

HNH-00015760 IP26-00006483
 Master SRIVANSH KOLA
 20-07-2015 10 Y (M)
 Dr. MUKTA SUBHASH WAQHARE



SURGERY DETAILS

Date: 3/6/26

Patient Name: Master srivansh kola Date of Birth: 20/7/2015 Age: 10yrs

Gender: female Ward: OT UHID No.: HNH-00015760

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

Name of the Surgery: Crombision

Time in: 11:05 am Time Out: 11:45 am

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>D Mukta</u>	
2. Anaesthetist	<u>Dr. Ayesha</u>	
3. Assistant Surgeon		
4. OT Technician	<u>Dr. Saichandy</u>	
5. Circulating Nurse	<u>Sr. Pooja</u>	
6. Assistant Nurse	<u>Sr. Sushobha</u>	

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

Signature of the Surgeon: [Signature] Signature of Circulating Nurse: [Signature]

Order No.: 26-000203888 Order by: Sushobha 3/6/26

@ 1:02 PM

Handwritten marks at the top right corner, possibly initials or a signature.

Handwritten text, possibly a date or a name, located in the upper left quadrant.

Handwritten number '70' located in the middle right area.



Master Saichand Kela
 Patient Sticker
 Dr. Mukta

Circumcision



CONSUMABLES OF OT

Circulating staff : Technician : Dr Saichand Date : 3/6/20 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>Igel 2.5</u>		<u>01</u>	Major Pack <u>General</u>		<u>01</u>	Inj Vit.K		
LMA			Sutures <u>9913</u>		<u>01</u>	Cord Clamp		
ECG leads : A/P/N		<u>04</u>	<u>3650</u>		<u>01</u>	Suction Catheter		
HME filter : A/P/N						Feeding Tube		
Syringes : 10 cc		<u>04</u>				Vaccum Suction Set		
05 cc		<u>05</u>	Gloves <u>Encore-6.5/6.0</u>		<u>2+2</u>	Surgical Gloves		
02 cc		<u>03</u>				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A/P/N		<u>01</u>	Surgical blade <u>15</u>		<u>02</u>	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		<u>01</u>	Cautery pencil		<u>01</u>	TRANSOAX		<u>01</u>
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			WONTELL		<u>01</u>
<u>PMO Cone</u>		<u>01</u>	Ointments					
<u>5cc syringe</u>		<u>01</u>	Suction Catheter					
Fentanyl		<u>01</u>	Cap, Mask		<u>10+10</u>			
Morphine			Gauze Pack <u>7.5</u>		<u>05</u>			
Ketamine			Mop Pack		<u>01</u>			
Propofol		<u>03</u>	Steristrip					
Rocuronium			Underpad		<u>02</u>			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22 <u>25gpm</u>		<u>01</u>	Urobag					
Bupivacaine 0.25%		<u>01</u>	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		<u>01</u>	Romodrain bag					
Antibiotics			Bandage					
<u>lox 2%</u>		<u>01</u>	Tegaderm					
Suppositories			loban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		<u>01</u>			
<u>O2 mask (A)</u>		<u>01</u>	Microshield		<u>01</u>			
<u>Atropine</u>		<u>01</u>	Cotton Balls		<u>01</u>			
<u>Adrenaline</u>		<u>01</u>	Latex Gloves		<u>0</u>			
<u>Verlyon 16G</u>		<u>01</u>	Ramdione Scrub					
<u>encore 6.5</u>		<u>01</u>	Saral					

Surgeon Anaesthesiologist Nurse OT Technician
 Order No. : 26-0000203914/913 Ordered by : Saichand 3/6/20
 Doc. No. : RCH / FRM / GENERAL / 125 26-0000203922 1.5 PM



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015760 Name : Master SRIVANSH KOLA
Age / Sex : 10 Y / Male Doctor : MUKTA SUBHASH WAGHMARE
Adm/Reg Date/Time : 03/06/2026 09:04 Payor : HERITAGE HEALTH INSURANCE TPA PVT LTD
Order Date : 03/06/2026 13:50 Ordernumber : 26-0000203913
Visit ID : IP26-00006483 Ward/Bed No : 2F-PRIVATE ROOM / PVT-209
Patient Address : H.NO: 1-1-5/15/3. MAHALAXMI COLONY., Armoor, Nizamabad, Telangana, INDIA, 503224

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Ordered
2	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Ordered
3	CUROPINE (ATROPINE) INJ 1 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Ordered
4	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		3 Nos	Ordered
5	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Ordered
6	DSYRINGE 50 ML LUER SLIP NIPRO	SYRINGE 50ML	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
7	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
8	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Ordered
9	SPINAL NEEDLE 22	SPINAL NEEDLE 22G	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
10	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		5 Nos	Ordered
11	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
12	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		10 Nos	Ordered
13	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Ordered
14	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	10 Days		10 Nos	Ordered
15	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
16	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered

MUKTA SUBHASH WAGHMARE

Reg No : 08964

* This document is just for reference purpose only. Not to be considered as primary report.

