MLC

COUNSELLING SHEET

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar , Hyderabad- 500029

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

	TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	12 TO 12 NOON BILLING POLICY
BED CHARGES				PHARMACY (separate)	
				INVESTIGATION (separate)	
DOCTORS CHARGES				CROSS CONSULTATION	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED)
				CONSUMABLES	
				BLOOD PRODUCTS	VISITING HOURS 04:00pm TO 05:00pm.
				OXYGEN	
NURSING CHARGES	13,500	17,500		HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP	IN ICU EITHER MOTHER OR FATHER ALLOWED(NO VISITORS)
				EQUIPMENT	
DIET CHARGES			157. ws on op	PROCEDURE	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
				NEBULISATION	
TOTAL		1,65,000/- ~~1,50,000+~~ 1,45,000	↑ Investigation	MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

PATIENT NAME		AGE/SEX	
UHID		INSURANCE NAME	

dad & father.

ATTENDENT SIGNATURE

CAUTION DEPOSIT	80%

COUNSELLING PERSON SIGNATURE

MLC charges → 3,000

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
4-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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SURGERY DETAILS

Date : 3/7/2026

Patient Name: Baby Ayesha nida Fatima Date of Birth: 4-08-2020 Age: 5Yrs

Gender: Female Ward : OT UHID No. HNH-00016320

Date of Surgery: 3/07/2026 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Debridement + advancement flap + Collagen ® Face

Time in : 9:30 am Time Out : 10:30 am

		NAME	AMOUNT
1.	Surgeon	Dr. Madur venkat naveen	Rs-35,000/-
2.	Anaesthetist	Dr. Sanjay. Dr Sapna.	
3.	Assistant Surgeon		
4.	OT Technician	Ss. Pallavi	
5.	Circulating Nurse	Ss. Sangeetha	
6.	Assistant Nurse	Ss. Balu.	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: OT-00002102149 Order by: Sangeetha

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

Suturing
Colleyan dressing

CONSUMABLES OF OT

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Circular ..... Technician : ..... Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube I.gel 2.0		01	Major Pack			Inj Vit.K		
LMA			Sutures SILK. 0415	1	1	Cord Clamp		
ECG leads : A / P / N		03 1205			01	Suction Catheter		
HME filter : A / P / N		OR				Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc			Gloves S.G7.0	2		Surgical Gloves		
02 cc			Ethicon 7-0		OR	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 15		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil		01			
NS : 10ml / 100ml / 500ml / 1000ml		02	Koochies					
Transo HFV		01	Ointments collegan 10x20		01			
Nasal cannula [P]		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10+10				
Morphine			Gauze Pack 10x10cm	3+02				
Ketamine			Mop Pack		01			
Propofol		02	Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate		01	Draw sheet 10X 2% Jelly		01			
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Hydrocort		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		00	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		.			
Ryles tube 10		01	Microshield		01			
			Cotton Balls					
			Latex Gloves		1			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. 26-0000210241/242/261/262. Ordered by : Sangeetha.

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

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	HNH-00016320	**Name**	: Baby AYESHA NIDA FATIMA
Age / Sex	5 Y 10 M 19 D / Female	**Doctor**	: MADUR VENKAT NAVEEN
Adm/Reg Date/Time	03/07/2026 04:57	**Payor**	: SELFPAY
Order Date	03/07/2026 11:07	**Ordernumber**	: 26-0000210241
Visit ID	IP26-00006722	**Ward/Bed No**	: 2F -PICU / PICU-202
Patient Address	. 2-4-712,A.K.M QUATERS, Kachiguda, Hyderabad, Telangana, INDIA, 500027		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	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		2 Nos	Dispensed
3	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
4	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
5	TRANSOFIX DEVICE-4090500		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	ADVAMRYL ADVA1205		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
10	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
11	PREGELLED SURGICAL PLATES PEAD (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	SURGICAL BLADE 15	SURGICAL BLADE 15	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		2 Pkt	Dispensed
14	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
15	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
16	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
17	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
18	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
19	VICRYL RAPIDE 5-0 9915W	VICRYL RAPIDE5-09915W	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

MADUR VENKAT NAVEEN

DISCHARGE SUMMARY

Name	Baby AYESHA NIDA FATIMA	**UHID**	HNH-00016320
Father/Guardian	Mr MOHAMMED SAIF UDDIN	**Age/Gender**	5 Y 10 M 19 D/ Female
Address	2-4-712,A.K.M QUATERS, Kachiguda, Hyderabad, Telangana, INDIA, 500027		
IP No	IP26-00006722	**Admission Date**	03-07-2026
Ref Doctor	Self.		
Discharge Date	04.07.2026		

Consultant:
Dr. MADUR VENKAT NAVEEN
CONSULTANT PLASTIC SURGEON

Co-Consultant
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
RIGHT FACE FRICTION BURN + SOFT TISSUE LOSS OVER RIGHT LOWER EYE LID	

Procedure : DEBRIDMENT + LOCAL ADVANCEMENT FLAP + SUTURES +

Name	Baby AYESHA NIDA FATIMA	UHID	HNH-00016320
IP No	IP26-00006722	Admission Date	03-07-2026

COLLAGEN

History: Baby AYESHA NIDA FATIMA, 5 Y 10 M 19 D child presented with complain of alleged history of sustained injury over right side of the face, eyebrow and eyelid after fall from an auto while travelling at 02:10 am on 03.07.2026 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 80 /min, Blood Pressure - 97/55 mmHg and Respiratory rate - 29/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 forehead laceration of 3 x 1 x 0.5 cm, right lower eyelid injury(deep abrasion) of 1 x 0.5 cm x 0.5 cm.

