Patien

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

Cultred

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JRGERY DETAILS

Date : 11/7/26.

Patient Name: BABY. CHATRA SRI Date of Birth: Age: 34

Gender: F Ward : PCR - OT UHID No.: KUH-00149846

Date of Surgery: 11/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB (I) GA

Time in : 10:45 AM Time Out : 12:30 pm.

		NAME	AMOUNT
1.	Surgeon	DR NAMRATA	DP-II
2.	Anaesthetist	DR. TGTA	
3.	Assistant Surgeon	-	
4.	OT Technician	BR Renuka.	
5.	Circulating Nurse	Sr. Reejni. G	
6.	Assistant Nurse	BR. Sr ICU	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others COLLECT ~~8000~~ 4000/- TOWARDS CROWNS

Namrata
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9679894 Order by: G. Reejni

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

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dental

13Kg

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CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : 11/7 .... Time : 10.30Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5 Reinforced 4. 4.5 + 5	1+1+1	01	Major Pack Surgical pack		1	Inj Vit.K		
LMA 2	01	—	Sutures			Cord Clamp		
ECG leads : A / (P) / N	05	03				Suction Catheter		
HME filter : A (P) / N	01	01				Feeding Tube		
Syringes : 10 cc	10	09				Vaccum Suction Set		
05 cc	10	09	Gloves 6, 6½, 7, 7½	2+2+2	—	Surgical Gloves		
02 cc	10	03	PF 6, 6½, 7, 7½	2+2+2	1+1+1	Gauze Pack		
01 cc	05	—				Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil			DS 500ml	2	1
NS : (10ml) / (100ml) / 500ml / 1000ml	4+1	01	Koochies			Transfix	1	1
Mini spike	01	01	Ointments			10cc, 5cc	2+2	1+1
O2 mask (P)	01	—	Suction Catheter			Roll Gauze	1	1
Fentanyl	01	01	Cap, Mask	5/5	5/5	26 Needle	1	1
Morphine		—	Gauze Pack (RTN)	5/5	1	Lox Adreline	1	1
Ketamine		—	Mop Pack	1	1	Micro pore	1	1
Propofol	02	01	Steristrip			probe	2	2
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1				
Myopyrolate (Neo)	01+2	02	Abgel		+			
Ondansetron	01	01	Foleys catheter			Dexa Tranexa	1+1	01+1
Pencan 25g/ Spinal Needle 22		—	Urobag			Dexmed	01	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			grange gloves	4+4	03+1
Bupivacaine 0.25%(Heavy)		—	Romodrain bag					
Antibiotics Inj pure	01	—	Bandage					
P.C.M	01	01	Tegaderm					
Suppositories		—	Ioban					
Anamol : 80mg / 250mg / 170 mg		—	Double J Stent					
Supridol : 100mg		—	Vaccum Suction set	1	1			
Justin : (12.5 mg) / (25mg) / 100mg	1+1	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg		—	Betadine Solution	1	1			
Vaccum set	01	01	Microshield	1	—			
3 ways 10+100cm	1+1	01	Cotton Balls	1	—			
O.A (01)	1+1	—	Latex Gloves	10p	10p			
N.A (20, 18)	1+1	—	Ramdione Scrub					
IV Canula (22+24)	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 969792 .... Ordered by : ....

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

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Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176247 **Admit Date** : 11-Jul-2026 **Admit Time** : 08:51 AM **UHID** : KUH-00149846

Patient Details :

Patient Name	: Baby CHAITRASRI	**Age**	: 3 Y 1 M 24 D
Guardian	: Mr RAJ KUMAR	**DOB**	: 17-05-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO:3-2, OLD POST BAZAR, VILL: BALAPALA, MAN: KURAVI, DISTL MAHABUBABAD., PADMASHALIPURAM, Cathedral Compound Warangal Telangana INDIA 506381	**Phone No**	: 9121987263
		E-mail	: divya603232@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 403 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 403 **Admission Type** : First Visit

Contact Details :

Name : Mr RAJ KUMAR **Relationship** : Father

Contact Address : H.NO:3-2, OLD POST BAZAR, VILL: BALAPALA, MAN: KURAVI, DISTL MAHABUBABAD., PADMASHALIPURAM, Cathedral Compound Warangal Telangana INDIA 506381 **Phone No** : / 9121987263

Signature

Doctor Details :

Doctor Name : Dr. NAMRATA KAMALAKAR RAO KOTHAPALLI **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	9:26Am	ER	OT	Abhishek
11/7/26	1PM	OT	Billing	Sravi

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
11/07	CBP.	69322	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
04/04	iv placement PAC (op Basis)	1	7523	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : CHAITRASRI Date : 11/07/26

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

Start Time of Assessment: ..... Weight: 12 Kg

Allergic History: .....

