



SURGERY DETAILS

Date : 7/7/26

Patient Name: MASTER MD UMER Date of Birth: Age: 7 yrs

Gender: MALE Ward: P.O.T UHID No.: BAH-00418293

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

Name of the Surgery: Ritual Circumcision

Time in : 10am

Time Out : 10:40am

	NAME	AMOUNT
1. Surgeon	Dr. Nabeel	
2. Anaesthetist	DR. Sri Surya	
3. Assistant Surgeon		
4. OT Technician	VITAY KUMAR	
5. Circulating Nurse	TEENA PAKKIATHAS	
6. Assistant Nurse	RIKLAI	

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: 9691541

Order by:



Circumcision

37kg **CONSUMABLES OF OT**

Technician : Date : *7/7* Time : *9:04*

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used	Qty	Issued	Used	Qty	Issued	Used	Qty
ET tube	<i>147</i>	<i>147</i>	Major Pack	<i>1</i>	<i>1</i>	Inj Vit.K		
LMA	<i>01</i>	<i>01</i>	Sutures	<i>2</i>	<i>1</i>	Cord Clamp		
ECG leads : A/P/N	<i>5+5</i>	<i>5+5</i>	<i>99/5</i>			Suction Catheter		
HME filter : A/P/N	<i>01</i>	<i>1</i>				Feeding Tube		
Syringes : 10 cc	<i>20</i>	<i>10</i>				Vaccum Suction Set		
05 cc	<i>20</i>	<i>10</i>	Gloves	<i>6, 6/2, 7/2, 2/2, 2/2</i>	<i>1</i>	Surgical Gloves		
02 cc	<i>20</i>	<i>10</i>	<i>PF 6, 6/2, 7/2, 2/2, 2/2</i>	<i>1</i>		Gauze Pack		
01 cc	<i>5</i>	<i>1</i>				Syringe 1ml / 2ml		
Cautery plate : A/P/N	<i>01</i>	<i>1</i>	Surgical blade	<i>15</i>	<i>1</i>	Surgical Blade # 20		
IV set	<i>01</i>	<i>1</i>	NG tube			Koochies (S)		
RL	<i>01</i>	<i>1</i>	Cautery pencil			<i>15500ml</i>	<i>2</i>	<i>1</i>
NS : 10ml / 100ml / 500ml / 1000ml	<i>5+14</i>	<i>10</i>	Koochies			<i>Tranexamic acid</i>	<i>1</i>	<i>1</i>
<i>line splice</i>	<i>01</i>	<i>1</i>	Ointments			<i>100g 15%</i>	<i>2</i>	<i>1</i>
<i>vacuum set</i>	<i>01</i>	<i>1</i>	Suction Catheter			<i>cut cell 10x10</i>	<i>1</i>	<i>1</i>
Fentanyl	<i>01</i>	<i>1</i>	Cap, Mask	<i>5/5/5/5</i>	<i>1</i>	<i>mask</i>	<i>1</i>	<i>1</i>
Morphine	<i>01</i>	<i>1</i>	Gauze Pack	<i>5/5/5</i>	<i>1</i>			
Ketamine			Mop Pack					
Propofol	<i>4</i>	<i>2</i>	Steristrip					
Rocuronium	<i>01</i>	<i>0</i>	Underpad	<i>1</i>	<i>1</i>			
Glycopyrolate	<i>01</i>	<i>1</i>	Draw sheet	<i>1</i>	<i>1</i>			
Myopyrolate	<i>01</i>	<i>1</i>	Abgel					
Ondansetron	<i>01</i>	<i>1</i>	Foleys catheter					
Pencan 25g/ Spinal Needle 22	<i>01+1</i>	<i>1</i>	Urobag					
Bupivacaine 0.25%	<i>01</i>	<i>1</i>	Chest Drainage Catheter			<i>0 A. 1/2</i>	<i>14</i>	<i>1</i>
Bupivacaine 0.25%(Heavy)	<i>01</i>	<i>1</i>	Romodrain bag			<i>N A. 22/24</i>	<i>14</i>	<i>1</i>
Antibiotics			Bandage			<i>02mm CO2</i>	<i>01</i>	<i>1</i>
<i>IV pcm</i>	<i>9</i>	<i>01</i>	Tegaderm			<i>CO2 pump (A)</i>	<i>01</i>	<i>1</i>
Suppositories			Ioban			<i>Deemed (100)</i>	<i>01</i>	<i>1</i>
Anamol : 80mg / 250mg / 170 mg			Double J Stent			<i>Clonidine</i>	<i>01</i>	<i>1</i>
Supridol : 100mg			Vaccum Suction set	<i>1</i>	<i>1</i>	<i>Succ + Moup +</i>	<i>14</i>	<i>1</i>
Justin : 12.5 mg / 25mg / 100mg	<i>01</i>	<i>1</i>	Plastic Bed Sheet	<i>1</i>	<i>1</i>	<i>3uy stoproce</i>	<i>01</i>	<i>1</i>
Tab. Misoprost : 200mg			Betadine Solution	<i>1</i>	<i>1</i>	<i>ASAP + Schuile</i>	<i>14</i>	<i>14</i>
<i>3uy 1000 + 1000 cm</i>	<i>14</i>	<i>1</i>	Microshield	<i>1</i>	<i>1</i>	<i>midaz + split</i>	<i>14</i>	<i>14</i>
<i>Gauze + clove</i>	<i>5+14</i>	<i>1</i>	Cotton Balls	<i>1</i>	<i>1</i>	<i>CO2 pump + canister</i>	<i>14</i>	<i>14</i>
<i>Dice + 10mm</i>	<i>14</i>	<i>1</i>	Latex Gloves	<i>10</i>	<i>5</i>	<i>na + suction</i>	<i>04</i>	<i>1</i>
<i>IV cath. 20, 22</i>	<i>14</i>	<i>1</i>	Ramdone Scrub					
<i>Q. ant. splint 1/3</i>	<i>14</i>	<i>1</i>	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : *7691567*

