

BAH-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY



SURGERY DETAILS

SmithNephew
EVAC® 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2201075
2028-10-21

rainbow
children's
hospital
es a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

81075

Date : 9/7/26
Patient Name: Baby Larmika Reddy Date of Birth: 27-05-2022 Age: 4y
Gender: Female Ward: OT UHID No.: 661065
Date of Surgery: 09/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☒ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Adeno to milkobomy to tableting

Time in: 6:45pm Time Out: 7:45pm

	NAME	AMOUNT
1. Surgeon	Dr. P V L N MURTHY	
2. Anaesthetist	Dr. Anurag	
3. Assistant Surgeon		
4. OT Technician	Anan	
5. Circulating Nurse	Sujata	
6. Assistant Nurse	Sreavani	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Colateral used → 9695149

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9695148

Order by: Alam

ESTIMATION SLIP

Date : 09/Jul/26 UHID / IP No. : TPA No 661065 SI No. 81075
 Name of Patient : Baby Laxmi Aishly Vignayam Age : Gender :
 Father's / Husband's Name : Mr. Manoj Corporate / Occupation :
 Address : Phone : 7095660560 Email :
 Procedure / Plan : Adenotonsillectomy & Coblation

MODE OF PAYMENT : ☐ SELF ☐ TPA : ☒ GISA : ☒ OTHERS

TARIFF INFORMATION :

r Day)	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
	Room Rent & Nursing Charges										
	Doctor's Fee		1000			NA					
	L. Tax		2000								
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				In play.							
O.T. Consumables				7500							
Instrument Charges				7500							
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation							
Equipment Charges	Monitor :			Oxygen :				Infusion pump / Syringe pump :			
	Ventilator :		Conventional :		HFO-SLE 5000 :		HFO Sensormedix :				
	Phototherapy :		Single Surface :		Double Surface :		Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation							
Package				519680							
Others				15000 & Final Bill							
Initial Minimum Deposit				15000							

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
- Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I, Mr. Manoj, have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client

Signature Relationship

Signature of the Financial Counselor

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	5:15 pm	ER	OT	[Signature]
9/7/26	8:20 pm	OT	145	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Vijwala	10/7/26	9695223	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Date	
9/7	

Investigations

CBP

Order No.	
68720	

Signature

Sammy



CEP

68720

Samby

5244

ADENO CONSUMABLES OF OT

Circulating staff : Technician : Date : Time : 9:30pm

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Qty			Qty			Qty		
Issued	Used		Issued	Used		Issued	Used	
ET tube 7.5	01	01	Major Pack <u>Drape</u>	1		Inj Vit.K		
LMA		-	Sutures			Cord Clamp		
ECG leads : A/P/N	5	03				Suction Catheter		
HME filter : A/P/N	1	01				Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	05	Gloves			Surgical Gloves		
02 cc	10	03	G. 1/2, 2, 2 1/2	242		Gauze Pack		
01 cc			prf 1/2, 2 1/2	242	1H	Syringe 1ml / 2ml		
Cautery plate : A/P/N			Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube	2	2	Koochies (S)		
RL	01	01	Cautery pencil			MS foam	1	1
NS : 10ml / 100ml / 500ml / 1000ml	1H	1H	Koochies			Transphie	1	1
Mini Brie	1	01	Ointments			Roller, ice	24	1
			Suction Catheter			Jelly	1	1
Fentanyl	1	01	Cap, Mask	5/5	45	Suction	11	0
Morphine			Gauze Pack	5H	2	Ang. Analer	3	2
Ketamine			Mop Pack	1	-	B. Intra Col drops	1	-
Propofol	2	01	Steristrip					
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	1	01	Draw sheet	1	1			
Myopyrolate	1	01	Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Aug 60mg	1	01	Bandage					
TV pen	1	01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	1			
Justin : 12.5 mg / 25mg / 100mg	1	01	Plastic Bed Sheet	1	-			
Tab. Misoprost : 200mg			Betadine Solution	1	-			
bers + Transure	1H	1H	Microshield	1	-			
100 cm	1	01	Cotton Balls	1	-			
			Latex Gloves	1	16P			
			Ramdione Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9695157

Ordered by : Y. Sen

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

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
09/07/26	IV Placem	①	.94903	} Samohy
	PAC Done on	OP	Bas,)	
	NIHA	①	9695673	Per

ANY OTHER INFORMATION

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Date : 10/6/26

Time : 9:30AM

Prepared By : Surhug

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Surhug	SPW		



ADMISSION SHEET

Registration Details :

Admission No : IP5-00176164 Admit Date : 09-Jul-2026 Admit Time : 04:27 PM UHID : BAH-00661065

Patient Details :

Patient Name : Baby LARMIKA REDDY VIPPAGUNTA Age : 4 Y 1 M 12 D
Guardian : Mr VIPPAGUNTA MANOJ KUMAR DOB : 27-05-2022
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 1-58 SRI YSR STREET MAIN ROAD Phone No : 7095660548/ 9494495691
Vidavalur Nellore Andhra Pradesh INDIA 524318 E-mail : VVMANOJKUMAR92@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 401 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 401 Admission Type : First Visit

Contact Details :

Name : Mr VIPPAGUNTA MANOJ KUMAR Relationship : Father
Contact Address : H NO 1-58 SRI YSR STREET MAIN ROAD Phone No : 7095660548 / 9494495691
Vidavalur Nellore Andhra Pradesh INDIA 524318

V.V. Manoj Kumar
Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



PEDIATRIC IN-PATIENT MEDICAL RECORD

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27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Larmika Reddy Vippagunta Age/Sex 4y0/F
Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Mouth breathing
Disturbed sleep pattern } x 6 months
Mouth breathing

History of present illness :

Mouth breathing
Disturbed sleep pattern } x 6 months
Mouth breathing

↓
Diagnosed → Adenotonsillitis

↓
Now admitted for
coblation Adenotonsillectomy.