Chief Complaints: Case of Decayed teeth & Admitted for Comprehensive Oral rehabilitation

Pediatric Assessment Triangle

A Appearance - TICLS ②

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

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

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

Any urgent interventions needed: ☐ Yes ☑ No

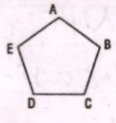
If Yes .....

Significant Past History: NICU stay for 12 days (on mechanical ventilator) Speech delay (+).

Medication History: –

Relevant Investigations: –

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Breathing

Rate: 28/min SpO_2 on ~~FiO_2~~ 98% on RA

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Rhythm: .....

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AEB

Palpation Findings (If necessary).....

Circulation

HR: 118/min | CFT — Central .... | Peripheral < 2sec | Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

BP: 90/59 (67) mmHg

Pulse Volume: — Central — Peripheral: Good

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU: ....

Pupils: — Responsive ☐ Non-Responsive ☐ — Size — Right .... — Left ....

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

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Exposure

Temp.: 97.8°F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned: ~~CBC~~ N/B Advised

Treatment Planned: NPO continue, PAC-Done. Comprehensive oral rehabilitation today w/f LDNS

Need for Oxygen: ☐ Yes ☑ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): ~~ECC~~ Decayed teeth, admitted for comprehensive oral rehabilitation

Assessment done by

Name of the Doctor: N. Prathwsen

Signature: N. Pr

Date & Time: 11/7/26, 9 am.

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

Weight. 12 kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dr. [redacted]

Weight. ..... Ward. .....

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/7/26	9 A.M	Inj PARACETAMOL	180mg	IV		Bilqui Devers.

Dr. NAMRATA KAMALAKAR RAO (F)

IP5-00176247 KUH-00149846 Baby CHAITRASRI

I.V. FLUIDS CHART

Weight. 12 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
11/2/26.	Stop	DNS	IV	40	N.[illegible]	[signature] [signature]		[signature]	[signature] [signature]
11/2/26.	10:30AM	RINGER LACTATE	IV	120.	[signature]	B.[illegible] [signature]	11/2/26		B.[illegible] [signature]

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

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 COMPREHENSIVE ORAL REHAB (I) GA .

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)
RELIEF OF PAIN AND INFECTION .	

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. NO COMPLICATIONS .

b.

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

~~Patient~~ / Patient Attendant:

Signature: .....

Name: Eerelli Rajkumar

Relationship with patient: Father

Date & Time: 11/7/26 @ 10.24 am

Witness:

Signature: .....

Name: Teena

Date & Time: 11/07/26 @ 10.25 am

Doctor (who is taking consent):

Signature: ..... Name: DR NAMRATA IC Date 11/07/26 Time: 10:22 AM

Patient Sticker

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శస్త్రచికిత్స / ప్రొసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రొసీజర్(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 / ప్రొసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రొసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రొసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రొసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రొసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచి / ప్రొసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రొసీజర్ 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: .....

SURGICAL SAFETY CHECKLIST

Surgeon : DR. NAMRATA
Asst. Surgeon :
Anaesthetist : DR TEJA
Scrub Nurse : BR BICHI

Patient Name : Bab. CHAITRASRI Age : 34 Gender : F
UHID No. : KUH-00149846 Surgery Name : ovarian cystectomy
Date : 11/7/26 In-time : 10:45A Out-time : 12:45pm

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:40AM

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 : [signature]
Name : Dr. Tejaswini

Before Skin Incision ➤➤

TIME OUT Time: 10:54 AM

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

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

Anticipated Critical Events

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

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☑ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [signature]
Name : [signature]

Before Patient Leaves Operating Room

SIGN OUT Time: 12:42pm

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 : Namrata
Name : DR NAMRATA K

Patient Sticker

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 11/7/26

To Be Filled In By Assigned Nurse :

Department : PED-OT Duration of Procedure : 1 hour

Name of Surgeon : DR NAMRATA.K Date of Admission : 11/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☑ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : —	peyjri
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	peyjri
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 : 11/7/26 at — Date & Time procedure started : 11/7/26 at 10:50 AM	peyjri

- 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

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

Patie

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OPERATION THEATER NOTES

Patient's Name : BABY. CHAITRASRI Age : 3Y Gender : ☐ Male ☑ Female

UHID No.: KUH-00149846. Weight : 12 Kg Height : .....

