BAH-00579893 IP5-00176212
Master MORGI ENOSH PREM
11-09-2023 2 Y 9 M 29 D (M)
Dr. RAVI CHANDER RAO

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SURGERY DETAILS

Date : 10/7/26

Patient Name: Morgi Enosh prem Date of Birth: 11-9-2023 Age: 2 y

Gender: Male Ward : P. OT UHID No.: BAH-00579893

Date of Surgery: 10/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Debridement & Suturing

Time in : 4.00 pm Time Out : 4.20 pm

		NAME	AMOUNT
1.	Surgeon	Dr. Ravichander	
2.	Anaesthetist	Dr. Durga	
3.	Assistant Surgeon		
4.	OT Technician	Shrestha	
5.	Circulating Nurse	Thijas	
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: 9696543 Order by: Kumar

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

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Suturing

CONSUMABLES OF OT

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

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5.4.4.5	1+1+1	—	Major Pack Drape	1	—	Inj Vit.K		
LMA 2	01	—	Sutures Proline 5.0	1	1	Cord Clamp		
ECG leads : A / (P) / N	5	03	Pds. 5.0, 6.0	2	—	Suction Catheter		
HME filter : A / (P) / N	01	—	9915	2	—	Feeding Tube		
Syringes : 10 cc	10	2	~~monocryl 2.0, 4.0~~	2	—	Vaccum Suction Set		
05 cc	10	2	Gloves			Surgical Gloves		
02 cc	10	2	G 6, (6½), (7), 7½	2+2	0+1	Gauze Pack		
01 cc			PF 6, 6½, 7, 7½	2+2	—	Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	—	Surgical blade 15	1	—	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			NS 500ml	1	—
NS : 10ml / (100ml) / 500ml / 1000ml	01	01	Koochies			Trangofix	1	—
Mini Spike	01	01	Ointments			10cc, 5cc, 2cc	2+2	—
Gauze	03	01	Suction Catheter			Inj. Loxe [illegible]	1	—
Fentanyl	01	01	Cap, Mask	5/5	—	26 g needle	1	—
Morphine			Gauze Pack (N)	5+5	1			
Ketamine			Mop Pack	1	—			
Propofol	02	01	Steristrip	1	—			
Rocuronium	01	—	Underpad	1	—			
Glycopyrolate	01	—	Draw sheet	1	—			
~~Myopyrolate~~ Neo	02	—	Abgel			Midaz	01	—
Ondansetron	01	—	Foleys catheter			O2 Nasal prongs (N)	01	01
Pencan 25g/ Spinal Needle 22			Urobag			Nasal Airway		—
Bupivacaine 0.25%			Chest Drainage Catheter			14,16,18	1+1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Oral Airway		
Antibiotics			Bandage			0,1	1+1	—
O2 mask (P)	01	—	Tegaderm			IV cannula		
Suppositories			Ioban			22,24	1+1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : (12.5)mg / (25mg) / 100mg	1+1	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	—			
Vacuum set	01	—	Microshield	1	—			
[illegible]	1+1	—	Cotton Balls	1	—			
[illegible]	5+1	—	Latex Gloves	1	—			
[illegible]	1+1	—	Ramdione Scrub					
[illegible] 3cc	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9696576 Ordered by : ....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176212 **Admit Date** : 10-Jul-2026 **Admit Time** : 01:00 PM **UHID** : BAH-00579893

Patient Details :

Patient Name	: Master MORGI ENOSH PREM NANDAN	**Age**	: 2 Y 9 M 29 D
Guardian	: Mr MORGI NAVEEN KUMAR	**DOB**	: 11-09-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: SUBHASH NAGAR, NEAR SWAMI TAKIES S R Nagar Hyderabad Telangana INDIA 500038	**Phone No**	: 9014742705/ 7995547782
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 413 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 413 **Admission Type** : First Visit

Contact Details :

Name : Mr MORGI NAVEEN KUMAR **Relationship** : Father

Contact Address : SUBHASH NAGAR, NEAR SWAMI TAKIES S R Nagar Hyderabad Telangana INDIA 500038 **Phone No** : 9014742705

Signature

Doctor Details :

Doctor Name : Dr. RAVI CHANDER RAO **Specialisation** : PLASTIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No BAH-00579893 IP5-00176212 : _____ Dept : _____
Master MORGI ENOSH PREM
11-09-2023 2 Y 9 M 29 D (M)
Dr. RAVI CHANDER RAO

Date of Admission: _____ scharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	1:25 pm	ER	OT	
10/7/26		OT	Billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7/20	IV placement	1	96180.	[signature]
	PAC op			

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr Ravi Chander Rao Date : 10/7/26

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

Start Time of Assessment: 12:50pm Weight: 12Kg

Allergic History: .....