Pediatric Multiorgan History & Physical Examination

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

Not significant

Birth & Neonatal History:

FT/LSCS/CTAB/B.Wt-3.6kg
NO H/O NICU admission

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Achieved as per age in all 4 domains

Immunization History :

As per schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 26.7 kg (Centile _____)

On Examination :

Temperature : 98.7°F Pulse Rate : 102 bpm B.P. 100/60 mmHg SpO2 100% RA

Resp. rate and type of breathing : 26 br/min

Rash _____ } ⊖

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKA

Respiratory System :

Inspection (any s/o distress) : _____ } BLAER, clear.

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____ } S1 S2 ⊕

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____ } soft, nondistended

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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 : 15/15

Cranial Nerves : 30

Motor System:

Nutriton : 30

Tone: 30

Power 30

Co-ordinator : 30

Posture : 30

Involuntary Movements : 30

Reflexes :

DTR 30

Superficials: 30

Plantars 30

Sensory System :

Bladder / Bowel : 30

Clinical Summary & Diagnostic:

Adenotonsillitis



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Bleeding
sepsis

Desired goals of the treatment :

Hemodynamic Stability

Planned Labs:

Planned Management

- NPO as advised
- IVF DMS

NIB

sign

9/7/26

5:15 pm

Signature of the Doctor: Nalal

Name of the Doctor: Dr. Nandam

Date & Time: 09/07/2026, 4:30 PM

Signature of the Consultant: [Signature]

Name of the Consultant: PVLN MURTHY

Date & Time: 9/7/26

DR. PVLN MURTHY
Registration No: 47267

DR. PVLN MURTHY
Registration No: 47267



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. Adeno tonsillectomy & Glandectomy
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)
<u>Good results</u>	

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. Bleedily, change in voice, vocal registration
- b. rec. of Adenoid

1. I authorize Dr. P V L N MURTHY 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: V.V. Manoj Kumar
Name: V.V. Manoj Kumar
Relationship with patient: Parent
Date & Time: 9/7/26 @ 6pm

Witness:

Signature: X. Roathi Jahnavi
Name: Yasham Roathi Jahnavi
Date & Time: 9/7/26 @ 6pm

Doctor (who is taking consent):

Signature: [Signature] Name: P V L N MURTHY Date: 9/7/26 Time: _____

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:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. 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

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ రోగానా, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా 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.	

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION THEATER NOTES

Patient's Name : Baby Larmika Reddy Age : 4y Gender : ☐ Male ☒ Female
UHID No. : BAH-00661065 Weight : 27kg Height :

Surgeon : PVLN MURTHY Asst. Surgeon :

Anesthetist :

OT Nurse:

OT Technician:

Pre-Operative Diagnosis: Ch. Adenomatoid

Surgical Procedure : Adenotomectomy & Coblation

Indications for Surgery :

Date : 9/7/26 Start Time :

End Time :

Pre Operative Preparations:

.....

.....

.....

.....

.....

.....

Post Operative Diagnosis:

.....

.....

Peri-Operative Complications:

.....

.....

.....

.....

Operation Notes: Adenotomectomy & Coblation

.....

.....

.....

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.....

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.....

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.....

.....

.....

.....

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1 SYP. ACQUAMENON DDS Sml BID 2wly	
2 SYP. OMNACORTIL Sml BID-1wly	
3 SYP. KYZAL-M - Sml BID 2wly	
4 SYP. CROLINDS 7.5 Sml TID 2wly	
5 T. LANAZOLE 30 T BID 2wly	
6 T. TRANEXA 500mg 1/2 tab BID 2wly	
7 Salt water gargle TID 2wly	

Name of the Surgeon: Pooni Meetha

Signature of the Surgeon: [Signature]

Date & Time: 9/7/26

BAH-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY




**Rainbow
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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

Date & Time	Progress Notes	Doctor's Order
9/29/26 9pm	<u>SIB</u> <u>Resident</u> plan. A: Chronic Adenomatoiditis (1) cont. same SIP Adenomatoiditis (2) plan DIC tomorrow Chk alert Vitals stable	
10/2/26 8AM	<u>SIB</u> <u>Resident</u> A: Chronic Adenomatoiditis. Vitals stable Chk alert O/R. fair	plan. (1) cont same (2) plan DIC

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital : Uw Langara

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

chr adenotomies

Signature: Madhu

Findings and Recommendations :

pt: Chronic adenotomies
post tonsillectomy

O/E: Child alert
—
PM
CVS
MA | normal

Plan
① cont. care
② plan Dk

Reinforce hymp.

