BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

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SURGERY DETAILS

80494

Date : 3/6/19

Patient Name: Master M. Rohan Date of Birth: 17/5/2019 Age: .....

Gender: M Ward : P-OT UHID No.: 00821860

Date of Surgery: 3/6/19 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : ~~Ep~~ Cyst Excision

Time in : 8:15 Am Time Out : 8:45 Am

		NAME	AMOUNT
1.	Surgeon	: Dr. Harish	
2.	Anaesthetist	: Dr. Ravi	
3.	Assistant Surgeon	:	
4.	OT Technician	: Prashanth	
5.	Circulating Nurse	: Divya	
6.	Assistant Nurse	: Suman	

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: 9640586 Order by:

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

BAH-00621360 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
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Cyst Excision

CONSUMABLES OF OT

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Technician : ..... Date : ..... Time : 8 AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.5, 5.0, 5.5	1+1+1	—	Major Pack drape	1	—	Inj Vit.K		
LMA 2½, 3	1+1	—	Sutures 9915	2	—	Cord Clamp		
ECG leads : A / P / N	5	02	2303, 2304, 2317	2+2+2	—	Suction Catheter		
HME filter : A / P / N	1	—	2437,	2	—	Feeding Tube		
Syringes : 10 cc	10	4	Prolene 3, 4	2+2	—	Vaccum Suction Set		
05 cc	10	2	Gloves			Surgical Gloves		
02 cc	10	—	6, 6½, 7, 7½	2+2+2	2+1	Gauze Pack		
01 cc	3	—	PF 6, 6½, 7, 7½	2+2+2		Syringe 1ml / 2ml		
Cautery plate : A / P / N	1+1	—	Surgical blade 11 + 15	1+1	1	Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S) Soft Silk	01	01
RL	1	—	Cautery pencil	1	—	NS 50ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	3+1	01	Koochies (XL)	1	—	10cc, 5cc	2+2	1
O2 Mask (C)	1	—	Ointments			Jelly	1	—
Airway 2.1	1+1	—	Suction Catheter			Tox plain	1	1
Fentanyl	1		Cap, Mask	5/5	5/5	6-0 prolene	2	1
Morphine			Gauze Pack (N+R)	3+3	2	26 G Needle	1	1
Ketamine			Mop Pack	1	—	Inj Tramadol 22.24	(1)	—
Propofol	2	02	Steristrip			Dexa	1	—
Rocuronium	1	—	Underpad	1	1	Tranexa	1	—
Glycopyrolate	1	—	Draw sheet	1	1	Mini Spike	1	01
Myopyrolate	1	—	Abgel			Dexamide 5cc	1	—
Ondansetron	1	—	Foleys catheter			Clonidine	1	—
Pencan 25g/ Spinal Needle 22	1	—	Urobag			Atropine	1	01
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Adrenaline	1	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			Midaz + Laxicord	1+1	1+1
Antibiotics Aeqvertin 1.2	1	1	Bandage			Nasal Airway 16.18.20		—
			Tegaderm			Etco2 Nasal prong	1	01
Suppositories			Ioban			Splint 3.5 NO	1+1	—
Anamol : 80mg / 250mg / 170 mg	1+1+1	—	Double J Stent			Q Sine	1	—
Supridol : 100mg			Vaccum Suction set	1	—	NG 1.5.6.7.8.9.10		—
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	—	Suction cath 6.8.10		
Tab. Misoprost : 200mg			Betadine Solution	1	1	Soft roll 4.6	4+1	1+1
Vaccum set	1	01	Microshield	1	—	Adrenorising	01	01
Gauze	3	01	Cotton Balls	1	1			
Gloves and	4	—	Latex Gloves	5P	5P			
IV p.CM	1	01	Ramdione Scrub					
3-way 100+110cm	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9642056 Ordered by : .....

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

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03:50pm

Re-Approval.

ESTIMATION SLIP

Date : 30-May-26. UHID / IP No. : BAH-00621860 Sl No. 80494

Name of Patient : Mast. M. Rohan Age: 1y Gender: Male

Father's / Husband's Name : Mr. Srikanth Manepally Corporate / Occupation : Business

Address : — Phone : +91-7089-4405 Email: —

Procedure / Plan : Epidermoid preputial cyst Excision c IDW in OT

MODE OF PAYMENT : ☐ SELF ☐ TPA : Star health 2nd-2025 ☐ CGHS ☐ PSA: DN Obaidullah ☐ OTHERS

TARIFF INFORMATION : Rathaniesh Jayaram O/P/W (GPS 50)

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges				1340/- per day						
	Doctor's Fee										
	L. Tax										

PARTICULARS			AMOUNT (₹)		
Surgeon's / Anesthetists's Fee / O.T. Charges			(PR+ASF)		(PR+ASF)+(OT)
O.T. Consumables			PR → 31680	Subject to approval by TPA / Insurance Company	11520 1000/hr
Instrument Charges			→ 1500	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.			Extra	As per actual - Not Included in Estimation	
Package					
Others					
Initial Minimum Deposit			10,000/- Final bill clearance		

RISK GR → 90,000/- OT Expert → 5,000/-

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **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.**
3. 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.
4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission. Room Upgrade STA → 12 noon cycle
5. 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.
6. **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.**
7. During Non-working hours of O.T (8:00 PM ot 7:00AM), 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
8. 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.
9. 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 Srikanth Manepally 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 — Father — Signatory Relationship — Signature of the Financial Counselor

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 : IP5-00174669 **Admit Date** : 03-Jun-2026 **Admit Time** : 06:19 AM **UHID** : BAH-00621860

Patient Details :

Patient Name	: Master M ROHAN	**Age**	: 7 Y 0 M 17 D
Guardian	: Mr M. SRIKANTH	**DOB**	: 17-05-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: 15-15-207 DWARKA NAGAR Koya Chelka Khammam Telangana INDIA 507002	**Phone No**	: 7337089708/ 6309761758
		E-mail	: nomailid@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 M. SRIKANTH **Relationship** : Father

Contact Address : 15-15-207 DWARKA NAGAR Koya Chelka Khammam Telangana INDIA 507002 **Phone No** : 7337089708 / 6309761758

Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

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ACTIVITY RECORD FOR BILLING

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

Name :_____ _____

UHID No. : _____ iltant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
03/06/26	6:45am	ER	OT	
3/6	10:25am	OT	32/1	

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
3/6/26	CBP	26056145	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/6/26.	IV placement PA C on OP basis	(1)	40392	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: M. Rohan

BAH-00621860 IP5-00174569
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

UHID ID: _____

Department: _____

Consultant: _____

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

4o Epidermoid prepuce cyst
&
Surgical Removal Epidermoid cyst 1 day ago

History of present illness :

H/o physiological phimosis and small Epidermoid cyst on ventral aspect of prepuce.

No H/o fever, Burning micturition

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
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Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

H/S/NO NICU stay

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Immunized till date

(P.T.O.)

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 32.8 (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 110/min B.P. 109/67 (78) 98% CR/A SPO2 _____

Resp.rate and type of breathing : 26/min

Rash —

Lymphadenopathy —

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : Bilateral

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (P).

Any murmur :

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

Per Abdomen :

Inspection

Palpation : Soft

Ausculation :

Spine : External Genitelia :

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

BAH-00621860 IP5-00174669
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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves :

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Epidermoid prep vaginal cyst Excision

(P.T.O.)

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Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Infection.

Desired goals of the treatment : Resolution of Symptoms.

Planned Labs:

CBP

Planned Management

1. NPO
2. PAC
3. Cyst Excision today
4. W/F DNS for maintanance

NB informed.

Signature of the Doctor: N.PD
Name of the Doctor: N. Prathusha
Date & Time: 03/6/26, 8

Signature of the Consultant:
Name of the Consultant: D. Harish
Date & Time: 3/6/26 8-15

Dr. HARISH JAYARAM
Reg. No: 66254

BAH-00621860 IP5-00174669
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 4:55pm	C/S/B Dr Nikhita	
	POD-0 Epidermoid cyst- excision	
	Afebrile	
	vitals – stable	Adv – Full feeds as tolerated
	P/A soft	
	Dressing intact	Dr Nikhita 3/6/26 4:55pm
	Dr. HARISH JAYARAM Reg. No: 66254 3/6/26 5.20 P.M.	
	C/S/B Dr Harish	
4/6/26 8:45 am	POD-1	
	Afebrile	Adv 1) Full feeds.
	vitals – stable	
	P/A soft	2) Plan discharge today
	Wound – healthy	
	Dr. HARISH JAYARAM Reg. No: 66254 4/6/26 8:45 AM	Malika Dr. Malika 4/6/26 8:45 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

(P.T.O)

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
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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 Epidermoid cyst excision

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)
- Removal of cyst	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. Bleeding, infection explained

b.

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

Patient / Patient Attendant:
Signature: .....
Name: .....
Relationship with patient: Father
Date & Time: 3/6/26 @ 8.10 am

Witness:
Signature: M. Saidani
Name: M. Saidevi
Date & Time: 3/6/26 @ 8 am

Doctor (who is taking consent):
Signature: ..... Name: Dr. Harish Jayaram Date 3/6/26 Time: 8.10 AM
Dr. HARISH JAYARAM Reg No: 66254

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనోబో 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: .....

పేర్లు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

BAH-00621860 IP5-00174669
Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

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OPERATION THEATER NOTES

Patient's Name : Master M Mohan Age : 7y Gender : ☑ Male ☐ Female

UHID No.: BAH-00621866 Weight : Height :

Surgeon : Dr. Harish Jayaram		Asst. Surgeon : Dr. Maliha.
Anesthetist :	OT Nurse:	OT Technician:

Pre-Operative Diagnosis: Epidermoid Cyst (Prepuce).

Surgical Procedure : Cyst Excision

Indications for Surgery : Epidermoid Cyst

Date : 3/6/26.	Start Time : 8:15 Am	End Time : 8:45 Am

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Swelling of 2x1 cm on preputial skin.

Procedure

1) Elliptical incision taken to include swelling.

2) ~~Incl~~ Cyst excised and wound sutured c 7-0 PDS interrupted sutures

Amount of Blood Loss: ~ 1ml | Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination: —

Peri-Operative Complications: —

Name of the Surgeon: Dr. Harish.

Signature of the Surgeon: .....

Date & Time: 3/6/26, 9:30 AM

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Cyst Excision

Post-Surgical Diagnosis: Prepucial Epidermoid Cyst

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

~~Dre~~ —

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

As early as possible

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: 3/6/26 Time: 9:30 AM

Note: Plan of care will be readjusted if necessary.

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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 : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

P

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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: EK Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Praveen. M.D

Date & Time : 03/06/26. 6:30 am

Nurse Name & Signature: Revathi

Date & Time : 3/6/26 @ 6:30 am

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DRUG CHART

Date of Admission: 3/6/26 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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REGULAR PRESCRIPTIONS

Weight. 32.8 Ward. ....

				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 : TAB PARACETAMOL				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
500mg	PO	TID	3/6/26	
Name & Signature of the Doctor Starting the Drugs: Maliha Dr. Maliha				
Additional Instructions: —				
Daily Doctor's Endorsement by a Sign				

DRUG : SYRUP PARACETAMOL				Date ▸ / Time ▾	3/6	4/6
Dose	Route	Frequency	Start Date			Pooja
10 ml	PO	Q8h	3/6/26	7AM	✓	Revathi
Name & Signature of the Doctor Starting the Drugs: Maliha Dr. Maliha				9:31AM		
				3PM	[illegible]	
Additional Instructions: —				11PM	Pooja / Revathi	
Daily Doctor's Endorsement by a Sign					Mal	Mal

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				

Master M ROHAN
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Weight. 32.8 kg Ward. ....

	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
03/6/26	8[25] AM	PARACETAMOL	500mg	IV	RC	[signature] Sumam

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

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I.V. FLUIDS CHART

Weight. 32.8kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/6/26		DNS	IV	70	N.P.D	Shirish / Shirish	not (Cancelled)		Shirish / Shirish

Signature .....

VERIFIED BY : Name .....

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Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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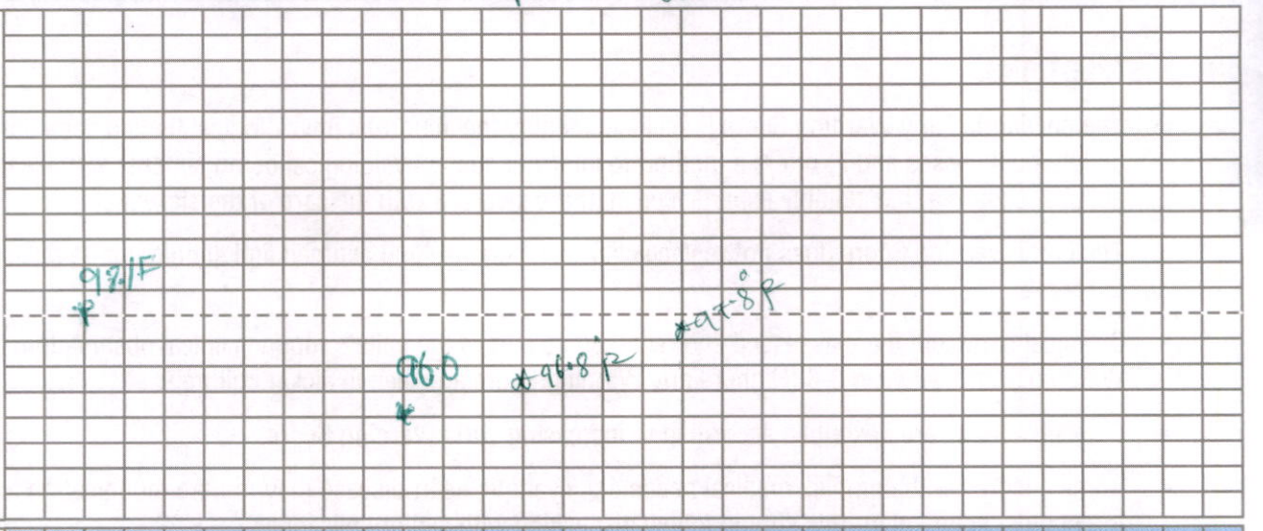
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/6/26 Time: 11:30AM 6pm 10 pm 6 am

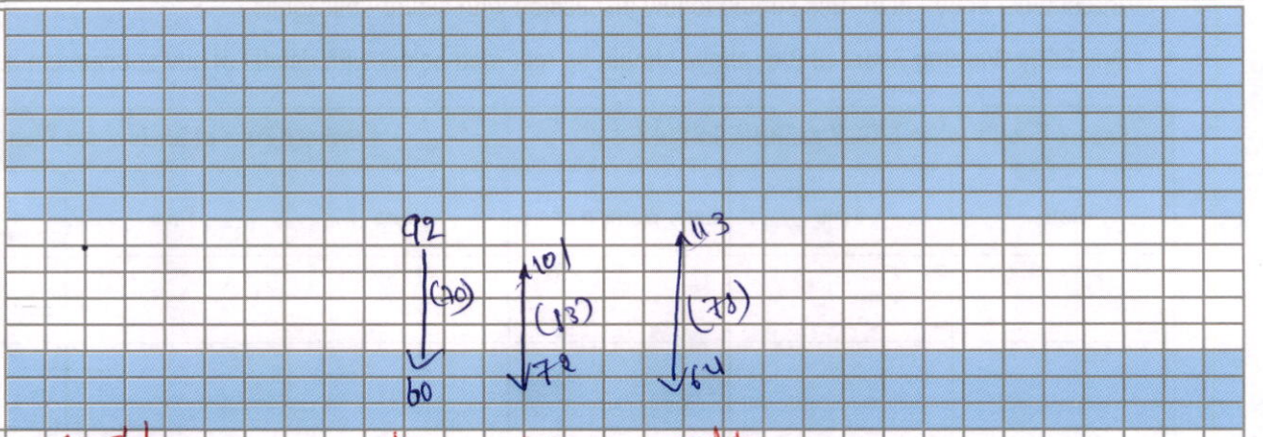
Doctor / Nurse / Family Concern?

Temperature (F)



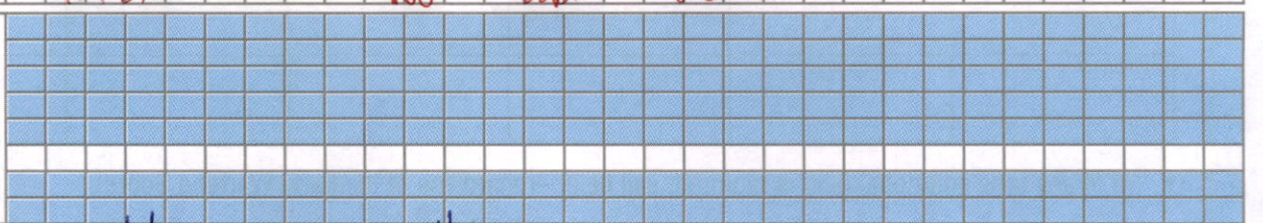
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number) 107 b/m 100 b/m 82 b/m 89 b/m

Resp. Rate (bpm) (Over 1 Minute) *



Resp Rate (Number) 28 b/m 22 b/m 22 b/m 22 b/m

Resp Distress	Mod/ Severe			
	None / Mild			
Receiving O_2 (l/min)				
O_2 Saturations (%)		99%	100%	100%	98%
Conscious Level	Normal			
	Altered			
GCS *		15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials		[illegible]	[illegible]	OK	[illegible]

ACTIONS NB: Scores 3 should be *recorded overleaf*	
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.

Patient Sticker

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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)

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: cer

Arrival Time: 6 am Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA Body Weight: 32.6 Kg

Height: — cm

Past Medical History: Obtained From ☐ Patient ☑ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: No history significant

Is the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, —

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: —

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☑ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 32.8 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4 F HR: 80 b/m RR: 20 b/m BP: 90/50 mmHg

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 0 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 26) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

Character of Pain — Location — Frequency — Duration —

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 ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

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

Social History: Lives With ..... Parents .....

Siblings in household ☐ Yes ☐ No (if yes How Many?) .....

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Mother .....

Nurse Signature: .....

Nurse Name: ..... Teena .....

Date: ..... 3/6/20 .....

Time: ..... 6.50 am .....

Pati

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
3/6	08:00 am											
	09:00 am		H2O			—	—	—	—	—	0	
	10:00 am		Boost	~	~	—	✓	~	—	✓	0	
	11:00 am										0	
	12:00 pm		Jelly				NP		✓	✓	0	Nisha
	01:00 pm		H2O				1		.		0	
Total Intake :						**Total Output :** M – 1 U – 1						
	02:00 pm										0	
	03:00 pm		H2O								0	
	04:00 pm						NP			✓	0	Annamma.
	05:00 pm		H2O								0	
	06:00 pm										0	
	07:00 pm		H2O								6	
Total Intake :						N – 0 **Total Output :** U – 1						
3/6	08:00 pm										0	
	09:00 pm										0	
	10:00 pm		H_2O							✓	6	
	11:00 pm						NP				6	Vanitha
	12:00 am										0	
	01:00 am										0	
Total Intake :						**Total Output :**						
4/6	02:00 am										0	
	03:00 am		H_2O								0	
	04:00 am						NP				0	
	05:00 am									✓	0	Vanitha
	06:00 am		H_2O								0	
	07:00 am										0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	orally taken	Total 24 hrs. Output	U = 4 m = 0

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FLUID CHART

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Sheet No. : .....

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

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

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

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mast. Rohan Age: 7yr Sex: Male UHID.No :

Date: 2/06/26 Time: 2:45PM Proposed Operation: Epidermoid cyst Excision.

Diagnosis: cyst on Prepuce

B.P / CRT: H.R: Weight: 33Kgs ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: NKDA.

Medical History: CVS : –

RESP : – Diabetes : –

CNS : No milestone delays.

Renal : –

Hepatic / GE : – Physical Activity: –

Others : –

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: adequate Mentonyoid Distance: (N) Neck: (N) Teeth: loose upper incisor

Lungs : BAE+, clear

Heart: S1 S2 +

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions: C.D.D.

Signature: A. Naresh Babu Name: Dr. A. Naresh

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

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ ~~No~~		Fasting Status: CONFIRMED	
Physical Status:	☑ ~~Patient Identified~~	☑ Consent Present	☑ ~~Chart Reviewed~~

H.R: 86 /min.	B.P / ~~CRT~~: 90/68	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: RENAL CYST Operation: CYST excision Date: 23/5/19

Surgeon: HARISH. Anaesthesiologist: RAVI Technician: VENKAT

TIME 8¼

N_2O /AIR / O_2 LPM

HALO /SO /SEVO

Drugs:

MIDAZOLAM 1.5

PROPOFOL 60 30 30

FENTANYL 05

PARACETAMOL 500mg

FIO_2 / SaO_2 99 100

$ETCO_2$

ECG SR SR

Temperature

Urine Output

Fluids / Blood

~~Antibiotic~~

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG (X)

GRBS

Others

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

Position: SUPINE

☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 9.15 AM
OP Start:
OP End:
Leave OR: 9.45 AM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts:
Difficulty Why?

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

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

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

Name of the Doctor: RAVI
Signature of the Doctor:

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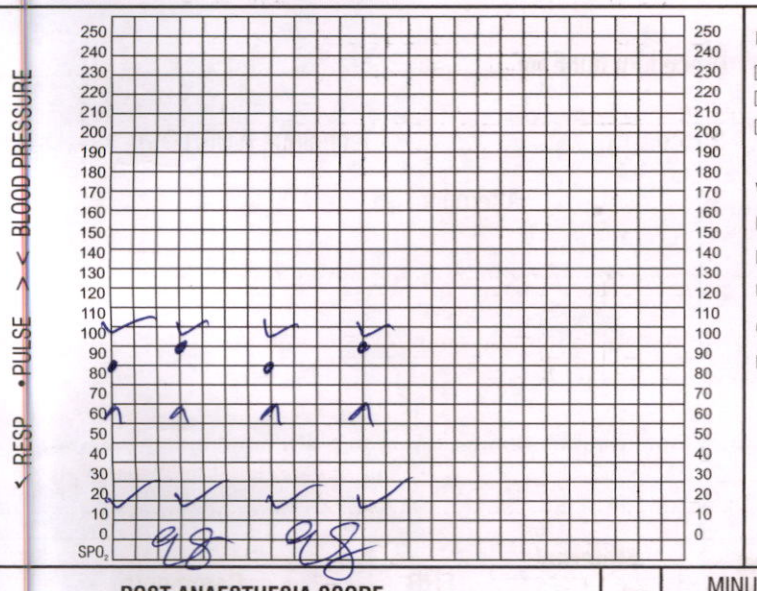
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Divya Time Received : 8:50 Am Time Discharged : 10:10 Am



IV Cannula Site : RT
- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☑ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

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

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6	8:50A	1/10	—	Divya

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

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

Anaesthesiologist Name : Dr M. Subrahmanyam
Anaesthesiologist Signature: [signature]
Date & Time: 3/6/26 10:20 PM

PACU Nurse Name : Divya
PACU Nurse Signature: Divya
Date & Time: 3/6/26 10A

Transferred to Unit by (PACU): 321
Date & Time: 3/6/26 10A

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Master M ROHAN
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Patient Name : Mast. M. Rohan Age : 7yrs Gender : Male ☑ Female ☐

UHID NO: ..... Surgeon Name: .....

Anaesthesiologist : Dr. A Danesh Babu

Operative procedure planned : Epidermoid cyst excision

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 without numbness can be achieved by infusing weak solutions of local anesthetics arid 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 mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

Comments : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mast. M. Rohan the above mentioned operation / Diagnostic / Therapeutic procedures cyst. Excision

I authorize and give consent for anaesthesia / ☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : .....

Name : M. Srikanth

Relationship with Patient: Father

Date & Time : 03/06/2026

Witness :

Signature : M. Saideni

Name : M. Saideni

Date & Time : 03/6/2026

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. A Naresh Babu

Date & Time : 2/06/26, 2:45 PM

Master M ROHAN
17-05-2019 7 Y 0 M 17 D (M)
Dr. HARISH JAYARAM

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/6/26 Time: 10am

Weight: 52.8kg's Centile: >90th

Height: 125cm Centile: >25th

Inference: Obese child

RDA: — Calories: 1500kcal/D Protein: 26gm/D

Diet Recommendations: Normal diet

Re-Assesment: avoid spicy chilled and outside foods

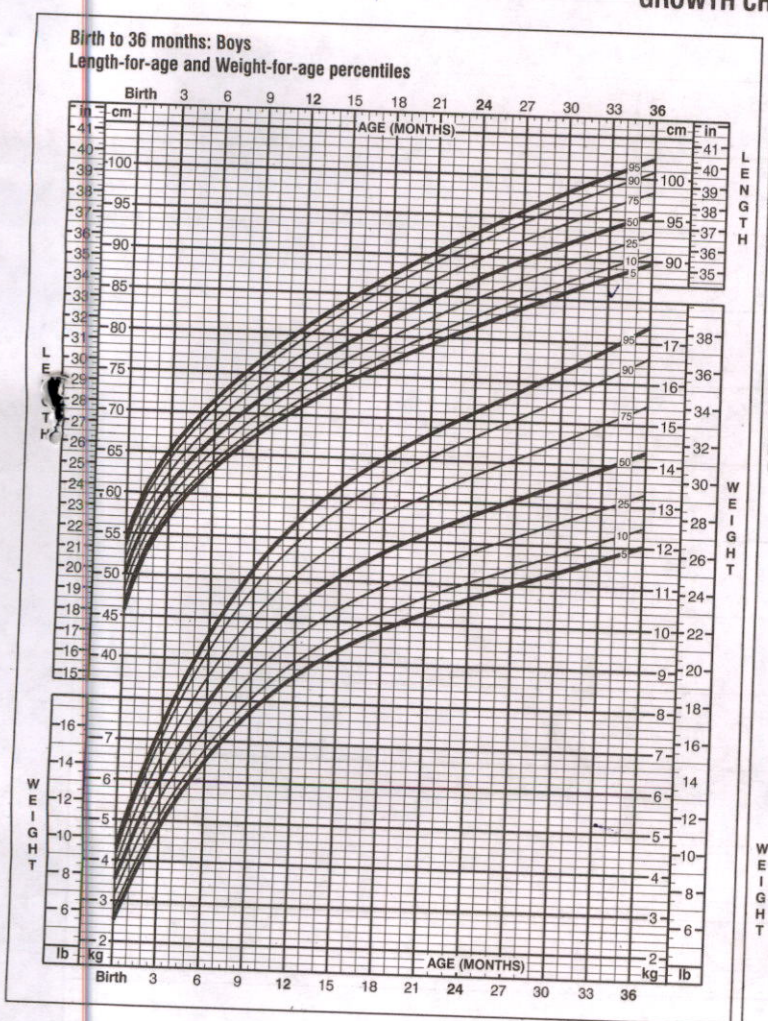
Food Allergies: No Veg/Non-veg Non-veg

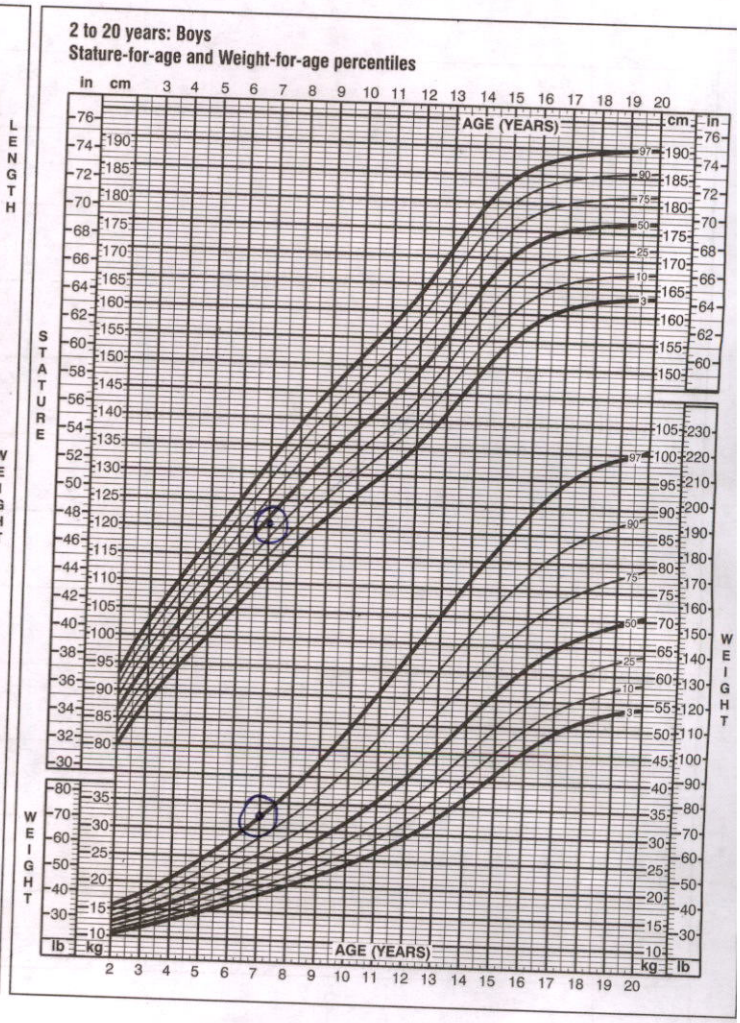
Diagnosis: Epidermoid cyst excision

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Saima

Dietician's Signature Saima

Daily Notes: