HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 15/07/26

Patient Name: Master. Abdul Ahad Khan Date of Birth: 27/10/2025 Age: 8 months

Gender: Male Ward : OT - R UHID No.: HNH-00012234

Date of Surgery: 15/07/26 ☐ OT -1 ☒ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (21) open Standard orchidopexy

Time in : 8:15am Time Out : 9:15am

		NAME	AMOUNT
1.	Surgeon	: Dr. Swapna Palakurthy	
2.	Anaesthetist	: Dr. Samir / Dr Aditi	
3.	Assistant Surgeon	:	
4.	OT Technician	: Br. Arvind	
5.	Circulating Nurse	: Sr. Karuna Sandya	
6.	Assistant Nurse	: Sr. Natasha / Sandhya	

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

Signature of the Surgeon

Karuna
Signature of Circulating Nurse

Order No: 26-00002139752

Order by: Sandhya 15/7/26 @ 10:17am.
(Or record saved)

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

Standered

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Left orchidopexy

CONSUMABLES OF OT

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Circulating staff :..... Technician : Arvind Date : 15/07/26 Time :.....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube O2 mask (P)		01	Major Pack General pack		01	Inj Vit.K		
LMA Midazolam		01	Sutures			Cord Clamp		
ECG leads : A / (P) / N		03	2303, 2305	1+1	1	Suction Catheter		
HME filter : A / P / N			9915	1		Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc		05	Gloves			Surgical Gloves		
02 cc		02	Encore 6/2	2+1		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / (P) / N		01	Surgical blade 15		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil		01			
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
PCM		01	Ointments					
Aquamantra 15		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10+10				
Morphine Atropine		01	Gauze Pack 10x-ray	1+1				
Ketamine Adrenaline		01	Mop Pack					
Propofol		02	Steristrip					
Rocuronium Encore 7.0		01	Underpad		01			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron		01	Foleys catheter					
Pencan 25g/ Spinal Needle 22 (Vygon)		01	Urobag					
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban		01			
Neomol Anamol : 80mg / 250mg / 170 mg		01	Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield		01			
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002139 61/960/9771 Ordered by : Sandhya 15/7/26 @ 11:20am

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

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012234	**Name**	: Master ABDUL AHAD KHAN
Age / Sex	: 0 Y 8 M 18 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 15/07/2026 05:40	**Payor**	: SELFPAY
Order Date	: 15/07/2026 10:50	**Ordernumber**	: 26-0000213961
Visit ID	: IP26-00006846	**Ward/Bed No**	: 4F -OT / PRE/POST-420
Patient Address	: Chilkalguda, Hyderabad, Telangana, INDIA, 500061		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		1 Pkt	Dispensed
3	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
5	SURGICAL BLADE 15	SURGICAL BLADE 15	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	VICRYL RAPIDE 5-0 9915W	VICRYL RAPIDE5-09915W	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	VICRYL 5-0 VP 2303	VICRYL 5-0 NW 2303	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	VICRYL 4-0 NW 2305	VICRYL 4-0 NW 2305	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		3 Nos	Dispensed
10	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
12	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	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.**

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012234	**Name**	: Master ABDUL AHAD KHAN
Age / Sex	: 0 Y 8 M 18 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 15/07/2026 05:40	**Payor**	: SELFPAY
Order Date	: 15/07/2026 10:50	**Ordernumber**	: 26-0000213960
Visit ID	: IP26-00006846	**Ward/Bed No**	: 4F -OT / PRE/POST-420
Patient Address	: Chilkalguda, Hyderabad, Telangana, INDIA, 500061		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Ordered
2	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
3	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered

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.**

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012234	**Name**	: Master ABDUL AHAD KHAN
Age / Sex	: 0 Y 8 M 18 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 15/07/2026 05:40	**Payor**	: SELFPAY
Order Date	: 15/07/2026 11:25	**Ordernumber**	: 26-0000213977
Visit ID	: IP26-00006846	**Ward/Bed No**	: 4F -OT / PRE/POST-420
Patient Address	: Chilkalguda, Hyderabad, Telangana, INDIA, 500061		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	PREGELLED SURGICAL PLATES PEAD (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	NEOMOL SUPPOSITORIES 250 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
5	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
6	Oxygen Mask With Tubing - PeadROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	SPINAL NEEDLE 22G	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
10	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	ANAWIN INJ VIAL 0.25% 20 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
13	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
14	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
15	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.**

Printed Date/Time : 15/07/2026 11:37 Printed By : SUNKARI SANGEETHA

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
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				
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)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
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				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	23			

Signature and Date : 15/7/2026 (P.T.O)

Rainbow Children's Hospital

BirthRight by Rainbow

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006846 **Admit Date** : 15-Jul-2026 **Admit Time** : 05:40 AM **UHID** : HNH-00012234

Patient Details :

Patient Name	: Master ABDUL AHAD KHAN	**Age**	: 0 Y 8 M 18 D
Guardian	: Mr AZMATH KHAN	**DOB**	: 27-10-2025 06:36 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Chilkalguda Hyderabad Telangana INDIA 500061	**Phone No**	: 8978600315/
		E-mail	: 8978600315@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 AZMATH KHAN **Relationship** : Father

Contact Address : Chilkalguda Hyderabad Telangana INDIA 500061 **Phone No** : 8978600315

Signature

Doctor Details :

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

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 80000.00

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

DISCHARGE SUMMARY

Name	Master ABDUL AHAD KHAN	**UHID**	HNH-00012234
Father/Guardian	Mr AZMATH KHAN	**Age/Gender**	0 Y 8 M 18 D/ Male
Address	Chilkalguda, Hyderabad, Telangana, INDIA, 500061		
IP No	IP26-00006846	**Admission Date**	15-07-2026
Ref Doctor	Self.		
Discharge Date	16.07.2026		

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

DIAGNOSIS	ICD CODE
LEFT UNDESCENDED TESTIS	

Procedure : LEFT OPEN STANDARD ORCHIDOPEXY DONE ON 15.07.2026

History: Master ABDUL AHAD KHAN, 0 Y 8 M 18 D child presented with history of left undescended skin testis noticed at 1 month of age prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for

Name	Master ABDUL AHAD KHAN	**UHID**	HNH-00012234
IP No	IP26-00006846	**Admission Date**	15-07-2026

surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 110/min and Respiratory rate - 36 /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: 7.9 kilo grams.

Investigations: Enclosed reports.

Procedure : LEFT OPEN STANDARD ORCHIDOPEXY DONE ON 15.07.2026

Surgery Notes:
* Left testis small in size 0.5 x 0.5 cm size in mild inguinal region.
* Left epididymo testicular dissociation is seen.
* Right testis 1 x 1.5 cm size normal is scrotal sac.

Procedure: Under aseptic precautions the above said region cleaned and drapped.
* Inguinal clax incision given.
* Opened in layer.
* Testis separated from sac, herniotomy done.
* Lengthening of cord structure done.
* Testis brought into scrotum and fixed.
* Inguinal incision closed.
* Haemostasis secured.
* Post procedure uneventful.

Post-Operative Notes: Post operative period was uneventful. Child was

Name	Master ABDUL AHAD KHAN	**UHID**	HNH-00012234
IP No	IP26-00006846	**Admission Date**	15-07-2026

initiated on oral feeds gradually which child tolerated well. He remained hemodynamically stable during the hospital stay and operated site remained healthy. Child is being discharged with the following advice.

Advice:

1. CROCIN DROPS (1ML/100MG) 1.2 ML SOS OR 6TH HOURLY

Review consultation with Dr. SWAPNA PALAKURTHY after 2 weeks in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Follow up immediately in Emergency Room if pain, bleeding, 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.

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

Name	Master ABDUL AHAD KHAN	**UHID**	HNH-00012234
IP No	IP26-00006846	**Admission Date**	15-07-2026

free number **18002122.**

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Rainbow Children's Medicare Ltd. Hyderabad Himayathnagar 500029

Registrar/Resident/C.M.O

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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

ACTIVITY RECORD FOR BILLING

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Name: --- ----------

UHID No ---------- Consultant : ---------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	6:30 PM	ER	OT	A.12 / Sangeetha
15/7/26	9:30 PM	OT	MICU	Sandhya / Kavya
15/7/26	12:50 pm	MICU	3rd floor	Nafeesa / d

Cross Consultation Visit

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

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

INVESTIGATIONS

Date	Investigations	Order No.	Sign
15/7/4	CBP CT - BT	11748 Cross checking done	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2026 0 Y 8 M 18 D
Dr. SWAPNA PALAKURTHY (M)

Date	Name of Equipment	Connecting Time	Disconnecting Time	O	

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/7/26	IV placement	1	13909	[illegible]
	[PAC done op before]			
15/7/26	NHA	(1)	214039	[illegible]
			cross checked done	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : Abdul Ahad Khan

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Name : Abdul Ahad Khan Sex 8m/m

Informant mother Reliability good

Chief Presenting Complaints & Duration (Chronologically):

(L) undescended testis noticed at 1 month of age

History of present illness :

An 8m old boy c
(L) undescended testis noticed at 1 month of age.

planned for (L) standard open orchidopexy

no fever
no antibiotics

NPO since 12am (solids)
6am (liquids)

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

-

Birth & Neonatal History :

no neonatal complications

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information : -

Developmental History :

as per age

Immunization History :

as per. schedule.

Anthropometry

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

Weight (kgs) 7.9 kgs (Centile _____)

On Examination :

Temperature : 98.4°F. Pulse Rate: 110/min Description _____

B.P. _____ SPO2 98 % at RA

Resp. rate and type of breathing : 36/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

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

Air entry & breath sounds : N WS (+)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (N)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation : BS (+)

Spine: (N) External Genitelia : (N) Scrotal sac empty

Relevant data from outside (CT, USG etc.,) Palpable testes in inguinal canal.

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : (N)

Cranial Nerves :

(N)

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture : (N)

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

(R) Undescended testis for
(R) open orchidopexy

Preventive aspects of the treatment :

present complications

Desired goals of the treatment :

Hemodynamic stability

Planned Labs :

CBP,
BT i CT

Planned Management :

1. NPO
2. IV fluids
3. Shift to OT on call

Sd
(Dr. Naman)

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-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26	IB Dr. Archana .	
2pm	POD0 -	
	Post op case of Left Open Orchidopexy .	
	Dressing @ surgical site (+)	Adv .
	No bleeding	· Continue NBM until 12:30 pm .
	Afebrile .	· Syp PARACETAMOL (SOS)
	.	if pain .
	ole	
	vitally stable	· Inj PAN stat .
		· Inform SOS if pain/bleeding
	sle	· Discharge .
	WNL .	
		.

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00012234 IP26-00005846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 6 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 15/7/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

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

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Syp PARACETAMOL				Date / Time
Dose	Route	Frequency	Start Date	
2.5ml	PO	TDS	15/7/25	
Name & Signature of the Doctor Starting the Drugs: Laf				
Additional Instructions: 240 mg (5ml)				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

		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
15/07	7:45AM	INJ AMOXICLAV	210 mg	IV - ATD	[illegible]	[illegible]
15/7	915 am	PARACETAMOL	250 mg	PR	[illegible]	[illegible]
15/7.	2pm	Syp PCM (250mg/5ml)	2.5 ml .	stat.	[illegible]	[illegible]
15/7	2pm	Inj PAN .	7mg IV.	stat	[illegible]	[illegible]

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

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. 7.9kg Ward. .....

Date		osition of I.V. Fluid (If infusion, ...ention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7	6:30 AM	DNS (since NPO)	IV	20 ml/h	[illegible]	A.D			
						A.D			
15/7	8AM	RINGER LACTATE	IV	50	[illegible]	[illegible]	15/7	[illegible]	[illegible]
						[illegible]			

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

Abdul Ahad Khan

Patient Sticker

DM 18 D

311

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 15/7/26 Time: 1120 pm

Weight: 7.9 kg Centile: < 5th

Height: – Centile:

Inference: Underweight child

RDA: – Calories: 98 Kcal/day Protein: 1.6 gms/day

Diet Recommendations: Cerelac stage (2) [+Complementary food] (1:3 ml dilution)

Re-Assesment: Stage (2) Complementary food on Weaning food & HEE.

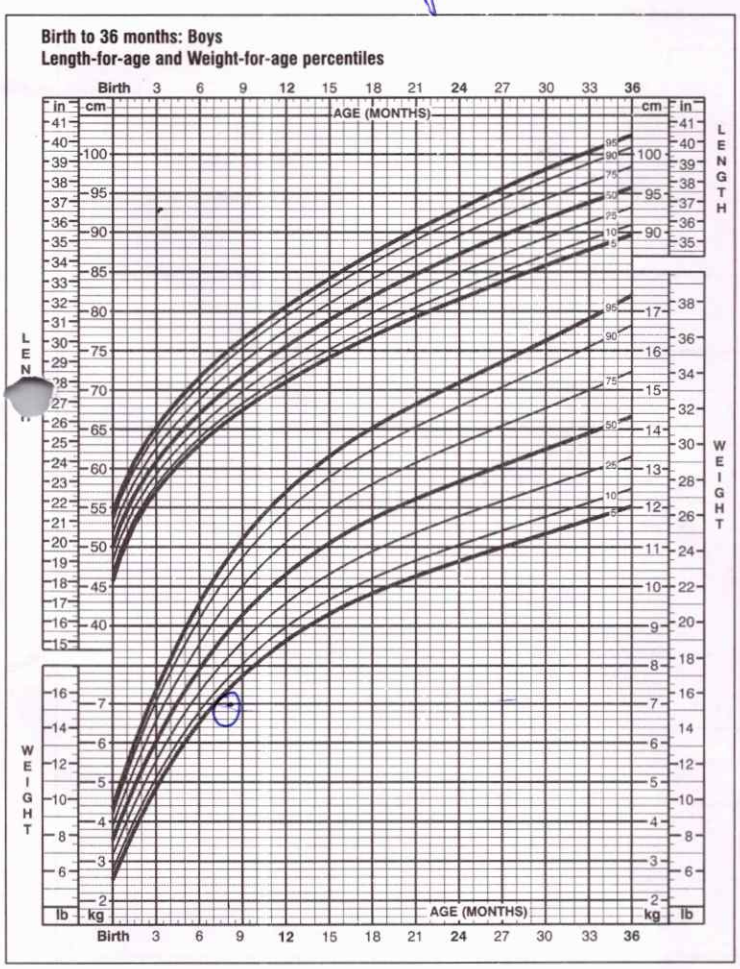
Food Allergies: Nil Veg/Non-veg Non veg

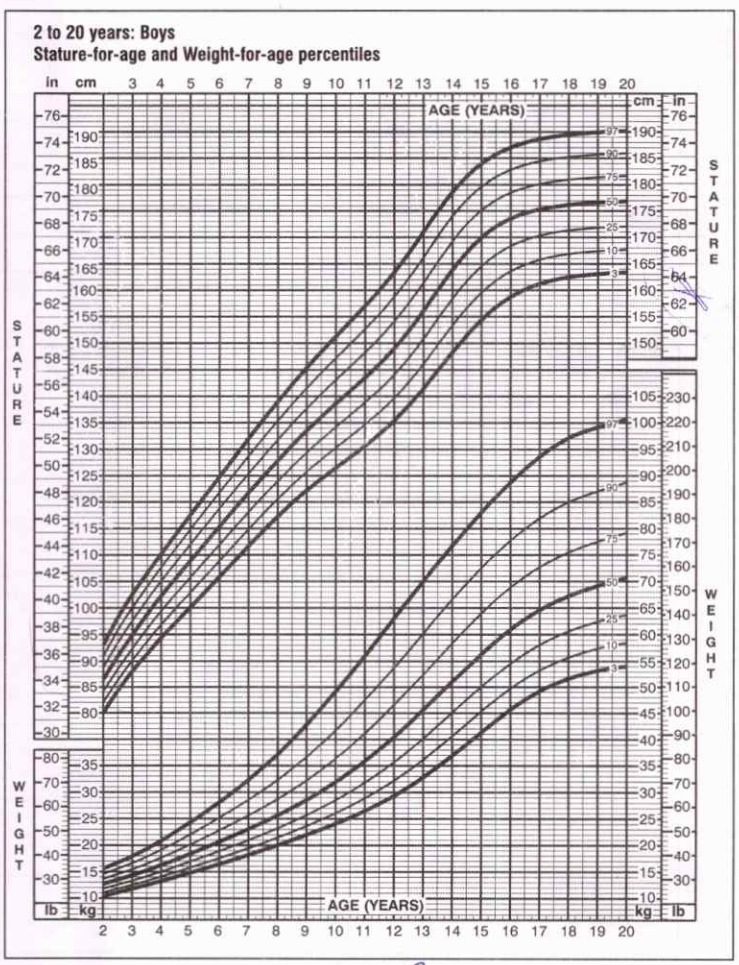
Diagnosis: (1) Undescended testis for (1) year on video.

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Afreen Begum

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer

Dietician's Signature Sobiya

Docu. No. : RCH /FRM / CLINICAL / 160

(P.T.O.)

Daily Notes:

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

OPERATION THEATER NOTES

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Patien .....Age : .....Gender : .....

UHID. .....I.P.No. :.....Weight : .....

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : (R/L) Open Standard Orchidopexy

Indications for Surgery : (R/L) Undescended testis (palpable)

Date :	Start Time : 8:15am	End Time : 9:15am

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings :

- (R/L) testis small in size 0.5 x 0.5cms size in mid inguinal region.
- (R/L) Epididymis testicular dissociation is seen.
- (R/L) testis 1 x 1.5 cm size - (N) in scrotal sac

Procedure :

- Asp the above said region cleaned & draped
- inguinal clear incision given
- opened in layers
- above said findings noted
- testis separated from sac, herniotomy done
- lengthening of cord structures done
- Testis brought into scrotum & fixed in subdartos pouch

- inguinal lymph node cleared
- Haemostasis secured
- post procedure uneventful.

POST - OPERATIVE ORDERS :

Npo till 3 hrs.

IVF - ½ DNS @ 28ml/hr

Inj. pcm 1gm/iv/tid

Inj pan 40mg/iv/od

Monitor vitals/Inform sos.

.....

Consultant Surgeon's Name

.....

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

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

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

Age : Gender :
Surgery Name : (L) Orchidopexy
Date 15/07/26 In-time : 8:15 AM Out-time : 9:15 AM

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: 8AM

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

(L) side

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 : [signature]

Before Skin Incision ➢ ➢

TIME OUT Time: 8:20AM

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
  (Surgery 1 hour, 5ml)

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 : Karuna
Name : Karuna @ 8:20AM

Before Patient Leaves Operating Room

SIGN OUT Time: 9:10 AM

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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012234 IP26-00006846 Master ABDUL AHAD KHAN 27-10-2025 0 Y 8 M 18 D (M) Dr. SWAPNA PALAKURTHY	15/7/26 @ 5:40 AM	15/7/26 @
	Transfer Ordered by Dr. Samir	Reason for Transfer Observation
From Unit OT	To Unit MICU	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File —	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.	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
Sr. Karuna	Dr. Samir.

Patient & Clinical Records Received by : Karuna

Date & Time of Patient Received : 15/7/26 @ 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

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012234 IP26-00006846 Master ABDUL AHAD KHAN 27-10-2025 0 Y 8 M 18 D (M) Dr. SWAPNA PALAKURTHY	15/7/26 @. 5:40 PM	15/7/26 @. 12:35
	Transfer Ordered by Dr SAMIR	Reason for Transfer Observation
From Unit OT.	To Unit 3rd Floor	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	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.	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
Sr. Natasha Natasha	Dr. Samir.
Patient & Clinical Records Received by : Sweety	
Date & Time of Patient Received : 15/7/26 @ 12:40 pm	

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

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012234 IP26-00006846 Master ABDUL AHAD KHAN 27-10-2025 0 Y 8 M 18 D (M) Dr. SWAPNA PALAKURTHY	15/7/26	15/7/26
	Transfer Ordered by Dr. Rahman	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File —	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
Anupam	Dr. Rahman.

Patient & Clinical Records Received by : Rasung 15/7/26

Date & Time of Patient Received :

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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. Nadim

Date & Time : 15/11/26

Nurse Name & Signature: Anju

Date & Time : 15/11/26 @ 6AM

Duty Anesthesia 9246160941 | 2AM | ← 8AM J'C

FORMULA SOLIDS — (6AM) WATER/ORS.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Rainbow® Children's Hospital — It takes a lot to treat the little. | BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Name: Abdul Ahad. Age: 8m Sex: Male UHID.No: HNH-12234

Date: 13/7 Time: 12pm Proposed Operation: (L) OPEN ORCHIDOPEXY

Diagnosis: (L) UDT

B.P / CRT: .... H.R: .... Weight: (2) 7.9 kgs ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 11.8	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 3.48	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:

RESP: Child apparently fit & healthy Diabetes:

CNS: No significant medical history.

Renal:

Hepatic / GE: Developmentally (N). Physical Activity:

Others: Birth 32 wks / LSCS / CAEB / ~~NO~~ NNJ / Immunised.

Past Anaesthetic History: nil.

Physical Exam: cooperative, alert.

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

Lungs: BAE (+) clear

Heart: S1S2+

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: peripheral Spine Exam for regional: Caudal midline ~~fel~~ felt

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

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

CURRENT MEDICATIONS	DOSAGE
MVT.	

Pre-Operative Instructions:

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:

11AM = SOLIDS FORMULA; 3pm = WATER ORS.

- Check wt. — SOLIDS @ 12:00 AM; MILK @ 2:00 AM; WATER @ 6:00 AM
- CAP

Signature: [signature] Name: Dr Sanmi Mayalk.

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

Patient Sticker

ANAESTHESIA CHART

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Ok. - noted	
Physical Status:	☐ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R.: 96/m | B.P / CRT: 84/48 | SpO_2: 100% | R.R.: 19/m | Last Feed: >6hrs.

Pre-OP Diagnosis: (L) UDT | Operation: (L) orchidopexy | Date: 15/7

Surgeon: Dr. Swapna palahuthy | Anaesthesiologist: Dr. Sanu / Dr. AH | Technician: Aravind

TIME	8:15	8:45	9:15
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
PROPOFOL	15 + 15 + 5mg		
MIDAZOLAM	0.6mg		
FENTANYL	20mcg		
FIO_2 / SaO_2	100	100	100 / 100
$ETCO_2$			
ECG	SR	SR	SR / SR
Temperature			
Urine Output			
Fluids / Blood	RL		

Antibiotic: 8mg.
Suppository: Pcm 250mg
Blood Loss: ~ 2ml
NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate
Tourniquet on Time / Tourniquet off Time
Throat Pack In / Throat Pack Out
(Scale: 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: (R) LL
☐ Art Site:
☑ EKG Lead 3 lead
☑ Temp Site skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 8:15am
OP Start: ↓
OP End: ↓
Leave OR: 9:15am

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 24G (L) DV
☐ 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 spontaneous c facemask

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☑ Caudal
Others:
Position: (L) lateral
Site: Caudal space
Needle Size: 20G Depth: -
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: 5ml 0.25% bupivacaine.
Bolus:
Infusion:
Block Level: adq.
Comments:
Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr. AMW
Signature of the Doctor: [signature]

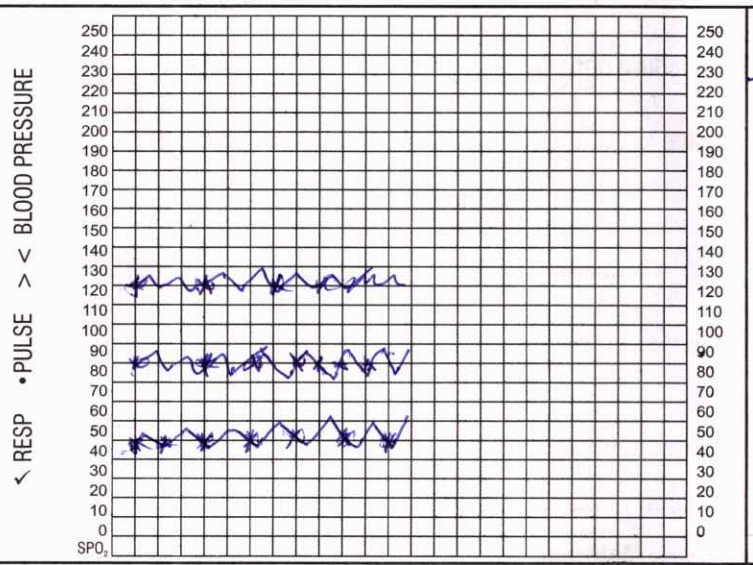
Patient Sticker Mrs Abdul Ahad Khan

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Karuna Time Received : 8:00 Am Time Discharged : .....



IV Cannula Site : Left Side

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

Vomiting : ☐ Yes ☑ No Drug: Augmentin 2.2 gm.

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☐ Yes ☑ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☐ Yes ☐ No

IV Fluids: RL

Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	1	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	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/7/26	8:20am	0	Normal	
15/7/26	8:25am	0	Normal	
15/7/26	8:40am	0	Normal	
15/7/26	9:10Am	0	Normal	

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : Karuna

PACU Nurse Signature: Kar

Date & Time: 15/7/26 @ 9:45am

Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 : .....

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

wt - 7.9 kg

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Abdul Ahad Khan Age : 8m **Gender:** ☑ Male ☐ Female

Date : 15/7/26 Time of Arrival : 5:40 Am

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

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2 PR: 110 BP: ..... RR: ..... SpO_2: 98%

Chief Complaints: C/O come from orchidopexy

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 : 5:42 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 : Anupam

Signature of Triage Nurse : .....

Date & Time : 15/7/26

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/9/26 Time of arrival : 5:40 Pm.

Chief Complaints: C/O 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: ..... 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 .....

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

Time of Initial assessment completed by ER Nurse : 5:50 Am

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

Time	Nursing Notes
	Assessed the patient condition
	vital checked.
	IV placement done.

Samples collected by:

Samples sent by : vidaya.

Time:

Time: 6 Am

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: 115 BP: 85/60 CFT: NO	Shift - out from ER to: OT
RR: 32 SPO_2 : 98	Time of Shift - out: 6:30 Am
GCS: 15/15 Temperature :	Handover given to: Sangeetha
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anu Ram

Signature of the Nurse : A.R

Date & Time : 13/7/26 @ 6 Am

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 ABDUL AHAD KHAN**	**Age :**	**0 Y 8 M 18 D**
IP No:	**IP26-00006846**	**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:.....).

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:

Name: AZMATH KHAN

Relationship: FATHER

Date: 15/07/2026 Time: 5:53 Am

Witness Name:

Witness Signature:

Patient Address:

Chilkalguda Hyderabad Telangana
INDIA 500061

HNH-00012234 IP26-00006846
Master ABDUL AHAD KHAN
27-10-2025 0 Y 8 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25 of being the guiding light

BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Master. ABDUL AHAD Age : 8M Gender : Male ☑ Female ☐

UHID NO: HNH-0012234 Surgeon Name: Dr. SWAPNA

Anaesthesiologist : Dr. SAMIR

Operative procedure planned : Lt. OPEN ORCHIDOPEXY

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 : .....

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. ABDUL AHAD the above mentioned operation / Diagnostic / Therapeutic procedures Lt. OPEN ORCHIDOPEXY

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.

Afreen Begum

Patient / Patient Attendant :

Signature : .....

Name : AFREEN BEGUM

Relationship with Patient: Mother

Date & Time : 15/7/26 7:45 AM

Witness :

Signature : .....

Name : AZMATH KHAN

Date & Time : 15/7/26 7:45 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. SAIRAM

Date & Time : 15/07/2026 7:45 AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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)

..... (L7) open Standard Orchidopexy .....

..... 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.

- Retraction of testis
- Atrophy of testis
- Infection, Bleeding

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 : Afreen Begum

Name : AFREEN BEGUM

Relationship with Patient: Mother

Date & Time : 15/7/26

Witness :

Signature : .....

Name : AZMATH KHAN.

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : .....

26-0000213912

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MASTER ABDUL AHAD KHAN	Age:	0Y 8M	Gender:	M.
UHID No:	AHH-0001223	IP No:	IP26-0000654	Date:	15/7/26
Time:	6:46 Am				
Diagnosis:	LEFT OPEN STANDARD ORCHIDOPEXY.				

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	one Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SAIRAJ. V

Doctor Registration No: APMC 75177

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26 0000 654 6 **Date:** 15/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MASTER ABDUL AHAD KHAN	**Remarks**
2.	Complete postal address (with contact number, if any)	CHITKALGUDA HYD.
3.	Brief description of the illness	LEFT OPEN STANDARD ORCHIDOPEXY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7/26	FENTANYL	one Amp		

Dispensed by (Name & ID No.): Samia (08442) Signature: .....

Received by (Name & ID No.): SAI CHANDU 021153 Signature: .....

Time: 8:18

Docu. No: RCH / FRM / CLINICAL / 133

26-0000213912

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MASTER ABDUL AHAD KHAN		Age: 0Y 8M	Gender: M
UHID No: [illegible]	IP No: IP26-0000 6546	Date: 15/7/26	Time: 6:46 Am
Diagnosis: LEFT OPEN STANDARD ORCHIDOPEXY [illegible]			
PRESCRIPTION DETAILS (Tick only one of the following)			

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100MCG	one Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. GANPAT V

Doctor Registration No: APMC 75[illegible]

Signature: [signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26 0000 6546 **Date:** 15/7/26

Aadhaar No. of the Patient (Optional): ....

1.	**Name :** MASTER ABDUL AHAD KHAN	**Remarks**
2.	Complete postal address (with contact number, if any)	CHILKALGUDA HYD
3.	Brief description of the illness	LEFT OPEN STANDARD ORCHIDOPEXY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7/26	FENTANYL	one Amp	[signature]	

Dispensed by (Name & ID No.): Sama (02142) Signature: ....

Received by (Name & ID No.): SAI CHANDU 02153 Signature: [signature]

Time: 7:(8)

Docu. No: RCH / FRM / CLINICAL / 133