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 : IP5-00176015 **Admit Date** : 06-Jul-2026 **Admit Time** : 10:30 AM **UHID** : BAH-00656652

Patient Details :

Patient Name	: Master SUDAISI GARAD FARAH HUSSEIN	**Age**	: 6 Y 5 M 29 D
Guardian	: Mr GARAD FURAH HUSSAIN	**DOB**	: 07-01-2020
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: PARAMOUNT COLONY Tolichowki Hyderabad Telangana INDIA 500008	**Phone No**	: 9573764055
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

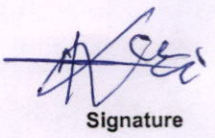
Bed Type : DAY CARE **Bed No** : PICU - DC 229 **Ward Name** : 2F-PICU II

Room No : PICU - DC 229 **Admission Type** : First Visit

Contact Details :

Name : Mr GARAD FURAH HUSSAIN **Relationship** : Father

Contact Address : PARAMOUNT COLONY Tolichowki Hyderabad Telangana INDIA 500008 **Phone No** : 9573764055



Signature

Doctor Details :

Doctor Name	: Dr. M N V POUSHYA SAI	**Specialisation**	: PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	: Dr. Prashant Bachina		

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 6 M 29 D (M)
Dr. M N V POUSHYA SAI

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	1pm	ER	229	

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
06/07	CBP, LFT, PT/APTT/INR, GGT, Ultrasound	done on op basis	Ismail
6/7/26	Biopsy for Histopathology Liver	26067580	
	Ultrasound guided procedure	33505	Dr

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/7/26	Inv. monitor	12pm		9690089	[illegible]
	Inf. pump			9690069	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	iv placement	1	9942	
6/7/26	Conscious Sedation	(1)	9690068	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. M N V poushyasai Date : 06/7/20.

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

Start Time of Assessment: .... Weight: 21.6 kg

Allergic History: ....

Chief Complaints:
? Autoimmune hepatitis
↓
Admitted for liver biopsy

Pediatric Assessment Triangle (N)

A Appearance - TICLS ....

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: CFT / LFT / INR, USG-abd - (N)
↳ 39 ↳ 1

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: 24/min SpO$_2$ on FiO$_2$ 98% RA

Rhythm: ....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: ....

Palpation Findings (If necessary) ....

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

Circulation

HR: 102/min CFT [Central ..... / Peripheral 2 sec]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

Pulse Volume: [Central ..... / 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: ..... AVPU: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Pupils: [Responsive ☐ Non-Responsive ☐ / Size [Right ..... / Left .....]]

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 98.6°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: .....

Labs Planned: .....

Treatment Planned: .....

- NPO from 11 PM
- INF - NS
- Liver Biopsy today.

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

Final Diagnosis with possible Differential Diagnosis (If necessary): ? Autoimmune hepatitis → Liver Biopsy plan today

Assessment done by

Name of the Doctor: N. Prathibha

Signature: N.P.

Date & Time: 08/7/25, 10:30 am.

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH (M)
07-01-2020 6 Y 5 M 29 D
Dr. M N V POUSHYA SAI

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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: 228

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 : M. Poushya. M.P.N.V

Date & Time : 6/7/26, 10:30 am.

Nurse Name & Signature: Nur. Sushita

Date & Time : 6/7/26 @ 10:30 am

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/06/26 12:20 AM	Procedure Note, (Liver biopsy)	Ultrasound Guided
	+ Aseptic precaution, Liver biopsy was performed using 18G × 16 cm. biopsy needle under ultrasound guidance. Procedure went uneventfully. Post procedure check ultrasound show no pneumothorax or local Hematoma. or other complication.	
	Post procedure:	
	Hemodynamically Stable	
	HR = 106/min	
	RR = 20/min	
	SPO₂ = 100% on RA	
	BP = 110/64 mmHg.	Dr. Kunal.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

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DRUG CHART

Date of Admission: 6/7/26 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 :				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:				

Signat...

VERIFIED BY : Name .....

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Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

REGULAR PRESCRIPTIONS

Weight. 21.6 kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

Weight. 21.6kg 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

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

Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

I.V. FLUIDS CHART

Weight. 21.6 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
06/7/26	12pm	DNS	IV	60	N.Ans	[signature] [signature]			

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

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Master. Sudaisi Farah Gender: ☐ Male ☑ Female

UHID No : BAH-00 65865 2. Department : PW Date : 6/7/26

I ..... S / D / W / O .....

Here by give consent for procedure of : Liver Biopsy.

For my patient, Named : .....

The doctors have clearly explained to me that the procedure has following possible complications:

Infection, hematoma, Bleeding, Pneumothorax.
Injury to adjacent structure.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: ~~Dr. Abba~~ | ~~Dr Poushya~~ | DR. Kunal

Patient Attendant :

Signature : .....

Name : Riyaz

Relationship with Patient: ~~Uncle~~ Mother

Date & Time : 6/7/26 @12pm

Witness :

Signature : .....

Name : Khadar Translate

Date & Time : 6/7/26 @12pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Kunal.

Date & Time : 6/7/26 @12pm

ప్రత్యేక విధానాలకు సమ్మతి

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రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు : .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
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Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO_2	Pain Score	Weight
117/74	99b/m	23b/m	98.7°F	100%	0/10	21 Kgs

Diagnosis: Autoimmune hepatitis.

Procedure: Liver biopsy.

Comorbidities:

☐ Risk, benefits & alternatives discussed;
☐ Patient understand & elects to proceed
☐ Consents for procedure and sedation signed and dated

ASA Physical Status

☑ ASA PS 1: Healthy Patient
☐ ASA PS 2: Mild Systemic Disease, no functional limitations
☐ ASA PS 3: Severe Systemic Disease, functional limitations
☐ ASA PS 4: Severe Systemic Disease, constant threat to life
☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes
☐ E: Emergency procedure

GCS: E M V

☐ IV Site: Gauge:

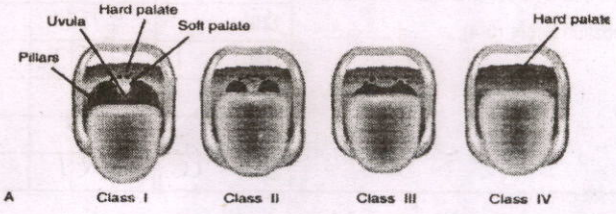
Sedation Plan: IV Ketamine.

Allergies:

AIRWAY EVALUATION

Mouth:
☑ Normal
☐ Loose Teeth
☐ Small Mouth
☐ Protruding Incisors
☐ Receding Lower Jaw
☐ Dentures

Neck:
☐ Normal
☐ Decreased ROM
☐ Thyromental Distance Less Than 6 cm
☐ Short Neck



Mallampati Class: ☐ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O_2 Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

☑ A - Alert
☐ V - Verbally Responsive
☐ P - Painfully Responsive
☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O_2 Sat%	O_2 Supplementation	Comments / Initials
Baseline						
12:20PM	100/60	110	26	98%	RA.	–
12:35PM	110/60	120	26	98%	RA.	–
12:50	100/70	110	24	98%	RA.	–

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj ketamine	IV	20mg	12:20PM	–

Doctor Notes: procedure uneventful.

Time of transportation to post sedation care room: .... LOC: ....

Doctor Name: Dr. [illegible] Signature: [signature]

Post Sedation Care Room

Time		Temp – 98.3°F
Monitoring: ECG NBP Oximeter	180	
	160	HR – 111
Pain Score (0-10)	140	
Sedation Score (0-4)	120	117
	100	BP –
	80	
	60	74
	40	Resp – 24

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O_2>92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal oncalling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O^2>90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: ....

Nurse Name: [signature] Signature: [signature]

Date: 6/7/26 Time: ....

Consultant Name: DR. [illegible] Sri. Signature: ....

Stamp

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

Patient

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CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure Hypotension, Bradycardia, Respiratory depression
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. _____ and his / her team to perform the procedural sedation upon the patient / myself.
- 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: Liaq

Relationship with patient: Mother

Date & Time: 6/7/26 @12pm.

Witness:

Signature: .....

Name: Isha Jar Translater

Date & Time: 6/7/26 @12pm

Doctor (who is taking consent):

Signature: ..... Name: Dr. kumar. Date 6/7/26 Time: @12pm

Patient Sticker

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ప్రొసీజరల్ సెడేషన్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రొసీజర్‌కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

_____

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు:
  గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జీ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రొసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రొసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రొసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. 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: .....

PROCEDURI T (TIMEOUT OUTSIDE OT)

BAH-00656652 IP5-00176015
Master SUDAISI GARAD FARAH
07-01-2020 6 Y 5 M 29 D (M)
Dr. M N V POUSHYA SAI

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name: ..... Gender: ☑ Male ☐ Female UHID. No: BAH-00656652 Age: 64yr

Date: 6/1/26 In-Time: 12:23 pm Out-Time: 12:27 pm

Doctor Performing Procedure: DR. Kunal Doctor Giving Sedation: DR. Mateen Assisting Nurse: Sis. Samaiita

SIGN IN Time: 12:23 pm	Yes	No	NA
Patient is verified using two identifires (Name & UHID)	☑	☐	☐
All required documents, images, studies are available	☑	☐	☐
NPO Status Checked from Patient / Patient Attendant	☑	☐	☐
Consent is Signed	☑	☐	☐
Any need for blood products	☐	☑	☐
If Yes Comment:			
Any Risk of Hemodynamic Compromise	☐	☑	☐
If Yes Comment:			
Any drug or food allergy	☐	☑	☐
If Yes Comment:			
Correct Site of Procedure Marked	☑	☐	☐
All resources required are correct, available and functioning	☑	☐	☐

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

TIME OUT Time: 12:25 pm	Yes	No	NA
Correct Patient	☑	☐	☐
Correct Site	☑	☐	☐
Correct Procedure	☑	☐	☐
All the team members introduced	☑	☐	☐

Signature of the Nurse: Samaiita
Name of the Nurse: Samaiita

SIGN OUT Time: 12:27 pm	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded	☐	☑	☐
Instrument, Sponge and Needle Count Completed	☑	☐	☐
Specimens are labeled	☑	☐	☐
Any equipment problems are addressed	☐	☑	☐

Signature of the Nurse: Samaiita
Name of the Nurse: Samaiita.

Any Adverse / Unexpected Events

Nil

Docu. No. : RCHBH /FRM / CLINICAL / 083

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00656652 IP5-00176015 Master SUDAISI GARAD FARAH 07-01-2020 6 Y 5 M 29 D (M) Dr. M N V POUSHYA SAI	6/7/26 @ 10:30 am	6/7/26 @
	Transfer Ordered by Dr. Prathiba	Reason for Transfer Admission
From Unit ER	To Unit ~~ER~~ 229	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Inj. Ketamine 2ml	(1)
2.		
3.	Nil	
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nsr - Sushmita	Dr. prathiba

Patient & Clinical Records Received by : Lavanya

Date & Time of Patient Received : 6/7/26 @11:05 am

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