

VIH-00118393 IP5-00176705
Baby CHAKRAVARAM HRUDYA
04-07-2019 7 Y 0 M 17 D (F)
Dr. HARISH JAYARAM



Patient

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

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Your Right to a Safe Delivery

SURGERY DETAILS

Date : 21/08/19

Patient Name: Baby CHAKRAVARAM HRUDYA Date of Birth: 4-07-2019 Age: 7 Y

Gender: F Ward : P. V. T. UHID No.: 0126805

Date of Surgery: 21/08/19 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Laparoscopic Appendicectomy -

Time in : 4.30 pm

Time Out : 6.00 pm

NAME

AMOUNT

1. Surgeon : Dr. Nabeel
2. Anaesthetist :
3. Assistant Surgeon :
4. OT Technician : Gouthami
5. Circulating Nurse : Archi
6. Assistant Nurse : Nam

Special Equipment: ☒ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

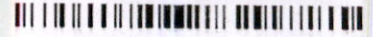
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9215038

Order by: J. Ramakrishna

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176760

Admit Date : 22-Jul-2026

Admit Time : 10:57 AM **UHID :** BAH-00662239

Patient Details :

Patient Name :	Master ZAYED MOHAMMED RASHID AL MAANI	Age :	1 Y 9 M 15 D
Guardian :	Mr MOHAMMED RASHID MOHAMED AL MAANI	DOB :	07-10-2024 01:00 AM
Gender :	Male	Religion :	
Occupation :		Martial Status :	Single
Address (H) :	ROAD NO- 1 , BLUE BERRY SERVICE APARTMENT , Banjara Hills Hyderabad Telangana INDIA 500034	Phone No :	8639597371
		E-mail :	NOMAIL@GMAIL.COM

Admission Details :
Bed Type : DAY CARE

Bed No : POST OP 410

Ward Name : 4F-OT COMPLEX

Room No : POST OP 410

Admission Type : First Visit

Contact Details :

Name :	Mr MOHAMMED RASHID MOHAMED AL	Relationship :	Father
Contact Address :	ROAD NO- 1 , BLUE BERRY SERVICE APARTMENT , Banjara Hills Hyderabad Telangana INDIA 500034	Phone No :	8639597371


 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



TOP APPENDECTOMY CONSUMABLES OF OT

Surgeon: _____ Technician: _____ Date: _____ Time: _____

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube 5.5, 5.5, 6.	1+1	1	Major Pack	1	1	Inj Vit.K		
LMA 2, 2.5	1+1	1	Sutures	2	1	Cord Clamp		
ECG leads : A/P/N	05	3				Suction Catheter		
HME filter : A/P/N	1	1				Feeding Tube		
Syringes : 10 cc	10	3				Vaccum Suction Set		
05 cc	10	3	Gloves	2	2	Surgical Gloves		
02 cc	10	3				Gauze Pack		
01 cc	-	-				Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	1	Surgical blade 11	1	1	Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	1	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml	1	1	Koochies					
Minicheck	1	1	Ointments					
O2 mask (P)	1	1	Suction Catheter					
Fentanyl	1	1	Cap, Mask					
Morphine			Gauze Pack					
Ketamine			Mop Pack					
Propofol	3	2	Steristrip					
Rocuronium	1	1	Underpad					
Glycopyrolate	1	1	Draw sheet					
Myopyrolate	2	2	Abgel					
Ondansetron	1	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22	1	1	Urobag					
Bupivacaine 0.25%	1	1	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
IV PCM	1	1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg	1+1	1	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum set	1	1	Microshield					
3way 10 + 100 cm	1+1	1	Cotton Balls					
(O.S.A) 0.5, 2	1+1	1	Latex Gloves					
(N.S.A) 22, 24	1+1	1	Ramdione Scrub					
IV cannula 22, 24	1+1	1	Saral					

Surgeon: _____ Anaesthesiologist: _____ Nurse: _____ OT Technician: _____
Order No.: 97151028 Ordered by: _____
Doc. No.: RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

BAH-00662239 IP5-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 16 D (M)
Dr. HARISH JAYARAM



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/07/26	11:30am	ER	OT	Kut.
22/7/26	9pm	OT	341	☺

Cross Consultation Visit

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

[illegible]

Date

Investigations

Order No.

