HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
Dr. MUKTA SUBHASH WAGHMARE

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SURGERY DETAILS

Date : 22/7/26'

Patient Name: B/O. Ramadevi' Date of Birth: ..... Age: 2yrs/male

Gender: male Ward : OT UHID No.: HNH-00000170

Date of Surgery: 22/7/26' ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Tubalesioned Bleomycin injection

Time in : 11:15 AM Time Out : 11:40 AM

		NAME	AMOUNT
1.	Surgeon	: Dr Mukta	
2.	Anaesthetist	: Dr. Samir.	
3.	Assistant Surgeon	:	
4.	OT Technician	: Saraswathi'	
5.	Circulating Nurse	: Priya	
6.	Assistant Nurse	: Sushma.	

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: 26-000021598 Order by: Sushma 22/7/26'

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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CONSUMABLES OF OT

Circulating staff : Jaya Technician : Saraswathi Date : 22/7/26 Time :

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				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		✓03+3				Vaccum Suction Set		
05 cc		✓03	Gloves Gmcreb/2		✓2	Surgical Gloves		
02 cc		✓03				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Bleomycin.		✓01	Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask					
Morphine			Gauze Pack 7-5		✓8			
Ketamine			Mop Pack					
Propofol		✓01	Steristrip					
Rocuronium			Underpad					
Glycopyrolate			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					
D- water		✓06	Tegaderm					
Suppositories			Ioban					
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					
O2 mask (P)		✓01	Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-000021985/86 Ordered by : Sushma 22/7/26 @ 1.23 Pm.

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

RAINBOW CHILDREN'S MEDICARE LIMITED

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

VAT TIN : CIN :

DL NO :

Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP26-00006911	**Ward**	4F -OT
Patient Name	Baby Of RAMADEVI	**Bed Name**	PPO-417
Age/Sex	2 Y 8 M 21 D / Male	**Order No**	26-0000215985
Date	22/07/2026 13:21	**Prescription No**	PRIP26-0093721
Payor	SELFPAY	**Dispensed Date**	22/07/2026 13:23
UHID	HNH-00000170		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BLEOCEL INJ VIAL 15 MG 1 ML	Celon Laboratories Ltd		BMI2410AC	11/26	1	711.00	711.00
2	DSYRINGE 5ML(NIPRO)	NIPRO	GENERAL	26E02K55	04/31	3	21.56	64.68
3	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26C23K41	02/31	3	11.25	33.75
4	Encore Microptic gloves-6.5		H	26030O711T	03/29	2	128.00	256.00
5	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	2	100.00	200.00
6	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	1	69.10	69.10
7	Oxygen Mask With Tubing - PeadROMSONS-FC		GENERAL	G26B040154	01/31	1	460.00	460.00
8	SGLOVE # 6.5 (SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26F8079M	05/31	2	91.00	182.00
						Total :	**1,591.91**	**1,976.53**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GUVVALA VIJAYA SUSHEELA

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DISCHARGE SUMMARY

Name	Baby Of RAMADEVI	**UHID**	HNH-00000170
Father/Guardian	Mr PAVAN KUMAR	**Age/Gender**	2 Y 8 M 21 D/ Male
Address	Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006911	**Admission Date**	22-07-2026
Ref Doctor	Self.		
Discharge Date	22.07.2026		

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

DIAGNOSIS	ICD CODE
LYMPHANGIOMA RIGHT CERVICAL REGION	

Procedure : INTRA LESIONAL USG GUIDED BLEOMYCIN INJECTION DONE ON 22.07.2026

History: Baby Of RAMADEVI, 2 Y 8 M 21 D child presented with history of swelling on right side of the neck since last 8 months 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 140/min and Respiratory rate - 30/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. Right sided cervical swelling noted, extending posteriorly and towards supramediastinum.

Weight on admission: 12 kilo grams.

Investigations: Enclosed reports.

Name	Baby Of RAMADEVI	UHID	HNH-00000170
IP No	IP26-00006911	Admission Date	22-07-2026

Procedure : INTRA LESIONAL USG GUIDED BLEOMYCIN INJECTION DONE ON 22.07.2026

Surgery Notes:
* USG Guided intralesional injection. Bleomycin given.

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.
* Syrup. Augmentin DDS (Amoxicillin - 400mg + Potassium clavulanate - 57mg/5ml) 3 ml twice daily (1 hour before food or 2 hours after food) for 5 days (Should be kept in refrigerator after reconstitution, consume within 7-days)
* Syrup. P-250 mg 4ml, thrice daily for 2 days.

Fever Management
* Syrup. P-250 (Paracetamol - 5ml/250mg) 4 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. MUKTA SUBHASH WAGHMARE after 4 weeks in OPD at Himayatnagar with prior appointment **(Review consultation will be charged).**

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

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.

Name	Baby Of RAMADEVI	**UHID**	HNH-00000170
IP No	IP26-00006911	**Admission Date**	22-07-2026

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

Registrar/Resident/C.M.O

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

HNH-0000170

Patient Sticker

Baby of Rabia delli

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DEFICIENCY CHECK LIST OF CASE SHEET

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

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : (P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP26-00006911 **Admit Date** : 22-Jul-2026 **Admit Time** : 07:13 AM **UHID** : HNH-00000170

Patient Details :

Patient Name	: Baby Of RAMADEVI	**Age**	: 2 Y 8 M 21 D
Guardian	: Mr PAVAN KUMAR	**DOB**	: 01-11-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 6309643243/ 7729870840
		E-mail	: SRAVANSAIKANTH19@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr PAVAN KUMAR **Relationship** : Father

Contact Address : Amberpet Hyderabad Telangana INDIA 500013 **Phone No** : 7729870840

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

Deposit Amount : 12000.00

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

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ACTIVITY RECORD FOR BILLING

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
Dr. MUKTA SUBHASH WAGHMARE

Name :_____

UHID No. : _____ IP No : _____ 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
22/7/26	8:20 AM	ER	OT	Puja.
22/7/26	11:40 AM	OT	[illegible]	[illegible]

Cross Consultation Visit

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

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
Dr. MUKTA SUBHASH WAGHMARE

INVESTIGATIONS

Date	Investigations	Order No.	Signature
22/7/26	CBP	12247	[signature]

HNH-00000170 IP26-00005911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M
Dr. MUKTA SUBHASH WAGHMARE

MEDICAL EQUIPMENT (WARD & ICU)

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

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
Dr. MUKTA SUBHASH WAGHMARE

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/26	I/V placement	①	15867	
	PAC	①	15868	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Baby g Ramadevi Gender: ☐ ~~Male~~ ☐ Female Age : 2y

UHID No : HNH-170 Date : 22/7

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)
BIFONMYCIN INJECTION

upon
(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.
Desatuation, bleeding, Need for potop hospital stay

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

Name of the Doctor who is performing the Surgery / Procedure:

Consentee :
Signature : Rama
Name : Karuna
Date & Time : 22/7/26 @ 11:10 Pm

Witness :
Signature :
Name : Pavan Kumar
Date & Time : 22/7/26 @ 8:50am

Patient Attendant :
Signature : Rama
Name : Ramadevi
Relationship with Patient: Mother
Date & Time : 22/7/26 @ 8:41am

Doctor (who is taking the consent) :
Signature : (for Doctor Name)
Name : Dr. Ayesha
Date & Time : 22/7/26

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Baby g Ramadevi Age : 2y Gender : Male ☐ Female ☑

UHID NO: HNH-0000010 Surgeon Name: Dr. MUKTA SUBHASH NAGAITHANE

Anaesthesiologist : Dr. SAMIR / Dr. Ayesha

Operative procedure planned : BLEOMYCIN INJECTION

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 Aacidosls

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Desatuation, laryngospasm, Bronchospasm

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 Baby g Ramadevi ..... the above mentioned operation / Diagnostic / Therapeutic procedures BLEOMYCIN INJECTION

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 : Ramadevi

Name : Ramadevi

Relationship with Patient: Mother

Date & Time : 22/7/26 @ 8:41am

Witness :

Signature : B Pavan

Name : Pavan kumar

Date & Time : 22/7/26 @ 8:50am

Doctor (who is taking the consent) :

Signature : Ayesha

Name : Dr. SK. Ayesha

Date & Time : 22/7/26, 9:00Am

Patient Sticker

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OPERATION NOTES

Surgeon : Dr Nikita	Asst. Surgeon :
Pre-Operative Diagnosis: Lymphangioma (R) ~~Side~~ Cervical region	
Surgical Procedure : Intralesional USG guided Bleomycin injection	
Indications for Surgery :	
Date :	Start Time : / End Time :

Post Operative Diagnosis:

Peri-Operative Complications: —

Amount of Blood Loss: —	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination: —

Operation Notes:

USG guided intralesional injection given.

Postop

Syp. AUGMENTIN DDS (457/5ml)
4 ml BD x 5days.

Syp. P-250mg 4ml TID x 2days

R/V after 4wks in OPD

Name of the Surgeon: D Murli

Signature of the Surgeon: [signature]

Date & Time: 11·46 Am 22/7/16

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Mukta
Asst. Surgeon :
Anaesthetist : Dr. Samir.
Scrub Nurse : Sr. Sushela

Patient Name : B/o Ramadevi Age : 2yrs Gender Male
UHID No. : RNH-0000070 Surgery Name : R/O Cervical lymphadenitis
Date : 22/7/26 In-time : 11:15Am Out-time : 11:40Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:10Am

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

(R) side NECK

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 : Dr Samir
Name :

Before Skin Incision ➤➤

TIME OUT Time: 11:20Am

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

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

Anticipated Critical Events

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

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

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

Signature : Karuna
Name : Karuna @ 11:20Am

Before Patient Leaves Operating Room

SIGN OUT Time:

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
~~[illegible]~~ Baby of Rama Devi	22/7/26 @ 7:13Am	22/7/26 @ 11:40Am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Mukta	Dr Samir.	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	MICU	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.	DNS	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
Karuna	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

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATIC

Name: Baby of RAMA DEVI Age: 2y 8 months Sex: M UHID.No : HNH-00000170

Date: 22.7.27 Time: 7:30 AM. Proposed Operation: Bleomycin Injection.

Diagnosis: ® cervical lymphangioma. / cystic swelling.

B.P / CRT: .... H.R: .... Weight: 12.43Kgs 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	14/7/26 : USG Neck.
INR:	Mg++:	Amylase:	TSH	Multiloculated lesion (12x4.2)
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS : ⊝ LSCS / 2.4Kg / NO NICU Stay / Developments & Normal

RESP : No URI / fever Diabetes :

CNS : ⊝

Renal : ⊝

Hepatic / GE : ⊝ Physical Activity: Active

Others : O/E

Past Anaesthetic History: H/o 4 Bleomycin doses ↓ sedation / last injection on April 2025 5th in OP without seda

Physical Exam: alert, afebrile.

Airway: MP ① 2 3 4 Mouth Opening: >3f Mentohyoid Distance: >2fb Neck: ↓ movements - ® side restricted Teeth: -X|X- / XX|XX - Caries - B

Lungs : BAE ⊕, No added sounds.

Heart: S1S2 ⊕

CNS: —

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site ⊕ Spine Exam for regional : —

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 — Dinner at 8:30PM. 21/7
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

~~6. CBP drug cannulation~~

Signature: Amm Name: Dr. AMREEN

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

HNH-00000170 IP26-00006911
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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: adq

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 89/m | B.P / CRT: <2sec | SpO_2: 100% | R.R: 18/m | Last Feed: 7hrs

Pre-OP Diagnosis: cystic hygroma | Operation: Excisional biopsy | Date: 2

Surgeon: Dr MW | Anaesthesiologist: Dr Sanju | Technician: Saraswati

TIME 1115 — 1140

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

MIDAZOLAM 0.6 mg

PROPOFOL 20 + 30 mg intermittently

KETAMINE 15 mg iv

FIO_2 / SaO_2 100 100

$ETCO_2$

ECG sr a

Temperature

Urine Output

Fluids / Blood 1/2 pnts

Antibiotic —

Suppository —

Blood Loss —

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP ☑ DVL
☐ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead
☑ Temp Site skin
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☑ Nerve Stimulator

Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 1115
OP Start: .....
OP End: .....
Leave OR: 1140 am

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: 22G DVL
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

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

Spontaneous - face mask

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 Sanju
Signature of the Doctor: .....

HNH-00000170 IP26-00006911
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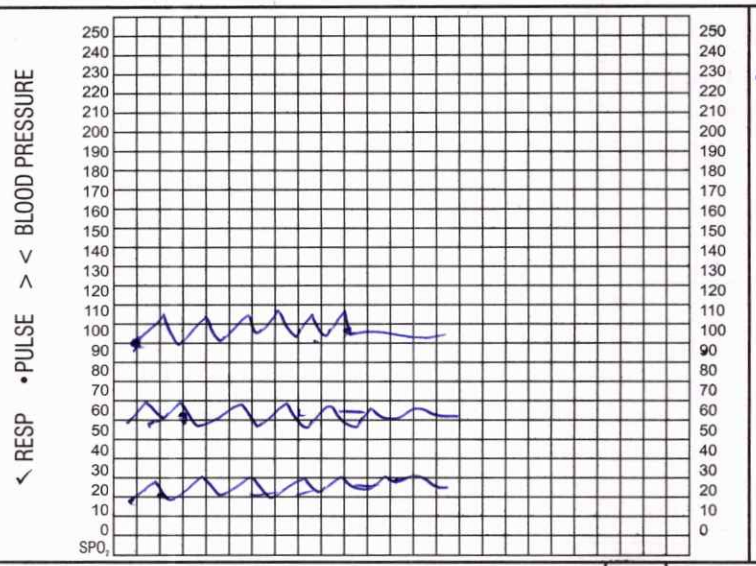
POST ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Karuna Time Received : 11:20am Time Discharged : .....



IV Cannula Site : left
☑ 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: DNS.
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
22/7/26	11:15 Am	0	Normal	
22/7/26	11:20 Am	0	Normal	
22/7/26	11:30 Am	0	Normal	
22/7/26	11:35 Am	0	Normal	Karuna

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

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

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

PACU Nurse Name : Karuna
PACU Nurse Signature: Karuna
Date & Time: 22/7/26 @ 12:50 Pm

Transferred to Unit by (PACU): Karuna
Date & Time: 22/7/26 @ 12:50 Pm

HNH-00000170 IP26-00006911
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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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

HNH-00000170 IP26-00006911
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/05/2026 9am	Daycare notes Case of swelling on (R) side of the neck since last 6-8 months Cervical lymphangioma for USG guided bleomycin injection	
	No fever no acute illness HR - 114/min SpO_2 98% @ RA CVS RS (N) P/A soft NPO since last night (8:30 pm) L/E - Large cystic swelling (R) Cervical region extending posteriorly & supramediastinum region.	Plan (1) Bleomycin injection under sedation (2) PAC (3) NPO (4) Shift to OT on call (Dr. Nasreen)

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

(P.T.O)

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Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7		
2pm	Child stable Post OP	Rx
	Pain @	1) D/C Today &
	Tolerated feed	R/V after 4 week
		2) Wound Dressing
	Vitals Stable	P-Sol - 4ml

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DRUG CHART

Date of Admission: 22/07/26 Drug Allergies: .... ☑ ~~Not~~ known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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REGULAR PRESCRIPTIONS

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

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

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

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

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

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Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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Weight. ..... Ward. .....

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

HNH-00000170 IP26-00006911
Baby Of RAMADEVI
01-11-2023 2 Y 8 M 21 D (M)
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I.V. FLUIDS CHART

Weight. 12kgs Ward. .....

		osition 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
22/7		DNS (Inj. NPO)	IV	30 ml/hr	[illegible]				

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

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wt - 12 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O Ramadevi Age : 2y 8 month **Gender:** ☑ Male ☐ Female

Date : 22/7/26 Time of Arrival : 7 AM

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2°F PR: 140 b/m BP: ..... RR: ..... SpO_2: 100 %

Chief Complaints: C/O .....

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 : 7:03 AM

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Prabin

Signature of Triage Nurse : .....

Date & Time : 22/7/26 @ 7:03 AM

HNH-00000170 IP26-00006911
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 22/7/26 Time of arrival : 7:AM

Chief Complaints: C/C RBS: .....

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

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 7:03 Am

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

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

Samples collected by: / Time:

Samples sent by : / Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 140 b/m BP: ..... CFT: 2sec	Shift - out from ER to: OT
RR: ..... SPO_2 : 100%	Time of Shift - out: .....
GCS: 15/15 Temperature : 98.2°F	Handover given to: ..... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

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

Date & Time : 22/7/26 @ 7:03 PM