BAH-00643144 IP5-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

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SURGERY DETAILS

Date : 22/7/26

Patient Name: Mast. T. Neehal Eshwar Date of Birth: 19/3/24 Age: 2years

Gender: Male Ward : UPS-OT-1 UHID No.: BAH-00643144

Date of Surgery: 22/7/26 ☐ OT -1 ☐ OT -2 UPS OT ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Urodynamic Study ↓ sedation

Time in : 1.45pm Time Out : 2.45pm

	NAME	AMOUNT
1. Surgeon	Dr. Harish	
2. Anaesthetist	DR. Akhila	
3. Assistant Surgeon		
4. OT Technician	Shiresha.	
5. Circulating Nurse	Kavaka.	
6. Assistant Nurse	Kanaka Durga	

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: 9716634 Order by: Sujata

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

Patient Sticker

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Master T NEEHAL ESHWAR
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UDS

CONSUMABLES OF OT

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Ci..... Technician : Shumaila Date : ..... Time : .....

Anaesthesia	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		05				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		02	Gloves			Surgical Gloves		
02 cc		02				Gauze Pack		
01 cc		02				Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
Inj Spica		01	Ointments					
O2 Mask (A)		01	Suction Catheter					
Fentanyl		01	Cap, Mask					
Morphine			Gauze Pack					
Ketamine			Mop Pack					
Propofol		02	Steristrip					
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
IV Cannula (24)		01	Microshield					
25D		01	Cotton Balls					
(			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9716695 Ordered by : .....

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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 URODYNAMIC STUDIES UNDER SEDATION

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)
- To understand function of bladder - filling & voiding phase.	- Nil -

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. Infection, UTI

1. I authorize Dr. Harish Jayram 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: K. Sandhya Sadhya

Name: .....

Relationship with patient: Mother

Date & Time: 22/3/24. 1.05 pm

Witness:

Signature: .....

Name: Lakshmi

Date & Time: 22/3/24. 1 p.m.

Doctor (who is taking consent):

Signature: A.K. Sandhya Name: Dr Nikhita Date 22/3/24 Time: 1:05 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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19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

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PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Patient Name: Master T NEEHAL ESHWAR Gender: ☑ Male ☐ Female UHID. No: BAH-00643144 Age: 2Y/Male

Date: 22/7/26 In-Time: ..... Out-Time: .....

Doctor Performing Procedure: ..... Doctor Giving Sedation: ..... Assisting Nurse: .....

SIGN IN

Time: 1:40PM

	Yes	No	NA
Patient is verified using two identifires (Name & UHID)	✓		
All required documents, images, studies are available	✓		
NPO Status Checked from Patient / Patient Attendant	✓		
Consent is Signed	✓		
Any need for blood products		✓	
If Yes Comment:			
Any Risk of Hemodynamic Compromise		✓	
If Yes Comment:			
Any drug or food allergy		✓	
If Yes Comment:			
Correct Site of Procedure Marked			✓
All resources required are correct, available and functioning	✓		

Signature of the Doctor: .....

Name of the Doctor: Dr. Akhila. K

TIME OUT

Time: .....

	Yes	No	NA
Correct Patient	✓		
Correct Site	✓		
Correct Procedure	✓		
All the team members introduced	✓		

Signature of the Nurse: Kanaka

Name of the Nurse: Kanaka

SIGN OUT

Time: .....

	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded	✓		
Instrument, Sponge and Needle Count Completed			✓
Specimens are labeled			✓
Any equipment problems are addressed			✓

Signature of the Nurse: Kanaka

Name of the Nurse: Kanaka

Any Adverse / Unexpected Events

.....

.....

.....

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19-03-2024 2 Y 4 M 3 D (M)
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OPERATION THEATER NOTES

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

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

Surgeon :	Asst. Surgeon :	
Anesthetist : Dr. D[illegible]a	OT Nurse: kanakar	OT Technician: Shivesha
Pre-Operative Diagnosis: Neurogenic bladder S/P PUV fulguration		
Surgical Procedure : Urodynamic Study ↓ Sedation		
Indications for Surgery : Neurogenic bladder S/p PUV fulguration.		
Date : 22/7/26	Start Time : 1 4r pm	End Time : 2 4r pm

Pre Operative Preparations:

Post Operative Diagnosis: Neurogenic bladder.

Peri-Operative Complications:

-

Operation Notes: Findings:

High pressure bladder.

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. Harish

Signature of the Surgeon:

Date & Time: 22/7/26 2:30pm.

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Urodynamic Study + sedation

Post-Surgical Diagnosis: Neurogenic Bladder.

Post-Operative Monitoring Parameters /Frequency:

TPR for every 15 min for 1st 1 hr

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

as early as possible.

Special Referrals:

—

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

—

Treating Surgeon
(Signature & Stamp)

Date: 22/7/26 Time: 2:30 pm

Note: Plan of care will be readjusted if necessary.

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 : IP5-00176764 **Admit Date** : 22-Jul-2026 **Admit Time** : 12:18 PM **UHID** : BAH-00643144

Patient Details :

Patient Name	: Master T NEEHAL ESHWAR	**Age**	: 2 Y 4 M 3 D
Guardian	: Mr T NARESH	**DOB**	: 19-03-2024
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 7-32/4/7, JYOTHI NAGAR COLONY Boduppal Hyderabad Telangana INDIA 500092	**Phone No**	: 8465851442/ 8686308933
		E-mail	: SANDHYAKUNCHALA123@GMAIL.CO

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 T NARESH **Relationship** : Father

Contact Address : H NO - 7-32/4/7, JYOTHI NAGAR COLONY Boduppal Hyderabad Telangana INDIA 500092 **Phone No** : 8465851442 / 8686308933

K. Sandhya
Signature

Doctor Details :

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

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00643144 IPS-00176764 Master T NEEHAL ESHWAR 19-03-2024 2 Y 4 M 3 D (M) Dr. HARISH JAYARAM	22/07/26 at 12:18 PM	22/07/26 @ 12:50 PM
	Transfer Ordered by Dr. Ramya	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant sandhya Yes ☑ No ☐ If Yes, what? ..op file..	Patient shifted with ID band: Yes ☑ No ☐ If No: .....
Number of Imaging Films		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	M' gown	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nr- Geetha	Dr. Balaji

Patient & Clinical Records Received by : Kanaka

Date & Time of Patient Received : 22/7/26 @ 1pm

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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ACTIVITY RECORD FOR BILLING

Name :_ BAH-00643144 IPS-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

UHID No _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/07	12:50pm	ER	OT	

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
22/7	Iv placement	(1)	6266	
22/7/20	PAC	(1)	971641	Kavitha

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-00643144 IPS-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00643144 IP5-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

R/U PUV with bilateral 5 VUR (Resolved)
& c/o dribbling of urine
Repeat ~~MCUG~~,
Admitted for Urodynamic Stud

History of present illness :

Child was a case of PUV with bilateral 5 VUR (Resolved)
&
Repeat MCUG showed dilated posterior urethra
&
Repeat cystoscopy on 5/2/26 revealed ~~no~~ ~~residual~~
no residual valves

Now child came with complaints of
dribbling of urine

No No fever, cough

BAH-00643144 IP5-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

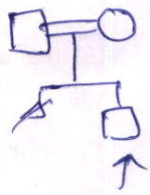
Pediatric Multiorgan History & Physical Examination

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

Case of bL 5VUR - Resolved
past history - fulgurated on Dt 1st life

Birth & Neonatal History:

Term / LSCS / CIAB



N/o NICU admission i/v/o difficulty passing in urine

Birth & Socio Economic History:

About Father :
About Mother : upper middle class
Any additional Information :

Developmental History :

Attained all as per age

Immunization History :

Immunized till now

(P.T.O.)

BAH-00643144 IP5-00176764
Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10.7 kgs (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 116 bpm B.P. 92/67 (71) SPO2 97% RA

Resp.rate and type of breathing : 22, No RD

Rash

Lymphadenopathy (-)

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BAS (+) Clear (+)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : No murmurs

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

Per Abdomen :

Inspection

Palpation : Soft

Ausculation :

Spine : External Genitelia :

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

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15

Cranial Nerves : N

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel : -

Clinical Summary & Diagnostic:

F/U PUV with bilateral SVUR (Resolved)

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment : Resolution of Symptoms

Planned Labs:

CUS done yesterday on op basis

Planned Management

Urodynamic study if sedation

- NPO as advised
- IVF DNS
vital monitoring

PAC to be done

Signature of the Doctor: .....
Name of the Doctor: Dr. Balaji
Date & Time: 22/7/26 ; 12:20 p.m.

Signature of the Consultant: .....
Name of the Consultant: .....
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: 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	Syp - BACTRIM	2.5 ml	Po	BD	21/7/26 8PM	☐C ☐DC
	Syp CEFIXIME	50 mg	Po	BD	22/7/26 8AM	☐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 : Dr Balaji

Date & Time : 22/7/26 ; 12:25 Pm

Nurse Name & Signature: Keerthi K

Date & Time : 22/07/26 @ 12Pm

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DRUG CHART

Date of Admission: 22/7/26 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 *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 .....

Master T NEEHAL ESHWAR
19-03-2024 2 Y 4 M 3 D (M)
Dr. HARISH JAYARAM

REGULAR PRESCRIPTIONS

Weight. 10.7 kgs Ward. .....

DRUG : Syp. CEFIXIME

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	22/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Balaji

Additional Instructions:
(5ml = 100mg)
Give 50mg

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Syp. BACTRIM

Dose	Route	Frequency	Start Date
2.5ml	PO	OD	22/7/26

Name & Signature of the Doctor Starting the Drugs: (Dr. Balaji)

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

Dr. HARISH JAYARAM

Weight. 10.7 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.	

Signature .....

CERTIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

19-03-2024 2 Y 4 M 3 D (M)

Dr. HARISH JAYARAM

IP5-00176764 BAH-00643144

I.V. FLUIDS CHART

Weight. 10.7 kgs. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/7/26		3VF-DNS (4/3rd maintenance)	IV	25 ml/hr		Not connected			

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