BAH-00357797 IP5-00176193
Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

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SURGERY DETAILS

Date : 10/07/26

Patient Name: Advika Adhrith Date of Birth: 04-09-2012 Age: 8Y

Gender: Female Ward : P. OT UHID No.: 0357797

Date of Surgery: 10/07/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : DENTAL EXTRACTION

Time in : 10:30Am Time Out : 10:45Am

		NAME	AMOUNT
1.	Surgeon	SRINIVAS.N	DENTAL EXTRACTION X L
2.	Anaesthetist	Dr. Shabna	
3.	Assistant Surgeon		
4.	OT Technician	Vijay	
5.	Circulating Nurse	Kumari	
6.	Assistant Nurse	Bikram	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 96958472 Order by: Kumari

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Dental Extraction

CONSUMABLES OF OT

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Circulating staff : ..... Technician : ..... Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube Nasal 4, 4.5, 5	1+1+1	—	Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N	05	3				Suction Catheter		
HME filter : A / P / N	01	—				Feeding Tube		
Syringes : 10 cc	20	10				Vaccum Suction Set		
05 cc	20	4	Gloves			Surgical Gloves		
02 cc	20	—	6, 6 1/2, 7, 7 1/2	2+2	—	Gauze Pack		
01 cc	10	—	P/F 6, (6 1/2), 7, 7 1/2	2+2	1+1+1+1	Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL			Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	01	1	Koochies			Ranitidine	1	1
Mini Spike	01	0	Ointments			IOC (FCU) cc	2+2	1
O2 Mask (P)	01	—	Suction Catheter			26 log. Needle	1	1
Fentanyl	01	1	Cap, Mask	5/5	5/5	Saporate	1	1
Morphine			Gauze Pack (N)	5+5	3	Ribbon Gauge	1	1
Ketamine			Mop Pack	1	1			
Propofol	03	2	Steristrip					
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	—	Draw sheet	1	1	Adrenaline + Atropine	1+1	1+1
Myopyrolate	01	—	Abgel			Lox 2% + Telly	1+1	1+1
Ondansetron	01	—	Foleys catheter			Midaz	01	1
Pencan 25g/ Spinal Needle 22			Urobag			Dexa + Tramcee	1+1	—
Bupivacaine 0.25%			Chest Drainage Catheter			Dexmed (100 mcg)	01	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			SOC + pmo line	1+1	—
Antibiotics			Bandage			Osite + Splint 1, 3	1+1	—
IV pcm	01	1	Tegaderm			NG tubes all a	5	—
Suppositories			Ioban			Suction catheter	6	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			ETCO2 + Nasal (P)	1	1
Supridol : 100mg			Vaccum Suction set	1	—			
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	—			
Vacuum set	01	0	Microshield	1	—			
Nasal airway 16,18	1+1	—	Cotton Balls	1	—			
Oral airway 1,2	1+1	—	Latex Gloves	1	~~1~~ ~~0~~			
3 way 10cm + 100cm	1+1	—	Ramdione Scrub					
IV cannula, 22, 24	1+1	—	Saral					

Surgeon 9769595959 Anaesthesiologist Nurse OT Technician

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

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

Rainbow Children's Hospital

BirthRight Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176193 **Admit Date** : 10-Jul-2026 **Admit Time** : 08:25 AM **UHID** : BAH-00357797

Patient Details :

Patient Name	: Baby ADVIKA ADHRITH	**Age**	: 8 Y 10 M 6 D
Guardian	: MRS SHALINI	**DOB**	: 04-09-2017
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO-12-180,GOUTHAMI NAGAR Manchiriyal Adilabad Telangana INDIA 110005	**Phone No**	: 9866277678/ 9493169393
		E-mail	: SELECT.SARIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 409 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 409 **Admission Type** : First Visit

Contact Details :

Name : MRS SHALINI **Relationship** : MOTHER

Contact Address : H NO-12-180,GOUTHAMI NAGAR Manchiriyal Adilabad Telangana INDIA 110005 **Phone No** : / 9866277678

Signature

Doctor Details :

Doctor Name : Dr. SRINIVAS NAMINENI **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 : Advitha

UHID No. : _____ IP

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Dr. SRINIVAS NAMINENI

ant: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7	8:50Am	CR	OT	Ramadevi.
10/7	11:40Am	OT	billing	Dutt

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
10/7/16	CBP	8895	Dwst

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7/26	Iv Placement	1	95724	
	PAL OP			

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Advika Adhrith ~~Gowtu~~ Dr. Srinivas Date : 10/07/2026

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

Start Time of Assessment: 8.15 Am Weight: 24.1 Kg

Allergic History: NKDA

Chief Complaints:

K/C/O Ankylosis of tooth

↓

Now came for Dental extraction.

Pediatric Assessment Triangle

A Appearance - TICLS Normal

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

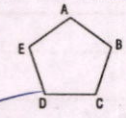
If Yes .....

Significant Past History: —

Medication History: —

Relevant Investigations: —

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Breathing

Rate: 26 bpm/min SpO_2 on FiO_2 100% RA

Rhythm: Normal

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE+, clear

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Circulation

HR: 90 b/m

CFT — Central: <3sec; Peripheral: <3sec

Any urgent interventions needed: ☐ Yes ☐ ~~No~~

If Yes .....

BP: 106/62 mmHg

Pulse Volume: Central: Good; 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: A

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 3mm; Left 3mm

Active Seizures: ☐ Yes ☑ ~~No~~ Sugars: -

Signs of Neurological compromise: -

Any urgent interventions needed: ☐ Yes ☐ ~~No~~

If Yes .....

Exposure

Temp.: 98.4°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:

Normal

Labs Planned:

CBP

NTB
sagar
10/7/26
8:55 AM

Treatment Planned:

- NPO as advised
- I.V. DNS

NTB
sagar
10/7/26
8:55 AM

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Ankylosis of tooth

Assessment done by

Name of the Doctor: Dr. Nandan

Signature:

Date & Time: 10/7/26, 8.20 AM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER ..... Shifted to: OT .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ 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 : Dr. Nandini, Dr. Nandini

Date & Time : 10/07/2026, 8.30AM

Nurse Name & Signature: Sagar

Date & Time : 10/7/26 @ 8:55 am

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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 EXTRACTION OF ANKYLOSED TOOTH.

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)
PREVENT IRREGULARITY	NONE

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.

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: Shalini
Relationship with patient: mother
Date & Time: 10/7/26 @ 9.54 AM

Witness:
Signature: .....
Name: Teena
Date & Time: 10/7/26 @ 9.30 a.m

Doctor (who is taking consent):
Signature: ..... Name: SRINIVAS.N Date 10/7 Time: 9.30 a.m

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Srinivas
Asst. Surgeon :
Anaesthetist : Dr Chandram
Scrub Nurse : Rekha

Patient Name : Advika Age : 8 Y Gender : F
UHID No. : 357297 Surgery Name : Dental Extract
Date : 10/09/17 In-time : 10:30 AM Out-time : 10:45 AM

BAH-00357797 IP5-00176193
Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 10:22 AM

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- 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 : SC

Name : Dr SHARON.

Before Skin Incision ➤ ➤

TIME OUT Time: 10:38 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? None ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews: None

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 : Rekha

Name : Rekha

Before Patient Leaves Operating Room

SIGN OUT Time: 10:40 AM

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

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

Signature :

Name :

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Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : .....

To Be Filled In By Assigned Nurse :

Department : ..... Duration of Procedure : .....

Name of Surgeon : ..... Date of Admission : .....

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 :	
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	
3.	Patient's body temperature immediately post operation (Recovery Room)_____ ^{0}C ☐ Oral Or ☐ Axilla (Goal : 36-37 ^{0}C)	
4.	Name of doctor or staff administering the antibiotic : ..... Date & Time of antibiotic administration : ..... Date & Time procedure started :	

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

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OPERATION THEATER NOTES

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

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

Surgeon :		Asst. Surgeon :
Anesthetist :	OT Nurse:	OT Technician:

Pre-Operative Diagnosis:

Surgical Procedure : EXTRACTION OF TEETH ~~ANKYLOSED MOLAR~~

Indications for Surgery :
ANKYLOSED MOLAR

Date :	Start Time :	End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:
IV IV SEDATION
EXTRACTION of 75, 74, 73 61

SOFT DIET
GENTLE BRUSHING
RT IBW IN 3 DAYS.
BY
IBU & DSIC - 1-0-1 x 3 DAYS.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: .....

Signature of the Surgeon: SRINIVAS.N

Date & Time: .....

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04-09-2017 8 Y 10 M 6 D (F)
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POST-SURGICAL CARE PLAN FORM

Procedure Done: DENTAL EXTRACTION

Post-Surgical Diagnosis: ....

Post-Operative Monitoring Parameters /Frequency:
CHECK BLEEDING EVERY 15 MIN

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.

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04-09-2017 8 Y 10 M 6 D (F)
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DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name ..... Signature

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Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

REGULAR PRESCRIPTIONS

Weight. 24.95 kg Ward. ....

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

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

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

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

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Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

Weight. 24.95kg Ward. .....

DRUG :	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
10/7/26	10.30am	PAPACE Tablet	40mg	IV		

Signature

VERIFIED BY : Name

Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

I.V. FLUIDS CHART

Weight. 24.95 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
10/7/2	8.25 AM	IVF. DNS	IV	65 ml/hr	[signature]		Not connected		

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

Patient

BAH-00357797 IP5-00176193
Baby ADVIKA ADHRITH
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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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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04-09-2017 8 Y 10 M 6 D (F)
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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							
	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	

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**	

BAH-00357797
Baby ADVIKA ADHRITH (F)
04-09-2017 8 Y 10 M 6 D
Dr. SRINIVAS NAMINENI

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Dental Extraction

Anaesthesiologist: Dr. Tejasvini Surgeon: Dr. Srinivas Namineni

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

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: Shalini
Name: Shalini Lingam
Relationship with patient: mother
Date & Time: 8/7/26 5:45pm

Witness:
Signature: Sagar
Name: Sagar
Date & Time: 18/7/26 @ 8:55 pm

Doctor (who is taking consent):
Signature: Name: Dr. Tejasvini Date 8/7/26 Time: 5:45pm

Patient Sticker

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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 అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ 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 నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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.
  ☐ లీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ 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 స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

BAH-00357797 IP5-00176193
Baby ADVIKA ADHRITH
04-09-2017 8 Y 10 M 6 D (F)
Dr. SRINIVAS NAMINENI

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby Advika Adhrith Age: 8Y6M Sex: Female UHID.No : BAH-00357797

Date: 8/7/26 Time: 5:35 pm Proposed Operation: Dental Extraction.

Diagnosis: Ankylosis of tooth.

B.P / CRT: ..... H.R: ..... Weight: 24.95kg 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: NKDA.

Medical History: CVS : H/O ASD at 1 to 2yrs of age was asymptomatic, currently ECG (N)

RESP : URTI (-) Diabetes : -

CNS : H/O seizures @ 3 yrs of age used MV for 3 years; currently ab

Renal :

Hepatic / GE : -

Physical Activity: Active.

Others : -

Past Anaesthetic History: -

Physical Exam: (N)

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

Lungs : BAE (+) clear

Heart: S1 S2 (+)

CNS: HMF (+).

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
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   CBP during cannulation.

Signature: ..... Name: Dr. Tejaswini

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No — Fasting Status: adequate

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

H.R: 98 | B.P / CRT: 94/45 | SpO_2: 100 | R.R: 20 | Last Feed: >6h

Pre-OP Diagnosis: Ankylosis of tooth Operation: Dental Extraction Date: 10/7/26

Surgeon: Dr Srinivas Anaesthesiologist: Drs RS/Dr Shalu Technician: Vijay

TIME 10.30 *

N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:
Iv-MIDAZ 0.5
Iv FENTANYL 50 mcg
Iv PROPOFOL 60+20
PARACETAMOL 300mg
FIO_2 / SaO_2 100 100 100
$ETCO_2$
ECG SR SR SR
Temperature
Urine Output
Fluids
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. R arm
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 10.30am
OP Start: .....
OP End: .....
Leave OR: 10.45am

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: L hand 22
☐ IV: .....
☐ IV: .....

Induction
☐ IV ☐ Inhal O_2 via nasal
☐ Pre O_2 ☐ RSI mask
☐ Others

☐ Mask ☐ SGA O_2 via nasal
☐ Airway ☐ Oral ☐ Nasal mask
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

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

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

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

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor: Dr Shalu
Signature of the Doctor: .....

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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : [signature] Time Received : 10:50 Am Time Discharged : 11:30 A

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: ...

✓ RESP • PULSE > < BLOOD PRESSURE (chart 0–250); SPO₂: 98, 98

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

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/7	10:50A	1/10	—	[signature]

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

Anaesthesiologist Name : DR. TEJASVINI
Anaesthesiologist Signature: [signature]
Date & Time: 10/7/26 11:A
PACU Nurse Name : [signature]
PACU Nurse Signature: [signature]
Date & Time: 10/7/26 @ 12pm

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): [signature]
Date & Time: 10/7/26 12pm

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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 : .....