BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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SURGERY DETAILS

Date : 23/07/26

Patient Name: PARISHA SAHU Date of Birth: 12-05-2022 Age: 4Y

Gender: Female Ward : P.OT UHID No.: BAH-00662003

Date of Surgery: 23/07/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB.

Time in : 9:20Am Time Out : 11Am

	NAME	AMOUNT
1. Surgeon	: DR NAMRATA	DP-II
2. Anaesthetist	: Dr. Sarika	
3. Assistant Surgeon	:	
4. OT Technician	: Kulsum	
5. Circulating Nurse	: Bikulai	
6. Assistant Nurse	: Thijas	

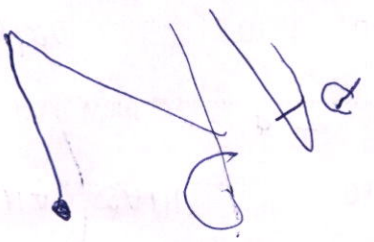
Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others COLLECT 2000/- TOWARDS CROWNS

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9717945 Order by:

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



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Dental

18.10.24

CONSUMABLES OF OT

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Circulating staff : ..... Technician : ..... Date : 22/4 ..... Time : 9AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube PC Nasal 3.5 4.0 4.5	1+1+1	1+1	Major Pack Surgical pack	1	1	Inj Vit.K		
LMA 2	1	—	Sutures			Cord Clamp		
ECG leads : A (P) N	5	5				Suction Catheter		
HME filter : A (P) N	1	1				Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	05	Gloves 6 6½ 7 7½ 8 2+2		2+2	Surgical Gloves		
02 cc	10	05	PF 6 6½ 7 7½ 8 2+2		2+2	Gauze Pack		
01 cc	2	—				Syringe 1ml / 2ml		
Cautery plate : A (P) N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	1	Cautery pencil			NS 500ml	2	0
NS : 10ml 100ml 500ml / 1000ml	2+1	1	Koochies			Inj Tranexa	1	0
O2 Mask (P)	1	1	Ointments			10% EC Jelly	2+2	0+0
Airways 0.1	1+1	—	Suction Catheter					
Fentanyl	1	1	Cap, Mask	5/5	5/5	Roll Gauze	1	2
Morphine			Gauze Pack RM	5/5	5/5	2% Lidocaine	1	1
Ketamine			Mop Pack			20% Albumin	1	1
Propofol	2	1	Steristrip					
Rocuronium	1	1	Underpad	1	1	IV cannula 22, 24	1+1	—
Glycopyrolate	1	1	Draw sheet	1	0	Dexa	1	1
Myopyrolate + Neostigmine	2	2	Abgel			+ ranexa	1	1
Ondansetron	1	1	Foleys catheter			Minispine	1	1
Pencan 25g/ Spinal Needle 22	1	—	Urobag			NG 5, 6 7 8 9 10		—
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Suction cath 6.8.10		—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dexmedomide 50	1	—
Antibiotics			Bandage			Clonidine	1	—
			Tegaderm			Atropine + Adrenaline	1+1	1+1
Suppositories			Ioban			Lasix + Mida z	1+1	1+1
Anamol : 80mg / 250mg / 170 mg	1+1+1	—	Double J Stent			Splint 3 N (+)	1+1	—
Supridol : 100mg			Vaccum Suction set	1	0	Q Site	1	—
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	0	Nasal Airway 16 18 20	1+1+1	—
Tab. Misoprost : 200mg			Betadine Solution	1	—			
Vaccum set	1	1	Microshield	1	—			
Gauze	3	0	Cotton Balls	1	1			
Gloves and	4	—	Latex Gloves	1	10			
IV P.cm	1	1	Ramdione Scrub	~~1~~	~~1~~			
3-way 100 Pcm	1+1	1	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9717787 Ordered by : .....

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

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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 REHAB (D) 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)
RELIEF OF PAIN AND INFECTION .	

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. NO COMPLICATIONS .

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: Nava
Relationship with patient: father
Date & Time: 23/7/26 @ 9 am

Witness:
Signature: Nalu
Name: Ujjwala
Date & Time: 23/7/26 @ 9 am

(who is taking consent):
Signature: Namrata Name: DR NAMRATA K. Date 23/07/26 Time: 9:03 AM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ 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 భాషలో 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

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

Surgeon : Dr. Namrata
Asst. Surgeon :
Anaesthetist : Dr. Sarita
Scrub Nurse : Thejas

Patie... Age : 4Y Gender : F
UHID ... e : Dental
Date : 25/07/26 In-time : 9:20Am Out-time : 11:20

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:15 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 : .....

