

ACTIVITY RECORD FOR BILLING

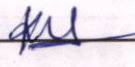
Name : _____
 UHID No. : _____
 Date of Adm. : _____
 Room / Bed No. : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00383671 IP5-00175983
 Master MADAS RUPIN
 26-03-2016 10 Y 3 M 9 D (M)
 Dr. RAVI CHANDER RAO


Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	9:35 AM	ER	OT	
5/7	3pm	OT	10/1	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. V. G. V. V. V.	6/7/26	9689741	
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Date _____

Investigations

Order No.

Signature

१/२

CBP

7253

[Handwritten signature]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/7	iv placement	①	88527	<i>[Signature]</i>
5/7	PAC	①	9688848	<i>[Signature]</i>
5/7	NHA	①	260352	<i>[Signature]</i>

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175983 Admit Date : 05-Jul-2026 Admit Time : 09:07 AM UHID : BAH-00383671

Patient Details :

Patient Name	: Master MADAS RUPIN	Age	: 10 Y 3 M 9 D
Guardian	: Mr MADAS UDAY	DOB	: 26-03-2016
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO - 8-2-173, PRATAP NAGAR , Panjagutta Hyderabad Telangana INDIA 500082	Phone No	: 9989699563/ 7032301771
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type	: DAY CARE	Bed No	: PRE OP 401	Ward Name	: 4F-OT COMPLEX
Room No	: PRE OP 401	Admission Type	: First Visit		

Contact Details :

Name	: Mr MADAS UDAY	Relationship	: Father
Contact Address	: H NO - 8-2-173, PRATAP NAGAR , Panjagutta Hyderabad Telangana INDIA 500082	Phone No	: 9989699563 / 7032301771

Signature

Doctor Details :

Doctor Name	: Dr. RAVI CHANDER RAO	Specialisation	: PLASTIC SURGERY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. FAISAL B NAHDI		

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 50000.00
		Payor Name	: STAR HEALTH AND ALLIED INSURANCE CO LTD

EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list <i>Therapeutic</i>	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Extra</i>	4			
	Total No. of Pages	32			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175983

Admit Date : 05-Jul-2026

Admit Time : 09:07 AM UHID : BAH-00383671

Patient Details :

Patient Name : Master MADAS RUPIN

Age : 10 Y 3 M 9 D

Guardian : Mr MADAS UDAY

DOB : 26-03-2016

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO - 8-2-173, PRATAP NAGAR , Panjagutta
Hyderabad Telangana INDIA 500082

Phone No : 9989699563/ 7032301771

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 401

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 401

Admission Type : First Visit

Contact Details :

Name : Mr MADAS UDAY

Relationship : Father

Contact Address : H NO - 8-2-173, PRATAP NAGAR , Panjagutta
Hyderabad Telangana INDIA 500082

Phone No : 9989699563 / 7032301771

✓ Signature

Doctor Details :

Doctor Name : Dr. RAVI CHANDER RAO

Specialisation : PLASTIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00383671

IP5-00175983

Master MADAS RUPIN

26-03-2016

10 Y 3 M 9 D

(M)

Dr. RAVI CHANDER RAO



Patient Name:

Rupin

UHID ID:

Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : _____

Information given by: _____ Age/Sex _____

Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Alleged H/o Accidental injury to
Right Index finger at 7:30pm at
home while playing with bicycle

History of present illness :

↓
sustained laceration over
Right Index finger.

no h/o cold/cough/fever

BAH-00383671

IP5-00175983

Master MADAS RUPIN

26-03-2016

10 Y 3 M 9 D

(M)

Dr. RAVI CHANDER RAO



paediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal transition

Birth & Socio Economic History:

About Father : _____
About Mother : _____ middle
Any additional Information : _____

Developmental History :

appropriate for age

Immunization History :

vaccinated till date

Pediatric Multiorgan History & Physical Examination**Anthropometry :**

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 20.59 kgs (Centile _____)**On Examination :**Temperature : 98.2°F Pulse Rate : 110/min B.P. 97/62/55 SP02 100%Resp.rate and type of breathing : 22/min

Rash _____

Lymphadenopathy nil

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Ruag ⊕

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2(N)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : _____

Spine : _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Laceration - Right index finger



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: complications

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CBP

Planned Management

1) NPO
2) PAC
3) DNS
4) Shift to OT on call

Signature of the Doctor: Madhvi

Name of the Doctor: Madhvi

Date & Time: 5/2/26 10am

Signature of the Consultant:

Name of the Consultant:

Date & Time:



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Ravichander rao. Date : 05/01/2016

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

Start Time of Assessment: _____ Weight: 30.59 kg

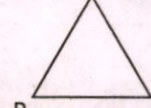
Allergic History: _____

Chief Complaints: _____

Alleged H/o Accidental
injury to Right index finger
at 7:30pm in home yesterday.
↓
laceration over Right index finger
H/o Bleeding from it.

Pediatric Assessment Triangle

A Appearance - TICLS (2)



B Breathing ☐ Normal

C Circulation ☐ Abnormal

- Breathing
- ☐ ↑ WOB
 - ☐ ↓ WOB
 - ☒ Normal
 - ☐ Gasping / Apnea
- Circulation
- ☐ Pallor ☐
 - ☐ Cyanosis ☐
 - ☐ Mottling ☐
 - ☐ Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening ☐
☐ Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

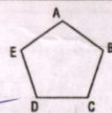
If Yes _____

Significant Past History: PDA ~ small size.

Medication History: on Augmentin DJS.

Relevant Investigations: (none)

Primary Assessment



Airway



- ☒ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing



Rate: 21/min SpO₂ on FIO₂ 98.1% 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: 117/min CFT ☐ Central ☒ PeripheralAny urgent interventions needed: ☐ Yes ☒ No

BP: 97/62 (72) mmHg

Pulse Volume: ☐ Central ☒ PeripheralIf in Shock: ☐ Compensated ☒ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☒ No

If Yes

**Disability**

GCS: AVPU:

Pupils: ☐ Responsive ☐ Non-Responsive ☐
Size ☐ Right
☐ LeftActive Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure

Temp.: 98.2°F

Any Rash: ☐ Yes ☒ No,

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

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:

CBP

NIB

Sagan

5/7/26

Treatment Planned:

- NPO

- PAC to be done

- WF - DNS

- Sp - Surgery under sedation

NIB

Sagan

5/7/26

Need for Oxygen: ☐ Yes ☒ Noif yes Low Flow ☐High Flow ☐PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary):

Laceration over right index finger - sutured under sedation

Assessment done by

Name of the Doctor: N. P. Narain Sh

Signature: N. P. Narain Sh

Date & Time: 5/7/26, 9:16 am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

Date & Time	Progress Notes	Doctor's Order
5/12/26 5pm	SIR Resident active vitals stable oli - fair	plan ① cont. same ② plan D/C tomorrow
		Madhus
6/7/26 8am	Seen by Resident finger laceration wound debridement & repair pain under control hemodynamically stable	Plan can be discharged today
		\$ Sant

IP5-00175983

26-03-2016

10 Y 3 M 9 D

(M)

Dr. RAVI CHANDER RAO



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



BirthRightTM
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO



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RESULT SHEET

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

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

Culture and Sensitivities :

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.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO




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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☒ 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	Syr - Augmentin DDS	5ml	PO	84	4/3/26 10pm	☒ C ☐ DC
-						☐ 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 : N. Prashanth. P. Prashanth

Date & Time : 05/07/26, 9am

Nurse Name & Signature : Sagar

Date & Time : 5/7/26 @ 9:00 Am



DRUG CHART

Date of Admission: 5/7/26 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:																			

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 30.59 kg Ward.

DRUG : Syrup. Augmentin CS				Date Time	5/7
Dose 5ml	Route PO	Frequency BD	Start Date 5/7/26		
Name & Signature of the Doctor Starting the Drugs: <u>Madhusu</u>				10am	
Additional Instructions:				10pm 50mg	
Daily Doctor's Endorsement by a Sign					
DRUG : Tab. Lantus long				Date Time	5/7
Dose 1 tab	Route PO	Frequency OD	Start Date 5/7/26		
Name & Signature of the Doctor Starting the Drugs: <u>Madhusu</u>				6am 10pm	
Additional Instructions:				50mg	
Daily Doctor's Endorsement by a Sign					
DRUG : Tab. Tab 500mg				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 : Syrup. Urokin DS				Date Time	5/7
Dose 9ml	Route PO	Frequency TID	Start Date 5/7/26		
Name & Signature of the Doctor Starting the Drugs: <u>Madhusu</u>				6am	
Additional Instructions:				200mg 500mg	
				11:30	
				10pm 50mg	
Daily Doctor's Endorsement by a Sign					



Weight. 30.59 kg Ward.

