BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

SmithNephew
EVAC° 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2200917
2028-10-13

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SURGERY DETAILS

NVPL

Date : 27-05-26

Patient Name: Baby: Chilamkurty Niyati Date of Birth: 08-07-2018 Age: 7y

Gender: Female Ward : OT UHID No.: BAH-00454722

Date of Surgery: 27/05/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Coblation Assisted Adenotonsillectomy

Rd. SBI - Grade-III

Time in : 2:05 PM Time Out : 3:05 PM

		NAME	AMOUNT
1.	Surgeon	: Dr Manish Gupta	
2.	Anaesthetist	: Dr. Aiswarya	
3.	Assistant Surgeon	:	
4.	OT Technician	: Neshanth	
5.	Circulating Nurse	: Sujata	
6.	Assistant Nurse	: Akash	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Coblator used → 9629914

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9629913

Order by: Y. Ramadevi

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

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Baby CHILAMKURTY NIYATI
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Dr. MANISH GUPTA

Adeno

CONSUMABLES OF OT

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Circulating staff : ..... Technician : Adithealth Date : 27/5 Time : 12:30pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5, 4, 6.5	1+1+1	01	Major Pack Surgl.		1	Inj Vit.K		
LMA 1, 1½,	1+1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	05	03				Suction Catheter		
HME filter : A / P / N	01	01				Feeding Tube		
Syringes : 10 cc	10	10				Vaccum Suction Set		
05 cc	10	6	Gloves 6 6½ 7 7½ PF 2 2 2 1+1			Surgical Gloves		
02 cc	10	9				Gauze Pack		
01 cc	05	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube 6	2	2	Koochies (S)		
RL	01	0	Cautery pencil			NL 100ml	2	0
NS : 10ml / 100ml / 500ml / 1000ml	1+1	0+1	Koochies			10cc	2	1
Mini Spike	01	0	Ointments			Adrenalin	3	3
O2 mask (P)	01	—	Suction Catheter			Savlon	1	1
Fentanyl	01	01	Cap, Mask	4S	S/C			
Morphine			Gauze Pack NTR	3 PP	2			
Ketamine			Mop Pack	1	—			
Propofol	03	02	Steristrip					
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	0			
Myopyrolate INEO	02	01	Abgel			Gauze + Gloves all	4+4	1+1
Ondansetron	01	01	Foleys catheter			Dexa + Tranexa	1+1	—
Pencan 25g/ Spinal Needle 22			Urobag			Dermed	01	—
Bupivacaine 0.25%			Chest Drainage Catheter			50ce + pmo line	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Inpem	01	01	Bandage					
Aug (600mg)	01	01	Tegaderm					
Suppositories			Ioban					
Anamol 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	2			
Justin : 2.5 mg / 25mg / 100mg	1+1	01	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	—				
Vacuum Set	01	01	Microshield	1	0			
Oral airway 0,1		—	Cotton Balls	—	—			
Nasal airway 16, 18		—	Latex Gloves	1 pr	1 pr			
IV cannula 22, 24		—	Ramdione Scrub					
Zuxy 10mg (100ml)		01	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9629788 Ordered by : .....

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

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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 : IP5-00174381 **Admit Date** : 27-May-2026 **Admit Time** : 11:24 AM **UHID** : BAH-00454722

Patient Details :

Patient Name	: Baby CHILAMKURTY NIYATI	**Age**	: 7 Y 10 M 19 D
Guardian	: Mr CHILAMKURTY SAGAR	**DOB**	: 08-07-2018
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 407, SUNRISE RESIDENCY, PLOT NO 48, GOUTHAMI ENCLAVE, BESIDE CHIREC PUBLIC SCHOOL, Kondapur Hyderabad Telangana INDIA 500084	**Phone No**	: 9000841475/ 8879432244
		E-mail	: TEJASWINITALUPULA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 411 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 411 **Admission Type** : First Visit

Contact Details :

Name : Mr CHILAMKURTY SAGAR **Relationship** : Father

Contact Address : FLAT NO 407, SUNRISE RESIDENCY, PLOT NO 48, GOUTHAMI ENCLAVE, BESIDE CHIREC PUBLIC SCHOOL, Kondapur Hyderabad Telangana INDIA 500084 **Phone No** : 9000841475 / 8879432244

Tejasiram

Signature

Doctor Details :

Doctor Name : Dr. MANISH GUPTA **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

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

Payor Name : STATE BANK OF INDIA

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 20 D (F)
Dr. MANISH GUPTA

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CROSS CONSULTATION FORM

Doctor Name : Dr. Annapoorna T. Date : 28/5/26 Time : .....

Diagnosis : Post adenotonsillectomy.

Hospital : RCH-BH

Referred for : ☑ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Opinion on discharge

Signature: Sahithi

Findings and Recommendations :

Adenotonsillar hypertrophy
post adenotonsillectomy.
No fever / vomiting / bleeding.
Accepting orally

O/E.
Child alert, afebrile
hemodynamically stable.
chest clear
abdomen soft
throat healthy.

Plan.
1. Can be discharged today
2. follow up with ENT surge

Consultant :

Name : Dr Annapoorna T Signature : Date & Time : 28/5/26 10Am

Tadavarthy Annapoorna
Reg. No: 53054

Doc. No. : RCH / FRM / CLINICAL / 049

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ 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
27/5	12:36pm	ER	OT	Tanu
9/5	11:29pm	OT	319	Divya

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
27/8/16	Dr Placement	1	9181	Dr
	PAC op			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o recurrent episodes of cold, cough
nose block ⊖
Open mouth Breathing ⊖
Snoring Issues

History of present illness :

As per informant, child apparently well. Then had recurrent episodes of cold, cough, nose block, Open mouth Breathing ⊖ Snoring Issues ⊖

O/E : Had Adenoid Hypertrophy.

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Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

DTO

Normal perinatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information : middle

Developmental History :

Attained appropriate for age

Immunization History :

Immunized till date

(P.T.O.)

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08-07-2018 7 Y 10 M 19 D (F)
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Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs))_____(Centile _____)

On Examination :

Temperature : _____ Pulse Rate :_____ B.P. _____ SPO2 _____

Resp.rate and type of breathing : _____

Rash_____

Lymphadenopathy_____

Oedema :_____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : BAE (+), clear

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 Heard

Any murmur :_____

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

Per Abdomen :

Inspection (N)

Palpation : soft, non tender

Ausculation : BS (+)

Spine : (N) External Genitelia : (N)

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

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Baby CHILAMKURTY NIYATI
03-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert/Active

Cranial Nerves : Intact

Motor System:

Nutriton : Normal

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements : Nil

Reflexes :

DTR (N) **Superficials:**

Plantars

Sensory System :

Bladder / Bowel : regular

Clinical Summary & Diagnostic:

chronic Adenotonsillitis
Now for ablation Adenotonsillectomy

(P.T.O.)

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Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent Complications

Desired goals of the treatment : For Hemodynamic stability

Planned Labs:

CBP
IV Cannula
N/B
Tcul
28/5/26
1PM

Planned Management

1) Continue NPO
2) IV fluids
3) Shift to OT on call

CB Suman
28/5/26
1PM

Signature of the Doctor: Pavani
Name of the Doctor: Pavani V
Date & Time: 28/5/26 11:30 AM

Signature of the Consultant: Dr. Padavarthy Annapoorna G. Reg. No: 53057
Name of the Consultant: Annapoorna G.
Date & Time: 28/5/26 10 Am

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Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
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Patien

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/20 11:50pm	CLS/13 - Resident Adenotonsillar hypertrophy S/P - Adenotonsillectomy coblation hemodynamically stable	Plan - medicat as per chart Parent Noted by Sister in charge
23/5/20 9 AM	Seen by Resident : Dr Sahithi Adenotonsillar hypertrophy post adenotonsillectomy coblation. No fresh issues Accepting orally hemodynamically stable	Plan 1. Discharge today Sahithi

BAH-00454722 IPS-00174381
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

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OPERATION THEATER NOTES

Patient's Name : BABY CHILAMKURTY NIYATI Age : 7 Y Gender : ☐ Male ☑ Female

UHID No.: BAH-00454722 Weight : 20kgs Height : .....

