Patient Stick

KUH-00213437 IP5-00176066
Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 2/4/24

Patient Name: Baby. Tanvika Date of Birth: 28-03-2024 Age: 24

Gender: F Ward : P. OT UHID No.: 0176066

Date of Surgery: 2/4/24 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB.

Time in : 11:55 pm Time Out : 12:55 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Sri Meghana	D.P - II
2.	Anaesthetist	:	
3.	Assistant Surgeon	:	
4.	OT Technician	: Shivaleela	
5.	Circulating Nurse	: Achi	
6.	Assistant Nurse	: Swarna	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 969847 Order by: Thijay.

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Dental

12kg

CONSUMABLES OF OT

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Circulating Staff ..... Technician : ..... Date : 7/7 Time : 10:30 AM

Anaesthesia Disposables (NP)	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5 (4.0) 4.5	1+1	01	Major Pack Surgical pack	1	1	Inj Vit.K		
LMA 2	01	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	05				Suction Catheter		
HME filter : A / P / N	01	01				Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	05	Gloves 6 6½ (7) 7½	2+2+2	1+1	Surgical Gloves		
02 cc	10	05	PF 6 6½ (7) 7½	2+2+4	2	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil			NS 500ml	2	0
NS : 10ml / 100ml / 500ml / 1000ml	01	01	Koochies			Transfix	1	1
Mini spike	01	01	Ointments			16 1 15	2+2	4
vaccay Set	01	01	Suction Catheter			26 Needle	1	1
Fentanyl	01	01	Cap, Mask	5+5	5+5	Roll Gauze	1	1
Morphine			Gauze Pack (2 Pkt)	5+5	2			
Ketamine			Mop Pack	2+1	—			
Propofol	03	01	Steristrip					
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	1			
Myopyrolate (Inj eo)	02	02	Abgel					
Ondansetron	01	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			OP 01	1+1	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			DA 18.20	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Ozmore (P)	01	—
Antibiotics			Bandage			Dermed (100)	01	—
Inj Pcm	01	01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	01	01	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	0	—			
3 way 10cm + 100cm	1+1	01	Microshield	1	1			
Gauze + Yellow Clay	Stat	—	Cotton Balls	1	1			
Dere + Tmeka	1+1	—	Latex Gloves	1 pr	1 pr			
IV cath. 22, 24	1+1	—	Ramdione Scrub					
Q- cuter Sp 1+1, 3	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9.69.180 Ordered by : .....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176066 **Admit Date** : 07-Jul-2026 **Admit Time** : 09:46 AM **UHID** : KUH-00213437

Patient Details :

Patient Name	: Baby POLNATI TANVIKA	**Age**	: 2 Y 3 M 9 D
Guardian	: Mr POLNATI VENKAT	**DOB**	: 28-03-2024
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 111, BLOCK A, GIRIJA MARVEL, CHANDANAGAR, MIYAPUR Chandanagar Hyderabad Telangana INDIA 500050	**Phone No**	: 9912656116/ 9553695566
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 405 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 405 **Admission Type** : First Visit

Contact Details :

Name : Mr POLNATI VENKAT **Relationship** : Father

Contact Address : FLAT NO 111, BLOCK A, GIRIJA MARVEL, CHANDANAGAR, MIYAPUR Chandanagar Hyderabad Telangana INDIA 500050 **Phone No** : / 9912656116

Signature

Doctor Details :

Doctor Name : Dr. Sri Meghana **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : Tanvi

KUH-00213437 IP5-00176066
Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

UHID No. : _____ IP N _____ nt: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	10:5am	ER	OT	Pooja
7/7/26	2.30 pm	OT	Billing	Thyer.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
07/07	CBP	67875	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	in placement PAC op Basis	1	92483	Tanuf

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sri Meghana Date : 07/07/2026

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: 9.20 AM Weight: 12.5 Kg

Allergic History: NKDA

Chief Complaints: Consult for Comprehensive oral rehabilitation for Early childhood caries

Pediatric Assessment Triangle

A Appearance - TICLS Normal

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

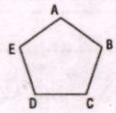
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: —

Medication History: —

Relevant Investigations: —

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing

Rate: 28 SpO_2 on FiO_2 100% RA

Rhythm: Abnormal

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE, Clear

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 106 b/m CFT Central <3 sec, Peripheral <3 sec

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 96/60 mmHg

Pulse Volume: Central Good, Peripheral Good

If in Shock: Compensated ..... Hypotensive .....

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

Murmurs: ☐ Yes ☒ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☒ No

Disability

GCS: 15/15 AVPU: A

Any urgent interventions needed: ☐ Yes ☒ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 3 mm, Left 3 mm

Active Seizures: ☐ Yes ☒ No Sugars: .....

Signs of Neurological compromise .....

Exposure

Temp.: 98.4°F

Any urgent interventions needed: ☐ Yes ☒ No

If Yes .....

Any Rash: ☐ Yes ☒ No,

If yes describe the rash .....

Active bleed —

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: —

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

Secondary Assessment: Head to toe examination with positive findings: Normal

Labs Planned:

CBP N/S Inj 07/07

Treatment Planned:

- NPO as advised
- I.V.F. DNS
- Shift to OT

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Early childhood caries

Assessment done by

Name of the Doctor: Dr. Nandan

Signature:

Date & Time: 07/07/2026, 9:30 AM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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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. Nanda

Date & Time : 07/07/2026, 9:30AM

Nurse Name & Signature: Nur. Sussmita

Date & Time : 7.7.26 @ 9:50 a.m.

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RESULT SHEET

Date	7/7/26					
Time	9.55					
Hb	13.1					
PCV	41.6					
RBC	5.25					
WBC	9.93					
N/L	33/60.9					
Platelets	437					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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FLUID CHART

Sheet No. : ..... 1 .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
1/4/26	04:00 pm	water	50 ml	-	-	-	-	-	-	-	0	
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

FLUID CHART

Rainbow® Children's Hospital
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Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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DRUG CHART

Date of Admission: 07/07/2026 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Sig[illegible]e

VERIFIED BY : Name .....

KUH-00213437 IP5-00176066
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Dr. Sri Meghana

REGULAR PRESCRIPTIONS

Weight. 12.5 kg Ward. ....

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dr. Sri Meghana

Weight. 12.5kg Ward. .....

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.	

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
07/07/26	12:10pm	INJ PARACETAMOL	190 mg	IV		
07/07/26	12:00pm	SUP DICLOFENAC	12.5 mg	P/R		

Signature .....

VERIFIED BY : Nam .....

Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

IPS-0017606 6

KUH-0021343 7

I.V. FLUIDS CHART

Weight. 12.5 Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
07/07/2026	9.30 AM	DNS	IV	45 ml/hr		N/C			
07/07/26	11:55AM	RINGER LACTATE	IV	120 ml/hr			7/7		

Signature .....

VERIFIED BY : Name .....

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 Comprehensive Oral Rehes U GA.

2 .....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a.

b.

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

Patient / Patient Attendant:

Signature: .....

Name: VENKAT.

Relationship with patient: FATHER

Date & Time: 07/06/26 @ 11.30 am

Witness:

Signature: .....

Name: SATYA MADHURI

Date & Time: 07/06/26 @ 11.30 am

Doctor (who is taking consent):

Signature: ..... Name: Dr. Sri Meghana Date 7/6/26 Time: 11:30 am.

Patient Sticker

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.
b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్‌ను 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. Meghana
Asst. Surgeon :
Anaesthetist : DR. Shainy
Scrub Nurse : Swapna

Patient Name : Baby. Tanvi... Age : 2y Gender : F
UHID No. : 0176066 Surgery Name : Complete urethroplasty
Date : 28/8/24 In-time : 11:55 AM Out-time : 12:55 p.m

KUH-00213437 IP5-00176066
Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:55 AM

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 : Shainy
Name : DR SHINY

Before Skin Incision ➤➤

TIME OUT Time: 12:07 pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? NA ☐ Yes ☐ No ☑ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☑ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature :
Name : DR SHINY

Before Patient Leaves Operating Room

SIGN OUT Time: 12:57 p.m

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

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

Signature :
Name : Dr. Sri Meghana

Patient

KUH-00213437 IP5-00176066
Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

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BirthRight BY RAINBOW HOSPITALS
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 2/8/26

To Be Filled In By Assigned Nurse :

Department : P. OT Duration of Procedure : 1 hr

Name of Surgeon : DR. Sri Meghana Date of Admission : 7/1/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☑ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☑ No Name of the Antibiotic : —	
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 37.5 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : — Date & Time of antibiotic administration : — Date & Time procedure started : 2/8/26 @ 12.10pm	

- 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

KUH-00213437 IP5-00176066
Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

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OPERATION THEATER NOTES

Patient's Name : Baby Tanvika Age : 2Y Gender : ☐ Male ☐ Female

UHID No.: 0126066 Weight : Height :

Surgeon : Dr. Sri Meghana	Asst. Surgeon :	
Anesthetist : Dr. shiny	OT Nurse: Swapna	OT Technician: Shivakoda

Pre-Operative Diagnosis:

Surgical Procedure : Comprehensive Oral Rehes U GA

Indications for Surgery : Early Childhood caries

Date : 9/3/26	Start Time : 12:10pm	End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

p. Intubation done @ 11:20 am.
pulpectomy done in 52, 51, 61, 62.
pulpectomy & crown insertion - 54, 64.
crown insertion - 74, 84.

post op instructions
soft diet
Gentle brushing } (3) days

K

Syrup Ibugesic 3ml - 0 - 3y.

Review after 1week.

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. Sri Mythane

Signature of the Surgeon:

Date & Time: 7/7/26. 12:3pm

Baby POLNATI TANVIKA
28-03-2024 2 Y 3 M 9 D (F)
Dr. Sri Meghana

Patient Sticke

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Comprehensive ORJ Rehab U.G.A

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

—

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

Recovery position

Nutritional Instructions:

—

When to Start Mobilization:

—

Special Referrals:

—

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.