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

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

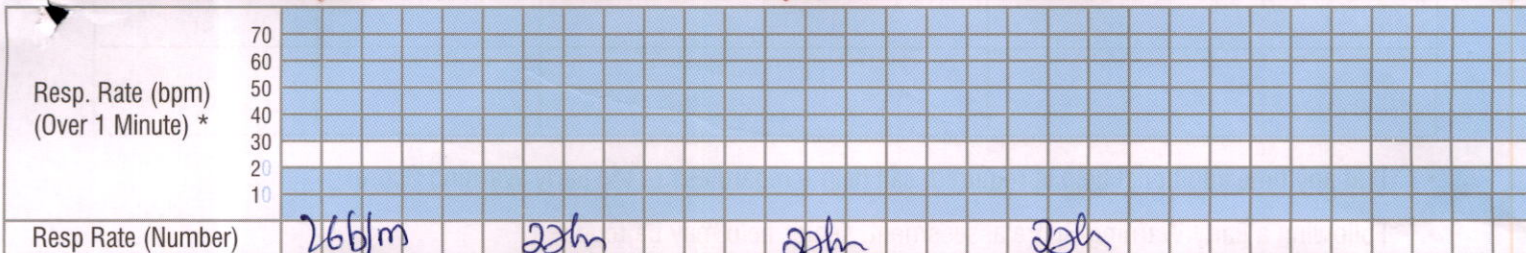
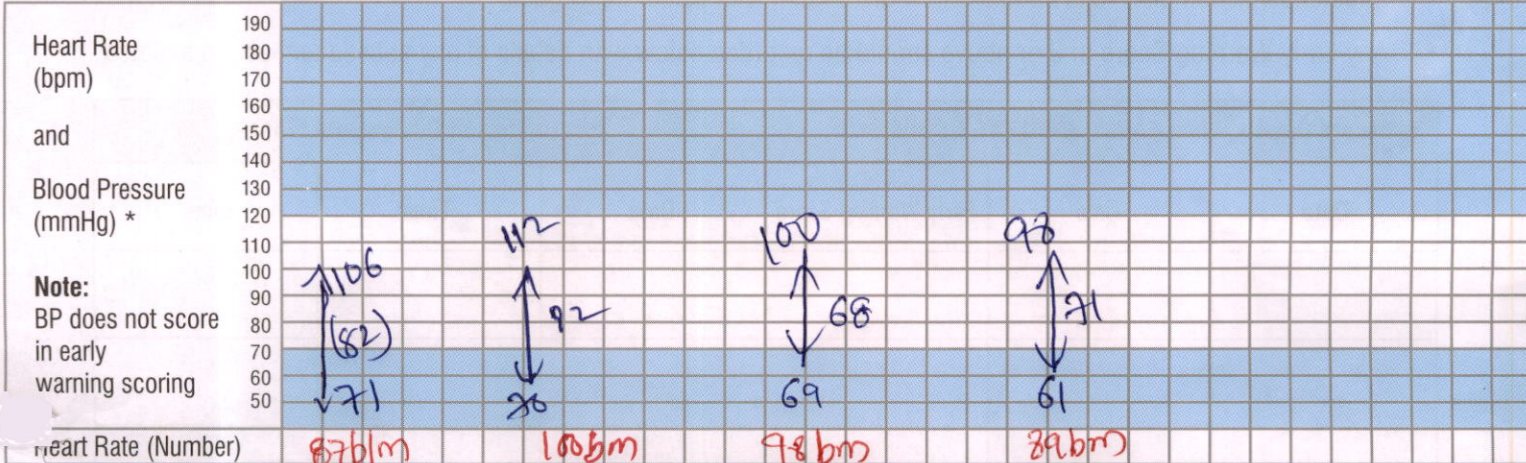
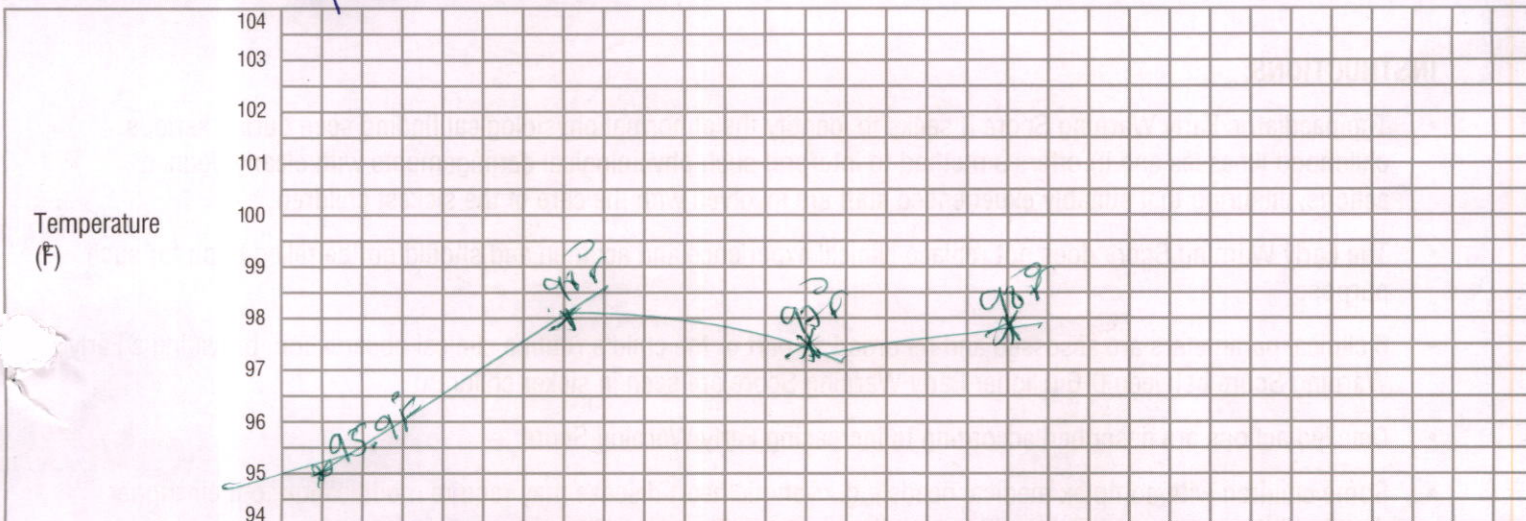
STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/7/16	12:00pm	Inj CEFOTAXIM	1g	IV		

Signature
 VERIFIED BY : Name

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/4 Time: 10pm 2am 6am
Doctor / Nurse / Family Concern? 6pm



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
Observer's Initials		

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
5/2	02:00 pm	mpo	water	-	-	-	-	-	-	-	0	R
	03:00 pm			-	-	-	-	-	-	-	0	
	04:00 pm			60ml							0	
	05:00 pm	DNS	Idly	60ml			NP			✓	0	
	06:00 pm			60ml							0	
	07:00 pm			60ml							0	
Total Intake :					Total Output :							
5/2	08:00 pm			60ml							0	R
	09:00 pm			60ml							0	
	10:00 pm			60ml							0	
	11:00 pm	DNS		60ml			NP				0	
	12:00 am			60ml					✓		0	
	01:00 am			60ml							0	
Total Intake :					Total Output :							
5/2	02:00 am			60ml							0	R
	03:00 am			60ml							0	
	04:00 am			60ml							0	
	05:00 am	DNS		60ml			NP				0	
	06:00 am			60ml							0	
	07:00 am			60ml							0	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2018 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO



FLUID CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

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



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: pain related to surgery as evidenced by suturing

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3:30 pm	Assess the pt condition	4 pm	Assess the pt condition	After plan of care pt condition improved
	monitor vitals	5:30 pm	monitored vitals	
4 pm	maintain I/O chart	6 pm	maintained I/O chart	
5 pm	provide comfortable position	6:30 pm	provided comfortable position	
6 pm	Administer medication as per chart	7:30 pm	Administered medication as per chart	
7:15 pm	Give Inj: PCM Pain Reducing	7:30 pm	Given Inj: PCM pain Reduced	

Re-Assessment: pain Reduced

Special Notes: D/C T/M

Nurse Signature: [Signature]

Nurse Name: Kalyan

Date & Time: 5/7/26 @ 8 p

BAH-00383671
Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO

IP5-00175983

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date:

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient	9pm	Assessed the general condition of the patient	Baby condition is good
10pm	monitor the vitals signs	11pm	monitored the vitals signs	
12am	maintain I/O chart	1am	maintained I/O chart	
2am	Administer medication as per as chart	3am	Administered medication as per as chart	
5am	ensure the patient safety	7am	Ensured the patient safety	

Re-Assessment: Re-assessment

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: *Abhishek*

Date & Time: 6/7/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Ravi chander Department: ER Date of Admission: 5/7/26

SITUATION	Diagnosis: <u>Laceration over right finger</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	<u>ER</u>	<u>OT</u>	<u>1st floor 2pm to 8pm</u>	<u>1st floor 8pm to 2am</u>	
	Shift Time	<u>9:35 AM</u>				
	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.1°F</u>	<u>96.1°F</u>	<u>98.2°F</u>	<u>97°F</u>	
	Res:	<u>82 b/p</u>	<u>82 b/p</u>	<u>26 b/m</u>	<u>22 b/m</u>	
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	
	Pulse:	<u>112 b/m</u>	<u>112 b/m</u>	<u>112 b/m</u>	<u>110 b/m</u>	
	BP:	<u>108/52</u>	<u>108/52</u>	<u>102/62</u>	<u>100/69</u>	
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>	
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Others Specify:		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sagar</u>	<u>Kalyan</u>	<u>Ravina</u>	<u>Nikita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>5/7/26</u>	<u>5/7</u>	<u>5/7</u>	<u>6/7</u>	
Time:		<u>9:35 AM</u>	<u>3pm</u>	<u>@ 8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Kalyan</u>	<u>Ravina</u>	<u>Nikita</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>5/7</u>	<u>5/7</u>	<u>5/7</u>		
Time:		<u>@ 10am</u>	<u>@ 3pm</u>	<u>3pm</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time				
	Medical Condition (Any special condition to be noted):					
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:		Temp:			
			Res:			
			SpO ₂ :			
			Pulse:			
			BP:			
	Fall Risk Score:					
	Pain Score:					
Recommendations	Safety Needs:					
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:					
	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:					
Post Operative Procedure Special Orders:						
Handed Over By Name :						
Signature :						
Date:						
Time:						
Taken Over By Name :						
Signature :						
Date:						
Time:						



THE HUMPTY DUMPTY SCALE

5/7 6/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	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	2			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			10	10			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	44				
Call device within reach	Yes	44				
Wheels Locked	Yes	44				
Room free of clutter	Yes	44				
Adequate Lighting	Yes	44				
Wheel Chair Support	No	no				
Other Intervention(s) Specify	No	no				
Nurse's Name :	Sagan	Nibati				
Signature :	[Signature]	[Signature]				
Date :	5/7	6/2				
Time :	9:10 AM	6:00 AM				

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2018 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO



BRADEN 'Q' SCALE

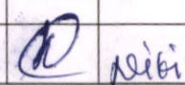
				Date : 5/7/26	6:17		
				Time : 9:10 AM	6 AM		
	completely immobile: is not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
				TOTAL SCORE	28	28	
				Evaluator's Name	[Signature]		

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

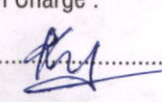
CHECKLIST FOR THROMBOPHLEBITIS

5/2/26

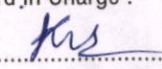
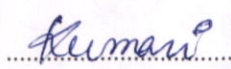
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-								
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	9:10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
5/7	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
6/7	1am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

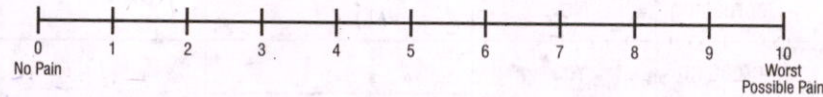
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

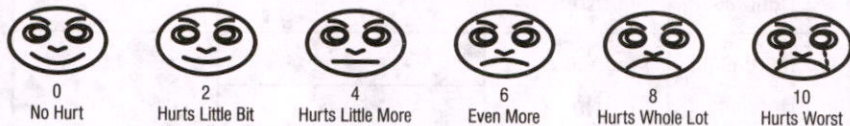
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





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. Right index finger - cut injury debridement
2. T. Suturing

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.

The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>faster healing</u>	<u>Dressing</u>

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. Ranichand 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: [Signature]

Name: Uday

Relationship with patient: FATHER

Date & Time: _____

Witness:

Signature: [Signature]

Name: SHILPA (Mother)

Date & Time: _____

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Ranichand Date: 5/7/26 Time: _____

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1
2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.
b.

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- 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. Ravir udhoo
Asst. Surgeon :
Anaesthetist : Dr. Thejaswini
Scrub Nurse : Thejas

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO


Age : Gender :
Name :
Out-time :


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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

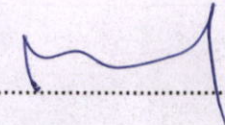
Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>12:15 pm</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☒ Yes ☐ No ☐ NA	
Signature : <u></u>		
Name : <u>Dr. Thejaswini</u>		

TIME OUT		Time: <u>12:25 pm</u>
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>none to note</u>	☐ Yes ☐ No ☐ NA
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?		☐ Yes ☒ No ☐ NA
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?		☐ Yes ☒ No ☐ NA
Is Essential Imaging Displayed?		
		☐ Yes ☒ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.		
		☐ Yes ☒ No
Signature : <u></u>		
Name : <u>Thejas</u>		

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 : <u></u>		
Name :		

Patient St

BAH-00383671 IP5-00175983
 Master MADAS RUPIN
 26-03-2016 10 Y 3 M 9 D (M)
 Dr. RAVI CHANDER RAO



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 5/7/26

Department : Duration of Procedure : 30 min

Name of Surgeon : Dr. Ravi Chander Rao Date of Admission : 5/2

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 : Py. Tazem 1g	ky
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Nil Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	ky
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	ky
4.	Name of doctor or staff administering the antibiotic : Venkat Date & Time of antibiotic administration : 5/7/26 @ 12 pm Date & Time procedure started : 5/7/26 @ 12:30 pm	ky

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

Docu. No. : RCHBH/ FRM / CLINICAL / 038



Pat

OPERATION THEATER NOTES

Patient's Name : Madas Rupin Age : Gender : ☐ Male ☐ Female

UHID No.: Weight : Height :

Surgeon : Dr Ravi Chander Asst. Surgeon :

Anesthetist :

OT Nurse:

OT Technician:

Pre-Operative Diagnosis:

Surgical Procedure :

② Index finger cut injury

Indications for Surgery :

Debridement + Tendon repair + Digital nerve repair

Date :

5/7/26

Start Time :

12:20pm

End Time :

1:10pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

↓ LA exploration of the wound
done

Extensor tendon cut & Digital nerve
partial cut.

Tendon repaired & 4-0 prolene.
Digital nerve repaired & 9-0 Ethilon
skin sutured.

Splint given.

BAH-00383671 IP5-00175983
Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO

Patient Stic




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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

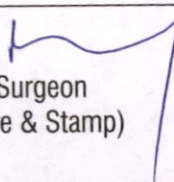
When to Start Mobilization:

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.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Musker Madas Rujin Age: 104.3m Sex: male UHID.No: BAN-00383671
Date: 5/7/2026 Time: 11:05 AM Proposed Operation: Suturing Right Index Finger
Diagnosis: Laceration on Right Index
B.P / CRT: 97/62 mmHg H.R: 117/min Weight: 30kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies:

Medical History: CVS: h/o Small PDA & L-R shunt @ 4 years of age.
(249mm Hg)

RESP: NO h/o apnoea, breathlessness Diabetes:

CNS: Seizures @

Renal: -

Hepatic / GE: -

Physical Activity: Active.

Others: -

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 (N) 2 3 4 Mouth Opening: Adequate Mento-hyoid Distance: 2FB Neck: (N) Teeth: loose tooth lower canine

Lungs: BARE @

Heart: S1S2 @

CNS: HMF @

Pregnant: ☐ Yes ☐ No ☒ NA

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Tejaswini



ANAESTHESIA CHART

Pre Induction

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status: confirmed

Physical Status:

☐ Patient Identified

☐ Consent Present

☒ Chart Reviewed

H.R: 108/min

B.P / CRT: 116/73mmHg

SpO₂: 100

R.R: 20/min

Last Feed: > 6hr

Pre-OP Diagnosis: Right Index Finger Laceration Operation: Suturing Rt. Index Finger Date: 5/7/26

Surgeon: Dr. Ravichandell

Anaesthesiologist: Dr. Tejasmini

Technician: Venkat

TIME

N₂O / AIR / O₂ LPM

HALO / ISO / SEVO

Drugs:

MIPRAZOLAM

1mg

FENTANYL

30mcg

PROPOFOL

50mg + 30mg + 50mg

FiO₂ / SaO₂

ETCO₂

ECG

Temperature

Urine Output

Fluids
Blood

Antibiotic

CEFTAXIM

1g IV

Suppository

Blood Loss

NOTES

RINGER LACTATE 180ml/2

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site: Right

☐ Art Site:

☒ EKG Lead 3 leads

☒ Temp Site skin

☐ FIO₂ Monitor

☐ Agent Monitor

☒ Pulse Oximeter

☒ Capnograph

☐ Ventilator

☐ Nerve Stimulator

Position: supine

☒ Pressure Points Checked

Eye Care:

☒ Oint

☐ Tape

☐ Padding

☐ Awake

Temp:

☐ HME

☐ Cling Film

☒ Hugger's

☐ Other

Fluid Warmer

OH Warmer

Cotton Wool

Times:

Anaes Start: 12:20pm

OP Start: 12:25pm

OP End: 1:05pm

Leave OR: 1:10pm

Anaesthesia:

☐ GA

☒ Monitored Anaesthesia Care

☐ Regional

Line (Size & Location)

☐ CVP:

☐ ART:

☒ IV: 22 G DUL

☐ IV:

☐ IV:

Induction

☐ IV

☐ Pre O₂

☐ Others

☐ Inhal

☐ RSI

☐ Mask

☐ Airway

☐ Oral

☐ Tracheostomy

☐ Drug:

☐ Awake

☐ Video Laryngoscopy

☐ Fiberoptic

Blade#

Attempts:

Difficulty Why?

☐ Bilat = BS

☐ Semi-Closed Circle

☐ Closed Circle

☐ Other

Regional:

Extremity

☐ Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU

Relaxant Reversed

Name of the Doctor: Dr. Tejasmini

Signature of the Doctor:

Specify:

☐ Epidural

☐ Caudal

Depth:

Yes

No

cm

cm

cm

cm

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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Kalyan Time Received : 1:10pm Time Discharged : 3pm

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 BLOOD PRESSURE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 BLOOD PRESSURE	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			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	2		2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2	2		2	
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	2	2	2		2	
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1						
BP $\pm$ 50 of Pre Anaesthetic leve	= 0						
Fully awake	= 2	1	2	2		2	
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2		2	
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	9	10		10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name : DR. TEJASVINI

Anaesthesiologist Signature: [Signature]

Date & Time: 5/7/26 @ 3pm

PACU Nurse Name : Kalyan

PACU Nurse Signature: [Signature]

Date & Time: 5/7/26 @ 3pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): 101

Date & Time: 5/7/26 3pm

Department of ...



