Patient Sticker

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Your Right to a Safe Delivery

SURGERY DETAILS

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

Date : 22/05/26

Patient Name: ..... Date of Birth: 01/05/2021 Age: 5Y

Gender: Male Ward : OT UHID No.: MAH-00336553

Date of Surgery: 22/05/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Tongue tie release

Time in : 9:10 AM Time Out : 9:30AM

		NAME	AMOUNT
1.	Surgeon	: Dr. Jyoti Bothra	
2.	Anaesthetist	: Dr. Ayesha	
3.	Assistant Surgeon	: -	
4.	OT Technician	: Sr. Saraswathi	
5.	Circulating Nurse	: Sr. Susheela	
6.	Assistant Nurse	: Br. Sudipta	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-aaaaa01327

Order by: Sushela 22/5/26 11:11 Am

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

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

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CONSUMABLES OF OT

Circulating staff : ..... Technician : Saraswathi Chandu Date : 22/5/26 Time : 9:30 AM.

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / (P) / N		03	5003		1	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc	02	03				Vaccum Suction Set		
05 cc		05	Gloves Sq-7		1	Surgical Gloves		
02 cc		02	Encore 6/12	1		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / (P) / N		01	Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
Adrenaline		01	Ointments					
Atropine		01	Suction Catheter					
Fentanyl		01	Cap, Mask	3	3			
Morphine			Gauze Pack 7.5		2			
~~Ketamine~~ Midaz		01	Mop Pack					
Propofol		02	Steristrip					
Rocuronium			Underpad					
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Capnography (P)		01	Tegaderm					
Suppositories			Ioban ~~mucous extractor~~		1			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00020139/1330 Ordered by : Sushma 22/5/26 @ 11:26 AM.

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	01			
2	Discharge Summary	01			
3	Nursing Initial assessment	01			
4	Patient Transfer form	02			
5	In-patient Medical record	01			
6	Doctors progress sheets	01			
7	Nursing plan of care and handover sheets	01			
8	Consultation sheet	01			
9	General consent for treatment				
10	Consent for Surgery	01			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)	01			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list	01			
26	Surgical safety checklist	01			
27	Operation Theatre notes	01			
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)	01			
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	14			

Signature and Date :

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow 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 : IP26-00006400 **Admit Date** : 22-May-2026 **Admit Time** : 07:48 AM **UHID** : MAH-00336553

Patient Details :

Patient Name	: Master AARAV HAMISH REDDY KASERLA	**Age**	: 5 Y 0 M 21 D
Guardian	: Mr DR HAREESH REDDY	**DOB**	: 01-05-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: GMR BRUNDHAVANA APARTMENTS B BLOCK FLAT NO 101 VADDEPALLE Hanamkonda Warangal INDIA 506001	**Phone No**	: 8886064888
		E-mail	: amithareddy1989@hotmail.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 DR HAREESH REDDY **Relationship** : Father

Contact Address : GMR BRUNDHAVANA APARTMENTS B BLOCK FLAT NO 101 VADDEPALLE Hanamkonda Warangal INDIA 506001 **Phone No** : 8886064888 / 8886063888

Signature

Doctor Details :

Doctor Name : Dr. JYOTI BOTHRA **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 50000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

26.0000201289.

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MASTER. AARAV HAMISH REDDY	Age:	5Y	Gender:	M
UHID No:	MAH-003365	IP No:	IP26-00006400	Date:	22/5/26 Time: 8:15 AM
Diagnosis:	TONGUE TIE RELEASE.				OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Swapna. S Doctor Registration No: 69924

Signature:

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

IP Registration No: IP26-00006400 **Date:** 22/5/26

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

1.	**Name :** MASTER. AARAV HAMISH REDDY.	**Remarks**
2.	Complete postal address (with contact number, if any)	GMR BRUNDAVANA APARTMENTS T3 BLOCK. VADDEPALLE
3.	Brief description of the illness	TONGUE TIE RELEASE.
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
22/5/26	FENTANYL	ONE Amp.		

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

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

Time: .....

26-0000201289

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MASTER AARAV HAMISH REDDY		Age: 5Y		Gender: M	
UHID No: MAH.00336553	IP No: EP26.00006400	Date: 22/5/26		Time: 8:15 Am	
Diagnosis: TONGUE TIE RELEASE OT					
PRESCRIPTION DETAILS (Tick only one of the following)					

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

Doctor Name: Dr. Swapna S

Doctor Registration No: 69924

Signature: [signature]

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

IP Registration No: EP26.00006400 **Date:** 22/5/26

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

1.	**Name :** MASTER AARAV HAMISH REDDY	**Remarks**
2.	Complete postal address (with contact number, if any)	GMR BRUNDHAVANA APARTMENTS B BLOCK UPPERPALLE
3.	Brief description of the illness	TONGUE TIE RELEASE
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
22/5/26	FENTANYL	one Amp	[signature]	

Dispensed by (Name & ID No.): Sonia (01840?) Signature: Sonia

Received by (Name & ID No.): SAI CHANDU 02115 3 Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

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ACTIVITY RECORD FOR BILLING

Name MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
UHID | Dr. JYOTI BOTHRA ---------- Consultant : ---------- Dept : ----------

Date c Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/5/26	9 AM	ER	OT	JYOT /
22/5/26	9:40	OT	PICU	/

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
22/5/26	CBP	8620	
~~18/5/26~~	~~PAP Done~~		

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 6 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22/5/26	IV Placement	(1)	1286	
22/5/26	PAC (OP)	(1)	204467	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

Patient Name :

Patient ID# :

Consultant : DR. JYOTHI BOTHRA.

Final Diagnosis : TONGUE TIE RELEASE

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Came for tongue tie release.

History of present illness :

Tongue tie release -
Shifted to Dr. Jyoti M/c on 16/5/26.
Posted for Sx today.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

N

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally N

Immunization History :

As per NIS.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 15.6 kgs. (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: 90/min. Description _____

B.P. _____ SPO2 100% at RA.

Resp. rate and type of breathing : _____

Rash N.

Lymphadenopathy

Oedema :

Respiratory system :

Inspection (any s/o distress) :

Air entry & breath sounds : N.

Any addes sounds :

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

Cardiovasclular System :

Inspection of procordium :

Heart Sounds : N.

Any murmur :

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

Per Abdomen :

Inspection

Palpation : N.

Ausculation :

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

TONGUE TIE RELEASE.

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
31-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBC.
HB Platelet

Planned Management :

NPO
IVF
PAC → Done.
HB Platelet

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

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

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

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Tongue tie release

Indications for Surgery : Tongue tie

Date : 22/5/26	Start Time : 9:10PM	End Time : 9:30PM

PRE-OPERATIVE PREPARATION :

- NBM

OPERATION NOTES:

- Tongue tie release done with electrocautery.
- Hemostasis confirmed

POST - OPERATIVE ORDERS :

- NO NBM

- TPR

- I/O chart.

- On RL

Oral hygiene - Water gargles after meals

Zytee gel locally 1-1-1 x 3days.

Syp CROCIN 5ml SOS for pain

R/W SOS

Dr Sydi Bottin

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 22/5/26 Time : 9:30AM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Jyothi
Asst. Surgeon : –
Anaesthetist : Dr. Ayesha
Scrub Nurse : Dr. Sudippa

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

Age : ..... Gender : Male
Name : Tongue tie / Frenectomy
Date : 22/5/26 In-time : 9:00AM Out-time : 9:30AM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:00AM

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Ayesha
Name : Dr. SK Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 9:10AM

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? 15min ☐ 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 : B
Name : Sudippa

Before Patient Leaves Operating Room

SIGN OUT Time: 9:30AM

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
MAH-00336553 IP26-00006400 Master AARAV HAMISH REDDY 01-05-2021 5 Y 0 M 21 D (M) Dr. JYOTI BOTHRA	22/5/26 @ 7:48 AM	22/5/26 @ ~~9:35~~ 01:35 AM
	Transfer Ordered by Dr. Ayesha	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.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sudipta	Dr. Ayesha

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

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
MAH-00336553 IP26-00006400 Master AARAV HAMISH REDDY 01-05-2021 5 Y 0 M 21 D (M) Dr. JYOTI BOTHRA	22/5/26 @7:48AM	22/5/26 @ 8:40AM
	Transfer Ordered by Dr. Varun	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR Anupam / NR	Dr. Varun

Patient & Clinical Records Received by : Sudipta / [illegible]

Date & Time of Patient Received : 22/5/26 @ 8:40 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

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

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DRUG CHART

Date of Admission: 22/5/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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 .....

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

REGULAR PRESCRIPTIONS

Weight. 15.6kgs 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
22/5/26	9:25 Am	DICLOFENAC suppository	12.5mg	PR		

Signature .....

VERIFIED BY : Name .....

MAH-00336553 IP26-00006400
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Dr. JYOTI BOTHRA

I.V. FLUIDS CHART

15.6 kgs.
Weight. ..... Ward. .....

Date		ition 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
24/5/21	8AM	PLASMALYTE 400ml + 100ml 25% Dx	IV	50ml/hr					

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

22/5/26

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name MASTER AARAV HAMISH REDDY Age: 5Y Sex: Male UHID.No : MAH-00336553

Date: 16/5/26 Time: 1:10pm Proposed Operation: Tongue tie release

Diagnosis: TONGUE TIE

B.P / CRT: <3sec H.R: 116/min Weight: 15.68kg 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:	Stress/Anglo:
PT:	K:	LDH:	T3 :	Other:
PTT:	Ca++:	Alk phos:	T4 :	
INR:	Mg++:	Amylase:	TSH :	
	Cl -:	SGOT/SGPT:		

Allergies: NIL

Medical History: CVS : NIL SIGNIFICANT

RESP :

CNS :

Renal :

Hepatic / GE :

Others :

Diabetes :

preterm 34wks | Twin II | LSCS | MCH | 1.3Kg. NICU admission for ? BIN x 1 Sch

Physical Activity: Immunisation

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE (+), clear, SpO2 : 98% on RA

Heart: S,S, (+)

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site : Peripheral (+)

Spine Exam for regional : Midline

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

8hrs – Solids
4hrs – clear liquid (Water, Coconut Water)

Signature: Name: Dr. Sk. Ayesha

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

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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: 120/min | B.P / CRT: < 3sec | SpO_2: 98% c RA | R.R: 22/min | Last Feed: > 6hr

Pre-OP Diagnosis: TONGUE TIE | Operation: TONGUE TIE RELEASE | Date: 22/5/2

Surgeon: Dr. Jyothi Bothra | Anaesthesiologist: Dr Ayesha / Dr. Rama Bhadra | Technician: Saichand

TIME	9:05	9:15	9:30
N_2O /AIR/O_2 LPM	2Lit/min		
HALO /SO /SEVO			
Drugs:	Inj. MIDAZOLAM 1mg IV		
	Inj. FENTANYL 100mcg IV		
	Inj. Propofol 40mg + 20mg + 20mg IV		
	DICLOFENAC supp PR		
FIO_2 / SaO_2	100% / 100%	100% / 100%	100% / 100%
$ETCO_2$	32 / 30	28 / 30	28 / 30
ECG	SR / SR	SR / SR	SR / SR
Temperature		36.5°C	
Urine Output			
Fluids / Blood			

Antibiotic

Suppository: DICLOFENAC 12.5mg PR

Blood Loss

NOTES

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

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

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

LAB Values

ABG
GRBS
Others

☑ Equipment Checked and Functional
☐ BP
☐ Cuff Site: Lt UL
☐ Art Site:
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position:
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 9:10AM
OP Start: 9:15AM
OP End: 9:25AM
Leave OR: 9:30AM

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☑ Mask ☐ SGA — Nasal prongs
☐ 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:
Site:
Needle Size: ..... Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

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

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

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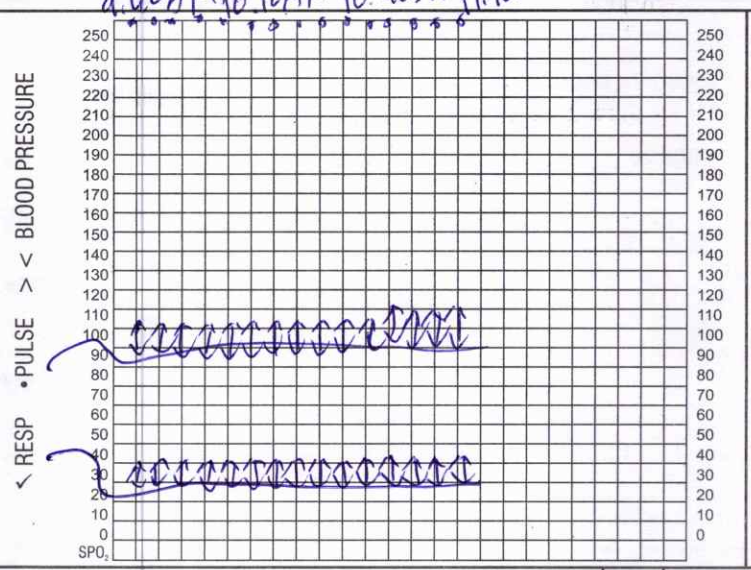
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sudipta Time Received : 9:40 AM Time Discharged : .....

9:40AM 10:10AM 10:40AM 11:10AM



IV Cannula Site : (R) Hand

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

Vomiting : ☐ Yes ☑ No Drug: –
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☑ Yes ☐ No

IV Fluids: –
Oral Feeds: Yes

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
22/5/26	9:40AM	0	NIL	
22/5/26	10:10AM	0	NIL	
22/5/26	10:40AM	0	NIL	
22/5/26	11:10AM	0	NIL	

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

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

PACU Nurse Name : Sudipta
PACU Nurse Signature: .....
Date & Time: 22/5/26 @ 10:30AM

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: 22/5/26 @ 10:30AM

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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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name: MASTER AARAV HAMSH REDDY ..... Age : 5Y ..... Gender : Male ☑ Female ☐

UHID NO: MAH-00236553 ..... Surgeon Name: Dr: JYOTHI BOTHRA .....

Anaesthesiologist : Dr: SK. Ayesha .....

Operative procedure planned : TONGUE TIE RELEASE .....

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 : Laryngoscopy, Bronchoscopy .....

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 AARAV HAMSH REDDY above mentioned operation / Diagnostic / Therapeutic procedures .....

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

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

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

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

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

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Amitha

Name : Amitha Reddy

Relationship with Patient: Mother

Date & Time : .....

Witness :

Signature : .....

Name : Dr. Ajitha

Date & Time : 16/5/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sk. Ayesha

Date & Time : 16/5/26, 1:17pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Aarav Haresh Gender: ☑ Male ☐ Female Age : 5yrs

UHID No : Date : 22/5/26

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)

Tongue tie release.

upon

(Name of the Patient) Aarav

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, Bleeding

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Sruthi Botla

Consentee :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature :

Name : DR. HAREESH

Relationship with Patient: FATHER

Date & Time : 22/05/2026 @ 8:40 Am

Witness :

Signature :

Name : Amitha Reddy

Date & Time : 22/5/2026 @8:40 AM

Doctor (who is taking the consent) :

Signature : Botla

Name : Dr Sruthi Botla

Date & Time : 22/5/26, 9:00AM

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Dr. JYOTI BOTHRA

Wt + 15.65kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Aarav hamish Age : 5Y **Gender:** ☐ Male ☐ Female

Date : 22/5/26 Time of Arrival : 7:25Am

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.6F PR: 131 BP: 89/63 RR: SpO$_2$: 100

Chief Complaints: C/o coming for torture fit

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 : 7:27Am

Communicable Disease Triage Screening

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

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

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location:
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Anupam

Signature of Triage Nurse : A.E

Date & Time : 22/5/26 @ 7:27A

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 22/5/26 Time of arrival : 7:25Am

Chief Complaints: Comes for tongue tie RBS: .....

Height : ..... Weight : 15.68 BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: ..... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character — ☐ Location tongue ☐ 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 : 7:30Am

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

Time	Nursing Notes
7)33P	Assessed the Patient condition vital checked. - IV placement Done - Smple Collected

Samples collected by: Jyoti Time: 8A

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: 102bpm BP: ..... CFT:	Shift - out from ER to: OT
RR: 20bpm SPO_2 : 100-1.	Time of Shift - out: 8:40AM
GCS: 15/15 Temperature : 98-1.	Handover given to: Sudipta (Nurse's Name)
Pain Score: —	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV Placement Done

Name of the Nurse : Anupam Signature of the Nurse : A.K

Date & Time : 22/5/26 @ 7:36A

MAH-00336553 IP26-00006400
Master AARAV HAMISH REDDY
01-05-2021 5 Y 0 M 21 D (M)
Dr. JYOTI BOTHRA

Rainbow® Children's Hospital
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 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. Varun

Date & Time : 22/5/26 @ 7:40 Am

Nurse Name & Signature: Jyoti

Date & Time : 22/5/26 @ 7:42 Am