Chief Complaints:
Accidental fall while playing &
sustained laceration near right Eyebrow
RTA on 9/7/26 @ 7pm
NO H/o LOC, fever, headache, vomiting,
ENT bleed.
Planned for suturing & sedation

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

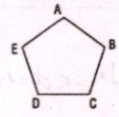
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing
Rate: 24/min SpO_2 on FiO_2 100% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BLAE (+)
Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 97 /min

CFT: Central ..... Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 105/58 (77) mmHg

Pulse Volume: Central ..... Peripheral .....

If in Shock: Compensated ..... Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right ..... Left .....

Active Seizures: ☐ Yes ☑ No Sugars: .....

Signs of Neurological compromise .....

.....

Exposure

Temp.: 98 F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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 on cannulation
- NIB
- Sagar
- 10/7/26
- 1 pm

Treatment Planned:

- Suturing tr Sedation
- NPO to continue
- IV Fluids
- NIB
- Sagar
- 10/7/26
- 1 pm

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: Dr. Ramya

Signature: .....

Date & Time: 10/5/26; 1pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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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: ~~Ward~~ 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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr: RAMYA

Date & Time : 10/7/26; 12:50 pm.

Nurse Name & Signature: Sagar

Date & Time : 10/7/26 @ 1 pm

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DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

VERIFIED BY : Name Signature

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REGULAR PRESCRIPTIONS

Weight. 12 kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

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Weight. 12 Kg Ward. .....

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
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
10/7	4:00pm	IND. AMOXICILLIN POTASSIUM CLAVULANATE	360MG	IV		
10/7	4:05pm	IND. PARACETAMOL	180MG	IV		

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

Master MORGI ENOSH PREM
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I.V. FLUIDS CHART

Weight. 12kg 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
10/7/26		DNS (During NPO only)	IV	45	[signature]	Gopi	Not Connected		

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

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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.,) : .....

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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 Eye brow laceration - Suturing

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)
fasta healing	Dressing Glue

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. wound infection

b.

1. I authorize Dr. Ravichander 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: Naveen
Relationship with patient: father
Date & Time: 10/7/26 3:56pm

Witness:
Signature: .....
Name: Prameela
Date & Time: 10/7/26 3:57pm

Doctor (who is taking consent):
Signature: ..... Name: Dr Ravichander Date 10/7/26 Time: 3:55PM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Ravichander
Asst. Surgeon : ....
Anaesthetist : Dr Durga
Scrub Nurse : Suma

Patient Name : Morgi Enosh prem Age : 2Y Gender : m
UHID No. : BAH-00579893 Surgery Name : Suturing under sedation
Date : 10/1/26 In-time : 4:00 pm Out-time : 4:20 pm

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11-09-2023 2 Y 9 M 29 D (M)
Dr. RAVI CHANDER RAO

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 4pm

Patient Has Confirmed

Identity	☑ Yes ☐ No
Site (Right)	☑ Yes ☐ No
Procedure	☑ Yes ☐ No
Consent	☑ Yes ☐ No
Site Marked (Right)	☑ 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 : Dr. N
Name : Dr. Durga Bhavani 10/1/26

Before Skin Incision ➤➤

TIME OUT Time: 4:03pm

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

Correct Patient (Check ID Band)	☑ Yes ☐ No
Correct Site	☑ Yes ☐ No
Correct Procedure	☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? (nil, 20min, nil)	☑ 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 : [signature]
Name : Priyas

Before Patient Leaves Operating Room

SIGN OUT Time: 4:18pm

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 : [signature]
Name : Dr Ravichander

Patient Stick

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 10/7/26

To Be Filled In By Assigned Nurse :

Department : ~~Inj: Augment~~ P:OT Duration of Procedure : 20 mins

Name of Surgeon : Dr. Ravichander Date of Admission : 10/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ ~~Yes~~ ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : Inj: Augmentin	Thejas
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	Thejas
3.	Patient's body temperature immediately post operation (Recovery Room) 37.6 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	Thejas
4.	Name of doctor or staff administering the antibiotic : Teena Date & Time of antibiotic administration : 10/7/26 @ 4:pm Date & Time procedure started : 10/7/26 @ 4:04 pm	Thejas.

- 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

Patient St

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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Dressing change Tuesday

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

en to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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OPERATION THEATER NOTES

Patient's Name : Morgi Enosh prem Age : 2y Gender : ☐ Male ☐ Female

UHID No.: BAH-00579893 Weight : Height :

Surgeon : Dr Ravichander	Asst. Surgeon :	
Anesthetist : Dr. Durga	OT Nurse: Suman	OT Technician: Shirisha
Pre-Operative Diagnosis:		
Surgical Procedure : Debridement & Suturing		
Indications for Surgery : CLW (R) eye brow.		
Date :	Start Time : 6:04 pm	End Time :
Pre Operative Preparations:		
Post Operative Diagnosis:		
Peri-Operative Complications:		
Operation Notes: I/O- Debridement of the wound done. Orbicularis occuli muscle repaired skin sutured in layers.		

Doc. No. : RCHBH/ FRM / CLINICAL / 099 (P.T.O.)

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

SYRUP AUGMENTIN DDS 1000 BD
400mg/5ml
2.5ml/BD

SYRUP COMBIFLAM 10ml TID

Name of the Surgeon: Dr Ravi

Signature of the Surgeon:

Date & Time: 10/9/24

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: Enosh Age: 3y Sex: M UHID.No :

Date: 9/7/26 Time: 10.35 pm Proposed Operation: Suturing

Diagnosis:

B.P / CRT: H.R: Weight: 12 kg. 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 : Not Significant

RESP :

CNS :

Renal :

Hepatic / GE :

Others :

- LSCS / Term / 2.8kg / NICU stay due to Meconium staining
- Diabetes : Nil
- Vaccinated upto date
- Milestones achieved as per age
- Physical Activity: Active

Past Anaesthetic History: —

Physical Exam: —

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth: All teeth intact

Lungs : BAE (+), clear

Heart: $S_1 S_2$ (+)

CNS: Grossly Intact

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site : Accessible

Spine Exam for regional : (N)

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

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

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 IV Cannulation

Last meal: 4:00pm
Liquid: 6:00pm

Explained

Signature: Name: Dr. K. Srisurya.

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ANAESTHESIA CHART

Pre Induction Assessment:

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

H.R: 110	B.P / CRT: 99/60	SpO_2 98%	R.R 20	Last Feed: 5hr

Pre-OP Diagnosis: Laceration Operation: Suturing over Right Forehead Date: 10/9/23

Surgeon: Dr. Ravi Chander Rao Anaesthesiologist: Dr. Divya Bhavani Technician: Venkat

TIME: 4pm

N_2O / AIR / O_2 LPM: 2 l/min

HALO / SO / SEVO: 4%

Drugs:
- MIDAZOLAM 0.6 Mg IV
- FENTANYL 25 mcg IV
- PROPOFOL 50 Mg IV
- PARACETAMOL 180 Mg IV

FIO_2 / SaO_2: 98% / 98%
$ETCO_2$: 36 / 36
ECG: NSR / NSR
Temperature: 36.5
Urine Output

Fluids / Blood

Antibiotic: PARACETAMOL(?) 360 Mg IV
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
(Chart scale 0–240; entries plotted around 100 and 50–60)

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional	**Temp:** ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☑ Other: Blanket	**Induction** ☑ IV ☐ Inhal ☐ Pre O_2 ☐ RSI ☐ Others	**Regional:** Extremity Specify: .... ☐ Spinal ☐ Epidural ☐ Caudal Others: .... Position: ....
☑ BP ☑ Cuff Site: Lt UL ☐ Art Site: .... ☑ EKG Lead: Need(?) ☑ Temp Site: Lt axilla ☐ FIO_2 Monitor ☐ Agent Monitor ☑ Pulse Oximeter ☑ Capnograph ☐ Ventilator ☐ Nerve Stimulator	**Times:** Anaes Start: 4pm OP Start: 4:05pm OP End: .... Leave OR: 4:20pm	☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# .... at .... cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug:	**Site:** .... Needle Size: .... Depth: .... Parasthesia ☐ Yes ☐ No Catheter at skin .... cm Drug Name & Conc: .... Bolus: .... Infusion: .... Block Level: .... Comments: ....
Position: SUPINE ☑ Pressure Points Checked	**Anaesthesia:** ☐ GA ☑ Monitored Anaesthesia Care ☐ Regional	☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# .... Attempts: .... Difficulty Why?	Transportation to ☑ PACU ☐ ICU ☐ Other
Eye Care: ☐ Oint ☑ Tape ☐ Padding ☐ Awake	**Line (Size & Location)** ☐ CVP: .... ☐ ART: .... ☑ IV: LUL ☐ IV: .... ☐ IV:	☐ **Bilat = BS** ☐ Semi-Closed Circle ☐ Closed Circle ☐ Other	Relaxant Reversed ☐ Yes ☐ No ☑ NA Name of the Doctor: Dr. Divya Bhavani Signature of the Doctor: [signature]

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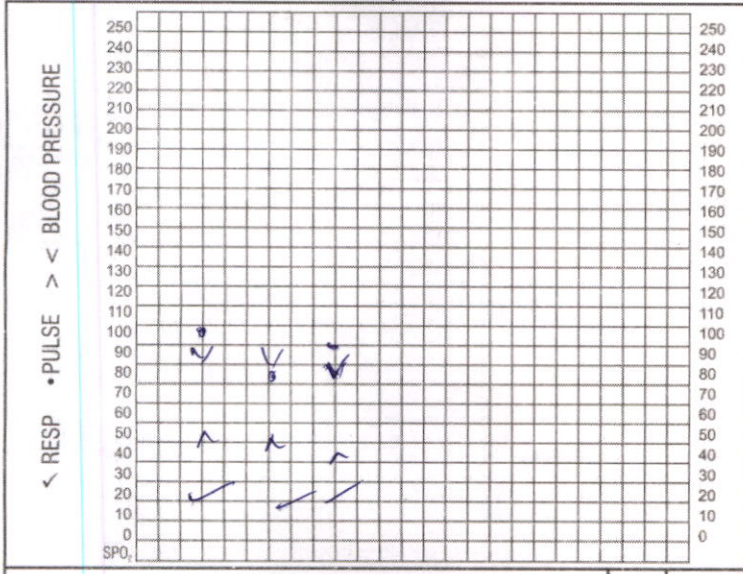
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Thejas. Time Received : 4:20 pm Time Discharged : .....



IV Cannula Site : .....

- ☐ 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: N.S
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	0	1				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				
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				
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	0	1				
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2				
	TOTAL	6	8				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/7/26	5.00pm	1/10	nil	Thej

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

Anaesthesiologist Name : Dr. Tejaswini
Anaesthesiologist Signature: .....
Date & Time: 10/7/26.

PACU Nurse Name : Thejas
PACU Nurse Signature: .....
Date & Time: 10/7/26 @

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

Transferred to Unit by (PACU): Thejas
Date & Time: 10/7/26 @ 4:20 pm.

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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 : .....

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Suturing

Anaesthesiologist: Dr. Subhramanyam. Surgeon: Dr. Ravichandra

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 Post procedure On 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:
Name: Naveen
Relationship with patient: Father
Date & Time: 9/7/26 10:43 pm

Witness:
Signature:
Name: Team
Date & Time: 10/7/26 @ 12:43 pm

Doctor (who is taking consent):
Signature: Name: Dr. K Sai Surya Date 9/7/26 Time: 10:40 pm.

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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.

లీజనల్ 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.
  ☐ లీజనల్ 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, లీజనల్ 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: .....