Ordered by :

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176060 Admit Date : 07-Jul-2026 Admit Time : 08:04 AM UHID : BAH-00418293

Patient Details :

Patient Name	: Master MD UMER	Age	: 7 Y 9 M 4 D
Guardian	: Mr MD SHABBER AHMED	DOB	: 03-10-2018
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 42-245/1, RTC COLONY New Ganj Nalgonda Telangana INDIA 509103	Phone No	: 9491136504
		E-mail	: NA@RAINBOW.IN

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 402 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 402 Admission Type : First Visit

Contact Details :

Name : Mr MD SHABBER AHMED Relationship : Father
Contact Address : H NO 42-245/1, RTC COLONY New Ganj Phone No : / 9491136504
Nalgonda Telangana INDIA 509103

Shabber
Signature

Doctor Details :

Doctor Name : Dr. NABEEL ALAM QADRI Specialisation : PEDIATRIC SURGERY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26.	8:40am	ER	OT	<i>[Signature]</i>
7/7	11:40am	OT	billing	<i>[Signature]</i>

Cross Consultation Visit

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

[illegible]

Signature

Ismael

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	iv placement PAC	1 op Basis	91360	[Signature]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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. Ritual Circumcision

2. _____

I acknowledge the following:

- 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)
① Circumcision for Ritual purposes.	- Nil -

- 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:

- Bleeding, infection, need for redo surgery
-

- I authorize Dr. Nabeel Alam and his / her team to perform the procedural sedation upon the patient / myself.
- 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.
- 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: Mr. Shabbir Ahmed
Relationship with patient: Father
Date & Time: 7/7/20
8:50a

Witness:

Signature: [Signature]
Name: Apsara Begum
Date & Time: 7/7/20
8:50a

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Nikhita Date: 7/7/20 Time: 8:50a

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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. శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి
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 / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి. ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు సమస్యలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:

శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తప్రావం, ఇన్ ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అల్త్రీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రాంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. 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 / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయవశాతం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.

6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇవ్వారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం:

పేరు:

Docu. No.: RCHH/IRM CLINICAL / 027 (26)

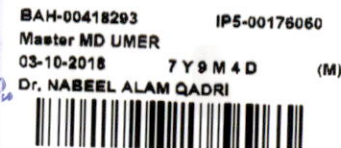
తేదీ & సమయం:

(P.T.O)

SURGICAL SAFETY CHECKLIST

Surgeon : DR. NAE EL
Asst. Surgeon :
Anaesthetist : DR. S. Furus
Scrub Nurse : B. KHALI

Patient Name : MAST. UMER Age : 7 Gender : M
UHID No. : BPA-004190 Surgery Name : RITUAL CIRCUM
Date : 7/7 In-time : 10⁰⁰ AM Out-time :



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: <u>9:45 AM</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>[Signature]</u>	
Name : <u>Dr. R. S. Sanyal</u>	

TIME OUT	Time: <u>10 AM</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, <u>20m</u> Anticipated Blood Loss? <u>1 ml</u> ☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews: <u>110 seizures</u>	
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>[Signature]</u>	
Name : <u>Belra</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>[Signature]</u>	
Name : <u>Dr. Nabeel</u>	