Consultant :

Name : Dr Vjwale Signature : DOA Date & Time : 10/7/20

BAH-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY

Pat




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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: ICU

Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Nalini, Dr. Nandan

Date & Time: 09/07/2026, 4:30 PM

Nurse Name & Signature: Sagar

Date & Time: 01/7/26 @ 5:15 pm

BAH-00661065 IP5-00176164
 Baby LARMIKA REDDY VIPPAGUNTA
 27-05-2022 4 Y 1 M 12 D (F)
 Dr. P V L N MURTHY



RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date							
Time							
CUE - Alb							
CUE - Sugar							
CUE - Ketones							
CUE - PUS Cells							
CUE - RBC Cells							
CUE							
Stool Pus Cell							
OVA / Cyst							
Occult Blood							

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

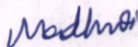
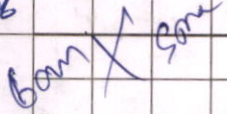
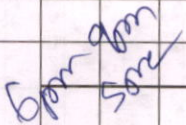
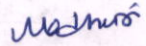
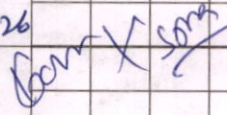
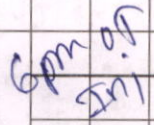
 MRI :

 Others (ECG, Contrast Studies etc.,) :

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : Tab. LANZOL 30mg				Date Time	dp	10														
Dose	Route	Frequency	Start Dt.																	
1 tab	P/O	BD	9/7/26																	
Name & Signature of the Doctor Starting the Drugs:				 																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Tab. TRANEXAMIC ACID				Date Time	dp	10														
Dose	Route	Frequency	Start Dt.																	
1/2 tab	P/O	BD	9/7/26																	
Name & Signature of the Doctor Starting the Drugs:				 																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: 09/07/2026 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:				

Weight. 26.80 kg Ward.

Page: 2/4



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/7	6:45pm	Iv- PARACETAMOL	390 mg	Iv	Am	Am
9/7	7pm	Iv. DEXAMETHASONE	2mg	Iv	Am	Am
9/7	7pm	Iv. TRANEXEMIC ACID	200mg	Iv	Am	Am
9/7	7pm	Iv. AUGMENTIN	750mg	Iv	Am	Am
9/7/26	9pm	1st. ONDANSETRON	4mg	Iv	Am	Am

IP5-00176164

BAH-00661065
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY

Baby LARMIKA REDDY (F)
27-05-2022 4 Y 1 M 12 D
MURTHY

27-05-2022
Dr. P V L N MURTHY



I.V. FLUIDS CHART

Weight. 26.7kg Ward.

[illegible]

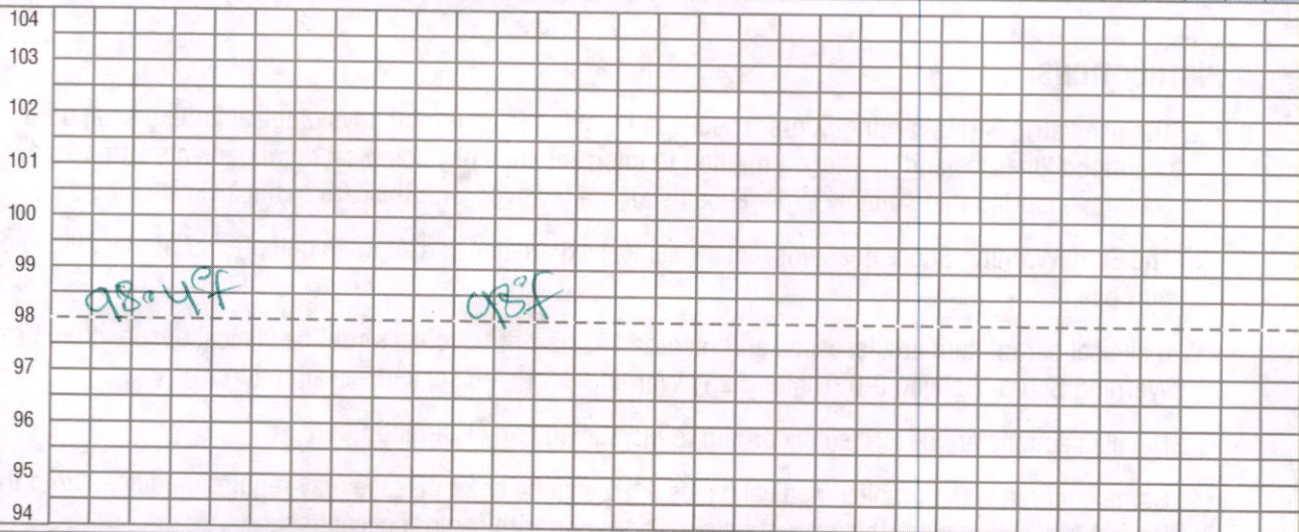
SCHOOL AGE (5-12 years)
**Children's Observation &
 Early Warning Scoring Chart**

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/2/26 Time: 2 AM 8 AM

Doctor / Nurse / Family Concern?

Temperature
 (F)

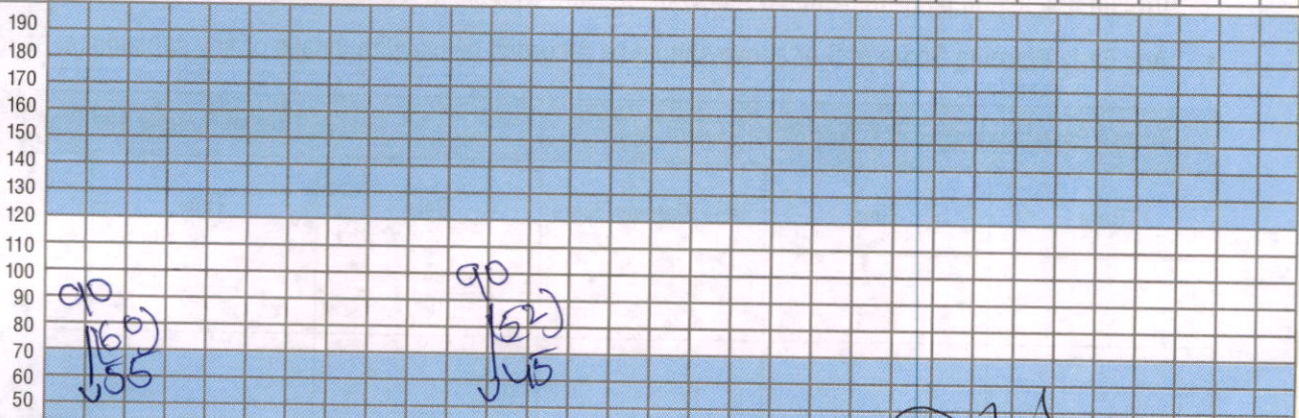


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

120b/mt 116b/mt

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



Resp Rate (Number)

28b/mt 28b/mt

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂(l/min)
 O₂Saturations (%)

98% 99%

Conscious Level
 Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 1

Pain Score

0 0

Observer's Initials

0 0

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

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)



SCHOOL AGE (5-12 years)

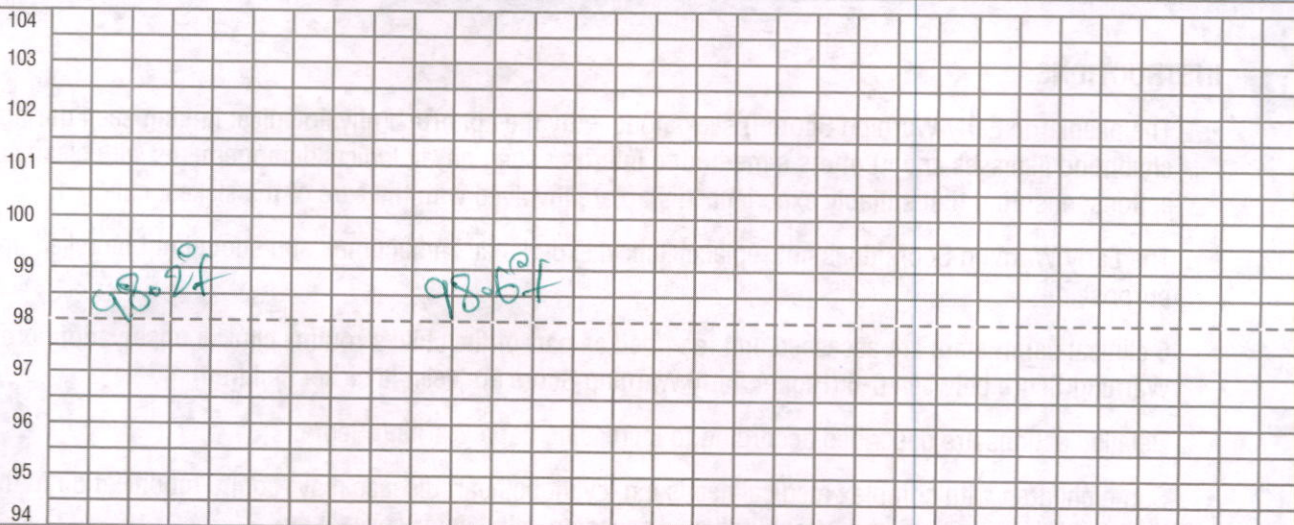
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/7/26 Time: 8pm 10pm

Doctor / Nurse / Family Concern?

Temperature
(F)

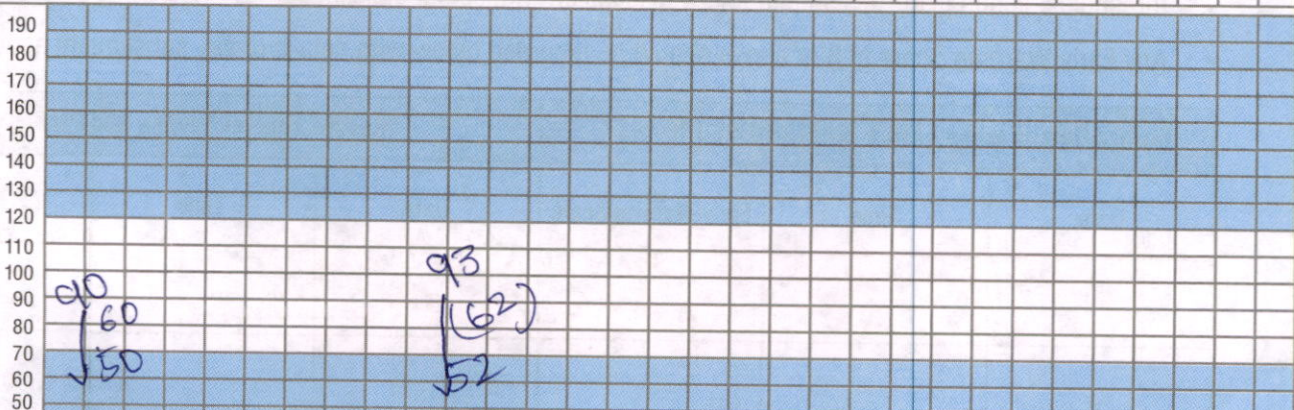


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

130b/min 126b/min

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



Resp Rate (Number)

28b/min 28b/min

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100% 100%
15/15 15/15

Conscious Normal
Level Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 7
0 0
0 0

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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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.

