BAH-00662515 IP5-00176814
Baby AYESHA ARIBAH
27-06-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

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SURGERY DETAILS

Date : 23/7/26

Patient Name: Baby Ayesha Date of Birth: Age: 1.4 y

Gender: Female Ward : P-OT UHID No.:

Date of Surgery: 23/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☑ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : UGI endoscopy + Biopsy

Time in : 2:10 pm Time Out : 2:40 pm

		NAME	AMOUNT
1.	Surgeon	: Dr Alisha	
2.	Anaesthetist	: Do - Rani	
3.	Assistant Surgeon	: —	
4.	OT Technician	: Ranjan	
5.	Circulating Nurse	: Babi	
6.	Assistant Nurse	: Suman	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : Endoscopy — 9718409

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9718409 Order by: Babi

Docu. No. : RCHBH/FRM/GENERAL/114

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Upper GI Bleeding

CONSUMABLES OF OT

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Circulating staff : ..... Technician : ..... Date : 23/7 Time : 2 pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 6.0, 6.5, 7.0	1+1	—	Major Pack			Inj Vit.K		
LMA 3, 4	1+1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	3				Suction Catheter		
HME filter : A / P / N	1	0				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	4	Gloves 6, 6½, 7, 7½	2+2	—	Surgical Gloves		
02 cc	10	3	(P) 6, 6½ (A) 7½	2+2	1+1	Gauze Pack		
01 cc	2					Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	1	Cautery pencil			NS 500ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	3+1	1	Koochies			Transfix	1	1
O2 Mask (A)	1	—	Ointments			10cc, 50cc, 5cc	2+1	1+1
Airway #2.3	1+1	1	Suction Catheter			Jelly	1	1
Fentanyl	1	1	Cap, Mask	5/5	3/5			
Morphine			Gauze Pack (2+1)	5/5	4/5			
Ketamine			Mop Pack	1	1			
Propofol	3	4	Steristrip					
Rocuronium	1	—	Underpad	1	1	Iv cannula 20.22	1+1	—
Glycopyrolate	1	1	Draw sheet	1	—	Dexa	1	—
Myopyrolate	1	—	Abgel			Tranexa	2	—
Ondansetron	1	—	Foleys catheter			Minispire	1	1
Pencan 25g/ Spinal Needle 22			Urobag			Nasal Airway 26.28	1+1	—
Bupivacaine 0.25%			Chest Drainage Catheter			Etco2 Nasal prong (A)	1	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			Midaz	1	1
Antibiotics			Bandage			50ml D5+PMO Line	1+1	1+1
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum Set	1	1	Microshield	1	1			
Gauze	3	—	Cotton Balls					
Gloves and	4	—	Latex Gloves	1pr	1pr			
IV P.C.M	1	—	Ramdione Scrub					
3-way 100+10cm	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 971848 Ordered by : .....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176814 **Admit Date** : 23-Jul-2026 **Admit Time** : 12:41 PM **UHID** : BAH-00662515

Patient Details :

Patient Name	: Baby AYESHA ARIBAH	**Age**	: 14 Y 0 M 26 D
Guardian	: Mr KHAJA MUNAWAR UDDIN	**DOB**	: 27-06-2012
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 12-2-790/49 FLAT NO 503, 5TH FLOOR KHAJA RESIDENCY APARTMENT, Mehdipatnam Hyderabad Telangana INDIA 500028	**Phone No**	: 9849216981/ 9392678323
		E-mail	: MKHAJA7172@GMAI.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 410 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 410 **Admission Type** : First Visit

Contact Details :

Name : Mr KHAJA MUNAWAR UDDIN **Relationship** : Father

Contact Address : **Phone No** : 9849216981

Signature

Doctor Details :

Doctor Name : Dr. ALISHA BABBAR **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00662515 IP5-00176814 Baby AYESHA ARIBAH 27-06-2012 14 Y 0 M 26 D (F) Dr. ALISHA BABBAR sultant: _____ Dept : _____

Date of Admission: ____ te of Discharge : _____ Time: _____

Room / Bed No : _____ Ward . _____ uggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26	1:20 pm	ER	OT	
23/7/26	4:30 pm	OT	Billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
23/7/16	CBP. Electrolyte	3954	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/7/24	IV placement PBC OP	(1)	OP basis	Chandan

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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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 UGI Endoscopy

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)
Diagnosis & Treatment of source of UGI bleed	

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. Bleeding
b. perforation

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

Patient / Patient Attendant:
Signature: .....
Name: Khaja Nizamuddin Uddin
Relationship with patient: Father
Date & Time: 23/4/26 @ 1.47 pm

Witness:
Signature: .....
Name: Taseen
Date & Time: 23/4/26 @ 1 pm

Doctor (who is taking consent):
Signature: ..... Name: Dr Alisha Babbar Date 23/4/26 Time: 1:45 pm

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

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, 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 _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికి / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.

