

KUH-00097528 IP5-00176063
Baby SAI TANVISREE MOGILI
07-05-2020 6 Y 2 M 0 D (F)
Dr. M N V Poushya SAI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheshay
08/07/26

81060

SURGERY DETAILS

Date : 7/7/26

Patient Name: S/o Saitanvisree Date of Birth: 7/5/96 Age: 6Y

Gender: F Ward: P.O.T UHID No.: 97528

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

Name of the Surgery : upper GI endoscopy + foreign body removal

Time in : 9:10am

Reliance
SST

Time Out : 9:45am

PTH-6

	NAME	AMOUNT
1. Surgeon	Dr. Poushya	SF - 43200
2. Anaesthetist	Dr. Saitul	AN - 12960
3. Assistant Surgeon		OT - 34560
4. OT Technician	Bapu	COR - 1296
5. Circulating Nurse	Deepa	
6. Assistant Nurse	Bikhal	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☒ Others Endoscopy 78682183

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 8682183

Order by: Suman

FB removal

CONSUMABLES OF OT

Circulating staff : Technician : Date : Time :

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube	4.5 / 5.5 / 8.5	144	1	Major Pack				Inj Vit.K			
LMA	1/2/3	144	1	Sutures				Cord Clamp			
ECG leads : A / P / N		5	3					Suction Catheter			
HME filter : A / P / N		1	1					Feeding Tube			
Syringes : 10 cc		10	9					Vaccum Suction Set	1	1	
05 cc		10	3	Gloves				Surgical Gloves			
02 cc		10	3					Gauze Pack			
01 cc		5	3					Syringe 1ml / 2ml			
Cautery plate : A / P / N		1	—	Surgical blade				Surgical Blade # 20			
IV set		1	1	NG tube				Koochies (S)			
RL		1	0	Cautery pencil				Telw	1	1	
NS : 10ml / 100ml / 500ml / 1000ml		1	0	Koochies				50cc	2	2	
minisplice		1	1	Ointments							
mask (P)		1	1	Suction Catheter							
Fentanyl		1	1	Cap, Mask		5/5	5/5				
Morphine				Gauze Pack		5/5	4/8				
Ketamine				Mop Pack		1					
Propofol		3	2	Steristrip							
Rocuronium		1	1	Underpad		1	1				
Glycopyrolate		1	0	Draw sheet		1	1				
Myopyrolate	1/2	1	—	Abgel							
Ondansetron		1	0	Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag							
Bupivacaine 0.25%				Chest Drainage Catheter							
Bupivacaine 0.25%(Heavy)				Romodrain bag							
Antibiotics				Bandage							
Supperm		1	1	Tegaderm				pacapras-fur	1	1	
Suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set		1	1				
Justin : 12.5 mg / 25mg / 100mg		144	—	Plastic Bed Sheet							
Tab. Misoprost : 200mg				Betadine Solution							
Vaccum set		1	1	Microshield							
Oral glycopy Oil		144	—	Cotton Balls							
Nasal glycopy 18x20		144	—	Latex Gloves		5/5	5/5				
300g/100cm + 100cm		144	—	Ramdione Scrub							
For Camera 22/24				Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 7691528

Ordered by :

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

ESTIMATION SLIP

per official.

Date: 07/07/2026 UHID / IP No.: KUH-00097538 ST No. 81060
Name of Patient: Ruby Sai Tanu'sree Age: 64/20 Gender: F.
Father's / Husband's Name: Mr. Rakesh Corporate / Occupation: TEKADATA
Address: Phone: 9700 2197 89. Email:
Procedure / Plan: Endoscopic Removal of Foreign Body.

MODE OF PAYMENT: ☐ SELF ☒ TPA: Insured. ☐ GIPSA: OTHERS

TARIFF INFORMATION:

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee			15000							
L. Tax			ring		SLIA					

PARTICULARS

PARTICULARS		AMOUNT (₹)
Surgeon's / Anesthetists's Fee / O.T. Charges	TSW	47520
O.T. Consumables	7500	Subject to approval by TPA / Insurance Company
Instrument Charges	Endoscopy 28000	Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations	Cash	As per actual - Not Included in Estimation
Equipment Charges	Monitor : Ventilator : Phototherapy :	Oxygen : Infusion pump / Syringe pump : HFO-SLE 5000 : HFO Sensormedix : Double Surface : Triple Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.	Cash	As per actual - Not Included in Estimation
Package		
Others		
Initial Minimum Deposit	15000	Final amount 15000

REMARKS:

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

DECLARATION

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

Signature of the Client

Signature Relationship

Signature of the Financial Counselor

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ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	9:11 am	ER	OT	poorj's
7/7/26	12:10 pm	OT	110	Dies

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	iv placement	1	91383	Tenaf
7/7	PAC	1	91419	Teena
7/7	NMI	1	969227	82

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

.....

Date : 8/2/26

Time :

Prepared By : cr-Drugs

Staff Nurse Drugs.	Shift / Ward	Billing Assistant	Billing Supervisor
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ADMISSION SHEET
Registration Details :


Admission No : IP5-00176063

Admit Date : 07-Jul-2026

Admit Time : 08:34 AM UHID : KUH-00097528

Patient Details :

Patient Name : Baby SAI TANVISREE MOGILI

Age : 6 Y 2 M 0 D

Guardian : Mr RAKESH MOGILI

DOB : 07-05-2020

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : PLOT NO 190/A, SAI BALAJI RESIDENCY, G3, ADDAGUTTA SOCIETY, WESTREN HILLS, Jntu Kukat pally Hyderabad Telangana INDIA 500085

Phone No : 9700212789

E-mail : rakesh.mogili@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 403

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 403

Admission Type : First Visit

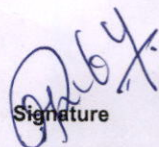
Contact Details :

Name : Mr RAKESH MOGILI

Relationship : Father

Contact Address : PLOT NO 190/A, SAI BALAJI RESIDENCY, G3, ADDAGUTTA SOCIETY, WESTREN HILLS, Jntu Kukat pally Hyderabad Telangana INDIA 500085