		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												
9/5/26	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
9/5/26	08:00 pm	1/20											
	09:00 pm												
	10:00 pm												
	11:00 pm	NO	Ice Cream										
	12:00 am	NO											
	01:00 am												
Total Intake :						Total Output :							
10/5/26	02:00 am												
	03:00 am		Juice										
	04:00 am	NO											
	05:00 am	NO											
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



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							
	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: 19/7/26

Assessment:

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 pt General Condition.	8am	Assessed the pt General Condition.	pt is Conscious & oriented
10pm	Relieve pain & Discomfort	10pm	Relieved Pain & Discomfort	vital stable
12AM	monitor vital signs	12AM	monitored vital signs	no bleeding
2AM	monitor for bleeding	2:10 AM	monitored for bleeding	no vomiting
4AM	maintain nro status	4:10 AM	NPO broken, water given	Shifted
6AM	provide Psychology Support	6:10 AM	provided Psychological Support	
8AM	pt shift to the ward	8:10 AM	pt shifted to the ward	

Re-Assessment:

Baby is feeling uncomfortable

Special Notes:

Nurse Signature: 

Nurse Name: Divya

Date & Time: 19/7/26 8AM

BAH-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 13 D (F)
Dr. P V L N MURTHY



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

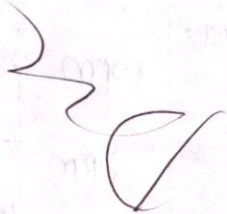
Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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
				

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:



THE HUMPTY DUMPTY SCALE

9/7 10/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	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	1			
TOTAL			10	10			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		YES	YES			
Call device within reach		YES	YES			
Wheels Locked		YES	YES			
Room free of clutter		YES	YES			
Adequate Lighting		YES	YES			
Wheel Chair Support		NO	NO			
Other Intervention(s) Specify		NO	NO			
Nurse's Name :		Sagar	Rama			
Signature :		[Signature]	[Signature]			
Date :		9/7	10/7			
Time :		5:15 PM	6 AM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. PVL Murthy Department: ER Date of Admission: 9/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>Adenostomy</u>		If Yes Specify:				
BACKGROUND	Area	Shift Time	ER 5:15 pm	OT 8:00 am - 9:00 am	ICU 8:00 am - 9:00 am		
	Medical Condition (Any special condition to be noted):		Nil	NA	NA		
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:	98°F	98.6°F	98.2°F		
		Res:	24 blm	25 blm	28 blm		
		SpO ₂ :	100%	100%	100%		
		Pulse:	100 bpm	95 bpm	100 bpm		
		BP:		91/42	100/70		
	Fall Risk Score:	10	10	10			
Pain Score:	0	1/10	0/10				
Recommendations	Safety Needs:	Yes	yes	yes			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	Nil	NA	NA			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	Nil	NA	NA			
Post Operative Procedure Special Orders:		Nil	NA	NA			
Handed Over By Name :		Sagan	Deleg	Rama			
Signature :		[Signature]	[Signature]	Rama			
Date:		9/7/26	9/7/26	10/7/26			
Time:		5:15 pm	8:00 am	8 am			
Taken Over By Name :		Deleg	Rama	Sushree			
Signature :		[Signature]	[Signature]	[Signature]			
Date:		9/7/26	9/7/26	10/7/26			
Time:		5:30 pm	8 am	3 pm			

BAH-00661065
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 13 D (F)
Dr. P V L N MURTHY

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	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		Fall Risk Score:					
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ 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:							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	5:15 pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil/Nil	[Signature]
9/7	7:50 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	[Signature]
10/7	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
				☐ 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		
				☐ 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		
				☐ 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:

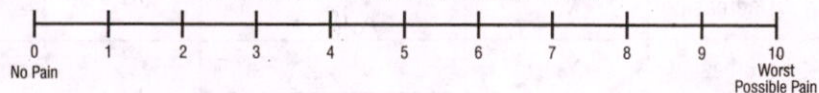
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

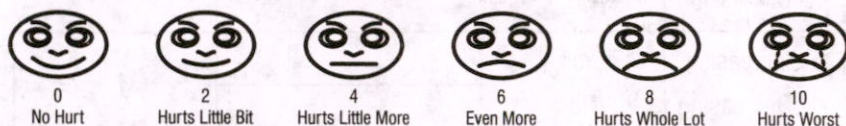
Numerical Pain Scale (Obstetric and Gynecology)



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



BRADEN 'Q' SCALE

					Date :	9/7/26	10/7/26		
					Time :	5:15pm	6am		
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			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting 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			
Nutritional Usual food 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 or 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 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			
Tissue Perfusion & Oxygenation	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					28	28			
Evaluator's Name					[Signature]				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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	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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telegu/Hindi 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		
9/7/26	5:15 pm	8.	Procedures	M	4	0	1	1	-	[Signature]
10/7/26	7am	9	soft diet	M	1	0	1	1	-	[Signature]

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference																					
Understanding:	1. Verbalizes Understanding	2. De	rates Understanding	3. Needs Review																			



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: Adenostomy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/27/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillar hypertrophy.	Hemodynamic stability	Adenotonsillectomy & Coblation		☐ Nursing ☐ Others:
9/27/26	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Adenotonsillar	H - stability	vitals monitoring		☒ Medical ☐ Others:
10/27/26 7am	☐ Medical ☐ Nursing ☒ Others: Dichhan	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillitis	soft diet	ROA:- e1 - 1350 kcal/d p :- 23 g/d		☐ 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 TRANSFER FORM

Patient Name & UHID No. BAH-00661065 IP5-00176164 Baby LARMIKA REDDY VIPPAGUNTA 27-05-2022 4 Y 1 M 12 D (F) Dr. P V L N MURTHY 		Date & Time of Admission 9/7/26 @ 8:30 PM	Date & Time of Transfer Order 9/7/26 @ 8:30 PM
		Transfer Ordered by Dr. P V L N MURTHY	Reason for Transfer Post-Op
From Unit OT	To Unit ICU	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			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	op file - ①		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. P V L N MURTHY	
Patient & Clinical Records Received by : Ramadevi			
Date & Time of Patient Received : 9/7/2026 8 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



Patient Name:

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4:27pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction nil Body Weight: 26 Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Family History: nothing 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: 26 Length: Head Circumference (< 2 years):

Temp.: 98.6 HR: 84 RR: 22 BP: 105/64

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 Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

Siblings 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 ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☐ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to mother

Nurse's Name: ajef Date: 9/7/26 Time: 5pm

[Signature]
Signature



CHECKLIST FOR THROMBOPHLEBITIS

9/7/26

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-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 12 D (F)
Dr. P V L N MURTHY

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 08 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

4. 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: 9/7/26 @

DISCHARGE PLANNING FORM

1. Patient Name:

2. Date of Discharge:

3. Discharge Location:

4. Discharge Time:

5. Discharge Status:

6. Discharge Reason:

7. Discharge Type:

8. Discharge Location:

9. Discharge Status:

10. Discharge Reason:

11. Discharge Type:

12. Discharge Location:

13. Discharge Status:

14. Discharge Reason:

15. Discharge Type:

16. Discharge Location:

17. Discharge Status:

18. Discharge Reason:

19. Discharge Type:

20. Discharge Location:

21. Discharge Status:

22. Discharge Reason:

23. Discharge Type:

24. Discharge Location:

25. Discharge Status:

26. Discharge Reason:

27. Discharge Type:

28. Discharge Location:

29. Discharge Status:

30. Discharge Reason:

31. Discharge Type:

32. Discharge Location:

33. Discharge Status:

34. Discharge Reason:

35. Discharge Type:

36. Discharge Location:

37. Discharge Status:

38. Discharge Reason:

39. Discharge Type:

40. Discharge Location:

41. Discharge Status:

42. Discharge Reason:

43. Discharge Type:

44. Discharge Location:

45. Discharge Status:

46. Discharge Reason:

47. Discharge Type:

48. Discharge Location:

49. Discharge Status:

50. Discharge Reason:



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Adenotonsillectomy

Anaesthesiologist: Dr. Tejaswini Surgeon: BAH-00661065

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Desaturation, Laryngospasm, bronchospasm.

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Y. Maruthi Jahnavi

Name: Yellam Maruthi Jahnavi

Relationship with patient: Mother

Date & Time: 8/7/26 7:55pm

Witness:

Signature:

Name:

Date & Time:

Doctor (who is taking consent):

Signature: Dr. Tejaswini Name: Dr. Tejaswini

Date 8/7/26 Time: 7:55pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00661065 IP5-00176164
Baby LARMIKA REDDY VIPPAGUNTA
27-05-2022 4 Y 1 M 13 D (F)
Dr. P. V. L. N. MURTHY

ogy
LUATION

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Name: Larmika Reddy Vippagunta Age: 4 Y 1 M Sex: F UHID No: BAH-00661065
Date: 8/07/26 Time: 8 p.m. Proposed Operation: Adenotonsillectomy & Coblation
Diagnosis: Grade IV Adenoids
B.P / CRT: H.R: Weight: 26.7 Kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: NKA

Medical History: CVS: -

RESP: snoring (+) mouth breathing (+) Diabetes: -
CNS: - disturbed sleep pattern Term hscs. delivery
Renal: - B.Wt: 3.6 kg.
Hepatic / GE: - No NICU stay.
Others: - (+) development.
Physical Activity: Active.

Past Anaesthetic History:

Physical Exam: Chubby child.
Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mento-hyoid Distance: 2 FB Neck: (N) Teeth: intact
Lungs: BAE (+) clear
Heart: S1 (+)
CNS: -

Pregnant: ☐ Yes ☒ No ☐ NA Venous Access Site: chubby difficult. 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:
- NIL ORAL $\rightarrow$ Water / ORS 2 Hours
 $\rightarrow$ Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: CBP during cannulation

Signature: [Signature] Name: Dr. Tejaswini



ANAESTHESIA CHART

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BirthRight
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Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No

Physical Status: ☒ Patient Identified ☒ Consent Present ☒ Chart Reviewed

Fasting Status: Adequate

H.R: 116/mt B.P/CRT: 100/50 mm SpO₂: 100 % R.R: 22/mt Last Feed: 6hr

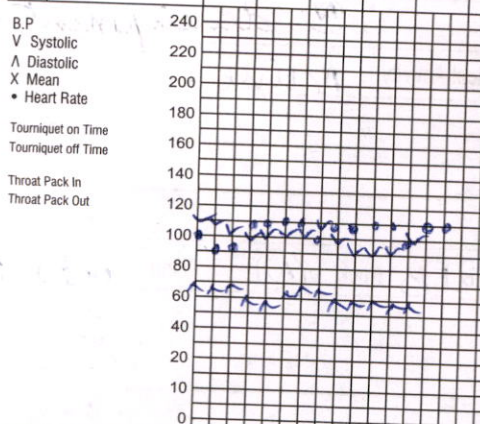
Pre-OP Diagnosis: Adenoid Hypertrophy Operation: Adenotomyllectomy Date: 27/05/2022

Surgeon: Dr. P.V.L.N. Murthy Anaesthesiologist: Dr. R.C. Di. AN Technician: Shreelaksha

TIME	6:45	7:15	7:45	8:15
N ₂ O/AIR/O ₂ LPM	100/40	100/40	100/40	100/40
HALO/ISO/SEVO	100/0/1	100/0/1	100/0/1	100/0/1
Drugs:				
MIDAZOLAM	0.5mg			
PROPOFOL	70mg			
FENTANYL	60mcg			
ROCURONIUM	12mg			
PARACETAMOL	330mg			
AS DEKAMETHASONE	2mg			
TRANEXEMICACID	200mg			

FiO ₂ (SaO ₂)	100	100	100	100	100
ETCO ₂	38	36	36	38	31
ECG	5R	5R	5R	5R	5R
Temperature	36.1	35.6	35.6	35.6	35.4
Urine Output					

Fluids	Ringer's Lactate	200ml	→	→	→	→
Blood						



LAB Values

ABG

GRBS

Others

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

Temp:

☒ HME ☐ Fluid Warmer

☐ Cling Film ☐ OH Warmer

☐ Hugger's ☐ Cotton Wool

☒ Other

Times:

Anaes Start: 8:45PM

OP Start: 8:45PM

OP End: 9:15PM

Leave OR: 9:15PM

Anaesthesia:

☒ GA

☐ Monitored Anaesthesia Care

☐ Regional

Induction

☒ IV ☐ Inhal

☐ Pre O₂ ☐ RSI

☐ Others

☐ Mask ☐ SGA

☐ Airway ☐ Oral ☐ Nasal

ETT# 4.5mm at 1 cm

☐ Oral ☐ Nasal ☐ Cuff

☐ Tracheostomy ☐ Topical

☒ Drug: Rocuronium

☐ Awake ☐ Direct Vision

☐ Video Laryngoscopy ☐ Stylette / Bougie

☐ Fiberoptic

Blade# 3 Attempts: 2

Difficulty Why?

Regional:

Extremity Specify:

☐ Spinal ☐ Epidural ☐ Caudal

Others:

Position:

Site:

Needle Size: Depth:

Parasthesia ☐ Yes ☐ No

Catheter at skin: cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to ☐ PACU ☐ ICU ☒ Other

Relaxant Reversed ☐ Yes ☐ No ☒ NA

Name of the Doctor: Dr. Anurag

Signature of the Doctor:

Line (Size & Location)

☐ CVP:

☐ ART:

☒ IV: Hand

☐ IV:

☐ IV:

☒ Bilat = BS

☐ Semi-Closed Circle

☒ Closed Circle

☐ Other



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Deef Time Received : 7:50 PM Time Discharged :

RES PULSE < BLOOD PRESSURE 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 SPO₂	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>225 R hand</u> ☐ O₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids : Oral Feeds :
	Graph showing vital signs over time. The graph has a grid with time on the x-axis and vital signs on the y-axis. Handwritten data points are plotted for PULSE, RES, and SPO₂.	

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/7	7:50 PM	1/10		Deef

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

Anaesthesiologist Name : Dr. Anneel

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 9/7/26 @ 9 PM

Reassessment Frequency:

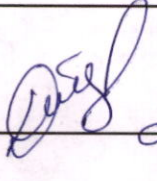
- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 145

Date & Time: 9/7/26 @ 9 PM

Date and Time :

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661065 IP5-00176164 Baby LARMIKA REDDY VIPPAGUNTA 27-05-2022 4 Y 1 M 12 D (F) Dr. P V L N MURTHY 		Date & Time of Admission 01/7/26 @ 4:30 pm	Date & Time of Transfer Order 01/7/26 @ 5:15 pm
		Transfer Ordered by Dr. Ramya	Reason for Transfer Emergency
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op file	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Gowne	①	
2.	Adult koochee	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 01/7/26 @ 5:15 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