Surgeon : Dr. MANISH GUPTA	Asst. Surgeon : —	
Anesthetist : DR AYESWORYA	OT Nurse: AKHIL	OT Technician: NISHANTH

Pre-Operative Diagnosis: Adenotonsillar Hypertrophy

Surgical Procedure :
Coblation Assisted Adenotonsillectomy

Indications for Surgery :
Adenotonsillar Hypertrophy

Date : 27/05/26	Start Time : 02:19 pm	End Time : 3.00 pm

Pre Operative Preparations:
NBM for 6 hrs

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: ↓ GA & oral Endotracheal intubation
Coblation Assisted Adenotonsillectomy done.

Post-op Instructions
① NBM till further orders as advised by Anaesthetist
② Inj Augmentin 30 mg/kg/IV BD
③ Inj PCM 15 mg/kg/IV TID
④ Otrivin-P nasal drops 2 drops in each nostril BD

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	

Name of the Surgeon: Dr Manish Gupta

Signature of the Surgeon:

Date & Time: 27/1/26 3 p.m.

Patient

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 27/5/26 Time: 3 pm

Note: Plan of care will be readjusted if necessary.

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Manish Gupta
Asst. Surgeon : .....
Anaesthetist : Dr. Ayeshwarya
Scrub Nurse : Akhil

Patient Name : Baby. N. yati Age : 7y Gender : F
UHID No. : BAH-00454722 Surgery Name : coblation assisted adenotonsillectomy
Date : 27/05/26 In-time : 02:03pm Out-time : 3:05pm

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2 pm

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 : Ayesh
Name : Dr. ASTHWARYA

Before Skin Incision ➤➤

TIME OUT Time: 02:17pm

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, 1hr Anticipated Blood Loss? 10ml ☐ 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 : Sujata
Name : Sujata

Before Patient Leaves Operating Room

SIGN OUT Time: 3Pm

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 : Manish Gupta
Name : Dr Manish Gupta

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Baby CHILAMKURTY NIYATI
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 27/05/26

To Be Filled In By Assigned Nurse :

Department : OT Duration of Procedure : 1 hr

Name of Surgeon : Dr. Manish Gupta Date of Admission : 27/05/26

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

		Staff Signature
	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 : Inj. Augmentin 600mg	Suj
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	Suj
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Suman
4.	Name of doctor or staff administering the antibiotic : SIs Teena Date & Time of antibiotic administration : 27/05/26 @ 01:55pm Date & Time procedure started : 27/05/26 @ 02:17pm	Suj

- 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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RESULT SHEET

Date	27/05					
Time	11:54am					
Hb	13.1					
PCV	39					
RBC	4.76					
WBC	12.32					
N/L	1					
Platelets	460					
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.,) : .....

MC-7573

Laboratory Report

Baby CHILAMKURTY NIYATI	9000841475
7 Y 10 M 19 D	BA26053855
Female	27-05-2026 11:51 AM
IP5-00174381	27-05-2026 11:54 AM
BAH-00454722	27-05-2026 01:58 PM
Dr. MANISH GUPTA	4F-OT COMPLEX / POST OP 411

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED		
HEMOGLOBIN (Colorimetry)	13.1	g/dL		11.5 - 15.5
RBC COUNT (DC detection method)	4.76	10^12/L		4 - 5.2
PCV/HCT (Calculated)	39.0	VOL%		35 - 45
MCV (Calculated)	81.9	fL		77 - 95
MCH (Calculated)	27.5	pg/cells		25 - 33
MCHC (Calculated)	33.6	g/dL		32 - 36
RDW-CV (Calculated)	12.5	%		11.5 - 15
PLATELET COUNT (DC Detection Method)	**460**	**10^9/L**	H	150 - 450
MPV (Calculated)	8.6	fL		6.5 - 10
WBC COUNT (DC Detection Method)	12.32	10^9/L		5 - 14.5
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**57**	**%**	H	32 - 54
LYMPHOCYTES (Microscopy, Leishman stain)	36	%		28 - 48
MONOCYTES (Microscopy, Leishman stain)	4	%		4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	3	%		1 - 6
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC - NORMOCYTIC / NORMOCHROMIC WBC - MORPHOLOGY NORMAL PLATELETS - ADEQUATE**			

INTERPRETATION

A Complete blood picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections.
This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed.
All the abnormal results are to be correlated clinically.

DISCLAIMER

Test results released pertain to the specimen submitted. All test results are dependent on the quality of the sample received by the laboratory. Test Result may show interlaboratory variations. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the referring physician.