5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశ గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.

6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
   ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Alisha
Asst. Surgeon :
Anaesthetist : Dr - Rani
Scrub Nurse : Sumera

Patient Name : Baby Ayesha Age : 1 Y 4 M Gender : F
UHID No. : 662515 Surgery Name : Endoscopy
Date : 23/11/26 In-time : Out-time :

BAH-00662515 IP5-00176814
Baby AYESHA ARIBAH
27-08-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2:10pm

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 :
Name : Dr. Tejasvini

Before Skin Incision ➤➤

TIME OUT Time: 2:17pm

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? 30 mins. NIL ☑ 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 :
Name :

Before Patient Leaves Operating Room

SIGN OUT Time:

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : Dr. Alisha
Name : Dr. Alisha

SURGICAL SAFETY CHECKLIST

Surgeon : .....
Asst. Surgeon : .....
Anaesthetist : .....
Scrub Nurse : .....

Patient Name : ..... Age : ..... Gender : .....
UHID No. : ..... Surgery Name : .....
Date : ..... In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time:.....

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 :.....

Name :.....

Before Skin Incision ➤ ➤

TIME OUT Time:.....

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 :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded ☐Yes ☐No

That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☐Yes ☐No ☐NA

The Specimen is Labelled (including patient name) ☐Yes ☐No ☐NA

Whether there are any Equipment Problems to be addressed ☐Yes ☐No ☐NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐Yes ☐No

Signature :.....

Name :.....

BAH-00662515 IP5-00176814
Baby AYESHA ARIBAH
27-06-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

P

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Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 23/7/26

Department : P-OT Duration of Procedure : 30 mins

Name of Surgeon : Dr. Alisha Date of Admission : 23/7/26

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) 36 °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 : @ 2:17pm, 23/7/26	

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

BAH-00662515 IP5-00176814
Baby AYESHA ARIBAH
27-06-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

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OPERATION THEATER NOTES

Patient's Name : Baby. Ayesha Aribah Age : 14Y Gender : ☐ Male ☐ ~~Female~~

UHID No.: 00662515 Weight : Height :

Surgeon : Dr Alisha | Asst. Surgeon : | OT Technician: Ahsaan.

Anesthetist : Dr. | OT Nurse: Sneha, Seema.

Pre-Operative Diagnosis: Pain Abd + Ugi bleed & evaluation

Surgical Procedure :
UGI Endoscopy + Biopsy

Indications for Surgery :
UGI Bleed.

Date : 23/7/26 | Start Time : | End Time :

Pre Operative Preparations:

Post Operative Diagnosis:
Gastritis

Peri-Operative Complications:
-

Operation Notes: UGI Endoscopy

E- lower end nodularity ⊕
irregular Z line @ GE junction

S- antral erythema, patchy whitishness
nodularity ⊕
NO hiatal hernia
Body & fundus (N)

(P.T.O.)

Doc. No. : RCHBH/ FRM / CLINICAL / 099

D (N)

Amount of Blood Loss: ×

Blood Transfused (in ML) ×

Name and Number of Surgical Specimen sent for examination:

(3) (1) Duod. (2) Antrum (3) Esophagus

Peri-Operative Complications:

×

Adv

(1) Tab Pantop 40mg ~~twice~~ daily (½ hr before breakfast). → 1 month ✓

(2) Syrup Sucralfate 10 ml TDS – 1 week.

Review in OPD after 5 days with biopsy.

(3) Tab Amoxycillin 1000 mg TDS. 2 weeks.