Phone No : / 9700212789


Doctor Details :

Doctor Name : Dr. M N V POUSHYA SAI

Specialisation : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : self

Phone No :

Co-Consultant : Dr. Prashant Bachina

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : RELIANCE GENERAL INSURANCE COMPANY LTD

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list <i>monitoring</i>	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Extra</i>	1			
	Total No. of Pages	32			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Tannisree

UHID ID:

Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

injury

Desired goals of the treatment :

Successful removal of foreign body.**Planned Labs:****Planned Management**

- Continue NPO
- IV fluids @ 100% maint
- Plan upper GI endoscopy & FB removal under sedation

Signature of the Doctor: [Signature]Name of the Doctor: SahitriDate & Time: 7/7/26 8 AMSignature of the Consultant: [Signature]

Name of the Consultant: _____

Date & Time: _____

Date & Time	Progress Notes	Doctor's Order
7/2/26 4:30 pm	S/B Dr. Poushpa <u>Accidental foreign body ingestion</u>	<u>Plan:</u> ① Discharge T/n.
	S/I upper GI endoscopy + foreign body removal	
	S/E: Alert vitals - stable	
	<u>refer</u>	<u>refer</u>
8/3/26 10:00 am	S/B Dr. Poushpa Sai FB ingestion doing well	<u>Adv:</u> D/S today.
	<u>refer</u>	<u>refer</u>

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
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						

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: OT

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 7/7/26 : 8:30am

Nurse Name & Signature: pous

Date & Time : 7/7/26 : 8:30am

DRUG CHART

Date of Admission: 2/2/26 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
Additional Instructions:				

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

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

Signature
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 18 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 :				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 :				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 :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

Weight. 19.1kg... Ward.



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. 19 kg Ward.

[illegible]

Signature

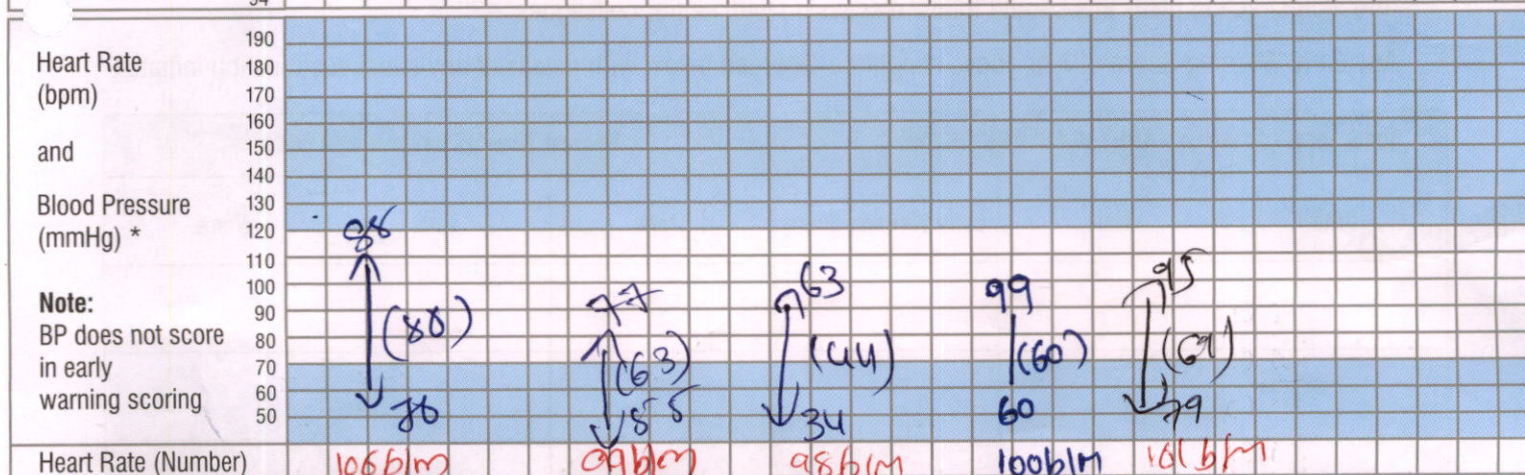
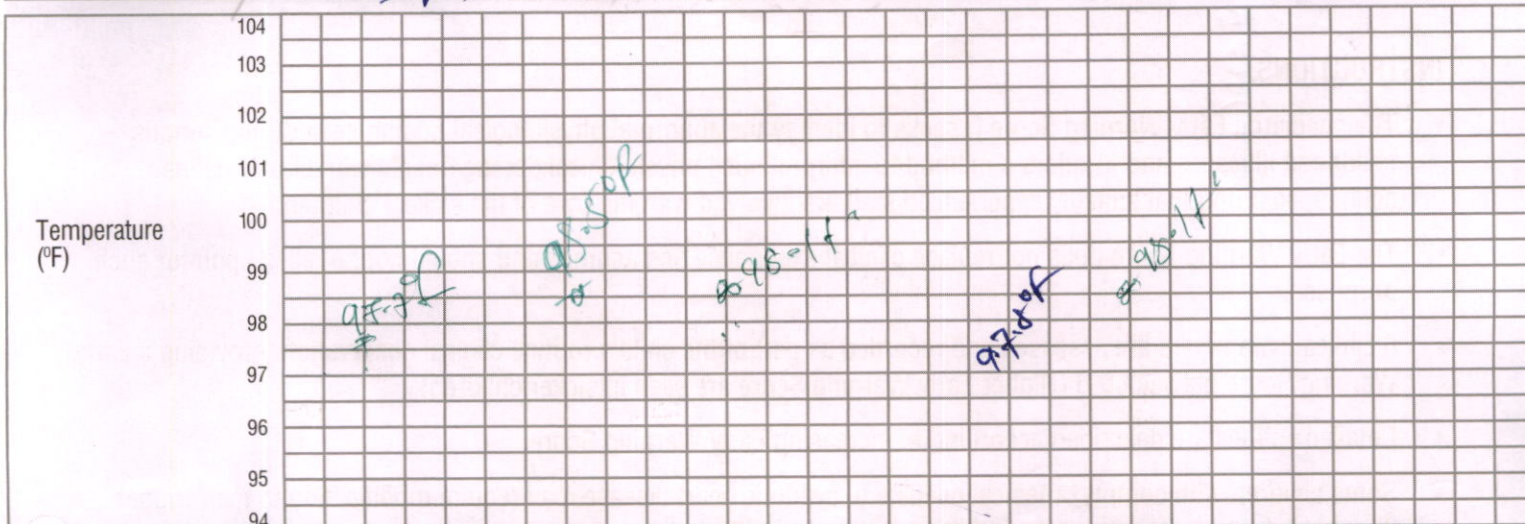
VERIFIED BY : Name



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7/20 Time : 12:30pm 5PM 10PM 2AM 6AM
 Doctor / Nurse / Family Concern? 12:30pm 5PM 10PM 2AM 6AM



Resp. Rate (bpm) per 1 Minute *

Resp Rate (Number)

Time	Resp Rate (bpm)
12:30pm	28b/m
5PM	29b/m
10PM	28b/m
2AM	27b/m
6AM	28b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

GCS *

Time	Resp Mod/ Severe Distress	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	GCS *
12:30pm		99%	99%	Normal	15/15
5PM		99%	99%	Normal	15/15
10PM		100%	100%	Normal	15/15
2AM		99%	99%	Normal	15/15
6AM		100%	100%	Normal	15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Time	Number of shaded boxes	Pain Score	Observer's Initials
12:30pm	1	0	0
5PM	1	0	0
10PM	1	0	0
2AM	1	0	0
6AM	1	0	0

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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								
7/7	08:00 am												
	09:00 am												
	10:00 am	1	H ₂ O								0	Diya	
	11:00 am	NO NF	Proch								0	Diya	
	12:00 pm										0	Diya	
	01:00 pm	1	Proch								0	Diya	
Total Intake :						Total Output :							
7/7	02:00 pm	1									0	Diya	
	03:00 pm	NO	chepathi								0	Diya	
	04:00 pm	UP									0	Diya	
	05:00 pm										0	Diya	
	06:00 pm										0	Diya	
	07:00 pm										0	Diya	
Total Intake :						Total Output :							
8/7	08:00 pm	1									0	Diya	
	09:00 pm										0	Diya	
	10:00 pm	NO									0	Diya	
	11:00 pm	UP									0	Diya	
	12:00 am										0	Diya	
	01:00 am	1									0	Diya	
Total Intake :						Total Output :							
8/7	02:00 am	1									0	Diya	
	03:00 am										0	Diya	
	04:00 am	NO									0	Diya	
	05:00 am	UP									0	Diya	
	06:00 am										0	Diya	
	07:00 am	1									0	Diya	
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

KUH-00097528 IP5-00176063
 Baby SAI TANVISREE MOGILI
 07-05-2020 6 Y 2 M 1 D (F)
 Dr. M N V P OUSHYA SAI



FLUID CHART

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Sheet No. :

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

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

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

NURSING CARE RECORD



Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment:

Acute 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
8am	Assess the pt General Condition.	8am	Assessed the pt General Condition.	pt is Conscious & oriented
9am	Relieve pain & Discomfort	9am	Relieved Pain & Discomfort	pt vital stable
10am	monitor vital signs	10am	monitored vital signs	no bleeding
11am	monitored for bleeding	11am	monitored for bleeding	maintained
12pm	maintain I/O chart	12pm	maintained I/O chart	no vomiting
1pm	no status maintain	1pm	no broken, water given	shifted
2pm	pt shift to the ward	2pm	pt shifted to the ward	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 7/7/26

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 Baby SAI TANVISREE MOGILI
 07-05-2020 6 Y 2 M 1 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7

Assessment: Baby having 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
3pm	→ Assess the baby general condition	3:10pm	→ Assessed the baby general condition	baby condition is improve
4pm	→ monitor the vital's	4:10pm	→ monitored the vital's	
5pm	→ Provide comfortable position	5:10pm	→ provided comfortable position	
6pm	→ Administer medication as per doctor order's	6:10pm	→ Administered medication as per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 7/7

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: pt having 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
8PM	→ Assess the pt general condition	8PM	→ Assessed pt general condition	pt condition is normal.
10PM	→ monitor vital signs	10PM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administered the medications as per doctors order.	8AM	→ Administered the medications as per doctors order.	

Re-Assessment: Will

Special Notes:

Nurse Signature: [Signature] Nurse Name: Sravanthi? Date & Time: 8/7/26 8AM



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Date:

Assessment:

Goals

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

[illegible]

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

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 Baby SAI TANVISHREE
 07-05-2020 6 Y 2 M 0 D (F)
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THE HUMPTY DUMPTY SCALE

#12 5/17

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	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			10	10			

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 :		poor	sourth			
Signature :		R	Qip			
Date :		7/12	8/17			
Time :		9:15 AM	6:07			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. M.N.V. Pouhyas Department: OT Date of Admission: 7/12/26

SITUATION		Diagnosis: <u>Endoscopy removal Foreign body</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:	
BACKGROUND	Area	Shift Time	<u>9:11a</u>	<u>OT 8am-11:30</u>	<u>11:30-2pm</u>	<u>2pm-8pm</u>	<u>8pm-8am</u>
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA
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°F</u>	<u>98.6°F</u>	<u>98.2°F</u>	<u>98.3°F</u>	<u>97.9°F</u>
		Res:	<u>28bpm</u>	<u>25bpm</u>	<u>28bpm</u>	<u>25bpm</u>	<u>28bpm</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>112bpm</u>	<u>94bpm</u>	<u>106bpm</u>	<u>107bpm</u>	<u>103bpm</u>
		BP:	<u>99/52</u>	<u>101/61</u>	<u>100/62</u>	<u>101/65</u>	<u>94/34</u>
Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</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	
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ 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>Pooji</u>	<u>Quel</u>	<u>Suresh</u>	<u>Spishan</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>7/12/26</u>	<u>7/12/26</u>	<u>7/12/26</u>	<u>7/12/26</u>	
Time:			<u>9:11a</u>	<u>11:30a</u>	<u>2pm</u>	<u>8pm</u>	
Taken Over By Name :			<u>Keren</u>	<u>Suresh</u>	<u>Spishan</u>	<u>Spishan</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>7/17/26</u>	<u>7/17/26</u>	<u>7/17/26</u>	<u>8/17/26</u>	
Time:			<u>9:11a</u>	<u>2pm</u>	<u>2pm</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:						

KUH-00097528

IP5-00176063

Baby SAI TANVISREE MOGILI

07-06-2020

6 Y 2 M 0 D

(F)

Dr. M N V POUISHYA SAI



BRADEN 'Q' SCALE

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					Date :	7/7	8/2		
					Time :	9:15 PM	8:30		
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 or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
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		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	poor	Q		

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
21/2/26	9:15 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	post
21/2	9:50 pm	1/10	SS	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Deep
21/2	10:00	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	stably
21/2	10:00	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sub
				☐ 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:

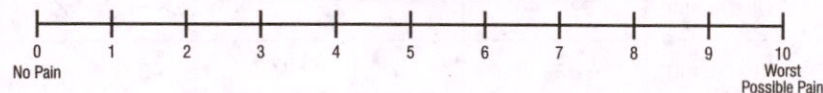
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

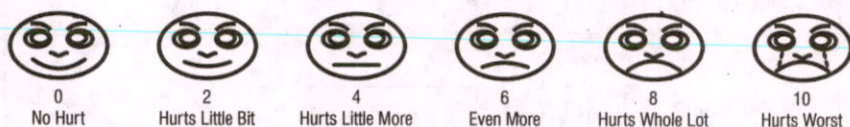
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Pa

Patient's / Learner Language: Religion 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		
8/12/20	9:15 AM	2	Infection control measures	M	4	0	1	1	-	
8/12/20	12:30 PM	9	Normal diet	M	1	0	1	1	-	Nithya

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive Limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive Limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive Limitations	10. Financial Difficulties	13. Cultural/Religion Practice																			
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3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference																					
Understanding:	1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																				



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/2/26 9:30 ✓	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	ingestion of zipper	hemodynamic stability	endoscopic removal of foreign body	<i>[Signature]</i>	☒ Nursing ☐ Others:
7/2/26 9:30 an	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Surgery	W - stable	Endoscopic removal.	<i>[Signature]</i>	☒ Medical ☐ Others:
7/2/26 12:30pm	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	upper GI endoscopy + foreign body removal	Normal diet	<u>RDs:-</u> E:- LUTOKALIQ P:- 25g/d	<i>Nicitha</i>	☐ 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:

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	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>									

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]*



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9am Mode of Arrival: walkway Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NK DR Body Weight: 19 Kg
 Height: — cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: nothing significant

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

If yes please list,

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

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

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

Observations: Weight: 19 Length: — Head Circumference (< 2 years): —
 Temp: 98.4° F HR: 26/100 RR: 26/100 BP: 90/60mm Hg

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 1 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 20) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening:☒ No Significant 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 ParentsSiblings 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 FatherNurse Signature: [Signature]Nurse Name: ReemDate: 7/7/21Time: 9:10 am

IPS-00176063 (F)
KUH-00097528
Baby SAI TANVIREE MOGILI
07-05-2020
Dr. M N V POUSSHYA SAI

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 22 Feb Baby order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 2/7/26 @ 10:30 AM



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Poushya Sai

Date : 7/7/26

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

Start Time of Assessment: 8:10 am

Weight: 19 kg

Allergic History:

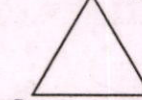
Chief Complaints:

Accidental ingestion of metallic foreign
body (Zip) @ 11 pm on 6/7/26

X ray erect abdomen s/o Zip stuck
pass

Pediatric Assessment Triangle

A Appearance - TICLS



B Breathing ☒ Normal ☐ Abnormal

☐ ↑ WOB ☐ ↓ WOB ☒ Normal ☐ Gasping / Apnea

☐ Pallor ☐ Cyanosis ☐ Mottling ☐ Bleeding

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening ☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment

Airway



☒ Open ☐ Maintainable ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes



Breathing

Rate: 25/min SpO₂ on FiO₂ 98.1 on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BILAE

Palpation Findings (If necessary)

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

 **Circulation** HR: CFT ☐ Central ☒ Peripheral Any urgent interventions needed: ☐ Yes ☒ No

BP: 92/49 (58) mmHg Murmurs: ☐ Yes ☒ No If Yes

Pulse Volume: ☐ Central ☐ Peripheral Liver Span: ECG:

If in Shock: ☐ Compensated ☐ Hypotensive Any Signs of Heart Failure: ☐ Yes ☒ No

Muffled Heart Sound: ☐ Yes ☒ No Engorged Neck Veins: ☐ Yes ☒ No

 **Disability** GCS: 15/15 AVPU: Any urgent interventions needed: ☐ Yes ☒ No

Pupils: ☒ Responsive ☐ Non-Responsive ☐ If Yes

Size ☐ Right ☐ Left Active Seizures: ☐ Yes ☒ No Sugars: Signs of Neurological compromise

 **Exposure** Temp.: 98 F Any urgent interventions needed: ☐ Yes ☒ No

Any Rash: ☐ Yes ☒ No, If yes describe the rash If Yes

Active bleed Lacerations ☐ Abrasions ☐ bruises ☐ Describe:

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned: <u>No Labs</u> <u>N/D</u> <u>[Signature]</u>	Treatment Planned: • NPO to continue • IV fluids • Endoscopic removal of foreign body in sedation.
---	--

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐
 Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by Name of the Doctor: <u>Dr. Ramya</u> Signature: <u>[Signature]</u> Date & Time: <u>7/7/26; 8:20am</u>	Sr. Doctor on Duty (If necessary) Name of the Sr. Doctor: Signature: Date & Time:
---	--

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. Upper GI endoscopy + foreign body removal.
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>foreign body removal</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:

- a. Bleeding
- b. Perforation

I authorize Dr. Pouishya 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: M. Hema
 Name: M. Hema
 Relationship with patient: Mother
 Date & Time: 7/7/26, 9 AM

Witness:

Signature: [Signature]
 Name: Rakesh Mogili
 Date & Time: 7/7/26 9 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Hema Tulsi Date: 7/7/26 Time: 9 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్ఫో 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 రోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

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

a.
b.

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. M. N. Poushya
Asst. Surgeon :
Anaesthetist : Dr. Sariful
Scrub Nurse : Bikhal

KUH-00097528 IP5-00176063
Baby SAI TANVISREE MOGILI
07-05-2020 6 Y 2 M 0 D (F)
Dr. M N V POUSHYA SAI



Age : 6y Gender : F
Surgery Name : Endoscopic + Laparoscopic
Date : 7/7/26 In-time : 9:10am Out-time : 9:45am

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: <u>9:05am</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>Dr. R. Sri Sungs</u>		
Name : <u>Dr. R. Sri Sungs</u>		

Before Skin Incision ➤ ➤

TIME OUT		Time: <u>9:17am</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?		
☐ Yes ☒ No ☐ NA		
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>9:31am</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 :		
Name :		

IP5-00...
KUJH-00097528
Baby SAI TANVISREE MOGILI
07-05-2020 6 Y 2 M 0 D
Dr. M N V POUSHYA SAI
(F)

Patient

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 7/7

Department : P-OT Duration of Procedure :

Name of Surgeon : Dr. M. N. V. Poushya Sai Date of Admission : 7/7

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 :	<i>[Signature]</i>
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	<i>[Signature]</i>
3.	Patient's body temperature immediately post operation (Recovery Room) 37.6°C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<i>[Signature]</i>
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 7/7 26 @	<i>[Signature]</i>

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

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



OPERATION THEATER NOTES

Patient's Name: Baby. Sai Tanvisree Mogili Age: 6y Gender: ☐ Male ☒ Female
 UHID No.: BAH - 00097528 Weight: Height:

Surgeon :		Asst. Surgeon :	
Anesthetist : <u>Dr. Saritha</u>	OT Nurse: <u>Bikshu</u>	OT Technician: <u>Vijay</u>	
Pre-Operative Diagnosis: <u>Accidental foreign body ingestion</u>			
Surgical Procedure : <u>upper GI endoscopy + foreign body removal</u>			
Indications for Surgery : <u>foreign body ingestion</u>			
Date : <u>07/05/20</u>	Start Time : <u>9:14 am</u>	End Time : <u>9:31 am</u>	
Pre Operative Preparations: <u>-</u>			
Post Operative Diagnosis: <u>accidental foreign body ingestion</u>			
Peri-Operative Complications: <u>nil</u>			
Operation Notes: <u>Under strict aseptic precautions, an</u> <u>endoscope was passed from the mouth</u> <u>into the esophagus and further advanced</u> <u>till the stomach.</u> <u>foreign body seen in the body of stomach.</u> <u>(Zip)</u> <u>foreign body removed using a Roth net.</u> <u>check endoscopy done - normal.</u>			

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 Baby SAI TANVISREE MOGILI
 07-05-2020 6 Y 2 M 0 D (F)
 Dr. MNV POUSHYA SAI

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Upper GI endoscopy + foreign body removal
 Post-Surgical Diagnosis: Accidental foreign body ingestion

Post-Operative Monitoring Parameters /Frequency: Monitor for 1 hr

Wound Care:

/Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization: Immediately

Special Referrals:

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

☐ Yes ☒ No

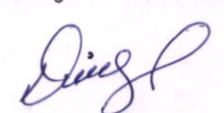
Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
 (Signature & Stamp)

Date: 7/7/20 Time: 9:30 am

Note: Plan of care will be readjusted if necessary.

PATIENT TRANSFER FORM

Patient Name & UHID No. KUH-00097528 IP5-00176063 Baby SAI TANVISREE MOGILI 07-06-2020 6 Y 2 M 0 D (F) Dr. M N V POUISHYA SAI 		Date & Time of Admission 7/7/26 @ 8:30 AM	Date & Time of Transfer Order 7/7/26 @ 12:10 PM
		Transfer Ordered by Dr. Sariful	Reason for Transfer Post-op
From Unit OT	To Unit 110	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 92	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	op file - ①		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Sariful	
Patient & Clinical Records Received by : Suresh			
Date & Time of Patient Received : 7/7/26 @ 12:30 PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Sai Tanvi free Age: 6y Sex: F UHID.No: 604-0097528

Date: 7/7/26 Time: 9:00 AM Proposed Operation: Endoscopic removal of foreign body

Diagnosis: Metallic foreignbody ingestion

B.P / CRT: H.R: Weight: 17.01kg 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/Anglo:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies:

Medical History: CVS: ✓ C-Section / Full term / 2866g / No NICU admission

RESP: Not significant Diabetes: ✓ Vaccinated upto date.

CNS: ✓ Milestones achieved as per age

Renal: Physical Activity: productive cough 3 days

Hepatic / GE: ✓

Others: ✓

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mento-hyoid Distance: Neck: Teeth: 2 loose upper central incisors

Lungs: BAE (+)

Heart: S1S2 (+)

CNS: Grossly Intact

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: 22g @ hand Spine Exam for regional: ✓

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: NPD! 8:30 pm - med 6:00 AM - lig
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient /Attended
- Other Instructions:

Signature: [Signature] Name: D. K. S. S. S.

Change in Patient Condition: ☐ Yes ☒ No		Fasting Status: <u>Confirmed</u>	
Physical Status: ☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed	

H.R: 100bpm	B.P / CRT:	SpO ₂ : 98% on R.A	R.R: 20/min	Last Feed: > 6hr
Pre-OP Diagnosis:		Operation: Endoscopic removal of		Date: 7/7/26
Surgeon: Dr. Poushya		Anaesthesiologist: Dr. K. Subra / Preethi		Technician: Vijay

	TIME	9:10	9:20	9:30	9:45
N ₂ O(AIR)/O ₂ (LPM)	70/10				
HALO(SO/SEVO)(MAC)					
Drugs:					
Rx IMIDA-ZOLAM	1mg				
Rx FENTANYL	40mcg				
Rx PROPOFOL	60mcg				
Rx ROCURONIUM	10mg				
Rx NEOSTIGMINE	1mg				
Rx GLYCOPYROLATE	0.2mg				
FIO ₂ /SaO ₂	100	100	100	100	
ETCO ₂	31	38	38	38	
ECG	NSR	NSR	NSR	NSR	
Temperature					
Urine Output					

Antibiotic

Suppository

Blood Loss

NOTES

Fluids		Blood		Urine		Sweat		Tears		Saliva		Mucus		Other	
B.P.															
V	Systolic														
Λ	Diastolic														
X	Mean														
•	Heart Rate														
Tourniquet on Time															
Tourniquet off Time															
Throat Pack In															
Throat Pack Out															

0 10 20 40 60 80 100 120 140 160 180 200 220 240

B.P.
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values	ABG
	GRBS

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: <u>RAOL</u> ☒ Art Site: _____ ☒ EKG Lead ☒ Temp Site ☒ FIO₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator	Temp: ☒ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other _____ Times: Anaes Start: <u>9:10 AM</u> OP Start: <u>↓</u> OP End: <u>9:45 AM</u> Leave OR: _____ Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional	Induction ☒ IV ☒ Inhal ☒ Pre O₂ ☐ RSI ☐ Others _____ ☒ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ☒ ET# <u>4.5mm</u> at <u>14</u> cm ☐ Oral ☐ Nasal ☒ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: <u>ROCURONIUM</u> ☐ Awake ☒ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# <u>2</u> Attempts: <u>1</u> Difficulty Why? _____	Regional: Extremity _____ Specify: _____ ☐ Spinal ☐ Epidural ☐ Caudal Others: _____ Position: _____ Site: _____ Needle Size: _____ Depth: _____ Parasthesia ☐ Yes ☐ No Catheter at skin _____ cm Drug Name & Conc: _____ Bolus: _____ Infusion: _____ Block Level: _____ Comments: _____
Position: <u>6 lateral</u> ☒ Pressure Points Checked Eye Care: ☐ Oint ☒ Tape ☒ Padding ☐ Awake	Line (Size & Location) ☐ CVP: _____ ☐ ART: _____ ☒ IV: <u>22G Rphand</u> ☐ IV: _____ ☐ IV: _____	☒ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other _____	Transportation to ☒ PACU ☐ ICU ☐ Other _____ Relaxant Reversed ☒ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. K. S. Sengupta</u> Signature of the Doctor: <u>[Signature]</u>

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IP5-00176063
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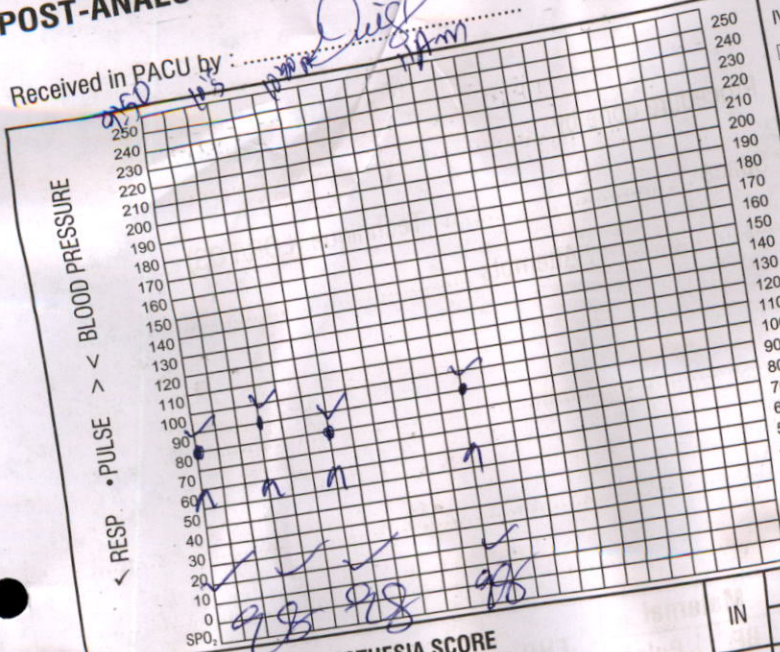
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: *Quish*

Time Received: *9:50 AM*

Time Discharged: *12:10 PM*



IV Cannula Site: *22G PP hand*

☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting: ☐ Yes ☒ No
 NG Tube: ☐ Yes ☒ No
 Drain: ☐ Yes ☒ No
 Urinary Catheter: ☐ Yes ☒ No
 Chest Tube: ☐ Yes ☒ No
 Nil Oral ☐ Yes ☒ No

IV Fluids: _____
 Oral Feeds: _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT
		IN	30	60	90
Able to move 4 extremities voluntary or on command	= 2	1	1	1	2
Able to move 2 extremities voluntary or on command	= 1				
Able to move 0 extremities voluntary or on command	= 0				
Able to deep breathe & cough freely	= 2	2	2	2	2
Dyspnea or limited breathing	= 1				
Apneic	= 0				
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2	2
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1				
BP $\pm$ 50 of Pre Anaesthetic level	= 0				
Fully awake	= 2	1	1	2	2
Arousable on calling	= 1				
Not responding	= 0				
Pink	= 2	2	2	2	2
Pale, dusky, blotchy, jaundiced, other	= 1				
Cyanotic	= 0				
TOTAL		8	8	9	

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGE FORM

Date	Time	Pain Score	Signature
<i>7/7/20</i>	<i>9:50 AM</i>	<i>7/10</i>	<i>Quish</i>

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

Anaesthesiologist Name: *D. K. S. S.*

Anaesthesiologist Signature: *[Signature]*

Date & Time: *7/7/20 11:10*

PACU Nurse Name: *Quish*

PACU Nurse Signature: *[Signature]*

Date & Time: *7/7/20 11:10*

Reassessment

- Every 15 minutes
- For postoperative all hospitalized patients,
 - tient, patient with chronic pain, patient with severe pain
 - hours for first 24 hours
 - hours every 4 hours
 - relieving intervention minutes after pain relief intervention

Transferred to

Date & Time: *7/7/20 11:10*

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD



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Date: Time: Procedure done by
 CSE / Spinal / Epidural
 Depth: Position: Space:
 Catheter at Skin: Attempts:
 Technique (LOR/LOS)
 Anesthesia: Yes/No if yes details:
 Solution Composition:
 Other issues:

Any other issues :

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR
			Left	Right	BP	Pul	

[illegible]

AR: ..
..... SVD / Instrumental / LSCS (if LSCS Details)
.....

Delivery Details : Time :
Inspected by and Tip Inspected :

Delivery Details : Time :
Catheter Removed by and Tip Inspected :
Inspection :

Discharge/Shipping ordered by _____
for Signature: _____
Name: _____

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Baby SAI TANVISHREE MOGILI
07-05-2020 6 Y 2 M 1 D (F)
Dr. M N V POUISHYA SAI



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Endoscopic removal of foreign body

Anaesthesiologist: Dr. Subhramaayan Surgeon: Dr. Poushya Sai

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 Laryngospasm, Bronchospasm, post-op O2 support, post-op Ventilator Support

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 sore 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: M. Hema
Name: M. Hema
Relationship with patient: _____
Date & Time: _____

Witness:

Signature: [Signature]
Name: _____
Date & Time: _____

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. P. S. Srinivas

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి

☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు:

శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి
సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. జనరల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత ధృక్పాతిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

సిఫిక్ హై లిస్ట్:

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

హృదయ వ్యాధి ☐ రక్తపోటు

☐ మధుమేహం

☐ మూత్రపిండాల వైఫల్యం

☐ బహుళ అవయవ వైఫల్యం

నాలేయ సమస్యలు ☐ షాక్

☐ ఊబకాయం

☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి అటెండెంట్

అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.

☐ జనరల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్

అనస్థీషియా ఉపయోగంలో అభ్యుదయపూర్వకంగా జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ బ్లిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.

శస్త్రచికిత్స సమయంలో అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్టిరియల్ లైన్, సపోజిటరీలు, నొప్పి వారణ కోసం నర్స్ బ్లాక్సులు, జనరల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి ను అనుమతి ఇస్తున్నాను.

శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న

శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనుమతి ఇస్తున్నాను.

శస్త్రచికిత్స కోసం కూడా నేను అనుమతి ఇస్తున్నాను. నాకు ప్రశ్నలాడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో

శస్త్రచికిత్స కోసం కూడా నేను అనుమతి ఇస్తున్నాను. నాకు ప్రశ్నలాడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

తేదీ & సమయం:

(P.T.O)

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Endoscopic removal of foreign body

Anaesthesiologist: Dr. Subhramanyam Surgeon: Dr. Poushya Sai

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: Laryngospasm, Bronchospasm, post-op O2 support, post-op Ventilator Support.

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: M. Hema
Name: M. Hema
Relationship with patient: _____
Date & Time: _____

Witness:

Signature: [Signature]
Name: Neelish Saba
Date & Time: _____

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. K. S. Srinivas Date: 7/1/20 Time: 9:05AM

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 శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

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

స్పెసిఫిక్ హై రిస్క్:

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 ఇంజక్షన్ 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 లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

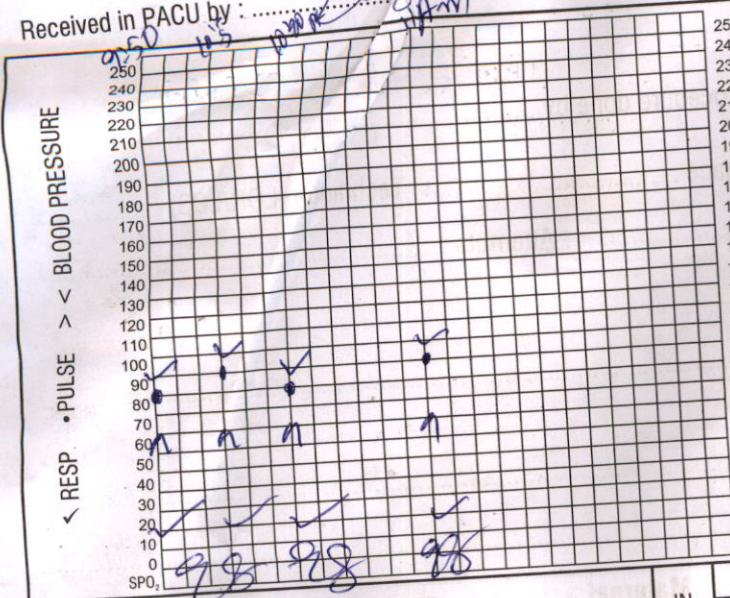
సంతకం: పేరు:

Docu. No. : RCHBH / FRM / CLINICAL / 021(26)

తేదీ & సమయం:

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. S. S. Suresh Time Received : 9:50 AM Time Discharged : 11:10 AM



IV Cannula Site : 2 EG (PD) hand

☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☒ No Drug : _____
 NG Tube : ☐ Yes ☒ No
 Drain : ☐ Yes ☒ No
 Urinary Catheter : ☐ Yes ☒ No
 Chest Tube : ☐ Yes ☒ No
 Nil Oral ☐ Yes ☒ No
 IV Fluids : _____
 Oral Feeds : _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	1	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	1	1	2	2		
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
7/7/26	9:50 AM	1/10		<u>Dr. S. S. Suresh</u>

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

Anaesthesiologist Name : Dr. S. S. Suresh

Anaesthesiologist Signature : [Signature]

Date & Time : 7/7/26 @ 11:10 AM

PACU Nurse Name : [Signature]

PACU Nurse Signature : [Signature]

Date & Time : 7/7/26 @ 11:10 AM

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): 11:10

Date & Time: 7/7/26 @ 11:10 AM

Patient Sticker

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

CSE /Spinal /Epidural

Depth:

Parasthesia : Yes/No if yes details :

Any other issues :

Time	Infusion Rate			

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)
Catheter Removed by and Tip Inspected :
Patient Satisfaction :

Doctor Signature:

Date and Time:

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 26/12/2020 Time: 12:30 pm

Weight: 19 kgs Centile: 25th

Height: 110 cms Centile: > 10th

Inference: Well child

RDA: - Calories: 1450 kcal/d Protein: 25 g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled & outside foods

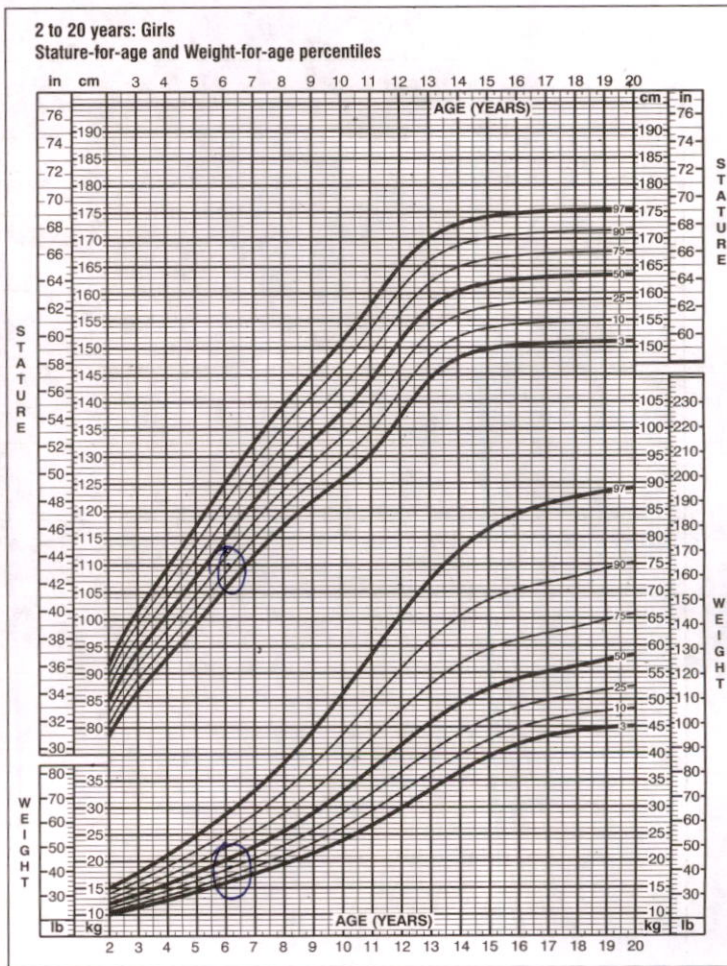
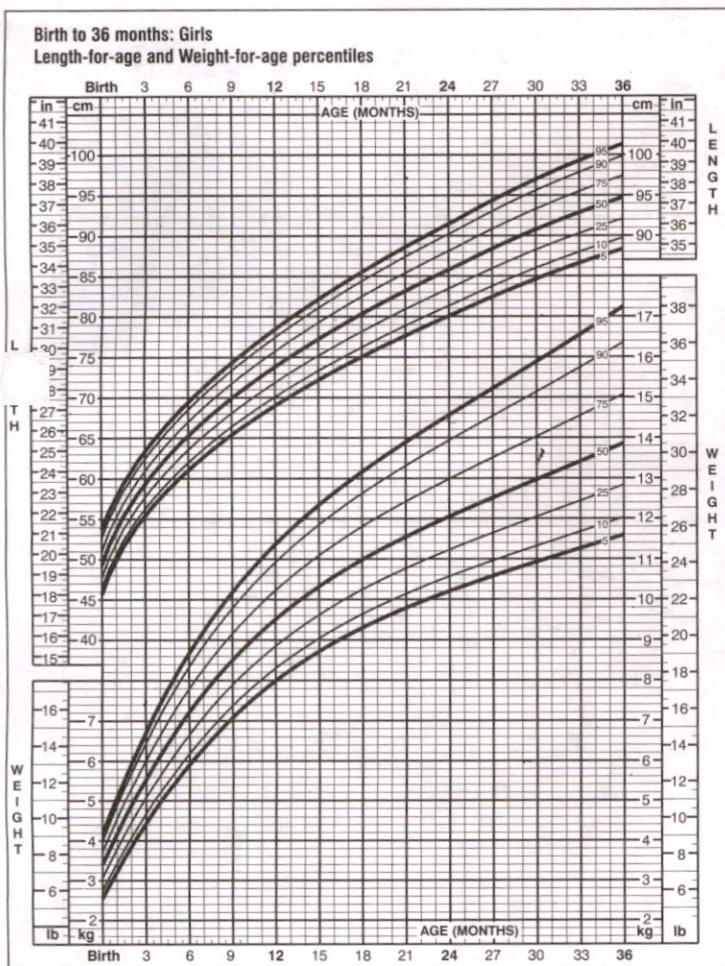
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Upper GI Endoscopy + Foreign body Removal

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: M. Hema

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.