

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



SmithNephew
EVAC° 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2203235
2028-11-06

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 6/7/26

Patient Name: Mr. Sai Akshith Reddy Date of Birth: 24-9-2008 Age: 17 Y

Gender: Male Ward: P.O.T UHID No.: BAH-00657356

Date of Surgery: 6/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Adenotomectomy + Tonsillectomy + Septoplasty + FESS

Time in: 5:30pm Time Out: 7:45pm

NAME

AMOUNT

- Surgeon : P V L N MURTHY
- Anaesthetist :
- Assistant Surgeon :
- OT Technician : Amaan
- Circulating Nurse : Sravani
- Assistant Nurse : Suman. Surata

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : Cobulator - 29691023

Signature of the Surgeon

Signature of Circulating Nurse

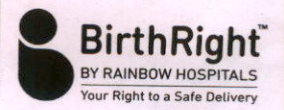
Order No: 9691022

Order by: Kalyan

BAH-00657356
IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



Adeno + Tushi + septo
3760
CONSUMABLES OF OT
Technician : Date : Time : 4pm



Anaesthesia Disposables			Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
	Issued	Used				Issued	Used				Issued	Used
ET tube 6.0, 6.5, 7.0	14/1	01	Major Pack Drape			1	1	Inj Vit.K 27/18			1	1
LMA 3.4	4/1	-	Sutures					Cord Clamp				
ECG leads A/P/N	5	3	4.0 27/18			1	1	Suction Catheter				
HME filter A/P/N	1	01						Feeding Tube				
Syringes : 10 cc	10	5						Vaccum Suction Set				
05 cc	10	5	Gloves					Surgical Gloves				
02 cc	10	5	6.0 1/2 27/18			2/2	1	Gauze Pack				
01 cc	2	1	pr 6.0 1/2 27/18			2/2	1	Syringe 1ml / 2ml				
Cautery plate A/P/N	1	-	Surgical blade 15			1	1	Surgical Blade # 20				
IV set	1	01	NG tube			2	2	Koochies (S)				
RL	1	01	Cautery pencil			1	-	NS sponul			1	2
NS : 10ml / 100ml / 500ml / 1000ml	2+2+2	1+1+1	Koochies Sepgard				1	Transderm			1	1
09 nose (A)	1	1	Ointments					1001, 1001, 1001			2/2	3
Alpraxam 2-3	1/1	-	Suction Catheter					sanul			1	1
Fentanyl	1	01	Cap, Mask			5/5	10/10	Inj. Ashal			03	5
Morphine			Gauze Pack			5/5	2/1	Rubidol drops			1	-
Ketamine			Mop Pack			1	1	Nasal spray			1	1
Propofol	3	02	Steristrip									
Rocuronium	1	01	Underpad			1	1	Turcamla 20.18			1/1	-
Glycopyrolate	1	-	Draw sheet			1	1	Dexa			1	01
Myopyrolate	1	01	Abgel					Tromexa			2	01
Ondansetron	1	-	Foleys catheter					minispine			1	01
Pencan 25g/ Spinal Needle 22			Urobag					Dextomide 100			1	01
Bupivacaine 0.25%	1		Chest Drainage Catheter					Clonidine			1	-
Bupivacaine 0.25% (Heavy)			Romodrain bag					mfdcl 2			1	01
Antibiotics Augmentin 1.2	1	01	Bandage					metapraul			1	-
			Tegaderm					Nasolarynx 28.30			1/1	1
Suppositories			Ioban					50cc + pmoline			1/1	-
Anamol : 80mg / 250mg / 170 mg			Double J Stent					8g Diclo			01	01
Supridol : 100mg	1	-	Vaccum Suction set			2	2	Eugenader			01	01
Justin : 12.5 mg / 25mg / 100mg	2/1	-	Plastic Bed Sheet			1	-					
Tab. Misoprost : 200mg			Betadine Solution			1	-					
Vaccum Set	1	01	Microshield			1	-					
Gauze	3	01	Cotton Balls			1	-					
Gloves	4	-	Latex Gloves			1	1					
Sup.pcm	1	01	Ramdone Scrub									
3-way 100+10cc	1/1	01	Saral									

Surgeon : Anaesthesiologist : 96902856 Nurse : OT Technician :
Order No. : Ordered by :
Doc. No. : RCH / FRM / GENERAL / 125

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 :

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176041

Admit Date : 06-Jul-2026

Admit Time : 03:02 PM **UHID** : BAH-00657356

Patient Details :
Patient Name : Mr KANCHARLA SAI AKSHITH REDDY

Age : 17 Y 9 M 12 D

Guardian : Mr KANCHARLA ASHOK REDDY

DOB : 24-09-2008

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : PLOT NO-55, FLAT NO-204, HIG HUDA
 COLONY Chandanagar Hyderabad Telangana
 INDIA 500050

Phone No : 7386749500/ 9491875960

E-mail : 7386749500@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 KANCHARLA ASHOK REDDY

Relationship : Father

Contact Address : PLOT NO-55, FLAT NO-204, HIG HUDA
 COLONY Chandanagar Hyderabad Telangana
 INDIA 500050

Phone No : / 7386749500

X. Ashok Reddy
 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

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Charge : _____ Time: _____

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

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	3:45 PM	ER	OT	B
6/7	9 PM	OT	236	Ky

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Faisal B	7/7/26	9691427	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00857356 IPS-00178041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY

Patient Name:

K. SAI AKSHITH REDDY

UHID ID:

Department:

Consultant:

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 68.12 (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 66/min B.P. 123/84 (78) SpO2 98.5% RA
Resp. rate and type of breathing : 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Alertness intact 10/10

Adenopathy in axilla & groin, B/L Tuberous sclerosis ±

Syphilis

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

infection

Desired goals of the treatment : _____

Resolution of symptoms

Planned Labs:

Cep-Done - outside

Planned Management

NPO Continue

PAC-Done

WF-DNS

Sx - Adenotonsillectomy + coblation

3L Turbinateptomy + septoplasty

NIB

*Results
6/7/26*

Signature of the Doctor: _____

N. Per

Name of the Doctor: _____

N. Per

Date & Time: _____

6/7/26, 3pm

Signature of the Consultant: _____

*DR. P V L N MURTHY
Registration No: 47267*

Name of the Consultant: _____

DR. P V L N MURTHY

Date & Time: _____

DR. P V L N MURTHY



OPERATION THEATER NOTES

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

UHID No. : Weight : Height :

Surgeon : PVLN Murthy Asst. Surgeon :

Anesthetist :

OT Nurse :

OT Technician :

Pre-Operative Diagnosis: Ch. Adeno tonsillitis + ALT + DNS Eddy + CRS

Surgical Procedure : Adeno tonsillectomy + Ectomy
BLC tuberosplasty + septoplasty +

Indications for Surgery : Apne Excision + FESS

Date :

Start Time :

End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Adeno tonsillectomy + Ectomy
BLC tuberosplasty
+ septoplasty + Apne Excision
FESS (1) Maxillary sinusotomy



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

7/7/28 (P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26	<u>S/B Resident</u>	
	D: chronic adenotonsillitis + H1 + + DNS C spray + CRS.	
		<u>Plan.</u>
	S/P Adenotonsillectomy + Coablation	① continue medication
	B/L turbino plasty + septoplasty + spur Enucleation + FESS	② monitor vitals
	encourage oral intake	③ Report Bleed/SOS
	mild bleed	<u>Soluh</u>
	hemodynamically stable	
	vitals : stable	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CROSS CONSULTATION FORM

Doctor Name : Dr. Faisal N Date : 7/7/26 Time : 9am

Diagnosis :

Hospital :

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:

Aderotomectomy & Coablation
Tubomplasty / Septoplasty

Spun Accoun Signature: [Signature]

Findings and Recommendations :

Could post surg
Cerv stand
Alecub
No vomit
Bleedy reports

Plan
Cerv disfigured
femoral sed.

Consultant :

Name : Mr N Signature : [Signature] Date & Time : 7/07/26

BAH-00857356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



①

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	27/6/26				
Time					
Hb	15.4				
PCV	45.5				
RBC	5.5				
WBC					
N/L	65/26				
Platelets	263000				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

BAH-00657356 IP5-00176041
Mr. KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY

Patient



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: 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. Perumal - N.P.

Date & Time: 06/11/20, 3pm.

Nurse Name & Signature: Penurka

Date & Time: 06/11/20 & 3:00pm.

Dept. Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
2 Puffs	nasal	TID	06/07	617 717 X
Name & Signature of the Doctor Starting the Drugs:				2pm X
Additional Instructions:				10pm X
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				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Dept. 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																				

VERIFIED BY : Name Signature

BAH-00657356 IP5-00176041
 Mr KANCHARLA SAI AKSHITH REDDY
 24-09-2008 17 Y 9 M 12 D (M)
 Dr. P V L N MURTHY



DRUG CHART

Date of Admission: 6/7/26 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



REGULAR PRESCRIPTIONS

Weight. 68.12 Kg. Ward.

DRUG : TAB AUGMENTIN D				Date Time	06/07	07/07														
Dose	Route	Frequency	Start Date																	
625mg	P/O	BID	06/07	10am	X	11am														
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				10pm Dip 11pm																
Daily Doctor's Endorsement by a Sign																				
DRUG : T. XYZAL M				Date Time	06/07	07/07														
Dose	Route	Frequency	Start Date																	
5mg	P/O	BID	06/07	10am	X	11am														
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				10pm Dip 11pm																
Daily Doctor's Endorsement by a Sign																				
DRUG : T. HYFENAC P				Date Time	06/07	07/07														
Dose	Route	Frequency	Start Date																	
1 tab	P/O	BID	06/07	10am	X	11am														
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				10pm Dip 11pm																
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB TRAMEXA				Date Time	06/07	07/07														
Dose	Route	Frequency	Start Date																	
1 tab	P/O	BID	06/07	10am	X	11am														
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				10pm Dip 11pm																
Daily Doctor's Endorsement by a Sign																				

Weight. 68kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
6/1/16	8:40 PM	INT DEYANCTHANE	4mg	W	[Signature]	[Signature]
6/1/16	5:41 PM	INT TRANAXAMIC ACID	1g	W	[Signature]	BAPA Sree
6/1/16	5:45 PM	INT DICLOFENAC	75mg	W	[Signature]	BAPA Sree
6/1/16	5:00 PM	INT PARACETMOL	1g	W	[Signature]	BAPA Sree



I.V. FLUIDS CHART

Weight. 68.12 kg Ward.

[illegible]



AH-00657356
NPO-9AM (Solid)

NPO 8:40am

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Maat. Sai Akshith Reddy Age : 174 Gender: ☒ Male ☐ Female
Date : 6/10/2026 Time of Arrival : 1:17pm Triage Completion Time : 1:18pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify)
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Vital Signs: Temp: 98.2°F PR: 66/101 BP: 123/84 (78) RR: 22/101 SpO₂: 100%
Chief Complaints: Camp for Adenobulbar + Turbinoplasty on septoplasty

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☒ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

X Release Patient
Signature of Parent / Guardian

Communicable Disease Triage Screening

RT A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Arav Singh

Signature of Triage Nurse : Arav Singh

Date & Time : 6/10/2026 at 1:18pm

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 06/07/20 Time of arrival : 12:20 PM
Chief Complaints : came for Adenotonsillectomy + rhinoplasty on septorhasty RBS : NA
Height : Weight : 68.12 kg BMI : Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify : NO
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☒ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair
- Uses furniture for support

☐ Yes ☒ No

☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

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
- Feeding Problem
- Special diet
- Special feeding method

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 family

Siblings in household ☒ Yes ☐ No (if yes How Many?) 1 (Sister)

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NO Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 12:22 PM

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
3:10pm	→ Assess the child condition.
	→ Seeing Dr - Prathibha.
	→ vitals are recorded.
	→ FU placement done.
	→ samples done in op BODS.
	→ shifted to OT.

Samples collected by: / NA
 Samples sent by: / NA

Time: / NA
 Time: / NA

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 66b/min BP: 123/84/63 CFT: 2 sec RR: 24b/min SPO ₂ : 100% GCS: 15/15 Temperature: 98.6° Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: OT. Time of Shift - out: 3:40pm Handover given to: Teena (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

— FU placement done —

Name of the Nurse : Renuka Signature of the Nurse : R

Date & Time : 6/7/2018 1:30pm

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00857356 IP5-00176041
Mr. KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



Telugu Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education

- | | | | |
|----------------------------|--|--|---|
| 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		
06/07/18	3:20 PM	8	procedure	M	4	0	1	1	-	Penel

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/26/2026 3:20 PM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	MONITOR VITAL	H- STABLE	- Sx - IV fluids	<i>[Signature]</i>	☐ Nursing ☐ Others:
6/27/26 3:30 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adeno	H- stability	IV fluids	<i>[Signature]</i>	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4pm Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKA Body Weight: 67kg Kg

Height: — cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>Circumcision</u>	<u>Circumcision</u>

Family History: Nothing Signs of recent

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: 67kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4°F HR: 88b/m RR: 28b/m BP: 90/50mmHg

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 1 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 21) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain — Location — Frequency — Duration —

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

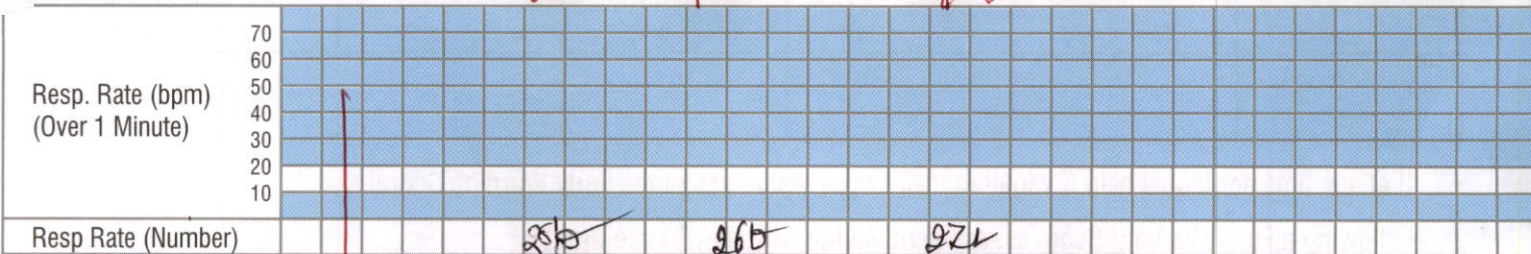
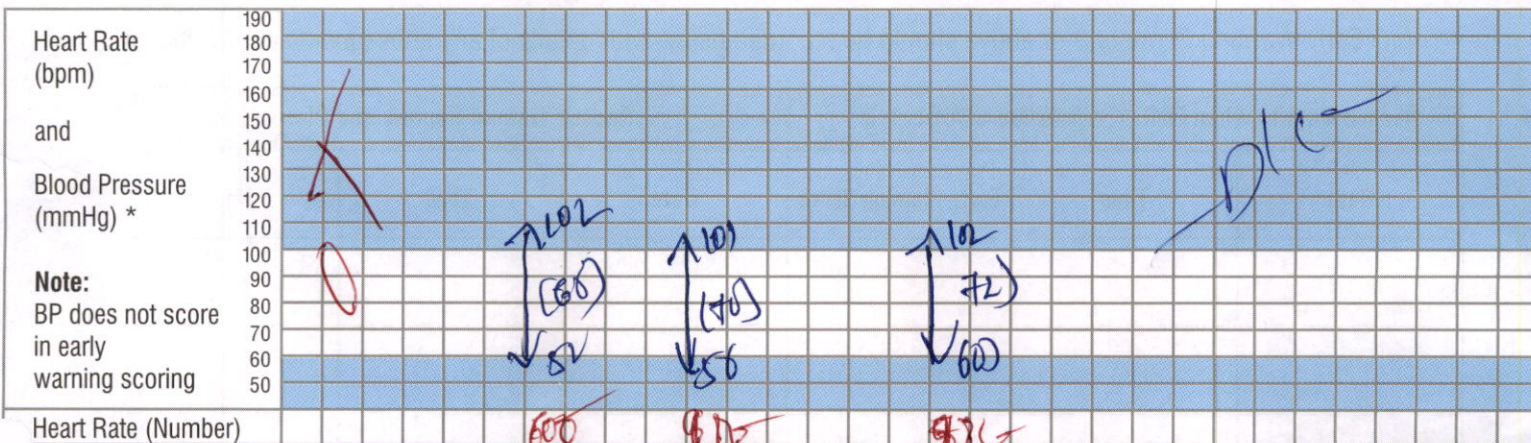
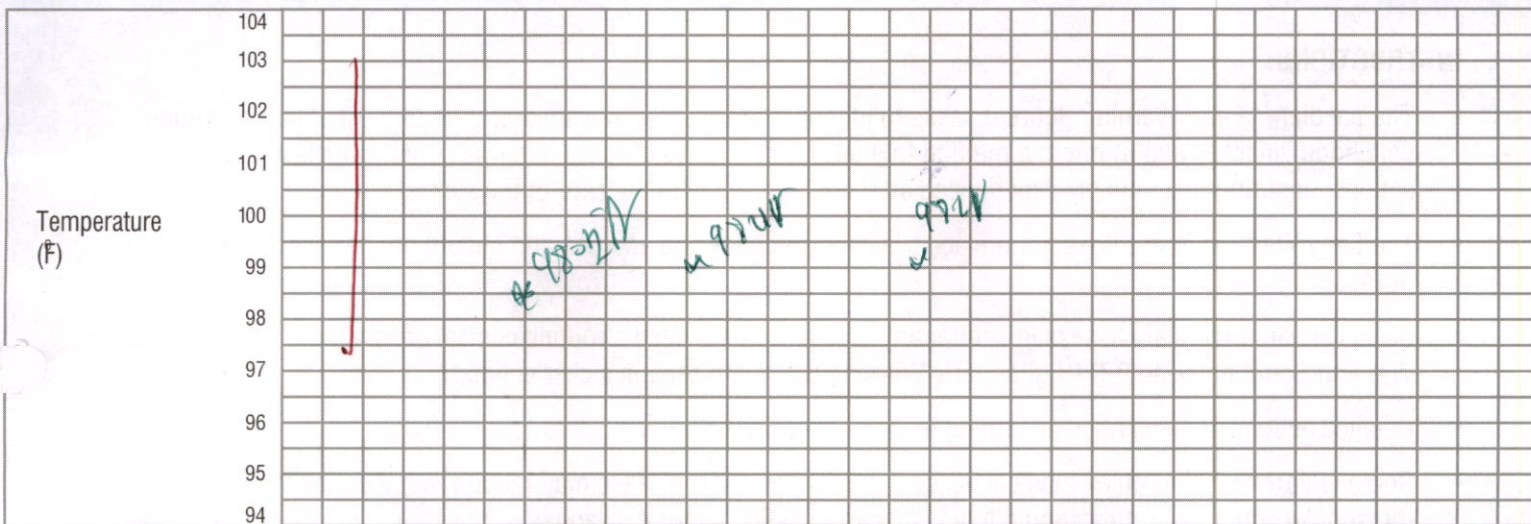
Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *Parents*Siblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *Mother*Nurse Signature: *[Signature]*Nurse Name: *Reena*Date: *6/7/26*Time: *4pm*



TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10pm	2AM	6AM
Doctor / Nurse / Family Concern?				



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
Observer's Initials		

ACTIONS 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)

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
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

FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
8/9	08:00 pm	mp water	water	-	-	-	-	-	-	-	0	20
	09:00 pm	mp water	-	-	-	-	-	-	-	-	0	20
	10:00 pm	mp water	-	-	-	-	-	-	-	-	0	20
	11:00 pm	mp water	-	-	-	-	-	-	-	-	0	20
	12:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	01:00 am	mp water	-	-	-	-	-	-	-	-	0	20
Total Intake :						Total Output :						
2/9	02:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	03:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	04:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	05:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	06:00 am	mp water	-	-	-	-	-	-	-	-	0	20
	07:00 am	mp water	-	-	-	-	-	-	-	-	0	20
Total Intake :						Total Output :						
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							

BAH-00657356 IP5-00176041
 Mr KANCHARLA SAI AKSHITH REDDY
 24-09-2008 17 Y 9 M 12 D (M)
 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 ☒ noon ☒ Night

Date: 6/5/26

Assessment: pain related to surgery as evidenced by tonsillectomy

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
	Assess the pt condition monitor vitals maintain I/O chart provide comfortable position provide cold & soft diet Administer medication as per chart		Assessed the pt condition monitored vitals maintained I/O chart. provided comfortable position provided cold & soft diet administered medication as per chart	After plan of care pt condition Improved

Re-Assessment:

Special Notes: pain Reduced cold & soft diet

Nurse Signature: *[Signature]*

Nurse Name: Kalyan

Date & Time: 6/5/26 @

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 PM	* Assess The pt General condition	8:10 PM	* Assessed The pt General condition	All plan are Implemented
12 AM	* ensure safety.	12:10 AM	* provided side rails	
11 AM	* Maintain fluid balance	11:10 AM	* Maintained fluid balance	
6 AM	* Maintained personal hygiene	6:10 AM	* Maintained personal hygiene	
8 AM	* Administer medication as per doctor orders	8:10 AM	* Administered medication as per doctor orders	

Re-Assessment: Re-Assessment was done

Special Notes: WIP bleeding

Nurse Signature: [Signature]

Nurse Name: Swathi

Date & Time: 7/7/26 @ 8 AM

Patient:

BAH-00857356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
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

NURSING T HAND OVER FORM - WARD

Treating Doctor: Dr. Murthy Department: _____ Date of Admission: 06/07/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>Adenotonsillectomy</u>		If Yes Specify: _____				
BACKGROUND	Area	Shift Time	<u>24hr</u>	<u>8hr</u>	<u>8hr</u>		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>		
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:	<u>98.2°F</u>	<u>98.3°F</u>	<u>98.2°F</u>		
		Res:	<u>24b/min</u>	<u>20b/min</u>	<u>29b/min</u>		
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>98%</u>		
		Pulse:	<u>66b/min</u>	<u>66b/min</u>	<u>70b/min</u>		
		BP:	<u>123/62</u>	<u>123/62</u>	<u>122/60</u>		
		Fall Risk Score:	<u>9</u>	<u>9</u>	<u>9</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>See order</u>	<u>Yes</u>	<u>Yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Renuka</u>	<u>Kalyan</u>	<u>Swathi</u>			
Signature :		<u>R</u>	<u>K</u>	<u>S</u>			
Date:		<u>06/07/20</u>	<u>07/07/20</u>	<u>07/07/20</u>			
Time:		<u>3:45pm</u>	<u>2:45pm</u>	<u>07:00am</u>			
Taken Over By Name :		<u>Teehan</u>	<u>Swathi</u>	<u>Mounika</u>			
Signature :		<u>T</u>	<u>S</u>	<u>M</u>			
Date:		<u>07/07/20</u>	<u>07/07/20</u>	<u>07/07/20</u>			
Time:		<u>07:00pm</u>	<u>07:00pm</u>	<u>08:00am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

Patient Sticker

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



PAIN ASSESSMENT FORM

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign		
6/10	3:20pm	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Remed
6/10	8pm	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	PR	Sweet
6/10	11pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	F-Hypenacp given	Sweet
7/7/20	12AM	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	PR NO	Sweet
				☐ 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:

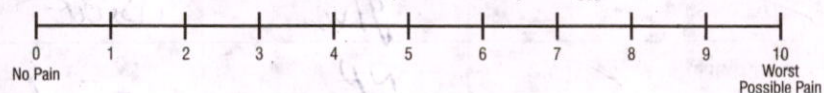
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

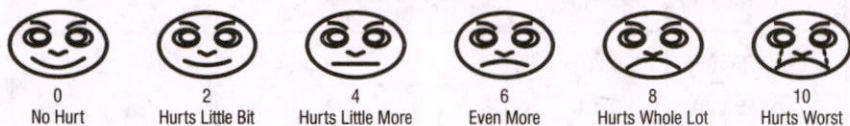
Numerical Pain Scale (Obstetric and Gynecology)



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

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



				Date : 21/11/21 Time : 3:20 PM			
Mobility	in body or position without assistance.	1. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	2. 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					Dentula		

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



CHECKLIST FOR THROMBOPHLEBITIS

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							
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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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 : Kalyan

Signature of Ward In Charge :

Signature : [Signature] Name : Kumari

BAH-00657356 IP5-00178041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
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

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1	1			
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	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			9	9			

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	yes	no			
Other Intervention(s) Specify	yes	no			
Nurse's Name :	Nenuk S. S. S.				
Signature :	E. S.				
Date :	6/12/20				
Time :	3:00 PM				

PRE - OPERATIVE CHECK LIST



Date: 06/07/26

Patient's Name: SAI AKSHITH REDDY Age: 17y/9m Gender: ☒ M ☐ F
Blood Group: UHID: BAH-00657356
Planned Surgery: Appendicectomy Surgeon: Dr. P.V.L.N. Murthy
Anesthetist: Dr. Subramanyam Date & Time of Operation: 06/07/26 @

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

S.No.	INSTRUCTIONS	ER/Ward,Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1	Weight checked recorded ? wt:- 68-12 Kg	☒	☐	☐	☒	☐	☐
2	Is the patient fasting for over 6 hours Pre-Operatively ?	☒	☐	☐	☒	☐	☐
	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screening, CXR etc) Available before starting the procedure	☒	☐	☐	☒	☐	☐
4	Enema given / Bowel Preparation	☒	☐	☐	☒	☐	☐
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☒	☐	☐	☒	☐	☐
6	Sterile Gown Given	☒	☐	☐	☒	☐	☐
7	Is Blood arranged as required ?	☒	☐	☐	☒	☐	☐
8	If Blood has been ordered - is Blood bag ready ?	☒	☐	☐	☒	☐	☐
9	IV Cannula to be placed / IV fluids if Indicated RI-	☒	☐	☐	☒	☐	☐
10	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐	☒	☐	☐
11	Pre Medications Given ? (Sedatives / etc)	☒	☐	☐	☒	☐	☐
12	Skin Preparation	☒	☐	☐	☒	☐	☐
13	Site is marked	☒	☐	☐	☒	☐	☐
14	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☒	☐	☐	☒	☐	☐
15	Implants are available	☒	☐	☐	☒	☐	☐
	Equipment is available (Eval)	☒	☐	☐	☒	☐	☐
17	Antibiotic Prophylaxis is given within the last 60 minutes	☒	☐	☐	☒	☐	☐
18	Other (if any)	☒	☐	☐	☒	☐	☐

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : OT Nurse Name : Teena ER/Ward Nurse Name : Tanya

Billing Executive Signature : Signature of OT Nurse : Signature of ER/Ward Nurse :

Date & Time : 2-12-2021, Survey No: 403, Beside Park Date & Time : 6/7/21 Date & Time : 06/07/26

Road No. 2, Banjara Hills,
Hyderabad - 500034, Telangana
Phone No: 040-44885465

335
3pm

340



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. Adenotomectomy + Coblation + B/C Tuberoplasty
2. + septoplasty + ESS

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Good procedure</u>	

- 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. Bleeding, Change in shape of nose, Septal
b. perforation

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

Patient / Patient Attendant:

Signature: [Signature]
Name: K. Hemalatha
Relationship with patient: Mother
Date & Time: 6/7/26 @ 5:11 PM

Witness:

Signature: [Signature]
Name: Y. Ramadevi
Date & Time: 6/7/26 @ 5:12 PM

Doctor (who is taking consent):

Signature: [Signature] Name: P V L N MURTHY Date: 6/7/26 Time: 5:10 PM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్టీషియా 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.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



BAH-00657356 IPS-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY

Name: Mr. K. Sai Akshith Reddy Age: 17Y Sex: Male UHID.No: BAH-00657356
Date: 04/07/26 Time: 6:10 pm Proposed Operation: Adenotomyllectomy & Coblation B/L Turboplasty ± septoplasty
Diagnosis: DNS, Adenoiditis, sinusitis
B.P / CRT: H.R: Weight: 67kg 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:

Medical History: CVS: -
RESP: - H/O Snoring, mouth Breathing Diabetes: -
CNS: -
Renal: -
Hepatic / GE: -
Others: - Physical Activity: METS > 6

Past Anaesthetic History: Circumcision ? GA → U/E
Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mento-hyoid Distance: (M) Neck: (N) Teeth: Intact
Lungs: B/L AEF
Heart: S1 S2
CNS: Conscious, oriented
Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site: Accessible 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:

1. DVT Prophylaxis: Explained
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 on cannulation
Consent Withnesh pending

Signature: DR SHINY Name: DR SHINY

Patient Sticker

ANAESTHESIA CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status:

Confirmed

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R: 67 BPM

B.P / CRT: 120/80 alt

SpO₂: 99%

R.R: 18 BPM

Last Feed:

6hr

Pre-OP Diagnosis:

Adenotonsillar Hypertrophy

Operation:

Adenotonsillectomy

Date:

6/1/25

Surgeon:

DR MURTHY

Anaesthesiologist:

DR K RINAMYA

Technician:

VANIKA

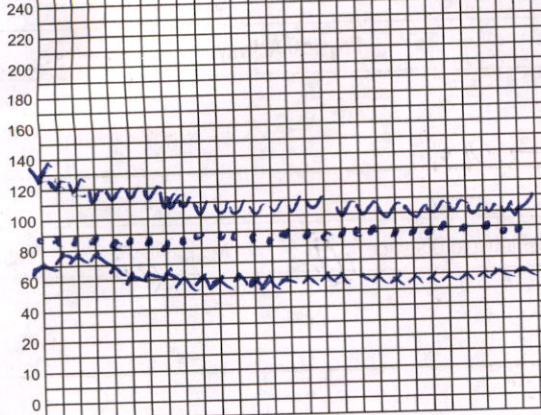
TIME
N₂O AIR O₂ LPM
HALO / SO / SEVO
Drugs:

INTIMIDAZOLAM 2mg
GNS FENTANYL - 100mcg
GNS PROPOFOL - 100mg + 20mg
GNS DEVOXATONAM - 1mg
GNS ROCURONIUM - 1mg
GNS TRANAXAMIVICID - 1mg

FiO₂ / SaO₂ 100 100 99 100 100 100 100 100
ETCO₂ 32 32 32 32 32 32 32 32
ECG
Temperature
Urine Output

Fluids
Blood 10ml → 10ml

B.P
V Systolic
A Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out



LAB Values

ABG
GRBS
Others

☒ Equipment Checked and Functional
☒ BP
☒ Cuff Site
☒ Art Site
☒ EKG Lead
☒ Temp Site
☒ FiO₂ 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: 8:30 PM
OP Start: 1
OP End: 9:45 PM
Leave OR: 9:45 PM

Anaesthesia:

☒ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)

☐ CVP:
☐ ART:
☒ IV: AT. Dorsal
☐ IV:
☐ IV:

Induction

☒ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 7 at 21 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☒ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 3 Attempts: 1
Difficulty Why?

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

Regional:

Extremity
☐ Spinal ☐ Epidural ☐ Caudal

Others:

Position:

Site:

Needle Size: Depth:
Paresthesia ☐ Yes ☐ No
Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

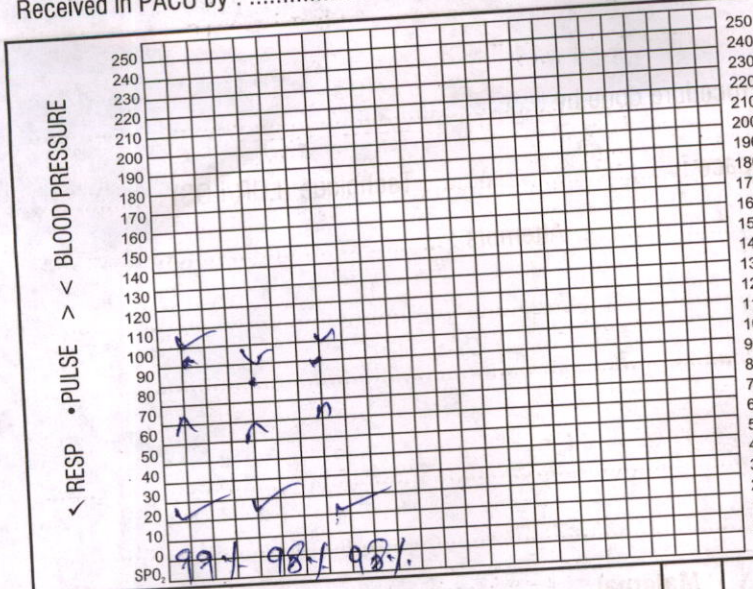
Name of the Doctor:

Signature of the Doctor:

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. S. S. S. S. S. Time Received : 7:45 PM Time Discharged :



IV Cannula Site : 22
☐ 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 :

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT
			30	60	90	
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	2	2
Able to move 2 extremities voluntary or on command	= 1					
Able to move 0 extremities voluntary or on command	= 0					
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2
Dyspnea or limited breathing	= 1					
Apneic	= 0					
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1					
BP $\pm$ 50 of Pre Anaesthetic level	= 0					
Fully awake	= 2	CONSCIOUSNESS	1	2	2	2
Arousable on calling	= 1					
Not responding	= 0					
Pink	= 2	COLOR	2	2	2	2
Pale, dusky, blotchy, jaundiced, other	= 1					
Cyanotic	= 0					
TOTAL			8	9	10	10

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

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

Anaesthesiologist Name : Dr. K. S. R. R. R.

Anaesthesiologist Signature: [Signature]

Date & Time: 6/5/26 @ 9 PM

PACU Nurse Name : Kalyan

PACU Nurse Signature: [Signature]

Date & Time: 6/5/26 @ 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): 237

Date & Time: 6/5/26 @ 9 PM

Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Patient Satisfaction :

Disturbance Shifting ordered by
Signature:

BAH-00657356 IP5-00178041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: ADENOTONSILLECTOMY WITH COBLATION + SEPTORHINOMY
Anaesthesiologist: DR SHINY Surgeon: P.V.L.N MURTHY TURBINOMY

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 BRONCHOSPASM, LARYNGOSPASM

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: [Signature]
Name: K. Hemalatha
Relationship with patient: Mother
Date & Time: 04/07/26, 4:32pm

Witness:

Signature: [Signature]
Name: Team
Date & Time: 04/07/26 @ 4:30pm

Doctor (who is taking consent):

Signature: [Signature] Name: DR SHINY Date 04/07/26 Time: 4:30pm

అనస్థీషియా కోసం అనుమతి పత్రం

మరు: ☐ రోగి ☐ రోగి అబ్సెన్స్

పేరు: శస్త్రచికిత్స నిపుణుడు:

మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

ఈ అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ అనుభవించడు. దీనిని శిరస్థాపన ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

ఈ అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత పశుమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా సార్కోబ్లిక్ మందులను నిరంతరం ఆ భాగానికి

సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అది నివృత్తి చేయబడ్డాయి.

☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

లు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

లండ్

సందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.

అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్

సంయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు వానం వంటి సమస్యలు ఉండవచ్చు.

యంత్రంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టిరియల్ లైన్, సపోజిటరీలు, నొప్పి సర్క్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి ఇస్తున్నాను.

యంత్రంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వారికి కూడా నేను అనుమతి ఇస్తున్నాను.

ధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను నేను.

అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో నానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

లండ్:

సాక్షి:

సంతకం:

పేరు:

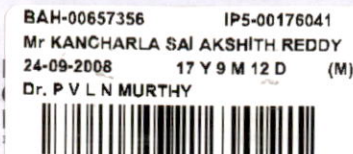
తేదీ & సమయం:

పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Murthy
Asst. Surgeon :
Anaesthetist : Dr. Senidev
Scrub Nurse : Suman

Patient Name : Mr. Kancharla Sd Age : 17 Y Gender : M
UHID No. : 90657356 Surgery Name : Adenotom
Date : 6/7/14 In-time : Out-time :



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>6 PM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☒ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☐ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Sri Ramya</u>		

TIME OUT		Time: <u>6:15 PM</u>
Confirm all team members have introduced themselves by Name and Role		
☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☒ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☒ No		
Signature : <u>[Signature]</u>		
Name : <u>[Signature]</u>		

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

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
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

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 6/7/26

Department : P.O.T. Duration of Procedure : 1 hour

Name of Surgeon : Dr. Murthy Date of Admission : 6/7/26

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 : Dr. - Augmentin	<i>[Signature]</i>
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Nil Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	<i>[Signature]</i>
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	<i>[Signature]</i>
4.	Name of doctor or staff administering the antibiotic : <i>[Signature]</i> Date & Time of antibiotic administration : 6/7/26 @ 8pm Date & Time procedure started : 6/7/26 @ 8m	<i>[Signature]</i>

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

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

BAH-00657356 IP5-00176041
Mr KANCHARLA SAI AKSHITH REDDY
24-09-2008 17 Y 9 M 12 D (M)
Dr. P V L N MURTHY



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.



236

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 9am

Weight: 68kgs Centile: >50th

Height: 178cms Centile: >50th

Inference: well child

RDA: - Calories: 2000 kcal/d Protein: 36g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy outside foods

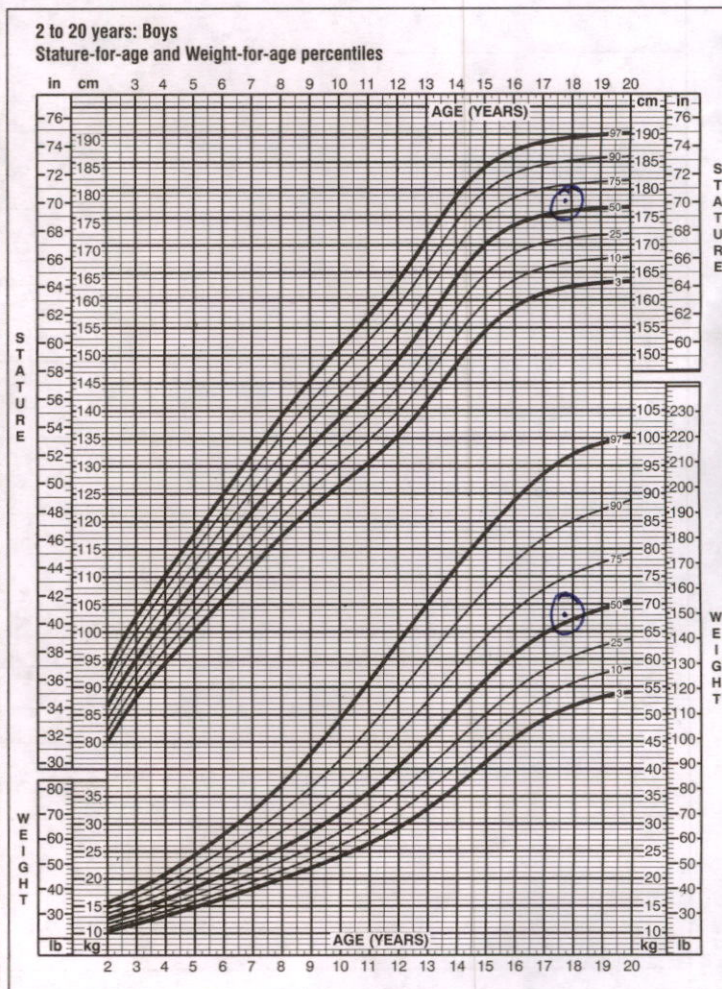
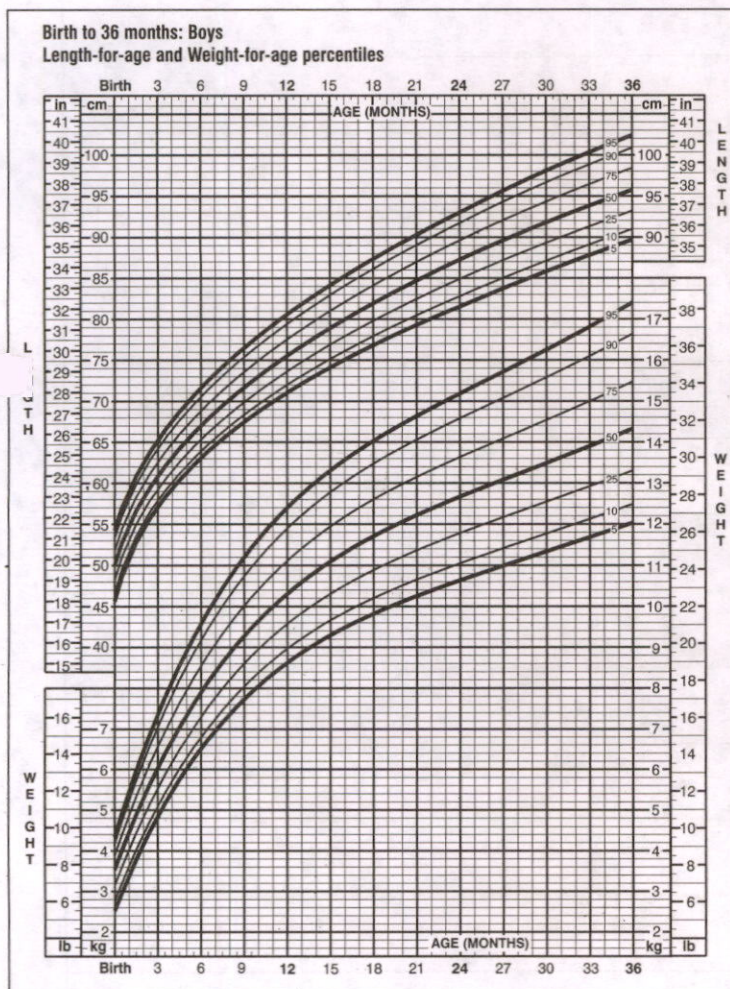
Food Allergies: No Veg/Non-veg Non - Veg

Diagnosis: A denotomilectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

