BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 5 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 8/7/26

Patient Name: master G. manukrishna Date of Birth: 3/12/22 Age: 3Y

Gender: M Ward : P-OT UHID No.: 0599956

Date of Surgery: 8/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Meatotomy

Time in : 10 AM Time Out : 10:30 Am

	NAME	AMOUNT
1. Surgeon	Dr. Harish.	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Vijay	
5. Circulating Nurse	Kumari	
6. Assistant Nurse	B. Khali	

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

Signature of the Surgeon

Signature of Circulating Nurse Kumari

Order No: 969307 Order by:

BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 6 D (M)
Dr. HARISH JAYARAM

(EUA)

CONSUMABLES OF OT

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Circulating staff : ..... Technician : ..... Date : ..... Time : 9:30 AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4, 4.5, 5,	HHH	—	Major Pack Drape	1	—	Inj Vit.K		
LMA 2½	01	—	Sutures			Cord Clamp		
ECG leads : A / P / N	05	3				Suction Catheter		
HME filter : A / P / N	01	—				Feeding Tube		
Syringes : 10 cc	1	09				Vaccum Suction Set		
05 cc	1	10	Gloves 6, 6.5, 7, 7.5 2+2+2+2			Surgical Gloves		
02 cc	1	10	AF, 6, 6.5, 7, 7.5 2+2+2+2			Gauze Pack		
01 cc	05	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade 11		1	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			NS 500ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	4+	0	Koochies			Bransohix	1	1
Minispike	01	1	Ointments			Gauze	1	1
O2 Mask (P)	01	—	Suction Catheter			16G, 18G	2+2	—
Fentanyl	01	1	Cap, Mask	5|5	5|5	Camera covers	2	—
Morphine			Gauze Pack (N)	3	1	IV Set	1	—
Ketamine			Mop Pack					
Propofol	03	2	Steristrip					
Rocuronium	01	—	Underpad	1	1	Adrenalin + Atropine	1ml	1ml
Glycopyrolate	01	—	Draw sheet	1	1	Lox Gel + 2% jelly	1ml	1ml
Myopyrolate / Neo	1ml	—	Abgel			Midaz + Ephedrine	1ml	1ml
Ondansetron	01	—	Foleys catheter			Gauze roll (4, 6)	2+2	—
Pencan 25g/ Spinal Needle 22	01	—	Urobag			NG + Suction adj	—	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			Q Set / Splint (13)	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Tranexa + Dexa	1+1	—
Antibiotics IV pen	01	—	Bandage			Dexmed	01	—
			Tegaderm			50 CC + mole	1ml	—
Suppositories			Ioban			gauge + gloves	4+4	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg	01	—	Plastic Bed Sheet	1	—	ETCO2 + Nasal Prg (P)	1	1
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Vaccum set	01	1	Microshield	1	—			
2 ways 10 / 100 cm	1+1	—	Cotton Balls	1	—			
0.A [0, 1]	1+1	—	Latex Gloves	10p	—			
N.A [20, 22]	1+1	—	Ramdione Scrub					
IV Canula [22+24]	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9692953 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 : IP5-00176093 **Admit Date** : 08-Jul-2026 **Admit Time** : 07:10 AM **UHID** : BAH-00599956

Patient Details :

Patient Name	: Master GORITIYALA MANU KRISHNA	**Age**	: 3 Y 7 M 5 D
Guardian	: Mr GORITIYALA RAJLAXMAN	**DOB**	: 03-12-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 8-69, INDRA REDDY ALLWYN COLONY , MIYAPUR Hyderabad Telangana INDIA 500049	**Phone No**	: 9948181308/ 8464065445
		E-mail	: rajlaxmang@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 401 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 401 **Admission Type** : First Visit

Contact Details :

Name : Mr GORITIYALA RAJLAXMAN **Relationship** : Father

Contact Address : **Phone No** : 9948181308 / 8464065445

Signature

Doctor Details :

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

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 20000.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00599956 IPS-00176093
Master GORITIYALA MANU KRISHNA (M)
03-12-2022 3 Y 7 M 5 D
Dr. HARISH JAYARAM

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ____ ____ate of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
08/7	7:40am	ER	OT	
8/7	12:30pm	OT	billing	

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
8/7/26	IV placement	(1)	2778	Charan
8/7	PACOP bath.			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 5 D (M)
Dr. HARISH JAYARAM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26	C/S/B SR doctor Meatal stenosis	
	O/E child conscious peripheries warm pulse vol. good S1S2 (+), 120/m B/L NVBS, 28/m P/A soft non tender CNS - NAD Dr. Hemanth 8/7/26 9:30 AM	Plan (1) EUA (2) NPO (3) IVF DNS

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 5 D (M)
Dr. HARISH JAYARAM

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DRUG CHART

Date of Admission: 08/07/26 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 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 :				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 .....

03-12-2022 3Y7M6D (M)
Dr. HARISH JAYARAM

REGULAR PRESCRIPTIONS

Weight. 21kg 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

Weight. 21.9 ..... Ward. .....

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.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

Dr. HARISH JAYARAM

Master GORITYALA MANU KRISHNA
IP5-00176093 BAH-00599956

I.V. FLUIDS CHART

Weight. 214 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
8/2/16	9am	DNS	IV	60	[illegible]		Cancelled		

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

BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 6 D (M)
Dr. HARISH JAYARAM

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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 EXAMINATION UNDER ANAESTHESIA.

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)
Resolution of symptoms	

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. Infection, Recurrence.

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

Patient / Patient Attendant:
Signature: Ray
Name: Raj Laxman
Relationship with patient: Father
Date & Time: 8/7/26 8:25AM

Witness:
Signature: Ray
Name: Laxman
Date & Time: 8/7/26 8:25AM

Doctor (who is taking consent):
Signature: Maliha Name: Dr. Maliha Date 8/7/26 Time: 8:25 AM

Docu. No.: RCHBH/FRM CLINICAL / 027 (26)

(P.T.O)

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 శస్త్రచికి / 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. Hari SG
Asst. Surgeon :
Anaesthetist : Dr. Anneen .
Scrub Nurse : Bikhali

Patient Name : master G. manu Krishna Age : ..... Gender : M
UHID No. : 599956 Surgery Name : Appendectomy
Date : 8/7/22 In-time : 10 Am Out-time 10:30 Am

BAH-00599956 IP5-00176093
Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 6 D (M)
Dr. HARISH JAYARAM

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 8:45 AM

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : ....
Name : Dr. Anneen.

Before Skin Incision ➤ ➤

TIME OUT Time: 10.05 AM

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

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

Anticipated Critical Events

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

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

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

Signature : ....
Name : Bikhali

Before Patient Leaves Operating Room

SIGN OUT Time: 10:21 AM

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

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

Signature : ....
Name : DR HARISH

Patient S

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Master GORITIYALA MANU KRISHNA
03-12-2022 3 Y 7 M 5 D (M)
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 8/7/26

To Be Filled In By Assigned Nurse :

Department : P.OT Duration of Procedure : 3andhalf

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 8/7/26

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 :	Kumari
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	Kumari
3.	Patient's body temperature immediately post operation (Recovery Room) 37.6 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Dilip
4.	Name of doctor or staff administering the antibiotic : — Date & Time of antibiotic administration : — Date & Time procedure started : 8/7/26	Kumari

- 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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OPERATION THEATER NOTES

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

UHID No.: ..... Weight : ..... Height : .....

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

Pre-Operative Diagnosis: Meatal Stenosis.

Surgical Procedure :
Meatotomy.

Indications for Surgery :
Meatal Stenosis.

Date : 8/7/26	Start Time : 10 AM	End Time : 10.21 AM

Pre Operative Preparations:

Post Operative Diagnosis: Meatal Stenosis.

Peri-Operative Complications:

Operation Notes:

1) Meatotomy done using 5-0 PDS sutures.

Amount of Blood Loss: 1 ml.

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Advice:

1) Syrup CROCIN DS (5ml = 240mg) ml thrice daily for 2 days then SOS

2) CIPROFLOXACIN EYE DROPS for local application 2 drops thrice daily for 1 week.

Review after 1 week in OP c Dr. Harish Jayaram

Name of the Surgeon: Dr. Harish

Signature of the Surgeon:

Date & Time: 8/7/26 11AM

Patient

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Meatotomy

Post-Surgical Diagnosis: Meatal Stenosis

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 min

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

ds

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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POST-SURGICAL CARE PLAN FORM

Procedure Done: Meatotomy.

Post-Surgical Diagnosis: Meatal Stenosis.

Post-Operative Monitoring Parameters /Frequency:

TPR for every 15min for 1st 1hr.

Wound Care:

-

Drain /Special Lines/Catheters:

-

Special Patient Positioning and Requirements:

-

Nutritional Instructions:

Full feeds

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: 8/7/26 Time: 11 am

Note: Plan of care will be readjusted if necessary.

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mast. Manu Krishna Age : 3yr 6months Gender : Male ☑ Female ☐

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

Anaesthesiologist : Dr. A Naresh Balaji

Operative procedure planned : EUA

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mast. Manu Krishna the above mentioned operation / Diagnostic / Therapeutic procedures EUA .....

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

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Roy

Name : Roy Saaran

Relationship with Patient: Father

Date & Time : 07/07/26 @2:45pm

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : A. Naresh Babu

Name : Dr. A. Naresh Babu

Date & Time : 07/07/26, 2:45 PM.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mast. Manu Krishna 3yr 6months Age: ..... Sex: Male UHID.No : .....

Date: 07/07/26 Time: 2:45 PM Proposed Operation: Examination under Anaesthesia

Diagnosis: .....

B.P / CRT: ..... H.R: ..... Weight: 21 kgs 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: Dust allergy.

Medical History: CVS : —

RESP : — Diabetes : —

CNS : Preterm born

Renal : —

Hepatic / GE : — Physical Activity: —

Others :

Past Anaesthetic History: → hypospadiasis repair done on 3/3/26 ↓GA.

Physical Exam: —

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

Lungs : BAE+, clear

Heart: S1 S2 +

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

.....

.....

Signature: A. Dareshbabu Name: Dr. A. Dareshbabu

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ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 120/min | B.P / CRT: 90/60mmHg | SpO_2: 100-1. | R.R: 20/min | Last Feed: >6hr

Pre-OP Diagnosis: Meatal Stenosis Operation: Dilatation of meatus Date: 8/7/26.

Surgeon: Dr. Harish Jayram Anaesthesiologist: DR: SD / DR: BJ Technician:

TIME	10	10:30 AM
N_2O /AIR /O_2 LPM		2L/min
HALO /SO /SEVO		
Drugs:		
MIDAZOLAM	0.8mg	
FENTANYL	30mcg	+10mcg
PROPOFOL	30mg	+30mg+20+20.
FIO_2 / SaO_2	99	98
$ETCO_2$		
ECG	SR	SR
Temperature		
Urine Output		
Fluids / Blood	R	

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throa. 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: (L) UL
☐ Art Site:
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 10 AM
OP Start:
OP End:
Leave OR: 10:30 AM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ LMA NASAL PRONGS
☐ Airway ☐ Oral ☐ Nasal
ETT# ... at ... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

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

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

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

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

Name of the Doctor: Dr. Tejaswini
Signature of the Doctor:

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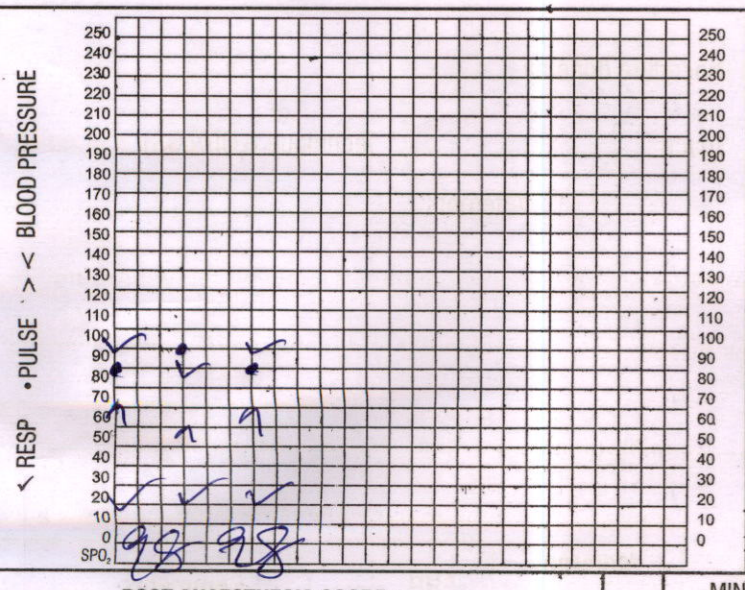
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 10:30Am Time Discharged : .....



IV Cannula Site : 22G R DVL

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

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	1	1				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	1	1				
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2				
	TOTAL	8	8				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/7	10:35pm	1/10	—	

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

Anaesthesiologist Name : Dr-D-RAMADEVI
Anaesthesiologist Signature: Dramadevi
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 8/7/26@

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): .....
Date & Time: 8/7/26@

atient Sticker

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RAL ANALGESIA RECORD

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

inal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

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

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

Composition : .....

ner issues :

.....

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 : .....