Hafsa

Dr. HAFSA AHMAD
MBBS,DCP
CONSULTANT CLINICAL PATHOLOGY
Reg No : 36473

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Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

Patient

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CROSS CONSULTATION FORM

Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

.....

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Consultant :

Name : ..... Signature : ..... Date & Time : .....

BAH-00454722 IP5-00174381
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: 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 : Pawan U

Date & Time : 27/5/26 11 am

Nurse Name & Signature: Israel - Anil

Date & Time : 27/05/26 @ 11 am

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

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Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

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

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Date ▸ Time ▾

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Dose	Route	Frequency	Start Dt.

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Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

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

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DRUG CHART

Date of Admission: 27/05 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Syp IBUPROFEN				Date / Time
Dose	Route	Frequency	Start Date	
10ml	PO	SOS	27/5	
Doctor's Signature		Valid Period	Pharm.	
Sahithi		7 days		
Additional Instructions: 5 ml/100 mg for severe pain maximum 3 daily				

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

VERIFIED BY : Name ..... Signa

IP3-00174381
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REGULAR PRESCRIPTIONS Weight. 20.1kg Ward. P.O.T

DRUG : Inj AMOXICILLIN-CLAVULANIC

Dose	Route	Frequency	Start Date
600mg	IV	TID	27/5

Name & Signature of the Doctor Starting the Drugs: Pavani

Additional Instructions:

Date	27/5	28/5
Time		
6AM	X	Sumaiya Shaik
2PM	X	
10PM	Sumaiya	

Daily Doctor's Endorsement by a Sign

VERIFIED

DRUG : Inj PARACETAMOL

Dose	Route	Frequency	Start Date
300mg	IV	TID	27/5

Name & Signature of the Doctor Starting the Drugs: Pavani

Additional Instructions:

Date	27/5	28/5
Time		
6AM	X	Sumaiya Shaik
2PM	X	
10PM	Sumaiya Shaik	

Daily Doctor's Endorsement by a Sign

VERIFIED

DRUG : OTRIVIN-Paediatric

Dose	Route	Frequency	Start Date
2	each nostril	Q12H	27/5

Name & Signature of the Doctor Starting the Drugs: Pavani

Additional Instructions:

Date	27/5	28/5
Time		
6AM	X	Sumaiya Shaik
6PM	9PM Sumaiya	

Daily Doctor's Endorsement by a Sign

VERIFIED

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
20mg	IV	OD	27/5

Name & Signature of the Doctor Starting the Drugs: Pavani

Additional Instructions:

Date	28/5
Time	
6AM	Sumaiya Shaik

Daily Doctor's Endorsement by a Sign

VERIFIED

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Weight. 20 kg Ward. P.OT

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
27/5/26	1:50 pm	~~Inj Augmentin 30mg/kg~~	~~30mg/kg BD~~	IV		
27/5/26	1:55 pm	INJ. AUGMENTIN	600mg	IV	Ashy	Jeevan Nageshwari Suma Sujata
27/5/26	2:10 pm	INJ. DEXAMETASON E	2mg	IV	Ashy	Suman Sujata
27/5/26	2:10 pm	Inj TRANEXAMIC ACID	300mg	IV	Ashy	Suman Sujata
27/5/26	2:05 pm	Supp DICLOFENAC	12.5mg	PR	Ashy	Suman Sujata
27/5/26	2:20 pm	INJ PARACETAMOL	300 mg	IV	Ashy	Suman Sujata

VERIFIED VERIFIED

VERIFIED BY : Name Signature

Baby CHILAMKURTY NIYATI
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I.V. FLUIDS CHART

Weight. 19.6 kg Ward. P-OT

		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
22/5		IVF · DNS.	N	60ML/Hr			Not	Connected	
27/5/26	2:15 pm	RINGER LACTATE	IV	220 ml/hr			27/5		

Signature .....

VERIFIED BY : Name .....

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: RCHBH/ FRM / CLINICAL / 126

27/5/2026

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	6PM	10PM	2AM	6AM
Doctor / Nurse / Family Concern?				