Signature

22/7/26

CBP

3512

Charan

[illegible]

PROCEDURE				
Date	Procedure	Quantity	Order No.	Signature
22/7/26	Ev placement PAC op	(1)	6098	Chen
ANY OTHER INFORMATION				
Date : Time : Prepared By :				
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor	

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

UHID ID:

Department:

Consultant:

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Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 16 D (M)
Dr. HARISH JAYARAM





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

No left empty scrotum.

History of present illness :

Child is examined for RU above GU →

On Examination → left small nubbie felt in high scrotal region



Diagnosed as left undescended / atrophic testes.

Hence planned for laproscopic left orchiopexy / Remnant orchiectomy.

BAH-00862239 IPS-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 15 D (M)
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Pediatric Multisystem History & Physical Examination

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

Birth & Neonatal History:

LSCS / Lethal PT / 3.2kg / twin - 1 /
NO H/O NICU admission.

Birth & Socio Economic History:

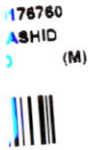
About Father : _____
About Mother : _____ } upper middle class.
Any additional Information : _____

Developmental History :

Ⓝ development, speech delay Ⓟ

Immunization History :

Immunization till date



Ped. Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13.6 kg (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 112/min B.P. 109/50 (64) SP02 100% on RA

Resp. rate and type of breathing : RR = 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BIL AET

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 A

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT.

Ausculation : _____

Spine : _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :.

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Left undescended / Atrophic testis

↓

Came for laproscopic left orchidopexy / Remnant
orchidectomy.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP on coagulation

Planned Management

- Admit in OT.
- FVPO to continue
- IV fluids.

Signature of the Doctor: Ramy

Name of the Doctor: Dr. RAMYA SILPA

Date & Time: 22/7/26; 10:20am

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Harish

Date & Time: 22/7/26 12.10 PM

DR. HARISH JAYARAM
Registration no. 66054



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	2			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation	2			
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds	10			
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
		36			
	Total No. of Pages				

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



OPERATION THEATER NOTES

Patient's Name : Master Zayed Mohammed Rashid Age : 1y 9m Gender : ☒ Male ☐ Female
UHID No.: BAH-00662237 Weight : Height :

Surgeon : Dr. Harish Jayaram Asst. Surgeon :

Anesthetist : OT Nurse: OT Technician:

Pre-Operative Diagnosis: (L+) UDT

Surgical Procedure :

Indications for Surgery :

(L+) UDT

Date : 22/07/26 Start Time : 01:20pm End Time :

Pre Operative Preparations:

Post Operative Diagnosis: (L+) UDT

Peri-Operative Complications:

Operation Notes:

FINDINGS :-

1) Left nubbin palpable in scrotum (left upper)

2) (R+) testis palpable in scrotum

Laparoscopy :- 1) Right vas and vessels entering closed inguinal ring

2) Left vas - blind ending.

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

Procedure

1) 5mm umbilical port placed.
Findings noted

2) ~~Converted to open~~ Midline scrotal incision made.

3) Right testis fixed $\bar{c}$ 3-0 prolene 3 point

Amount of Blood Loss: $\sim 1\text{ml}$

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

1) Left nubbin for HPE

Peri-Operative Complications:

fixation

4) Left nubbin dissected and excised. — sent for HPE

5) Port closure done $\bar{c}$ 3-0 vicryl and skin $\bar{c}$ rapid vicryl 5-0 suture

6) Scrotal incision closed $\bar{c}$ catgut chromic in interrupted sutures.

Name of the Surgeon: Dr. Harish Jayaram

Signature of the Surgeon: 

Date & Time: 22/7/26, 2:06 pm



POST-SURGICAL CARE PLAN FORM

Procedure Done: Diagnostic Laparoscopy ⊕ Left remnant orchiectomy

Post-Surgical Diagnosis: ⊕ UDT

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

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:

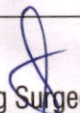
—

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

☐ Yes ☒ No

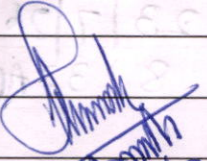
Any Other Post-Operative Care Needed including Required Follow Up

—


Treating Surgeon
(Signature & Stamp)

Date: 22/7/26 Time: 1:54pm

Note: Plan of care will be readjusted if necessary.

Date & Time	Progress Notes	Doctor's Order
22/7/26 4:50pm	C/S/B Dr. Maliha POD - (6)	22/7/26 MA 25-28
	No fever spikes Vitals stable P/A - soft L/E - dressing intact	<u>Actv</u> 1) Full feeds 2) Plan discharge tomorrow
 22/7/26 5:40 PM		Maliha 22/7/26 4:50pm NB - Rinaldi 20/08/23
	DR. HARISH JAYARAM Registration No: 66254	



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BAH-00682239 IP5-00178760
 Master ZAYED MOHAMMED RASHID
 07-10-2024 1 Y 9 M 15 D (M)
 Dr. HARISH JAYARAM




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RESULT SHEET

Date	28/7/26				
Time	11.05am				
Hb	11.5				
PCV	36				
RBC	5.61				
WBC	8.19				
N/L	21.8/11				
Platelets	242				
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.,) :

BAH-00682230
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 16 D (M)
Dr. HARISH JAYARAM

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ranya

Date & Time : 22/7/26 : 11am

Nurse Name & Signature : 11am

Time : 22/07/26 @ 11am

DRUG CHART

Date of Admission: 22/07/26 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:																			



REGULAR PRESCRIPTIONS

Weight. 13.6 kg Ward.

DRUG : LNT PARACETAMOL				Date Time	20/8	22/8														
Dose	Route	Frequency	Start Date																	
200mg	IV	Q8h	22/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
2236pm																				
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																				
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. 12.6kg Ward.

VARIABLE DOSE		Date Time						
			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.	
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
22/7/20	12 ⁵⁰ pm	DICLOFENAC	12.5 mg	IV	Re	Sigah Singh



Weight. 13.6 kg Ward.

[illegible]

22/7/26

INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
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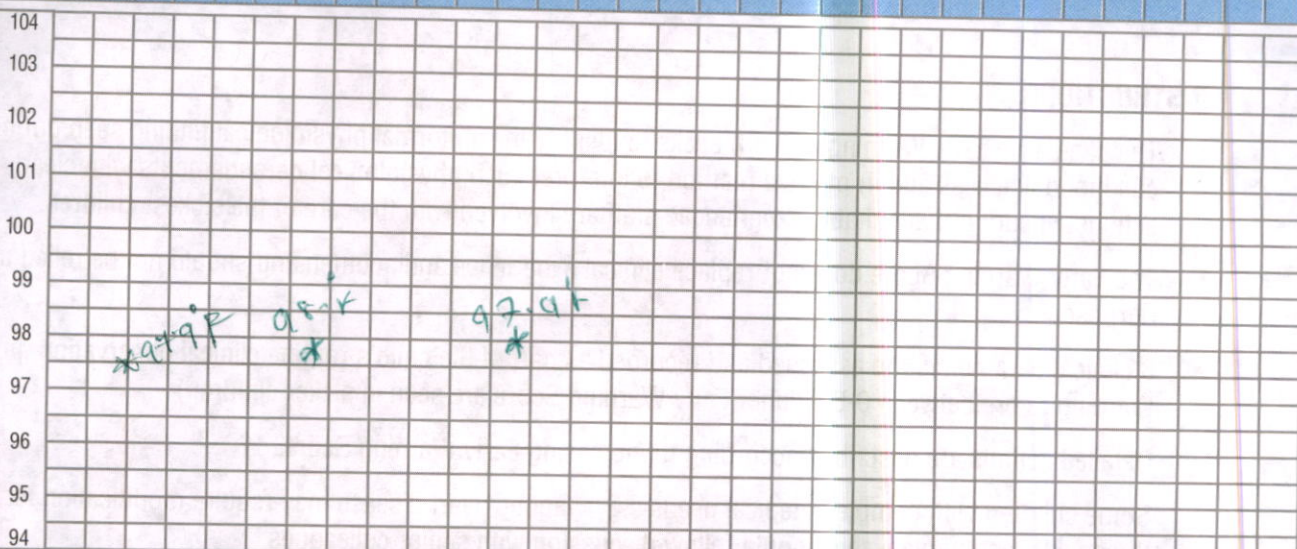
BirthRight
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7pm 11pm 6am

Doctor/Nurse/Family Concern?

Temperature
(F)



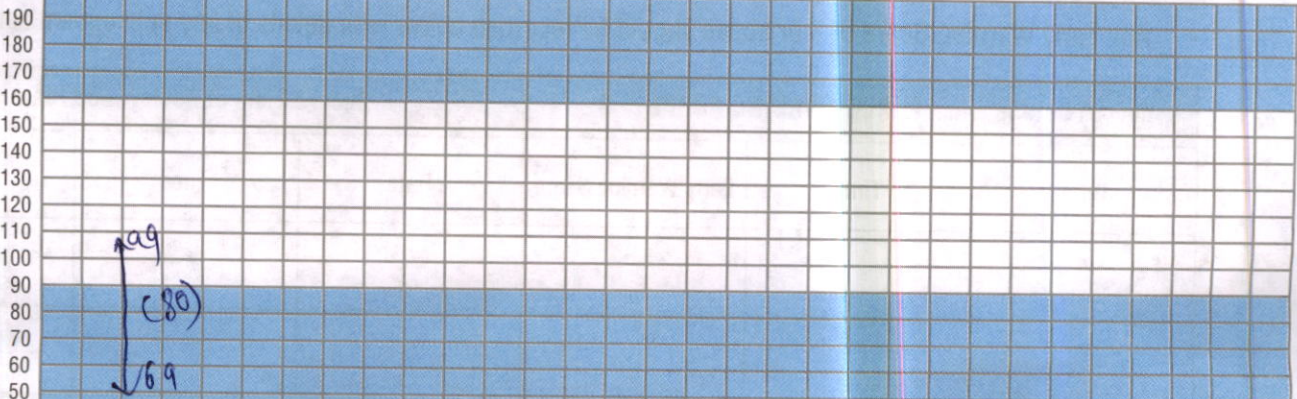
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring



Heart Rate (Number) 139bpm 149bpm 139bpm

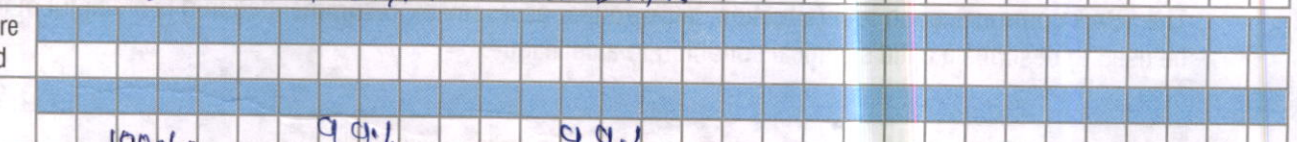
Resp. Rate (bpm)
r 1 Minute) *



Resp Rate (Number) 21bpm 22bpm 22bpm

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)



Conscious Level Normal
Altered

GCS *

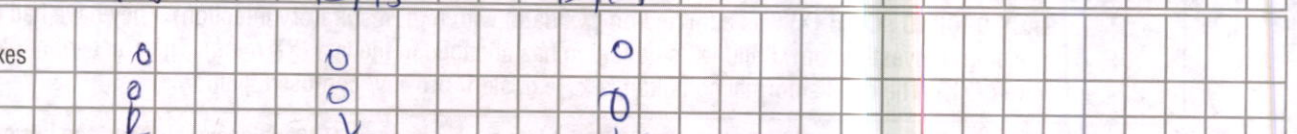


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time: 8:30		
Doctor / Nurse / Family Concern?		am		
Temperature (°F)	104			
	103			
	102			
	101			
	100			
	99			
	98	98.4		
	97			
	96			
	95			
Heart Rate (bpm)	190			
	180	100 bpm		
	170			
	160			
	150			
	140			
	130	98.4		
	120			
	110			
	100			
Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early warning scoring				
Heart Rate (Number)				
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60	20		
	50			
	40			
	30			
	20			
	10			
	0			
	Resp Rate (Number)			
	Resp Distress	Mod/ Severe		
	None / Mild			
Receiving O ₂ (l/min)				
O ₂ Saturations (%)				
Conscious Level	Normal			
	Altered			
GCS *				
TOTAL SCORE				
Number of shaded boxes				
Pain Score				
Observer's Initials				
ACTIONS	Score 1	: Continue normal observation by staff nurse		
	Score 2	: Shift in charge nurse to be informed and continue hourly observations		
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.		
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see		
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.		
NB: Scores 3 should be recorded overleaf				

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
22/7	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm	fruity									
	Total Intake :			Total Output :							
22/7	02:00 pm	D2O								0	
	03:00 pm									0	
	04:00 pm									0	
	05:00 pm									0	
	06:00 pm	no ivp								0	
	07:00 pm									0	
	Total Intake :			Total Output : U2 M=0							
	08:00 pm	milk								0	
	09:00 pm									0	
	10:00 pm	milk								0	
	11:00 pm									0	
	12:00 am									0	
	01:00 am	milk								0	
	Total Intake :			Total Output : M=0 U=2							
	02:00 am									0	
	03:00 am	milk								0	
	04:00 am									0	
	05:00 am									0	
	06:00 am	milk								0	
	07:00 am									0	
	Total Intake :			Total Output : M=0 U=2							
Total 24 hrs. Intake											
Total 24 hrs. Output		U=5									

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment:

Acute pain & Discomfort

Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☐ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
2 pm	* Assess the pt General condition	2pm	* Assessed the pt General condition	* Pt is Conscious & oriented
4pm	* Relieve pain & discomfort	4:30 pm	* Relieved pain & Discomfort	* vital stable
5pm	* monitor vital signs	5:30 pm	* Monitored vital signs	* No bleeding
6pm	* Monitor for bleeding	6:30 pm	* Monitored for bleeding	* Maintained
7pm	* Maintain Ilo chart	7:30 pm	* Maintained Ilo chart	* NO vomiting
8pm	* Npo Status Maintain	8pm	* water given Npo broken	* Satisfied.
	* pt shift to the ward		* Pt shifted to the ward	

Re-Assessment:

Re - Assessment

Special Notes:

nil

Nurse Signature: Dinya

Nurse Name: Dinya

Date & Time: 22/7/26 @ 8pm

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: patient having Acute pain & discomfort

Goals

- | | | | | | |
|---|---|---|---|--|--|
| ☒ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient General condition	8:30 pm	Assessed the patient General condition on bed	⇒ patient is stable.
10pm	To monitor vitals	10:30 pm	monitored patient vitals	
12am	To monitor I/O chart	12:30 am	monitored patient I/O chart	
2am	To provide comfortable position	2:30 am	provided patient comfortable position	
4am	To Administer medication	4:30 am	Administered medication	
6am	To prevent Infection	6:30 am	To prevent patient medication	

Re-Assessment: To provide patient comfortable position

Special Notes: NA

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 23/7/26 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Harish Jayaram Department: pediatric Date of Admission: 22/07/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>orchidopexy</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>ER</u> <u>11:30 AM</u>	<u>OT</u> <u>8:00 AM</u>	<u>2nd floor</u> <u>up to 8 PM</u>	<u>3rd floor</u> <u>8 AM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.0 F</u>	<u>98.6 F</u>	<u>97.9 F</u>	<u>98.1 F</u>
		Res:	<u>24 blm</u>	<u>25 blm</u>	<u>22 blm</u>	<u>21 br/h</u>
		SpO ₂ :	<u>100.1</u>	<u>100.7</u>	<u>99.1</u>	<u>99.1</u>
		Pulse:	<u>130 blm</u>	<u>121 blm</u>	<u>135 blm</u>	<u>131 blm</u>
		BP:	<u>90/58</u>	<u>84/42</u>	<u>90/70</u>	<u>11/40</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
	Pain Score:	<u>0/10</u>	<u>1/10</u>	<u>0/10</u>	<u>0/10</u>	
	Safety Needs:	<u>✓</u>	<u>Yes</u>	<u>side rail</u>	<u>Yes</u>	
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Recommendations	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Handed Over By Name :		<u>Arathi</u>	<u>Arathi</u>	<u>Arathi</u>	<u>Satya</u>
	Signature :		<u>Arathi</u>	<u>Arathi</u>	<u>Arathi</u>	<u>Satya</u>
	Date:		<u>22/07</u>	<u>22/7</u>	<u>22/07</u>	<u>22/07</u>
	Time:		<u>11:30 AM</u>	<u>9 AM</u>	<u>8 PM</u>	<u>8 AM</u>
	Taken Over By Name :		<u>Arathi</u>	<u>Arathi</u>	<u>Arathi</u>	<u>Kerath</u>
	Signature :		<u>Arathi</u>	<u>Arathi</u>	<u>Arathi</u>	<u>Kerath</u>
	Date:		<u>22/7</u>	<u>22/07</u>	<u>22/7</u>	<u>23/07</u>
	Time:		<u>11:30 AM</u>	<u>9 PM</u>	<u>8 PM</u>	<u>8 AM</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time					
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:		Temp:				
			Res:				
			SpO ₂ :				
			Pulse:				
			BP:				
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

IP5-00176760
00662239
Member ZAYED MOHAMMED RASHID (M)
07-1 Y 9 M 15 D
D-2024
HARISH JAYARAM

BRADEN 'Q' SCALE



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little ones.



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BRADEN 'Q' SCALE				Date: 12/07/23	Time: 11:00 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4
SKIN to moisture	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4
FRICION-SHEAR	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Inability to move without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4	4
Intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and OR generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4
Perfusion & Circulation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4
TOTAL SCORE				20		
Evaluator's Name				Ketha Sathy		

Risk Score	Category	Action	Support Surfaces
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7/26	11Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Cultu
22/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	water
22/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty
23/7/26	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty
23/7/26	3am	2/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tri-pm	Saty
23/7/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

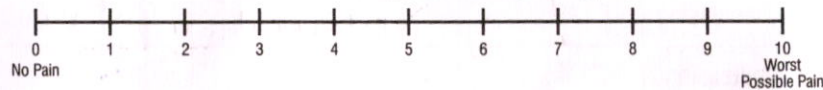
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/7	11AM	2	Treatment & Care Plan	F	1	1	1	0	-	(G)

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/7/26 11Am	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	orchidopexy	H. stability	procedure		☐ Nursing ☐ Others:
22/7/26 11Am	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	orchidopexy	H. stability	IV fluids & procedure	ICS	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Patient



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			12				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓				
Call device within reach		✓				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate Lighting		✓				
Wheel Chair Support		✓				
Other Intervention(s) Specify		✓				
Nurse's Name :		Kethi				
Signature :		Kj				
Date :		22/7				
Time :		11:40				



CHECKLIST FOR THROMBOPHLEBITIS

22/12/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-							
Signature of the Nurse				[Signature]									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

BAH-00662239 IP5-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 15 D (M)
Dr. HARISH JAYARAM

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Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: as per Doctor order.

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☒ Yes	☐ No
☐ Eating	☒ Yes	☐ No
☐ Walking	☒ Yes	☐ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☒ Yes	☐ No

yes

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication.

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 17/12/26



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. LAPAROSCOPIC LEFT ORCHOPEXY ± REMNANT ORCHIECTOMY

2. _____

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Prevention of torsion. & increased surveillance for malignancy.	

- As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- Bleeding, Infection
- Need for orchiectomy.

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

Patient / Patient Attendant:

Signature: _____
Name: Mohammed Rashid
Relationship with patient: Father
Date & Time: 22/7/26, 11:58 AM

Witness:

Signature: _____
Name: SHARIFA ALI AMOUR
Date & Time: 22/7/26, 11:58 AM

Doctor (who is taking consent):

Signature: Maliha Name: Dr. Maliha
(26)

Date 22/7/26 Time: 11:58 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు 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:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ గానా, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, 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.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- 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:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 16 D (M)
Dr. HARISH JAYARAM



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 22/07/24

Department : OT Duration of Procedure : 45 min

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 22/07/24

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 : _____	Sujata
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	Sujata
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 22/07/24 @ 01:20pm	Sujata

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Harish Jayaram
Asst. Surgeon :
Anaesthetist : Dr. Parv Chandra
Scrub Nurse : Suman

Patient Name : Mr. Mohammed Rashid Age : 1y Gender : M
UHID No. : 662239 Surgery Name : Lap. (D) Ovaryopexy
Date : 22/07/24 In-time : Out-time : ± Remnant
Orthotopy

BAH-00662239 IP5-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 15 D (M)
Dr. HARISH JAYARAM


Before Induction of Anaesthesia >>

SIGN IN		Time: <u>12:19pm</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☒ NA	
Blood Units Reserved	☐ Yes ☐ No ☒ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>Harish</u>		
Name : <u>Harish</u>		

Before Skin Incision >>

TIME OUT		Time: <u>01:14pm</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>1hr</u> Anticipated Blood Loss? <u>1ml</u> ☐ 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 : <u>Sugata</u>		
Name : <u>Sugata</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>1:51pm</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☒ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>Dr. Harish</u>		
Name : <u>DR HARISH</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :

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Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☐ Yes ☐ No	
Site	☐ Yes ☐ No	
Procedure	☐ Yes ☐ No	
Consent	☐ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☐ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☐ No ☐ NA	
Signature :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
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 :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?		☐ Yes ☐ No
Signature :		
Name :		

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00662239 IP5-00176760 Master ZAYED MOHAMMED RASHID 07-10-2024 1 Y 9 M 15 D (M) Dr. HARISH JAYARAM 		Date & Time of Admission 22/7/2024 10:57 AM	Date & Time of Transfer Order 22/7/2024 @ 4 PM
		Transfer Ordered by Dr. Harish	Reason for Transfer post-OP
From Unit OT	To Unit 341	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films pi			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Diva		Name of Person Ordered Transfer Dr. Harish	
Patient & Clinical Records Received by : Swathi			
Date & Time of Patient Received : 22/7/2024 @ 4 PM			

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

BAH-00662239 IP5-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 15 D (M)
Dr. HARISH JAYARAM

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11 AM Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NKA Body Weight: 13 Kg
Height: cm

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
nil	nil	nil

Family History: not doing significant

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☒ No

Current Medication: ☒ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 13 kg Length: Head Circumference (< 2 years):

Temp.: 98.6 HR: 84 RR: 25 BP: 84/41

Pain Score: 0 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 24) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☐ Yes ☒ NoWaste Disposal Explained: ☐ Yes ☒ NoInfusion Pump: ☐ Yes ☒ NoHand hygiene Explained: ☐ Yes ☒ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☒ NoInformation given to *noted*Nurse Signature: *[Signature]*Nurse Name: *[Signature]*Date: *22/7*Time: *11:30 AM*

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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BAH-00662239 IP5-00176760
Master ZAYED MOHAMMED RASHID
07-10-2024 1 Y 9 M 15 D (M)
Dr. HARISH JAYARAM



Name: Zayed Md Rashid Age: 1y 9m Sex: M UHID.No: BAH-00662239
Date: 20/7/26 Time: 5:15pm Proposed Operation: (L) UDT
Diagnosis: (L) lap orchiopexy
B.P / CRT: 138/80 H.R: 110 Weight: 13.2kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: - Nil -

Medical History: CVS:

RESP:

CNS:

Renal:

Hepatic / GE:

Others:

USG / Late PT / 3.2kgs / twin-1

Diabetes: NO NICV admin.

motor development (L)

Speech delay (L)

Physical Activity: Immunised till date

Past Anaesthetic History: - Nil -

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Good Mento-hyoid Distance: Good Neck: Good Teeth: Good

Lungs: BAE (L) Ch

Heart: S1 S2 (L) NO murmur

CNS: Alert

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:

- DVT Prophylaxis: (1) (2) (3) coconut water
- NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: CBC on cannulation

Signature: [Signature] Name: Dr. Akhila K



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:

BP / CRT: 72 / sec.

SpO₂:

R.R:

Last Feed:

Pre-OP Diagnosis: (2) Underscended testis

Operation: lap ORCHIDECTOMY

Date: 22/1/24

Surgeon: HARISH

Anaesthesiologist: RUP

Technician: KURBAN

N₂O / AIR / O₂ / PM

HALO / SO / SEVO

Drugs:

MIDAZOLAM 0.5
PROPOFOL 40 mg
FENTANYL 30
ROCURONIUM 9.5

Antibiotic

Suppository

Blood Loss

NOTES

FIO₂ / SaO₂: 0.45 / 99
ETCO₂: 39
ECG: 32
Temperature: 36.5
Urine Output: 32

Fluids
Blood

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values

- ☒ Equipment Checked and Functional
- ☒ BP
- ☒ Cuff Site: 0.5
- ☒ Art Site: 0.5
- ☒ EKG Lead
- ☒ Temp Site
- ☒ FIO₂ Monitor
- ☒ Agent Monitor
- ☒ Pulse Oximeter
- ☒ Capnograph
- ☒ Ventilator
- ☒ Nerve Stimulator
- Position: 20106
- ☒ Pressure Points Checked

Temp:

- ☒ HME
- ☐ Cling Film
- ☐ Hugger's
- ☐ Other
- ☐ Fluid Warmer
- ☐ OH Warmer
- ☐ Cotton Wool

Times:

Anaes Start: 12:15 pm
OP Start: 1:00 pm
OP End: 1:55 pm
Leave OR: 1:55 pm

Anaesthesia:

- ☒ GA
- ☐ Monitored Anaesthesia Care
- ☒ Regional

Line (Size & Location)

OP: 20106
ART: 20106
ECG: 20106
Temp: 20106
FIO₂: 20106
Pulse Ox: 20106
Capnograph: 20106
Ventilator: 20106
Nerve Stimulator: 20106

Induction

- ☒ Inhal
- ☐ Pre O₂
- ☐ RSI
- ☐ Others

Mask ☐ SGA
Airway ☐ Oral ☐ Nasal
ETT# 3.5 at 11 cm
Oral ☒ Nasal ☐ Cuff
Tracheostomy ☐ Topical
Drug: ROCURONIUM

- ☐ Awake
- ☒ Direct Vision
- ☐ Video Laryngoscopy
- ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade# Attempts: ONE

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

Regional:

- Extremity
- Specify: Caudal
- Spinal
- Epidural

Others: 2 lateral

Position: 2 lateral

Site: 229

Needle Size: 229

Paresthesia: Yes No

Catheter at skin: 0.25 f

Drug Name & Conc: BUPIVACINE

Bolus: 1.8 ml

Infusion: 1.8 ml

Block Level: 229

Comments: 229

Transportation to

PACU ICU Other

Relaxant Reversed: Yes No NA

Name of the Doctor: 20106

Signature of the Doctor: 20106



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Deigh Time Received : 2pm Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SP0 ₂		250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>226</u>
			☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
Vomiting : ☐ Yes ☒ No Drug:			
NG Tube : ☐ Yes ☒ No			
Drain: ☐ Yes ☒ No			
Urinary Catheter: ☐ Yes ☒ No			
Chest Tube: ☐ Yes ☒ No			
Nil Oral ☐ Yes ☒ No			
IV Fluids:			
Oral Feeds:			

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	1	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP ± 20 of Pre Anaesthetic leve	= 2	2	2	2	2		
BP ± 20-50 of Pre Anaesthetic leve	= 1						
BP ± 50 of Pre Anaesthetic leve	= 0						
Fully awake	= 2	1	1	2	2		
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
22/7	2pm	1/10	—	

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

Anaesthesiologist Name : Dr. Abdul W

Anaesthesiologist Signature: [Signature]

Date & Time: 22/7/24

PACU Nurse Name : Deigh

PACU Nurse Signature: [Signature]

Date & Time: 22/7/24 @ 3pm

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time: 22/7/24 @ 3pm

De nent of Anaesthesiology

EL JRAL ANALGESIA RECORD

Date: Time: Procedure done by:

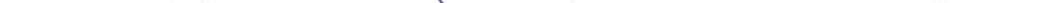
CSE al/Epidural Position : Space : Technique (LOR/LOS)

Dept: Catheter at Skin: Attempts :

Parasitosis : Yes/No if yes details :

Solute Composition :

Any other issues :

a) 

b)

[illegible]

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

CONSENT FORM FOR ANAESTHESIA



Patient Name : Zayed Md Rashid Age : 1y 9m Gender : Male ☒ Female ☐
UHID NO: BAH-00662239 Surgeon Name: Dr. Harish Jayaram
Anaesthesiologist : Dr. Subramanyam Operative procedure planned : Lap (if) Orchiopexy

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 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 mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : laryngospasm, bronchospasm

- 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 the above mentioned operation / Diagnostic / Therapeutic procedures.

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

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [Signature]
Name : MOHAMED RASHID MOHAMED
Relationship with Patient : FATHER
Date & Time : 20/7/26 5:20pm

Witness :

Signature : [Signature]
Name : SHARIFA ALI AMOUR (Mother)
Date & Time : 20/7/26 5:20pm

Doctor (who is taking the consent) :

Signature : [Signature] Name : Dr. Akhilesh Date & Time : 20/7/26 5:20pm

Docu. No. : RCH / FRM / CLINICAL / 021