Surgeon : DR. NAMRATA	Asst. Surgeon : -	
Anesthetist : DR TEJU	OT Nurse: DR. BINNI	OT Technician: Ramesh.
Pre-Operative Diagnosis:		
Surgical Procedure : COMPREHENSIVE ORAL REHAB (I) GA		
Indications for Surgery : DENTAL CARIES.		
Date : 11/7/26.	Start Time : 10:30AM	End Time : 12:40PM
Pre Operative Preparations:		
Post Operative Diagnosis:		
Peri-Operative Complications:		
Operation Notes: GA (I) NASAL INTUBATION.		
1. RADIOGRAPHS EXPOSED.		
2. PULPECTOMY DONE ON # 54, 62, 64, 74, 84		
3. STAINLESS STEEL CROWN PLACED ON 54, 64, 74, 84.		
4. EXTRACTION DONE OF 52		
5. COMPOSITE RESTORATION DONE ON 53, 51, 61, 63.		
REVIEW AFTER 3 DAYS.		

SOFT FOOD FOR 3 DAYS

GENTLE BRUSHING FOR 3 DAYS.

℞

Syrup IBUGESIC (3.5ml) × 3days.
(1 — 1 — 1)

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: DR NAMRATA IC

Signature of the Surgeon: Namrata

Date & Time: 11/07/26 12:30 PM

Patien

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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POST-SURGICAL CARE PLAN FORM

Procedure Done: PULP THERAPY + CROWNS + FILLINGS + EXTRACTION

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care: BLEEDING EVERY 15 MINS

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

Namrata

Treating Surgeon
(Signature & Stamp)

Date: 11/07/26 Time: 12:30 PM

Note: Plan of care will be readjusted if necessary.

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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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 : N. Pentcoshw. N. [illegible]

Date & Time : 11/7/26, 8:50am.

Nurse Name & Signature: Abhishek

Date & Time : 11/7/26 @ 9:00Am

Docu. No. : RCHBH /FRM / GENERAL / 090

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RESULT SHEET

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

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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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.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
11/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm			101								
	01:00 pm											
Total Intake :						**Total Output :**						
11/7	02:00 pm		120	—		—	—	—	—	—	0	
	03:00 pm		120	—		—	—	—	—	—	0	
	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**	

Patient Sticker

FLUID CHART

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

Patient Name : Chaitra Sri Age : 3y Gender : Male ☐ Female ☑

UHID NO: KUH-00149846 Surgeon Name: Dr. Namrata.

Anaesthesiologist : Dr. Subramanyam.

Operative procedure planned : Comprehensive Oral Rehabilitation.

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others :

Comments : 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 Chaitra Sri the above mentioned operation / Diagnostic / Therapeutic procedures Comprehensive Oral Rehabilitation

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

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

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

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

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

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : A. Divyasree

Name : A. Divyasree

Relationship with Patient: Mother

Date & Time : 8/7/26 5:15pm.

Witness :

Signature : T Rajkumar

Name : Terelli Rajkumar

Date & Time : 8/7/26 @ 5pm

Doctor (who is taking the consent) :

Signature : Akhila

Name : DR. AKHILA. K

Date & Time : 8/7/26 5:15pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

Name: chaitra sri Age: 3y Sex: F UHID.No : KUH-00149846

Date: 8/7/26 Time: 5:15pm. Proposed Operation: Comprehensive Oral Rehabilitation.

Diagnosis: Decayed tooth.

B.P / CRT: <3sec H.R: ..... Weight: ?11kgs (to be checked) ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: NIL

Medical History: CVS : / Emesis | late PT (36 wks) | 3kgs | in NICU for 12 days.

RESP : Diabetes : on MV for few days.

CNS : Development - Motor - (N) Speech - delayed.

Renal : NIL Vaccinations → upto date.

Hepatic / GE : Physical Activity: ↓ active.

Others :

Past Anaesthetic History: NIL

Physical Exam:

Airway: MP (1) 2 3 4 Mouth Opening: 3FB. Mentohyoid Distance: 3FB. Neck: (N) Teeth:

Lungs : BAE (+) CLR

Heart: S1 S2 (+)

CNS: active

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : accessible Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis : ✓
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours } explained
   6 hrs → food, milk
   2 hrs → water / ORS.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - CBC on cannulation

Signature: (signature) Name: DR. ARHILA. K.

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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: 130/min | B.P / CRT: 88/60 mmHg | SpO_2: 100% | R.R: 18/min | Last Feed: 6hrs

Pre-OP Diagnosis: Dental caries | Operation: Comprehensive oral Rehabilitation | Date: 11/7/26

Surgeon: Dr. Namrata | Anaesthesiologist: Dr. Tejasvini | Technician: Ramesh

TIME	10:45	11:30	12 pm	12:30
N_2O /AIR /O_2 LPM	0.8L/min	/ /	/ /	
HALO /SO /SEVO				
Drugs:				
MIDAZOLAM	0.5mg			
FENTANYL	2mcg			
PROPOFOL	30mg			
ROCURONIUM	5mg			
PARACETAMOL	180mg			
NEOSTIGMINE & GLYCOPYROLATE			0.5mg 120mcg.	
FIO_2 / SaO_2	100	100	100	100
$ETCO_2$	36	39	39	39
ECG	SR	SR	SR	SR
Temperature	35.4	35.6	35.7	
Urine Output				
Fluids: RINGER LACTATE	120ml/hr.			
Blood				

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

ABG

GRBS

Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead 3 leads
☑ Temp Site skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: ROSE
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 10:45 AM
OP Start: 10:55AM
OP End: .....
Leave OR: 1?:30

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 22G (L) UL -
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 3.5 at 14 cm
☐ Oral ☑ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☑ Drug: ROCURONIUM

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 1
Difficulty Why? .....

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

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

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

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

KUH-00149846 IP5-00176247
Baby CHAITRASRI
17-05-2023 3 Y 1 M 24 D (F)
Dr. NAMRATA KAMALAKAR RAO

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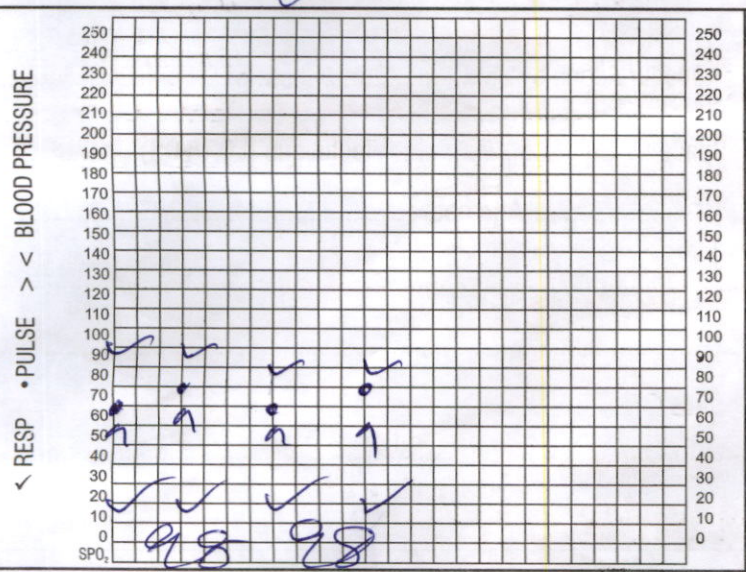
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 12:35pm Time Discharged : .....



IV Cannula Site : 22G

- ☐ 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 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	1	1	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 deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2	2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	1	1	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2		
	TOTAL	8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
17/5	12:35pm	1/10	—	

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

Anaesthesiologist Name : Dr Ameen
Anaesthesiologist Signature: .....
Date & Time: 17/5/23 @ 1pm

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 17/5/23 @ 1pm

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): billing
Date & Time: 17/5/23 @ 1pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....