IP26-00006424
ALAPATI KOUSHIK
7 Y 7 M 12 D (M)
PALAKURTHY

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SURGERY DETAILS

Date : 25/5/26

Patient Name: Master. Koushik Date of Birth: 13-10-2018 Age: 7Yrs

Gender: female Ward : OT UHID No.: HNH-0001509I
IP26-00006424

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 : 8:30 Am Time Out : 9:10 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: 26-00002019 84 Order by: Sushmita 25/5/26 @ 10.11 Am

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

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CONSUMABLES OF OT

Circulating staff :........................ Technician :........................ Date :........................ Time :........................

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack [illegible]		01	Inj Vit.K		
LMA			Sutures 2303		01	Cord Clamp		
ECG leads : A / (P) / N		03	Encore 6½		02	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		05				Vaccum Suction Set		
05 cc		05	Gloves			Surgical Gloves		
02 cc		05	Thermocare 2½ jelly		01	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		,	Surgical blade 15		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies Large		01			
Capnograph (P)		01	Ointments					
Oxygen mask (A)		01	Suction Catheter					
Fentanyl		01	Cap, Mask					
Morphine			Gauze Pack 2-ply 7.5x7.5		[illegible]			
~~Ketamine~~ Inj. Midaz		01	Mop Pack		01			
Propofol		02	Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag cutcel		01			
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Spinal needle 22 Gvygon		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : (12.5 mg) / 25mg / 100mg		2	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
6½ Encore Glove		01	Microshield		01			
Gauze		01	Cotton Balls		01			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0002d987/1988 Ordered by : Sangeetha

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

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015091	**Name**	: Master BONDALAPATI KOUSHIK
Age / Sex	: 7 Y 7 M 12 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 25/05/2026 06:50	**Payor**	: SELFPAY
Order Date	: 25/05/2026 10:22	**Ordernumber**	: 26-0000201987
Visit ID	: IP26-00006424	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: flat no 202, syno 65, maha nagar brundavanam , road no 4, Nagole, Hyderabad, Telangana, INDIA, 500068		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
2	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		3 Nos	Dispensed
3	THEMICAINE 2% 30ML INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
6	VICRYL 5-0 VP 2303	VICRYL 5-0 NW 2303	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	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
9	SURGICAL BLADE 15	SURGICAL BLADE 15	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
11	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	SPINAL NEEDLE 22G	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	JUSTIN SUPPOSITORIES 12.5 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		2 Nos	Dispensed
15	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
17	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	: HNH-00015091	**Name**	: Master BONDALAPATI KOUSHIK
Age / Sex	: 7 Y 7 M 12 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 25/05/2026 06:50	**Payor**	: SELFPAY
Order Date	: 25/05/2026 10:22	**Ordernumber**	: 26-0000201988
Visit ID	: IP26-00006424	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: flat no 202, syno 65, maha nagar brundavanam , road no 4, Nagole, Hyderabad, Telangana, INDIA, 500068		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
2	ADULT DIAPER LARGE 10 S	DIAPER 10 L	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
5	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	GAUZE SWABS-510X10 12 PLY XRAY STERILE	1 Pkt	External / Once Daily	1 Days		1 Pkt	Dispensed
7	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
8	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	CAPNOGRAPHY NASAL CANNULA-PEAD		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
10	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
11	CUTICEL CLASSIC 10 X 10 (PARAFFIN)	CHLOROHEXDINE-LIQUID PARAFFIN DRESSING 1	1 NU	External / 10 AM	1 Days		1 NU	Dispensed
12	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

SWAPNA PALAKURTHY

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Note

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*** Do not refill medicines.**

DISCHARGE SUMMARY

Name	Master BONDALAPATI KOUSHIK	**UHID**	HNH-00015091
Father/Guardian	Mr B ANAJANEYULU	**Age/Gender**	7 Y 7 M 12 D/ Male
Address	flat no 202, syno 65, maha nagar brundavanam , road no 4, Nagole, Hyderabad, Telangana, INDIA, 500068		
IP No	IP26-00006424	**Admission Date**	25-05-2026
Ref Doctor	DR. SAI PRASAD P V		
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	

Name	Master BONDALAPATI KOUSHIK	**UHID**	HNH-00015091
IP No	IP26-00006424	**Admission Date**	25-05-2026

Procedure : Circumcision done on 25.05.2026.

History: Master BONDALAPATI KOUSHIK, 7 Y 7 M 12 D child presented with history of pain during micturition, recurrent UTI, prior to admission. For the above complaints child was evaluated and found to have adenotonsillar hypertrophy, in view of which 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 102 /min 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: 21 kilo grams.

Investigations: Enclosed reports.

Indications for surgery : Phimosis with recurrent UTI.

Surgery Notes:
- Phimosis with chordee present.
- Thick phimosis ring present.
- Standard sleeve circumcision done.
- After prepaid skin excession chordee corrected, no residual chordee seen.
- Haemostasis secured.
- Suturing done with 5-0 rapid vicryl
- Post procedure uneventful.

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Name	Master BONDALAPATI KOUSHIK	**UHID**	HNH-00015091
IP No	IP26-00006424	**Admission Date**	25-05-2026

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. Ibugesic 5 ml(Ibuprofen-5ml/100mg) thrice daily after food for 3 days.
* Betadine ointment for local application twice daily after 5 days.
* Sitz bath twice daily.

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 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.

Name	Master BONDALAPATI KOUSHIK	**UHID**	HNH-00015091
IP No	IP26-00006424	**Admission Date**	25-05-2026

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**

Registrar/Resident/C.M.O

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

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

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EFICIENCY 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	1			
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	1			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
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	27			

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

Rainbow Children's Hospital

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Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006424 **Admit Date** : 25-May-2026 **Admit Time** : 06:50 AM **UHID** : HNH-00015091

Patient Details :

Patient Name	: Master BONDALAPATI KOUSHIK	**Age**	: 7 Y 7 M 12 D
Guardian	: Mr B ANAJANEYULU	**DOB**	: 13-10-2018
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: flat no 202, syno 65, maha nagar brundavanam , road no 4 Nagole Hyderabad Telangana INDIA 500068	**Phone No**	: 9441889498
		E-mail	: 9441889498@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 ANAJANEYULU **Relationship** : Father

Contact Address : flat no 202, syno 65, maha nagar brundavanam , road no 4 Nagole Hyderabad Telangana INDIA 500068 **Phone No** : 9441889498

Signature

Doctor Details :

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

Referral Doctor : DR. SAI PRASAD P V **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 20000.00

Payor Name : SELFPAY

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

Wt - 20.9 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : master kousik Age : 8 Y **Gender:** ☑ Male ☐ Female

Date : 25/5/26 Time of Arrival : 6:45AM

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: 106bpm BP: ..... RR: ..... SpO_2: 98%

Chief Complaints: c/o cons for surgery (circumcission)

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 : .....

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 : Jyothi

Signature of Triage Nurse : .....

Date & Time : 25/5/26 @ 6:47PM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/5/26 Time of arrival : 6:49 Am

Chief Complaints: C/O Cons for Surgery RBS: .....

Height : ..... Weight : 20.9 kg 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 N/A ☐ 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?) 1

Time of Initial assessment completed by ER Nurse : 6:51 A

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vits
	- IV placemet done
	-

Samples collected by: Time:

Samples sent by : Time:

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: ..... BP: ..... CFT:	Shift - out from ER to: .....
RR: ..... SPO_2 :	Time of Shift - out: .....
GCS:..... Temperature :	Handover given to: .....
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

..... IV Placemet Done .....

Name of the Nurse : Iyeri Signature of the Nurse : .....

Date & Time : 25/5/26 6:54 Am

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015091 IP26-00006424 Master BONDALAPATI KOUSHIK 13-10-2018 7 Y 7 M 12 D (M) Dr. SWAPNA PALAKURTHY	25/5/26 @	25/5/26 @
	Transfer Ordered by Dr. Alekya	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
Jis Jyoti	Dr. Alekya

Patient & Clinical Records Received by :

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

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ACTIVITY RECORD FOR BILLING

Name: -- HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
UHID No 13-10-2018 7 Y 7 M 12 D (M) ---------- Consultant : ---------- Dept : ----------
Dr. SWAPNA PALAKURTHY

Date of A ne : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/5/26		ER	OT	

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
23/5/26	PAC Done By GP Basic		[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/5/26	IV placement	(1)	1954	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Master Bondalapati Kaushik

Patient ID# :

Consultant : Dr. Swapna Palakurthy

Final Diagnosis :

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

Pediatric Multiorgan History & Physical Examination

Name : Master. B. Kashik. Age/Sex 7y6m

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o Phimosis & recurrent UTI.

History of present illness :

Pt presented c complaint of Phimosis.

No c/o fever

No c/o Cough

No c/o Cold.

No c/o Current UTI

Pediatric Multiorgan History & Physical Examination

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

Not Significant

Birth & Neonatal History :

Normal.

Birth & Socio Economic History :

About Father :

About Mother : Normal.

Any additional Information :

Developmental History :

Normal

Immunization History :

Immunised

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 21kg (Centile _____)

On Examination :

Temperature : 98.3°F Pulse Rate: 102 Description _____

B.P. _____ SPO2 98 % at _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy (-)

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Normal

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : GCS - 15/15

Cranial Nerves :

(N)

Motor System :

Nutrition :

Tone : Power

(N)

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

(N)

Plantars

Sensory System :

Normal

Bladder / Bowel : Normal.

Clinical Summary & Diagnostic :

PHIMOSIS & RECURRENT UTI

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

IVF PLASMALYTE @ 40 ml/kg (2/3rds).

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-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

(P.T.O)

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015091 IP26-00006424
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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 : 1gx P PARACETAMOL				Date / Time
Dose	Route	Frequency	Start Date	
6.5ml	PO	SOS	2/5/r	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions: (240mg/5ml).				

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:				

Signature .....

VERIFIED BY : Name .....

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

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

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 : INJ PAN

Dose	Route	Frequency	Start Date
20mg	IV	OD	8/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : INJ ONDEM

Dose	Route	Frequency	Start Date
4mg	IV	OD	2/5

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

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.	

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/5	7am	INJ CEFOTAXIM	1 g M	IV		
25/5	7am	INJ PAN	40mg	IV		
25/5	7am	INJ ONDEM	4 mg	IV		
25/5	8:40AM	Inj: PARACETAMOL	300MG	IV		
25/5	9:00AM	DICLOFENAC Suppository	~~200~~ 25 mg	PR		

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

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

Date	Time	sition 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
25/5	2am	IVF PLASMALYTE (2/3rds)	IV	60 ml/kg					

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

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N/A ..... ☐ 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. Alekya .....

Date & Time : ..... 25/5/26 @ 7 AM .....

Nurse Name & Signature: ..... Syni / .....

Date & Time : ..... 25/5/26 @ 7:02 PM .....

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OPERATION THEATER NOTES

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

Patient's Name : .. .. Age : 7y ..... Gender : male

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

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

Surgical Procedure : Circumcision

Indications for Surgery : phimosis

Date : 25/5/26	Start Time : 8.30Am	End Time : 9.10Am.

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings:

- phimosis with chordee (+)
- Thick phimosis ring (+)

Surgery :- Standard sleeve circumision done
- After prepaid skin excision chordee corrected ; NO Residual chordee seen
- Haemostasis secured
- Suturing done with 4-0 vicryl
- post procedure uneventful.

POST - OPERATIVE ORDERS :

wt : 20.9 kg

- Npo till 3 hrs
- IVF → ½ DNS @ 60ml/hr
- Sy. Ibugesic 5ml/po/TID
  5ml — 5ml — 5ml
  × 3 days
- R/A 2 days to opd (5–6 pm)
- SIT2 Bath BD
- Betadine – Gm ointment for W/A
  mp — sig

After primary closure

.....

Consultant Surgeon's Name

.....

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
Asst. Surgeon : Dr.
Anaesthetist : Dr Samir
Scrub Nurse : Dr. Sangeetha
Date : 25/5/26

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : 7Y Gender : M
UHID No. : Circumcision
Date : 25/5/26 8.30AM
Age : 9.10AM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:20Am

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 : Ayesha
Name : Dr. SK. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 8.35Am

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) master-Koushik. ☑ Yes ☐ No
- Correct Site NA circumcision ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

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

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? Bleeding, desaturation ☐ 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

Inj. cefotaxime 1gm @ 7Am

Signature : Sushmita
Name : Sushmita 25/5/26 @ 8.35Am

Before Patient Leaves Operating Room

SIGN OUT Time: 9.15Am

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☑ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature :
Name : Dr. Swapna.

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015091 IP26-00006424 Master BONDALAPATI KOUSHIK 13-10-2018 7 Y 7 M 12 D (M) Dr. SWAPNA PALAKURTHY	25/5/26 @.	25/5/26 @
	Transfer Ordered by Dr. Ayesha.	Reason for Transfer Observation
From Unit OT	To Unit post-op	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 22	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.	RL	(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
Srs. Puja	

Patient & Clinical Records Received by : Sushela

Date & Time of Patient Received : 25/5/26 @ 9.20 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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : ..... Gender: ☑ Male ☐ Female Age : 7y/7m/1male

UHID No : ..... Date : 25/5/26

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 .....

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

..... - Residual disease. .....

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 : .....

Patient Attendant :

Signature : B. Nag

Name : B. ANJANEYULU

Relationship with Patient: father

Date & Time : 25.5.2026

Witness :

Signature : M. Padmavathi (MOSHO)

Name : .....

Date & Time : 25/5/26 @ 8:10 am.

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Swapna Palakurthy

Date & Time : 25/5/2026, @ 8:10 am.

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Master. B. KOUSHIK Age : 7y Gender : Male ☑ Female ☐

UHID NO: HNH-0001509l Surgeon Name: Dr: Swapna Palakurthy

Anaesthesiologist : Dr: Ayesha

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 : Laryngospasm, Bleeding

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 Master. B. KOUSHIK the above mentioned operation / Diagnostic / Therapeutic procedures CIRCUMCISION

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 : B. Anj

Name : B. ANJANEYULU

Relationship with Patient: father

Date & Time : 25-5-2026

Witness :

Signature : M. Padmavathi (mother)

Name :

Date & Time : 25/5/26 @ 8:10 am

Doctor (who is taking the consent) :

Signature : Dr. Sk. Ayesha

Name ~~Dr.~~ Ayesha

Date & Time : 25/5/25, 8:10 am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Master Koushik Age: 8y Sex: M. UHID.No :

Date: 23/5 Time: 12:54 pm Proposed Operation: Circumcision

Diagnosis: phimosis

B.P / CRT: .... H.R: .... Weight: 20.9 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

22/5

Hgb: 13.1	Glucose:	Protein:	HIV:	X-Ray:
PCV: 39.5%	Urea:	Alb:	HBS Ag:	ECG:
WBC: 10,100	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4,21,000	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 : Recurrent UTI – 5 months ago.

RESP : Diabetes :

CNS : nil contrib. BH – LSCS / 2.9 kg / BFD / NICU (-)

Renal :

Hepatic / GE : Physical Activity: good, active

Others :

Past Anaesthetic History: nil

Physical Exam: Ac cele

Airway: MR 1 2 3 4 (1 circled) Mouth Opening: 3fb Mentohyoid Distance: 3fb Neck: adeq. Teeth: missing upper teeth nil.

Lungs : B/L AE (=)

Heart: S1S2 (+)

CNS: (N)

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : (-) Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: 23/5/24 explained

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

Signature: [signature] Name: Archana

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

HNH-00015091 IP26-00006424
Master BONDALAPATI KOUSHIK
13-10-2018 7 Y 7 M 12 D (M)
Dr. SWAPNA PALAKURTHY

ANAESTHESIA CHART

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Pre Induction Assessment

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

H.R: 108/min	B.P / CRT:	SpO_2: 98% @ RA	R.R: 20/min	Last Feed: > 6hrs

Pre-OP Diagnosis: PHIMOSIS Operation: CIRCUMCISION Date: 25.5.26

Surgeon: Dr. SWAPNA PALAKURTHY Anaesthesiologist: Dr. Ayesha for. Sanu Technician: Saichand

TIME	8:30	8:40	8:50	9:00	9:10
N_2O /AIR/O_2 LPM		5lit/min			
HALO /SO/SEVO					
Drugs:					
Inj. MIDAZOLAM 0.8mg IV					
Inj. PROPOFOL 40+20+20+30mg IV					
Inj. FENTANYL 50mcg IV					
Inj. PARACETAMOL 300mg IV					
FIO_2 / SaO_2	100/	100/	100/	100/	100/
$ETCO_2$	24	22	24	23	24
ECG	SR	SR	SR	SR	SR
Temperature			36.2		
Urine Output					

Antibiotic

Suppository: DICLOFENAC 12.5mg + 12.5mg PR

Blood Loss

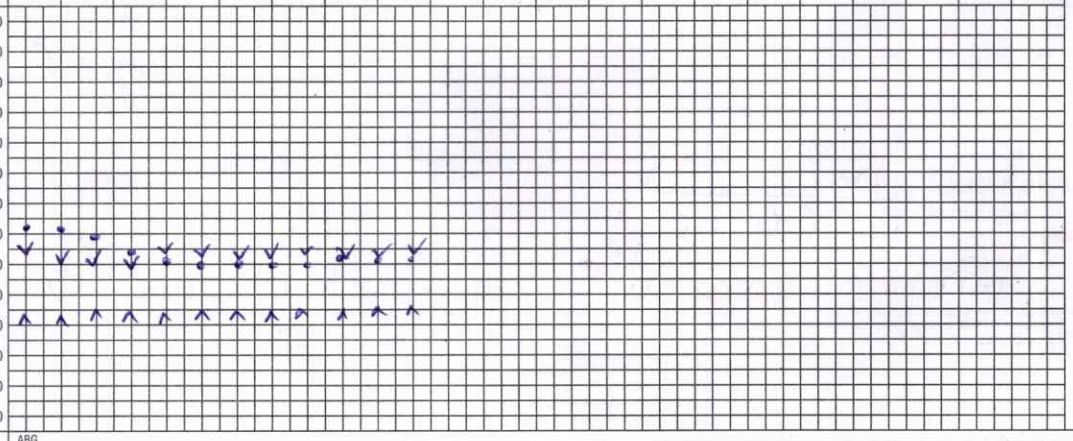
NOTES

Fluids / Blood: RL 200ml/hr

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out



LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (Rt) Lt
☐ Art Site:
☑ EKG Lead 3lead
☑ 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: 8:30Am
OP Start: 8:35Am
OP End: 9:00Am
Leave OR: 9:10Am

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 22G IV on (Rt) LL
☐ IV:
☐ 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: Caudal
☐ Spinal ☐ Epidural ☑ Caudal
Others:
Position:
Site:
Needle Size: 22G Depth:
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 0.25% BUPIVACAINE
Bolus: 15ml
Infusion:
Block Level:
Comments:

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

Name of the Doctor: Dr. Ayesha
Signature of the Doctor: for Ayesha

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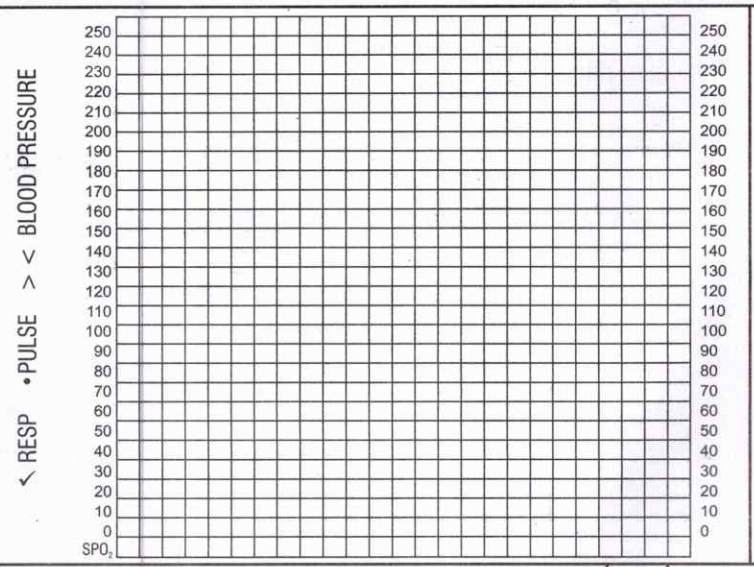
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sujatha ..... 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: I
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	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		2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2	2	
		TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/5	9AM	0	NA	
25/5	9:30AM	0	NA	
25/5	10 AM	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 : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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 : .....

Rainbow Childrens Hospital-Himayatnagar
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.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master BONDALAPATI KOUSHIK**	**Age :**	**7 Y 7 M 12 D**
IP No:	**IP26-00006424**	**Sex:**	**Male**
Consultant:	**Dr. SWAPNA PALAKURTHY**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature: B.A.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: B.Ah

Name: B.ANJANEYULU

Relationship: Father

Date: 25-5-2026 Time: 6:50 Am.

Witness Name: Yaseen ali khan

Witness Signature: Yasee

Patient Address:

flat no 202, syno 65, maha nagar
brundavanam , road no 4 Nagole
Hyderabad Telangana INDIA 500068