

Patient

IP5-00176107
BAH-00660993
Baby ANISHKA RAHUL SINGADE (F)
15-11-2024 1 Y 7 M 23 D
Dr. PILLARISETTI NAVEEN SARADHI

Optimal

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

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80984

SURGERY DETAILS

Date : 8-07-26
Patient Name: Baby Anishka Rahul Date of Birth: 15-11-2024 Age: 1y
Gender: Female Ward: OT UHID No.: 660993
Date of Surgery: 8/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Flexible bronchoscopy

Time in: 3:40 pm

CPASH
GICW

Time Out: 5:40 pm

	NAME	AMOUNT
1. Surgeon	Dr. Naveen Saradhi	SF 15,250
2. Anaesthetist	Dr. Saneta	AF- 6863
3. Assistant Surgeon		OT- 24,400
4. OT Technician	Venkat	OT- 9500
5. Circulating Nurse	Theja	ASF - 1525 3050
6. Assistant Nurse	Suman	AAF - 1525 3050
		CSSD - 458

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9693537

Order by: S. Romane

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SURGERY DETAILS

Date : 8/7/26
Patient Name: Baby Anishka Rahul Date of Birth: 15/11/2024 Age: 24
Gender: F Ward: O.T UHID No.: BAH-00660993
Date of Surgery: 8/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Rigid Bronchoscopy

Time in : 3:40PM Time Out : 5:40PM

Cash
Glew

	NAME	AMOUNT
1. Surgeon	DR. Nabeel	RF, 15250
2. Anaesthetist	DR. Suresh	
3. Assistant Surgeon	DR. Harish Jayaram	
4. OT Technician	Venkatesh Baram	
5. Circulating Nurse		
6. Assistant Nurse	Ramya, Suman	

Am in First sheet

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9693556

Order by: y. Ramya

Circulating staff : Technician : Date : Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 3.0, 3.5, 4.0	11	—	Major Pack			Inf-Vit-K foglic cache		
LMA 112	1	01	Sutures			Cord Clamp 2f	1	1
ECG leads : A / P / N	5	03				Suction Catheter 8.0	11	11
HME filter : A / P / N	1	01				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	5	Gloves 16 (16) 272-272	272	272	Surgical Gloves		
02 cc	10	01	16 (16) 272-272	272	272	Gauze Pack		
01 cc	3	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL	1	—	Cautery pencil			MS 500 ml	2	2
NS 10ml / 100ml / 500ml / 1000ml	41	01	Koochies			Transobix	1	1
Waspilce	1	01	Ointments			10g	3	3
Vaccum set	1	01	Suction Catheter			Mules extractor	3	2
Fentanyl	1	01	Cap, Mask	45	10/10	July	1	2
Morphine			Gauze Pack N	3	3	Micromix	1	—
Ketamine			Mop Pack	1	1	Saxlon	1	1
Propofol	5	02	Steristrip			1 cc	3	3
Rocuronium	1	01	Underpad	1	1	Methylprednisolone		
Glycopyrolate	1	01	Draw sheet	1	0	40mg	1	1
Myopyrolate	2	02	Abgel			NA (16, 18, 20)	11	—
Ondansetron	1	—	Foleys catheter			O.A (00, 0)	11	—
Pencan 25g/ Spinal Needle 22	1	—	Urobag			Nasal pathway		
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Nasal probe	1	
Bupivacaine 0.25% (Heavy)			Romodrain bag			EtO ₂ (P)		01
Antibiotics			Bandage			Dexamed (10mg)	1	01
IV PCM	1	—	Tegaderm			10cc + pmolins	11	11
ippositories			Ioban			Catheter mount	1	01
1amol : 80mg / 250mg / 170 mg			Double J Stent			Box + Adrenaline	01	01
Supridol : 100mg			Vaccum Suction set	1	0	Levolin	01	01
Justin : 12.5 mg / 25mg / 100mg	11	—	Plastic Bed Sheet	1	0	Budecort	01	01
Tab. Misoprost : 200mg			Betadine Solution	—	—	DNS	1	1
3way 10x100cm	11	—	Microshield	1	1	IV set	1	1
Glove all + glove	11	01	Cotton Balls	—	—	or Nabal (P)	1	1
Theraxa + dexta	11	01	Latex Gloves	10	10	DN		
O ₂ mask (P)	1	—	Ramdone Scrub					
IV cathula (222)	11	—	Saral					

Order No. : 7693862

Ordered by :

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

ESTIMATION SLIP

Date : 08/07/2026 UHID / IP No. : BAH-00660993 SI No. 80984

Name of Patient : Baby. Anishika. Rao. Singadi Age: 1y/7m Gender: F.

Father's / Husband's Name : Mr. Rahul. Rao. Corporate / Occupation : _____

Address : _____ Phone : 7875943137 Email: _____

Procedure / Plan : Flexible +/- Rigid Bronchoscopy.
Bronchoscopy. C/S

MODE OF PAYMENT : ☒ SELF ☐ TPA : _____ ☐ GIPSA : _____ OTHERS _____

TARIFF INFORMATION :

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

PARTICULARS

Surgeon's / Anesthetists's Fee / O.T. Charges	AMOUNT (₹)	AF + O.T.F	TOT
O.T. Consumables			
Instrument Charges			
Pharmacy, Consumables & Investigations			
Equipment Charges			
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.			
Package			
Others			
Initial Minimum Deposit			

MARKS: 10:35K.

- 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. Rahul. Rao. 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: Rahul Rao Signatory Relationship: Father Signature of the Financial Counselor: Anishika

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

BAH-00660993 IP5-00176107
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Ultant: _____ Dept: _____

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



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	2:40 pm	ER	OT	pooja
8/7/26	7:20	OT	121	freew

Cross Consultation Visit

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

[illegible]

Investigations

Signature

8



[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
08/07	Tr Placement	①	3244	Samsky
8/7	PAC	①	9693293	Reem
8/7	Nebulisation	①	9693292	Reem
10/7	WHA	①	976321	

ANY OTHER INFORMATION

CXR — 

Date: 11/7/26

Time: 1pm

Prepared By: Saurathi

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Saurathi			

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176107

Admit Date : 08-Jul-2026

Admit Time : 02:05 PM UHID : BAH-00660993

Patient Details :

Patient Name : Baby ANISHKA RAHUL SINGADE

Age : 1 Y 7 M 23 D

Guardian : Mr RAHUL RAMKRUSHNA SINGADE

DOB : 15-11-2024 01:00 AM

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO - 508 , 5TH FLOOR , BLOCK - A ,
ANURAG SOCITY, Thumkunta Hyderabad
Telangana INDIA 500015

Phone No : 7875943137/ 8080948582

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 401

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 401

Admission Type : First Visit

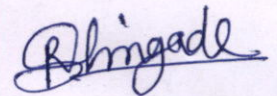
Contact Details :

Name : Mr RAHUL RAMKRUSHNA SINGADE

Relationship : Father

Contact Address : FLAT NO - 508 , 5TH FLOOR , BLOCK - A ,
ANURAG SOCITY, Thumkunta Hyderabad
Telangana INDIA 500015

Phone No : 7875943137 / 8080948582



Signature

Doctor Details :

Doctor Name : Dr. PILLARISETTI NAVEEN SARADHI

Specialisation : PULMONOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SHRUTI KOTAPALLI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Anishka

UHID ID:

Department:

Consultant:

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15-11-2024 1 Y 7 M 23 D (F)
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Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Cough 2 weeks

Noisy breathing - post tussive

History of present illness :

child is apparently normal 2 weeks ago. child developed above mentioned complaints.

Cough since 2 weeks

→ Noisy breathing - post tussive

→ Improvement mild after nebs.

→ 7 Acetaminophen injection 2 weeks ago.

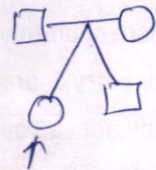


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

9 months / LSCS / 2.7kg NO H/O NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

(N) development

Immunization History :

vaccination till date

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 8.6 kg (Centile _____)

On Examination :

Temperature : 98.2° P Pulse Rate : 106/min B.P. 93/44 (57) SPO2 97% on RA
Resp. rate and type of breathing : RR = 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+), B/L wheeze (+)

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT.

Ausculation : _____

Spine : _____ External Genitalia : _____

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

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Flexible Bronchoscopy ± Rigid bronchoscopy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Plain } collected in EPR
EDTA }

Planned Management

• Flexible Bronchoscopy ± Rigid
bronchoscopy.

• PAC.

• NPO

• IV Amoxic (2/3rd maint)

• Inj Methylpred 1mg/kg OD

• Inj Augmentin

• Levoflox QID.

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya A

Date & Time: 8/7/26 ; 2pm

Signature of the Consultant: Dr. Naveen

Name of the Consultant: Dr. Naveen Saradhi

Date & Time: 8/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/2026 2 pm.	U/s/m Dr. Naveen Saradhi. adu % Suspected Foreign Body ? almond in @ Side Symptoms → Started by 29th July Cough x 1m 29th O/E SpO₂ - 97% HR - 106 RR - 28/min. Chest → @ Sided ↓ aurally in mammary area @ Side wheeze + in mammary area B/L wheeze in Posterior Interscapular region OT Observed % hyperinflation in @ Side.	① NPO ② IV Fluids (2/3rd) ③ Flexible Bronchoscopy + Rigid Bronchoscopy ④ iv Methylpred 1mg/kg Stat. ⑤ iv Augmentin ⑥ Neb c levodin <i>[Signature]</i>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>5:30pm</u>	<u>S/p Bronchoscopy</u>	
	→ Foreign body ? almond in (L) Side upper bronchus with granulation tissue & edema of (L) upper bronchus. Foreign body extraction not successful due to surrounding edema + granulation tissue. To reattempt the procedure after 48 hours.	
	Child Sedated	
	Suprasternal R(+) mid sternal R(+) mid ICR (+) RR-23 HR	<u>adv</u> 1. iv Meflo/prad 1mg/kg BD 2 Neb C levalin 0.31mg QCH
	SpO ₂ - 100% E 4ml of Oxygen. Chest & air entry better.	3. iv Acetamin 10. 4. NPO till 7:30pm
		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/11/26 7:30pm	S/P Bronchoscopy On nasal prongs HR: 136/min SpO₂: 98% ± 2L/min Oxygen chest: B/c air entry (+) mild (↓) in left side mild subcutaneous retractions (+) Accepting breastfeeds.	Adv :- - Shift to ward. - Back to back Nebulisation 0.31 mg - 2 cycles stat (to give 30 mins post feed).
8/11/26 9:30pm	S/P Bronchoscopy On nasal prongs HR:- 126/min SpO₂:- 98% ± 2L/min Oxygen chest: B/c air entry (+) mild ↓ in (L) side Accepting orally.	Adv :- continue same.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26	9:00 AM C/o Foreign body in (left UL bronchus) side. low-flow O₂ @ 2L/min. ONE fever spike - 100°F. (axillary) cough (+). Accepting orally. SpO₂ :- 98% on O₂. chest :- mild ↓ in air entry on left side. R/L wheeze ↓. CVS: S₁S₂ (+). P/A: soft. case: conscious.	Adv :- Continue • Inj Augmentin - D₂. • Levofloxacin 4 hourly • Inj methylprednisolone 4 • Budecort Neb BD • Dr. Harish Sir consultation • Continue IV fluid. • Try to taper low flow oxygen to 1L/min • Chest XRay - AP • Keep NPO - ct IV fluid.
	Plan: To do bronchoscopy for Foreign body removal by laryngoscope due to impacted nature of foreign body. To shift the child by 3 PM to Yashoda Hospital for laryngoscopy.	<i>[Signature]</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 8:00 am	cf&B Dr. Naveen Saradhi/ Dr. Shrutti Kotapalli s/p Bronchoscopy - Foreign body Removal. No fever. cough (+) Accessing well orally. SpO₂: 96% in R.A. chest:- (L) sided wheeze (+) crepts (+), air entry improved. CVS: S/S (+) P/A: Soft. CNS: conscious -	Adv:- • Inj Augmentin - D₃ • Levofloxacin Neb - 4 hourly • Inj MPS - D₃ • Budecort Neb BD • Taper to low flow O₂ @ 12 l/min • continue iv fluid.
10/7/26 5 pm	cf&B Dr. Shrutti Kotapalli/ Dr. Naveen Saradhi No fever No RO SpO₂: 99% in R.A. chest:- (L) sided wheeze (+) B/L AE (+).	Adv:- - Taper off O₂. - Rest. continue same. - Stop iv fluid - - if fever → to put iv & Restart Inj. Augmentin - CXR tomorrow morning

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RESULT SHEET

Date	08/07/26				
Time					
Hb	12.6				
PCV	39.3				
RBC	4.91				
WBC	16.21				
N/L	(26/68)				
Platelets	503				
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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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. Ranaya

Date & Time : 8/12/26 ; 2pm

Nurse Name & Signature : poulis

Date & Time : 8/12/26 - 2pm

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : 1WJ METHYL PREDNISOLONE

Date & Time 8/2 9/10/24

Dose Route Frequency Start Dt.

10mg PO BD 2/7/24

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : BUDECORT NEB.

Date & Time 8/2 9/10/24

Dose Route Frequency Start Dt.

0.5mg neb. q12h 8/7

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : SYP: AUGMENTIN Duo

Date & Time 10/7

Dose Route Frequency Start Dt.

4ml oral BD 10/7

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : SYP: OMNACORTIL FORTE

Date & Time 10/7

Dose Route Frequency Start Dt.

2.5ml oral O.D 10/7

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Ward

DRUG CHART

Date of Admission: 8/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : Symp Brown DS				Date Time
Dose 2ml	Route PO	Frequency 80s	Start Date 8/7	
Doctor's Signature <i>[Signature]</i>		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:				



REGULAR PRESCRIPTIONS

Weight. 8.06 kg Ward.

DRUG : <u>Tab METHYL PREDNISOLONE</u>				Date Time
Dose <u>10mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>8/7/26</u>	<u>6am</u>
Name & Signature of the Doctor Starting the Drugs: <u>D. Ranga</u>				Stop
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Tab AUGMENTIN</u>				Date Time
Dose <u>270mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>8/7/26</u>	<u>6am</u>
Name & Signature of the Doctor Starting the Drugs: <u>D. Ranga</u>				changed to oral
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Neb Levolin 0.63mg</u>				Date Time
Dose <u>1 resp</u>	Route <u>Nasal</u>	Frequency <u>Q6H</u>	Start Date <u>8/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>D. Ranga</u>				Stop 8/1/26
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Neb Levolin 0.3mg</u>				Date Time
Dose <u>1 resp</u>	Route <u>Neb</u>	Frequency <u>Q4H</u>	Start Date <u>8/7/26</u>	<u>8am</u>
Name & Signature of the Doctor Starting the Drugs: <u>D. Ranga</u>				8/1/26
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

VERIFIED

0000993
 Baby ANISHKA RAHUL SINGADE
 15-11-2024 1 Y 7 M 23 D
 Dr. PILLARISETTI NAVEEN SARADHI (F)

Weight. 8.6 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
8/7/26	2:40pm	LEVOLIN NEB.	0.63mg 3 cycles	neb.	[Signature]	Teena Sree
8/7/26	5:30pm	Nebic Levolin	0.31mg	Neb	[Signature]	Teena Sree
8/7/26	6pm	my Melly/prochlorperazine	10mg	IV Slow	[Signature]	Teena Sree
8/7/26	7:20pm	LEVOLIN NEB.	0.63mg 2 cycles	Neb	[Signature]	Teena Sree
8/7/26	9:00am	LEVOLIN NEB	0.31mg 3 cycles	Neb	[Signature]	Teena Sree

Weight. 8.6 kg Ward.

[illegible]



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/11/24	Time: 10 AM
Doctor / Nurse / Family Concern? Cam	
Temperature (°F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	97.8 98.3 137b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	28b/m
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min) O ₂ Saturations (%)	97%, 100%
Conscious Level	Normal Altered
GCS *	15/5
TOTAL SCORE	
Number of shaded boxes	1
Pain Score	2
Observer's Initials	

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
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- 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/11/26	Time: 6am	10am	2pm	5pm	8pm	2am
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100	99.8*				
	99		98.8*			
	98			97.5*	97.8*	
	97					
	96					
	95					
Heart Rate (bpm)	190					
180						
170						
160						
150						
140						
130						
120						
110						
100						
90						
80						
70						
60						
50						
Blood Pressure (mmHg) *	130					
120						
110						
100						
90						
80						
70						
60						
50						
Note: BP does not score in early warning scoring						
Heart Rate (Number)		113b/m	102b/m	105b/m	120b/m	111b/m
Resp. Rate (bpm) (Over 1 Minute) *	70					
60						
50						
40						
30						
20						
10						
Resp Rate (Number)		29b/m	25b/m	28b/m	30b/m	25b/m
Resp Distress	Mod/ Severe					
	None / Mild					
Receiving O ₂ (l/min)		2out O ₂	2out O ₂	2out O ₂	off 2 O ₂	off O ₂
O ₂ Saturations (%)		96%	92%	100%	94% 100%	95% 100%
Conscious Level	Normal					
	Altered					
GCS *		15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		1	1	1	1	0
Number of shaded boxes		0	0	0	0	0
Pain Score		0	0	0	0	0
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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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)

BAH-00660993 IP5-00176107
 Baby ANISHKA RAHUL SINGADE
 15-11-2024 1 Y 7 M 24 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

No. : RCH/ FRM / CLINICAL / 125

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

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

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 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/11/2024	Time: 10:00 am	10:30 am	11:00 am	11:30 am	12:00 pm	
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99	98.5		99.5		
	98		97.5		97.5	98.2
	97					
	96					
	95					
94						
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	40					
Note: BP does not score in early warning scoring	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Heart Rate (Number)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Resp. Rate (bpm) Over 1 Minute *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Resp Rate (Number)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Resp Mod/ Severe Distress None / Mild	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Receiving O ₂ (l/min) O ₂ Saturations (%)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Conscious Level Normal / Altered	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
GCS *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
TOTAL SCORE	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Number of shaded boxes	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Pain Score	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Observer's Initials	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					

ACTIONS	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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)
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BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 24 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/7/26 Time: 10PM 9:17:26 12AM 9AM 6AM

Doctor / Nurse / Family Concern?

Temperature (F)	104				
	103				
	102				
	101				
	100	100.8F 54.8C 27.1			
	99		99.0F		
	98			98.0F	
	97				98.4F
	96				
	95				
	94				

Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90	90 (60) 72	80 (60) 70	90 (62) 75	90 (65) 70

Note:

BP does not score
in early
warning scoring

Heart Rate (Number) 130b/min 130b/min 128b/min 130b/min

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				

Resp Rate (Number) 30b/min 28b/min 26b/min 30b/min

Resp Mod/ Severe Distress None / Mild 28b/min

Receiving O₂ (l/min) O₂ Saturations (%) 98% O₂ 98% O₂ 98% O₂ 99% O₂

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes 1 1 1 1

Pain Score 0 0 0 0

Observer's Initials 0 0 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
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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)
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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. :

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

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

BAH-00660993 IP5-00176107
 Baby ANISHKA RAHUL SINGADE
 15-11-2024 1 Y 7 M 23 D (F)
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FLUID CHART

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
9/07/26			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am	DNS	NPO										
	12:00 pm												
01:00 pm													
Total Intake :						Total Output :							
9/07/26	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm	DNS											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
9/7/26	08:00 pm			36ml									
	09:00 pm			36ml									
	10:00 pm	DNS	Kididi water	36ml									
	11:00 pm			36ml									
	12:00 am			36ml									
	01:00 am			36ml									
Total Intake :						Total Output :							
10/7/26	02:00 am			36ml									
	03:00 am			36ml									
	04:00 am			36ml									
	05:00 am	DNS		36ml									
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00660993
 Baby ANISHKA RAHUL SINGADE
 15-11-2024 1 Y 7 M 23 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

FLUID CHART

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse											
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine														
10/7			Mouth	I.V	N.G																		
	08:00 am	Drosgoluy									0	Prishu											
	09:00 am									0													
	10:00 am									0													
	11:00 am	milk									0	Prishu											
	12:00 pm									0													
01:00 pm									0														
Total Intake :					Total Output :																		
10/7	02:00 pm										0	Sara											
	03:00 pm	which									0												
	04:00 pm									0													
	05:00 pm									0													
	06:00 pm	only									0		Sara										
	07:00 pm									0													
Total Intake :					Total Output :																		
10/8	08:00 pm										0	Chandel											
	09:00 pm										0												
	10:00 pm	no IVF									0		Chandel										
	11:00 pm									0													
	12:00 am									0													
	01:00 am									0													
Total Intake :					Total Output :																		
11/8	02:00 am										0	Chandel											
	03:00 am	No IVF									0												
	04:00 am									0													
	05:00 am									0													
	06:00 am									0													
	07:00 am								0	Chandel													
Total Intake :					Total Output :																		
Total 24 hrs. Intake												Total 24 hrs. Output											

FLUID CHART

Sheet No. :

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

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												

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



NURSING CARE RECORD

Sh

☐ Night

Date: 8/7/26

Assessment:

Irretable - Pain

Goals

- ☒ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☒ Improve Activity Tolerance
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

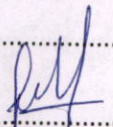
- ☒ Maintain Skin Integrity
☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8Am	* Assess the patient general condition.	8Am	* Assessed the patient general condition	
10Am	* Maintain I/o chat.	10Am	* Maintained I/o chat	
12pm	* Monitoring the vital signs.	12pm	* Monitoring the vital signs	* Administering the Medications AS per orders
1pm	* Ensure safety.	1pm	* ensured safety	
2pm	* Administering the Medications AS per doctors orders.	2pm	* Administering the Medications AS per doctors orders.	
4pm		4pm		
6pm	* Providing the comfortable position.	6pm	* Providing the comfortable position.	
8pm		8pm		

Re-Assessment:

Re - Assessment done.

Special Notes:

Nurse Signature: 

Nurse Name: Saccani

Date & Time: 8/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/2026

Assessment: Baby is having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the baby monitor vital signs provide comfortable bed and position administer medication as per doctor order educate personal hygiene	8:10pm	Assessed the general condition of the baby monitored vital signs	
10pm		10:20pm	provided comfortable bed and position	
12am		12:10 AM	Administered medication as per doctor order	
4am		4:20 AM		
6am				

The baby condition is Improving

Re-Assessment:

Baby is feeling discomfortable

Special Notes:

Nurse Signature: Rama Nurse Name: Rama Date & Time: 9/7/26 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/07/26

Assessment: pt having some activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess The pt General Condition	8:30 am	* Assessed The pt General Condition	
9am	* check The pt all vitals	9:30 am	* checked The pt all vitals	pt is stable
10am	* maintain s/o chest	11am	* maintained s/o chest	
11am	* provide comfortable position	12:30 pm	* provided comfortable position	
2pm	* administer all medication given by per doctor order	2pm	* administered all medication given by per doctor order	

Re-Assessment:

Special Notes:

NPO continue.

Nurse Signature:

Nurse Name: shanthi

Date & Time: 9/07/26 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having dull activity

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 baby general condition. monitor vital signs	8pm	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10pm	* provide comfortable position	10pm	* provided comfortable position	
12AM	* give nebulization	12AM	* given nebulization	
6AM	* Administered medication as per doctor order	6AM	* Administered medication as per doctor order	
8am	* ensure safety side rails	8am	* ensured safety side rails	

Re-Assessment:

Special Notes: 2L oxygen.

Nurse Signature: [Signature]

Nurse Name: Suneekha (221086)

Date & Time: 10/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Assessment: Baby having discomfort

Date: 10/17

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

Time	Plan of Care	Time	Implementation	Evaluation
9am	→ Assess the baby general condition	9:10am	→ Assessed the baby general condition	baby condition
10am	→ monitor the vital's	10:10am	→ monitored the vital's	& discomfort
11am	→ maintain IV fluid's	11:10am	→ maintained IV fluids	crying
12pm	→ given nebulization	12:10pm	→ Given the nebulization	
2pm	→ Administer medication as per doctor order's	1:10pm	→ Administered the medication as per doctor order's	

Re-Assessment:

Special Notes:

given the nebulization

Nurse Signature:

Nurse Name:

Siggle

Date & Time:

10/17 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: Baby having Cough / Respiratory distress

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 general condition of the child	2:5 pm	Assessed the general condition of the child	By doing all the procedure baby condition is improved
8pm	→ provide comfortable position	4pm	provided comfortable position	
4:30 pm	→ Maintain oxygen	5pm	→ 8pm oxygen kee OSL.	
5:30 pm	→ monitor the vital sign	5:20 pm	→ monitor the vitality	
6pm	→ To give nebulization	6:30 pm	→ To given nebulization	
8:30 pm	→ Administer medication as per doctor order	8:45 pm	→ Administered medicine as per doctor order	

Re-Assessment:

Special Notes:

O-5 O2 / continue nebulization

Nurse Signature:

Nurse Name: Swarnali

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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/12/24

Assessment: Baby having Discomfortable

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 Baby General Condition	8:10pm	→ Assessed the Baby general Condition	P ^{ts} stable
10pm	→ Check the Vital signs	10:10pm	→ Checked the Vital signs	
12am	→ plan for Administration medication	12:10am	→ Providing medication as per doctor Order	
2am	→ plan for Nebulization	2:10am	→ maintaining nebulization	
8am	→ plan for strictly I/O Chart	8:10am	→ strictly I/O Check	
	→ plan for Ensure Safety		→ Providing the Ensuring Safety	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: Nebulization

Nurse Signature: [Signature] Nurse Name: Chandana Date & Time: 11/12/24 @ 8am

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 28 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. NAVEEN Department: OT Date of Admission: 8/7/26

SITUATION	Diagnosis: <u>Bronchoscopy</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	CC 2:40	OT 2pm-8pm	1st floor 8pm to 8am	1st floor 8am to 4pm	1st floor 2pm-8pm	1st floor 8pm-8am
BACKGROUND	Medical Condition (Any special condition to be noted):		NA	N/A	NA	NA	NA	NA
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:	97.8°F	98.8°F	98.8°F	98.2°F	98.5°F	99°F
		Res:	32bpm	32bpm	30bpm	28bpm	28bpm	28bpm
		SpO ₂ :	100%	100%	100%	100%	99%	96%
		Pulse:	112bpm	113bpm	120bpm	120bpm	120bpm	118bpm
		BP:			80/70	100/60	100/60	89/58
		Fall Risk Score:	11	11	13	13	13	13
Pain Score:		0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:		yes	yes	yes	yes	yes	yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Pooja	Pranav	Rama	Shankh	Saavan	Sneha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7/26	8/7/26	9/7/26	9/7/26	9/7/26	10/7/26	
Time:		2:50 pm	@ 8pm	8am	2pm	8pm	8am	
Taken Over By Name :		Teena	Rama	Shankh	Saavan	Sneha	Saavan	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7	8/7/26	9/7/26	9/7/26	9/7/26	10/7	
Time:		2:15 pm	8pm	8am	2pm	8pm	8am	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. P. N. S. Department: ICU Date of Admission: 8/7/24

SITUATION	Diagnosis: <u>Bronchospasm</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area						
BACKGROUND	Shift Time	<u>1st floor 8am-2pm</u>	<u>2nd floor 2pm-8pm</u>	<u>1st floor 8pm-8am</u>			
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.5°F</u>	<u>96.1°F</u>	<u>98.5°F</u>		
		Res:	<u>28</u>	<u>24</u>	<u>26/bk</u>		
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>		
		Pulse:	<u>107</u>	<u>108</u>	<u>111/bk</u>		
		BP:	<u>107/61</u>	<u>110/54</u>	<u>95/60</u>		
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>			
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>10/7/24</u>	<u>10/7/24</u>	<u>11/7/24</u>			
Time:		<u>2pm</u>	<u>8pm</u>	<u>2am</u>			
Taken Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>10/7/24</u>	<u>10/7/24</u>	<u>10/7/24</u>			
Time:		<u>2pm</u>	<u>2pm</u>	<u>8am</u>			



THE HUMPTY DUMPTY SCALE

8/7 9/7 10/7 11/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	5	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	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	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	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	1	1	
TOTAL			11	11	11	11	

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes	yes	yes	
Call device within reach		yes	yes	yes	yes	
Wheels Locked		yes	yes	yes	yes	
Room free of clutter		yes	yes	yes	yes	
Adequate Lighting		yes	yes	yes	yes	
Wheel Chair Support		no	yes	no	no	
Other Intervention(s) Specify		no	no	no	no	
Nurse's Name :		Pooja	Ram	Sush	Chand	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date :		8/7	9/7	10/7	11/7	
Time :		2pm	6am	6am	6am	



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	puojs
8/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
9/7/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
9/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	pl
9/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suek
10/7/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Suek
10/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	S
10/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandam
11/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chend
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

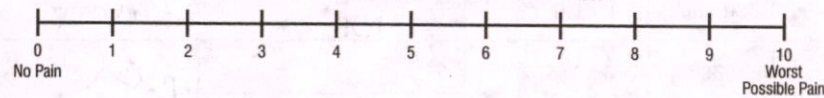
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

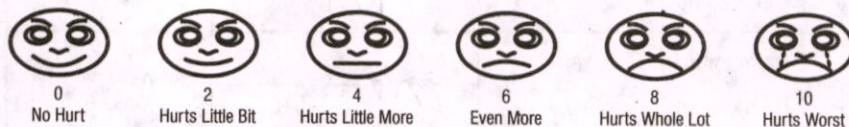
Numerical Pain Scale (Obstetric and Gynecology)



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



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	8/11/26	9/17/26	10/17/26	11/17
					Time :	2 pm	6 AM	6 AM	6 AM
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 e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	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	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	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	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	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	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	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	poofs	Rana	Sweh	Cy

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /FRM / CLINICAL / 119

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



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	0	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		NA	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
Signature of the Nurse					Rama		Sarav		Sarav		Sarav		

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 : Kumar Name : Kumar

Signature of Ward In Charge :

Signature : Sarav Name : Sarav

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Telugu 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		
8/12/26	2pm	8	Diagnostic test/procedures	F	4	0	1	1	NA	poys
9/12/26	8am	9	soft diet	f	1	0	1	1		Nithin

Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: flexible bronchoscopy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/11/26 2:15 pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI ? Foreign body	Hemodynamic stability	Flexible bronchoscopy	[Signature]	☒ Nursing ☐ Others:
8/11/26 2:20 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRT2	CR - stability	Flexible bronchoscopy	[Signature]	☒ Medical ☐ Others:
9/11/26 8am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	C/O suspected foreign body	soft diet	RDA e no kcalld p 20gld	[Signature]	☐ 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:



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. Flexible + Rigid bronchoscopy and 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>Diagnostic & Therapeutic</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:

- Hypoxia, laryngospasm, bronchospasm
-

I authorize Dr. Naveen Saradhi and his / her team to perform the procedural sedation upon the patient / myself.

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

Patient / Patient Attendant:

Signature: [Signature]
Name: Rahul Singade
Relationship with patient: father
8/7/26 2:50 pm

Witness:

Signature: - A's. Jnok
Name: Aniket Jnok
Date & Time: 8/7/26 @ 2:40 pm

(P.T.O.)
g consent):

Name: DR SOMASHREE Date 8/7/26 Time: 2:40 pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

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

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

a.	
b.	

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం 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 Naveen Saradhi
Asst. Surgeon :
Anaesthetist : Dr. Santhia
Scrub Nurse : Suman

Patient Name : Baby Anishka Age : 1y Gender : F
UHID No. : 660992 Surgery Name : Flexible bronchoscopy
Date : 8/7/26 In-time : Out-time :

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Before Induction of Anaesthesia >>

SIGN IN	Time: <u>3:20pm</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☒ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☒ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☐ Yes ☒ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Santhia</u>	

Before Skin Incision >>

TIME OUT	Time: <u>3:34pm</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? <u>112w</u> ☒ 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>Thijar</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>3:38pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No	
Signature : <u>Naveen Saradhi</u>	
Name : <u>Dr. Naveen Saradhi</u>	

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Patient



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 8/7/26

Department : Duration of Procedure : 30 min

Name of Surgeon : Dr Naveen Saradhi Date of Admission : 8/7/26

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 :	Sufata
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleansing surgical area with antiseptic agent)? ☐ Yes ☒ No	Sufata
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 8/7/26 @ 3:35 pm	Sufata

- 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 Anishka Age : 1Y 7M Gender : ☐ Male ☒ Female

UHID No. : BAH - 00660993 Weight : 9.8 kg Height :

Surgeon : Dr. Naveen. Asst. Surgeon : Dr. Nabeel Ali

Anesthetist : Dr. Saritha. OT Nurse : Suman - thejas OT Technician : Bapu

Pre-Operative Diagnosis:

Surgical Procedure : Flexible bronchoscopy

Indications for Surgery :

Date : 8/7/26 Start Time : 3:40 PM End Time : 5:30 PM

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

- Flexible Bronchoscopy done via Right Nasal passage
- Epiglottis, glottis, Subglottis normal
- Trachea normal
- (R) Bronchus, UL, ML & LL normal
- Foreign Body with granulation tissue & debris seen
- visible in (L) upper lobe
- Extraction of Foreign body tried - 3 times, but unable to do same due to surrounding edema and granulation tissue
- Foreign body Planned to try repeat extraction

after anti-inflammatory treatment, & ~~anti-edema measures~~
~~and~~ after 48 hours.

Child tolerated procedure well

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: Dr. Naveen Saradhi

Signature of the Surgeon: Naveen Saradhi

Date & Time: 8/7/26 5 pm.

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
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POST-SURGICAL CARE PLAN FORM

Procedure Done: Flexible bronchoscopy

Post-Surgical Diagnosis: _____

Post-Operative Monitoring Parameters /Frequency:

2 hourly monitoring for HR
SpO₂.

Wound Care:

nil

in /Special Lines/Catheters:

nil

Special Patient Positioning and Requirements:

nil

Nutritional Instructions:

Start feeds after 7.30 pm.

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Naveen Saradhi

Date: 8/7/26 Time: 5:30 pm

Note: Plan of care will be readjusted if necessary.

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE
15-11-2024 1 Y 7 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



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OPERATION THEATER NOTES

Patient's Name: Baby Anishka Age: 1y Gender: ☐ Male ☒ Female

UHID No.: BAH-00660993 Weight: Height:

Surgeon: Dr. Nabeel Asst. Surgeon: Dr. Harish

Anesthetist:

OT Nurse:

OT Technician:

Pre-Operative Diagnosis: ? FOREIGN BODY (R) UL BRONCHUS

Surgical Procedure:

RIGID BRONCHOSCOPY

Indications for Surgery:

? FOREIGN BODY (R) UL BRONCHUS

Date: 8/7/24

Start Time:

End Time:

Pre Operative Preparations:

Post Operative Diagnosis:

(R) UL BRONCHUS FOREIGN BODY

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Foreign body lodged in (R) Upper lobe bronchus

Procedure

Rigid bronchoscopy done. Findings noted. In view of severe edema, decided to do foreign body removal after 48

hours.

② main bronchus clear

Amount of Blood Loss: —

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications: —

Name of the Surgeon: Dr Nabeel

Signature of the Surgeon: 

Date & Time: 8/1/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660993 IP5-00176107 Baby ANISHKA RAHUL SINGADE (F) 15-11-2024 1 Y 7 M 23 D Dr. PILLARISETTI NAVEEN SARADHI		Date & Time of Admission 8/7/26 @		Date & Time of Transfer Order 8/7/26 @	
		Transfer Ordered by Dr. Naveen		Reason for Transfer Post op	
From Unit OT		To Unit 124		Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22		Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films NFI					
Medications / Consumables / Surgicals / Hand over					
Sl.No.	Item Name			Quantity	
1.					
2.					
3.					
4.					
5.					
Snorting Summary / Notes Written by Doctor : Yes ☐ No ☐					
Name & Signature of Person who is Transferring Savan			Name of Person Ordered Transfer Dr. Naveen.		
Patient & Clinical Records Received by : Ramadevi					
Date & Time of Patient Received : 8/7/2025 4pm					

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

BAH-00660993 IP5-00176107
Baby ANISHKA RAHUL SINGADE (F)
15-11-2024 1 Y 7 M 23 D
Dr. PILLARISETTI NAVEEN SARADHI

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

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:

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

Remarks

Nil

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

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

☐ Patient

☒ Family Member

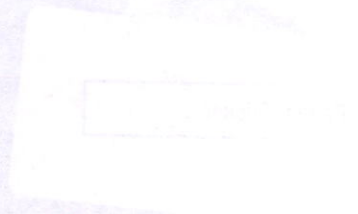
☐ Others:

Nurse Signature: [Signature]

Nurse Name: Saranya

Date and Time: 8/7/26 @ 2pm

Docu. No. : RCHBH /FRM / CLINICAL / 191



ORGANIZATION OF THE ...

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Baby Anishka Rahul Age: 1 Y 7 M Sex: F UHID.No: BAH-00660993
 Date: 8/7/24 Time: 2:40pm Proposed Operation: Flexible Bronchoscopy + Rigid Bronchoscopy
 Diagnosis: ? foreign body ingestion; cough noisy breathing
 B.P / CRT: 93/44 H.R: 106/min Weight: 8.6kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS: Term L&S delivery
 RESP: c/o cough since 1 week Diabetes: B.Wt: 2.7kg.
 CNS: Noisy breathing (+) NO NICU stay.
 Renal: c/o ? Almond ingestion 2 weeks ago.
 Hepatic / GE: Physical Activity: Active.
 Others:

Past Anaesthetic History: —

Physical Exam: (N)

Airway: MP 1 2 3 4 Mouth Opening:

Mentohyoid Distance:

Neck:

Teeth:

Lungs: B/L wheeze (+)

Heart: S2 (+)

CNS: EMF (+)

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site: 22G Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: last breast feed at 10 AM

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

CBP
Nebulisation with Duolin

Signature: [Signature] Name: Dr. Tejaswini



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Gravi Time Received : 5:50 PM Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>20</u>	☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway	☒ Nasal Prongs ☐ T-Piece ☐ Nasal Airway	Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : Oral Feeds :
		Drug:			

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/7	@ 8 PM	2/10	Dr. J. J. J.	

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature : [Signature]

Date & Time : 8/7/26 @ 8 PM

PACU Nurse Name : Gravi

PACU Nurse Signature : [Signature]

Date & Time : 8/7/26 @ 8 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): 121

Date & Time : 8/7/26 @ 8 PM

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Flexible bronchoscopy ± Rigid bronchoscopy

Anaesthesiologist: Dr. Tejaswini Surgeon: Dr. Naveen

Please read this before you consent for Anaesthesia

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

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

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

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others: Desaturation, bronchospasm, laryngospasm.

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: Rahul Singade

Name: Rahul Singade

Relationship with patient: Father

Date & Time: 8/7/26 2:45pm

Witness:

Signature: A.S. Dink

Name: Aniket Dink

Date & Time: 8/7/26 2:45pm

Doctor (who is taking consent):

Signature: Dr. Tejaswini Name: Dr. Tejaswini Date: 8/7/26 Time: 2:45pm

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

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

స్పెసిఫిక్ హై 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 ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ 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: తేదీ & సమయం:



121

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 9/7/26 Time: 8am

Weight: 8.6kg Centile: <5th

Height: 78cm Centile: >10th

Inference: Underweight child

RDA: - Calories: 1200 kcal/d Protein: 20g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, Chilled, outside foods

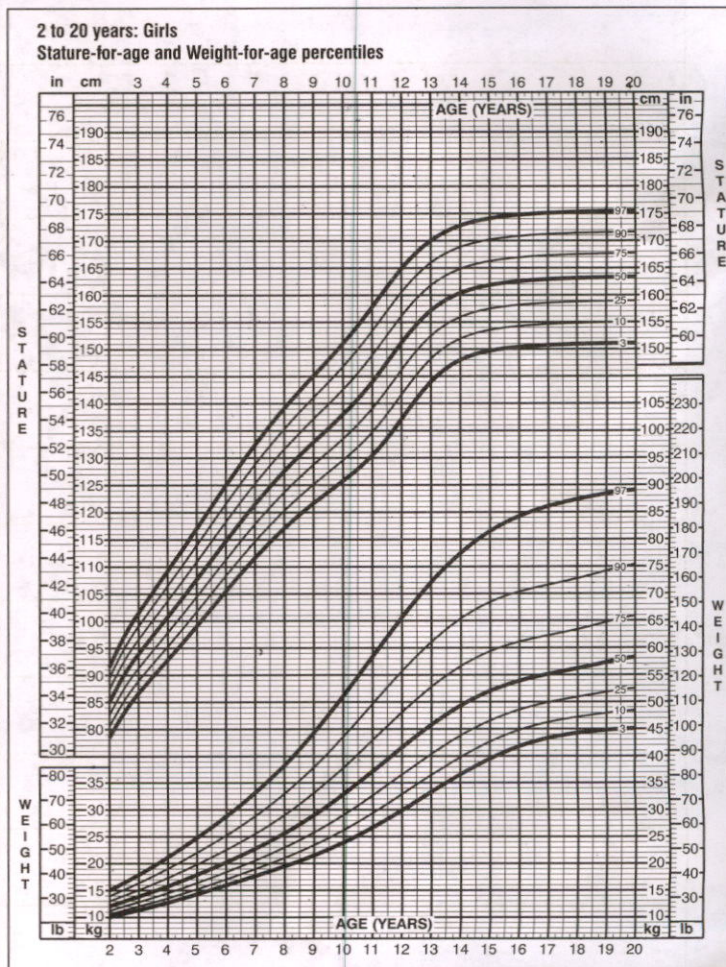
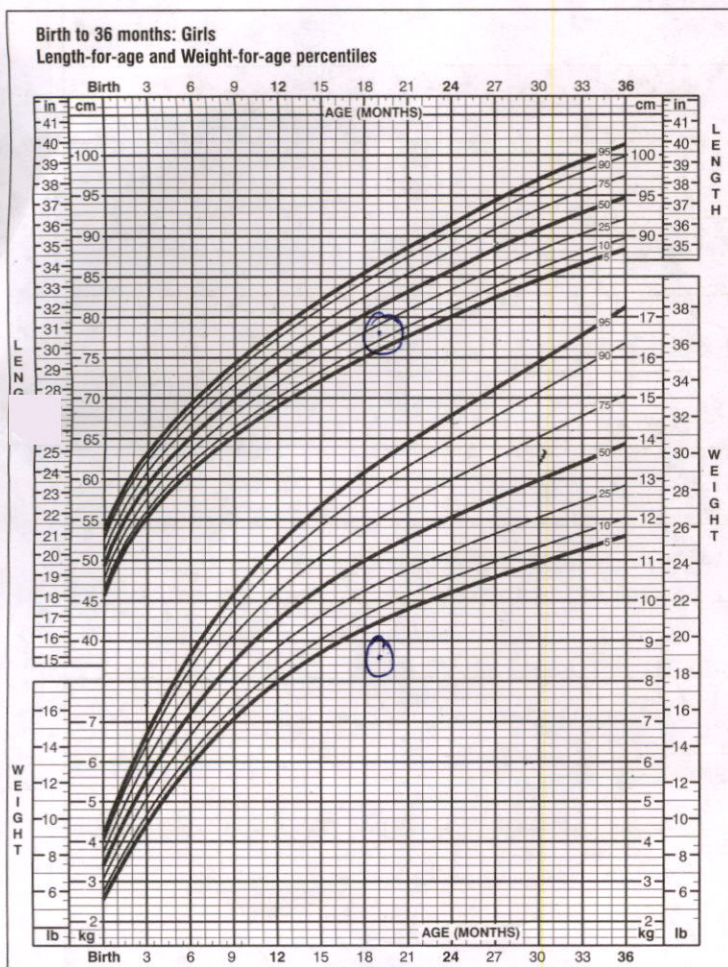
Food Allergies: No Veg/Non-veg: veg

Diagnosis: No suspected foreign body

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: A.S. Dhole

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

10/21/22
8:30am

Child is stable Oral Intake is well

Continue to soft diet.

- monitor

11/21/22
10am

Child is stable Intake is better

continue to soft diet

Monitor