DISCHARGE SUMMARY

Name	Master MORA TRINAV	**UHID**	VIH-00099066
Father/Guardian	Mr MORA VISWANATH	**Age/Gender**	8 Y 7 M 25 D/ Male
Address	H.NO-1-1-301/12,CHIKADAPALLY, HYD, Mushirabad, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006464	**Admission Date**	30-05-2026
Ref Doctor	Self		
Discharge Date	30.05.2026		

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

DIAGNOSIS	ICD CODE
VERY TIGHT PHIMOSIS	

Procedure : Circumcision done on 30.05.2026.

History: Master MORA TRINAV, 8 Y 7 M 25 D child presented with history of inability to retract prepuce associated occasional pain hence thought as very tight phimosis, tried medical management but did not resolve prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 104/min, Blood Pressure - 101/58 (70) mmHg and Respiratory rate - 28 /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.

Name	Master MORA TRINAV	UHID	VIH-00099066
IP No	IP26-00006464	Admission Date	30-05-2026

Weight on admission: 21.87 kilo grams.

Investigations: Enclosed reports.

Procedure : Circumcision done on 30.05.2026.

Surgery Notes:
* Firlit collar incision made.
* Extra skin excised
* Wound cleared with PDS.

Post-Operative Notes: Post operative period was uneventful. Child was 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:
* Diet as advised.
* Sitz bath twice daily for 7 days.
* T Bact ointment for local application twice daily for 7 days.
* Syrup. Ibugesic 5ml, once daily for 3 days.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. MUKTA SUBHASH WAGHMARE On Tuesday(02.06.2026) in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Name	Master MORA TRINAV	**UHID**	VIH-00099066
IP No	IP26-00006464	**Admission Date**	30-05-2026

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.

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

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

Rainbow Children's Medicare Ltd. Himayathnagar 500029 Hyderabad

Registrar/Resident/C.M.O

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

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 : IP26-00006464 **Admit Date** : 30-May-2026 **Admit Time** : 09:12 AM **UHID** : VIH-00099066

Patient Details :

Patient Name	: Master MORA TRINAV	**Age**	: 8 Y 7 M 25 D
Guardian	: Mr MORA VISWANATH	**DOB**	: 05-10-2017
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H.NO-1-1-301/12,CHIKADAPALLY, HYD Mushirabad Hyderabad Telangana INDIA 500020	**Phone No**	: 9490217211
		E-mail	: mora.vishwanath@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 MORA VISWANATH **Relationship** : S/O

Contact Address : H.NO-1-1-301/12,CHIKADAPALLY, HYD Mushirabad Hyderabad Telangana INDIA 500020 **Phone No** : 9490217211

M. Chs

Signature

Doctor Details :

Doctor Name : Dr. MUKTA SUBHASH WAGHMARE **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 20000.00

Payment Mode : DC/CC Card **Payor Name** : BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

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ACTIVITY RECO

VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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
29/5/26	9:20 pm	ER	OT	
30/5/26	11:10 Am	OT	pre-post	

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
30/5/26	CBP	0042	
	PAE OP Basic Done	27/5/26	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
	IV Placement	(1)	3063	

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

Patient Name : _____

Patient ID# : VIH-00099055 IP26-00006464
Master MORA TRINAV
05-10-2017 6 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Inability to retract prepuce
occasional pain ⊕

History of present illness :

c/o Inability to retract prepuce
a/w occasional pain, tried medical management
but didn't resolved

(Very tight Phimosis)

Pediatric Multiorgan History & Physical Examinatio

VIH-00099056 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Immunized as per age

Anthropometry

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

Weight (kgs) 21.87 kg (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: 104/min Description _____

B.P. 101/58 (71) mm Hg SPO2 99% at RA

Resp. rate and type of breathing : _____

Normal

Rash _____

Lymphadenopathy _____ / No

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BCAE. clear

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 Non tender

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score :

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Very tight Phimosis for Circumcision

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Prevent complications

Desired goals of the treatment :

Planned Labs :

CBP

NB Probable

Planned Management :

PAC

Surgical management

Circumcision

NB Probable

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 _____

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OPERATION THEATER NOTES

VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Circumcision

Indications for Surgery : Phimosis.

Date : 30/5/26.	Start Time : 10 : 22 Am	End Time : 11 Am

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Forcit collar incision made

Extra skin excised

Wound closed c 6-0 PDS.

POST - OPERATIVE ORDERS :

- full diet
- SITZ BATH BD x 7 day
- T-BACT OINT YA BD x 7 day
- ~~[illegible]~~
- Syp. IBUGESIC 5 ml (20) TID x 3 day

R/V on Tuesday

D. [illegible]

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 30/5/16 Time : 10.40 Am

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Mukta
Asst. Surgeon : Dr.
Anaesthetist : Dr. Brunda
Scrub Nurse : Sr. Archana.

VIH-00099066 IP26-00005464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

Patient Nam ..... Gender : Male
UHID No. : Circumcision
Date : 30/5/26 Time : 11 AM
10:25 AM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:10 am

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Brunda
Name : Dr. Brunda
30/5/26.

Before Skin Incision ➤➤

TIME OUT Time: 10:25am

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

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

Anticipated Critical Events

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

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

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

Signature : Rija @ 10:25am.
Name : Rija.

Before Patient Leaves Operating Room

SIGN OUT Time: 11 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 :
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00099066 IP26-00006464 Master MORA TRINAV 05-10-2017 8 Y 7 M 25 D (M) Dr. MUKTA SUBHASH WAGHMARE	30/5/26 @ 9:12 Am	30/5/26 @ 11:10 Am
	Transfer Ordered by Dr-Brunda.	Reason for Transfer observation
From Unit OT	To Unit Pre-post	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 50 ml.	(1)
2.		
3.		
4.		
5.		

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

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

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Master Mora Trinav Age : 8y Gender : Male ☑ Female ☐

UHID NO: VIH-00099066 Surgeon Name: Dr- Mukta

Anaesthesiologist : Dr-Samir

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 : Lorazepam

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 Mora Trinav 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 : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Bhanda

Date & Time : 30/5/26, 10 am

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

Patient Name : ..... Gender: ☐ Male ☐ Female Age : 8Y

UHID No : ..... Date : 30/5/26

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 Mora Trinav

(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

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: Dr Mukta

Consentee :

Signature : R

Name : .....

Date & Time : .....

Patient Attendant :

Signature : M. Ch

Name : M. Vishwanath

Relationship with Patient: Father

Date & Time : 30/5/26 @ 9:56am

Witness :

Signature : R.M...

Name : R. Mamatha

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Mukta

Date & Time : 10:00am 30/5/26

VIH-00099055 IP25-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

VIH-00089066 IP26-00006464
Master MORA TRINAV
05-10-2017 6 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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

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

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

Patient Sticker

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
30/5/26	10:15AM	SUPP. DICLOFENAC	25MG	P/R	B de	A Archie
30/5/26	10:30AM	INJ. PARACETAMOL	315MG	IV	B de	A Archie

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

VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
30/5/26	10:15AM	RINGER LACTATE	IV	100ml/HR	[signature]	[signature]	30/5/26	[signature]	

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

VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..G/2..... Shifted to: ..O.T.....

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. Prashant

Date & Time : 30/5/26 @ 9:20 AM

Nurse Name & Signature: Prabhu

Date & Time : 30/5/26 @ 9:20 AM

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

#-26-0000203057.

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Master Mora Trinav		Age: 8 Yrs	Gender: Male
UHID No: VIH-00099066	IP No: 26-00006464	Date: 30/5/26	Time: 9:16 Am
Diagnosis: circumcision			OT
PRESCRIPTION DETAILS (Tick only one of the following)			

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. [illegible] Doctor Registration No: 67929

Signature: [signature]

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

IP Registration No: 26-00006464 **Date:** 30/5/26

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

		Remarks
1.	Name : Master Mora Trinav	
2.	Complete postal address (with contact number, if any)	Chikadapally. Hyd. Musheerabad
3.	Brief description of the illness	circumcision
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
30/5/26	Fentanyl	01		

Dispensed by (Name & ID No.): Sania (018442) Signature: Sania

Received by (Name & ID No.): U. Pallavi 017921 Signature: U Pallavi

Time: ....

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#-26-0000203057.

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Master Mora Trinav		Age: 8 Yrs	Gender: Male
UHID No: VIH.00099066	IP No: 26-00006464	Date: 30/5/26	Time: 9 16Am
Diagnosis: circumcision			OT
PRESCRIPTION DETAILS (Tick only one of the following)			

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Amir

Doctor Registration No: 67929

Signature:

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

IP Registration No: 26-00006464 **Date:** 30/5/26

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

1.	**Name :** Master Mora Trinav	**Remarks**
2.	Complete postal address (with contact number, if any)	Chikadapally Hyd Musheerabad
3.	Brief description of the illness	circumcision
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
30/5/26	Fentanyl	01		

Dispensed by (Name & ID No.): Rama (VIS441) Signature: Rama

Received by (Name & ID No.): U Pallavi 017921 Signature: Pallavi

Time: ....

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Age: Sex:

OPD No: IP No: Date: Time:

Diagnosis:

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Pentazocine Lactate Inj. 30mg/ml		
2.	Morphine Sulphate Inj. 15mg/ml		
3.	Hemisuccinate Hydrocortisone Inj. 2MG		
4.	Betamethasone Inj. 4MG		

Doctor Name: Doctor Registration No:

Signature:

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

IP Registration No: Date:

Address (of the Patient if Different):

1.	Name :	Remarks
2.	Complete postal address (with contact number if any)	
3.	Brief description of the illness	
4.	Whether registered with any public registered medical practitioner / recognized medical institution (if yes, details of the records)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No): Signature

Prescribed by (Name & ID No): Signature

Dispensing SOP – Form No. 3E

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Master MORA TRINAV
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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Master Mora Trinav Age: 8 y Sex: M UHID.No :

Date: 27/5 Time: 1235 pm Proposed Operation: Circumcision

Diagnosis: Phimosis

B.P / CRT: .... H.R: .... Weight: 21.8 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group: O +ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: • MILK (+) - lactose intolerant? • FISH .

Medical History: CVS : Occasional pain (+) Redness (+)

RESP : Diabetes :

CNS : (-)

Renal :

Hepatic / GE : Physical Activity: active child.

Others :

Past Anaesthetic History: adenoidectomy 6 yrs old - J/GA - } uk
trigger finger 4 yrs old - J, sedation? }

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: adequate Mentohyoid Distance: Neck: Teeth: crooked teeth. (B) canine.

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 + caudal / Penile block

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: 930 am / 30/5 } adv 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: • IV cannulation + CBP • consent

Signature: [signature] Name: Dr. Keerne

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

VIH-00099065 IP26-00006464
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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: 92bpm | B.P / CRT: 96/53mmHg | SpO_2: 100% on RA | R.R: 16/min | Last Feed: last night

Pre-OP Diagnosis: Phimosis | Operation: Circumcision | Date: 30/5/26

Surgeon: Dr. Mukta | Anaesthesiologist: Dr. Samir / Dr. Brunda | Technician: Aravind Pattani

TIME (10:15) 10:30 (11) (11:15)

N_2O /AIR/O_2 LPM 4L

HALO /SO /SEVO

Drugs:

Inj. MIDAZOLAM 1mg IV
FENTANYL 40µg IV
PROPOFOL 40+40 mg IV
PARACETAMOL 315mg IV

Antibiotic —

Suppository DICLOFENAC 25mg PR

Blood Loss

NOTES

FIO_2 / SaO_2	100	100	100
$ETCO_2$			
ECG	NSR	NSR	NSR
Temperature			
Urine Output			
Fluids / Blood	RINGER LACTATE →		

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: left UL
☐ Art Site:
☑ EKG Lead 3lead
☑ Temp Site Rt axilla
☑ 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

Times:
Anaes Start: 10:15am
OP Start: 10:22am
OP End:
Leave OR: 11AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☑ Regional

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

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

☑ Mask O_2 @ 4L/min via nasal prongs ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic

Blade# ..... Attempts: .....
Difficulty Why? .....

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

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☑ Caudal
Others: .....
Position: left lateral
Site: Sacral hiatus
Needle Size: 22G Depth: .....
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: Inj-0.25%
Bolus: BUPIVACAINE 1.5cc
Infusion: .....
Block Level: Adequate
Comments: .....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr. Brunda
Signature of the Doctor: B

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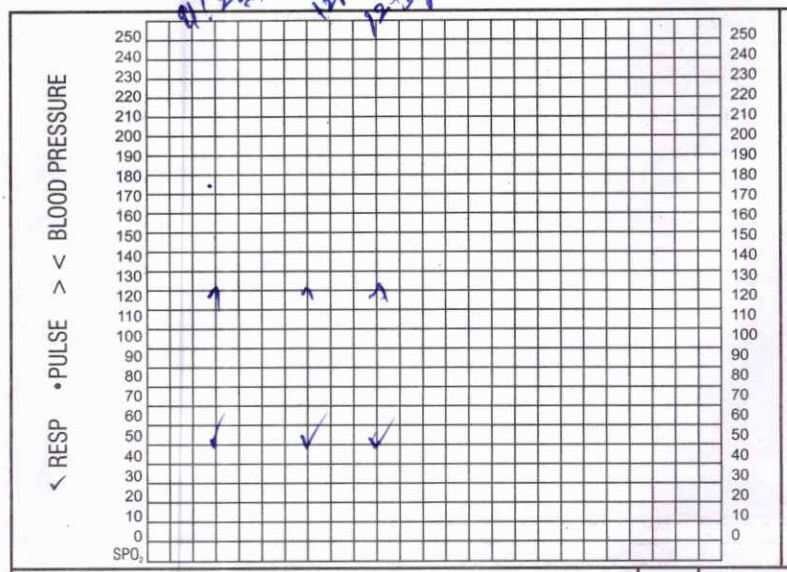
POST-ANAESTHESIA CARE UNIT RECORD

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



IV Cannula Site : Right

- ☑ 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: RL
Oral Feeds: Water

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		0	2	2		A Minimum Total Score of 8 is Required for Discharge
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		Exceptions to this, are to be explained in the space below by the Discharging Physician:
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		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		8	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
30/5/26	11:15Am	0	NO pain	

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

Anaesthesiologist Name : Dr. BHARATI
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : Archana
PACU Nurse Signature: .....
Date & Time: 30/5/26 @

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

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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 : .....

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Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

wt-21.87 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Mora Trinav Age : 8 years **Gender:** ☑ Male ☐ Female

Date : 30/5/26 Time of Arrival : 8:50 AM

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98°F, PR: 104b/m BP: 104/58 (71) RR: ..... SpO_2: 100%

Chief Complaints: c/o Pt is coming for surgery, circumcision

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 8:55 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 : Robin

Signature of Triage Nurse : .....

Date & Time : 30/5/26 @ 8:55 AM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/5/26 Time of arrival : 8:50 AM

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: 10' Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 8:55 AM

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals.

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: 101/58 mm CFT: 2 sec RR: ..... SPO_2: 100%/6 GCS: 15/15 ..... Temperature : 98°F Pain Score: 0 Repeat RBS (if applicable):	Shift - out from ER to: ..... Time of Shift - out: ..... Handover given to: ..... (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Prabin ..... Signature of the Nurse : .....

Date & Time : 30/5/26 @ 8:55 AM

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PATIENT TRANSFER FORM

VIH-00099066 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

	Date & Time of Admission	Date & Time of Transfer Order
	30/5/26 @	30/5/26 @ 9:30am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. mukta	Dr. Prashant	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
20		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
Rabin	Dr. Prashant

Patient & Clinical Records Received by : Archana

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

VIH-00099066 IP26-00005464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00099086 IP26-00006464
Master MORA TRINAV
05-10-2017 8 Y 7 M 25 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order