Name : Dr. SARITHA

Before Skin Incision ➤➤

TIME OUT Time: 9:37 Am

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, 1hrs
- Anticipated Blood Loss? less than 200 ml ☐ Yes ☑ No ☐ NA

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

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

Signature : .....

Name : .....

Before Patient Leaves Operating Room

SIGN OUT Time: 11:20

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 : Namrata

Name : DR NAMRATA K

SURGICAL SAFETY CHECKLIST

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

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

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

Patient Has Confirmed
- Identity ☐Yes ☐No
- Site ☐Yes ☐No
- Procedure ☐Yes ☐No
- Consent ☐Yes ☐No

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☐No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☐No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☐Yes ☐No ☐NA

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

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

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

Anticipated Critical Events

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

Anaesthesia Team Reviews:

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

Nursing Team Reviews:

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

Is Essential Imaging Displayed? ☐Yes ☐No ☐NA

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

Signature :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded ☐Yes ☐No

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

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

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

To Surgeon, Anaesthetist and Nurse:

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

Signature :.....

Name :.....

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 23/07/26

Department : P.OT Duration of Procedure : 1hr

Name of Surgeon : Dr. Namrata Date of Admission : 23/07/26

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 :	Bikela
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	Bikela
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Bikela
4.	Name of doctor or staff administering the antibiotic : Dr. N/A Date & Time of antibiotic administration : 22/07/26 at NA Date & Time procedure started : 23/07/26 at 9:37 AM	Bikela

- 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

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12-05-2022 4 Y 2 M 11 D (F)
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OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender : ☐ Male ☐ Female

UHID No.: ..... Weight : ..... Height : .....

Surgeon : DR NAMRATA	Asst. Surgeon :	
Anesthetist : DR. SARITHA	OT Nurse: B Thejas	OT Technician: Kulsum
Pre-Operative Diagnosis:		
Surgical Procedure : COMPREHENSIVE ORAL REHAB (↓) GA		
Indications for Surgery : DENTAL CARIES .		
Date : 23/07/26	Start Time : 9:37Am	End Time : 11 am

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: GA (↓) NASAL INTUBATION .

1. RADIOGRAPHS EXPOSED .
2. PULPECTOMY DONE ON 75, 85 .
3. STAINLESS STEEL CROWN INSERTION ON 64, 75, 85 .
4. GIC RESTORATION DONE ON 54, 55, 65, 74, 84 .

REVIEW AFTER 3 DAYS
GENTLE BRUSHING FOR 3 DAYS
SOFT FOOD FOR 3 DAYS .

℞

Syrup. IBUGESIC (5ml) × 3 days
(1 — 1 — 1)

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 NAMRATA K

Signature of the Surgeon: Namrata

Date & Time: 23/07/26 11:00 AM

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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POST-SURGICAL CARE PLAN FORM

Procedure Done: CROWNS + PULP THERAPY + FILLINGS.

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care: Bleeding Every 15 Mins.

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals: CONSULT ENT. Dr

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

Namrata

Treating Surgeon
(Signature & Stamp)

Date: 23/07/26 Time: 11:00 AM

Note: Plan of care will be readjusted if necessary.

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 : IP5-00176796 **Admit Date** : 23-Jul-2026 **Admit Time** : 07:23 AM **UHID** : BAH-00662003

Patient Details :

Patient Name	: Baby PARISHA SAHU	**Age**	: 4 Y 2 M 11 D
Guardian	: Mr NAVEEN KUMAR SAHU	**DOB**	: 12-05-2022
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO -312 HALLMARK VESTA OSMAN NAGAR KOLLUR Telangana INDIA 502300	**Phone No**	: 8686824547/ 9398493484
		E-mail	: NAVEENKU.SAHU@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 402 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 402 **Admission Type** : First Visit

Contact Details :

Name : Mr NAVEEN KUMAR SAHU **Relationship** : Father

Contact Address : FLAT NO -312 HALLMARK VESTA OSMAN NAGAR KOLLUR Telangana INDIA 502300 **Phone No** : 8686824547 / 9398493484

Signature

Doctor Details :

Doctor Name : Dr. NAMRATA KAMALAKAR RAO KOTHAPALLI **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : _____

IP5-00176796
BAH-00662003
Baby PARISHA SAHU (F)
12-05-2022 4 Y 2 M 11 D
Dr. NAMRATA KAMALAKAR RAO

UHID N _____ Consultant: _____ Dept : _____

Date of A _____ Date of Discharge : _____ Time: _____

Room / Be _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/07/26	7:00pm	ER	OT	
23/7	12pm	OT	billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
23/7	CBP	73800	Venkat

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/7	IV placement	2	17606	venkat
23/7	NAC done on	op basis		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

10
6:15 weeks.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7	CNB Resident	
	C/o	
	Delayed teeth	
		Plan
	O/E W - 18.5kg	CRP & Consulted
	- Abnormal teeth.	NPO
	- CVS S1S2 (+)	iv fluids
	RS - BAE (+), clear	
	P/A - (N)	noted by. Pradeep 23/7/22 7:25 AM
	NPO from - 10pm - Solid	
	6:15pm - Fluid	
	Temp - 97°F BP - 100/65 (93)	
	PR - 105 RR - 25/min	
	SpO2 - 99% in RA	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00652003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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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: GR 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. Sri Recordable

Date & Time : 23/7/26 at 1:10A

Nurse Name & Signature: Radeep

Date & Time : 23/7/26 at 1:20A

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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DRUG CHART

Date of Admission: 23/7/26 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

SOS / PRN (As Required Medication)

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

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

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

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

BAH-00652003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

REGULAR PRESCRIPTIONS

Weight. 18.0kg Ward. OT

Dose	Route	Frequency	Start Date	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Baby PARISHA SAHU IP5-00176796
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

Weight. 18.0kg Ward. OT

	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
23/7/26	9:35Am	INJ. TRANEXAMIC ACID	270mg	IV		
23/7/26	9:40Am	INJ. PARACETAMOL	270mg	IV		

Signature

VERIFIED BY : Name

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

I.V. FLUIDS CHART

Weight. 18kg Ward. OT

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
22/7		2NF DNS (FULL MF)	iv	50	By		23/7 discarded		
23/7	9:30am	RINGER LACTATE	IV	180	MF		23/7	MF	

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

Namrata Sahu.

BAH-00652003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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RESULT SHEET

Date	23/7/26					
Time	7.25am					
Hb	11.4					
PCV	36.1					
RBC	4.54					
WBC	5.98					
N/L	38.7 / 51					
Platelets	361					
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.,) : .....

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
23/7	12:00 pm	H2O	—			—	—	—	—	—	0	Dutt
	01:00 pm	Icecream	—			—	—	—	—	—	0	
Total Intake :						**Total Output :**						
	02:00 pm	Idly									0	
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

FLUID CHART

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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**	

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
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THE HUMPTY DUMPTY SCALE

23/04.

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
	TOTAL		10				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes				
	Call device within reach		Yes				
	Wheels Locked		Yes				
	Room free of clutter		Yes				
	Adequate Lighting		Yes				
	Wheel Chair Support		N/A				
	Other Intervention(s) Specify						
	Nurse's Name :		[illegible]				
	Signature :		[illegible]				
	Date :		23/4				
	Time :		7:30 AM				

Docu. No. RCHBH / FRM / CLINICAL / 005

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby Parisha Sahu Age: 4yr. Sex: F UHID.No : BAH-62003

Date: 21/2/26 Time: 3.30 pm Proposed Operation: Dental Caries

Diagnosis: Comprehensive Oral rehabilita

B.P / CRT: ..... H.R: ..... Weight: 18.5kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: NONE

Medical History: CVS : Not significant

RESP :

CNS :

Renal :

Diabetes : —

Hepatic / GE :

Physical Activity: ↓ (N)

Others : LSCS | B.wt - 2.5 kg | Term GA | No NICU admin

Past Anaesthetic History: N/K

Physical Exam: (N)

Airway: MP (1) 2 3 4 Mouth Opening: adequate Mentohyoid Distance: ✓ Neck: ✓ Teeth: No loose teeth

Lungs : B/L clear

Heart: S1S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☑ NA | Venous Access Site : ✓ Spine Exam for regional : NA

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours ✓ ; Others 6 Hours milk ✓.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   - Weight needs to be checked.
   - CBP on cannulation.
   - Consent pending

Signature: ..... Name: Dr. SRINIVAS.

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

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Confirmed

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

H.R: 122/min. | B.P/CRT: <3sec | SpO_2: 100% on RA | R.R: | Last Feed: Yesterday night

Pre-OP Diagnosis: Dental caries. | Operation: Oral comprehensive rehabilitation | Date: 23/7/22

Surgeon: Dr. Namrata. | Anaesthesiologist: Dr. Sasikiran | Technician: Mrs. Ieuhum

TIME: 9AM 9:30 10 10AM 11

N_2O /AIR /O_2 LPM 1:1 →

HALO /SO (SEVO) 1MAC →

Drugs:
Inj. Midaz 0.5mg
Inj. Fentanyl 40mcg
Inj. Pwrpfol 40mg + 20mg
Inj. Rocuronium 9mg
Inj. Neostigmine 2.5mg
Inj. Dexa 1.5mg
Inj. Paracetamol 1.25mg

FIO_2 / SaO_2	100%	100%	100%	100%	100%	100%	100%
$ETCO_2$	34	35	36	36	38	35	35
ECG	SR	SR	SR	SR	SR	SR	SR
Temperature							
Urine Output							

Fluids / Blood: RL @ 150ml/hr.

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

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

Position: Supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 9:20Am
OP Start: 9:35Am
OP End:
Leave OR: 11Am.

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
☑ T# 4.0 at 14 cm
☐ Oral ☑ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☑ Drug: Rocuronium

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: Single
Difficulty Why? —

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

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

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

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

BAH-00662003 IP5-00176796
Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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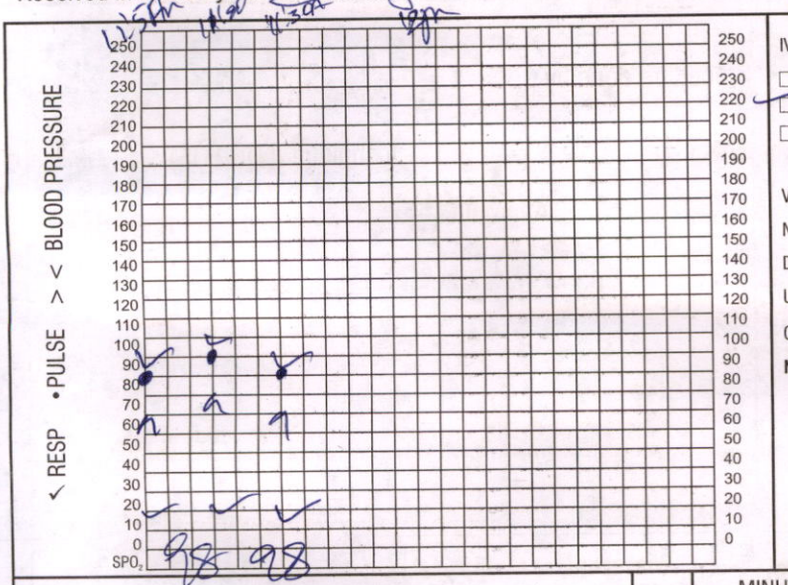
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 7.15AM Time Discharged : .....



IV Cannula Site : .....

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

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

IV Fluids: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/7	11.5PM	1/10	—	

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

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

Anaesthesiologist Name : Dr SUNDARAM
Anaesthesiologist Signature: Sundhaes
Date & Time: 23/7/26, 12pm

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 23/7/26 @ 12pm

Transferred to Unit by (PACU): .....
Date & Time: 23/7/26 @ 12pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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Baby PARISHA SAHU
12-05-2022 4 Y 2 M 11 D (F)
Dr. NAMRATA KAMALAKAR RAO

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: ORAL COMPREHENSIVE REHABILITATION.

Anaesthesiologist: Dr. SARITHA. Surgeon: Dr. NAMRATA.

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 .....

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: Vijaya
Name: Vijayala
Relationship with patient: Mother
Date & Time: 23/7/26 9:14AM.

Witness:
Signature:
Name: Nurse
Date & Time: 23/7/26 9:14Am

Doctor (who is taking consent):
Signature: Name: Dr. SARITHA Date 23/7/26 Time: 9:14 Am

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ రీజనల్ 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, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ 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 స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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