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

97.9F 98.0F 97.8F 98.0F

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

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

110 / (80) / 60 — 109 / (75) / 65 — 102 / (83) / 50 — 110 / (85) / 65

Note: BP does not score in early warning scoring

Heart Rate (Number)	101 b/m	100 b/m	105 b/m	

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

70 60 50 40 30 20 10

Resp Rate (Number)	26b/m	26b/m	26 b/m	26b/m
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min) O_2 Saturations (%)	100%	99%	100%	99%
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	S	S	S	S

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

Pratiksha Rainbow Children's Hospital
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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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FLUID CHART

Sheet No. : 1

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
			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 :**						
28/6	02:00 pm	RL	NPO	220ml	—	—	—	—	—	—	—	0
	03:00 pm	RL	NPO	220ml	—	—	1	—	—	1	—	0
	04:00 pm	H2O	Ice stream	50ml	—	—	1	—	—	1	—	0
	05:00 pm		Milk			NP				NP		0
	06:00 pm											0
	07:00 pm		Milk									0
Total Intake :						**Total Output :** N –				U –		
	08:00 pm		Food									0
	09:00 pm						1					0
	10:00 pm		Soup			NP						0
	11:00 pm									✓		0
	12:00 am		H2O									0
	01:00 am											0
Total Intake :						**Total Output :**	N – O	U – 1				
	02:00 am											0
	03:00 am		H2O				1					0
	04:00 am											0
	05:00 am		H2O			NP						0
	06:00 am									✓		0
	07:00 am		H2O									0
Total Intake :						**Total Output :**	N – O	U – 1				

Total 24 hrs. Intake		Total 24 hrs. Output	N – O U – 2

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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: Niyathi Age: 7yr Sex: F UHID.No : BAH-00454722

Date: 25.5.26 Time: 5:30pm Proposed Operation: Adenotonsillar hypertrophy grade iv adenoids.

Diagnosis: Coablation Assisted Adenotonsillectomy.

B.P / CRT: —/3sec H.R: 88/min Weight: 20kgs ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 13.1	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4,60,000	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: N known

Medical History: CVS : (-) Birth H/o → NVD / NO ICU stay)

RESP : No H/o cold / fever. Diabetes : (-) Developmt (N)

CNS : (-)

Renal : (-)

Hepatic / GE : Physical Activity: Active.

Others : (-)

Past Anaesthetic History: N°I

Physical Exam: afebrile.

Airway: MP (1) 2 3 4 Mouth Opening: > 3F Mentohyoid Distance: Neck: (N) Teeth: (N) Intact

Lungs :

Heart: NAD

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:

CBP on cannulation

Signature: Name: Dr. Anneen.

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ANAESTHESIA CHART

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Pre Induction Assessment: 2pm

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

H.R: 92/min B.P / CRT: <3sec SpO2: 100% R.R: Last Feed: 76 hrs

Pre-OP Diagnosis: Grade IV Adenoids Operation: Adenotonsillectomy Date: 27/5/26

Surgeon: Dr Manish Anaesthesiologist: Dr RC; Dr AL Technician: NISHANTH

TIME	2	2:20	3
N_2O / AIR / O_2 LPM	50%		
HALO / ISO / SEVO	1MAC		
Drugs:			
I. MIDAZOLAM			
IV. FENTANYL	40mg		
IV. PROPOFOL	60mg		
IV. ROCURONIUM	10mg		
IV. PARACETAMOL	300mg		
IV. DEXAMETHASONE	2mg		
IV. TRANEXAMIC ACID	300mg		
IV. GLYCOPYRROLATE		0.16mg	
IV. NEOSTIGMINE		1mg	
FiO_2 / SaO_2	100% 100% 100% 100% 100%		
$ETCO_2$	40 38 38 40 42		
ECG	SR SR SR SR SR		
Temperature	35.2 36.1 36 36.8 36.5		
Urine Output			
Fluids / Blood	RL 220ml/hr		

Antibiotic:

Suppository: Sup DICLOFENAC 12.5mg

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
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: ....
☐ Art Site: ....
☑ EKG Lead 3
☑ Temp Site skin
☑ 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: 2:05pm
OP Start: 2:08pm
OP End:
Leave OR: 3:05pm

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# 4.5 at 13 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: Rocuronium

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 1
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 : Dr. AISHWARYA
Signature of the Doctor : [signature]