Weight on admission: 13 kilo grams.

Investigations: Enclosed reports.

Procedure : DEBRIDMENT + LOCAL ADVANCEMENT FLAP + SUTURES + COLLAGEN

Pre-Surgery Examination:
* Soft tissue loss over right lower & upper eye lid.
* Right Temple friction burn.

Post-Operative Notes: Post operative period was uneventful. Child was initiated on oral feeds gradually which child tolerated well. She remained hemodynamically stable during the hospital stay and operated site remained

Name	Baby AYESHA NIDA FATIMA	**UHID**	HNH-00016320
IP No	IP26-00006722	**Admission Date**	03-07-2026

healthy. Child is being discharged with the following advice.

Advice:
* Diet as advised.
* Keep collagen dry.
* Syrup. Augmentin DDS (Amoxicillin - 400mg + Potassium clavulanate - 57mg/5ml) 3.5 ml twice daily (1 hour before food or 2 hours after food) for 5 days (Should be kept in refrigerator after reconstitution, consume within 7-days)
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4 ml thrice daily after food for 5 days and later SOS for pain.

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

Review consultation with Dr. MADUR VENKAT NAVEEN after 2 weeks in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

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

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

The content of the patient discharge summary, medication, food & drug

Name	Baby AYESHA NIDA FATIMA	**UHID**	HNH-00016320
IP No	IP26-00006722	**Admission Date**	03-07-2026

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**

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. MADUR VENKAT NAVEEN
CONSULTANT PLASTIC SURGEON

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : 3/07/26

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

(P.T.O)

26-0000210209

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	BABY AYESHA NIDA FATIMA	Age: 5Y	Gender: F
UHID No:	HNH-0001 6320	IP No: IP26-0006 6722	Date: 3/7/26 Time: 7:04 AM
Diagnosis:	DEBRIDEMENT + COLLAGEN DRESSING WOUND: OT		

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SAMIR Doctor Registration No: 67529

Signature:

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

IP Registration No: ..... **Date:** 3/7/26

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

		Remarks
1.	**Name :** BABY AYESHA NIDA FATIMA	
2.	Complete postal address (with contact number, if any)	2-4-712, AKM BUNGALOW KACHIGUDA HYD
3.	Brief description of the illness	DEBRIDEMENT + COLLAGEN DRESSING
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
3/7/26	FENTANYL	ONE Amp		

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

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

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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26-0000210209

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:		Age:	Gender:
UHID No:	IP No:	Date:	Time:
Diagnosis:			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SAMIR

Doctor Registration No: 67529

Signature:

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

IP Registration No: .....

Date: .....

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

1.	**Name :**	**Remarks**
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

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

Received by (Name & ID No.): ..... Signature: .....

Time: .....

Door No. 3-6-267,
Himayathnagar,
Opp: Café Niloufer, Hyderabad,
Telangana - 500029

MEDICO LEGAL RECORD

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To
The Station House officer,
P.S.
Dist. / City
Ref : Our Telephone Intimation Dated
Received by :
Patient Name : Ayesha Nida Fatima
S/o., W/o., D/o. Farheen Begum
Age : 5y 10m Sex : Male / Female Female
Address : 2-4-712, A.K.M Quarters Kachiguda Hyderabad Telangana INDIA 500027

Date
Time
M.L.C No. 074
UHID / I.P. No.

Accompanied by P.C. / Attendant
Name : Mr/ Mrs. Faaheen Begum
Relation : mother
Phone No : 7981517455
Signature :

Identification Marks
1) 1 mole over chest, right side
2) Mole under Right knee

Signature / LTI of Patient

Brief History of the case as stated by the patient / attendant :
Accidental fall from auto at 1 am on 3/2/2026

General Examination of the Patient on arrival at Emergency ✓Conscious Unconscious Semi - Conscious Brought Dead

Pulse : 80 /mt B.P. : 97/55 /mm Hg Resp. Rate 29 /mt Temp : 98.6 °F
Heart : 80 bpm S1S2 (+) M0 Lungs : AEBE Abdomen : soft Pupils : B/L reactive to light

DESCRIPTION OF INJURIES

S.No.	Description of wounds	Dimensions
	multiple lacerations on the face (Right > left) with abrasions.	
	• Right forehead laceration →	4.3 × 1 × 0.5 cm
	• Right below eyelid - laceration →	1 × 0.5 × 0.5 cms

Dying Declaration Required : Yes / No ✓

Name & Sign. of Doctor : Dr. Archana
Regn. No. 8253

MLC Received by :
Signature :
Name :
Designation :

Investigation Advised :

Treatment given :

1. Admitted in ________ Ward / ICU
2. Left Against Medical Advice
3. Patient condition at the time of transfer ________

Name & Sign. of Doctor :
Regn. No.

Docu. No: RCH /FRM / GENERAL / 093

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OPERATION THEATER NOTES

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

..................Age : ....Gender : ....

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure :

Debridement + local advancement flap + suturing + Collagen

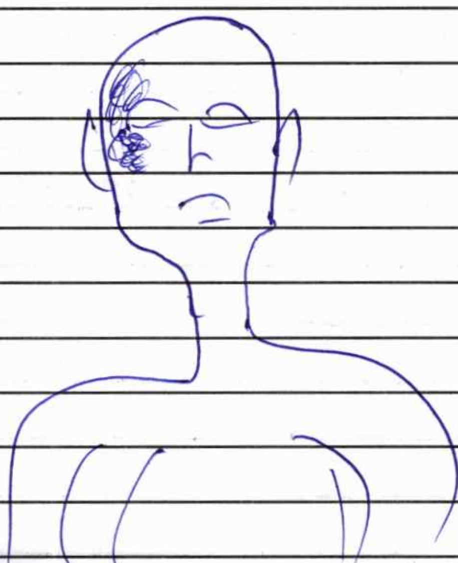
Indications for Surgery :

(R) Face Fracture Burn + soft tissue loss (R) lower eyelid + Temp

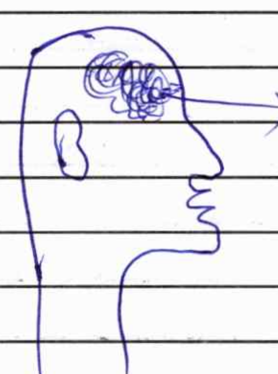
Date :	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:



Soft tissue loss lower eyelid + (R) upper eyelid



Temple fracture Burn

POST - OPERATIVE ORDERS :

- NBM for 6hrs after like ND
- vitals hourly
- IV fluids DNS - 40ml/hr x 4h
- keep Collgen dry
- Inj Augmentin | Inj PCM as advised by Peds
- Inform SOS

M. U. Naveen Reddy

Consultant Surgeon's Name

M U Naveen

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. M. Venkat Naveen
Asst. Surgeon : .....
Anaesthetist : Dr. Samr.
Scrub Nurse : Sr. Rekha.

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

..... Age : ..... Gender : .....
y Name : .....

Date : 3/4/26 In-time : 9:20am Out-time : 10:30am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:20am

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 : Dr. SEEMA
Name : Dr. SEEMA

Before Skin Incision ➤➤

TIME OUT Time: 9:30am

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 : S
Name : Sangeetha

Before Patient Leaves Operating Room

SIGN OUT Time: 10:30am

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

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

Signature : A
Name : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016320 IP26-00006722 Baby AYESHA NIDA FATIMA 14-08-2020 5 Y 10 M 19 D (F) Dr. MADUR VENKAT NAVEEN	3/7/26	3/7/26 @ 10:30a
	Transfer Ordered by Dr. Sreja	Reason for Transfer observation
From Unit OT	To Unit PICU	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
Sowjeatha	

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

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006722 **Admit Date** : 03-Jul-2026 **Admit Time** : 04:57 AM **UHID** : HNH-00016320

Patient Details :

Patient Name	: Baby AYESHA NIDA FATIMA	**Age**	: 5 Y 10 M 19 D
Guardian	: Mr MOHAMMED SAIF UDDIN	**DOB**	: 14-08-2020
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2-4-712,A.K.M QUATERS Kachiguda Hyderabad Telangana INDIA 500027	**Phone No**	: 7981517455/ 6300969388
		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 MOHAMMED SAIF UDDIN **Relationship** : Father

Contact Address : 2-4-712,A.K.M QUATERS Kachiguda Hyderabad Telangana INDIA 500027 **Phone No** : 7981517455

Signature

Doctor Details :

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

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

Co-Consultant : Dr. PRITESH NAGAR

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 36880.50

Payor Name : SELFPAY

MLC

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

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Name: Ayesha Nida Fatima Age: 5y 10m Gender: Male ☐ Female ☑

UHID.No : 00016320 Date: 3/7/2026

I Farheen Begum S/o, D/o, W/o, M/o Ayesha hereby declare that our patient Master/Baby Ayesha who is related to me as daughter is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 3/7/2026.

The doctors have explained to me in a language understood by me that my child has following health related issues :

.....

.....

.....

The doctors have clearly explained to me that my patient Master / Baby ..... during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : .... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: Farheen Begum

Name: FARHEEN BEGUM

Relationship with Patient: mother

Date & Time: 3/7/26 @ 2am

Witness :

Signature: Karu

Name: Karuna

Date & Time: 3/7/26 @ 10:35 Am

Doctor (who is taking the consent) :

Signature:

Name: Dr. Archana

Date & Time: 3/7/26 @ 3am

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MLC

ACTIVITY RECORD FOR BILLING

Name: ---- HNH-00018320 IP26-00006722
Baby AYESHA NIDA FATIMA
UHID No : 14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

Date of Ad ---------- Consultant : ---------- Dept : ----------

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	5:26 Am	ER	PICU	
3/7/26	10:35 Am	OT	PICU.	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
3/7/26	CBP	OP	
	CRP	Basic	JGV
	VBG	Done	
	(Rest details by Smt		

MEDICAL EQUIPMENT (WARD & ICU) MLC

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/7/26	invasive monitor		3/7/26 at 2pm		
	infusion pump	5.30 Am		10200	[signature]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
3/7/26	IV Plalement	(1)	10201	
3/7/26	PAC	1	0220	
3/7/26 12/30pm	NHA	(1)	0331	
	Cross checked by Supervisor on 3/7			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC

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RESULT SHEET

Date	3/7/26					
Time						
Hb	10.8					
PCV	30.9					
RBC	4.20					
WBC	20.53					
N/L	83.5/11.1					
Platelets	341					
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.,) : .....

Ref.No. F/IN/PR/10

MLC

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

AYESHA NIDAH FATHIMA

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

MLC

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant JJM _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o Alleged RTA subdural injury over face after fall from an auto while travelling at 2:30 AM.

History of present illness :

↓

Subdural injury over the face on the right side over the right eyebrow and below the right eyelid.

(RF) - Forehead laceration 3 x 1 x 0.5 cm

(RF) below eyelid - Laceration - 1 x 0.5 cm x 0.5 cm

↓

From there taken to Shalini hospital

↓

First aid done

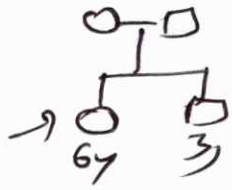
↓

brought to our hospital for further management.

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

Birth & Neonatal History :

Tca / AGA / LSCS / CTAB



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

NIS Schedule - Up-to-date

MLCM

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 13 kg (Approx) (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 96 % at RA

Resp. rate and type of breathing : _____

drowsy, Distressed

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BLE AE+

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 +

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : P/A soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

MLC

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : conscious Irritable
13/15

Cranial Nerves :

Motor System :

Nutrition : NI

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars (F)

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Laceration over the face
on (Rt) side
For debridement + collagen dressing
+ Suturing U GA

Preventive aspects of the treatment :

Desired goals of the treatment :

Suturing + debridement
+ collagen dressing

Planned Labs :

CBC
CRP
VBG

N/B strictly

Planned Management :

- Inj. AUGMENTIN 450mg IV TID
- Inj. PCM 120mg IV TID
- IVF DNS @ 40ml/hr
- Inj. ESMOPRAZOLE 10mg IV OD
- Inj. ONDANSETRON 2mg IV TID

N/B strictly

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
   (Including the name of City)
3. Contact number of the Referring Doctor : _____
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
   whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/8/20 6AM	S/B Dr. Archana	
	on Room Air Euthesmic (98.6°F) Lacerations over face (+) No bleed per site. No altered sensorium.	Advice • NBM for debridement + Suturing & dressing today
	D/E Vitally stable.	• Ct Inj AUGMENTIN • Ct Rest same • watch for Worsening of Sensorium. • PAC done.
	S/E CNS - Conscious, oriented CVS - S_1S_2 (+) Mo RS - AEBE P/A - soft.	Dr. Archana M/B Sunitha

HNH-00016320 IP26-00006722
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/26. 10 30 AM	c/s/by Dr Anusha	
	jaw laceration.	(post op - debridement
		& suture done
		collagen dressing).
	vital:-	(No Intraoperative
	HR = 134/min.	Event
	RR = 24/min	Consider Glycopyrrolate Given]
	SpO2 = 99%.	
	Temp = 96.4 → warmer started.	
	Bp	
	to check →	NPO for 1hour
		stat oral once child active
	(R/S) B/L AE (+) NVBS (+).	— frequent drying - collagen dressing.
	(CVS) S1S2 No murmur	— Inj AUGMENTIN PCM.
	can be discharged	— ct IV fluids till good oral intake
		— off once awake.
		NB Sujatha

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

AYESHA

MLC

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DRUG CHART

Date of Admission: 3/07/26 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 : ONDANISETRON SYP				Date / Time
Dose	Route	Frequency	Start Date	
5ml	PO	SOS	3/7/26	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

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

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC

REGULAR PRESCRIPTIONS

13 kg (Approx)

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

DRUG : Inj. AUGMENTIN

Dose	Route	Frequency	Start Date
450mg	IV	TID	3/7

Name & Signature of the Doctor Starting the Drugs: B. Sanyasi Rao

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																	
3/7																	
6AM	Sujatha (N)																
2pm	Vanaja																
10pm																	

DRUG : Inj. ESMOPRAZOLE

Dose	Route	Frequency	Start Date
10mg	IV	OD	3/7

Name & Signature of the Doctor Starting the Drugs: B. Sanyasi Rao

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																	
3/7																	
6AM	ER																

chye (SOS)

OD

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date
2mg	IV	TID	3/7

Name & Signature of the Doctor Starting the Drugs: B. Sanyasi Rao

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																	
3/7																	
6AM	ER																
2PM	Vanaja																
10pm																	

chye (SOS)

DRUG : Inj. PARACETAMOL

Dose	Route	Frequency	Start Date
120mg	IV	TID	3/7

Name & Signature of the Doctor Starting the Drugs: B. Sanyasi Rao

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																	
3/7																	
6AM	Sujatha (N)																
2pm	Vanaja																
10pm																	

chye.

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 13/4 Ward .....

DRUG : CROSINDS SYP

Dose	Route	Frequency	Start Dt.
4ml	PO	TID	3/7/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (240mg/5ml)

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : NEXPRO SACHET

Dose	Route	Frequency	Start Dt.
10mg	PO	OD	3/7/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

Patient Sticker

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

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

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

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC

Weight. 13 Kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	10Am.	Syp. DICLOFENAC	12.5mg	P/R		
3/7	10Am	Inj. HYDROCORTISONE	1mg	IV		

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

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC I.V. FLUIDS CHART

Weight. ..... 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
3/7	4:30 AM	DNS	IV	40 ML	R	Sweta	3/7/26		
3/7	9:30AM	RINGER LACTATE	IV	120ml/hr			3/7/26		

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

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

MLC

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Pritish Department: PIW Date of Admission: 3/7/26

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	2/7/26 N1	3/7/26 M1				
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6°F	96.8°F				
	Res:	26 b/m	22 b/m				
	SpO_2:	98%	100%				
	Pulse:	90 b/m	121 b/m				
	BP:	98/66	—				
	Fall Risk Score:		—				
	Pain Score:	~~5~~/10	~~9~~/10				
Recommendations	Safety Needs:	yes	Yes				
	Physiotherapy	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—				
	Special Diet:	☐ ~~Yes~~ ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	~~NA~~	~~NA~~				
Post Operative Procedure Special Orders:		yes	Yes				
Handed Over By Name :		Sowjanya	Jyothi				
Signature :							
Date:		3/7/26					
Time:		~~8~~ AM					
Taken Over By Name :							
Signature :							
Date:							
Time:							

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
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BRADEN 'Q' SCALE

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				Date : 3/7			
				Time : 6am			
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		
"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		
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		
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		
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."	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		
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		
				TOTAL SCORE	23		
				Evaluator's Name	[illegible]		

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

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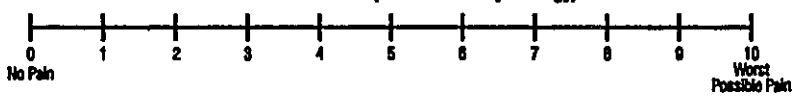
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	6am	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 2/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA							
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : Sunitha

Signature of Ward In Charge :

Signature : ..... Name : S.Sathe

Docu. No. : RCH /FRM / CLINICAL / 137

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 2/7	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	✓				
	13 years old and above	1					
Gender	Male	2					
	Female	1	✓				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	✓				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	✓				
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	✓				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	✓				
	Within 48 hours	2	✓				
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	✓				
	Total		10				

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓				
	Call device within reach		✓				
	Wheels Locked		✓				
	Room free of clutter		✓				
	Adequate lighting		✓				
	Wheel chair support		—				
	Other Intervention(s) Specify		✓				
	Nurse's Name:		Swathy				
	Signature:						
	Date:		3/7				
	Time:		8AM				

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NIL ..... ☐ 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: ..... PICU .....

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. Sreeja .....

Date & Time : ..... 3/07/26 @ 4:57 AM .....

Nurse Name & Signature: ..... Shivaraj .....

Date & Time : ..... 3/07/26 @ 5:26 AM .....

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wt - 13 KG

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Ayesha Nida Fatima Age : 5 year **Gender:** ☐ Male ☑ Female

Date : 3/07/26 Time of Arrival : 2:27AM

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: 98.6°F PR: 80b/m BP: 97/55 RR: 29b/m SpO_2: 97%

Chief Complaints: C/O fall down from auto injury over the face.

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 : 2:38 AM

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Shirisha Signature of Triage Nurse : .....

Date & Time : 3/07/26 @ 2:29 AM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/07/26 Time of arrival : 2:31AM

Chief Complaints: C/O fall down from auto c/o injury over the face. RBS: .....

Height : ..... Weight : 13 kgs. BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: -1 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character Acute ☐ Location face. ☐ Frequency ..... ☐ Duration 2 hours

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 : @ 2:33 AM

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

Time	Nursing Notes
2:35 AM	— Assess the patient condition
	— Monitor the vital sign
	— IV placement done
	— Sample collected

Samples collected by:

Samples sent by : Typhi

Time:

Time: 5:10 AM

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: 112 bpm BP: ..... CFT: N/A	Shift - out from ER to: ICU
RR: 24 bpm SPO_2 : 97%	Time of Shift - out: 5:26 AM
GCS: 15 Temperature : 98.2	Handover given to: .....
Pain Score: -	(Nurse's Name)
Repeat RBS (if applicable): N/A	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse : Shirley Signature of the Nurse :

Date & Time : 3/07/26 @ 2:38 AM

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Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

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UNDERTAKING FOR BALANCE DEPOSIT

To

The Management,

Rainbow Children's Hospital, Himayatnagar

Hyderabad-500029

Sub:- **Undertaking Balance Deposit**

I Mr./Mrs./Ms. Mohd. Saiff Uddin (Father/ Mother/ Other _____) of Master/ Baby/ Baby of/ Mrs./ Ms. Ayesha Nida Fatima was bought to your hospital on 03/07/2026 at 04:55am. Admitted in _____. Approximate charges deposit details were explained by the Front office/ Billing executive on duty. I have to pay the amount of 145K + 31128 as a caution deposit but for now I'm depositing 40K. The remaining amount _____ I'll deposit on 03/07/2026 at 01:00pm.

Thanking You

_____
Signature

Name:- Saifuddin

Ph. No.:- 7981517455

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Baby Ayesha Nida Fatima Age: 5y Sex: Female UHID.No : HNH- 16320

Date: 3/7 Time: 5pm. Proposed Operation: Collagen dressing + debridement

Diagnosis: Abrasions + Laceration over face

B.P / CRT: ≤2sec H.R: 98/m Weight: 13kg 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: NKDA.

Medical History: CVS : No H/o CHD⊖ / recent URTI⊖

RESP : Child apparently has no significant history Diabetes:⊖

CNS : No prior hospital admissions

Renal : Birth → Term / LSCS / CBAB / Immunised.

Hepatic / GE : No apparent dev. delays. Physical Activity: active.

Others : –

Past Anaesthetic History: nil.

Physical Exam: sleepy / irritable.

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

Lungs : BAE⊕ clear clinically.

Heart: S1+S2+ M⊖.

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA | Venous Access Site: Left/Right 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 : On N/O
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:

Signature: Name: Dr. Samir Nayak.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: >6hr	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 120 bpm	B.P / CRT: 90/60	SpO_2: 100%	R.R: 20/min	Last Feed: 2/7

Pre-OP Diagnosis: .... Operation: colkgun + Debridement Date: 3/7

Surgeon: Dr. Naveen Anaesthesiologist: Dr. Srijan Technician: P. Mani

TIME	9:30	(10)		
N_2O / AIR / O_2 LPM	2 L/min			
HALO / ISO / SEVO	1 MAC			
Drugs:				
GLYCOPYRROLATE 180mcg IV				
MIDAZOLAM 0.6mg IV				
FENTANYL 20mcg IV				
PROPOFOL 30mg IV				
FIO_2 / SaO_2	100	100	100	
$ETCO_2$	40	42	44	
ECG	SR	SR	SR	
Temperature		36		
Urine Output				
RL	"	^	"	
Fluids / Blood				

Antibiotic

Suppository

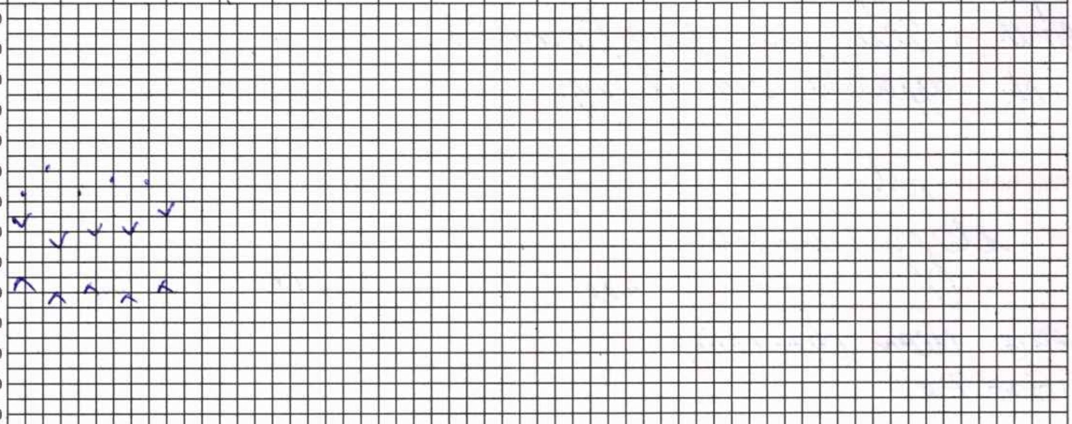
Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out



LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: Rt UL
☐ Art Site: ....
☑ EKG Lead
☑ Temp Site: Axi
☑ 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: 9:30Am
OP Start: ↓
OP End: ↓
Leave OR: 10:30Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

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

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

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

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: NA
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. Srijan
Signature of the Doctor: [signature]

Patient Sticker

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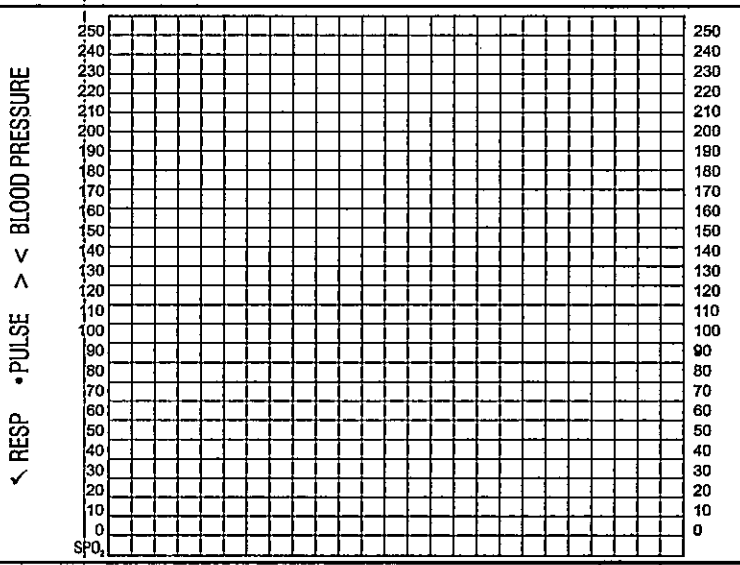
POST-ANAESTHESIA CARE UNIT RECORD

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



IV Cannula Site : .....

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

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

IV Fluids: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Baby Ayesha Nida Fatima ..... Age : 5y. ..... Gender : Male ☐ Female ☑

UHID NO: KNH-16320 ..... Surgeon Name: Dr. Naveen .....

Anaesthesiologist : Dr. Srija / Dr. Sanvi .....

Operative procedure planned : Collagen dressing + debridement .....

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 : O2 supplementation. .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

I understand that the above mentioned consultant 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 : Mr. Mohammed Saifuddin

Relationship with Patient: Father

Date & Time : 3/7 9 AM

Witness :

Signature : Farheen Begum

Name : Mrs. Farheen Begum

Date & Time : 3/7 9 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sanni Anayat

Date & Time : 3/7 at 515 am

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016320 IP26-00006722 Baby AYESHA NIDA FATIMA 14-08-2020 5 Y 10 M 19 D (F) Dr. MADUR VENKAT NAVEEN	3/07/26 @ 4:57 AM	3/07/26 @ 5:26 AM
	Transfer Ordered by Dr. Sreeghan	Reason for Transfer Admission
From Unit ER	To Unit PICU	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. Sreeghan

Patient & Clinical Records Received by : Sunitha

Date & Time of Patient Received : 3/7/26 at 5:26 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

Rainbow Childrens Hospital-Himayatnagar

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby AYESHA NIDA FATIMA**	**Age :**	**5 Y 10 M 19 D**
IP No:	**IP26-00006722**	**Sex:**	**Female**
Consultant:	**Dr. MADUR VENKAT NAVEEN**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

