BAH-00653931 IP5-00174455
Master IVAAN GAJBHIYE
22-02-2023 3 Y 3 M 6 D (M)
Dr. Prashant Bachina

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ENTERED

SURGERY DETAILS

Date : 28/05/26

Patient Name: IVAAN GAJBHIYE Date of Birth: 22-02-2023 Age: 3Y

Gender: Male Ward : P.OT UHID No.: BAH-00653931

Date of Surgery: 28/05/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : UGI endoscopy + Sclerotherapy

Time in : 3:30pm Time Out : 4pm

		NAME	AMOUNT
1.	Surgeon	Dr. Alisha.	
2.	Anaesthetist	Dr. Subrahmanyam	
3.	Assistant Surgeon		
4.	OT Technician	Venkat	
5.	Circulating Nurse	Bikela	
6.	Assistant Nurse	Beyamin	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Endoscope :— UGI Endoscopy. + Sclerotherapy.

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9631681 Order by: Bapmin

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

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Endoscopy + Selvoro

CONSUMABLES OF OT

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Circulating staff : .... Technician : .... Date : .... Time : 3:30 Pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.0 4.5 5.5	1+1	—	Major Pack Gown	2	—	Inj Vit.K		
LMA 1/2	1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	05	Appron	3	2	Suction Catheter		
HME filter : A / P / N	1	1				Feeding Tube		
Syringes : 10 cc	10	4				Vaccum Suction Set		
05 cc	10	2	Gloves			Surgical Gloves		
02 cc	10	2	6, 6½, 7, 7½	2+2+2	1	Gauze Pack		
01 cc	5	—	PF 6, 6½, 7, 7½	2+2+2	1+1+1	Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL	1	—	Cautery pencil			NS 500 ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	1	01	Koochies x2	1	1	20cc 50cc	1+1	1
minispike	1	01	Ointments			Jelly	1	1
Ommaya	1	—	Suction Catheter					
Fentanyl	1	01	Cap, Mask	5/5	5/5	Injector Needle	1	1
Morphine			Gauze Pack N	3	3			
Ketamine			Mop Pack	1	1			
Propofol	3	01	Steristrip					
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	—	Draw sheet	1	1			
~~Myopyrolate~~ Neo	2	—	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22	1	—	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter			Gauze	8	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			Gloves	4	—
Antibiotics			Bandage			Dexmed	1	—
Soupain	1	—	Tegaderm			Dexa+Ranitine	1+1	—
Suppositories			Ioban			50c+Priline	1+1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Nasal spray Otrivin	1	01
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution					
Vacumset	1	01	Microshield	1	1			
Oral airway 0, 1	1+1	—	Cotton Balls					
Nasal airway 16/18	1+1	—	Latex Gloves	5P	5P			
Bougay 10cm+11cm	1+1	—	Ramdione Scrub					
IV cannula 22/24	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse

Order No. : 963542 Ordered by : ....

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

OT Technician

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174455 **Admit Date** : 28-May-2026 **Admit Time** : 02:20 PM **UHID** : BAH-00653931

Patient Details :

Patient Name	: Master IVAAN GAJBHIYE	**Age**	: 3 Y 3 M 6 D
Guardian	: Mr RAHUL GAJBHIYE	**DOB**	: 22-02-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: D 104, SECTOR 5, NEAR PANCHVATI GARDEN, DEVENDRA NAGAR, RAJIVNAGAR Raipur CHHATTISGARH INDIA 492001	**Phone No**	: 8770710324/ 8349403111
		E-mail	: therahulgajbhiye@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 408 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 408 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL GAJBHIYE **Relationship** : Father

Contact Address : D 104, SECTOR 5, NEAR PANCHVATI GARDEN, DEVENDRA NAGAR, RAJIVNAGAR Raipur CHHATTISGARH INDIA 492001 **Phone No** : 8770710324 / 8349403111

Signature

Doctor Details :

Doctor Name : Dr. Prashant Bachina **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	3:05 pm	ER	OT	
28/5/26	5:35 pm	OT	Billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
28/8/20	CBD, PT/APTT	54281	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/8/16	IV Placement	1	31317	
	PAC done on Basis			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/2? 2pm	C/S/B Resident	
	Portal Cavernoma/EHPVO	Plan
	Came for VG/Endoscopy ± Sclerotherapy	NPO – liquids – 1pm; Solid – 9am
	Child sleeping	CB "IV cannulat" → CBP/INR/1 extra plac
	BP – 88/46 mmHg; HR – 99/min; Temp – 98.3°F; SpO_2 – 97% RA	° Blood grouping
	No vomiting; No fever; No cold, cough; Hemodynamically stable	Ayushman
	NB Bhavar 28/5/26	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Prashant   Date : 28/5/26

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

Start Time of Assessment: ....   Weight: 11.2kg

Allergic History: ....

Chief Complaints:
f/u/c – UTI / portal HTN
Now came for UGI endoscopy ± Sclerotherapy

Pediatric Assessment Triangle

A Appearance - TICLS ....

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

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

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

Any urgent interventions needed: ☐ Yes ☑ No
If Yes ....

Significant Past History: ....

Medication History: On Tab Propanolol 6mg BD, Vitcofol 2ml BD

Relevant Investigations: ....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes ....

Breathing
Rate: 24/min SpO_2 on FiO_2 97% RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE (+)
Palpation Findings (If necessary) ....

Any urgent interventions needed: ☐ Yes ☐ No ✓
If Yes ....

Circulation

HR: 99/min CFT [Central ..... / Peripheral 2sec]

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 88/46 mmHg

Pulse Volume: [Central ..... / Peripheral .....]

If in Shock: [Compensated ..... / Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: [Responsive ☑ / Non-Responsive ☐]

Size [Right ..... / Left .....] Equal

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 98.3°F

Any urgent interventions needed: ☐ Yes ☑ No

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

If Yes .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned:

CBP
LNP, Blood grouping
T exp. plain

NB Bhavik 28/5/26

Treatment Planned:

- NPO to cont.
- Shift to OT on call

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Portal Cavernoma / CHPVS for endoscopy

Assessment done by

Name of the Doctor: Dr. Ayushman

Signature: .....

Date & Time: 28/5/26, 2pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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DRUG CHART

Date of Admission: 28/5/26 Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

22-02-2023 3 Y 3 M 6 D (M)
Dr. Prashant Bachina

REGULAR PRESCRIPTIONS

Weight. 11.2kg..... Ward. OT.............

DRUG : Inj Esomeprazole				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
10mg	IV	OD	28/8	
Name & Signature of the Doctor Starting the Drugs: Ayushman.				
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				

Weight. 11.2kg Ward. OT

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

Dr. Prashant Bachina

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I.V. FLUIDS CHART

Weight. 11.2kg Ward. 05

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5	2pm	Inf DNS ½ maintenance	IV	22	[signature]	Not Entered			

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

IP5-00174455
IYE
3 M 6 D (M)

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INFORMED CONSENT FOR SURGERY / PROCEDURE

By: ☐ Patient ☑ Patient Attendant

igned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's
Avoid technical terms and leave no blank space)
UGI Endoscopy + Sclerotherapy

edge the following:

been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or
nostics performed.

benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available
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)
→ Diagnostic & Therapeutic procedure → To prevent Bleeding etc.	Nil

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.

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

a. · Abration, bleeding, perforation
b.

1. I authorize Dr. ALISHA BABBAR 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: Rahul Gaikwad (Father)
Relationship with patient: Father
Date & Time: 28/05/26 @ 3:30 p.m

Witness:
Signature: .....
Name: Deepali Gaikwad (mo
Date & Time: 28/05/26 @ 3:30 p

Doctor (who is taking consent):
Signature: ..... Name: Dr. Kunal
Date 28/05/26 Time: 3:30PM

Docu. No.: RCHBH/FRM CLINICAL / 027 (26)

(P.T.O)

Patient Sticker

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శస్త్రచికిత్స / ప్రొసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రొసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రొసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

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

ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్:

పేరు: ..... తేదీ & సమయం: .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. [illegible] h.a.
Asst. Surgeon : ...
Anaesthetist : Dr. Subrahmanya
Scrub Nurse : Benjamin

Patient Name : IVAAN GAJBHIYE Age : 3Y Gender : M
UHID No. : 653931 Surgery Name : UGI Endoscopy
Date : 28/5/26 In-time : 3:30 pm Out-time : 4 pm

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Master IVAAN GAJBHIYE
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Dr. Prashant Bachina

Before Induction of Anaesthesia ➢➢

SIGN IN Time: 3.25 PM

Patient Has Confirmed (Father)

Identity	☑ Yes ☐ No
Site	☑ Yes ☐ No
Procedure	☑ Yes ☐ No
Consent	☑ Yes ☐ No
Site Marked	☐ Yes ☐ No ☑ NA
Anaesthesia Safety Check Completed	☑ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☑ Yes ☐ No

Does Patient have a:

Known Allergy?	☐ Yes ☑ No

Difficult Airway / Aspiration Risk?

Yes, & Equipment / Assistance Available	☐ Yes ☑ No

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

Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☑ No ☐ NA
Blood Units Reserved	☐ Yes ☑ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☑ No ☐ NA

Signature : [signature]

Name : Dr. M. Subrahmanyam

Before Skin Incision ➢➢

TIME OUT Time: 3:45 pm

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 UGI Endoscopy	☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding, 15 min, 10 ml	☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

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

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☑ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?	☑ Yes ☐ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☐ Yes ☑ No

Signature : [signature]

Name : [signature]

Before Patient Leaves Operating Room

SIGN OUT Time: 3:58 pm

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 : for Dr Akisha [signature]

Name : Dr Akisha

Doc. No. : RCHBH/ FRM / CLINICAL / 111

Patient S

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Master IVAAN GAJBHIYE
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 28/05/26

To Be Filled In By Assigned Nurse :

Department : P.T Duration of Procedure : 15 min

Name of Surgeon : Dr. Alisha Date of Admission : 28/05/26

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 :	Bicon
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	Bicon
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Bicon
4.	Name of doctor or staff administering the antibiotic : Dr. Alisha Date & Time of antibiotic administration : 28/05/26 Date & Time procedure started : 28/05/26 at 3:45 pm	Bicon

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

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OPERATION THEATER NOTES

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

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

Surgeon : Dr. ALISHA BABBAR	Asst. Surgeon : Dr. Poushya. M.	
Anesthetist :	OT Nurse:	OT Technician:
Pre-Operative Diagnosis: PORTAL CAVERNOMA with lower esophageal varices.		
Surgical Procedure : UGI Endoscopy + Sclerotherapy		
Indications for Surgery : lower esophageal Varices.		
Date : 24/04/26	Start Time : 3:45 pm	End Time : 3:58 pm

Pre Operative Preparations:

NPD

Post Operative Diagnosis: Large varices lower esophageal area.

Peri-Operative Complications: Nil.

Operation Notes: Endoscope was passed from oral cavity into the esophagous forwaded into stomach & Duodenum:

1 Large, 1 Medium 1 small varix present @ GE junction, long and tortuous c- red color sign (+)

EST given with polydocanol 1ml 1.5ml and 0.75ml respectively.

Stomach - GOV, present

Mild portal hypertensive gastropathy

Duodenum - (N)

Amount of Blood Loss: 3ml | Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

Nil

Peri-Operative Complications:

Nil

Adv liquid diet for 48hr, Soft diet for 1 day followed by

- Sucralfate 4ml PO TID. x 2 weeks
- Tab. LANZOL 15mg OD x 2 weeks

Review after 4wks for repeat endoscopy.

- chest X Ray + X Ray erect abdomen - before discharge.

Name of the Surgeon: Dr. Alisha.

Signature of the Surgeon: for

Date & Time: 28/5/26, 4:30 pm.

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POST-SURGICAL CARE PLAN FORM

Procedure Done: UGI Endoscopy + Sclerotherapy

Post-Surgical Diagnosis: Lower esophageal varices

Post-Operative Monitoring Parameters /Frequency:

1 hrly

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

—

When to Start Mobilization: Immediately

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

— follow up endoscopy after 4 wk

Treating Surgeon
(Signature & Stamp)

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

Note: Plan of care will be readjusted if necessary.

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: MASTER IVAAN GAJBHIYE Age: 3Y 3m Sex: MALE UHID.No : BAH 00653931

Date: 27/5/26 Time: 5.29 pm Proposed Operation: UGI ENDOSCOPY PLUS SCLEROTHERAPY

Diagnosis: PORTAL CAVERNOMA / EHPVO

BP / CRT: 2 sec H.R: 102 Weight: 11.21 Kg Ht 89 cm ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data: 17/4/26

Hgb: 7.8	Glucose:	Protein: 7.2	HIV:	X-Ray:
PCV: 29.7	Urea: 4.3	Alb: 4.0	HBS Ag:	ECG:
WBC: 11.49	17/4/26 Creat: 0.4	Total Bill: 0.3 mg/dL	HCV:	2D Echo:
Plate: 302	Na: 136	Dir. Bill: 0.2 mg/dL	Blood group:	Stress/Anglo:
PT: 15 sec	K: 4.4	LDH:	T3	Other:
PTT:	Ca++:	Alk phos: 280	T4	
INR: 1.1	Mg++:	Amylase:	TSH	
	Cl -: 110	SGOT/SGPT: 32/23		

Allergies: No known allergy

Medical History: CVS : —

RESP : —

Diabetes : C section / FTB / Birth 2.2 / NICU admission on 2nd day on O2 7days → LOS

CNS : H/o of seizure due to hypoglycemia

Renal : —

Hepatic / GE : —

Physical Activity: playful active

Others : —

Past Anaesthetic History: UGI ENDOSCOPY plus SCLEROTHERAPY - GA 17/4/26

Physical Exam: No pallor, icterus, cyanosis, clubbing, lymphadenopathy

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

Lungs : AEBE, clear

Heart: S1 S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☑ NA

Venous Access Site : LUL RUL Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE
T PROPANOLOL 10mg	1/2 — 1/2

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours: COCONUT WATER → Others 6 Hours: SOLID FOOD/MILK
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

→ CBC: inform if Hb<8
- IV cannulation
→ Blood group, check availability
→

4 PRBC

Signature: Adi Name: Dr Adithi W

Docu. No. : RCH /FRM / CLINICAL / 044

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

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

Fasting Status: 6 hrs

H.R: 108 B.P / CRT: 93/51 SpO_2: 100 % R.R: 16

Pre-OP Diagnosis: Varices of esophagus Operation: Sclerotherapy Last Feed: 9 PM

Surgeon: Dr. Aleena Anaesthesiologist: M. Subbaheswaran Technician: Venkat Date: 25/3/26

TIME

N_2O /AIR /O_2 LPM 3 — 4

HALO /SO /SEVO

Drugs:

Midazolam 0.6 mg
Fentanyl 20 mcg
Propofol 140 mg

FIO_2 / SaO_2 O_2 Mask 100 % 100

$ETCO_2$

ECG NSR NSR

Temperature

Urine Output

Fluids DNS 100 ml/hr

Blood

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

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

Position: Left Lat

☐ Pressure Points Checked

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

Times:
Anaes Start: 3:30 PM
OP Start:
OP End:
Leave OR: 4.00 PM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 22 G RCL
☐ IV:

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

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

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

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

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

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

Name of the Doctor: M. Subbaheswaran
Signature of the Doctor:

Eye Care:

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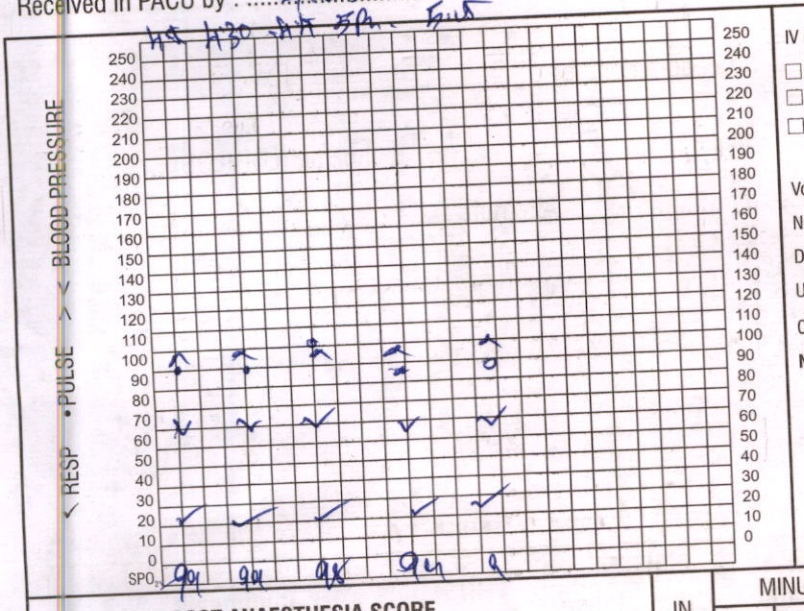
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : 4.05 PM Time Received : 4:05 PM Time Discharged : .....



IV Cannula Site (Rt) Hand

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☑ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: .....
Oral Feeds: Orally Alt

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	1	1	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	1	1	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2		
		TOTAL	8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
28/5/26	5.30	1/10	—	

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

Anaesthesiologist Name : Dr.
Anaesthesiologist Signature:
Date & Time: 28/5/26 5.30 PM

PACU Nurse Name :
PACU Nurse Signature:
Date & Time: 28/5/26 8

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

Transferred to Unit by (PACU): DL
Date & Time: 28/5/26 5.40 PM

Sticker

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Anaesthesiology

ANALGESIA RECORD

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

ural Position : ..... Space : ..... Technique (LOR/LOS) .....

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

Parasthesi... /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 : .....

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: UGI Scopy +/- Sclerotherapy

Anaesthesiologist: D.r Aditi Newaskar Surgeon: Dr Prashant Bachina

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 DESATURATION, BRADYCARDIA, + LARYNGOSPASM BLEEDING. SOS TRANSFUSED

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: Deepali
Name: Deepali Gaikwad.
Relationship with patient: Mother.
Date & Time: 27/5/21 5:19

Witness:
Signature:
Name: Rahul Gajbhiye (Father)
Date & Time: 27/5/21 5:19pm

Doctor (who is taking consent):
Signature: Aditi Name: Dr Aditi N. Date 27/5/21 Time: 5:19pm

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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.

రీజనల్ 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.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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