BAH-00418293 IPS-00176060
Master MD UMER
03-10-2018 7 Y 9 M 4 D (M)
Dr. NABEEL ALAM QADRI

Patient:

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 7/7/21

Department : P.O.T. Duration of Procedure : 20 min

Name of Surgeon : RITUAL CIRCUMCISION Date of Admission : 7/7/21

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 : _____	<i>[Signature]</i>
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	<i>[Signature]</i>
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<i>[Signature]</i>
4.	Name of doctor or staff administering the antibiotic : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 7/7/21 @ 10am	<i>[Signature]</i>

- 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

BAH-00418293 IP5-00176060
Master MD UMER
03-10-2018 7 Y 9 M 4 D (M)
Dr. NABEEL ALAM QADRI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION THEATER NOTES

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

UHID No.: Weight : Height :

Surgeon : <u>Dr. Nabeel</u>		Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:	
Pre-Operative Diagnosis: <u>Ritual purpose</u>			
Surgical Procedure : * <u>Ritual Circumcision</u>			
Indications for Surgery : <u>Ritual purpose</u>			
Date : <u>27/26</u>	Start Time :		End Time :
Pre Operative Preparations:			
Post Operative Diagnosis: <u>Ritual purpose</u>			
Peri-Operative Complications: <u>-</u>			
Operation Notes: <u>Findings:</u>			
1. Adequate testis collar.			

Procedure:

1. Prepuce retracted & prepuce adhesions released. Firlits collar defined
2. Circum coronal incision made leaving adequate firlits collar.
3. Prepuce excised.
4. Penile skin sutured to firlit collar.
5. Hemostasis achieved. Dressing done.

Amount of Blood Loss: 1ml

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Advice

1. Ciplox eye drops - 2 ^{drops} / time
3 times / day for 1 week.
2. TAB - PARACETAMOL 500mg p/o TID for
(5) days.
3. Remove dressing tomorrow.
Review after 1 week in OPD

Name of the Surgeon: Dr. Nabeel

Signature of the Surgeon: [Signature]

Date & Time: 2/2/26 10:20 am...



POST-SURGICAL CARE PLAN FORM

Procedure Done: Ritual Circumcision

Post-Surgical Diagnosis: Ritual purpose

Post-Operative Monitoring Parameters /Frequency:

TPR for every 15 min for 1st 1 hr.

Wound Care:

Ciplox eye drops - 2 drops 3 times/day
for week over circumcision site

Drain /Special Lines/Catheters:

✓

Special Patient Positioning and Requirements:

-

Nutritional Instructions:

Full orals allowed.

When to Start Mobilization:

as early as possible

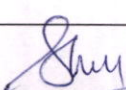
Special Referrals:

-

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: Time:

Note: Plan of care will be readjusted if necessary.

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor :

Date : 7/7/26

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

Start Time of Assessment:

Weight: 37.8kg

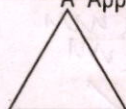
Allergic History: Not known

Chief Complaints:

No seizure & global
developmental delay.
K/c/o Smith Magenis
syndrome
came for circumcision.

Pediatric Assessment Triangle

A Appearance - TICLS Apert, conscious

B  C Circulation ☒ Normal ☐ Abnormal

Breathing normal

☐ ↑ WOB ☐ Pallor ☐

☐ ↓ WOB ☐ Cyanosis ☐

☐ Normal ☐ Mottling ☐

☐ Gasping / Apnea ☐ Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening ☐
☐ Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Significant Past History: K/c/o Smith Magenis syndrome

Medication History: On T. Oxetol, T. Arip, T. Serta, T. Oleanz,

Relevant Investigations: T. atomil.

Primary Assessment

Airway ☒ Open ☐ Maintainable ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Breathing 24/min normal SpO₂ on FiO₂

Rhythm:

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: absent

Palpation Findings (If necessary) 7 @

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Circulation  HR: 110/min

BP: 120/60 mmHg

Pulse Volume: ☐ Central ☒ Peripheral *well felt*

If in Shock: ☐ Compensated ☐ Hypotensive

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

CFT ☐ Central ☒ Peripheral *1-2 sec*

Murmurs: ☐ Yes ☒ No

Liver Span: ☐ Yes ☒ No

ECG: ☐ Yes ☒ No

Any Signs of Heart Failure: ☐ Yes ☒ No

Any urgent interventions needed: ☐ Yes ☒ No

If Yes:

Disability  GCS: 15 AVPU: Alert

Pupils: ☐ Responsive ☒ Non-Responsive

Size: ☐ Right ☒ Left *2mm*

Active Seizures: ☐ Yes ☒ No

Sugars:

Signs of Neurological compromise:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes:

Exposure  Temp.: 98.5

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

Treatment Planned: Keep NPO

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

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by
Name of the Doctor:

Signature:

Date & Time:

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor:

Signature:

Date & Time:

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

MEDICATION RECONCILIATION FORM

Drug Allergies: Not known ☒ 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	T. OXETOL	150mg	oral	BD.		☐ C ☐ DC
2	T. ARIP MT	2mg (1/2 tablet)	oral	O.D.		☐ C ☐ DC
3	T. OLEANZ	2.5mg	oral	O.D.		☐ C ☐ DC
4	T. ALTONIL	3mg (1/2 tablet)	oral	O.D.		☐ 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: Rashmi

Date & Time: 7/7/26 @ 8:10 am

Nurse Name & Signature: Nr. Seemita

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



REGULAR PRESCRIPTIONS

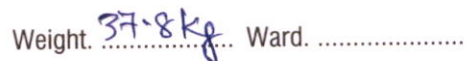
Weight. 87.8kg Ward.

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																			



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.

[illegible]

(M)

Weight. 37.8 kg Ward.

[illegible]

Signature

BAH-00418293 IP5-00176060
 Master MD UMER
 03-10-2018 7 Y 9 M 4 D (M)
 Dr. NABEEL ALAM QADRI


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

 **BirthRight™**
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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						

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	1/20												
	12:00 pm	1/14												
	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

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.
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													



CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Ritual circumcision
Anaesthesiologist: Dr. Swithen Surgeon: Dr. Nabeel Qadri

Please read this before you consent for Anaesthesia

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

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

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

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☒ Regional Anaesthesia ☒ General Anaesthesia ☒ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Apsana Begum
Name: Apsana Begum
Relationship with patient: Mother
Date & Time: 6/7/26 6pm

Witness:

Signature: Bates
Name: MD. Shabbees Ahmed
Date & Time: 6/7/26 6pm

Doctor (who is taking consent):

Signature: Dr. Swithen Name: Dr. Swithen Date 6/7/26 Time: 6pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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 అవి నివృత్తి చేయబడ్డాయి.

- ☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం
- ☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)
- ☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ 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, ఆర్టిరియల్ లైన్, సపోజిటలీలు, 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 స్వప్రమేన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00418293 IP5-00176060
Master MD UMER
03-10-2018 7 Y 9 M 4 D (M)
Dr. NABEEL ALAM QADRI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: MD. Umer Age: 8yrs Sex: M UHID.No: _____
Date: 7th 6/7/26 Time: 6pm Proposed Operation: Ritual Circumcision

Diagnosis: _____

B.P / CRT: _____ H.R: _____ Weight: 27kg 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: Nil

Medical History: CVS: _____

RESP: _____

Diabetes: _____

CNS: H/O. seizures at 14 yrs. ; Global developmental delay
on Rx for seizures ; last Episode 2yrs back.

Renal: _____

Hepatic / GE: _____

Physical Activity: _____

Others: Born by LSCS / 2.4kg / CIAB / no H/O ICU admissions

Past Anaesthetic History: _____

Physical Exam: microcephaly

Airway: MP 1 2 3 4 Mouth Opening: _____ Mentohyoid Distance: _____ Neck: _____ Teeth: _____

Lungs: cl. chry.

Heart: cl. chry.

CNS: not obeying commands, conscious.

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
<u>7. oxetol.</u>	<u>150mg BD</u>
<u>T. Arip MT</u>	<u>2mg 1/2 OD</u>
<u>T. olanz</u>	<u>2.5mg OD</u>
<u>T. Altonit</u>	<u>3mg 1/2 OD</u>

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. Sauter



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Durg

Time Received: 10:45 AM

Time Discharged: 11:30 AM

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 SPO ₂	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	IV Cannula Site: <u>22G R hand</u>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway
< RESP • PULSE > BLOOD PRESSURE		Vomiting: ☐ Yes ☒ No
		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	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 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	RESPIRATION	2	2	2			
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION	2	2	2			
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1							
BP $\pm$ 50 of Pre Anaesthetic leve	= 0							
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
7/7	10:45 AM	1/10	—	Dr. Durg

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

Anaesthesiologist Name: Dr. Durg, Shorini

Anaesthesiologist Signature: [Signature]

Date & Time: 7/7/20

PACU Nurse Name: [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 7/7/20 @ 11:30 AM

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): Billing

Date & Time: 7/7/20 @ 11:30 AM

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :