

BAH-00657233 IP5-00174636  
Master SHOURYA TUKARAM BARATE  
21-07-2023 2 Y 10 M 12 D (M)  
Dr. RAVI CHANDER RAO



### SURGERY DETAILS

SHOURYA

Date : 2/6/26

Patient Name: Shourya Tukaram Date of Birth: 21-7-2023 Age: 2y

Gender: Male Ward: P.O.T UHID No: BAH-00657233

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

Name of the Surgery: follows 2 plasty Palatoplasty

Time in: 2.40 pm

Time Out: 4.10 pm

	NAME	AMOUNT
1. Surgeon	Dr. Ravi Chander	
2. Anaesthetist	Dr. Tejaswini	
3. Assistant Surgeon		
4. OT Technician	Shirisha	
5. Circulating Nurse	Thapa	
6. Assistant Nurse	Suman	

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: 2630751

Order by: Suman

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CLEFT PALATE SURGERY

CONSUMABLES OF OT



Technician : \_\_\_\_\_ Date : 2/6 Time : 1:30 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube (4.0, 4.5, 5.0)	14	01	Major Pack Drapes	1	1	Inj Vit.K		
LMA	01	-	Sutures			Cord Clamp		
ECG leads : A P N	01	03	vic. 3.0.	2		Suction Catheter		
HME filter : A P N	01	01	Monocryl 3.0 (4.0)	2+2	2	Feeding Tube		
Syringes : 10 cc	10	04				Vaccum Suction Set		
05 cc	10	07	Gloves 6.6 1/2 7-7 1/2	2+4	2	Surgical Gloves		
02 cc	10	05	Pf. 6.6 1/2 (7.5 1/2)	2+4	3	Gauze Pack		
01 cc	5	01				Syringe 1ml / 2ml		
Cautery plate : A P N	01	-	Surgical blade (15+11)	1+1	2+1	Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil	1	-	NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	01	01	Koochies			transofix	1	-
new spike	01	01	Ointments			Jelly	1	1
valve 15	01	01	Suction Catheter			Juf. Augmentin	1	1
Fentanyl	01	01	Cap, Mask (NIR)	1	2+2	band		
Morphine			Gauze Pack (NIR)	1	2+2			
Ketamine			Mop Pack	1	1			
Propofol	03	01	Steristrip					
Rocuronium	01	01	Underpad					
Glycopyrolate	01	01	Draw sheet					
Myopyrolate (PEO)	02	02	Abgel					
Ondansetron	01	01	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			0.9. 0.1	14	-
Bupivacaine 0.25%	01	01	Chest Drainage Catheter			N.A. 20.18	14	
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dam 200ml	01	01
Antibiotics			Bandage			Deamed (10)	01	01
Suppositories (10 pc)	01	01	Tegaderm			500 T Phoshe	14	14
Anamol : 80mg / 250mg / 170 mg			Ioban			Moxycolate	1	0
Supridol : 100mg			Double J Stent					
Justi : 12.5 mg / 25mg / 100mg	01	01	Vaccum Suction set	1	1			
Tab. Misoprost : 200mg			Plastic Bed Sheet	1	-			
2 way lock (10 pc)	14	01	Betadine Solution	1	1			
Gauze + sponges	14	10	Microshield	1	-			
Spec + sponges	14	01	Cotton Balls	1	01			
I.V. Cath. 22G	14	-	Latex Gloves	1	50			
Q. tube. splint 1/2	14	-	Ramdione Scrub					
			Saral					

Surgeon \_\_\_\_\_ Anaesthesiologist \_\_\_\_\_ Nurse *Suman* OT Technician \_\_\_\_\_  
 Order No. : 7519.677 Ordered by : \_\_\_\_\_  
 Doc. No. : RCH / FRM / GENERAL / 125

# ESTIMATION SLIP

Date: 26-May-26 UHID / IP No.: BAH-0065#233 SI No. 80470  
 Name of Patient: Ms. Shourya Tukaram Barate Age: 2y Gender: Male  
 Father's / Husband's Name: Mr. Tukaram Barate Corporate / Occupation: Business  
 Address: \_\_\_\_\_ Phone: 9145334142 Email: \_\_\_\_\_  
 Procedure / Plan: palatoplasty

MODE OF PAYMENT:  SELF  TPA: \_\_\_\_\_  GIPSA: \_\_\_\_\_  OTHERS

## TARIFF INFORMATION:

Room Category	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
	Room Rent & Nursing Charges	<input checked="" type="checkbox"/>								
Doctor's Fee										
L. Tax	<u>10650/- per day</u>									
PARTICULARS				AMOUNT (₹)						
Surgeon's / Anesthetists's Fee / O.T. Charges				<u>(31188) - (11111) + (100)</u>						
O.T. Consumables				<u>11000 -</u> Subject to approval by TPA / Insurance Company						
Instrument Charges				Not Covered by TPA / Insurance company						
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				<u>Approx 2,15,000/- final bill clearance.</u>						

- 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-Medicinals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
  - During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
  - Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
  - Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms! And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

### DECLARATION

I, Devali 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: Devali Signatory Relationship: Mother Signature of the Financial Counselor: Devali

### ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_

Date of Admission : \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

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Consultant: \_\_\_\_\_ Dept: \_\_\_\_\_

Date of Discharge : 3/6/26 Time: \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/26	11:45 Am	ER	OT	RJ
4/6	5:10pm	OT	ICU	Devi

### Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Ujjwala	3/6	16405542	swlca
2				
3				
4				
5				
6				
7				
8				
9				
10				







## ADMISSION SHEET

## Registration Details :



Admission No : IP5-00174636

Admit Date : 02-Jun-2026

Admit Time : 10:59 AM UHID : BAH-00657233

## Patient Details :

Patient Name : Master SHOURYA TUKARAM BARATE

Age : 2 Y 10 M 12 D

Guardian : Mr TUKARAM BARATE

DOB : 21-07-2023

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : KASARKHEDA, DIST: Nanded H O Nanded  
Maharashtra INDIA 431601

Phone No : 9145334142 / 9096782395

E-mail : SM@GMAIL.COM

## Admission Details :

Admission Type : DAY CARE

Bed No : POST OP 410

Ward Name : 4F-OT COMPLEX

Room No : POST OP 410

Admission Type : First Visit

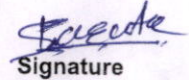
## Contact Details :

Name : Mr TUKARAM BARATE

Relationship : Father

Contact Address : KASARKHEDA, DIST: Nanded H O Nanded  
Maharashtra INDIA 431601

Phone No : 9145334142 / 9096782395

  
Signature

## Doctor Details :

Doctor Name : Dr. RAVI CHANDER RAO

Specialisation : PLASTIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. FAISAL B NAHDI

## Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

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Patient Name: \_\_\_\_\_

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_



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**Pediatric Multisystem History & Physical Examination**

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

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**Birth & Neonatal History:**

NVD / GA3 / 3kg / No meconium

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**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_  
Any additional Information : \_\_\_\_\_  
\_\_\_\_\_

**Developmental History :**

normal for age

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**Immunization History :**

Immunized till date

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### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): 93-5 (Centile \_\_\_\_\_)  
Weight (kgs) 12.35 (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 98.4°f Pulse Rate : 106/min B.P. 99/61(70) SPO2 98.1% RA  
Resp. rate and type of breathing : 26/min

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

Allergies (if any): \_\_\_\_\_

#### Respiratory System :

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : \_\_\_\_\_

Any addes sounds : \_\_\_\_\_

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

#### Cardiovascular System :

Inspection of procordium : \_\_\_\_\_

Heart Sounds : \_\_\_\_\_

Any murmur : \_\_\_\_\_ hrz

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

#### Per Abdomen :

Inspection \_\_\_\_\_

Palpation : \_\_\_\_\_

Ausculation : \_\_\_\_\_ hrz

Spine : \_\_\_\_\_ External Genitelia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

*Alert*

**Motor System:**

Nutrition : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

**DTR**

**Superficials:**

Plantars \_\_\_\_\_

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic:**

*Submucosal cleft palate → palatoplasty*

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### History & Physical Examination

Preventive aspects of the treatment: Resolution of symptoms

Desired goals of the treatment: Hemodynamic stability

#### Planned Labs:

CBC

#### Planned Management

NPO  
PAC Done  
WF DNS.  
Palate plasty surgery today  
1:30pm.  
NIB  
Renal  
2/6/10

Signature of the Doctor: N. Rao

Signature of the Consultant: .....

Name of the Doctor: N. Ravi Chander

Name of the Consultant: .....

Date & Time: .....

Date & Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/06/2026	C/S/B resident	
5PM	D: submandibular	Plan
	palatal cleft	
	S/P Furrow's 'z' plasty	- NPO as advised
	palatoplasty (POD-0)	F/B diet as advised
	On Room Air	- continue medication
	Hemodynamically stable	as charted
	pain & control	Monitor vitals
	No bleed / fever / vomiting	
		- w/o bleeding / vomiting

Plan:  
 (Dr. Nandan)

3/6/26  
8:30am

C/S/B Resident

S/P palatoplasty (POD-1)

no issues  
 accepting feeds -

Adv  
 (B) to day.

O/E: alert  
 active  
 chest clear.

Amish





# CROSS CONSULTATION FORM

Doctor Name : ..... Date : 03/06/2026 Time : .....

Diagnosis : Sub mucous palatal cleft

Hospital : RCH, Banjara

**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:

Signature: *[Handwritten Signature]*

**Findings and Recommendations :**

S/P Follows '3' party Palato party. (POD-1)

- On Room Air
- hemodynamically stable
- Oral intake - OK
- Pain & control
- No fever/vomiting/bleeding

Plan  
Can be discharged

**Consultant :**

Name : Dr. Ujjwal

DR. UJJWALA DESAI  
Registration No: 90550

Signature : ..... Date & Time : 03/06/2026



# 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. Forwards Palatoplasty  
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>Better speech</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. fishy, wound dehiscence
- b. \_\_\_\_\_

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

**Patient / Patient Attendant:**  
Signature: \_\_\_\_\_  
Name: Dipali Akshay Barate  
Relationship with patient: Mother  
Date & Time: 2/6/26 @ 2:30 pm

**Witness:**  
Signature: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date & Time: 2/6/26 @ 2:30 pm

**Doctor (who is taking consent):**  
Signature: \_\_\_\_\_ Name: Dr. Ravi Chander Rao Date: 2/6/26 Time: 2:30 pm

## శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

 (M)  
DATE  
1996

 అనుమతి ఇచ్చినవారు:  రోగి  రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్ఫో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) 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, అనస్థీషియా 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 &amp; సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ &amp; సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ &amp; సమయం: .....





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Master SHOURYA TUKARAM BARATE  
21-07-2023 2 Y 10 M 12 D (M)  
Dr. RAVI CHANDER RAO

Patient St



## 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

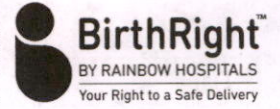
Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon  
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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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						

Handwritten signature: D C



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 Dr. RAVI CHANDER RAO



## MEDICATION RECONCILIATION FORM

Drug Allergies: .....

Not known any Drug Allergies

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

Shifting From: ER

Shifted to: OT

	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: N. Prathima N. Pr

Date & Time: 02/06/26, 10:45am

Nurse Name & Signature: Renuka

Date & Time: 2/6/26 10:50



# DRUG CHART

Date of Admission: 2/6/24 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)

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

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

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

VERIFIED BY: Name .....

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REGULAR PRESCRIPTIONS

Weight. 12 kgs Ward. ....

				Date	Time
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG : INV. AUGMENTIN</b>				Date	2/6/16
				Time	3/6
Dose	Route	Frequency	Start Date		
360mg	IV	q 8hrly	02/06	6AM	X <del>pramit Ravi</del>
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan				2:55 PM	OT
Additional Instructions:					
				10PM	<del>pramit Ravi</del>
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG : INV. PARACETAMOL</b>				Date	2/6/16
				Time	3/6
Dose	Route	Frequency	Start Date		
180mg	IV	q 8hrly	02/06	6AM	X <del>pramit Ravi</del>
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan				2:55 PM	OT
Additional Instructions:					
				10PM	<del>pramit Ravi</del>
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG : INV. ESOMEPRAZOLE</b>				Date	2/6/16
				Time	3/6
Dose	Route	Frequency	Start Date		
10mg	IV	OD	02/06		
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan				6AM	<del>pramit Ravi</del>
Additional Instructions:					
<b>Daily Doctor's Endorsement by a Sign</b>					



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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/6/26	2:55pm	Inj AUGMENTIN	360mg	IV		
2/6/26	2:55pm	Inj DEXAMETHASONE	2.4mg	IV		
2/6/26	2:50pm	SUP. DICLOFENAC.	12.5mg	PR		
2/6/26	3 pm	Inj TRANEXAMICACID	180mg	IV		
2/6/26	3:20pm	Inj PARACETAMOL	180mg	IV		
02/06/26	8 PM	INS. TRANEXA	180mg	IV		

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





**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 21/6/23 Time: 10 AM 2 PM 6 AM

Doctor / Nurse / Family Concern? PN

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98			
	97			
	96			
	95			
	94			

Handwritten data points: 97.0, 97.5, 98.0, 98.5

Heart Rate (bpm)	190			
	180			
	170			
	160			
and Blood Pressure (mmHg) *	150			
	140			
	130			
	120			
Note: BP does not score in early warning scoring	110			
	100			
	90			
	80			
	70			
	60			
	50			
	Heart Rate (Number)			

Handwritten data points: 122 bpm, 120 bpm, 121 bpm

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	Resp Rate (Number)			

Handwritten data points: 22 bpm, 25 bpm, 26 bpm

Resp Distress	Mod/ Severe			
	None / Mild			
Receiving O <sub>2</sub> (l/min)				
O <sub>2</sub> Saturations (%)				
Conscious Level	Normal			
	Altered			
GCS *				

Handwritten data points: 15/15, 15/15, 15/15

<b>TOTAL SCORE</b>			
Number of shaded boxes	1	1	1
Pain Score	0	0	0
Observer's Initials			

<b>ACTIONS</b>	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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

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# FLUID CHART

Sheet No : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
2/b	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm	Oral	well	4ml									
	07:00 pm			45ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
2/b	08:00 pm			45ml									
	09:00 pm												
	10:00 pm	Oral											
	11:00 pm			45ml									
	12:00 am												
	01:00 am			45ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
3/b	02:00 am			45ml									
	03:00 am			45ml									
	04:00 am	Oral											
	05:00 am			45ml									
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>												<b>Total 24 hrs. Output</b>	

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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.
3. 24 hrs. total to be entered in the kardex in RED.

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

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## CONSENT FOR ANAESTHESIA

Authorization By:  Patient  Patient Attendant

Operative Procedure: Palatoplasty

Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Ravichandee

### 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 Laryngospasm, Bronchospasm

### Declaration by Patient Attendant

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

### Patient / Patient Attendant:

Signature: [Signature]

Name: Dipali Barate

Relationship with patient: Mother

Date & Time: 20/5/26 6:00pm

### Witness:

Signature: [Signature]

Name: [Signature]

Date & Time: 20/5/26 @ 6pm

### Doctor (who is taking consent):

Signature: [Signature]

Name: Dr. Akhila-K.

Date 20/5/26 Time: 6:00pm

## 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 శిరస్థావం 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 రిస్క్స్:

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 సింట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటిలు, నొప్పి నివారణ కోసం నర్వ్ 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:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్:

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

Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

BAH-00657233 IP5-00174636  
Master SHOURYA TUKARAM BARATE  
21-07-2023 2 Y 10 M 12 D (M)  
Dr. RAVI CHANDER RAO



Name: Shourya T. Age: 2y 10m Sex: M UHID.No: BAH-00657233  
Date: 26/5/26 Time: 5:50pm Proposed Operation: Submucosal cleft palate  
Diagnosis: palatoplasty  
B.P / CRT: 138/80 H.R: 112 Weight: 12kgs ASA Physical Status:  1  2  3  4  5

Laboratory Data:

Hgb: <u>10.9</u>	Glucose: .....	Protein: .....	HIV: .....	X-Ray: .....
PCV: <u>33.2</u>	Urea: .....	Alb: .....	HBS Ag: .....	ECG: .....
WBC: <u>8.660</u>	Creat: .....	Total Bill: .....	HCV: .....	2D Echo: .....
Plate: <u>3.48</u>	Na: .....	Dir. Bill: .....	Blood group: .....	Stress/Anglo: .....
PT: .....	K: .....	LDH: .....	T3 .....	Other: .....
PTT: .....	Ca++: .....	Alk phos: .....	T4 .....	
INR: .....	Mg++: .....	Amylase: .....	TSH .....	
	Cl -: .....	SGOT/SGPT: .....		

Allergies:

Medical History: CVS: NVD / SKG / CIAB / no NICU admissions.  
Diabetes: Breastfed / formula fed well.  
Development appropriate.  
Immunised till date  
Physical Activity: active.  
RESP: .....

Past Anaesthetic History: NIL

Physical Exam:

Airway: MP 2 3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: (M) Teeth: (M)  
Lungs: BAE ⊕ chr. Submucosal cleft ⊕.  
Heart: S1S2 ⊕  
CNS: Alert

Pregnant:  Yes  No  NA Venous Access Site: accessible Spine Exam for regional: well felt

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE

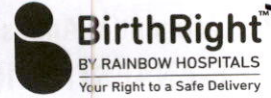
Pre-Operative Instructions:

- DVT Prophylaxis ✓
- NIL ORAL  $\left\{ \begin{array}{l} \text{Water / ORS . 2 Hours} \\ \text{Others 6 Hours} \end{array} \right\}$  explained.
- Informed Consent:  Standard  High Risk
- Post Operative Pain Management:  Discussed with Patient
- Other Instructions: CBC on cannulation

Signature: (Signature) Name: Dr. Akhila K



# ANAESTHESIA CHART



## Pre Induction Assessment:

Change in Patient Condition:  Yes  No Fasting Status: Confirmed

Physical Status:  Patient Identified  Consent Present  Chart Reviewed

H.R: 90/min B.P/CRT: 94/60mmHg SpO<sub>2</sub>: 100% R.R: 20/min Last Feed: >6hrs.

Pre-OP Diagnosis: Cleft Palate Submucosal Operation: Cleft Palate Repair Date: 2/06/2026

Surgeon: Dr. Ravi Chandar Rao Anaesthesiologist: Dr. Tejaswini / Dr. SD Technician: Srischa

TIME	2:30pm	3:30	4																	
N <sub>2</sub> O /AIR /O <sub>2</sub> LPM																				
HALO /SO /SEVO																				
Drugs:																				
MIDAZOLAM	0.6mg																			
FENTANYL	10mcg + 20mcg																			
PROPOFOL	30mg + 20mg																			
ROCURONIUM	8mg																			
PARACETAMOL	180mg																			
DEXMEDETOMIDINE	0.7mcg/kg/hr infusion																			
DEXAMETHASONE	2mg																			
TRANEXAMIC ACID	180mg																			
NEOSTIGMINE + GYLIOPROKATE	0.6mg + 120mcg																			
FiO <sub>2</sub> / SaO <sub>2</sub>	100	100	100	100	100	100														
ETCO <sub>2</sub>	41	40	40	40	40	40														
ECG	SR	SR	SR	SR	SR	SR														
Temperature	33	34	35.2	36	36	36														
Urine Output																				
Fluids																				
Blood																				
B.P																				
V Systolic																				
A Diastolic																				
X Mean																				
• Heart Rate																				
Tourniquet on Time																				
Tourniquet off Time																				
Throat Pack In																				
Throat Pack Out																				

Antibiotic  
 IN AUGMENTIN 360mg Suppository  
 Sup DICLOFENAC 12.5mg PR.

Blood Loss  
  
 NOTES

LAB Values

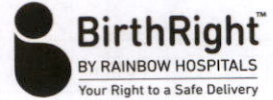
ABG

GRBS

Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input checked="" type="checkbox"/> Cuff Site: <u>OUL</u> <input type="checkbox"/> Art Site: ..... <input checked="" type="checkbox"/> EKG Lead <u>3 leads</u> <input checked="" type="checkbox"/> Temp Site <u>SKIN</u> <input checked="" type="checkbox"/> FIO <sub>2</sub> Monitor <input checked="" type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input checked="" type="checkbox"/> Capnograph <input checked="" type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator  Position: <u>ROSE</u> <input type="checkbox"/> Pressure Points Checked  Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input checked="" type="checkbox"/> Padding <input type="checkbox"/> Awake	<b>Temp:</b> <input checked="" type="checkbox"/> AWE <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input checked="" type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other  <b>Times:</b> Anaes Start: <u>2:40pm</u> OP Start: <u>3:05pm</u> OP End: <u>4:05pm</u> Leave OR: <u>4:10pm</u>  <b>Anaesthesia:</b> <input checked="" type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional  <b>Line (Size &amp; Location)</b> <input type="checkbox"/> CVP: ..... <input type="checkbox"/> ABT: ..... <input checked="" type="checkbox"/> IV: <u>22G OUL</u> <input type="checkbox"/> IV: ..... <input type="checkbox"/> IV: .....	<b>Induction</b> <input checked="" type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI <input type="checkbox"/> Others  <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT # <u>4</u> at <u>14.5</u> cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input checked="" type="checkbox"/> Drug: <u>ROCURONIUM</u>  <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input checked="" type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade # <u>2</u> Attempts: ..... Difficulty Why? .....  <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input checked="" type="checkbox"/> Closed Circle <input type="checkbox"/> Other	<b>Regional:</b> Extremity Specify: ..... <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: ..... Position: ..... <b>Site:</b> ..... Needle Size: ..... Depth: ..... Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin ..... cm Drug Name & Conc: ..... Bolus: ..... Infusion: ..... Block Level: ..... Comments: ..... <input checked="" type="checkbox"/> Transportation to <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Name of the Doctor: <u>Dr. Tejaswini</u> Signature of the Doctor:
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BAH-00657233 IP5-00174636  
 Master SHOURYA TUKARAM BARATE  
 21-07-2023 2 Y 10 M 12 D (M)  
 Dr. RAVI CHANDER RAO

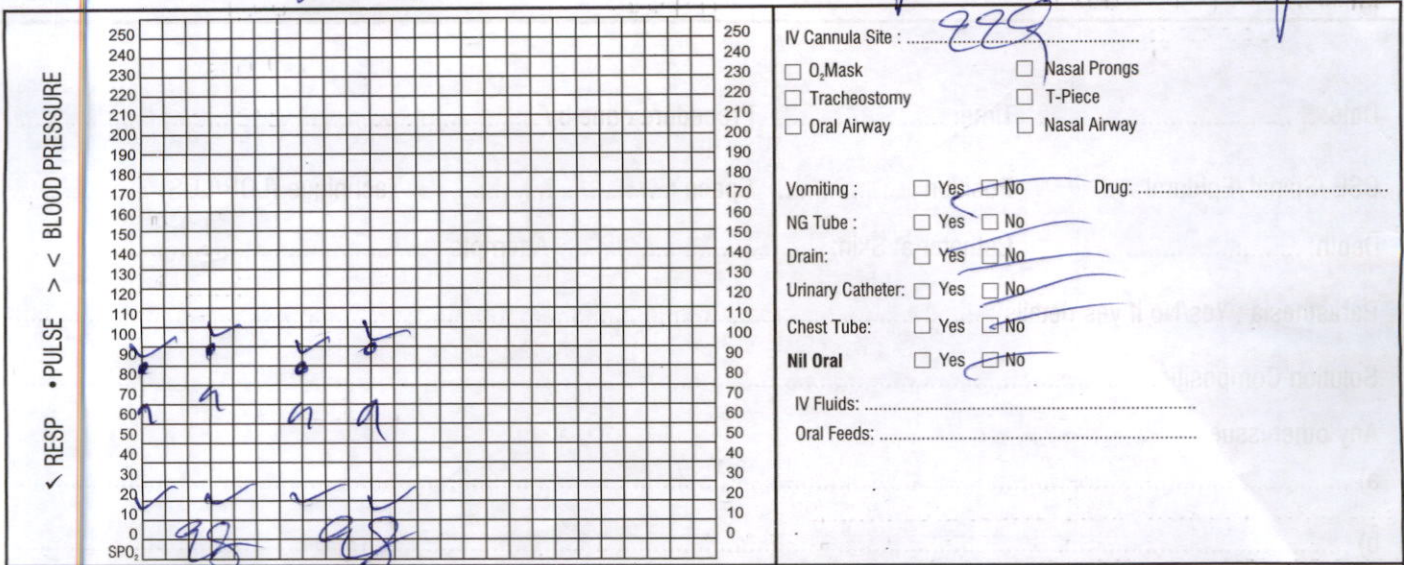


POST



T RECORD

Received in PACU by : *Deep* Time Received : *11:15pm* Time Discharged : *5pm*



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
<i>2/10</i>	<i>11:15pm</i>	<i>1/10</i>	<i>—</i>	<i>Deep</i>

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

- 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

Anaesthesiologist Name : *D. HISHWARUA*  
 Anaesthesiologist Signature: *Adhy*  
 Date & Time: *2/10/2023 11:15pm*  
 PACU Nurse Name : *Deep*  
 PACU Nurse Signature: *Deep*  
 Date & Time: *2/10/2023 5pm*

Transferred to Unit by (PACU): *BIC*  
 Date & Time: *2/10/2023 5pm*

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 : .....



# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/6/26 Time: 9 Am

Weight: 12.36 Centile: >5th

Height: 83cms Centile: <5th

Inference: underweight child

RDA: - Calories: 1250kcal/d Protein: 21g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, chilled and outside foods

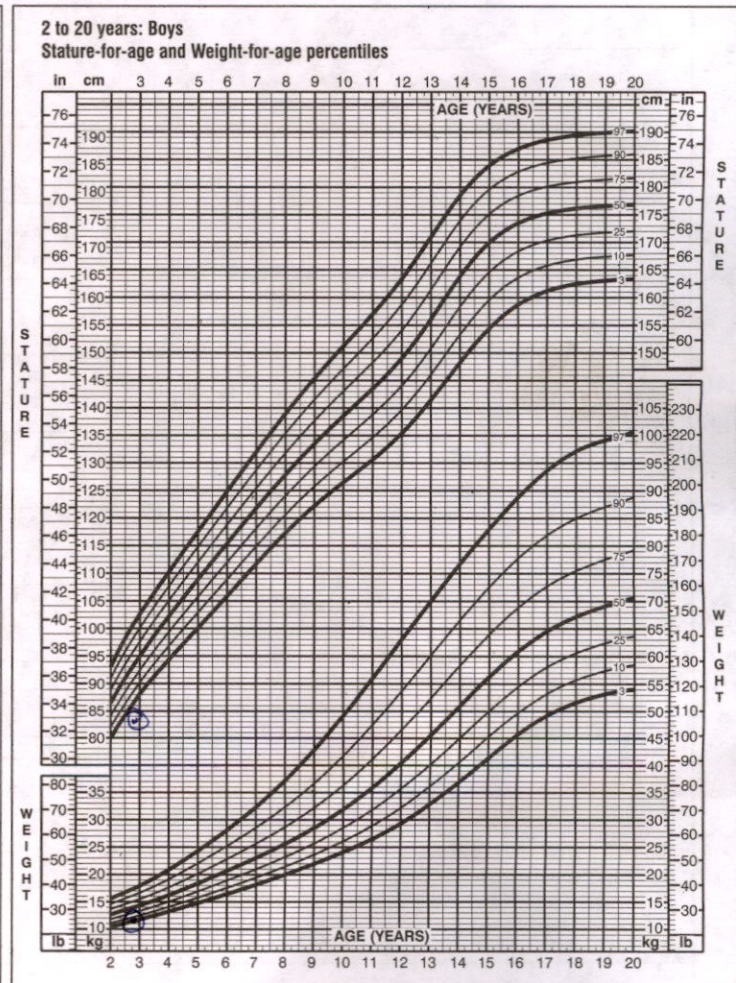
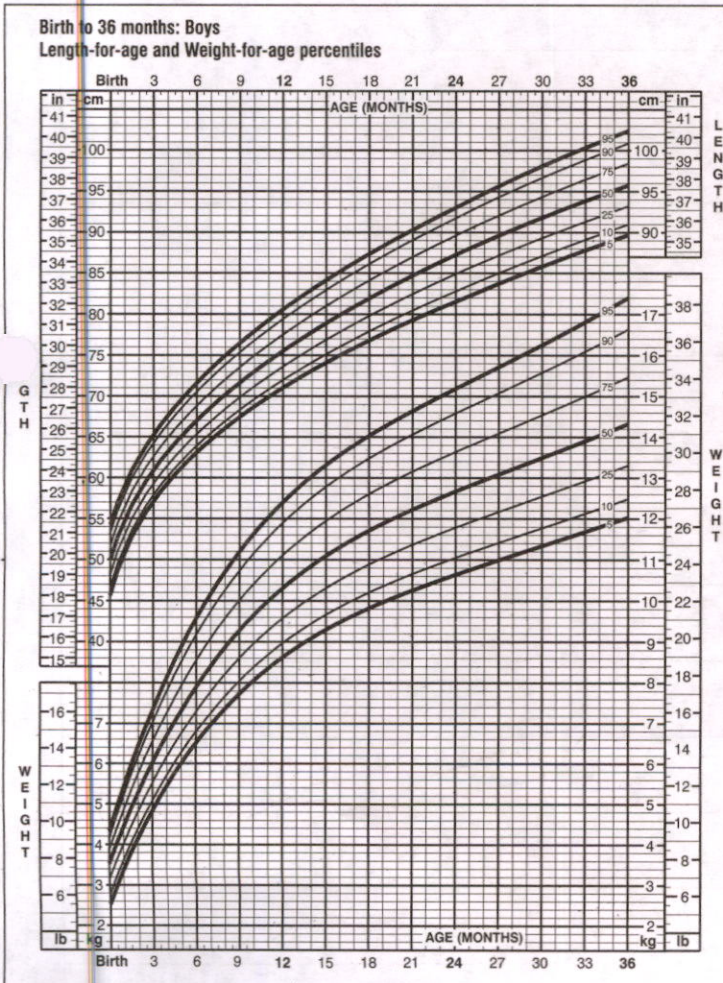
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: Submucosal cleft + palate → palatophony

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: [Signature]

## GROWTH CHART (BOYS)



Dietician's Name: Moula

Dietician's Signature: [Signature]