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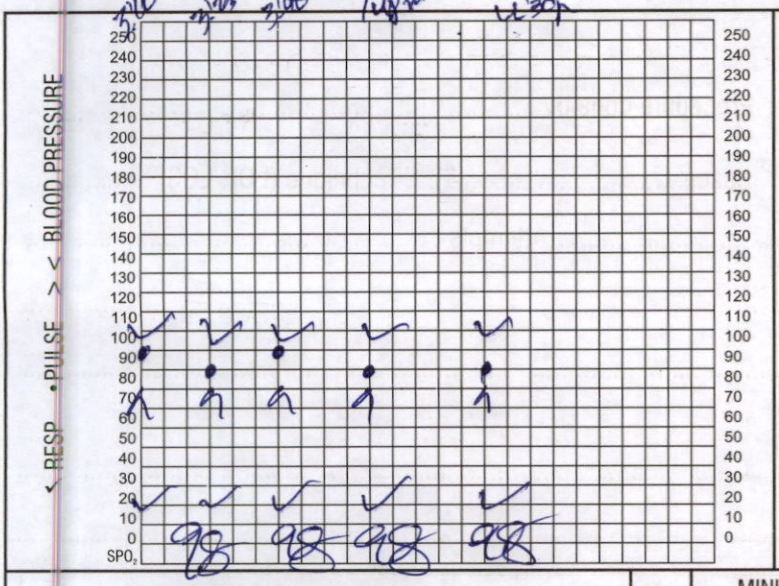
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: ..... Time Received : 3:10pm Time Discharged : 5:35pm



IV Cannula Site : 22G

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

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

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

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 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
27/5	3:10pm	01/10	—	

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

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. 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. AISHWARYA
Anaesthesiologist Signature: .....
Date & Time: 27/5/26; 4:30pm

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 27/5/26 4:30pm

Transferred to Unit by (PACU): 3/9
Date & Time: 27/5/26 5:30pm

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

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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		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 : .....

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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 Coblation Assisted Adenotonsillectomy

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)
Relief from Snoring & Mouth Breathing	Medical Mx

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

b.

1. I authorize Dr. Manish Gupta 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: Tejaswini
Name: T. Tejaswini
Relationship with patient: Mother
Date & Time: 1:57, 27/05/26

Witness:
Signature:
Name: V. Ratna Kumari
Date & Time: 27/05/26 01:57

Doctor (who is taking consent):
Signature: Name: Dr Manish Gupta Date 27/5/26 Time: 01:58 PM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Coablation Assisted Adenotonsillectomy.

Anaesthesiologist: Dr Subramanyan. Surgeon: Dr. Manish Gupta.

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 Laryngospasm, Bradycardia, post procedure O2 support

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: RR

Name: V. Ratnakumari

Relationship with patient: grandmother

Date & Time: 25.5.26 6pm.

Witness:

Signature: Tejasini

Name: TEJASWINI

Date & Time: 25.5.26 @ 6pm

Doctor (who is taking consent):

Signature: Jms Name: Dr. Anuja Date 25.5.26 Time: 6pm.

Patient Sticker

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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.

రీజనల్ 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 రిస్క్స్:

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.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ 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 స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

3/9

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NU...TIONAL HEALTH ASSESSMENT - GIRLS