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.



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 Age / Sex : 10 Y / Male Doctor : MUKTA SUBHASH WAGHMARE
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 Order Date : 03/06/2026 13:50 Ordernumber : 26-0000203914
 Visit ID : IP26-00006483 Ward/Bed No : 2F -PRIVATE ROOM / PVT-209
 Patient Address : H.NO: 1-1-5/15/3. MAHALAXMI COLONY., Armoor, Nizamabad, Telangana, INDIA, 503224

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ADROGLARE(ADRENALINE) INJ 1MG 1ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
2	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
3	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
6	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
7	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	Monocryl 3-0 W3650		1 Nos	/ 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
9	VICRYL RAPIDE 6-0 9913W	VICRYL RAPIDE6-09913W	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	SURGICAL BLADE 15	SURGICAL BLADE 15	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	PREGELLED SURGICAL PLATES PEAD (ADVANCE)	PREGELLED SURGICAL PLATES PEAD (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	VENFLON I -16 G	IV CANULLA 16	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
14	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
16	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	IGEL NO 2.5	IGEL 2.5	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	THEMICAINE 2% 30ML INJ		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
19	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

MUKTA SUBHASH WAGHMARE

Reg No : 08964

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DISCHARGE SUMMARY

Name	Master SRIVANSH KOLA	UHID	HNH-00015760
Father/Guardian	Mr SATEESH BABU	Age/Gender	10 Y / Male
Address	H.NO: 1-1-5/15/3. MAHALAXMI COLONY., Armoor, Nizamabad, Telangana, INDIA, 503224		
IP No	IP26-00006483	Admission Date	03-06-2026
Ref Doctor	SELF		
Discharge Date	03.06.2026		

Consultant:

Dr. MUKTA SUBHASH WAGHMARE

MBBS, DNB (Gen Surg), MCH (Pead Surg), FMAS
CONSULTANT PEDIATRIC SURGEON
08964

DIAGNOSIS	ICD CODE
BALANITIS XEROTICA OBLITERANS (BXO) WITH PHIMOSIS	

Procedure : Circumcision for Balanitis Xerotica Obliterans (BXO) with phimosis done on 03.06.2026.

History: Master SRIVANSH KOLA, 10 Y child presented with history of irritability to retract prepuce and skin infections, prior to admission. For the

Name	Master SRIVANSH KOLA	UHID	HNH-00015760
IP No	IP26-00006483	Admission Date	03-06-2026

above complaints child was admitted at Rainbow Children's Hospital for surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 72/min and Respiratory rate - 35 /min. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 44 kilo grams.

Investigations: Enclosed reports.

Procedure : Circumcision for Balanitis Xerotica Obliterans (BXO) with phimosis done on 03.06.2026.

Surgery Notes:

- Firlit collar incision made.
- Extra skin excised.

Post-Operative Notes: Post operative period was uneventful. Child was initiated on oral feeds gradually which child tolerated well. Child remained hemodynamically stable during the hospital stay and operated site remained healthy. Child is being discharged with the following advice.

Advice:

- * Diet as advised.
- * Sitz bath twice daily for 7 days
- * T-Bact ointment twice daily for local application twice daily for 7 days
- * Syrup. P-500 (Paracetamol - 5ml/500mg) 5 ml thrice daily after food for 2

Name	Master SRIVANSH KOLA	UHID	HNH-00015760
IP No	IP26-00006483	Admission Date	03-06-2026

days .

Fever Management

- * Syrup. P-500 (Paracetamol - 5ml/500mg) 5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
- * Tepid sponging if fever > 101 *F.

Review consultation^M with Dr. MUKTA SUBHASH WAGHMARE^{DO} after Monday (08.06.2026) in OPD₆ at Himayathnagar with prior appointment (**Review consultation will be charged**).

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Review consultation^M with Dr. MUKTA SUBHASH WAGHMARE^{DO} after Monday (08.06.2026) in OPD₆ at Himayathnagar with prior appointment (**Review consultation will be charged**).

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur** / **Kukatpally** / **Vikrampuri** / **LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website

consultation will be charged

Name	Master SRIVANSH KOLA	UHID	HNH-00015760
IP No	IP26-00006483	Admission Date	03-06-2026

www.rainbowhospitals.in


Registrar/Resident/C.M.O

Dr. MUKTA SUBHASH WAGHMARE
MBBS, DNB (Gen Surg), MCH (Pead Surg), FMAS
CONSULTANT PEDIATRIC SURGEON
08964

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006483 Admit Date : 03-Jun-2026 Admit Time : 09:04 AM UHID : HNH-00015760

Patient Details :

Patient Name	: Master SRIVANSH KOLA	Age	: 10 Y
Guardian	: Mr SATEESH BABU	DOB	: 20-07-2015
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: H.NO: 1-1-5/15/3. MAHALAXMI COLONY. Armoor Nizamabad Telangana INDIA 503224	Phone No	: 9885588869/ 6302918718
		E-mail	: SATEESHKOLAWAR@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : ER02 Ward Name : GF -EMERGENCY
Room No : ER02 Admission Type : First Visit

Contact Details :

Name : Mr SATEESH BABU Relationship : Father
Contact Address : H.NO: 1-1-5/15/3. MAHALAXMI COLONY.
Armoor Nizamabad Telangana INDIA 503224 Phone No : 9885588869


Signature

Doctor Details :

Doctor Name : Dr. MUKTA SUBHASH WAGHMARE Specialisation : PEDIATRIC SURGERY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 10000.00
Payor Name : HERITAGE HEALTH INSURANCE TPA PVT LTD



Wt 14 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Srivansh Kola Age : 10Y Gender: Male Female

Date : 03/06/26 Time of Arrival : 8:40 AM

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 101.3 F PR: 72 bpm BP: RR: SpO₂: 99%

Chief Complaints: C.I.D come for surgery (Circumcision)

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking	Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening
Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time :

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Jyoti

Signature of Triage Nurse : Jyoti

Date & Time : 3/06/26 @ 8:42 AM



1 2 3 4





NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/6/26 Time of arrival : 8:44 AM

Chief Complaints : C.I.C. come for surgery (Circumcision)

Height : Weight : 44 kg Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character N/A Location - Frequency Duration

<p>RISK FOR FALL:</p> <p>If patient is < 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If 'Yes' tick below fall risk intervention directly</p> <p>If Patient is > 6 years If 'Yes' Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Escort while ambulating <input type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention 	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality <p>Inform consultant for positive criteria</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method <p>Inform consultant for positive criteria</p>
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Psychological Screening: No Significant Findings
 Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?)

Time of Initial assessment completed by ER Nurse : 8:46 AM

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

Time	Nursing Notes
	- assess the pt condition
	- monitor vitals
	- IV placement done
	- sample collected

Samples collected by: *NIA*
 Samples sent by: *NIA*

Time: *NIA*
 Time: *NIA*

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>73b/m</i> BP: CFT:	Shift - out from ER to: <i>OT</i>
RR: <i>22b/m</i> SPO2 at FiO2: <i>100%</i>	Time of Shift - out: <i>10:37 AM</i>
GCS: <i>15/15</i> Temperature: <i>97°F</i>	Handover given to:
Pain Score: <i>-</i>	(Nurse's Name)
Repeat RBS (if applicable):	


Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): *IV placement done*

Name of the Nurse: *Tyson* Signature of the Nurse: *[Signature]*

Date & Time: *3/6/26 @*

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00015760 IP26-00006483 -----
 UHID No : ----- Master SRIVANSH KOLA 20-07-2015 10 Y (M) ----- Consultant : ----- Dept : -----
 Date of Admi  ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	10:38Am	ER	OT	Jyoti / S
3/6/26	12:43PM	OT	209 Room	S / Dny

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : *Sriranish Kola*

Patient ID# :

HNH-00015760 IP26-00006483
Master SRIVANSH KOLA
20-07-2016 10 Y (M)
Dr. MUKTA SUBHASH WAQHARE

Consultant :



Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : Sivamh kala Age/Sex 10y | M
Informant mother Reliability Good

Chief Presenting Complaints & Duration (Chronologically):

Inability to retract prepuce &
skin infections

History of present illness :

A 10y 10m old boy c
w/ Inability to retract prepuce and
skin infections

now admitted for circumcision

Fasting Solids (12am)
water (8:45am)

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) _____ (Centile _____) Height (cm) : _____ (Centile _____)

Weight (kgs) 44 kgs (Centile _____)

On Examination :

Temperature : (N) Pulse Rate: 72/min Description _____

B.P. _____ SPO2 99% at RA

Resp. rate and type of breathing : 35/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : nmbs (+)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : (N)

Heart Sounds : hs (+)

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection (N)

Palpation : loft

Ausculation : bs (+)

Spine: (N) External Genitelia : _____

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 :
| 5

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____ (M)

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Scared prence for discussion

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

prevent complications

Desired goals of the treatment :

hemodynamic stability

Planned Labs :

Planned Management :

① NPO

② IVF

③ Shift to OT on call

slam

Please fill up the following details

1. Name of the Referring Doctor : _____

2. Name of the Referring Hospital : _____
(Including the name of City)

3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)

4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

HNH-00015760 IP26-00006483
 Master SRIVANSH KOLA
 20-07-2015 10 Y (M)
 Dr. MUKTA SUBHASH WAGHMARE



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: D.I.

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						<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 : Dr. Nazmun


Date & Time : 3/6/26 @ 9 AM

Nurse Name & Signature: Syon / Syon

Date & Time : 3/6/26 @ 9:02 AM

Docu. No. : RCH / FRM / GENERAL / 090

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015760 IP26-00006483 Master SRIVANSH KOLA 20-07-2015 10 Y (M) Dr. MUKTA SUBHASH WAGHMARE 		Date & Time of Admission 3/6/26 @ 9:4 AM	Date & Time of Transfer Order 3/6/26 @ 10:37 AM
		Transfer Ordered by Dr. Nazmun	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis Syoni / [Signature]		Name of Person Ordered Transfer Dr. Nazmun	
Patient & Clinical Records Received by : [Signature] Sudipta			
Date & Time of Patient Received : 3/6/26 @ 10:37 AM			

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

OPERATION THEATER NOTES

HNH-00015760 IP26-00006483

Master SRIVANSH KOLA
20-07-2015 10 Y (M)
Dr. MUKTA SUBHASH WAGHMARE



Patient's Name : .. Age : Gender :

UHID : No. : Weight :

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : *Circumcision*

Indications for Surgery : *BXO & Phimosis*

Date : ~~3/6/26~~ 3/6/26 Start Time : 11:10 AM End Time : 11:45 AM

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

- follicle collar incision made

- Extra skin incision excised.

POST - OPERATIVE ORDERS :

SITZ Bath BD x 7day

T-Baer oint YA BD x 7day

P-500 sup smd TID x 2day

PO on VC. ~~after~~ on Monday

J. Miller

Consultant Surgeon's Name

[Signature]

Consultant Surgeon's Signature

Date : *2/2/26* Time : *10:40AM*

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Mukta
 Asst. Surgeon :
 Anaesthetist : Dr. Ayeella
 Scrub Nurse : Sr. Sushree

Patient Name :
 UHID No. :
 Date : 3/6/26

HNH-00015760 IP26-00006483
 Master SRIVANSH KOLA
 20-07-2015 10 Y (M)
 Dr. MUKTA SUBHASH WAGHMARE

Gender :



Before Induction of Anaesthesia >>

Before Skin Incision >>



Before Patient Leaves Operating Room

SIGN IN		Time: <u>11:00am</u>
Patient Has Confirmed		
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site Marked	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Does Patient have a:		
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature: <u>[Signature]</u>		
Name: <u>Dr. Sr. Ayeella</u>		

TIME OUT		Time: <u>11:05am</u>
Confirm all team members have introduced themselves by Name and Role <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Is Essential Imaging Displayed?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature: <u>[Signature]</u>		
Name: <u>Papa @ 11:05am</u>		

SIGN OUT		Time: <u>11:45am</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
The Specimen is Labelled (including patient name)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Whether there are any Equipment Problems to be addressed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature: <u>[Signature]</u>		
Name: <u>[Signature]</u>		

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015760 IP26-00006483 Master SRIVANSH KOLA 20-07-2015 10 Y (M) Dr. MUKTA SUBHASH WAGHMARE 		Date & Time of Admission 3/6/26 @ 9:00am	Date & Time of Transfer Order 3/6/26 @
		Transfer Ordered by Dr. Ajeesha	Reason for Transfer Observation
From Unit 05	To Unit —	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File —	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Rh	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Ajeesha	
Patient & Clinical Records Received by : Divya 12:49 PM 3/5/26			
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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: MAST. SRIVANSH KOLA Age: 10y Sex: MALE UHID.No: HNH-15760
 Date: 2/6 Time: 150pm Proposed Operation: Circumcision
 Diagnosis: BxO
 B.P / CRT: H.R: Weight: 44kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>13.3</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>39.6</u>	Urea: <u>13.9</u>	Alb:	HBS Ag:	ECG:
WBC: <u>6800</u>	Creat: <u>0.67</u>	Total Bill:	HCV:	2D Echo:
Plate: <u>2.6</u>	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
<u>CRP - 1.5</u>	Cl-:	SGOT/SGPT:		

Allergies: -NKDA-

Medical History: CVS: /
 RESP: H/O pneumonia 2010 - recovered Diabetes: -
 CNS: Child active & healthy
 Renal: /
 Hepatic / GE: / Physical Activity: active / NYHA - I
 Others:

Past Anaesthetic History: nil

Physical Exam: child alert / conscious

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

Lungs: BAE ⊕ Clinically clear

Heart: S1+S2 M^o

CNS:

Pregnant: Yes No NA Venous Access Site: peripheral Spine Exam for regional: midline

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA TIVA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>MVT</u>	

CAUDAL ANESTHESIA
 Pre-Operative Instructions: 12AM
 1. DVT Prophylaxis
 2. NIL ORAL ← Water 2 Hours / Ors 6 hrs
 3. Informed Consent Standard High Risk
 4. Post Operative Pain Management: Discussed with Patient
 5. Other Instructions: - CSF
8AM WATER
10AM

Signature: [Signature] Name: D. SANVI
 Docu. No.: RCH / FRM / CLINICAL / 044
INAYATH.

Patient Sticker

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: Adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 85/min B.P / CRT: 112/75/110 SpO₂: 98% R.R: 18/min Last Feed: > 6hrs

Pre-OP Diagnosis: PHIMOSIS Operation: CIRCUMCISION Date: 03/06/2026

Surgeon: Dr. Mukta Anaesthesiologist: Dr. Ayesha Technician: Saichand

TIME	11:00am	11:15	11:30	11:45am																
N ₂ O / AIR	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5	0.5 / 0.5
HALO / SO / SEVO																				
Drugs:	<u>3mg MIDAZOLAM 2mg IV</u> <u>3mg FENTANYL 100mcg IV</u> <u>3mg PROPOFOL 60mg 40+20mg IV</u>																			
FiO ₂ (SaO ₂)	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100	100/100
ETCO ₂	34	33	35	34	35	35	34	35	36	35	36	35	36	35	36	35	36	35	36	35
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature	<u>36.3 C</u>																			
Urine Output																				
Fluids Blood	<u>RL @ 300ml/hr</u>																			

Antibiotic
Suppository
DICLOFENAC 50mg PR
Blood Loss
NOTES
Ⓢ Monitor vitals, infern SOS

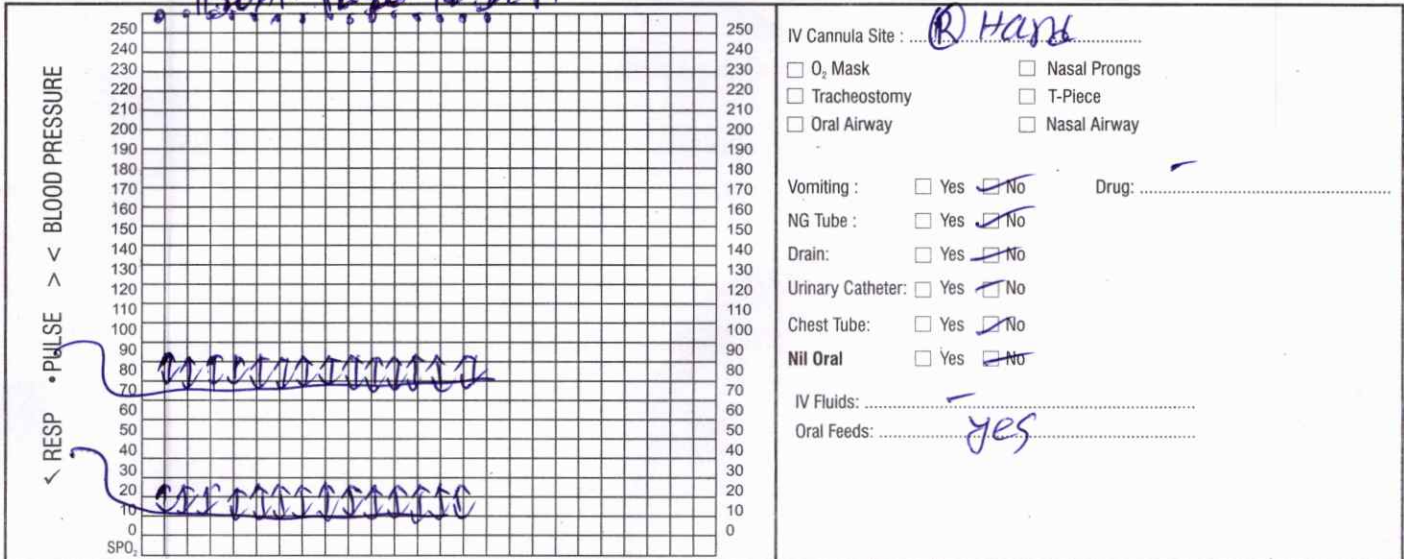
LAB Values

<p>Equipment Checked and Functional</p> <input checked="" type="checkbox"/> BP <u>HL</u> <input checked="" type="checkbox"/> Cuff Size <u>HL</u> <input checked="" type="checkbox"/> Art Site <u>3lead</u> <input checked="" type="checkbox"/> EKG Lead <input checked="" type="checkbox"/> Temp Site <input checked="" type="checkbox"/> FIO ₂ Monitor <input checked="" type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input checked="" type="checkbox"/> Capnograph <input checked="" type="checkbox"/> Ventilator <input checked="" type="checkbox"/> Nerve Stimulator <p>Position: <u>HL</u> Pressure Points Checked</p> <p>Eye Care: <input checked="" type="checkbox"/> Oint <input checked="" type="checkbox"/> Tape <input type="checkbox"/> Padding <input type="checkbox"/> Awake</p>	<p>Temp: <input checked="" type="checkbox"/> HME <input checked="" type="checkbox"/> Clear Film <input checked="" type="checkbox"/> Hugger's <input type="checkbox"/> Other</p> <p>Times: Anaes Start: <u>11:05am</u> OP Start: <u>11:05am</u> OP End: <u>11:45am</u> Leave OR: <u>11:50am</u></p> <p>Anaesthesia: <input type="checkbox"/> GA <input checked="" type="checkbox"/> Monitored <input checked="" type="checkbox"/> Regional</p> <p>Line (Size & L): <input type="checkbox"/> CVP: <input type="checkbox"/> ART: <input checked="" type="checkbox"/> IV: <u>22G</u> <input type="checkbox"/> IV: <input type="checkbox"/> IV:</p>	<p>Induction <input checked="" type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others</p> <p><input checked="" type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____</p> <p><input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade # _____ Attempts: _____ Difficulty Why? _____</p> <p><input checked="" type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other</p>	<p>Regional: Extremity <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input checked="" type="checkbox"/> Caudal</p> <p>Others: _____ Position: <u>Ⓢ Lateral</u> Site: <u>59-5</u> Needle Size: <u>22G</u> Depth: _____ Parasthesia: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: <u>0.25% BUPIVACAINE</u> Bolus: <u>20ml</u> Infusion: _____ Block Level: _____ Comments: _____</p> <p>Transportation to <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other <input checked="" type="checkbox"/> Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>Name of the Doctor: <u>Ayesha</u> Signature of the Doctor: <u>[Signature]</u></p>
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Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sudipta Time Received: 10:50 AM Time Discharged:



IV Cannula Site: R Hand

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting: Yes No Drug:

NG Tube: Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Nil Oral Yes No

IV Fluids:

Oral Feeds: yes

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	1	2	2	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 = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6/26	11:50 AM	0	NIL	[Signature]
3/6/26	12:20 PM	0	NIL	[Signature]
3/6/26	1:50 PM	0	NIL	[Signature]
3/6/26			NIL	

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: [Signature]

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: Sudipta

PACU Nurse Signature: [Signature]

Date & Time: 3/6/26 @ 12:20 PM

Transferred to Unit by (PACU):

Date & Time: 3/6/26 @ 12:20 PM

