BAH-00653300 IP5-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

Rainbow® Children's Hospital
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BirthR
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SURGERY DETAILS

Date : 22/07/26

Patient Name: Sayyed Hamzah Date of Birth: 31/03/2022 Age: 4 yrs

Gender: Male Ward : P.O.P. UHID No.: BAH - 006 r 3300

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

Name of the Surgery : DENTAL EXTRACTION I

Time in : 8:22 am Time Out : 8:48 am

		NAME	AMOUNT
1.	Surgeon	SRINIVAS-N	EXTRACTION XL
2.	Anaesthetist	Dr. Tajeshwini	
3.	Assistant Surgeon		
4.	OT Technician	Dr. P Nishanth	
5.	Circulating Nurse	Swapna	
6.	Assistant Nurse	Bikhlal	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 975919 Order by:

Rainbow Children's Hospital

BirthRight 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 : IP5-00176747 **Admit Date** : 22-Jul-2026 **Admit Time** : 07:07 AM **UHID** : BAH-00653300

Patient Details :

Patient Name	: Master SAYYAD HAMZAH	**Age**	: 4 Y 3 M 22 D
Guardian	: Mr SAYYAD MUBASSIR IKRAM	**DOB**	: 31-03-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: 5-6-190/A, AGAPURA, NAMPALLY Abids Road Hyderabad Telangana INDIA 500001	**Phone No**	: 9014293147/ 7287837398
		E-mail	: HBINTAZEEM@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 403 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 403 **Admission Type** : First Visit

Contact Details :

Name : Mr SAYYAD MUBASSIR IKRAM **Relationship** : Father

Contact Address : 5-6-190/A, AGAPURA, NAMPALLY Abids Road Hyderabad Telangana INDIA 500001 **Phone No** : 9014293147 / 7287837398

Signature

Doctor Details :

Doctor Name : Dr. SRINIVAS NAMINENI **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

BAH-00653300 IPS-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

Silurgical dental Extraction

m 24D/ male

CONSUMABLES OF OT

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Circulating staff : ..... Technician : ..... Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube Nasal 4.0, 4.5, 5.0, 5.5	1/1/1	—	Major Pack			Inj Vit.K		
LMA 2	1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	3				Suction Catheter		
HME filter : A / P / N	1	—				Feeding Tube		
Syringes : 10 cc	20	1				Vaccum Suction Set		
05 cc	20	1	Gloves 7no 7 1/2, 6 1/2	A 1/2	1+1	Surgical Gloves		
02 cc	20	1				Gauze Pack		
01 cc	10	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL	1	—	Cautery pencil			5cc, 10cc	2+2	1
NS : 10ml / 100ml / 500ml / 1000ml	4+1	0/1+0	Koochies			Lox + Adrenalin	1	1
minispike	1	0	Ointments			100ml saline	1	1
Vaccumset	1	1	Suction Catheter			Transofix	1	1
Fentanyl	1	1	Cap, Mask	5/5	5/5	26G Needle	1	1
Morphine			Gauze Pack N	5	5	Ribbon	1	1
Ketamine			Mop Pack	—		O2 nasal prong	1	1
Propofol	3	1	Steristrip					
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	—	Draw sheet	1	1	Lox Gel + Lox jelly	1+1	—
Myopyrolate + Neo	2+2	—	Abgel			Mida zolam + Ephedrine	1+1	1+0
Ondansetron	1	—	Foleys catheter			Adrenaline + Atropine	1+1	1+1
Pencan 25g/ Spinal Needle 22	1	—	Urobag			NGT + Suctional	1+1+0	—
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Nasal airway	1+1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			(18, 20, 22)		
Antibiotics			Bandage			oral airway	1/	—
IVP cm	1	—	Tegaderm			(0, 1)		
Suppositories			Ioban			Dexmed (10mg)	1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			50cc + Molines	2	—
Supridol : 100mg			Vaccum Suction set			stopcocks	2	—
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	—	Transpore	1	—
Tab. Misoprost : 200mg			Betadine Solution			duropore	1	—
3way 10+100cm	1+1	—	Microshield			micropore	1	—
Glove all + Gauze	4+4	—	Cotton Balls	1	—	Nasal prongs +	1	—
Tranexatpeta	1+1	—	Latex Gloves	SP	SP	stoc (P)		
O2 mask (P)	1	—	Ramdione Scrub			Orsitet splint (1, 3)	1+1	—
IV cannula (22, 24)	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9715996 Ordered by : .....

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

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ BAH-00653300 IPS-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

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
22/7/26	8Am	ER	OT	
22/7	10:10AM	OT	billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
21/7/16	CBP	73436	Dey

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/24	R placement	1	15791	
	PAC	OP Basis		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00653300 IP5-00176747
Master SAYYAD HAMZAH
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/3/22	SIR Resident	
~~22/3/22~~ ~~AM~~		plan.
	Δ: for Surgical dental extraction	① Send CBP
		② iv Cannula
		③ iv F
	no c/o fever / cold / cough	④ ct. NPO
		⑤ Shift to OT on call.
	O/E: Child alert	Noted by Rachel
	vitals stable	
	RS- BLAE ⊕	
	CVS- S1S2 (N)	
	P/A- Soft-	Madhu'

Docu. No. : RCHBH /FRM / CLINICAL / 088

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00653300 IP5-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

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

1 DENTAL EXTRACTION

2

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
TREATING INFECTION	NONE

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. SRINIVAS.N 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: Husna
Name: HUSNA
Relationship with patient: MOTHER
Date & Time: 8:15 22/07/26

Witness:
Signature:
Name: AZEEM M HAMID
Date & Time: 22/07/2026 8:15 AM

Doctor (who is taking consent):
Signature: Name: SRINIVAS.N Date 22/7 Time: 8:15 AM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే 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 : .....
Asst. Surgeon : .....
Anaesthetist : Dr. Tejeshini
Scrub Nurse : Bikshal

BAH-00653300 IP5-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

Patient Name ..... Gender : .....
UHID No. : ...
Date : ..... Out time : 8:48pm

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 8:24 AM

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

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : .....
Name : Dr. Tejaswini

Before Skin Incision ➤ ➤

TIME OUT Time: 8:25 am

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

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

Anticipated Critical Events

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

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

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

Signature : .....
Name : Swapna

Before Patient Leaves Operating Room

SIGN OUT Time: 8:30 am

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

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

Signature : .....
Name : Dr. Srinivas

SURGICAL SAFETY CHECKLIST

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

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

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

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

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

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

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

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

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

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

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

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

Anticipated Critical Events

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

Anaesthesia Team Reviews:

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

Nursing Team Reviews:

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

Is Essential Imaging Displayed? ☐Yes ☐No ☐NA

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

Signature :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

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

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

Signature :.....

Name :.....

Patie

BAH-00653300 IP5-00176747
Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 22/07/26

To Be Filled In By Assigned Nurse :

Department : P.O.T-I Duration of Procedure : 5 mints

Name of Surgeon : Dental Extraction Date of Admission : 22/07/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☑ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☑ No Name of the Antibiotic : —	
2.	Hair Removal ☐ Yes ☑ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : — Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room)_____ ^{0}C ☐ Oral Or ☐ Axilla (Goal : 36-37 ^{0}C)	
4.	Name of doctor or staff administering the antibiotic : — Date & Time of antibiotic administration : — Date & Time procedure started : 22/07/26 @ 8:25 a.m.	

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

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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:
CHECK BLEEDING & BP EVERY 15 MIN

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.

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OPERATION THEATER NOTES

Patient's Name : Sayyad Hamzah Age : 4y Gender : ☑ Male ☐ Female

UHID No.: BAH-00853300 Weight : ..... Height : .....

Surgeon : Dr. Srinivas	Asst. Surgeon :	
Anesthetist : Dr. Tejaswini	OT Nurse: Bikhlai/Sagar	OT Technician: Nishanth

Pre-Operative Diagnosis:

Surgical Procedure :

DENTAL EXTRACTIONS

Indications for Surgery :

INFECTED TEETH

Date : 22/07/26	Start Time : 8:25 am	End Time : 8:30 am

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

dt IV SEDATION
EXTRACTIONS of 52, 51, 61
DONE.

SOFT DIET - 2 DAYS.

℞ SYRUP
IBUGESIC - PLUS
5ml 1-1-1x 2 DAYS.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: SRINIVAS. D

Signature of the Surgeon: .....

Date & Time: .....

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DRUG CHART

Date of Admission: 22/7/26 Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

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Dr. SRINIVAS NAMINENI (M)

REGULAR PRESCRIPTIONS

Weight. 16 Kgs Ward. P. OT

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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Weight. 16kg Ward. P:07

	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

Signature

VERIFIED BY : Name

Master SAYYAD HAMZAH
31-03-2022 4 Y 3 M 22 D (M)
Dr. SRINIVAS NAMINENI

I.V. FLUIDS CHART

Weight. 16kg Ward. P.OT

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/9/26		DNS	I.V	50ml/hr			Not Required		

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

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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: ..... Shifted to: .....

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 : .....

Date & Time : 22/7 @ 7Am

Nurse Name & Signature: Rachel .....

Date & Time : 22/7/26 @ 7:30Am