(4) Tab clarithromycin 500 mg BD

(5) Tab Lansoprazole 40 mg OD

Name of the Surgeon: Dr Akshay

Signature of the Surgeon:

Date & Time: 23/7/26

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POST-SURGICAL CARE PLAN FORM

Procedure Done: UGI Endoscopy

Post-Surgical Diagnosis: Gastritis

Post-Operative Monitoring Parameters /Frequency:

Vitals 2hrly - 6 hrs

Wound Care:

×

Drain /Special Lines/Catheters:

×

Special Patient Positioning and Requirements:

×

Nutritional Instructions:

×

When to Start Mobilization:

Immediate

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: 23/6/12 Time: .....

Note: Plan of care will be readjusted if necessary.

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby Ayesha Aribah Age: 14Y Sex: Female UHID.No :

Date: 23/07/26 Time: 12:10 pm Proposed Operation: Upper GI Endoscopy.

Diagnosis:

B.P / CRT: H.R: Weight: 53 kg. 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 : — · FT/NVD/No NICU stay

RESP : — Diabetes :

CNS : — · Development as per age

Renal : — · Vaccination till date

Hepatic / GE : — Physical Activity: Active

Others : c/o pain Abdomen 2 wks/ Vomiting on & off 2 weeks; Blood in Vomiting 1 day.

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N). Teeth: ++++ / ++++

Lungs : B/L AE (+)

Heart: S1 S2 (+)

CNS: Conscious, oriented.

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : (L) UL 22 G. 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:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — 7:30 Am (Idli) Explained
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

CBP, S. electrolytes: on cannula
Can be taken up at 12:30 pm
Witness consent pending.

Signature: [signature] Name: DR SHINY

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

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: Confirmed

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: B.P / CRT: 121/80 mmHg SpO₂: R.R: 18/min Last Feed: 6 hrs

Pre-OP Diagnosis: ? H. Pylori Operation: Upper GI Endoscopy Date: 23/7/26

Surgeon: Dr. Alisha Anaesthesiologist: Dr. BT / Dr. RC Technician: Ramesh

TIME	2:00	2:30	3pm	3:30
N_2O /AIR /O_2 LPM		2L/min		
HALO /SO /SEVO				
Drugs:				
MIDAZOLAM		1.5mg		
FENTANYL		60mcg		
PROPOFOL		70mg		
PROPOFOL Infusion		50mcg/kg/min		
FIO_2 / SaO_2		100	100	
$ETCO_2$				
ECG		SR	SR	
Temperature				
Urine Output				
Fluids / Blood		RINGER LACTATE		

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: R UL
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: left lateral
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 2:10pm.
OP Start:
OP End:
Leave OR: 2:40pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 22G R UL
☐ IV:
☐ IV:

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

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

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts:
Difficulty Why?

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

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:

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dr. Tejaswini
Signature of the Doctor:

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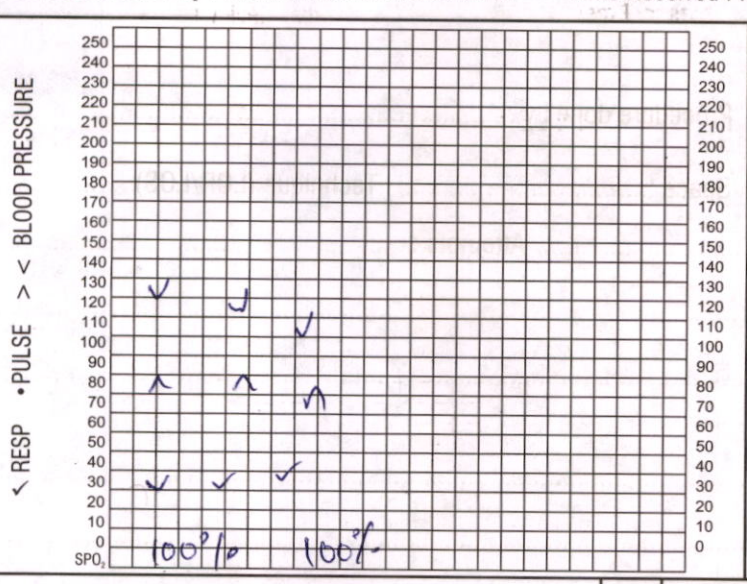
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sravani Time Received : 8 PM Time Discharged : .....



IV Cannula Site : 22

- ☐ O_2Mask
- ☐ 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 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY		1	1	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION		1	1	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS		2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR		1	1	2		
	TOTAL		8	8	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/7	@ 3PM	2/10	Nil	

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

Anaesthesiologist Name : Dr. Shyné
Anaesthesiologist Signature: Dr. Shyné
Date & Time: 23/7/26 @ 4PM.
PACU Nurse Name : Sravani
PACU Nurse Signature: Sravani
Date & Time: 23/7/26 @ 4PM

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): .....
Date & Time: 23/7/26 @ ...

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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BAH-00662515 IPS-00176814
Baby AYESHA ARIBAH
27-06-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

Patient Name : BABY AYESHA ARIBAH Age : 14Y Gender : Male ☐ Female ☑

UHID NO: RCWH-0000167447 Surgeon Name: DR ALISHA.

Anaesthesiologist : DR SHINY Operative procedure planned : UPPER GI ENDOSCOPY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : BRONCHOSPASM, LARYNGOSPASM

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [signature]

Name : Khaja Munawaruddin

Relationship with Patient: FATHER

Date & Time : 23/07/26, 12:11 pm

Witness :

Signature : [signature]

Name : [signature]

Date & Time : 23/7/26 @ 12:11 pm

Doctor (who is taking the consent) :

Signature : [signature] Name : DR SHINY Date & Time : 23/07/26, 12:10 pm

Docu. No. : RCH / FRM / CLINICAL / 021

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PROGRESS NOTES AND DOCTOR'S ORDER

wt: 53.5 kg

Date & Time	Progress Notes	Doctor's Order
	CI/R Resident (Dr. Baby)	
23/7/26 12:30 pm	D - ? H. pylori Gastritis	NPO since 7 am
	c/o Abd. pain No vomitings	
	O/E: Child - Alert, Afebrile CFT < 2 sec Pulses - well felt	plan - UGI Endoscopy - CBP, S. Electrolytes - NPO as advised - IVF - DNS - Monitor vitals
	Vitals: T - 98 °F PR - 81 bpm BP - 104/68 (mm) mmHg RR - 20/min SpO2 - 99% RA	
	I/E: BA: (+) S1S2 (+) P/A - Tenderness in epigastrium Rest	
	NIB Sagar 28/7/26 at 1:20 pm	(Dr. Baby)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: ....23/3/x............ 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 / 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 ....

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REGULAR PRESCRIPTIONS

Weight. 53-5 Kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Weight. 53.5 Kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

VERIFIED BY : Name ..... Signature .....

Baby AYESHA ARIBAH
27-08-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

I.V. FLUIDS CHART

Weight. 53.5 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
23/7/26	Not con	RVF-DNS (2/3 rd)	IV	55 ml/hr	[signature]	[signature] [signature]	Not connected		
23/7/26	2:10 pm	RINGER LACTATE	IV	1000 ml/hr	[signature]	[signature] [signature]	23/7/26	[signature]	[signature] [signature]

VERIFIED BY : Name .... Signature ....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00662515 IP5-00176814 Baby AYESHA ARIBAH 27-06-2012 14 Y 0 M 26 D (F) Dr. ALISHA BABBAR	23/7/26 @ 12:41 pm	23/7/26 @ 1:20 pm
	Transfer Ordered by Dr. Balaji	Reason for Transfer Surgery
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Personal belongings including clinical documents, if any handed over to attendant Yes ☑ No ☐ If Yes, what? op file	Patient shifted with ID band: Yes ☑ No ☐ If No: .....
Number of Imaging Films Nil		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Patient Gown	1
2.	Pooch	1
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR. Sagar	Dr. Balaji

Patient & Clinical Records Received by : Jaseem

Date & Time of Patient Received : 23/7/26 @ 1:28 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

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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. Balaji

Date & Time : 23/7/26 ; 12:30 pm

Nurse Name & Signature: Sagar

Date & Time : 23/7/26 @ 1:20 pm

BAH-00662515 IP5-00176814
Baby AYESHA ARIBAH
27-06-2012 14 Y 0 M 26 D (F)
Dr. ALISHA BABBAR

Rainbow® Children's Hospital
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RESULT SHEET

Date	23/7/26					
Time						
Hb	15.2					
PCV						
RBC	4.85					
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						

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.,) : .....

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

Patient Sticker

FLUID CHART

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	