LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 25/5/26

Patient Name: Master B. vihaan Date of Birth: 8/4/2025 Age: 1Yr

Gender: female Ward : OT UHID No.: LBH-00119379
IP26-00006423

Date of Surgery: 25/5/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Circumcision

Time in : 7:35 Am Time Out : 8:15 Am

		NAME	AMOUNT
1.	Surgeon	Dr. Swapna palakurthy	
2.	Anaesthetist	Dr. Samir	
3.	Assistant Surgeon	Dr.	
4.	OT Technician	Br. Arvind	
5.	Circulating Nurse	Sr. Puja	
6.	Assistant Nurse	Sr. Sangeetha	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-00002019789 Order by: Sangeetha

Patient Sticker

Masta. B Vihaan. Circumcision

Dr - Swapna Reddy

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CONSUMABLES OF OT

Circulating staff : ..... Technician : ..... Date : 25/05/24 Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube Igel 1.5		01	Major Pack Gemini		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		04	4915		01	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc		03	Gloves Encore 6½		02	Surgical Gloves		
02 cc		03				Gauze Pack		
01 cc			Lox 2% Jelly		01	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set		01	NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
PCM		01	Ointments					
O2 mask		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10	10 1			
Morphine			Gauze Pack 7.5x7.5		02			
Ketamine			Mop Pack		01			
Propofol		01	Steristrip					
Rocuronium		01	Underpad		01			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel cutrall		01			
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Midaz		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
Atropine		01	Microshield		01			
			Cotton Balls		01			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 20-00002019841/1983 Ordered by : Sangeetha

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

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Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad , Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: LBH-00119379	**Name**	: Master B VIHAAN
Age / Sex	: 1 Y 1 M 17 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 25/05/2026 05:35	**Payor**	: SELFPAY
Order Date	: 25/05/2026 10:02	**Ordernumber**	: 26-0000201982
Visit ID	: IP26-00006423	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: 303, Vaishnavi Elite, Netaji colony, Road no-3, Hayat Nagar, Hyderabad, Telangana, INDIA, 501505		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NEEDLE 22 G	DISPOSABLE NEEDLES 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	ROCUNIUM INJ 50 MG 5 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
3	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
8	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
9	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
10	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
11	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
12	Oxygen Mask With Tubing - PeadROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
14	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		10 Nos	Dispensed
16	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
17	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed

SWAPNA PALAKURTHY

* 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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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: LBH-00119379	**Name**	: Master B VIHAAN
Age / Sex	: 1 Y 1 M 17 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 25/05/2026 05:35	**Payor**	: SELFPAY
Order Date	: 25/05/2026 10:02	**Ordernumber**	: 26-0000201981
Visit ID	: IP26-00006423	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: 303, Vaishnavi Elite, Netaji colony, Road no-3, Hayat Nagar, Hyderabad, Telangana, INDIA, 501505		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
2	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	CUTICEL CLASSIC 10 X 30 (PARAFFIN)	CHLOROHEXDINE-LIQUID PARAFFIN DRESSING 1	1 Nos	Dental / Once Daily	1 Days		1 Nos	Dispensed
7	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
8	IGEL NO 1.5	IGEL 1.5	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
10	CUROPINE (ATROPINE) INJ 1 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
11	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed

SWAPNA PALAKURTHY

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412
O.C

DISCHARGE SUMMARY

Name	Master B VIHAAN	**UHID**	LBH-00119379
Father/Guardian	Mr B ANIL	**Age/Gender**	1 Y 1 M 17 D/ Male
Address	303, Vaishnavi Elite, Netaji colony, Road no-3, Hayat Nagar, Hyderabad, Telangana, INDIA, 501505		
IP No	IP26-00006423	**Admission Date**	25-05-2026
Ref Doctor	Pv Sai Prasad		
Discharge Date	25-05-2026		

CONSULTANT
Dr. SWAPNA PALAKURTHY
MBBS, MS, MCH
CONSULTANT PEDIATRIC SURGEON
69373

Co Consultant:
Dr. PAVULURI VENKATA SAIPRASADA RAO
GENERAL PEADIATRICS
02414

DIAGNOSIS	ICD CODE
PHIMOSIS WITH RECURRENT UTI	
CIRCUMCISION	

Procedure : Circumcision done on 25.05.2026.