Date and Time :

BAH-00383671
Master MADAS RUPIN
26-03-2018
Dr. RAVI CHANDER RAO
IP5-00175983
10 Y 3 M 9 D
(M)

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Suturing Right Index finger.

Anaesthesiologist: Dr. Tejaswini Surgeon: Dr. Ravi Chander

Please read this before you consent for Anaesthesia

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

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

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Desaturation

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: [Signature]

Name: Shilpa

Relationship with patient: Mother

Date & Time: 5/7/26 11:15AM

Witness:

Signature: [Signature]

Name: DAY

Date & Time: FATHER 5/7/26 11:15AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Tejaswini

Date 5/7/26 Time: 11:15AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

7820

Patient Name: MASICK, MADAS RUPIN	Age: 104	Gender: MALE	
UHID No: BAY-005R3671	IP No: 1PS-00175583	Date: 5/7/26 Time: 11:15 AM	
Diagnosis: SUTURING			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Inj. Fentanyl Citrate 100 mcg / 2 ml	100mcg	SO L
2.	Fentanyl Citrate 25 mcg patch	-	-
3.	Inj. Morphine 15 mg / ml	-	-
Doctor Name: DR. TEJASWINI		Doctor Registration No: 75004/FMR/16921.	
Signature: Tejaswini			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 1PS-00175583 Date: 5/7/26

Aadhaar No. of the Patient (Optional):

1.	Name : MASICK, MADAS RUPIN	Remarks		
2.	Complete postal address (with contact number, if any)	11-00-8-2 173 PATTABUR MADAGASTA KUDU-5		
3.	Brief description of the illness	SUTURING		
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	-		
5.	Details of essential Narcotic drug dispensed	INJ. FENTANYL		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
5/7/26	INJ. FENTANYL	ONE AMP	[Signature]	

Dispensed by (Name & ID No.): SANKHATHA 015095 Signature: [Signature]

Received by (Name & ID No.): K. Venkatasai 108555 Signature: [Signature]

Time : 12:45 PM

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: Telegu Patient / Learner Literacy: ☒ Read ☒ Write ☐ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☐ Yes ☒ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
5/7/26	9:10 AM	7	Infection control measures	M	4	0	1	1	-	
5/8/26	3pm	9	Normal diet	M	1	0	1	1	-	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: Intussusception under sedation

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5/7/26 9:10 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Leucocytosis over right index finger	Improve resolution of symptoms	Intussusception under sedation	N. Ar	☒ Nursing ☐ Others:
5/7/26 9:10 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Leucocytosis over right index finger	H-stability	Intussusception under sedation	[Signature]	☐ Medical ☐ Others:
5/7/26 3pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Leucocytosis over st little finger	Normal diet	RDA E - 1650 kcal/d P - 29 g/d	Nikitha	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

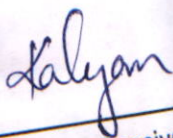
PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00383671 IP5-00175983 Master MADAS RUPIN 26-03-2016 10 Y 3 M 9 D (M) Dr. RAVI CHANDER RAO 	Date & Time of Admission 5/7/26 9:07	Date & Time of Transfer Order 5/7/26 3:30
	Transfer Ordered by Dr. Ravi chander Rao	Reason for Transfer Post op
From Unit OT	To Unit 101	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 30	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? op file	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films nil		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring 	Name of Person Ordered Transfer Dr. Ravi chander
---	---

Patient & Clinical Records Received by : V. Ravina	Date & Time of Patient Received : 5/7/26 @ 3pm
---	---

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

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00383671 IP5-00175983 Master MADAS RUPIN 26-03-2018 10 Y 3 M 9 D (M) Dr. RAVI CHANDER RAO 		Date & Time of Admission 05/07/26 @ 9:07 AM	Date & Time of Transfer Order 5/7/26 @ 9:35 AM
		Transfer Ordered by Dr. Prathiba	Reason for Transfer Admission
From Unit ER	To Unit OT	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? op file	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Gown	1	
2.	Kooche	1	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. prathiba	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 5/7/26 @ noon			

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

TRANSFER FORM

02/01/00 @ 00:00 PM 02/01/00 @ 00:00 PM

02/01/00 @ 00:00 PM

02/01/00 @ 00:00 PM

TO

FR

171

00

①

171

①

171

171

02/01/00 @ 00:00 PM

02/01/00 @ 00:00 PM

BAH-00383671 IP5-00175983

Master MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAONPO 12:30 AM
Solid & LiquidRainbow
Children's
Hospital
It takes a lot to treat the little.BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Rupin M Age : 10y Gender : ☒ Male ☐ Female
 Date : 5/7/26 Time of Arrival : 8:58 AM Triage Completion Time : 9:00 AM
 Allergies : ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify) : NA ☐ Not known any drug Allergies
 Source of Information : ☒ Parents ☐ Others (Specify) : NA
 Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life -Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.2F PR: 112b/m BP: 97/62 RR: 22b/m SpO₂: 100%
 Chief Complaints: Crush injury over Rt Index finger

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
 2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
 3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
 If yes, State Location:
 2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
☐ The patient should be given a surgical mask immediately, if not already wearing one.
☐ Both patient and triage staff should perform hand hygiene.
☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : PoojaSignature of Triage Nurse : [Signature]Date & Time : 5/7/26 @ 9:00am

Docu. No. : RCHBH / FRM / CLINICAL / 085



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/2/26 Time of arrival : 9:01 AM
Chief Complaints: suturing under sedation RBS: NA
Height : NA Weight : 30.59 kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify NA
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character nil ☐ Location nil ☐ Frequency nil ☐ Duration nil

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☒ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☒ No
• Weak ☐ Yes ☒ No
• Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
☐ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With parents

Siblings in household ☒ Yes ☒ No (if yes How Many?) 1 sister

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 9:03 AM

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
9:03 AM	Assess the child condition
	- monitored vitals & recorded
	- seen Dr. peethaba
	- shifted to OT

Samples collected by: NR. Rachel Keerthana

Time: 9:12 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>117 bpm</u> BP: <u>97/62</u> CFT: <u>large</u>	Shift - out from ER to: <u>OT</u>
RR: <u>28 bpm</u> SPO ₂ : <u>100%</u>	Time of Shift - out: <u>9:35 AM</u>
GCS: <u>4/5/6</u> Temperature: <u>97.8°F</u>	Handover given to: <u>[Signature]</u>
Pain Score: <u>0</u>	(Nurse's Name)
Repeat RBS (if applicable): <u>NA</u>	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

2v placement done

Name of the Nurse: pooja Signature of the Nurse: [Signature]

Date & Time: 5/7/2026 9:05 AM

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 5/7/26

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☒ Yes	☐ No
☐ Eating	☒ Yes	☐ No
☐ Walking	☒ Yes	☐ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☒ Yes	☐ No

Yes

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:
☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Diaper

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Talpan

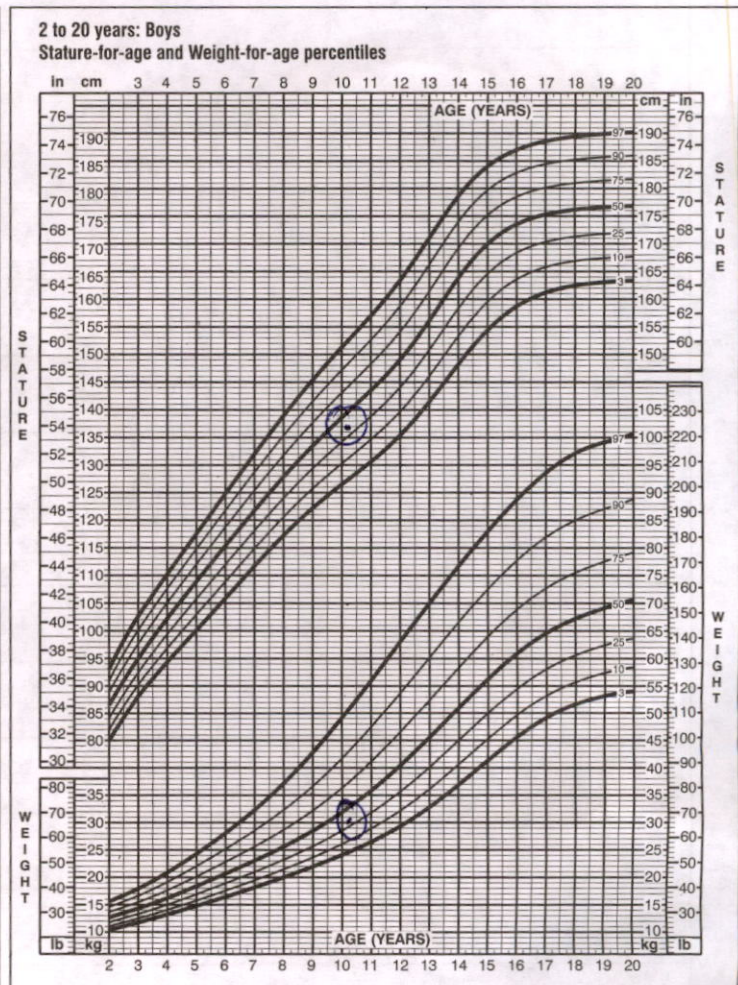
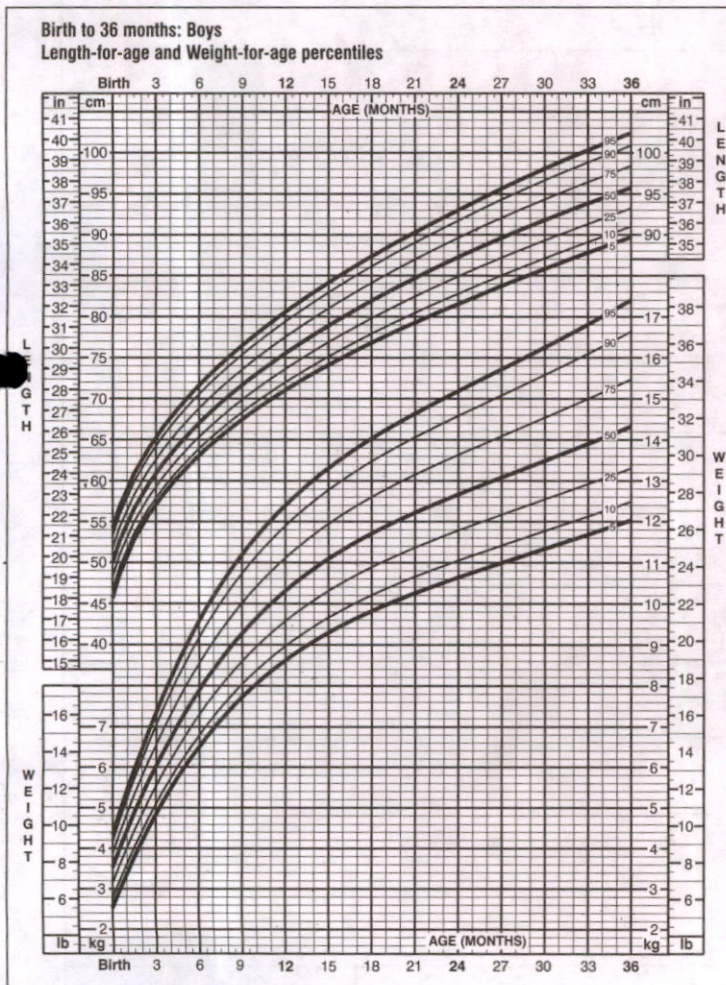
Date and Time: 5/7/26 @ 2pm

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/3/26 Time: 3pm

Weight: 30.5 kgs Centile: >25th
Height: 137 cm Centile: >25th
Inference: well child
RDA: - Calories: 1650 Kcal/d Protein: 29g/d
Diet Recommendations: Normal diet
Re-Assessment: Avoid spicy, Chilled, outside foods
Food Allergies: No Veg/Non-veg Non-Veg
Diagnosis: laceration over (RT) little finger
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

BAH-00383671 IP5-00175983

Master MADAS RUPIN

26-03-2018 10 Y 3 M 9 D (M)

Dr. RAVI CHANDER RAO



Patient

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

81045

Date : 5/7/26

Patient Name: Mst. Madas Rupin Date of Birth: Age: 10y

Gender: male Ward: POT UHID No.:

Date of Surgery: 5/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Tendon & Digital nerve repair

Time in : 12.20 pm

Star (Cakra)
sevt.

Time Out : 1.15 pm

	NAME	AMOUNT
1. Surgeon	Dr. R. Chandar	
2. Anaesthetist	Dr. Thejanevi	
3. Assistant Surgeon		
4. OT Technician	Venkat Sai	
5. Circulating Nurse	Kalyan	
6. Assistant Nurse	Thejas	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9688849

Order by: Thejas

BAH-00383671 IP5-00175983
Master, MADAS RUPIN
26-03-2016 10 Y 3 M 9 D (M)
Dr. RAVI CHANDER RAO



Suturing CONSUMABLES OF OT

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Technician : Date : Time :

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
	Issued	Used		Issued	Used		Issued	Used
ET tube 5150516	144	—	Major Pack		—	Inj Vit.K		
LMA 2123	1	—	Sutures 9915	1	1	Cord Clamp		
ECG leads : A/P/N	5	03	90-0 effilon		1	Suction Catheter		
HME filter : A/P/N	1	—	40 poolene		1	Feeding Tube		
Syringes : 10 cc	10	2				Vaccum Suction Set		
05 cc	10	2	Gloves 7.7.5	242	2	Surgical Gloves		
02 cc	10	2	7.7.5	242	1	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	—	Surgical blade 11(15)	144	1	Surgical Blade # 20		
IV set	1	—	NG tube		1	Koochies (S)		
RL	1	—	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	1	01	Koochies			Tranexatix	1	1
minispike	1	01	Ointments			10cc 5cc	144	144
02 mark	1	—	Suction Catheter			26 needle	1	1
Fentanyl	1	01	Cap, Mask	515	515	Lox 2 Adrenali	1	1
Morphine			Gauze Pack (N)	2	4			
Ketamine			Mop Pack					
Propofol	8	02	Steristrip					
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	—	Draw sheet		1			
Myopyrolate	1	—	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			Gauze	3	01
Bupivacaine 0.25%			Chest Drainage Catheter			Glassel	4	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			phosmid	1	—
Antibiotics			Bandage			Dexatranexa	144	—
Capam	1	—	Tegaderm			Octoprine	144	144
Suppositories			Ioban			Nasalpran	1	01
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		—			
Justin 12.5 mg / 25mg / 100mg	144	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Vaccum set	1	—	Microshield	1	1			
oral airway 112	144	—	Cotton Balls	58	58			
nasal airway 20122	144	—	Latex Gloves					
gum 10cm + 10cm	144	—	Ramdione Scrub					
Dozcaonda 21/24	144	—	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 7688822

Ordered by : [Signature]

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

ESTIMATION SLIP

Date: 05/JUL/26 UHID / IP No.: DAH-00383641 SI No. 81045
Name of Patient: Mart Madag Rupin Age: 104 Gender: Male
Father's / Husband's Name: Mr. M. Velay Corporate / Occupation: RA Group (Govt)
Address: _____ Phone: 99896 99563 Email: _____
Procedure / Plan: Tendon & Digital Nerve Repair

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

TARIFF INFORMATION:

(Per Day)	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
	Room Rent & Nursing Charges										
	Doctor's Fee										
	L. Tax										
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				82/100: 70,070 + 25,480 + 13,000/h							
O.T. Consumables				8200/- Subject to approval by TPA / Insurance Company							
Instrument Charges				Not Covered by TPA / Insurance company							
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation							
Equipment Charges	Monitor :			Oxygen :			Infusion pump / Syringe pump :				
	Ventilator :		Conventional :	HFO-SLE 5000 :			HFO Sensormedix :				
	Phototherapy :		Single Surface :	Double Surface :			Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation							
ckage											
Others											
Initial Minimum Deposit				Rs 15,000/- + formal dues clearing							

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00 AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm.
- Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I, M. Velay have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client

Signatory Relationship

Signature of the Financial Counselor