ESTIMATION SLIP

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date : 28/05/2026. UHID / IP No. : _____ Sl No. 4128

Name of Patient : Darsh Soni Age: _____ Gender: Male.

Father's / Husband's Name : Pritesh Soni Corporate / Occupation : _____

Address : Malakpet. Phone : 9700809591 Email : ~~9885801905~~

Procedure / Plan : Primary Suturing under Sedation (G.A) Dos: _____

MODE OF PAYMENT : ☐ **SELF** ☐ **TPA :** _____ ☐ **GIPSA :** _____ **OTHER**

TARIFF INFORMATION :

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges			75000/-							
	Doctor's Fee										
	L. Tax										

PARTICULARS	AMOUNT (₹) 75000/-
Surgeon's / Anesthetists's Fee / O.T. Charges	
O.T. Consumables	Subject to approval by TPA / Insurance Company
Instrument Charges	Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations	Extra — As per actual - Not Included in Estimation

Equipment Charges	Monitor :	Oxygen :	Infusion pump / Syringe pump :	
	Ventilator :	*Conventional :*	*HFO-SLE 5000:*	*HFOSensormedix :*
	Photo therapy :	*Single Surface :*	*Double surface*	*Triple Surface*

Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.	As per actual - Not Included in Estimation
Packages	
Others	
Initial Minimum Deposit	

REMARKS

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to Surgeon's decisions/Complications/Patient's requirements/Modes of Procedure (like Laparoscopie, Thoroscople, etc)/Unilateral to Bilateral Procedure,**
3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category
4. Room eligibility is purely subject to TPA approval and the Package/Room tariff starts from the time of admission.
5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA Insurance Company at later stage.
6. **For Non-Medicals, Disposables, Consumables, Infusion pump, Taxes, Implants, HIV/HbsAg, Medical Records, Insurance Processing Fee, Double occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.**
7. During Non-working hours of OT(8:00 PM to 6:00 AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this if not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9 am to 6pm. 8. Difference, if any between the final bill amount and amount permitted/approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICUS Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I _____ have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of the after discharge time I promise to settle the claim with the hospital

Signature of the Client

Pritesh Father.
Signatory Relationship

Signature of the financial Counselor

VIH-00203019 IP26-00006441
Master DARSH SONI
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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SURGERY DETAILS

Date : 28/5/26

Patient Name: Master Darsh Soni Date of Birth: 28-06-2024 Age: 1Y

Gender: Male Ward : OT-2 UHID No.: VIH-00203019 IP26-00006441

Date of Surgery: 28/5/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : primary Suturing

Time in : 5:00 PM Time Out : 5:15 PM

		NAME	AMOUNT
1.	Surgeon	Dr. Swapna P.	
2.	Anaesthetist	Dr Heena	
3.	Assistant Surgeon		
4.	OT Technician	Dr. Pallavi	
5.	Circulating Nurse	Sr. Karuna	
6.	Assistant Nurse	Sr- Sudipta	

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

Signature of the Surgeon

Karuna
Signature of Circulating Nurse

Order No: 26-0000202694 Order by: Sudipta @ 18:32 PM 28/5/26

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad , Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: VIH-00203019	**Name**	: Master DARSH SONI
Age / Sex	: 1 Y / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 28/05/2026 10:21	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 28/05/2026 18:12	**Ordernumber**	: 26-0000202687
Visit ID	: IP26-00006441	**Ward/Bed No**	: 3F -SEMI PRIVATE / SPVT-316
Patient Address	: malakpet, Malakpet Colony, Hyderabad, Telangana, INDIA, 500036		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	Injection / 10 AM	1 Days		1 Nos	Dispensed
2	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
3	MYOPYROLATE-INJ-5ML		1 Nos	Injection / Once Daily	1 Days		1 Ampule	Dispensed
4	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
5	VICRYL 5-0 VP 2303	VICRYL 5-0 NW 2303	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
6	NITRILE EXAMINATION GLOVES P F- LARGE		1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
7	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
8	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	10 Days		10 Cap	Dispensed
10	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	GAUZE SWABS-510X10 12 PLY XRAY STERILE	1 Pkt	External / Once Daily	1 Days		4 Pkt	Dispensed
11	CUROPINE (ATROPINE) INJ 1 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
12	OXYGEN NASEL CANNULA (PEAD)	OXYGEN NASAL CANULLA PED	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed

SWAPNA PALAKURTHY

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Note

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*** Do not refill medicines.**

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: VIH-00203019	**Name**	: Master DARSH SONI
Age / Sex	: 1 Y / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 28/05/2026 10:21	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 28/05/2026 18:12	**Ordernumber**	: 26-0000202688
Visit ID	: IP26-00006441	**Ward/Bed No**	: 3F -SEMI PRIVATE / SPVT-316
Patient Address	: malakpet, Malakpet Colony, Hyderabad, Telangana, INDIA, 500036		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
2	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
3	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
6	Oxygen Mask With Tubing - PeadROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
10	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
11	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
12	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
13	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed

SWAPNA PALAKURTHY

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VIH-00203019 IP26-00006441
Master DARSH SONI
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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CONSUMABLES OF OT

Circulating staff : Sudipta Technician : Pallavi Date : 28/5/24 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 2303 Vicryl	✓ 01		Cord Clamp		
ECG leads : A / P / N	✓	03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc	✓	04				Vaccum Suction Set		
05 cc	✓	04	Gloves PF-7.0,	2 ✓		Surgical Gloves		
02 cc	✓	02	Encore-6.0	02 ✓		Gauze Pack		
01 cc	✓	01	S.C-7.0	01 ✓		Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil			Lox jelly		01 ✓
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Midaz ✓	✓	01	Ointments			~~10cc~~		
O2 mask (P) ✓	✓	01	Suction Catheter					
Fentanyl			Cap, Mask	✓ 10+10 ✓				
Morphine			Gauze Pack 10X10, 7.5	4+2 ✓				
Ketamine			Mop Pack					
Propofol	✓	01	Steristrip					
Rocuronium			Underpad					
Glycopyrolate	✓	01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		✓	Urobag					
Bupivacaine 0.25%	✓	01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics		✓	Bandage					
PCM	✓	01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	01 ✓				
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	01 ✓				
Nasal cannula (P) ✓	✓	01	Microshield	01 ✓				
Atropine	✓	01	Cotton Balls	02 ✓				
			Latex Gloves	20				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse Sudipta OT Technician

Order No. : 26-00002026 87/2688 Ordered by :

2689

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

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: VIH-00203019	**Name**	: Master DARSH SONI
Age / Sex	: 1 Y / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 28/05/2026 10:21	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 28/05/2026 18:12	**Ordernumber**	: 26-0000202689
Visit ID	: IP26-00006441	**Ward/Bed No**	: 3F -SEMI PRIVATE / SPVT-316
Patient Address	: malakpet, Malakpet Colony, Hyderabad, Telangana, INDIA, 500036		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SGLOVE 7.0(POWDER FREE)			/	1 Days		2 Nos	Dispensed

SWAPNA PALAKURTHY

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DISCHARGE SUMMARY

Name	Master DARSH SONI	**UHID**	VIH-00203019
Father/Guardian	Mr PRITESH SONI	**Age/Gender**	1 Y / Male
Address	malakpet, Malakpet Colony, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006441	**Admission Date**	28-05-2026
Ref Doctor	Self.		
Discharge Date	29.05.2026		

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

DIAGNOSIS	ICD CODE
FOREHEAD LACERATION INJURY	

Procedure : Primary suturing done on 28.05.2026.

History: Master DARSH SONI, 1 Y child presented with history of fall at home in the night, injury over right side of forehead, prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for

Name	Master DARSH SONI	UHID	VIH-00203019
IP No	IP26-00006441	Admission Date	28-05-2026

surgical management.

Examination: Child was afebrile, maintaining saturations at room air. Heart rate was 138/min and Respiratory rate - 34/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 side laceration over forehead 3 x 1 x 0.5 mm

Weight on admission: 10.2 kilo grams.

Investigations: Enclosed reports.

Procedure : Primary suturing done on 28.05.2026.

Surgery Notes:
- 2 x 1 x 1 cm laceration over forehead.
- Primary suturing done.
- Haemostasis secured.
- Post procedure uneventful.

Post-Operative Notes: Post operative period was uneventful. Child was initiated on oral feeds gradually which child tolerated well. Child 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. Crocin DS (Paracetamol - 5ml/240mg) 3 ml thrice daily after food for 2 days.
* T- Bact ointment for local application

Name	Master DARSH SONI	**UHID**	VIH-00203019
IP No	IP26-00006441	**Admission Date**	28-05-2026

daily for 5 days.
* Syrup. ZIPRAX (Cefixime - 5ml/100mg), 2.5 ml, twice daily for 3 days

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 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. SWAPNA PALAKURTHY on Monday(0.1.06.26) in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

You can also take appointments at any time by going **online** to our website

Name	Master DARSH SONI	**UHID**	VIH-00203019
IP No	IP26-00006441	**Admission Date**	28-05-2026

www.rainbowhospitals.in

Registrar/Resident/C.M.O

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

Rainbow Childrens Hospital-Himayatnagar

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006441 **Admit Date** : 28-May-2026 **Admit Time** : 10:21 AM **UHID** : VIH-00203019

Patient Details :

Patient Name	: Master DARSH SONI	**Age**	: 1 Y
Guardian	: Mr PRITESH SONI	**DOB**	: 28-06-2024 10:47 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: malakpet Malakpet Colony Hyderabad Telangana INDIA 500036	**Phone No**	: 9700809591/
		E-mail	: na@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 PRITESH SONI **Relationship** : Father

Contact Address : malakpet Malakpet Colony Hyderabad Telangana INDIA 500036 **Phone No** : 9700809591

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : CARE HEALTH INSURANCE LIMITED

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PATIENT TRANSFER FORM

VIH-00203019 IP26-00006441
Master DARSH SONI
28-05-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

	Date & Time of Admission	Date & Time of Transfer Order
	28/5/26 @	28/5/26 @ 7pm
Treating Consultant Name: Dr. Swapna Palkurthy	Transfer Ordered by: Dr. Heena.	Reason for Transfer:
From Unit: OT	To Unit: 316	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.	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
Kaur.	Dr.

Patient & Clinical Records Received by : Sunanda @ 7pm

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

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ACTIVITY RECORD FOR BILLING

Name: ----- VIH-00203019 IP26-00006441 ----------
Master DARSH
28-06-2024 1 Y (M)
UHID No : - Dr. SWAPNA PALAKURTHY --------- Consultant : ---------- Dept : ----------
Date of Adr : ---------- Date of Discharge : ---------- Time: ----------
Room / Bed No : ---------- Ward : ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	11:00 Am	ER	316	AD
28/5/26	5 pm	316	OT	Sudha
28/5/26		OT		Kaur

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
28/5/26	CBP	89035	
	Cross checked by Sunanda	done	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/5/25	Infusion pum	12:49 pm.	28/5/25 @ 6PM	202592	[illegible]

Cross checked done by Sunanda

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/·	Iv canula.		✓ 2569	
28/5/26 11:38 AM	N+A	(1) ✓	202591	
28/5	PAC Done (IP)		✓ 2659	
		Cross check done by Sunanda		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Fall at home in the night & injury over Ⓡ side forehead.

History of present illness :

child brought with c/o fall at home yesterday night @ 12 AM & injury over Ⓡ side forehead

↓

Post fall child was taken to local hospital

↓

Where CT head was done

↓

No evidence of IC bleed

Ⓡ side Forehead injury - 3 x 1 x 0.5 cm laceration

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Upto 1yr ago

Not received 18m booster

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 10.2 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 138/m Description _____

B.P. _____ SPO2 99% at _____

Resp. rate and type of breathing : _____

Rash (R) side laceration over forehead - 3x1x0.5cm

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S_1S_2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft

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 :

® Side forehead laceration, crying

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

H. I) Stability

Planned Labs :

CBP C Cannula

Planned Management :

PAC

NPO :→ 6:30Am (Solid) Till 11:45Am (Liq)

IV Fluids

Inj Augmentin

Primary Suturing ↓ G/R

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 Dr Swapna on
   whose name the patient is being referred

Doctor's Signature Name _____ Date 28/5/24 Time _____

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/b Dr. Varun / Dr. Pravin.	
28/5/24 2:30PM	Dx is - (R) sided forehead laceration injury	
	- Baby is clinically stable.	
	- Kept NPO since 12PM.	
	- O/E - Vitals stable.	
	S/E - WNL.	Plan - Shift to OT ~~at xxx~~ in the afternoon.
		- Ct. IVF Inj. Augmentin.

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

VIH-00203019 IP26-00006441
Master DARSH
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6 7:00 AM	C/s/B. Dr. Naipreeja	Dr. Alekya.
	(Rt) sided. forehead laceration. injury ↓	Plan
	No fever.	- Cont Augmentin
	Vitals - Stable.	- Cont Syp-Cnavin
	R/S | NAD P/A |	- Monitor vitals
		- plan D/c today after rounds
	N/B priyanka	Dr. Neeraj
29/6/24 10 AM	case d/w Dr. Swapna	
	△ (RP) sided laceration on forehead	- Syp. CEFIXIME (54 (100mg) 2.5ml/BD x 3 days
		- Disch
	Afebrile Vitals Stable	- F/U on Monday
		N/V for Dr. Swapna

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 10kg Ward. .....

DRUG : Inj AMOXICILLIN + CLAVULANATE

Dose	Route	Frequency	Start Date
300mg	IV	TID	28/5

Name & Signature of the Doctor Starting the Drugs: Prasanna

Additional Instructions: 30mg/kg

Date / Time	28/5	29/5
6AM	X	
12:30 AM		
2pm		
10pm		

Daily Doctor's Endorsement by a Sign

DRUG : SYP CROSIN DS

Dose	Route	Frequency	Start Date
3ml	PO	TID	28/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time	28/5	29/5
6AM	X	
9PM	X	
10PM		

Daily Doctor's Endorsement by a Sign

DRUG : T. Bact Ointment

Dose	Route	Frequency	Start Date
	LA	BD	28/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time	
10AM	
10PM.	

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time

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
28/5	5.10pm	INJ. GLYCOPYRROLATE	100 mg	IV		
28/5	5.15pm	INJ. PARACETAMOL	1000 mg	IV		

VERIFIED BY / Name ..... Signature .....

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I.V. FLUIDS CHART

Weight. ...10.2 kg... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5	11 AM	IVF - DNS (2/3rd M)	IV	27 ml/hr					

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00203019 IP26-00006441 Master DARSH 28-06-2024 1 Y (M) Dr. SWAPNA PALAKURTHY	28/5/26 @10AM	28/5/26
	Transfer Ordered by Dr: Pranav	Reason for Transfer Admission
From Unit ER	To Unit 316	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr. Pranav

Patient & Clinical Records Received by : Sapna

Date & Time of Patient Received : 11:50 AM @ 28/5/26

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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

UHID No : ..... Date : .....

Instruction:
This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

..... Primary Suturing .....

..... 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.

- Infection - Hypertrophic scar.
- Wound gaping
- Keloid formation

My signature on this form indicates that

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

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

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Witness :

Signature : .....

Name : Priyanka

Date & Time : 28/5/26 @ 4:30 pm

Patient Attendant :

Signature : Paitesh

Name : Paitesh Soni

Relationship with Patient: Father

Date & Time : 28/05/2026 @ 4:30 PM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sowjya Pothuneedy

Date & Time : .....

PATIENT TRANSFER FORM

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Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

Treating Consultant	Date & Time of Admission: 28/9/26 5pm	Date & Time of Transfer Order: 28/5/25 5pm
	Transfer Ordered by: Dr. Pranav	Reason for Transfer: Surgery.
From Unit: 3rd 31b	To Unit: OT	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 10	Number of Imaging Films: Nil	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
Sis Suchida.	Dr. Pranav.

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

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... ER ..... Shifted to: ..... OT .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Pnam .....

Date & Time : ..... 28/5/26 @ 10:30 AM .....

Nurse Name & Signature: ..... Anupam .....

Date & Time : ..... 28/5/26 @ 10:30 Am .....

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

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3/6

B+ve blood grp

RESULT SHEET

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Date	28/5/26					
Time						
Hb	10.8					
PCV	31.6					
RBC	4.70					
WBC	11.79					
N/L	31/60					
Platelets	649					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Date						
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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RM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 28/5/26 Time: 1 10 PM 2 AM 6 AM

Doctor / Nurse / Family Concern? PM

Temperature (F)
104 103 102 101 100 99 98 97 96 95 94
98.2°F 98.0°F 98.3°F 97.1°F

Heart Rate (bpm) and Blood Pressure (mmHg) *
190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
90 (71) 69

Note: BP does not score in early warning scoring

Heart Rate (Number) 126/m 128bm 129bm 119bm

Resp. Rate (bpm) (Over 1 Minute) *
70 60 50 40 30 20 10

Resp Rate (Number) 32b/m 30bm 30bm 30b/m

Resp Distress	Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	99%	100%
Conscious Level	Normal / Altered			
GCS *	15/15	15/15	15/15	14/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

ACTIONS NB: Scores 3 should be recorded overleaf	
Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient Sticker

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
28/5/26	08:00 am										0	
	09:00 am										0	
	10:00 am										0	
	11:00 am			27ml							0	
	12:00 pm	DNS	N	27ml							0	
	01:00 pm		BM	27ml							0	
Total Intake :						**Total Output :**						
	02:00 pm										1	
	03:00 pm										1	
	04:00 pm							N/A			1	
	05:00 pm										0	
	06:00 pm										1	
	07:00 pm										1	
Total Intake :						**Total Output :**						
28/5/26	08:00 pm	1					1				1	
	09:00 pm		apple									
	10:00 pm	0	x				0					
	11:00 pm											
	12:00 am	1	Hmo				1				1	
	01:00 am				N/A			N/A		✓		
Total Intake :						**Total Output :**					M-0	U-1
29/5/26	02:00 am	1					1				1	
	03:00 am		Hmo									
	04:00 am						0					
	05:00 am	0	x								0	
	06:00 am	1	Hmo				1				1	
	07:00 am				N/A			N/A		✓		
Total Intake :						**Total Output :**					M-0	U-1

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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NURSING CARE RECORD

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Date: 28/5/24

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ Assess the Pt condition → Monitor the vitals → Maintain the IO chart → Administer medication as per drug chart	8am to 2pm	→ Assessed pt condition → Monitored vitals → Maintained IO chart → Administered medication as per drug chart	Patient is stable	→ Re-checked the vitals	Supriya
Afternoon	2pm to 8pm	- Assess the Pt Condition - Monitor the V/S - Maintain the I/O - Drug as per chart	2pm to 8pm	- Assess the Pt Condition - Monitor the V/S - Maintain the I/O - Drug as per chart	- Now patient is stable	- Rechecked the V/S	
Night	8pm to 8Am	- Assess the pt. condition - Monitor vitals & record - Maintain IO chart - Give medication as prescribed by doctor	8pm to 8Am	- Assessed the pt. condition - Maintained IO chart - ~~Maintained~~ Monitored vitals & record - Given medication as prescribed by doctor	patient is stable now	Re-checked vitals	

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NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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BRADEN 'Q' SCALE

				Date :	28/5/26	28/5		
				Time :	M6	N1		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	4		
				TOTAL SCORE	26	28		
				Evaluator's Name	D	D		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	28/5/26 M6	28/5/26 E2	28/5/26 N1			
	Medical Condition (Any special condition to be noted):	-	-	-			
	Diet:	NBM	NBM				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	-	-	-			
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.1°F	97.1°F	97.8°F			
	Res:	32b/m	32b/m	30b/m			
	SpO_2:	99%	99%	100%			
	Pulse:	128b/m	128b/m	128b/m			
	BP:	90/62		-			
	LOC:	-	-	-			
	Fall Risk Score:	-	-	-			
	Pain Score:	"0"	"0"	-			
	Skin Integrity	Good	Good	-			
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-	-	-			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NBM	NBM	-			
	Critical Lab Test / Values:	-	-	-			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	-	-	-			
Post Operative Procedure Special Orders:		-	-	-			
Handed Over By Name :		Supreeja	Sunanda	Priyanka			
Signature / ID :		SJ	SN	P			
Date:		28/5/26	28/5/26	29/5/26			
Time:		2pm	8pm	8AM			
Taken Over By Name :		Sunanda	Priyanka				
Signature / ID :		SN	P				
Date:		28/5/26	28/5/26				
Time:		2pm	8pm				

VIH-00203019 IP26-00006441
Master DARSH
26-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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VIH-00203019 IP26-00006441
Master DARSH SONI
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

THEATER NOTES

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

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

Surgeon : Dr. Swapna Palakurthy	Asst. Surgeon :
Anesthetist : Dr. Heena	OT Nurse :

Surgical Procedure : primary suturing

Indications for Surgery :

Date :	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings:

* 2x1x1cm laceration over forehead
* primary suturing done
* Haemostasis secured
* post procedure - uneventful

Cp-T-D)

POST - OPERATIVE ORDERS :

wt:- 10.2 kg.

* Npo till 8 hrs
* IVF - ½ DNS 40 ml/hr
* Inj P-250 mg IM/IV/OD
2nd ——— 2nd ——— 2nd
× 2 days
* Monitor vitals | Inform sos.
* T- Bact ointment for I/A
wg ——— Emp
× 5 days
* Revise sos .

.....

Consultant Surgeon's Name

.....

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna P.
Asst. Surgeon :
Anaesthetist : Dr. Hema
Scrub Nurse : R. Sudipta

VIH-00203019 IP26-00006441
Master DARSH SONI
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

..... Age : ..... Gender : .....
ry Name : .....
Date 28/5/24 In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 4:30pm

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 : .....
Name : Dr. Hema

Before Skin Incision ➤➤

TIME OUT Time: 5:10Pm

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 : .....
Name : Karuna @ 5:10Pm

Before Patient Leaves Operating Room

SIGN OUT Time: 5:20P

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☐ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☐ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☐ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No

Signature : .....
Name : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00203019 IP26-00006441 Master DARSH SONI 28-08-2024 1 Y (M) Dr. SWAPNA PALAKURTHY Dr. Swapna	28/5/26 @	28/5/26
	Transfer Ordered by Dr. Veena	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.	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
	Dr. Veena

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

(M)

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Master Darsh Age: 2y Sex: M UHID.No :

Date: 2-8-25 Time: 3pm Proposed Operation: Subluxation

Diagnosis: Laceration Forehead

B.P / CRT: H.R: Weight: 10.2 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: NKDA

Medical History: CVS : NIL/O - fall at home on 27/1 - injury and forehead laceration - 1 stitch - given

RESP : Adenoids (+) - snoring (+). Diabetes : CT Scan - (N)

CNS : Febrile seizures - Jan 2026 : On clobazam - stopped in March

Renal :

Hepatic / GE : Physical Activity: active

Others :

Past Anaesthetic History: Nil

Physical Exam: PICU E

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : / appears adequate.

Heart: / clinically (N).

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA | Venous Access Site : (+) Spine Exam for regional : (N)

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

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 } NPO - adv
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

.....

.....

.....

Signature: Name: Dr Keerthi

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

IP26-0000644?

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: (+)	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 136 bpm B.P / CRT: 96/50 mmHg SpO₂: 100% R.R: 20/min Last Feed: 5 hrs

Pre-OP Diagnosis: laceration Operation: suturing Date: 28/5

Surgeon: Dr Swapna Anaesthesiologist: Dr Keerthi Technician: Pallavi

TIME	5:30
N_2O /AIR /O_2 LPM	5
HALO /SEVO	3
Drugs: IV	
Midazolam	2 mg
Propofol	15 / 10 / 10
Ceftriaxone	1 gm
Paracetamol	150 mg
FIO_2 / SaO_2	100
$ETCO_2$	
ECG	SR
Temperature	
Urine Output	
Fluids / Blood	DNS —

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:
☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: Dr
☐ Art Site:
☑ EKG Lead 3L
☐ Temp Site
☐ 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, FAW

Times:
Anaes Start: 5 pm
OP Start:
OP End:
Leave OR: 8:15 pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others: Nasal prongs

☐ 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

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 Keerthi
Signature of the Doctor: [signature]

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Master Darsh Age : 2y Gender : Male ☑ Female ☐

UHID NO: ..... Surgeon Name: Dr Swapna.

Anaesthesiologist : Dr Reena Gupta

Operative procedure planned : Suturing

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 : laryngospasm, post-op O2 support

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 Suturing .....

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

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

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

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

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

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

- Pregnant: ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : Priyanka

Relationship with Patient: Mother

Date & Time : 28/5, 3pm

Witness :

Signature : .....

Name : Sunanda

Date & Time : 28/5, 3.20pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Heena

Date & Time : 28/5, 3.20pm

Patient Sticker

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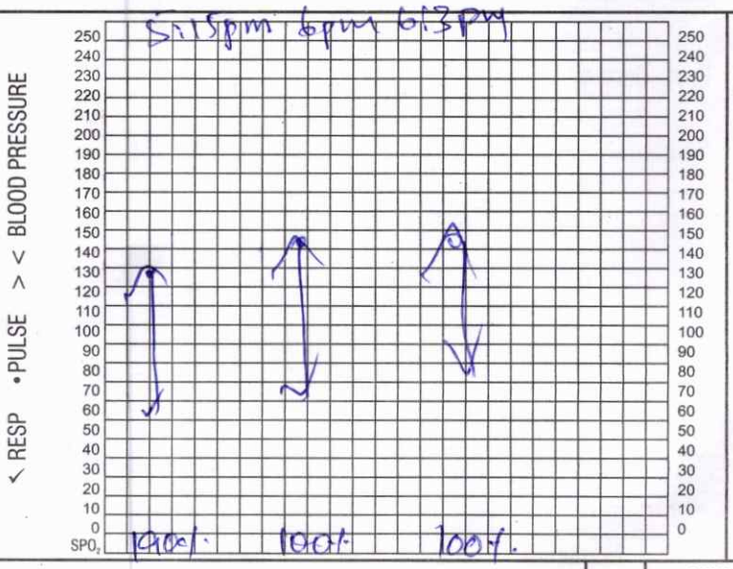
POST-ANAESTHESIA CARE UNIT RECORD

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



IV Cannula Site : (R)

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

Vomiting : ☐ Yes ☑ No Drug: ..... Inj Amox Refill

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☐ Yes ☑ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☐ Yes ☑ No

IV Fluids: DNS on Flow

Oral Feeds: NPO/M

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	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		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		10	9	9		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
28/5	5:15pm	0/10	No pain	
28/5	6pm	0/10	No pain	Karuna
28/5	6:30pm	0/10	No pain	
28/5	7pm	0/10	No pain	

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

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

Anaesthesiologist Name : Dr. .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : Karuna

PACU Nurse Signature: .....

Date & Time: 28/5/26. @

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

Date & Time: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		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 : .....

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

316

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 28/5/26 Time: 12pm

Weight: 10.2 kg Centile: 25th

Height: — Centile: —

Inference: underweight child

RDA: — Calories: 1200 kcal/d Protein: 20gms/d

Diet Recommendations: Soft high protain Diet

Re-Assesment: Avoid spicy, Chilled & Outside foods

Food Allergies: No Veg/Non-veg Veg

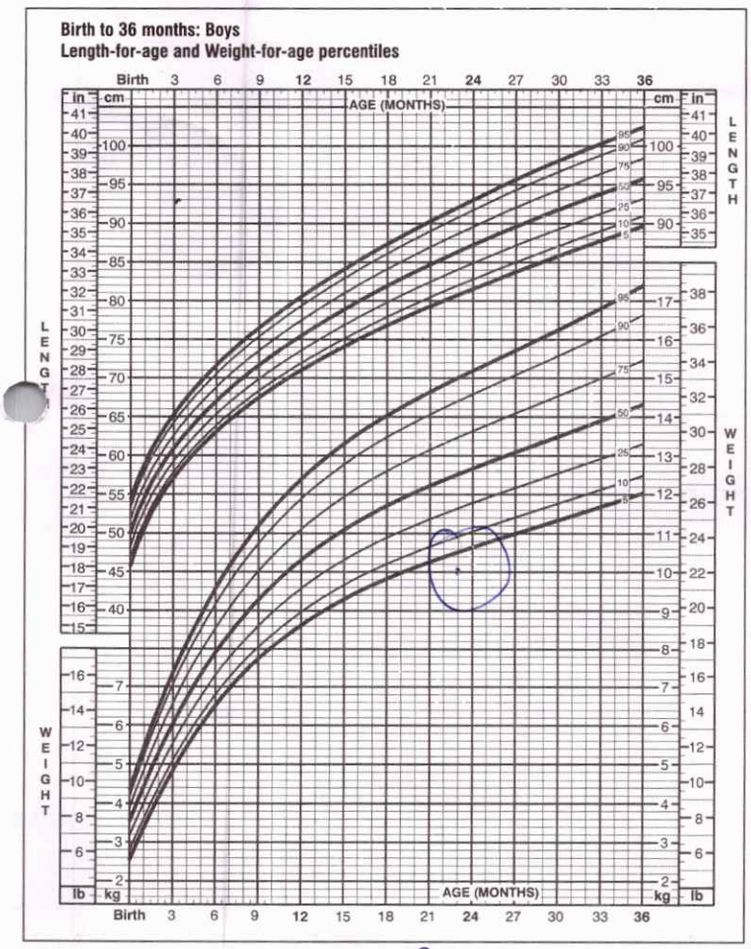
Diagnosis: Right side forehead injury

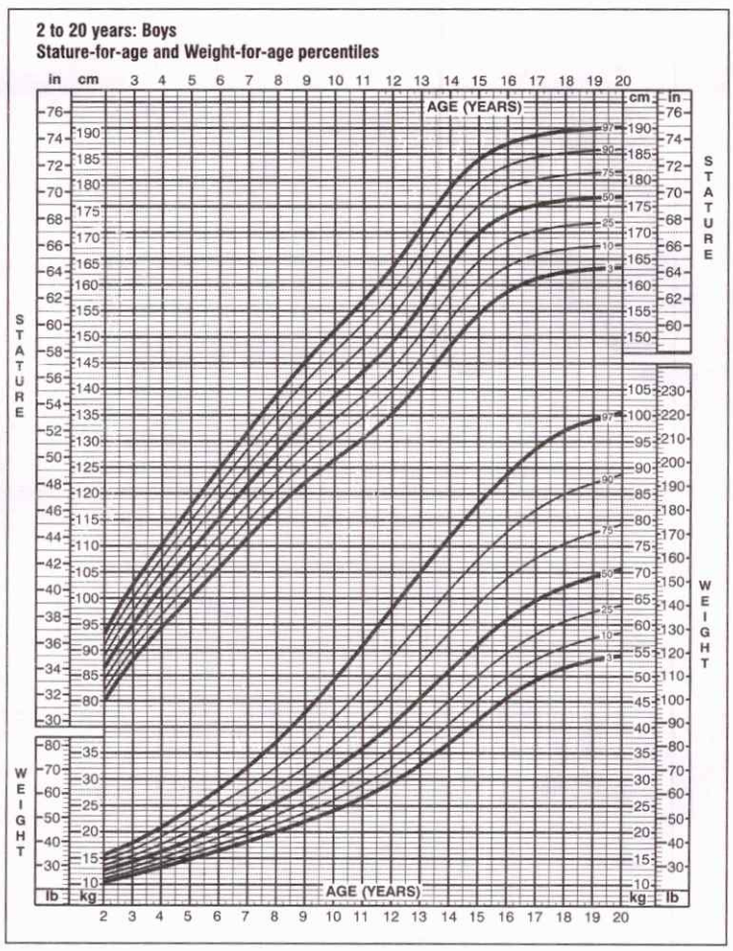
Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

P.T.O

GROWTH CHART (BOYS)





Dietician's Name Sathvika

Dietician's Signature

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

(P.T.O.)

Daily Notes:

28/5/26
12:5pm Child is on Npo till further advice

Sathwika. G
Dietitian

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Wt + 10.2kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Dansh Age : 17 **Gender:** ☐ Male ☐ Female

Date : 28/5/26 Time of Arrival : 10:2 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: 98.1 PR: 141 BP: RR: SpO_2: 100%

Chief Complaints: c/o fall in home in night insonid Right side forehead.

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 : 10:4Am

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.P

Date & Time : 28/5/26 @ 10:5Am

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/5/26 Time of arrival : 10:24 Am

Chief Complaints: c/o fall in home night immi Right side Forhead. RBS: .....

Height : ..... Weight : 10.2 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 ..... ☐ 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 : ..... 10:54 Am .....

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

Time	Nursing Notes
	Assessed the patient condition vital checked.

Samples collected by:

Samples sent by : Sufanda.

Time:

Time: 11:00am

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: 131 BP: 110/60 CFT:	Shift - out from ER to: 3/6
RR: 31 SPO_2: 100 %	Time of Shift - out: 11:00 AM
GCS: — Temperature : 98	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 : Anupam Signature of the Nurse : A.P

Date & Time : 28/5/26 @ 10:5 Am