PATIENT TRANSFER FORM

DATE OF TRANSFER 10/12/2014

FROM: Dr. Smith

TO: ER

REASON: 1114 00

① ———> Growth
② ———> Blood Pressure

Dr. Smith

Signature of Dr. Smith



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 10/7/26 Time: 7 am

Weight: 26.7 kgs Centile: > 95th

Height: 113 cms Centile: > 95th

Inference: Obese child

RDA: - Calories: 1350 kcal/d Protein: 23 g/d

Diet Recommendations: soft diet

Assessment: Avoid spicy & outside foods

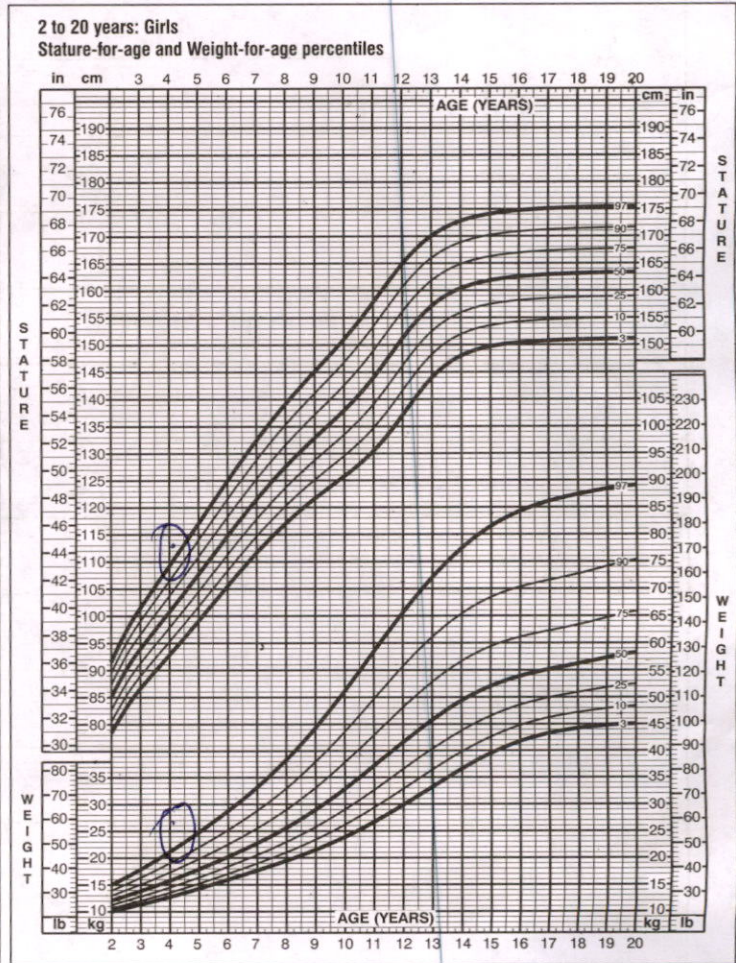
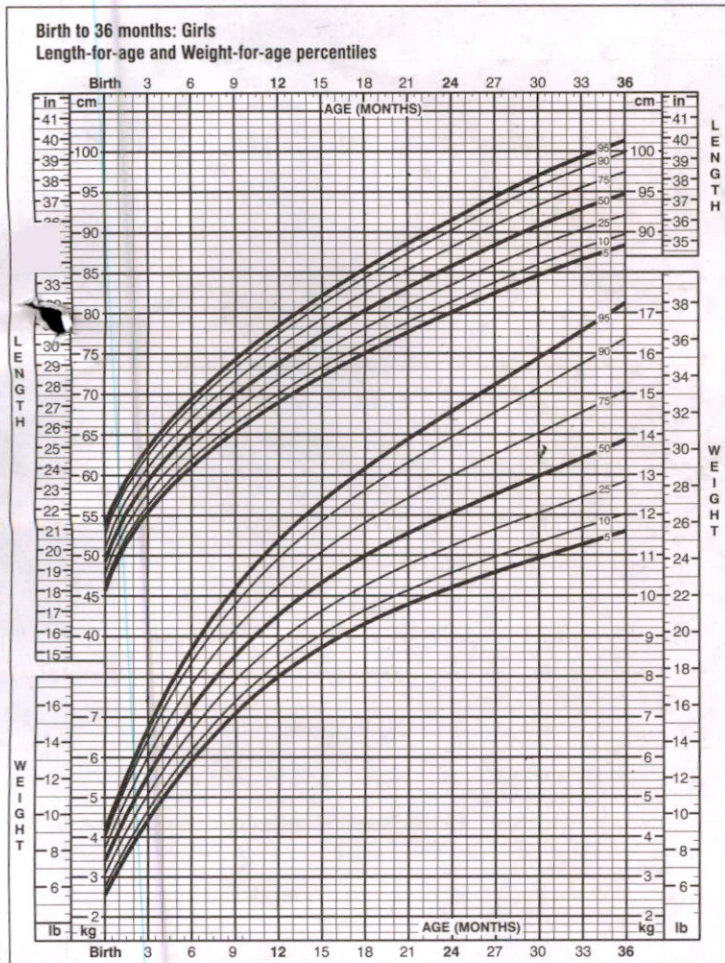
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Adenotonsillitis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Y. Vanti Jethi

GROWTH CHART (GIRLS)



Dietician's Name: Nikiitha

Dietician's Signature: Nikiitha

Daily Notes:

[Faint handwriting visible through the paper]