History: Master B VIHAAN, 1 Y 1 M 17 D child presented to ER, history of pain during urination, prior to admission. For the above complaints child was 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 121/min, Blood Pressure - 93/54 mmHg and Respiratory rate - 20/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: 10.46 kilo grams.

Investigations: Enclosed reports.

Indications for surgery : Phimosis with recurrent UTI.

Surgery Notes:
- Phimosis with smegmal collection present.
- Standard sleeve circumcision done.
- Haemostasis secured.
- Suturing done with 5-0 rapid vicryl
- Post procedure uneventfull.

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.
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 ml thrice daily after food for 3 days.
* Betadine ointment for local application twice daily after 5 days.
* Sitz bath twice daily

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 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 with Dr. SWAPNA PALAKURTHY after 2 days (27.05.2026) Wednesday in OPD at Himayatnagar 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

Name	Master B VIHAAN	**UHID**	LBH-00119379
IP No	IP26-00006423	**Admission Date**	25-05-2026

explained by doctor ..... in a language that I can understand and I acknowledge.

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 **www.rainbowhospitals.in**

Rainbow Children Medicare Ltd. Himayathnagar 500029

Registrar/Resident/C.M.O

Dr. SWAPNA PALAKURTHY
MBBS, MS, MCH
CONSULTANT PEDIATRIC SURGEON
69373

LBH-00119379 IP26-00006423
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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion	—			
12	Consent for chemotherapy	—			
13	Consent for high risk	—			
14	Consent for Restraint	—			
15	LAMA consent	—			
16	Consent for special procedure / Sedation	1			
17	Consent for Formula feed	—			
18	Consent for MTP	—			
19	Consent for Radiological Investigations	—			
20	Consent for HIV test	—			
21	Anaestesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam	—			
23	Medication Reconciliation	—			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation	—			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	—			
31	Drug chart (Regular Prescription)	—			
32	Investigation Values (result sheet)	—			
33	Nebulization chart	—			
34	Nutritional review chart	—			
35	Intensive care unit (ICU Charts)	—			
36	Consent for Admission in PICU / NICU	—			
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds	—			
41	Gastro monitoring chart	—			
42	Rch ED doctors note	—			
43	BP Monitoring chart	1			
44	RBS monitoring chart	—			
	Total No. of Pages	22			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date :

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006423 **Admit Date** : 25-May-2026 **Admit Time** : 05:35 AM **UHID** : LBH-00119379

Patient Details :

Patient Name	: Master B VIHAAN	**Age**	: 1 Y 1 M 17 D
Guardian	: Mr B ANIL	**DOB**	: 08-04-2025 01:09 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 303, Vaishnavi Elite, Netaji colony, Road no-3 Hayat Nagar Hyderabad Telangana INDIA 501505	**Phone No**	: 9515629011/
		E-mail	: na@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr B ANIL **Relationship** : Father

Contact Address : **Phone No** : 9515629011

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA PALAKURTHY **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name: ---- LBH-00119379 IP26-00006423 Master B VIHAAN

UHID No : 08-04-2025 1 Y 1 M 17 D (M) Dr. SWAPNA PALAKURTHY ---------- Consultant : ---------- Dept : ----------

Date of Ac : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/5/26	6:40 am	ER	GT	
25/5/26	7.00 Am	OT	POST OP	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/5/26	CBP	8791	
24/5/26	PAC Done OP Basic		

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/5/20	IV Placement	(1)	1950	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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RESULT SHEET

Date	25/5/26					
Time						
Hb	13.1					
PCV	36.4					
RBC	5.80					
WBC	26.26					
N/L	37.3/55.4					
Platelets	477					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anusha

Date & Time : 25/5/26 @ 5:30 Am

Nurse Name & Signature: Jyoti / VFA

Date & Time : 25/5/26 @ 5:32 Am

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Nature .....

VERIFIED BY : Name .....

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Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

Weight. ..... Ward. .....

DRUG : Inj ESMOPRAZOLE	Dose	Route	Frequency	Start Date
	10mg	iv	OD	25/5

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Inj ONDANSETRON	Dose	Route	Frequency	Start Date
	2mg	iv	TID	25/5

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :	Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :	Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Patient Sticker

Weight. ..... Ward. .....

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
25/5	6AM	Inj ONDANSETRON	2mg iv stat	iv		
25/5	6AM	Inj ESMOPRAZOLE	10mg stat	iv		
25/5	6AM	Inj CEFOTAXIME	500mg stat	iv		
			in 20ml NS over 30min.			
25/5	7.45am	PARACETAMOL	150mg	IV		

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

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. ..... Ward. .....

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
25/4	730 am	RINGER LACTATE	IV	100 ↓ 30					

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

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OPERATION THEATER NOTES

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

Patient's Name : .....Age : 1.4.....Gender : male.....

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

Surgeon : Dr. Swapna. P	Asst. Surgeon :
Anesthetist :	OT Nurse : Sangeetha.

Surgical Procedure : CIRCUMCISION

Indications for Surgery : PHIMOSIS with Reccurent UTI

Date : 25/5/26'	Start Time : 7.35 Am	End Time : 8.15 Am

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

- Phimosis & Smegmal collection (+).
- Standard sleeve circumcision done
- Haemostasis secured
- Suturing done with 5-0 rapid vicryl
- post procedure uneventful.

POST - OPERATIVE ORDERS :

- NPO till 3 hrs
- IVF → 1/2 DNS @ 40ml/hr
- Syp. P - 250mg / PO / TID
  3ml — 3ml — 3ml
  x 3 days
- R/A 2 days to OPD (5-6 pm) for primary ATD
- SITZ Bath BD
- Betadine - Gm ointment for L/A
  wet → dry

} After primary dressing

Consultant Surgeon's Name

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna Palakurthy
Asst. Surgeon : Dr.
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Sangeetha

Patient Name : LBH-00119379 IP26-00006423 Master B VIHAAN 08-04-2025 1 Y 1 M 17 D (M) Dr. SWAPNA PALAKURTHY
UHID No. :
Date : 25/5/25

Gender : Male (circumcision)

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7.35 Am – 8.15 AM.

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 7.30 am

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☐ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☐ No ☐ NA
- Blood Units Reserved ☐ Yes ☐ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : [signature]
Name :

Before Skin Incision ➤➤

TIME OUT Time: 7.48am

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA

Signature : [signature] 7.48am
Name : Puja

Before Patient Leaves Operating Room

SIGN OUT Time: 8.20AM

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 : [signature]
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
LBH-00119379 IP26-00006423 Master B VIHAAN 08-04-2025 1 Y 1 M 17 D (M) Dr. SWAPNA PALAKURTHY	25/5/26@5:35am	25/5/26@
	Transfer Ordered by Dr.	Reason for Transfer observation.
From Unit OT	To Unit Post-OP.	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Puja	Dr.

Patient & Clinical Records Received by :
Sushila.

Date & Time of Patient Received : 25/5/26 @ 8:30Am.

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

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

wt- 10.46

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : B, Vihaan Age : 13 month **Gender:** ☑ Male ☐ Female

Date : 25/5/26 Time of Arrival : 5:25 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: 97.7F PR: 139 b/m BP: ..... RR: ..... SpO_2: 98 %

Chief Complaints: C/O Phimosis ? Come for surgery circumcision

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 8:27 AM

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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

1. 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: .....
2. 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 : Rizabi

Signature of Triage Nurse : .....

Date & Time : 25/5/26 @ 5:27 AM

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/5/26 Time of arrival : 5'25 AM

Chief Complaints: c/o Phimosis Coome for surgery RBS: .....

Height : ..... Weight : ..... BMI : ..... 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 ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 5'30 AM

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals
	→ IV placement Done
	→ medication given

Samples collected by: / Time: /

Samples sent by : / Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	ondem	IV	2mg		
	esmeprasole	IV	40 mg		

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 96b/m BP: ..... CFT: 2sec	Shift - out from ER to: OT
RR: ..... SPO_2 : 98%	Time of Shift - out: 6:48 PM
GCS: 15/15 Temperature : 97.7°F	Handover given to: .....
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

.....

Name of the Nurse : Rabin Signature of the Nurse : .....

Date & Time : 25/5/26 @ 5:27 PM

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
LBH-00119379 IP26-00006423 Master B VIHAAN 08-04-2025 1 Y 1 M 17 D (M) Dr. SWAPNA PALAKURTHY	25/5/26 @	25/5/26 @
	Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis Jyoti	Dr. Anusha

Patient & Clinical Records Received by : Pooja

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

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : _____

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2026 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Child came yes. Circumcision Surgery.
i/v/o Phimosis.

History of present illness :

- Child presented to ER with h/o pain during minalion & parent noticed inability to retract the foreskin.
- No h/o fever
- No h/o cough & cold.
- no h/o. loose stools & vomitings.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History : FT / LSCS / CIAB / NAD / Immunized.

Not Significant

Birth & Socio Economic History :

About Father :

About Mother : Not Significant

Any additional Information :

Developmental History :

Appropriate

Immunization History :

Up to date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 10.5 kg (Centile _____)

On Examination :

Temperature : Afebrile. Pulse Rate: _____ Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : –

–

Rash – Phimosis (+)

Lymphadenopathy –

Oedema : –

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AC (+)

Any addes sounds : NVBS (+) No added sound

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : No murmur

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

Per Abdomen :

Inspection _____

Palpation : Soft Not distended

Ausculation : No organomegaly.

Spine: _____ 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 :

Motor System :

Nutrition :

Tone : N Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes : N

DTR **Superficials :**

Plantars

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic :

Phimosis.

"Came for · Circumcision".

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

→ Send CBP already. / iv cannul / PAC done

→ CAUDAL ANESTHESIA plan.

Noted By Resident

Planned Management :

- NPO till further order.
  (No food from 12AM)
  no water from 5AM).
- IV fluids 30 ml/hr. (D5NS) (2/3 M)
- Monitor vitals.

Noted By Resident

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 _____

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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

UHID No : ..... Date : .....

Instruction:
This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

.....

..... CIRCumcision .....

..... upon .....

(Name of the Patient)

.....

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized 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. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

..... - Bleeding, meatal stenosis .....

..... - Infection .....

..... - wound dehiscence .....

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: .....

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Witness :

Signature : BAnil

Name : Anil Boga

Date & Time : 25/5/26 @ 7.33

Patient Attendant :

Signature : Nikhitha

Name : Nikhitha

Relationship with Patient: Mother

Date & Time : 25/5/26 @ 7:13am

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Swapna Palaparthy

Date & Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : MAST. S. VIHAAN Age : 1y 1m Gender : Male ☑ Female ☐

UHID NO: RBH- 119379 Surgeon Name: Dr SWAPNA PALAKURTHY

Anaesthesiologist : Dr SAMIR INAMDATH

Operative procedure planned : CIRCUMCISION

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 without numbness can be achieved by infusing weak solutions of local anesthetics arid 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 mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Or Supplement-alon

Comments : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient ..... the above mentioned operation / Diagnostic / Therapeutic procedures .....

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : Nikhitha

Name : P. Nikhitha

Relationship with Patient: Mother

Date & Time : 25/5/26 @ 7:13 am

Witness :

Signature : BAnj

Name : Anil Boga

Date & Time : 25/5 at 715 am

Doctor (who is taking the consent) :

Signature :

Name : Dr Sanam Prayaka

Date & Time : 25/5 at 7 15 am

9246160961

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: MAST. B. VIHAN Age: 13m. Sex: MALE UHID.No : LBH - 119379

Date: 24/5 Time: 12 NOON Proposed Operation: CIRCUMCISION

Diagnosis: PHIMOSIS

B.P / CRT: < 2sec H.R: 95/m Weight: 10.5kg ASA Physical Status: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.1	Glucose:	Protein:	HIV:	X-Ray:
PCV: 36.4	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4.77	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: NKDA

Medical History: CVS : – NO H/O CHD

RESP : URTI LAST MONTH. Diabetes : –

CNS : –

Renal : –

Hepatic / GE : BIRTH FT / LSCS / CIAB / NNJ / IMMUNISED Physical Activity: ACTIVE

Others : NO APPARENT DEV. DELAYS.

Past Anaesthetic History: NIL.

Physical Exam: CHILD ACTIVE / ALERT

Airway: MP 1 (2) 3 4 Mouth Opening: ADQ Mentohyoid Distance: 3FB Neck: (N) Teeth: INTACT (✓)

Lungs : CLEAR

Heart: S1+S2+ M–

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site PERIPHERAL Spine Exam for regional :

Anaesthetic Plan: ☑ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA – CAUDAL ANESTHESIA –

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

CURRENT MEDICATIONS	DOSAGE
BACTICA / PROBIOTICS	

Pre-Operative Instructions:

1. DVT Prophylaxis : 6 HOURS FOR FOOD / FORMU
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — 2 HOUR FOR WATE OR
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions: CRP ON CANNULATION

12 AM | FOOD / FORMULA

5 AM → | WATER / ORS

Signature: Name: DR SAMIR

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

LBH-00119379 IP26-00006423
Master B VIHAAN
08-04-2025 1 Y 1 M 17 D (M)
Dr. SWAPNA PALAKURTHY

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: confirmed	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 121/m	B.P / CRT: 93/54	SpO₂: 100%	R.R: 20/m	Last Feed: >6hr

Pre-OP Diagnosis: phimosis Operation: Circumcision Date: 25/5

Surgeon: Dr. SP Anaesthesiologist: Dr Sam Technician: Br Arvind

TIME	7:20	8:00	8:30
N_2O / AIR / O_2 LPM	2L	→	→
HALO / SO / SEVO	MAC 0.6	→	
Drugs:			
PROPOFOL	10mg + 20mg IV		
MIDAZOLAM	0.4mg IV		
FENTANYL	20mcg IV		
PARACETAMOL	150mg IV		
FIO_2 / SaO_2	100	100	100
$ETCO_2$	42	42	42
ECG	SR	SR	SR
Temperature	←	36.5	→
Urine Output			
Fluids / Blood	RL @100 ml/hr →		

Antibiotic: Given
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: ....
☐ Art Site: ....
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: ....
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 7:35 AM
OP Start: ....
OP End: 8:15 AM
Leave OR: 8:20 Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: 22G IV on Rt UL
☐ IV: ....
☐ IV: ....

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

☐ Mask ☑ SGA LMA 1.5
☐ 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: Lateral
Site: Sacral hiatus
Needle Size: 22G Depth: ....
Parasthesia ☐ Yes ☑ No
Catheter at skin .... cm
Drug Name & Conc. 0.25% BUPIVACAINE 8ml
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....
Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor Dr Ayesha
Signature of the Doctor [signature]

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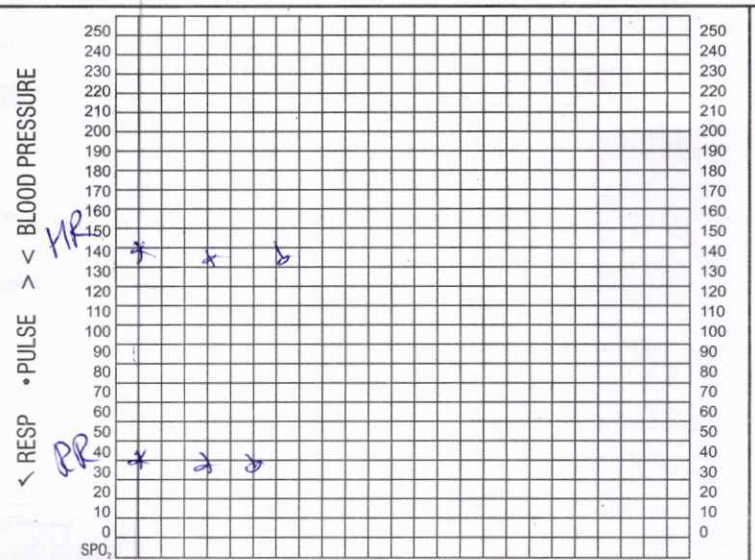
POST-ANESTHESIA CARE UNIT RECORD

Received in PACU by : Sundara Swathi Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

- ☐ O_2 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: NBM

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	2	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 Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	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	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2	2	
	TOTAL	9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/5	8AM	0	NA	
25/5	9AM	0	NA	
25/5	10AM	0	NA	
25/5	11AM	0	NA	

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

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

Anaesthesiologist Name : Dr. SK Ayesha
Anaesthesiologist Signature: .....
Date & Time: 25/5/26 @ 10AM

PACU Nurse Name : Swathi
PACU Nurse Signature: .....
Date & Time: 25/5/26 @ 10AM

Transferred to Unit by (PACU): .....
Date & Time: .....

Patient Sticker

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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 : .....