Date: 27/5/26 Time: 5pm

Weight: 20kg's Centile: >10th

Height: 112cm Centile: >10th

Inference: underweight child

RDA: - Calories: 1800 Kcal/d Protein: 26gm/d

Diet Recommendations: soft diet

Re-Assesment: avoid spicy and outside food

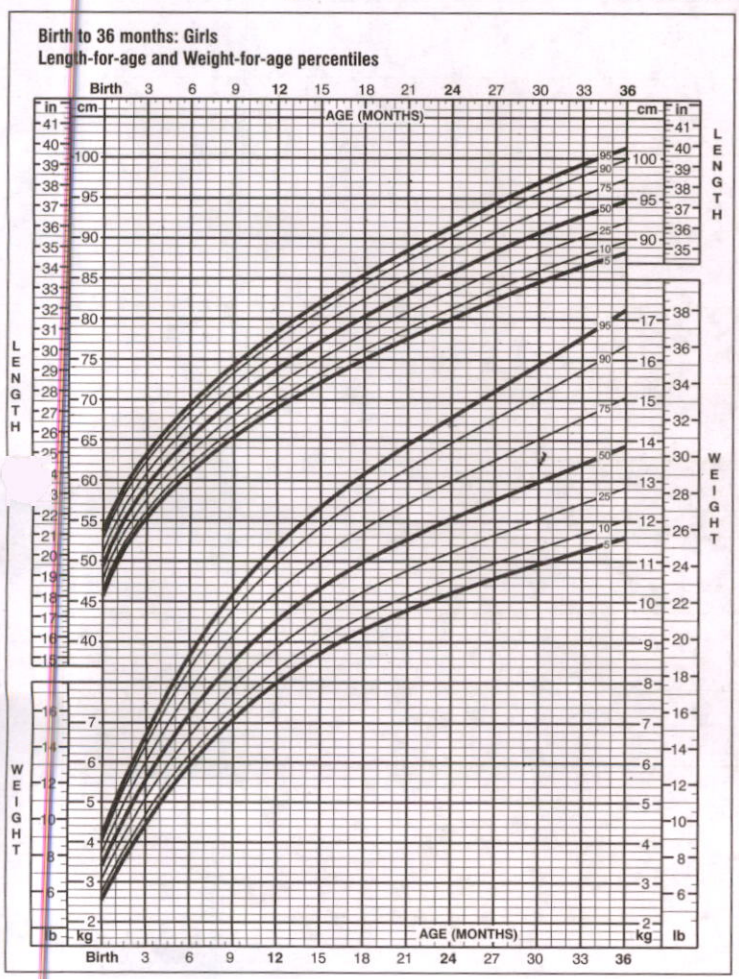
Food Allergies: No Veg/Non-veg

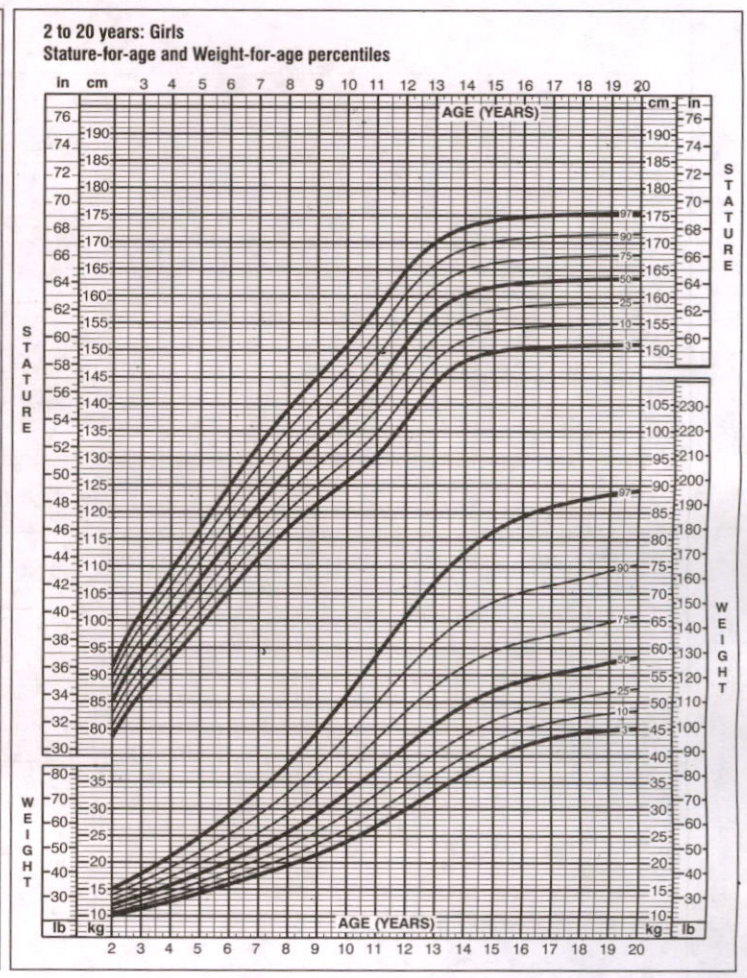
Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Tejasvini

GROWTH CHART (GIRLS)





Dietician's Name Saima Dietician's Signature Saima

Docu. No. : RCHBH / FRM / CLINICAL / 161

(P.T.O.)

Daily Notes: