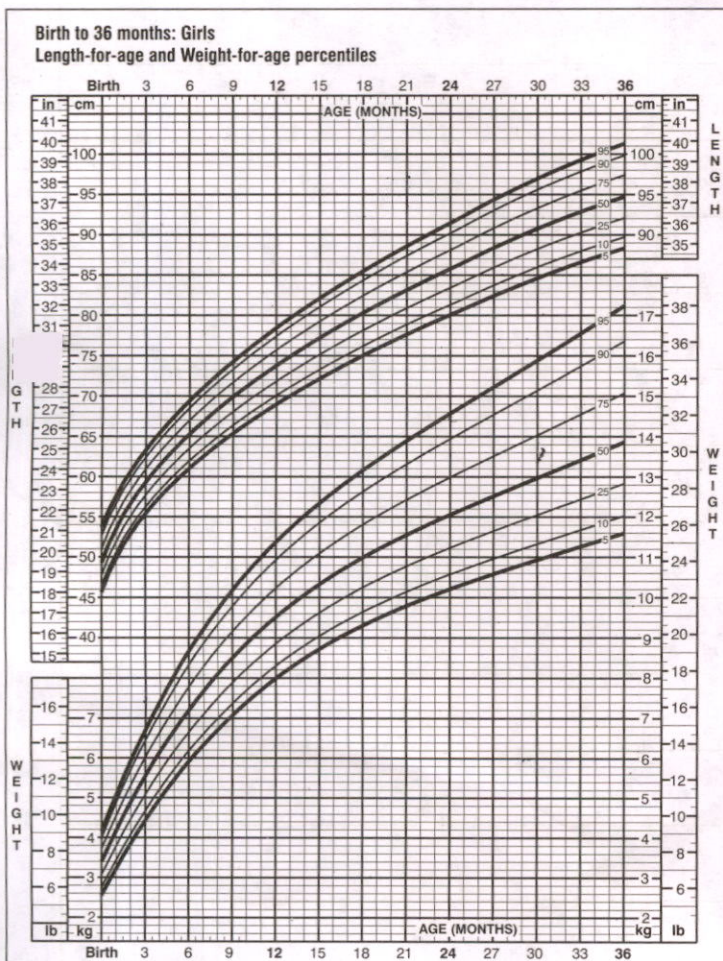
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: crush injury left finger suturing

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G. Jayanthi

GROWTH CHART (GIRLS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Ujjwala Desai Date : 6/7/26 Time :

Diagnosis : finger crush injury.

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:

opinion on discharge

Signature: _____

Findings and Recommendations :

ASIS - Rt finger crush injury
sft debridement + nail bed repair
+ suturing
pain under control
accepting orally.

O/E
child as hyp.afebrile
hemodynamically stable
chest clear
abdomen soft-

Plan
1. Can be discharged
2. F/U @ Plastic surgeon

Consultant :

Name : Dr. Ujjwala D. Signature : DR. UJJWALA DESAI Registration No: 90550 Date & Time : 6/7/26