

00015653 IP26-00006465  
 Master VEDA SHOURYA  
 28-06-2010 15 Y 11 M 2 D (M)  
 Dr. JYOTI BOTHRA



## SURGERY DETAILS

Date : 30/5/26

Patient Name: Master. veda souarya Date of Birth: 28/06/2010 Age: 15

Gender: Male Ward : OT UHID No: HNH-00015653  
 IP26-00006465

Date of Surgery: 30/5/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : (R) Wrist Ganglion cyst excision

Time in : 11:00 AM

Time Out : 11:45 AM

|                      | <u>NAME</u>            | <u>AMOUNT</u> |
|----------------------|------------------------|---------------|
| 1. Surgeon           | Dr. Jyoti              |               |
| 2. Anaesthetist      | Dr. Samir, Dr. Brunda  |               |
| 3. Assistant Surgeon | Dr. Mukta              |               |
| 4. OT Technician     | Sr. Pallavi, Br. Anind |               |
| 5. Circulating Nurse | Sr. Pooja              |               |
| 6. Assistant Nurse   | Sr. Sushela            |               |

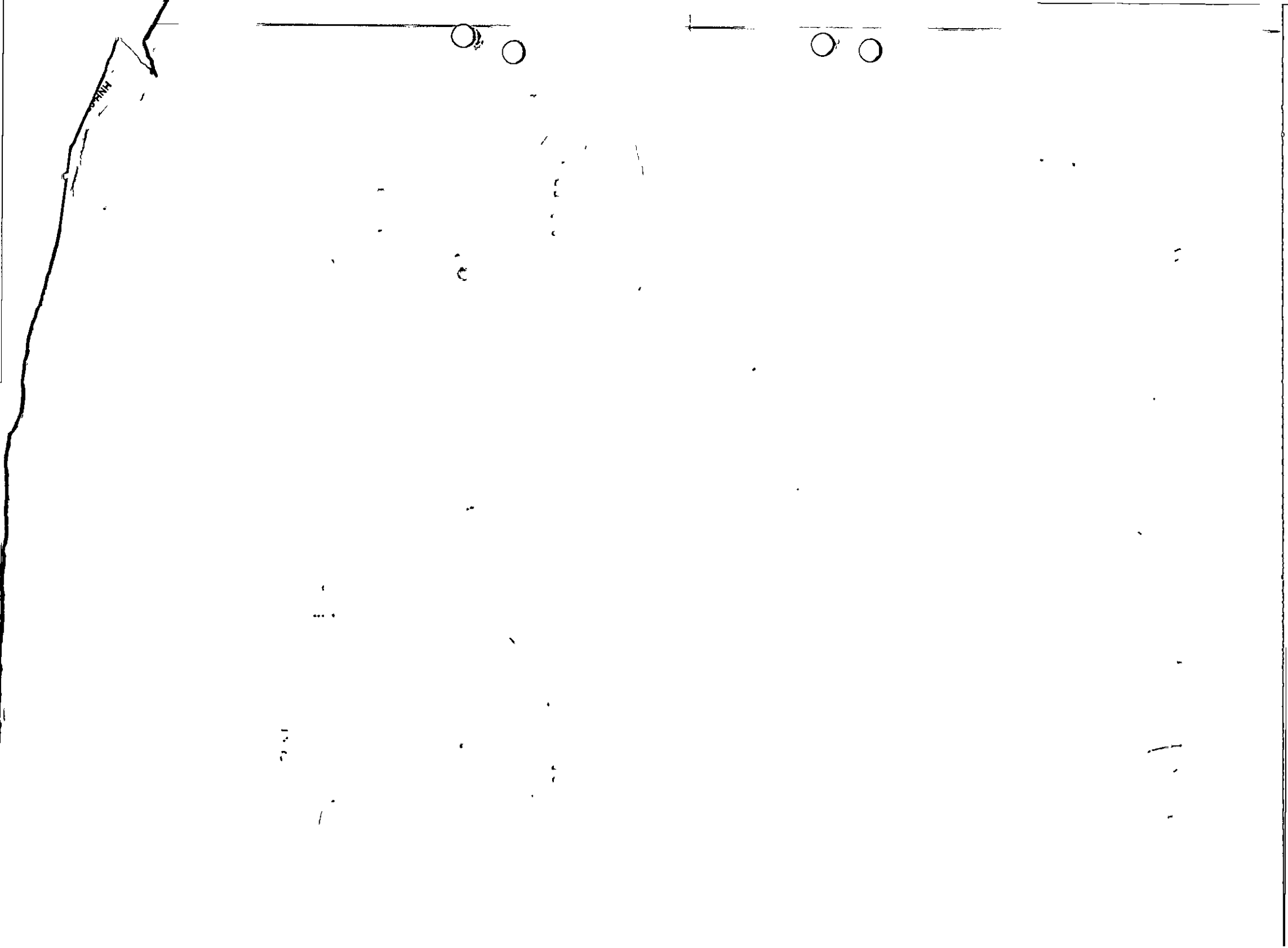
- Special Equipment:  Laparoscopy  Broncoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others .....

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000203125

Order by: Arishana 30/5/26 @ 12:18pm





yes

cyst excision

CONSUMABLES OF OT

Circulating staff : Durga Technician : Sr. Pellaur Date : 30/5/26 Time : .....

| Anaesthesia Disposables            | Qty    |                | Surgical Disposables      | Qty    |              | Disposables (Baby Side) | Qty    |      |
|------------------------------------|--------|----------------|---------------------------|--------|--------------|-------------------------|--------|------|
|                                    | Issued | Used           |                           | Issued | Used         |                         | Issued | Used |
| ET tube                            |        |                | Major Pack <u>General</u> | ✓      |              | Inj Vit.K               |        |      |
| LMA                                |        |                | Sutures <u>1884</u>       | ✓      |              | Cord Clamp              |        |      |
| ECG leads : A/P/N                  |        | <u>04</u>      |                           |        |              | Suction Catheter        |        |      |
| HME filter : A/P/N                 |        |                |                           |        |              | Feeding Tube            |        |      |
| Syringes : 10 cc                   |        | <u>04</u>      |                           |        |              | Vaccum Suction Set      |        |      |
| 05 cc                              |        | <u>03</u>      | Gloves <u>7(PF)-S.G</u>   | ✓      |              | Surgical Gloves         |        |      |
| 02 cc                              |        | <u>04</u>      | <u>Endo 6, 6 1/2</u>      | ✓      |              | Gauze Pack              |        |      |
| 01 cc                              |        |                |                           |        |              | Syringe 1ml / 2ml       |        |      |
| Cautery plate : A/P/N              |        |                | Surgical blade <u>15</u>  | ✓      |              | Surgical Blade # 20     |        |      |
| IV set                             |        | <u>01</u>      | NG tube                   |        |              | Koochies (S)            |        |      |
| RL                                 |        | <u>01</u>      | Cautery pencil            |        |              |                         |        |      |
| NS : 10ml / 100ml / 500ml / 1000ml |        | <u>2/1/0/1</u> | Koochies                  |        |              |                         |        |      |
| <u>Atropine</u>                    |        | <u>02</u>      | Ointments                 |        |              |                         |        |      |
| <u>Midoy</u>                       |        | <u>01</u>      | Suction Catheter          |        |              |                         |        |      |
| Fentanyl                           |        | <u>01</u>      | Cap, Mask                 |        | <u>10+10</u> |                         |        |      |
| Morphine                           |        |                | Gauze Pack                |        | <u>B</u>     |                         |        |      |
| Ketamine                           |        |                | Mop Pack                  |        |              |                         |        |      |
| Propofol                           |        | <u>02</u>      | Steristrip                |        |              |                         |        |      |
| Rocuronium                         |        |                | Underpad                  |        |              |                         |        |      |
| Glycopyrolate                      |        | <u>01</u>      | Draw sheet                |        |              |                         |        |      |
| Myopyrolate                        |        |                | Abgel                     |        |              |                         |        |      |
| Ondansetron                        |        |                | Foleys catheter           |        |              |                         |        |      |
| Pencan 25g/ Spinal Needle 22       |        |                | Urobag                    |        |              |                         |        |      |
| Bupivacaine 0.25%                  |        | <u>01</u>      | Chest Drainage Catheter   |        |              |                         |        |      |
| Bupivacaine 0.25%(Heavy)           |        |                | Romodrain bag             |        |              |                         |        |      |
| Antibiotics                        |        |                | Bandage                   |        |              |                         |        |      |
| <u>lox 2%</u>                      |        | <u>02</u>      | Tegaderm                  |        |              |                         |        |      |
| Suppositories                      |        |                | loban                     |        |              |                         |        |      |
| Anamol : 80mg / 250mg / 170 mg     |        |                | Double J Stent            |        |              |                         |        |      |
| Supridol : 100mg                   |        |                | Vaccum Suction set        |        | ✓            |                         |        |      |
| Justin : 12.5 mg / 25mg / 100mg    |        |                | Plastic Bed Sheet         |        |              |                         |        |      |
| Tab. Misoprost : 200mg             |        |                | Betadine Solution         |        | ✓            |                         |        |      |
| <u>O2 mask (A)</u>                 |        | <u>01</u>      | Microshield               |        |              |                         |        |      |
| <u>26 needle</u>                   |        | <u>01</u>      | Cotton Balls              |        |              |                         |        |      |
| <u>7.0 glove</u>                   |        | <u>01</u>      | Latex Gloves              |        | <u>10</u>    |                         |        |      |
| <u>PCM</u>                         |        | <u>01</u>      | Ramdione Scrub            |        |              |                         |        |      |
| <u>Gauze 7.5</u>                   |        | <u>01</u>      | Saral                     |        |              |                         |        |      |

Surgeon ..... Anesthesiologist ..... Nurse ..... OT Technician .....  
 Order No. : 26-0000203136 / 135 / 134 Ordered by : Arhana 30/5/26 @ 12:30 pm  
 Doc. No. : RCH / FRM / GENERAL / 125

Apr 1 1960

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### ELECTRONIC MEDICINE PRESCRIPTION

|  |   |
|--|---|
| MRN : HNH-00015653   | Name : Master VEDA SHOURYA                |
| Age / Sex : 15 Y 11 M 2 D / Male                           | Doctor : JYOTI BOTHRA                     |
| Adm/Reg Date/Time : 30/05/2026 09:28                       | Payor : MEDI ASSIST INSURANCE TPA PVT LTD |
| Order Date : 30/05/2026 12:32                              | Ordernumber : 26-0000203135               |
| Visit ID : IP26-00006465                                   | Ward/Bed No : 4F -OT / PDA-413            |
| Pat Address : Ramkotl, Hyderabad, Telangana, INDIA, 500095 |   |

| S.No | Description                               | Generic Name                | Dosage   | Route / Frequency      | Duration | Instruction | Qty      | Status    |
|------|---|-----------------------------|----------|------------------------|----------|-------------|----------|-----------|
| 1    | ENCORE MICROPTIC GLOVES-6 PF              |                             | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 2    | DSYRINGS 2.5ML(NIPRO)                     | SYRINGE 2ML                 | 1 Nos    | External / Once Daily  | 1 Days   |             | 4 Nos    | Dispensed |
| 3    | VACCUME SUCTION SET                       | VACCUME SUCTION SET         | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 4    | MONOCRYL 5-0 CUTTING Y844G                | MONOCRYL Y844G              | 1 Nos    | / Once Daily           | 2 Days   |             | 2 Nos    | Dispensed |
| 5    | RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE |                             | 1 Nos    | Injection / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 6    | ENCORE MICROPTIC GLOVES-7 PF              |                             | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 7    | THEMIPYRRNOM 0.2MG INJ                    |                             | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 8    | MEZOLAM INJ 5 MG 5 ML                     |                             | 1 Vial   | External / Once Daily  | 1 Days   |             | 1 Vial   | Dispensed |
| 9    | NS IV 10 ML AMPULE                        |                             | 1 Bottle | External / Once Daily  | 1 Days   |             | 1 Bottle | Dispensed |
| 10   | SURGICAL BLADE 15                         | SURGICAL BLADE 15           | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 11   | THEMICAINE 2% 30ML INJ                    |                             | 1 Nos    | External / Once Daily  | 1 Days   |             | 2 Nos    | Dispensed |
| 12   | RL 500 ML CLOSED SYSTEM                   | RINGER LACTATE 500ML CLOSED | 1 Bottle | / Once Daily           | 1 Days   |             | 1 Bottle | Dispensed |
| 13   | E.C.G ELECTRODES (ADULT)                  | ELECTRODES ADULT            | 1 Nos    | External / Once Daily  | 1 Days   |             | 4 Nos    | Dispensed |

**JYOTI BOTHRA**

**Reg No : TSMC/FMR/02962**

\* 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.





### ELECTRONIC MEDICINE PRESCRIPTION

|                   |  |             |                                     |
|-------------------|--|-------------|-------------------------------------|
| MRN               | : HNH-00015653                                 | Name        | : Master VEDA SHOURYA               |
| Age / Sex         | : 15 Y 11 M 2 D / Male                         | Doctor      | : JYOTI BOTHRA                      |
| Adm/Reg Date/Time | : 30/05/2026 09:28                             | Payor       | : MEDI ASSIST INSURANCE TPA PVT LTD |
| Order Date        | : 30/05/2026 12:32                             | Ordernumber | : 26-0000203134                     |
| Visit ID          | : IP26-00006465                                | Ward/Bed No | : 4F -OT / PDA-413                  |
| Patient Address   | : Ramkoti, Hyderabad, Telangana, INDIA, 500095 |             |                                     |

| S.No | Description                               | Generic Name               | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status  |
|------|---|----------------------------|--------|-----------------------|----------|-------------|--------|---------|
| 1    | GENERAL SURGICAL KIT (MEDITAKE)           | GENERAL SURGICAL KIT       | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Ordered |
| 2    | MCT-ROF 100MG 10ML                        |                            | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Ordered |
| 3    | NS 100ML ACCULIFE - EH                    |                            | 1 mL   | External / 10 AM      | 1 Days   |             | 1 mL   | Ordered |
| 4    | POVINANZ SOLUTION 10% 100 ML              |                            | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Ordered |
| 5    | CUROPINE (ATROPINE) INJ 1 ML              |                            | 1 Vial | External / Once Daily | 1 Days   |             | 2 Vial | Ordered |
| 6    | NITRILE EXAMINATION GLOVES P F- MEDIUM    | NITRILE GLOVES M           | 1 Nos  | / Once Daily          | 10 Days  |             | 10 Nos | Ordered |
| 7    | OxygenMask With Tubing - Adult ROMSONS-FC |                            | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Ordered |
| 8    | Encore Microptic gloves-6.5               |                            | 1 Nos  | / Once Daily          | 1 Days   |             | 2 Nos  | Ordered |
| 9    | GAUZE 7.5X7.5 12 PLY (5 NOS)              | GAUZE 7.5X7.5 12 PLY 5 NOS | 1 Nos  | External / Once Daily | 1 Days   |             | 4 Nos  | Ordered |
| 10   | NEEDLE 26 G                               | DISPOSABLE NEEDLES 26      | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Ordered |
| 11   | DSYRINGE 5ML.(NIPRO)                      | SYRINGE 5ML                | 1 Nos  | External / Once Daily | 1 Days   |             | 3 Nos  | Ordered |
| 12   | DSYRINGE 10ML (NIPRO)                     | SYRINGE 10ML               | 1 Nos  | External / Once Daily | 1 Days   |             | 4 Nos  | Ordered |
| 13   | BUPICAINE INJ VIAL 0.25% 20ML             |                            | 1 Nos  | External / 10 AM      | 1 Days   |             | 1 Nos  | Ordered |
| 14   | BCV-INTRAFIX SAFESET                      |                            | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos  | Ordered |
| 15   | FACE MASK 3 LAYER - ELASTIC               | FACE MASK 3 LAYER          | 1 Nos  | / Once Daily          | 10 Days  |             | 10 Nos | Ordered |
| 16   | SURGEON CAP(FEMALE)                       | FEMALE CAP                 | 1 Cap  | / Once Daily          | 10 Days  |             | 10 Cap | Ordered |

**JYOTI BOTHRA**

**Reg No : TSMC/FMR/02962**

\* 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.

A 1 + 10



# 26-0000203100

**NARCOTIC PRESCRIPTION FORM  
(PATIENT COPY)**

| Patient Name: <u>Master Veda Showrya</u>              | Age: <u>15 yrs</u>                  | Gender: <u>Female</u>                     |           |
|---|-------------------------------------|---|-----------|
| UHID No: <u>HNH-00015653</u>                          | IP No: <u>26-00006465</u>           | Date: <u>30/5/26</u> Time: <u>9:56 AM</u> |           |
| Diagnosis: <u>Right cyst excision</u>                 | Ward: <u>01</u>                     |   |           |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |   |           |
| S.No  | Drug Name                           | Dosage                                    | Remarks   |
| 1.  | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                             | <u>01</u> |
| 2.  | Morphine Sulphate Inj. 15mg/ML      |   |           |
| 3.  | Remifentanyl Hydrochloride Inj. 2MG |   |           |
| 4.  | Remifentanyl Hydrochloride inj. 1MG |   |           |
| Doctor Name: <u>[Signature]</u>                       |                                     | Doctor Registration No: <u>67929</u>      |           |
| Signature: <u>[Signature]</u>                         |                                     |   |           |

**NARCOTIC DISPENSING FORM  
APPENDIX 4 – FORM NO. 3E**

**(Details of the Patient to whom Essential Narcotic Drugs Dispensed)**

IP Registration No: 26-00006465 Date: 30/5/26

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

| 1.             | Name: <u>Master Veda Showrya</u>   | Remarks   |  |                 |
|----------------|--|-----------|--|-----------------|
| 2.             | Complete postal address (with contact number, if any) <u>Bamboti Hyderabad</u>   |           |  |                 |
| 3.             | Brief description of the illness <u>cyst excision</u>  |           |  |                 |
| 4.             | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) <u>No.</u> |           |  |                 |
| 5.             | Details of essential Narcotic drug dispensed <u>Fentanyl</u>   |           |  |                 |
| Date           | Name of the Essential Narcotic Drugs   | Quantity  | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>30/5/26</u> | <u>Fentanyl</u>  | <u>01</u> | <u>[Signature]</u>   |                 |

Dispensed by (Name & ID No.): Sama (01842) Signature: [Signature]

Received by (Name & ID No.): M Arvind Kumar (021257) Signature: [Signature]

Time: .....



Children's Hospital  
Tambow

# NARCOTIC PRESCRIPTION FORM

(PATIENT COPY)

|                     |  |      |  |
|---------------------|--|------|--|
| Patient Name        |  | Date |  |
| Age                 |  | Sex  |  |
| Address             |  | City |  |
| Disease             |  |      |  |
| Drug Name           |  |      |  |
| Quantity            |  |      |  |
| Signature of Doctor |  |      |  |

# NARCOTIC DISPENSING FORM

APPENDIX A - FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

Registration No. \_\_\_\_\_ Date \_\_\_\_\_

Name of the Patient (English) \_\_\_\_\_

|   |   |  |
|---|---|--|
| 1 | Name  |  |
| 2 | Complete name of drug (with trade name if any)  |  |
| 3 | Short description of the drug   |  |
| 4 | Whether dispensed with any other medicine or medicine prescribed by another authority. If so, details of the medicine |  |
| 5 | Details of essential narcotic drugs dispensed   |  |

|      |                                     |          |   |
|------|-------------------------------------|----------|---|
| Date | Name of the Essential Narcotic Drug | Quantity | Signature of the patient's Representative |
|      |                                     |          |   |

Signature of Dispensing Authority \_\_\_\_\_

Date \_\_\_\_\_

Place \_\_\_\_\_

**DISCHARGE SUMMARY**

|                        |  |                       |                     |
|------------------------|--|-----------------------|---------------------|
| <b>Name</b>            | Master VEDA SHOURYA                          | <b>UHID</b>           | HNH-00015653        |
| <b>Father/Guardian</b> | Mr T.VISHWESHWAR                             | <b>Age/Gender</b>     | 15 Y 11 M 2 D/ Male |
| <b>Address</b>         | Ramkoti, Hyderabad, Telangana, INDIA, 500095 |                       |                     |
| <b>IP No</b>           | IP26-00006465                                | <b>Admission Date</b> | 30-05-2026          |
| <b>Ref Doctor</b>      | Self.  |                       |                     |
| <b>Discharge Date</b>  | 30.05.2026                                   |                       |                     |

**Consultant:**

**Dr. JYOTI BOTHRA**

DNB, MCh (Pediatric Surgery), FMAS

SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY

TSMC/FMR/02962

| <b>DIAGNOSIS</b>                   | <b>ICD CODE</b> |
|------------------------------------|-----------------|
| RIGHT WRIST GANGLION CYST EXCISION |                 |

**Procedure :** Right wrist ganglion excision done on 30.05.2026.

100



|              |                     |                       |              |
|--------------|---------------------|-----------------------|--------------|
| <b>Name</b>  | Master VEDA SHOURYA | <b>UHID</b>           | HNH-00015653 |
| <b>IP No</b> | IP26-00006465       | <b>Admission Date</b> | 30-05-2026   |

**History:** Master VEDA SHOURYA, 15 Y 11 M 2 D child presented with history of ganglion cyst over right wrist 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 83/min, Blood Pressure - 118/63 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.

Weight on admission: 8.8 kilo grams.

**Investigations:** Enclosed reports.

**Procedure :** Right wrist ganglion excision done on 30.05.2026.

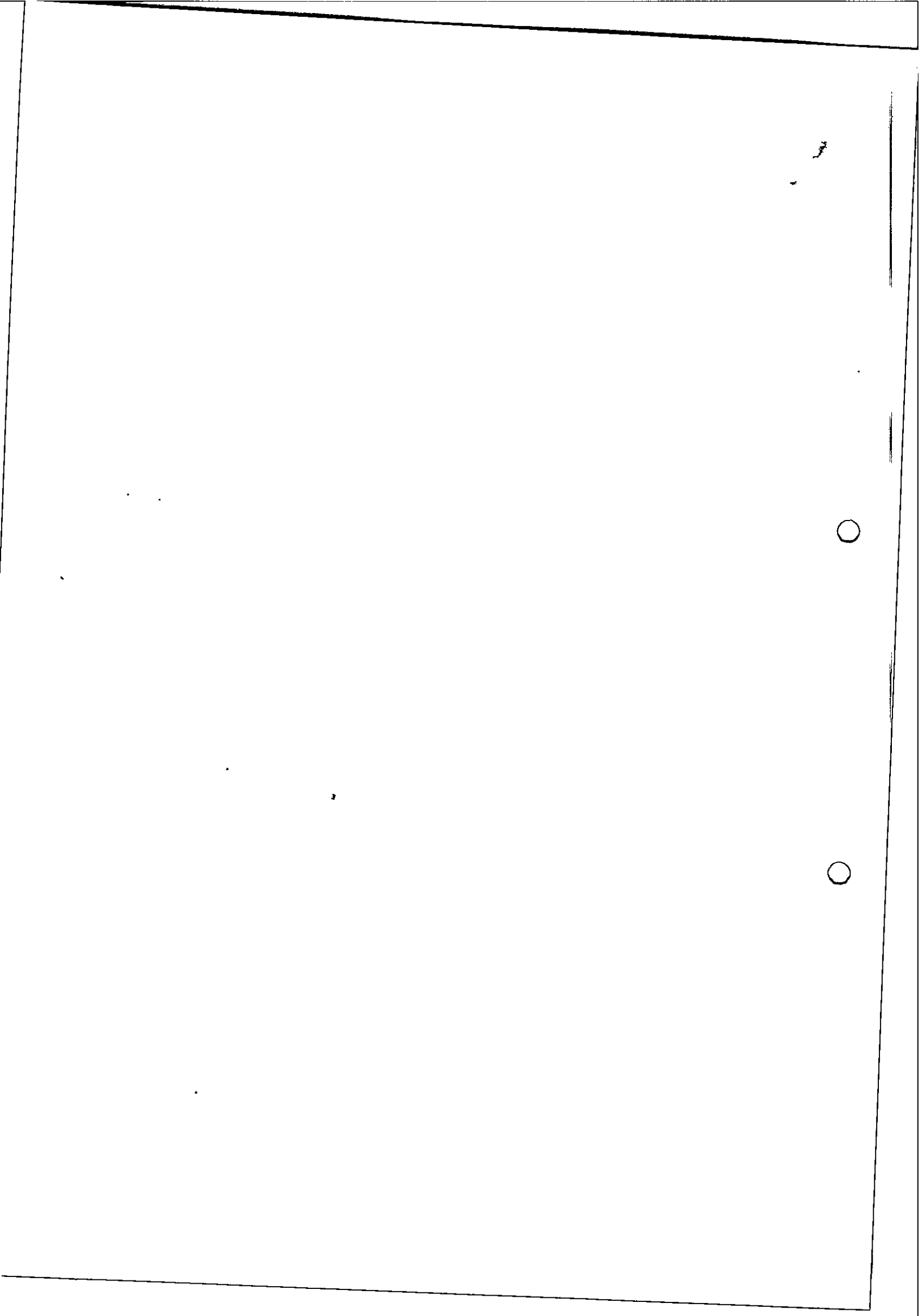
**Surgery Notes:**

- \* Linear incision over the cyst.
- \* Cyst dissected and divided till the base over the joint.
- \* Hemostasis confirmed.
- \* Incision closed with monocryl 5-0.

**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.
- \* Tablet. Combiflam, 1 tablet twice daily after food for 2 days.



|              |                     |                       |              |
|--------------|---------------------|-----------------------|--------------|
| <b>Name</b>  | Master VEDA SHOURYA | <b>UHID</b>           | HNH-00015653 |
| <b>IP No</b> | IP26-00006465       | <b>Admission Date</b> | 30-05-2026   |

- \* Remove dressing at home on tuesday and daily bath
- \* TAB DOLO 650MG TID FOR 2 DAYS .

**Fever Management**

- \* TAB DOLO 650MG 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. JYOTI BOTHRA after 1 week (06.05.2026) in OPD at Himayathnagar with prior appointment (**Review consultation will be charged**).

**Food instructions while taking medications:**

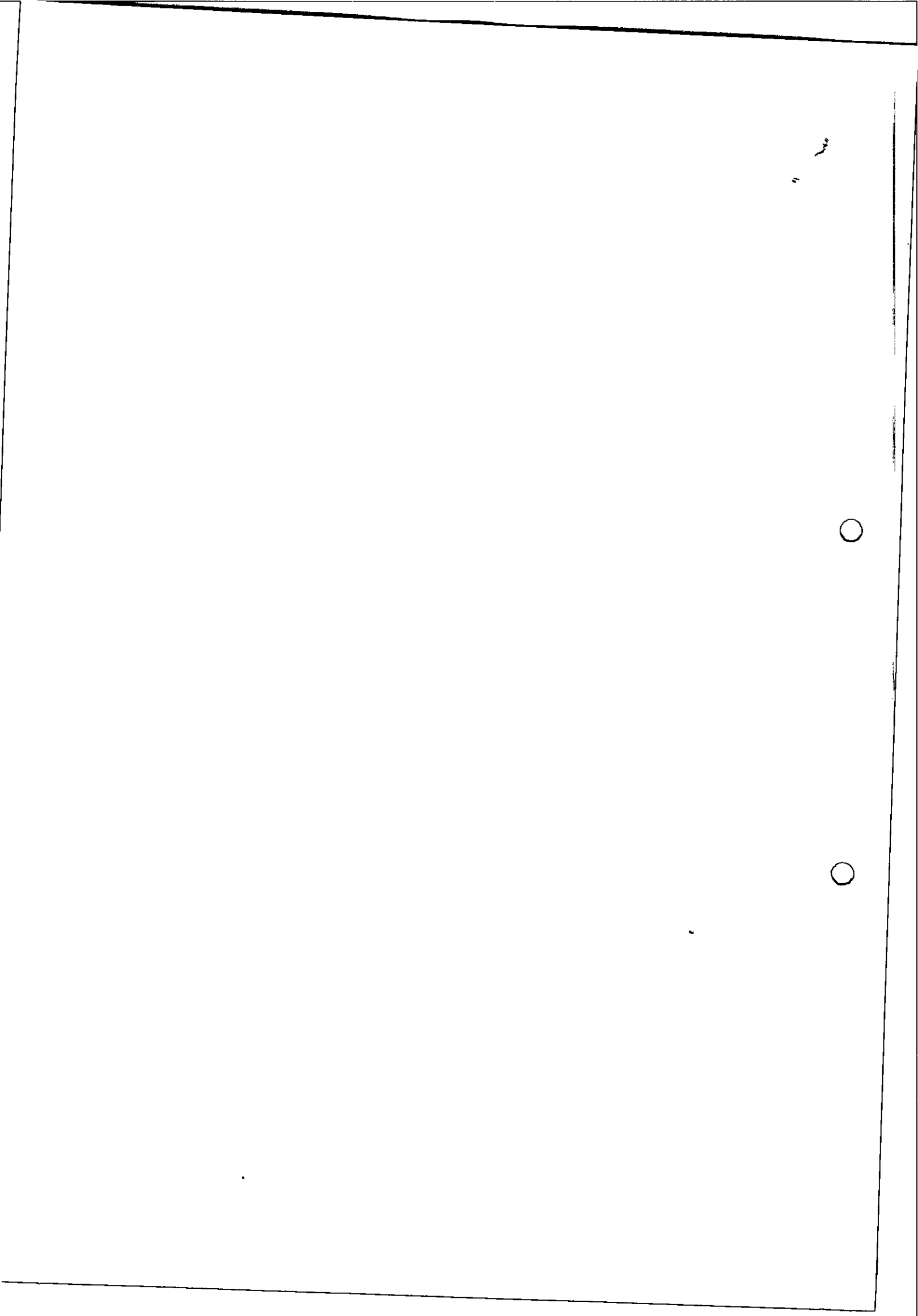
- \* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

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 peditrician on duty.



|              |                     |                       |              |
|--------------|---------------------|-----------------------|--------------|
| <b>Name</b>  | Master VEDA SHOURYA | <b>UHID</b>           | HNH-00015653 |
| <b>IP No</b> | IP26-00006465       | <b>Admission Date</b> | 30-05-2026   |

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

You can also take appointments at any time by going **online** to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**



**Registrar/Resident/C.M.O**

**Dr. JYOTI BOTHRA**

DNB, MCh (Pediatric Surgery), FMAS

SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY

TSMC/FMR/02962

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP26-00006465      Admit Date : 30-May-2026      Admit Time : 09:28 AM      UHID : HNH-00015653

**Patient Details :**

|              |  |                |                       |
|--------------|--|----------------|-----------------------|
| Patient Name | : Master VEDA SHOURYA                      | Age            | : 15 Y 11 M 2 D       |
| Guardian     | : Mr T.VISHWESHWAR                         | DOB            | : 28-06-2010          |
| Gender       | : Male                                     | Religion       | :                     |
| Occupation   | :  | Martial Status | :                     |
| Address (H)  | : Ramkoti Hyderabad Telangana INDIA 500095 | Phone No       | : 9885801906/         |
|              |  | E-mail         | : 9885801906@gmai.com |

**Admission Details :**

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

**Contact Details :**

|                 |  |              |              |
|-----------------|--|--------------|--------------|
| Name            | : Mr T.VISHWESHWAR                         | Relationship | : Father     |
| Contact Address | : Ramkoti Hyderabad Telangana INDIA 500095 | Phone No     | : 9885801906 |

*T. V. S. L.*  
Signature

**Doctor Details :**

|                 |                    |                |                     |
|-----------------|--------------------|----------------|---------------------|
| Doctor Name     | : Dr. JYOTI BOTHRA | Specialisation | : PEDIATRIC SURGERY |
| Referral Doctor | : Self.            | Phone No       | :                   |
| Co-Consultant   | :                  |                |                     |

**Payment Details :**

|              |        |                |                                     |
|--------------|--------|----------------|-------------------------------------|
| Payment Mode | : Cash | Deposit Amount | : 5000.00                           |
|              |        | Payor Name     | : MEDI ASSIST INSURANCE TPA PVT LTD |

**ACTIVITY RECORD FOR BILLING**

HNH-00015653 IP26-00006465

Master VEDA SHOURYA

28-06-2010 15 Y 11 M 2 D (M)

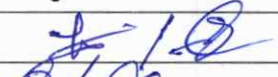

Name Dr. JYOTI BOTHRA -----

UHID I  ----- 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  |
|---------|---------|------|------|---|
| 30/5/26 | 9:20    | ER   | OT   |  |
| 30/5/26 | 12:00PM | OT   | MICU |  |
|         |         |      |      |   |
|         |         |      |      |   |

**Cross Consultation Visit**

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



















**OPERATION THEATER NOTES**

Patient's Name : **Master VEDA SHOURYA** Age : ..... Gender : .....  
 28-06-2010 15 Y 11 M 2 D (M)  
 Dr. JYOTI BOTHRA  
 UHID.: ..... P.No. : ..... Weight : .....

|               |                 |
|---------------|-----------------|
| Surgeon :     | Asst. Surgeon : |
| Anesthetist : | OT Nurse :      |

Surgical Procedure :  
 (R) Wrist langlion Cyst excision

Indications for Surgery :  
 (R) Wrist langlion Cyst -

Date : 30/5/26 Start Time : 11:00AM End Time : 11:45AM

PRE-OPERATIVE PREPARATION :  
 - NBM

OPERATION NOTES:

- linear incision over the cyst.
- Cyst dissected and divided till the base over the joint.
- Hemostasis confirmed.
- Incision closed with Monocryl 5-0.

POST - OPERATIVE ORDERS :

- No NBM

- FPR  
1/2 chart

On W/C

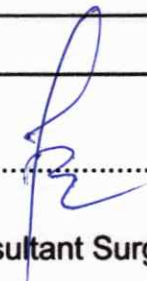
- Tab COMBIFLAM 1 tab twice a day  
X 2 days

- Remove dressing @ home on Tuesday  
& daily bath

- R/w after 1 week

Dr. Sadi Boten

Consultant Surgeon's Name



Consultant Surgeon's Signature

Date : 28/5/26 Time : 12:15 pm

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Jyoti  
 Asst. Surgeon : Dr. Mukta  
 Anaesthetist : Dr. Samir, Dr. Bred  
 Scrub Nurse : Sr. Susheela

Patient Name :  
 CHID No. :  
 Date :

HNH-00015653 IP26-00006465  
 Master VEDA SHOURYA  
 28-06-2010 15 Y 11 M 2 D (M)  
 Dr. JYOTI BOTHRA



Gender : M  
 e :




## Before Induction of Anaesthesia >>

## Before Skin Incision >>

## Before Patient Leaves Operating Room

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

| TIME OUT   |   | Time: <u>11:19am</u> |
|--|---|----------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |   |                      |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>  |   |                      |
| Correct Patient (Check ID Band)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Correct Site   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Correct Procedure  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Anticipated Critical Events</b>   |   |                      |
| <b>Surgeon Reviews:</b>  |   |                      |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |
| <b>Anaesthesia Team Reviews:</b>   |   |                      |
| Are There Any Patient-specific Concerns?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                      |
| <b>Nursing Team Reviews:</b>   |   |                      |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |
| Is Essential Imaging Displayed?  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                      |
| Signature : .....  | <u>Puja @ 11:19am</u>   |                      |
| Name : .....   | <u>Puja</u>   |                      |

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



## 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<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---|-------------------|---------------------------|-----------|--------------------------|--|
| 1    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 5    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 6    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 7    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 8    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 10   |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

**MEDICATION HISTORY RECORDED / VERIFIED BY**

Doctor Name & Signature : Dr. Prashant .....

Date & Time : 28/5/20 @ 9:20 AM .....

Nurse Name & Signature: Prabir .....

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



Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**

Name: Master VEDA SHOURYA Age: 15y Sex: M UHID.No: \_\_\_\_\_  
 Date: 27/5 Time: 12pm Proposed Operation: cyst excision  
 Diagnosis: Ganglion cyst @ forearm  
 B.P / CRT: \_\_\_\_\_ H.R: \_\_\_\_\_ Weight: 89kg 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: Blue 2D Echo: \_\_\_\_\_  
 Plate: \_\_\_\_\_ Na: \_\_\_\_\_ Dir. Bill: \_\_\_\_\_ Blood group: \_\_\_\_\_ Stress/Angio: \_\_\_\_\_  
 PT: \_\_\_\_\_ K: \_\_\_\_\_ LDH: \_\_\_\_\_ T3 \_\_\_\_\_ Other: \_\_\_\_\_  
 PTT: \_\_\_\_\_ Ca++: \_\_\_\_\_ Alk phos: \_\_\_\_\_ T4 \_\_\_\_\_  
 INR: \_\_\_\_\_ Mg++: \_\_\_\_\_ Amylase: \_\_\_\_\_ TSH \_\_\_\_\_  
 Cl -: \_\_\_\_\_ SGOT/SGPT: \_\_\_\_\_

Allergies: NKA

Medical History: CVS: swelling @ forearm - near wrist - ↑ in size - 1yr. pain @ Diabetes: \_\_\_\_\_  
 RESP: \_\_\_\_\_  
 CNS: not consulted  
 Renal: \_\_\_\_\_  
 Hepatic / GE: \_\_\_\_\_ Physical Activity: → good  
 Others: \_\_\_\_\_

Past Anaesthetic History: nil

Physical Exam: PCCCE  
 Airway: MP 1 2 3 4 Mouth Opening: 3/6 Mentohyoid Distance: 7/6 Neck: adq Teeth: nil  
 Lungs: SLA @  
 Heart: S2 @  
 CNS: (2)  
 Pregnant:  Yes  No  NA Venous Access Site: (F) Spine Exam for regional: (2)

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
|                     |        |
|                     |        |
|                     |        |
|                     |        |

Pre-Operative Instructions: 30/5, 10:30-11:30 a  
 1. DVT Prophylaxis: \_\_\_\_\_  
 2. NIL ORAL  $\left\{ \begin{array}{l} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{array} \right\}$  explained  
 3. Informed Consent:  Standard  High Risk  
 4. Post Operative Pain Management:  Discussed with Patient  
 5. Other Instructions: IV cannulation + CBF

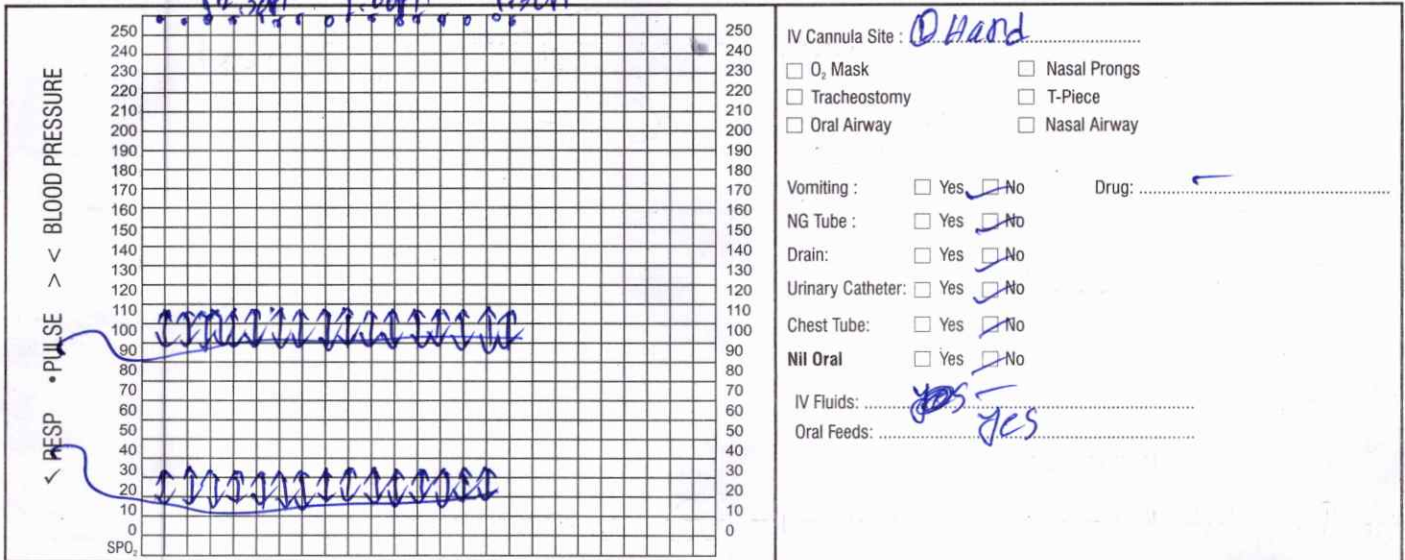
Signature: [Signature] Name: Aheena





**UNIT RECORD**

Received in PACU by: Sudipra Time Received: 12:00PM Time Discharged: .....



IV Cannula Site: Hand

O<sub>2</sub> 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: Yes

Oral Feeds: Yes

| POST ANAESTHESIA SCORE<br>(Modified Aldrete Score)   | IN            | MINUTES |    |    | OUT | SCORING INTERPRETATION   |
|--|---------------|---------|----|----|-----|--|
|  |               | 30      | 60 | 90 |     |  |
| Able to move 4 extremities voluntary or on command = 2<br>Able to move 2 extremities voluntary or on command = 1<br>Able to move 0 extremities voluntary or on command = 0 | ACTIVITY      | 1       | 2  | 2  | 2   | A Minimum Total Score of 8 is Required for Discharge<br><br>Exceptions to this, are to be explained in the space below by the Discharging Physician: |
| Able to deep breathe & cough freely = 2<br>Dyspnea or limited breathing = 1<br>Apneic = 0  | RESPIRATION   | 2       | 2  | 2  | 2   |  |
| BP ± 20 of Pre Anaesthetic level = 2<br>BP ± 20-50 of Pre Anaesthetic level = 1<br>BP ± 50 of Pre Anaesthetic level = 0  | CIRCULATION   | 2       | 2  | 2  | 2   |  |
| Fully awake = 2<br>Arousable on calling = 1<br>Not responding = 0  | CONSCIOUSNESS | 2       | 2  | 2  | 2   |  |
| Pink = 2<br>Pale, dusky, blotchy, jaundiced, other = 1<br>Cyanotic = 0   | COLOR         | 2       | 2  | 2  | 2   |  |
| TOTAL  |               | 9       | 10 | 10 | 10  |  |

**PAIN ASSESSMENT AND MANAGEMENT FORM**

| Date    | Time    | Pain Score | Intervention | Signature          |
|---------|---------|------------|--------------|--------------------|
| 30/5/26 | 12:30pm | 0          | NIL          | <u>[Signature]</u> |
| 30/5/26 | 1:00pm  | 0          | NIL          | <u>[Signature]</u> |
| 30/5/26 | 1:30PM  | 0          | NIL          | <u>[Signature]</u> |
| 30/5/26 | 2:00PM  | 0          | NIL          | <u>[Signature]</u> |

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

**Reassessment Frequency:**

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

Anaesthesiologist Name: .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name: Sudipra

PACU Nurse Signature: [Signature]

Date & Time: 30/5/26 @ 12:30PM

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

Date & Time: 30/5/26 @ 12:30PM



.....ology

# 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 : .....

# PATIENT TRANSFER FORM

|   |                         |  |   |
|---|-------------------------|--|---|
| Patient Name & UHID No.<br>HNH-00015653 IP26-00006465<br>Master VEDA SHOURYA<br>28-06-2010 15 Y 11 M 2 D (M)<br>Dr. JYOTI BOTHRA<br> |                         | Date & Time of Admission<br>30/5/26 @ 9:28 AM  | Date & Time of Transfer Order<br>30/5/26 @ 12:00 PM |
|   |                         | Transfer Ordered by<br>Dr. Samir   | Reason for Transfer<br>observation                  |
| From Unit<br>OT   | To Unit<br>MEU          | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| Number of Sheets in Clinical File   | Number of Imaging Films | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |   |
| Medications / Consumables / Surgicals / Hand over   |                         |  |   |
| Sl.No.  | Item Name               | Quantity   |   |
| 1.  |                         |  |   |
| 2.  |                         |  |   |
| 3.  |                         |  |   |
| 4.  |                         |  |   |
| 5.  |                         |  |   |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                         |  |   |
| Name & Signature of Person who is Transferring<br>   |                         | Name of Person Ordered Transfer<br>Dr. Samir   |   |
| 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

# PATIENT TRANSFER FORM

HNH-00015653  
Master VEDA SHOURYA IP26-00006465  
28-06-2010 15 Y 11 M 2 D (M)  
Dr. JYOTI BOTHRA



|  |   |  |
|--|---|--|
| Date & Time of Admission<br><i>30/5/26 @</i>   | Date & Time of Transfer Order<br><i>30/5/26 @</i> |  |
| Treating Consultant Name                       | Transfer Ordered by<br><i>Dr. Prashant</i>        | Reason for Transfer<br><i>Admission</i>  |
| From Unit<br><i>ER</i>                         | To Unit<br><i>OT</i>                              | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| Number of Sheets in Clinical File<br><i>20</i> | Number of Imaging Films                           | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>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<br><i>Robin</i> | Name of Person Ordered Transfer<br><i>Dr. Prashant</i> |
|--|--|

Patient & Clinical Records Received by :  
*Sudipal B*

Date & Time of Patient Received : *30/5/26 @ 11:00 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

# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



HNH-00015653 IP26-00006465  
Master VEDA SHOURYA  
28-06-2010 15 Y 11 M 2 D (M)  
Dr. JYOTI BATHRA

Patient Name: Dr. JYOTI BATHRA Age: 15 Gender: Male  Female

UHID NO:  Son Name: Dr. Jyoti Bathra

Anaesthesiologist: Dr. Jyoti Bathra

Operative procedure planned: Ganglion cyst excision

### 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 and 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 Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : Dr. supplementation

Comments :

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

### DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anaesthesiologist 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 : *[Handwritten Signature]*

Name : *V. Sai Vidya*

Relationship with Patient: *Mother*

Date & Time : *30/5 at 1045am*

**Witness :**

Signature : *[Handwritten Signature]*

Name : *I. V. ANANDHAR*

Date & Time : *30/5 at 1045am*

**Doctor (who is taking the consent) :**

Signature : *[Handwritten Signature]*

Name : *Dr. Lamin Arayath*

Date & Time : *30/5 1045am*

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



HNH-00015653 IP26-00006465  
 Master VEDA SHOURYA  
 28-06-2010 15 Y 11 M 2 D (M)  
 Dr. JYOTI BATHRA

Patient Name : .....

Gender:  Male  Female

Age : 15/2yr

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)

✓ (R) Wrist hanglim cyst excision

upon

(Name of the Patient)

Veda Shourya

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.

Infection & Recurrence

**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. Jyoti Bathra

**Consentee :**

Signature : .....

Name : .....

Date & Time : .....

**Patient Attendant :**

Signature : .....

Name : V. Sri Vidya

Relationship with Patient: Mother

Date & Time : .....

**Witness :**

Signature : T. V. Le

Name : T. V. Le

Date & Time : .....

**Doctor (who is taking the consent) :**

Signature : Dr. Jyoti Bathra

Name : Dr. Jyoti Bathra

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

HNH-00015653  
 Master VEDA SHOURYA  
 28-06-2010 15 Y 11 M 2 D (M)  
 Dr. JYOTI BOTHRA

IP26-00006465



EI



**TRIAGE FORM**

Patient's Name : T. Veda Shourya (Mast) Age : 15 years Gender:  Male  Female  
 Date : 30/5/26 Time of Arrival : 9:15 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: 99.2°R PR: 70b/m BP: 112/63 (70) RR: 16/m SpO<sub>2</sub>: 100%

Chief Complaints: Excitation of wound

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

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

**NOTE :** All immunocompromised children and preterm babies to be considered Level 2.  
 All Children less than 2 years age with high fever to be considered Level 3.  
 \* CTAS - Canadian Triage and Acuity Scale  
 Signature of Parent / Guardian \_\_\_\_\_  
 Triage Completion Time : .....

**Communicable Disease Triage Screening**

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

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 : Suganda Signature of Triage Nurse : Benny

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

HNH-00015853 IP26-00006465  
Master VEDA SHOURYA  
28-06-2010 15 Y 11 M 2 D (M)  
Dr. JYOTI BOTHRA



### NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/5/20 Time of arrival : 9:15 AM  
Chief Complaints : excitation of wound RBS: .....

Height : ..... Weight : 8.8 kg BMI : ..... Head Circumference (<2 years) .....

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: .....  
If yes, identify .....

Pain Screening:  Yes  No If Yes, Pain Score: ..... Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character n/a  Location n/a  Frequency n/a  Duration n/a

|  |   |
|--|---|
| <b>RISK FOR FALL:</b><br><input type="checkbox"/> If patient is < 6 years<br>tick below fall risk intervention directly<br><input type="checkbox"/> If Patient is > 6 years<br>Assess the below parameters<br>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Ambulatory Aids:</b><br>• Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>• Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Gait/Transferring:</b><br>• Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>• Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>• Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b><br><b>Fall Risk Intervention:</b><br><input type="checkbox"/> Escort while ambulating<br><input type="checkbox"/> Assist Patient<br><input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention | <b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected<br><input type="checkbox"/> Mobility Problem<br><input type="checkbox"/> Walking Problem<br><input type="checkbox"/> Developmental Delay<br><input type="checkbox"/> Musculoskeletal Congenital Abnormality<br><b>Inform consultant for positive criteria</b><br>.....<br><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected<br><input type="checkbox"/> Underweight<br><input type="checkbox"/> Overweight<br><input type="checkbox"/> Feeding Problem<br><input type="checkbox"/> Special diet<br><input type="checkbox"/> Special feeding method<br><b>Inform consultant for positive criteria</b> |
|--|---|

Psychological Screening:  No Significant Findings  
Unusual concerns about patient's Psychological Status:  Yes  No

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

Social History: Lives With Family  
Siblings in household  Yes  No (if yes How Many?) 1 younger Sister

Time of Initial assessment completed by ER Nurse : 9:20 AM

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



| Time   | Nursing Notes                                  |
|--------|--|
| 9:30am | Vitals checked & recorded<br>IV placement done |
|        |  |
|        |  |
|        |  |
|        |  |
|        |  |
|        |  |
|        |  |

Samples collected by: | Suganda | Time: | 9:45am.  
 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: 75b/min BP: ..... CFT: 28cc<br>RR: ..... SPO <sub>2</sub> : 100%<br>GCS: 15/15 Temperature: 99°F<br>Pain Score: 4<br>Repeat RBS (if applicable): ..... | Shift - out from ER to: OT<br>Time of Shift - out: 10:30 AM<br>Handover given to: .....<br>(Nurse's Name) |

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

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

Date & Time: 30/5/20 @ 0:20 PM

Ref.No. F/IN/PR/10



# Rainbow<sup>®</sup> Children's Hospital

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00015653      IP26-00006465

Master VEDA SHOURYA  
26-06-2010      16 Y 11 M 2 D      (M)  
Dr. JYOTI BOTHRA

Patient ID# : 

Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

do Ganglion cyst over right wrist

History of present illness :

do Ganglion cyst over the right wrist  
for surgical management  
(Excision of cyst)



Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_ ) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_ )

Weight (kgs) 8.8kg (Centile \_\_\_\_\_ )

**On Examination :**

Temperature : axillary Pulse Rate: 83/min Description \_\_\_\_\_

B.P. 118/63 mmHg SPO2 99% at RA

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_

Lymphadenopathy no

Oedema : \_\_\_\_\_

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : TSCG ⊕ clear

Any addes sounds : \_\_\_\_\_

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

**Cardiovascluar System :**

Inspection of procordium : \_\_\_\_\_

Heart Sounds : S1S2 ⊕

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : soft no

Ausculation : \_\_\_\_\_

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

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Central Nervous System :

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Motor System :

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

Reflexes :

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bladder / Bowel : \_\_\_\_\_

Clinical Summary & Diagnostic :

Ganglion cyst over Right wrist  
for Excision of cyst

Pediatric Multiorgan History & Phy

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Preventive aspects of the treatment :

Desired goals of the treatment :

**Planned Labs :**

**Planned Management :**

PAC (OP Basie Done 27/5/26)  
CBA

PAC  
CBA

Noted By Bothra

Surgical management  
(Excision of cyst)

MB Bothra

**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 \_\_\_\_\_