

BAH-00661960 IPS-00176755
Master G JESHWIK REDDY
17-06-2022 4 Y 1 M 6 D (M)
Dr. HARISH JAYARAM

Patient

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

8432

Date : 22/7/26

Patient Name: Master Jeshwik Re Date of Birth: 17-06-22 Age: 4y

Gender: Male Ward : P.O.R UHID No.: 00661960

Date of Surgery: 22/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Right open herniotomy

Time in : 11:55 Am

Time Out : 12 pm

NAME

AMOUNT

1. Surgeon : Dr. Harish
2. Anaesthetist :
3. Assistant Surgeon :
4. OT Technician : Kulsum
5. Circulating Nurse : Sravani
6. Assistant Nurse : Suvata

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9716597

Order by: Suvata



Herniotomy open 1/2

40/16719

CONSUMABLES OF OT

Technician : Date : Time :

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube 4.0, 4.5, 5.0	1+1	—		Major Pack		1	1	Inj Vit.K			
LMA 9	—	—		Sutures 9/15		1	1	Cord Clamp			
ECG leads : A / P / N	5	3		vic (3-0) (4-0)		2+2	1	Suction Catheter			
HME filter : A / P / N	1	1						Feeding Tube			
Syringes : 10 cc	10	05						Vaccum Suction Set			
05 cc	10	05		Gloves 6 1/2, 7, 7 1/2		A113	1	Surgical Gloves			
02 cc	10	03		Pt- 6 1/2, 7, 7 1/2		A113	1	Gauze Pack			
01 cc	3	—						Syringe 1ml / 2ml			
Cautery plate : A / P / N	1	1		Surgical blade 15		1	1	Surgical Blade # 20			
IV set	1	1		NG tube				Koochies (S)			
RL	1	1		Cautery pencil		1	1	100ml NS	1	1	
NS 40ml / 100ml / 500ml / 1000ml	4+1	1+1		Koochies XL Pel		1	1	Transolix	1	1	
mini epice	1	0		Ointments				10cc, 5cc	2+2	—	
vaccum set	1	1		Suction Catheter							
Fentanyl	1	1		Cap, Mask		10/10	3/3				
Morphine				Gauze Pack N		4	2				
Ketamine				Mop Pack		1P	1				
Propofol	3	3		Steristrip							
Rocuronium	1	—		Underpad		1	1				
Glycopyrolate	1	—		Draw sheet		1	1				
Myopyrolate + Neo	2	—		Abgel							
Ondansetron	1	—		Foleys catheter				midazolam	1	—	
Pencan 25g/ Spinal Needle 22	1	1		Urobag				O.A (0.1)	1g	—	
Bupivacaine 0.25%	1	1		Chest Drainage Catheter				N.A (18, 20, 22)	4+1	—	
Bupivacaine 0.25% (Heavy)				Romodrain bag				Naloxone	1	1	
Antibiotics				Bandage				Etcon (P)			
ivp cm	1	1		Tegaderm							
Suppositories				Ioban							
Anamol : 80mg / 250mg + 170 mg				Double J Stent							
Supridot : 100mg				Vaccum Suction set							
Justin : 12.5 mg / 25mg / 100mg	1+1	1		Plastic Bed Sheet							
Tab. Misoprost : 200mg				Betadine Solution		1	1				
3way 10+100cm	1+1	—		Microshield		1	—				
Glove au + Gauze	4+4	1+1		Cotton Balls		1	1				
tranexa + dexta	1+1	—		Latex Gloves		10p	10p				
O2 mask (P)	1	—		Ramdione Scrub							
IV cannula (22, 24)	1+1	—		Saral							

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

ESTIMATION SLIP

pre. Approval

Date : 12/07/2026 CHID / IP No. : BAH-00661960 SI No. 81132
Name of Patient : Marika. G. Jeshank Reddy Age: 24.11 Gender: M.
Father's / Husband's Name : Mr. Rajeshwar Reddy Corporate / Occupation : DIE BOLD
Address : _____ Phone : 7216160823 Email: 111X120R1
Procedure / Plan : Right Open Herniotomy.

MODE OF PAYMENT : ☐ SELF ☒ TPA : care health ☐ GIPSA : _____ OTHERS

TARIFF INFORMATION :

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Per Day)	Room Rent & Nursing Charges										
	Doctor's Fee				13240						
	L. Tax										
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				Subject to approval by TPA / Insurance Company							
O.T. Consumables				Not Covered by TPA / Insurance company							
Instrument Charges				As per actual - Not Included in Estimation							
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation							
Equipment Charges	Monitor :		Oxygen :				Infusion pump / Syringe pump :				
	Ventilator :		Conventional :		HFO-SLE 5000 :		HFO Sensormedix :				
	Phototherapy :		Single Surface :		Double Surface :		Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation							
Package											
Others											
Initial Minimum Deposit											

MARKS:

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

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

Signature of the Client: [Signature] Signatory Relationship: [Signature] Signature of the Financial Counselor: [Signature]

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176755

Admit Date : 22-Jul-2026

Admit Time : 09:10 AM **UHID** : BAH-00661960

Patient Details :

Patient Name :	Master G JESHWIK REDDY	Age :	4 Y 1 M 5 D
Guardian :	Mr G RAJESHWAR REDDY	DOB :	17-06-2022
Gender :	Male	Religion :	
Occupation :		Martial Status :	Single
Address (H) :	8-43/21/B, SRINIVAS COLONY Banjara Hills Hyderabad Telangana INDIA 500034	Phone No :	7416460323/
		E-mail :	NA@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 :	Mr G RAJESHWAR REDDY	Relationship :	Father
Contact Address :		Phone No :	7416460323 / 9030958679


 Signature

Doctor Details :

Doctor Name :	Dr. HARISH JAYARAM	Specialisation :	PEDIATRIC SURGERY
Referral Doctor :	Self	Phone No :	
Co-Consultant :			

Payment Details :

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

ACTIVITY RECORD FOR BILLING

BAH-00661060 IP5-00176755
Master G JESHWIK REDDY
Name : 17-06-2022 4 Y 1 M 6 D (M) _____
Dr. HARISH JAYARAM
UHID No  _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/07/26	9:40am	ER	OT	
22/7	4:20pm	OT	389	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/12/14	EV placement PAC op basis	①	5903	Chen

ANY OTHER INFORMATION

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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

Patient Name:

BAH-00661960 IPS-00176755
Master G JESHWIK REDDY
17-06-2022 4 Y 1 M 6 D (M)
Dr. HARISH JAYARAM

[Signature]

UHID ID:



Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : Jeshwik Reddy Age/Sex 4Y/M

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Swelling in right groin on & off x 1 week

History of present illness :

Swelling in right groin appearing
on & off x 1 week

↓

Not a/w pain

↓

Diagnosed ^{Right} inguinal hernia

↓

Planned for ~~next~~ Right inguinal
herniotomy today.



Pediatric Multiorgan History & Physical Examination

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

Not Significant

Birth & Neonatal History:

FT/LSCS/CTAB/B.Wt-3rd 75kg

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

Achieved as per age in all 4 domains

Immunization History :

completely immunized till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 16.79 kg (Centile _____)

On Examination :

Temperature : 98.3° Pulse Rate : 102 bpm B.P. 98/58 mmHg SPO2 100% RA

Resp. rate and type of breathing : 24 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : _____

Spine : _____

External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : 3 @

Motor System:

Nutriton : 3 @

Tone: 3 @

Power 3 @

Co-ordinator : 3 @

Posture : 3 @

Involuntary Movements : 3 @

Reflexes : 3 @

DTR 3 @

Superficials: 3 @

Plantars 3 @

Sensory System : 3 @

Bladder / Bowel : 3 @

Clinical Summary & Diagnostic:

Right inguinal Hernia

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: sepsis, ~~zoster~~ Bleeding

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

Minor Surgical
Proxide - done outside
on 16/7/26

Noted by
Krishna

Planned Management

NPO as advised
- I.V.F. D.N.S

DR. HARISH JAYARAM
F. Registration No: 66254

Signature of the Doctor: Nandani

Name of the Doctor: Dr. Nandan

Date & Time: 22/07/2026, 9:15 AM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Harish Jayaram

Date & Time: 22/7/26 10:20 AM

Date & Time	Progress Notes	Doctor's Order
22/7/26 4:50pm	C/S/B Dr=Malika	
	POD - (C)	<u>Adv</u>
	No fever spikes Vitals stable	1) Full feeds
	P/A - soft	2) Plan discharge tomorrow
	U/E - dressing intact	
 Dr. Hemanta 22/7/26 5:40 PM 		Malika 22/7/26 4:50 PM ✓ R/S Sema



OPERATION THEATER NOTES

Patient's Name : Jeshwik Reddy Age : 4yr Gender : ☒ Male ☐ Female

UHID No.: BAH 601960 Weight : Height :

Surgeon : Dr. Harish Asst. Surgeon :

Anesthetist : Dr. M. Subramanyam OT Nurse: OT Technician:

Pre-Operative Diagnosis: (R) Inguinal hernia

Surgical Procedure : (R) Open herniotomy.

Indications for Surgery : (R) Inguinal hernia

Date : Start Time : 11:5 am End Time : 12 pm

Pre Operative Preparations:

Post Operative Diagnosis: (R) Inguinal hernia

Peri-Operative Complications:

Operation Notes:

Findings

1. Thin hernial sac with no contents

at time of surgery.

Procedure

- (R) lower groin incision made
- Subcutaneous tissue & external oblique aponeurosis separated.
- Sac identified, lifted up separated from cord structures & double ligated at base deep ring & cut.
- Distal sac lay opened.

Amount of Blood Loss: 1ml

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

- Wound closed in layers.

Name of the Surgeon: Dr. Harish

Signature of the Surgeon: 

Date & Time: 22/7/20 12 pm



POST-SURGICAL CARE PLAN FORM

Procedure Done: (R) open herniotomy

Post-Surgical Diagnosis: (R) Inguinal hernia

Post-Operative Monitoring Parameters /Frequency:

TPR for every 15 min for 1st 1 hr.

Wound Care:

Dressing

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

as early as possible

Special Referrals:

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

☐ Yes ☒ No

Any Other Post-Operative Care Needed including Required Follow Up


Treating Surgeon
(Signature & Stamp)

Date: 22/7/26 Time: 12 pm

Note: Plan of care will be readjusted if necessary.



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. RIGHT OPEN HERNIOTOMY

2. _____

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Resolution of inguinal swelling</u>	

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

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

- a. Bleeding, Infection
- b. Recurrence

I authorize Dr. Harish Jayaram 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: D. Usha Rani

Name: D. USHA RANI

Relationship with patient: MOTHER

Date & Time: 22/7/26, 9:55 AM

Witness:

Signature: [Signature]

Name: [Name]

Date & Time: 22/7/26, 9:55 AM

Doctor (who is taking consent):

Signature: Malika Name: Dr. Malika

Date: 22/7/26 Time: 9:55 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రన్ 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 లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

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

a.	
b.	

- 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:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Harish Jayaram
Asst. Surgeon : Dr. Malina
Anaesthetist : Dr. Ravichandra
Scrub Nurse : Susala

Patient Name : Master Jashwik Age : 4Y Gender : M
UHID No. : 00661966 Surgery Name : Open herniotomy
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤

Before Skin Incision ➤ ➤

Before Patient Leaves Operating Room

SIGN IN		Time: <u>10.15 AM</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>Gravi</u>		
Name : <u>Ravi</u>		

TIME OUT		Time: <u>11:20 AM</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?	<u>Nil</u>	☐ Yes ☐ No ☐ NA
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	☐ Yes ☒ No ☐ NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<u>NO</u>	☒ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?		
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☒ Yes ☐ No	
Signature : <u>Harish</u>		
Name : <u>Harish</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>Harish</u>		
Name : <u>Harish</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

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



Before Induction of Anaesthesia ➤ ➤

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

Before Skin Incision ➤ ➤

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

Before Patient Leaves Operating Room

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



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 22/7/26

Department : P.O.T. Duration of Procedure : 45 min

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 22/7/26

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 : NA	
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : NA Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : NA Date & Time of antibiotic administration : NA Date & Time procedure started : NA	

- 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

BAH-00661960 IP5-00176755
Master G JESHWIK REDDY
17-08-2022 4 Y 1 M 6 D (M)
Dr. HARISH JAYARAM



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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					

Jeshwik Reddy

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: Nalini, Dr. Nandan

Date & Time: 22/07/2026 9:20 AM

Nurse Name & Signature: Geetha K

Date & Time: 22/07/26 @ 9:20 AM



Jeshwik Reddy

DRUG CHART

Date of Admission: 22/7/2026 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. **ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.**
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a **NEW PRESCRIPTION**. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the **FIVE RIGHTS** before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- **AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES**
(EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. 16.7 kg Ward.

DRUG : [NJ - PARACETAMOL				Date Time	22/6 237
Dose 250mg	Route IV	Frequency TID	Start Date 22/7/21	8 AM	Refused
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Shreyas</i>				8 PM	Refused
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					

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

VARIABLE DOSE		Date Time							
			Nurse Sig.		Nurse Sig.		Nurse Sig.		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[illegible]

I.V. FLUIDS CHART

Weight. 16.79kg Ward.

[illegible]



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
22/7	9AM	2	Treatment & care plan	F	1	1	1	0	-	Geetha
23/7/26	9am	9	Self diet	f/m	1	0	1	1	-	Same

Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/07 9am	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Herniotomy	H stability	procedure	[Signature]	☐ Nursing ☒ Others:
22/07/26 9Am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Herniotomy.	H stability	procedure	[Signature]	☒ Medical ☐ Others:
23/7/26 9am	☐ Medical ☐ Nursing ☒ Others: <i>hichu</i>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Right hemiotomy	soft diet	<i>RDA</i> E-1350kcal/d P-23gm/d	[Signature]	☐ 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:



22/7/20

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time: 6:30 PM		6am		
Doctor / Nurse / Family Concern?						
Temperature (°F)	104					
	103					
	102					
	101					
	100					
	99					
	98	97.0°	97.4°	98.0°		
	97					
	96					
	95					
	94					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
Blood Pressure (mmHg) *	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
	80					
Note: BP does not score in early warning scoring	70					
	60					
	50					
	40					
	30					
	20					
	10					
	Heart Rate (Number)	105b/m	107b/m	90b/m		
	esp. Rate (bpm) (Over 1 Minute) *	70				
		60				
		50				
40						
30						
20						
10						
Resp Rate (Number)		22b/m	26b/m	26b/m		
Resp Distress		Mod/ Severe				
		None / Mild				
Receiving O ₂ (l/min)						
	O ₂ Saturations (%)	100%	99%	100%		
Conscious Level	Normal					
	Altered					
GCS *	15/15	15/15	15/15			
TOTAL SCORE						
Number of shaded boxes	0	0	0			
Pain Score	0	0	0			
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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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 Master G JESHWIK REDDY
 17-06-2022 4 Y 1 M 5 D (M)
 Dr. HARISH JAYARAM

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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.

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	H ₂ O										
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	H ₂ O										
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output : m - o u						
	08:00 pm											
	09:00 pm	H ₂ O										
	10:00 pm											
	11:00 pm	H ₂ O										
	12:00 am											
	01:00 am	H ₂ O										
Total Intake :						Total Output :						
	02:00 am	H ₂ O										
	03:00 am											
	04:00 am	H ₂ O										
	05:00 am	H ₂ O										
	06:00 am	H ₂ O										
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output		m - o - u										

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 17/26

Assessment: Acute pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the pt General Condition	2:30 pm	Assessed the pt General Condition	pt is Conscious & oriented
3pm	Relieve pain & Discomfort	3:10 pm	Relieved pain & Discomfort	pt vital stable
4pm	monitor vital signs	4:20 pm	monitored vital signs	no vomiting
5pm	monitor for bleeding	5:30 pm	monitored for bleeding	normal lab
6pm	maintain I/O chart	6:10 pm	maintained I/O chart	shuffled
7pm	no status malnutrition	7:30 pm	no broken, water given	
8pm	pt shift to the ward	8pm	pt shifted to the ward	

Re-Assessment: provide comfortable position

Special Notes:

Nurse Signature: Nurse Name: Date & Time: 17/26 8pm

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Master G JESHWIK REDDY
17-06-2022 4 Y 1 M 5 D (M)
Dr. HARISH JAYARAM



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/20

Assessment: Discomfort & Poor Oral Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the patient	8:10pm	→ Assessed the general condition of the patient	- Patient is stable - Vitals normal - Has good oral intake
12am	→ To monitor vital signs	12:30 am	→ Monitored the vitals & recorded	
2am	→ To provide comfortable position	2:20 am	→ Provide comfortable position	
4am	→ To encourage oral intake	4:40 am	→ Encouraged oral intake	
7am	→ To maintain I/o chart	7:05am	→ Maintained I/o chart	

Re-Assessment: After providing comfortable position, discomfort has reduced.

Special Notes: Plan o/c - r/m

Nurse Signature:

Nurse Name: Kalyani

Date & Time: 23/7 at 8am

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>Herbotoxy.</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>CR</u> <u>9:00 AM</u>	<u>OT</u> <u>9:00 AM - 4:30 PM</u>	<u>3rd Floor</u> <u>8 PM</u>	<u>3rd Floor</u> <u>8 PM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.0 F</u>	<u>98.6 F</u>	<u>97.0 F</u>	<u>98 F</u>
			Res: <u>20 b/m</u>	<u>25 b/m</u>	<u>22 b/m</u>	<u>26 b/m</u>
			SpO ₂ : <u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
			Pulse: <u>120 b/m</u>	<u>60 b/m</u>	<u>105 b/m</u>	<u>107 b/m</u>
			BP: <u>90/58</u>	<u>91/42</u>	<u>87/59</u>	<u>85/52</u>
			Fall Risk Score: <u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>
Recommendations	Safety Needs:		☒ Yes	☒ Yes	☒ Yes	☒ Yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Centu</u>	<u>Shir</u>	<u>Siema</u>	<u>Kalyani</u>	
Signature :		<u>KE</u>	<u>Shir</u>	<u>Siema</u>	<u>Kalyani</u>	
Date:		<u>22/07</u>	<u>22/7</u>	<u>22/7/26</u>	<u>23/7</u>	
Time:		<u>9:00 AM</u>	<u>@ 4:30 PM</u>	<u>@ 8 PM</u>	<u>8 AM</u>	
Taken Over By Name :		<u>Shir</u>	<u>Shir</u>	<u>Kalyani</u>	<u>Shir</u>	
Signature :		<u>Shir</u>	<u>Shir</u>	<u>Kalyani</u>	<u>Shir</u>	
Date:		<u>24/7/26</u>	<u>22/7</u>	<u>22/7/26</u>	<u>23/7/26</u>	
Time:		<u>9:00 AM</u>	<u>@ 4:30 PM</u>	<u>8 PM</u>	<u>@ 8 AM</u>	

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 • <u>Make small shifts in their position</u> frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/07	9Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Deetti
22/7	10:30pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Deetti
22/7	2.5pm	1/10	SS	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Deetti
22/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
22/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Kalyani
23/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

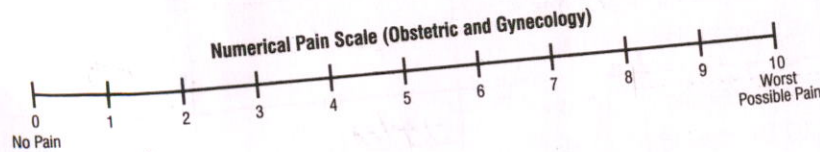
Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

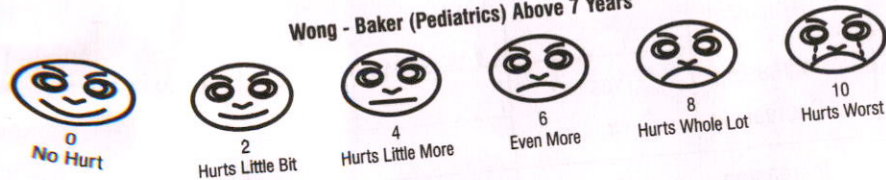
CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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



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, SaO ₂	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



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 Master G JESHWIK REDDY
 17-06-2022 4 Y 1 M 6 D (M)
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Patient Stic

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THE HUMPTY DUMPTY SCALE

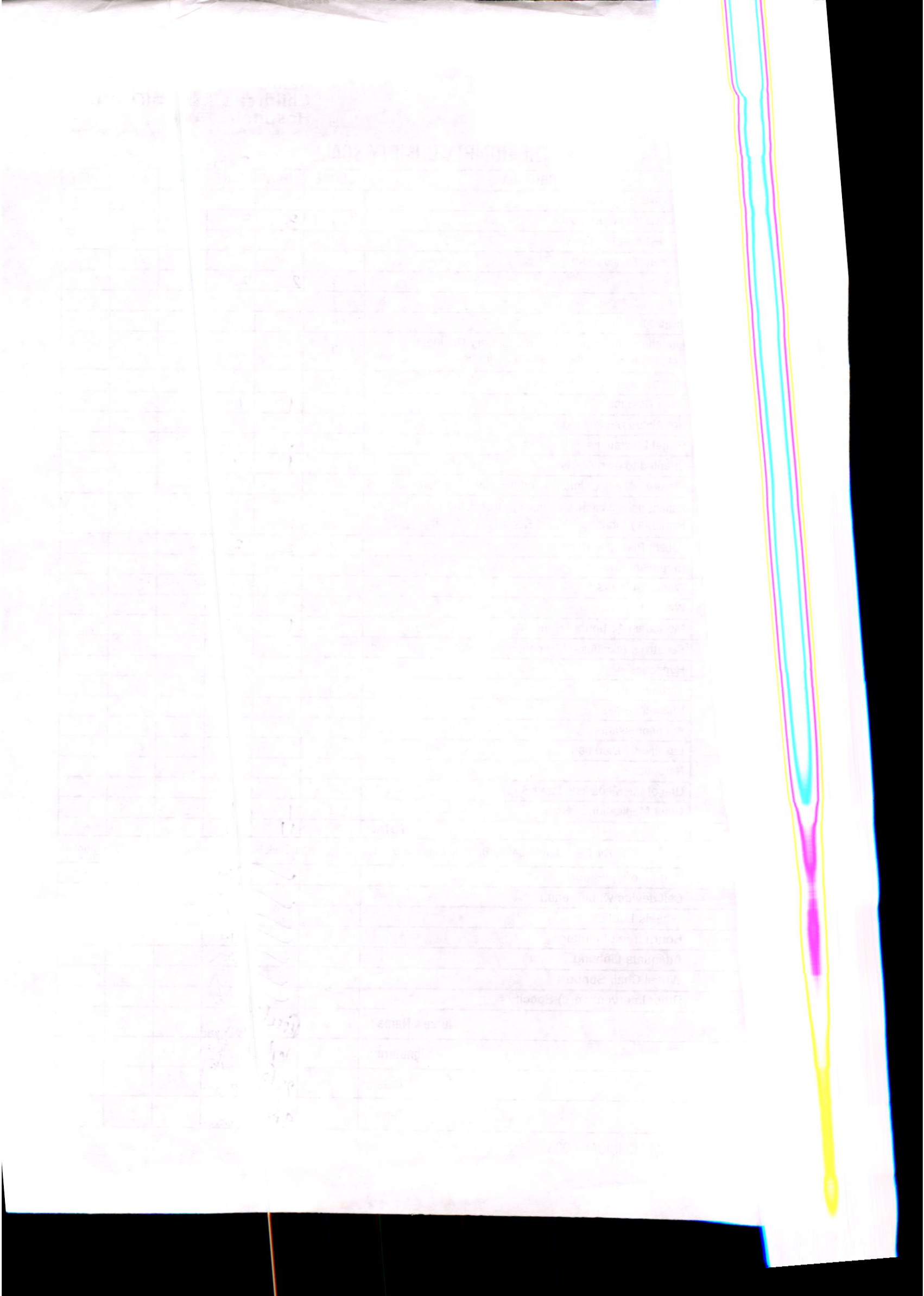
PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory 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			11	11			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	Yes			
Call device within reach		✓	Yes			
Wheels Locked		✓	Yes			
Room free of clutter		✓	Yes			
Adequate Lighting		✓	Yes			
Wheel Chair Support		✓	No			
Other Intervention(s) Specify		✓	No			
Nurse's Name :		Dr. [Signature]				
Signature :		[Signature]				
Date :		22/7	23/7			
Time :		9 AM	6 AM			





CHECKLIST FOR THROMBOPHLEBITIS

22/7

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	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 : Name :

Signature of Ward In Charge :

Signature : Name :

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 23/07/2022 Doctor order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 17/07/2022



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4⁵ 9 am Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: N/A Body Weight: 10 Kg

Height: — cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Nothing significant

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

If yes please list, —

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

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

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

Observations: Weight: 16.7 Length: — Head Circumference (< 2 years): —

Temp.: 98.4 F HR: 90 b/m RR: 26 b/m BP: 90/60 mmHg

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 20) (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 Family

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 ☐ No

Information given to Mother

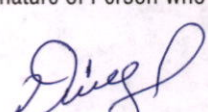
Nurse Signature: [Signature]

Nurse Name: Reenu

Date: 22/7/26

Time: 9:45 am

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661960 IP5-00176755 Master G JESHWIK REDDY 17-06-2022 4 Y 1 M 5 D (M) Dr. HARISH JAYARAM 		Date & Time of Admission 22/7/26 @ 9:10 AM	Date & Time of Transfer Order 22/7/26 @ 11 AM
		Transfer Ordered by Dr. Harish	Reason for Transfer Post-op
From Unit OT	To Unit 322	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	no file		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Harish	
Patient & Clinical Records Received by :		Suma 22/7/26 @ 4:30 PM	
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

DR. Harish Jayaram
22nd July (11:30 AM)

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: Master Peshwet Reddy Age: 4 Years Sex: Male UHID No: BAH-00661966

Date: 20-7-2026 Time: Proposed Operation: Right inguinal herniotomy

Diagnosis: right inguinal hernia

B.P / CRT: 103/72 H.R: 90b/m Weight: 16.79kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Temp 98.6°
SpO2 100%

Laboratory Data:

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

Allergies: NKDA

Medical History: CVS:

- full term / LSCS / CIAB / Part wt: 3.75kg

RESP:

Diabetes: - vaccinated till date

CNS:

- milestones achieved

Renal:

Hepatic / GE:

Physical Activity: active child

Others:

Past Anaesthetic History: -

Physical Exam: -

Airway: (2) MP 1' 2 3 4 Mouth Opening: adequate Mentohyoid Distance: Neck: Teeth: firm

Lungs: }

Heart: (2)

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site: (2) Spine Exam for regional: (2)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: NPO 6hrs - solids / milk / tea

1. DVT Prophylaxis:

2. NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$ 2hrs - water

3. Informed Consent: ☒ Standard ☐ High Risk

4. Post Operative Pain Management: ☒ Discussed with Patient

5. Other Instructions:

- CBP on cannulation

Signature: [Signature] Name: Dr. Shomeen

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status: <i>Confirmed</i>
Physical Status:	☒ Patient Identified	☒ Consent Present
		☒ Chart Reviewed

H.R:	BP / CRT:	SpO ₂ :	R.R:	Last Feed:
------	-----------	--------------------	------	------------

Pre-OP Diagnosis: (R) Inguinal Hernia Operation: (R) HERNIOTOMY Date: 22/12

Surgeon: HARISH Anaesthesiologist: RAVI Technician: KUNDA

[illegible][illegible]

PROFESSOR Dr. Dr. Dr.

[illegible][illegible][illegible]

(ii) 160 ml / 4C //

[illegible]

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Heart Rate (b/min)

140

120

100

80

60

40

20

0

0 5 10 15 20

Time (min)

Throat Pack In

Throat Pack Out

Hand-drawn graph on grid paper showing a decreasing trend. The y-axis is labeled from 80 to 100. The x-axis is labeled with '1' through '10'. The data points are approximately: (1, 100), (2, 98), (3, 95), (4, 92), (5, 90), (6, 88), (7, 85), (8, 82), (9, 80), (10, 78).

[illegible]

LAB VALUES	
GRBS	
Dilution	

 Equipment Checked and Functional	Temp: ☐ HME ☐ Fluid Warmer	Induction ☐ IV ☐ Inhal	Regional: Extremity Specify:

BP: ☒ BP ☐ Cling Film ☐ OH Warmer ☐ Pre O₂ ☐ RSI ☐ Spinal ☐ Epidural ☒ Caudal

Cuff Site: ☒ Hugger's ☐ Cotton Wool ☐ Others:

Art Site: ☒ Other:

☐ EKG Lead
☐ Temp Site
 Times: 11:05 AM
 Access Start: 11:05 AM
☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
 Position: Supine
 Site: 836

☐ FIO₂ Monitor
☐ Agent Monitor
☐ Pulse Oximeter

OP Start:
 OP End:

☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical

Needle Size: Depth:
 Paresthesia ☐ Yes ☒ No
 Catheter at site

☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator

Leave OR: 12:00pm
Anaesthesia:
☐ Drug: _____
☐ Awake ☐ Direct Vision
 Drug Name & Conc: 0.25-1
 Bolus: 60µg IV

☐ Nerve Stimulator ☐ GA ☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Monitored Anaesthesia Care ☐ Fiberoptic
☐ Regional ☐ Block Level:

Position: Supine Infusion: 14 ml

Pressure Points Checked: _____

Blade # _____ Attempts: _____

Difficulty Why? _____

Comments: _____

Transportation to _____

☐ Bilat = BS
☐ Semi-Closed Circle

☐ Oint
☐ Tape

☐ ART
☐ IV
☐ IV

☐ Closed Circle
☐ Other

Name of the Doctor :
 Signature of the Doctor :

☐ Padding	☐ IV			
☐ Awake	☐ IV			

BAH-00661960
Master G JESHWIK REDDY
17-06-2022 4 Y 1 M 5 D
Dr. HARISH JAYARAM (M)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: *Dr. J*

Time Received: *12:58pm*

Time Discharged: *1:18pm*

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SP0 ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <i>929</i>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway
Vomiting: ☐ Yes ☒ No NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral: ☐ Yes ☒ No		Drug:
IV Fluids: Oral Feeds:		

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
<i>22/7/2020</i>	<i>12:58pm</i>	<i>1/10</i>	<i>—</i>	<i>uJ</i>

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

Anaesthesiologist Name: *Dr. Tejaswini*

Anaesthesiologist Signature: *[Signature]*

Date & Time: *22/7/2020 1pm*

PACU Nurse Name: *Dr. J*

PACU Nurse Signature: *[Signature]*

Date & Time: *22/7/2020*

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): *30V*

Date & Time: *22/7/2020*

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Right inguinal Herniotomy

Anaesthesiologist: Dr. Samrana Sadique Surgeon: Dr. Harish Jayaram

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: hypotension / Bradycardia / Bronchospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☒ Regional Anaesthesia ☐ General Anaesthesia ☒ Monitored Anaesthesia Care sedation
- 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: Rajeshwari Reddy

Relationship with patient: father

Date & Time: 20/7/26 3:22pm

Witness:

Signature: D. Usha Rani

Name: Usha Rani (mother)

Date & Time: 20/7/26 - 3:22pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Samrana

Date: 20/7/26 Time: 3:22pm

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.

లిజనల్ 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 లిస్ట్:

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.
☐ లిజనల్ 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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్స్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

NUTRITIONAL HEALTH ASSESSMENT - BOYS

 Date: 23/7/26 Time: 9pm

 Weight: 16.7kg Centile: 25th

 Height: 90cm Centile: 25th

 Inference: no ill child

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

 Diet Recommendations: soft bkt

 Re-Assessment: Avoid spic, chilled & outside food

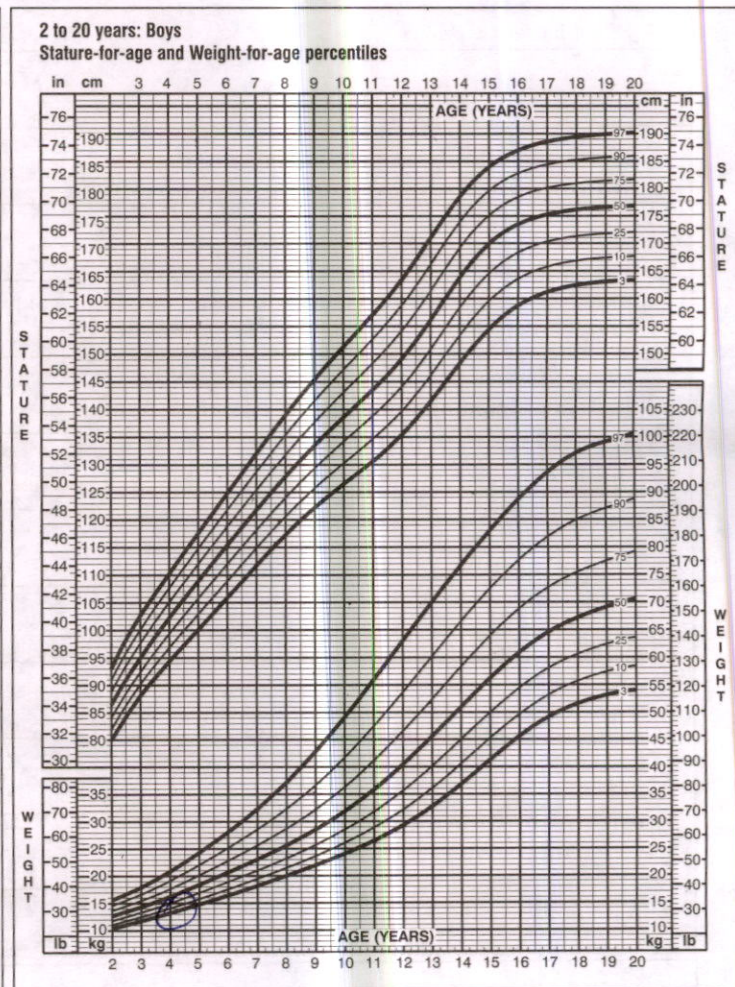
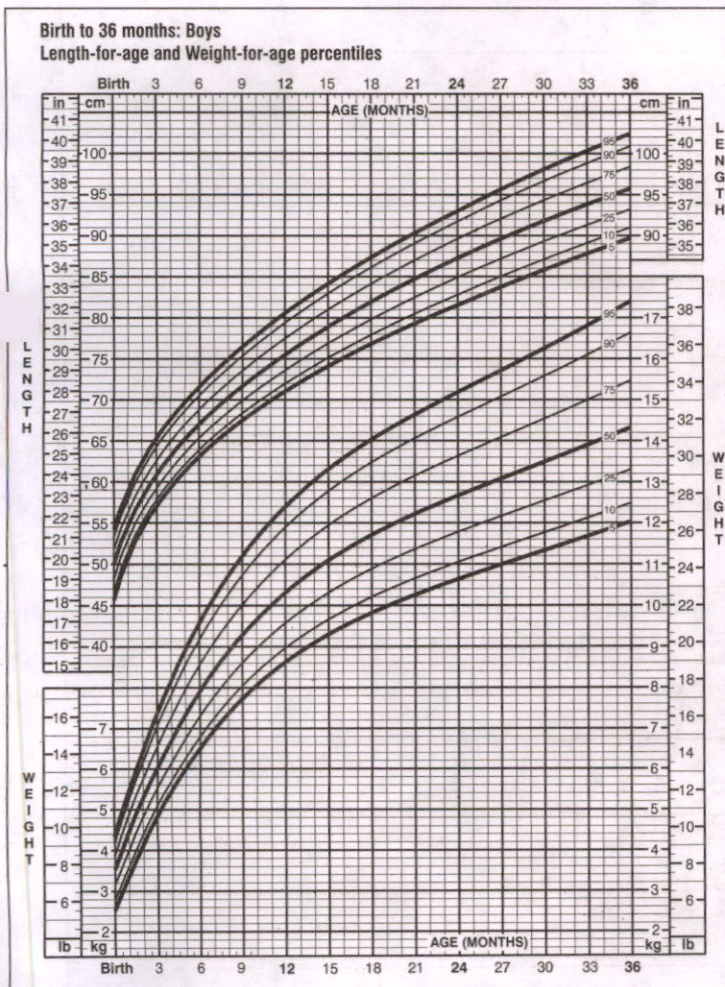
 Food Allergies: No Veg/Non-veg: NON-veg

 Diagnosis: (R) open herniotomy

 Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

 Patient's Signature: D. Usha Rani

GROWTH CHART (BOYS)


 Dietician's Name: Dr. Ma

 Dietician's Signature: Dr. Ma

Daily Notes: