HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

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SURGERY DETAILS

Date : 2/7/26

Patient Name: Master Chanda Deva Date of Birth: 03-7-2022 Age: 3 Yrs

Gender: Male Ward : OT-2 UHID No.: HNH-00016288
IP26-00006710

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

Name of the Surgery : Debridement + Suture Feeded Lacerat

Time in : 9.20 AM Time Out : 9.40 AM

		NAME	AMOUNT
1.	Surgeon	Dr. Madur Venkat Naveen	Rs-20,000/-
2.	Anaesthetist	Dr. Brunda	
3.	Assistant Surgeon		
4.	OT Technician	Br Arvind Sr. Saraswathi	
5.	Circulating Nurse	Sr. Keruna	
6.	Assistant Nurse	Sr. Natasha	

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

M. V Naveen
Signature of the Surgeon

Karuna
Signature of Circulating Nurse

Order No: 26-00002099 57 Order by: Sushma 2/7/26 @ 10.17 Am.

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

H-00016288 IP26-00006710
Master CHANDA DEVA
07-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Suturing

CONSUMABLES OF OT

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Circulating staff : Karuna Technician : Date : 2/7/26 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~~ (capnography (P))		01	Sutures Monocry 844		01	Cord Clamp		
ECG leads : A / P / N		03	Rapid 9913		01	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		03	Gloves S-Gr 6½		1	Surgical Gloves		
02 cc		02	Encore 7.0		01	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Aqumpazin 600mg		01	Ointments					
~~Inj 2% Lidocaine Adrenaline~~		01	Suction Catheter	5X		10cc Syringe		01
Fentanyl		01	Cap, Mask					
~~Morphine~~			Gauze Pack 7.5x7.5		01	5ml Syringe		01
~~Ketamine~~ Midazolam		01	Mop Pack					
Propofol		02	Steristrip					
Rocuronium			Underpad		01			
~~Glycopyrolate~~		~~01~~	Draw sheet					
~~Myopyrolate~~ Adrenaline		01	Abgel					
~~Ondansetron~~ ~~Adrenaline~~		00	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%		00	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Vygon 22G Spinal Needle		01	Tegaderm 8582		01			
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		01			
			Microshield					
			Cotton Balls					
			Latex Gloves		~~000~~			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002097975/977 Ordered by : Sushma 2/7/26 @ 11.06Am.

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

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016288	**Name**	: Master CHANDA DEVA
Age / Sex	3 Y 11 M 29 D / Male	**Doctor**	. MADUR VENKAT NAVEEN
Adm/Reg Date/Time	02/07/2026 07:32	**Payor**	: STAR HEALTH AND ALLIED INSURANCE CO LTD
Order Date	02/07/2026 11:02	**Ordernumber**	: 26-0000209975
Visit ID	IP26-00006710	**Ward/Bed No**	. 4F -OT / PDA-412
Patient Address	FLAT NO 510 BLOCK B VENKATRAMA TOWERS AVANTI NAGAR BASHEERBAGH, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		2 Nos	Dispensed
2	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	PREGELLED SURGICAL PLATES PEAD (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
7	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
8	CAPNOGRAPHY NASAL CANNULA-PEAD		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	POVINANZ SOLUTION 10% 00 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
13	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
14	VICRYL RAPIDE 6-0 9913W	VICRYL RAPIDE6-09913W	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	MONOCRYL 6-0 CUTTING Y844G		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
16	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	SPINAL NEEDLE 22G	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	ADROGLARE(ADRENALINE) INJ 1MG 1ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
18	TEGADERM WITH PAD 5X7CMS (3582)(8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

MADUR VENKAT NAVEEN

* This document is just for reference purpose only. Not to be considered as primary report.

DISCHARGE SUMMARY

Name	Master CHANDA DEVA	**UHID**	HNH-00016288
Father/Guardian	Mr CHANDA ANUP	**Age/Gender**	3 Y 11 M 29 D/ Male
Address	FLAT NO 510 BLOCK B VENKATRAMA TOWERS AVANTI NAGAR BASHEERBAGH, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006710	**Admission Date**	02-07-2026
Ref Doctor	Self.		
Discharge Date	02.07.2026		

Consultant
Dr. MADUR VENKATA NAVEEN ,
MBBS, MS (Gen. Surgery), DNB (Plastic Surgery), MCh. (Plastic Surgery),
CONSULTANT PLASTIC SURGEON
Reg No. 38362

DIAGNOSIS	ICD CODE
FOREHEAD LACERATION	

Procedure : DEBRIDEMENT + SUTURING OF FOREHEAD LACERATION DONE ON 02.07.2026.

History: Master CHANDA DEVA, 3 Y 11 M 29 D child presented with complain of fall and laceration injury over forehead since 1 day 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 98/min and Respiratory rate - 22 /minOn auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Name	Master CHANDA DEVA	**UHID**	HNH-00016288
IP No	IP26-00006710	**Admission Date**	02-07-2026

Weight on admission: 14.5 kilo grams.

Investigations: Enclosed reports.

Procedure : DEBRIDEMENT + SUTURING OF FOREHEAD LACERATION DONE ON 02.07.2026.

Surgery Notes:
* Debridement + suturing of forehead.
* Laceration in layer.

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 DUO (Amoxycillin 200 + Potassium Clavulanate 28.5 mg/5ml) 2.5 ml twice daily for 5 days.
* Syrup. Ibugesic 2.5 ml twice daily for 5 days.
* Neosporin ointment local application SOS.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. MADUR VENKAT NAVEEN after 1 week in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

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

Name	Master CHANDA DEVA	**UHID**	HNH-00016288
IP No	IP26-00006710	**Admission Date**	02-07-2026

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

Registrar/Resident/C.M.O

Consultant
Dr. MADUR VENKATA NAVEEN ,
MBBS, MS (Gen. Surgery), DNB (Plastic Surgery), MCh. (Plastic Surgery),
CONSULTANT PLASTIC SURGEON
Reg No. 38362

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
Mantu Chandra Deva	2/7/26 @	2/7/26 @ 12:45PM.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Nuveen.	Dr. Varun	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	Room 208	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. Varun.

Patient & Clinical Records Received by : Supriya

Date & Time of Patient Received : 12:50PM @ 2/7/26

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

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006710 **Admit Date** : 02-Jul-2026 **Admit Time** : 07:32 AM **UHID** : HNH-00016288

Patient Details :

Patient Name	: Master CHANDA DEVA	**Age**	: 3 Y 11 M 29 D
Guardian	: Mr CHANDA ANUP	**DOB**	: 03-07-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FLAT NO 510 BLOCK B VENKATRAMA TOWERS AVANTI NAGAR BASHEERBAGH Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9703040150
		E-mail	: NO@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 CHANDA ANUP **Relationship** : Father

Contact Address : FLAT NO 510 BLOCK B VENKATRAMA TOWERS AVANTI NAGAR BASHEERBAGH Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9703040150

Signature

Doctor Details :

Doctor Name : Dr. MADUR VENKAT NAVEEN **Specialisation** : PLASTIC SURGERY

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

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : Cash **Payor Name** : STAR HEALTH AND ALLIED INSURANCE CO LTD

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ACTIVITY RECORD FOR BILLING

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Name: ----------

UHID No ---------- Consultant : ---------- Dept : pediatric

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
2/07/26	8:30 Am	ER	OT	
2/7/26	9. 45AM	OT	post. OP	
2/7/26	12:45PM	OT	208 Room	

Cross Consultation Visit

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

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

INVESTIGATIONS

Date	Investigations	Order No.	Sign
2/7/26	CBP	10768	~~SJ07~~
	PSC OP basic done.		
		Cross	Checked done by Sm

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

MEDICAL EQUIPMENT (WARD & ICU)

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

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Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
2/7/26	IV placement	(1)	9932	VJ~~07~~

Cross Checked done by Sn

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

wt - 14.85 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : master chanda seva. Age : 3 years **Gender:** ☑ Male ☐ Female

Date : 2/07/26 Time of Arrival : 7:17 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: 97.9F PR: 78b/M BP: ..... RR: 22b/M SpO_2: 98 %

Chief Complaints: c/o laceration over 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.

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : .....

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : shirisha

Signature of Triage Nurse : .....

Date & Time : 2/07/26 @ 7:19 AM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 2/07/26 Time of arrival : 7:21AM

Chief Complaints: C/O laceration over forehead RBS: .....

Height : ..... Weight : 14.85kg 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 : ..... @ 7:23AM .....

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

Time	Nursing Notes
7:25 AM	Assess the patient condition monitor the vital sign

Samples collected by: / Time: /

Samples sent by : / Time: /

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: ..... BP: ..... CFT:	Shift - out from ER to: OT
RR: ..... SPO_2 :	Time of Shift - out: 8:30 Am
GCS:..... Temperature :	Handover given to: ..... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Jayathi Signature of the Nurse : .....

Date & Time : 21/7/26 @ 7:20 Am

INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY

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

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

I / We ..... have been explained by Dr. ..... M.V.Naveen Reddy ..... about the medical condition and the proposed procedure.

I / We have been told that our patient ..... has the following Medical Conditions / Diagnosis:

..... Perihead laceration .....

.....

.....

Proposed Treatment / Procedure / Operation:

..... Debridement + Suturing .....

.....

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned above and that our patient has following risks involved during the hospital stay

..... Infection / Sepsis / Hypertrophic Scar / Keloid .....

.....

I / We have been explained risk, benefits and alternatives of the procedure.

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results, complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

I / We have understood the consequences of not undergoing the proposed treatment.

I / We hereby give (my / our) full consent for the above – mentioned treatment.

I / We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences arising from the treatment.

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: Anup (Father) .....

Date & Time 2/7/26 @ 8:35 Am

Doctor (Who is talking the consent)

Signature: M.V.Naveen .....

Name: M.V.Naveen Reddy .....

Date & Time .....

Witness

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

Relative / Legal Guardian: (Relationship with Patient) ..... Mother .....

Address: .....

Date & Time 2.7.26 @ 8:35 Am .....

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 : Spandana Chathes

Relationship with Patient: Mother

Date & Time : 2/7/26 @ 8:35 AM

Witness :

Signature : .....

Name : Anup Chathes

Date & Time : 2/7/26 @ 8:35 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Bhanda

Date & Time : 2/7/26, 8:30 am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Master Chanda Deva Age : 3y Gender : Male ☑ Female ☐

UHID NO: HNH-00016288 Surgeon Name: Dr. Madur Venkat Naveen

Anaesthesiologist : Dr. Samir

Operative procedure planned : Suturing over forehead

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 : Laeyngospasm

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master Chanda Deva the above mentioned operation / Diagnostic / Therapeutic procedures Suturing over forehead

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.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Master. Chanda deva Age: 4yr Sex: M UHID.No : HNH-0001628?

Date: 1/7/26 Time: 4:30pm Proposed Operation: Suturing over forehead

Diagnosis: Laceration Over forehead

B.P / CRT: <3sec H.R: 98/min Weight: 14.6 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:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NIL

Medical History: CVS :

RESP : H/O Bronchiolitis @ age 9 2 month, treated
H/O Severe LRTI, 6 months ago.

Diabetes:

CNS :

Renal : } NIL SIGNIFICANT

Hepatic / GE :

Others :

FT/2SCS/2.8kg/MCh/NO NICU admission

Physical Activity:

Past Anaesthetic History: –

Physical Exam:

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

Lungs : BAE (+), Clear, SpO2: 97% on RA.

Heart: ~~NAD~~ S1S2 (+)

CNS: NAD

Pregnant: ☐ Yes ☑ No ☐ NA

Peripheral (+)
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
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   (1) CBP on admission
   (2) Consent due

Solids ← 8hrs
Water & Coconut Water ← 2-3hrs.

Signature: Name: Dr. Sr. Ayesha

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

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Adequate

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

H.R: 82bpm | B.P / CRT: 100/50 mmHg | SpO_2: 99% on RA | R.R: 18/min | Last Feed: 7:20am Mother

Pre-OP Diagnosis: Laceration over forehead | Operation: Suturing | Date: 2/4/26

Surgeon: Dr. Naveen | Anaesthesiologist: Dr. Brunda | Technician: Aravind

TIME: 9:20 9:35 9:50 10:05 10:20

N_2O /AIR/O_2 LPM: 4L

HALO /SO /SEVO

Drugs:
Inj. MIDAZOLAM 0.5mg IV
PARACETAMOL 30mg IV
PROPOFOL 30 20mg IV

Antibiotic: Inj AUGMENTIN 420mg IV

Suppository

Blood Loss

FIO_2 / SaO_2: 100 100

$ETCO_2$

ECG: NSR NSR

Temperature

Urine Output

NOTES

Fluids
Blood

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: Rt Lt
☐ Art Site:
☑ EKG Lead 3lead
☑ 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

Times:
Anaes Start: 9:20 am
OP Start:
OP End:
Leave OR: 9:40 am

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

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

☑ Mask 3 @ 4L/min ☐ 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: LA given at suture site
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. Brunda
Signature of the Doctor: B de

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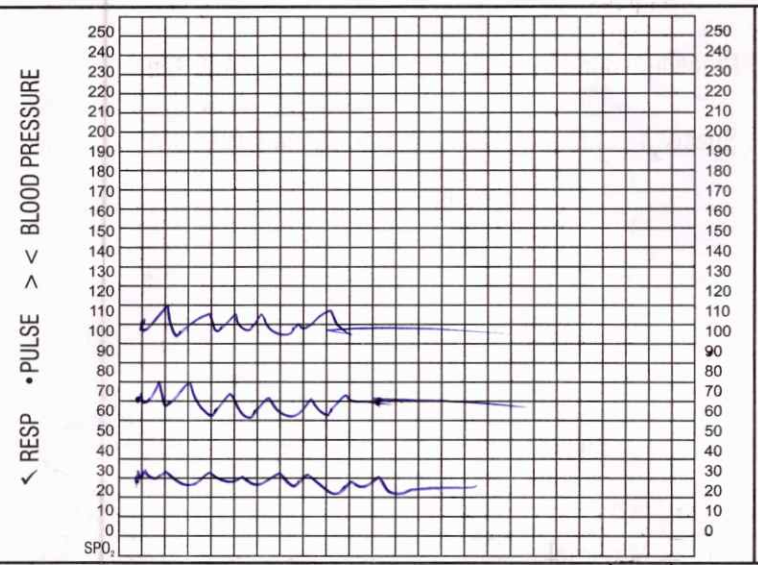
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sushila. Time Received : 9:45 Am. Time Discharged : .....



IV Cannula Site : Right Side

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/7/26	9:22Am	0	Normal	
2/7/26	9:28Am	0	Normal	
2/7/26	9:32Am	0	Normal	
2/7/26	9:35Am	0	Normal	

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

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

PACU Nurse Name : Karuna
PACU Nurse Signature: Karuna
Date & Time: 2/7/26 @ 12:40Pm

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): .....
Date & Time: .....

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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OPERATION THEATER NOTES

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Patient's Name : .. ..Age : 3yrs...Gender : ..male....

UHID.: ..... No. :.....Weight : 14.5 kgl.

Surgeon : Dr M. Mudaveen Reddy	Asst. Surgeon :
Anesthetist : Dr. Samir / Dr. Brunda.	OT Nurse : Natasha.

Surgical Procedure :

Debridement + Suturing of Forehead laceration

Indications for Surgery :

Forehead laceration 1½ x ½ x bone deep

Date : 2/7/26	Start Time : 9.20 Am	End Time : 9.40 Am.

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Debridement + Suturing of Forehead laceration. in 1 layer.

POST - OPERATIVE ORDERS :

- NBM for 1hr after 1hr ND
- IV fluids DNS - 30ml/hr x 4hrs
- Syrup Augmentin DUO - 2.5ml / BD x 5 days
- Syrup Ibugesic 2.5ml / BD x 5 days
- Neosporin ointment LA/
- Watch Lovely
- Inform Sir

M.U.N. Areen Rehdy

Consultant Surgeon's Name

M.U.N. Areel

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Naveen
Asst. Surgeon :
Anaesthetist : Dr. Brunda
Scrub Nurse : Sr. Natasha

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Master CHANDA DEVA
03-07-2022 3Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Patient Name :
UHID No. : .....
Date : 2/7/26. 9.20Am

.... Gender : male
.....
: 9.40Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:14am

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 : B de
Name : Dr. Brunda 2/7/26.

Before Skin Incision ➤➤

TIME OUT Time: 9:15Am

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 forehead. ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, 30 minutes. Nil. Anticipated Blood Loss? 5ml ☑ 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

Inj. Augmentine 1.2gm @ 9.25Am

Signature :
Name : 2/7/26 @ 9.15Am.

Before Patient Leaves Operating Room

SIGN OUT Time: 9.40Am.

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 : Dr. Naveen

OT

PATIENT TRANSFER FORM

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HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

	Date & Time of Admission: 2/7/26	Date & Time of Transfer Order: 2/7/26
Treating Consultant Name: Dr Naveen	Transfer Ordered by: Dr. Brunda	Reason for Transfer: Observation
From Unit: OT	To Unit: post-op Room 208	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 18	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.	DNS	10
2.		
3.		
4.		
5.		

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

Dr. Samar.

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

Patient & Clinical Records Received by :

Date & Time of Patient Received : 2/7/26 @ 9.50Am.

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016288 IP26-00006710 Master CHANDA DEVA 03-07-2022 3 Y 11 M 29 D (M) Dr. MADUR VENKAT NAVEEN	2/07/26 @	2/07/26@
	Transfer Ordered by Dr. pranav	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15 -/-	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
shirisha	Dr. pranav

Patient & Clinical Records Received by : Sushmitha.

Date & Time of Patient Received : 2/7/26 @ 8.30 am

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/o/hy: Ds-Anuch	
2/8/22 2pm		
	Δ - forehd laceration -	
	vital stab	
	s/e NAD	Plan
		discharge today
	Al	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Master CHANDA DEVA
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Dr. MADUR VENKAT NAVEEN

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

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Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Pediatric Multiorgan History & Physical Examinatio

Name : Chanda Deva

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Fall & Laceration injury over forehead - 1day ag

History of present illness :

child brought with complaints of accidental fall in play area on 1/7/26 at around 12:30p

↓

Laceration Injury over forehead & had some bleed ~3x1-5cm

No c/o Vomiting / LOC / Alt (N) movements

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Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

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

Birth & Neonatal History :

FT/LSCS/2.8kg/Boy

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Upto date -

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Pediatric Multiorgan History & Physical Exami

Anthropometry

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

Weight (kgs) 14.5 kg (Centile _____)

On Examination :

Temperature : 97.9°F Pulse Rate: 98/min Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : 22/min _____

Rash _____

Lymphadenopathy ~3x1.5cm Laceration injury over forehead

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L NEG

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

Laceration Injury over forehead
Nov. Fd Suturing & G.A

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

H. D Stability

Planned Labs :

CBP & Coags

Planned Management :

- IVF
- NPO till further adv
- NPO :- Water - 7:30 pm
  Solid - 8:30 pm (yest)
- Syrup ↓ Gt

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. Naveen on whose name the patient is being referred

Doctor's Signature Name Date 2/7/22 Time

HNH-00016288 IP26-00006710
Master CHANDA DEVA
03-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

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MEDICATION RECONCILIATION FORM

Drug Allergies: N/A ☐ 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. Pranav

Date & Time : 2/07/26 @

Nurse Name & Signature: S. Lakshmi

Date & Time : 2/07/26 @

HNH-00016288 IP26-00006710
Master CHANDA DEVA
33-07-2022 3 Y 11 M 29 D (M)
Dr. MADUR VENKAT NAVEEN

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 2/07/26 Drug Allergies: NIL ☐ 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:				

Sign

VERIFIED BY : Name

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REGULAR PRESCRIPTIONS

Weight. 14.5kg Ward. .....

DRUG : SYP AUGMENTIN DUO

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	2/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 9pm

Date / Time: 2/7 — 9AM ✓

Daily Doctor's Endorsement by a Sign

DRUG : SYP IBUGESIC

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	2/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 2pm

Date / Time: 2/7 — 2AM ✓

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

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

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

DRUG :	Date ▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
2/7/26	9:25AM	INJ- AUGMENTIN	420MG	IV		

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

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03-07-2022 3 Y 11 M 29 D (M)
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I.V. FLUIDS CHART

Weight. ...16...Kg. Ward. .....

		sition 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
2/7	7:30pm	IVF – DNS (2/3 ml (M))	IV	33	[illegible]				

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

26-0000209936

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MASTER CHANDA DEVA		Age: 34	Gender: M	
UHID No:	ANH-0001628	IP No: IP26-0000671	Date: 2/7/26	Time:	8:27 Am.
Diagnosis:	SUTURING.			wound OT.	

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr SK. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

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

IP Registration No: IP26-0000671 0 **Date:** 2/7/26

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

1.	**Name :** MASTER CHANDA DEVA.	**Remarks**
2.	Complete postal address (with contact number, if any)	FLAT NO 510 BLOCK B VENKATRAMA TOWERS HIMAYATHNAGAR
3.	Brief description of the illness	SUTURING
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
2/7/26	FENTANYL	ONE Amp		

Dispensed by (Name & ID No.): Rama 01SUU2 Signature:

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

Time: .....