MLC

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

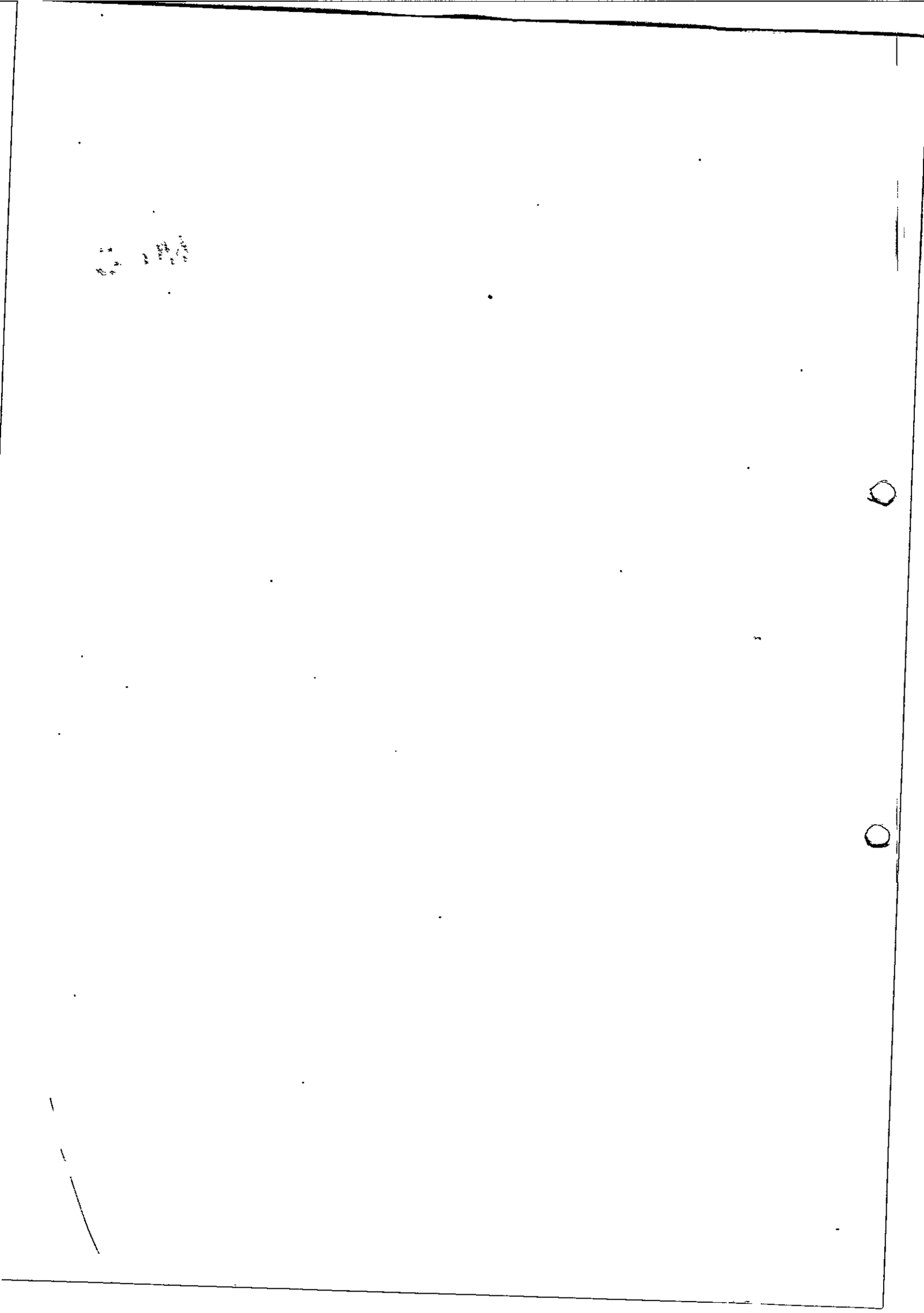
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Saifuddin
Relationship: father
Date: 03-07-2026 Time: 4:57 AM
Witness Name: Yaseen ali khan
Witness Signature:

Patient Address:

2-4-712,A.K.M QUATERS Kachiguda
Hyderabad Telangana INDIA 500027



HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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POST OPERATIVE - DOCTORS HANDOVER FORM

OT to ☑ PICU ☐ NICU ☐ MICU ☐ WARD

Date: 3/7/26. Time: .....

Name of the Surgery: Debridement + collagen dressing.

Drugs used for sedation during surgical procedure: MIDAZOLAM, FENTANYL, PROPOFOL.

.....

IV Fluids type / amount used using surgical procedure: RINGER LACTATE 130ml/hr

.....

Input ..... ml Output ..... ml Blood Loss 5-10 ml

Blood Transfusion if any .....

Any intra operative event: .....

.....

On arrival to PICU / NICU / MICU / WARD: ✓

Temp: ..... HR: 132bpm RR: 20-25/min BP: ..... CRT: .....

Peripheries: warm. SpO_2: 100% @ NP2LO2

Drains: .....

ET Tube: ☐ Cuffed ☐ Uncuffed

Size of ETT: ..... Length of Fixation of ETT: .....

Surgeon's Notes: ☑ Yes ☐ No

Time of Arrival to Unit: .....

Handover given by:

Anesthesiologist's Name Dr. SRIMA

Signature: Dr SRIMA

Date & Time: 3/7/26.

Handover taken by:

Doctor's Name .....

Signature: .....

Date & Time: .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

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)

....

.... Debridement + biting + (allsh + local
advancement flap ± ® .... upon ... lower eye lid + ® Temple

(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 / Sepsis / Hypertrophic scar / Keloid / delayed
healing ..... need for skin grafts / Ectropion / ~~Ha~~ ® lower
eye lid ......

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 : [signature]

Name : Karuna

Date & Time : 3/7/26 @

Patient Attendant :

Signature : Farheen Begum

Name : FARHEEN BEGUM

Relationship with Patient: ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature : M. V. Naveen

Name : M. V. Naveen Reddy

Date & Time : ....

HNH-00016320 IP26-00006722
Baby AYESHA NIDA FATIMA
14-08-2020 5 Y 10 M 19 D (F)
Dr. MADUR VENKAT NAVEEN

205

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 3/7/25 Time: 12:30 pm

Weight: 13 kg Centile: 3rd

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 1400 Kcal/day Protein: 24 gms/day

Diet Recommendations: Soft diet with liquid

Re-Assesment: No Junk, Oily food

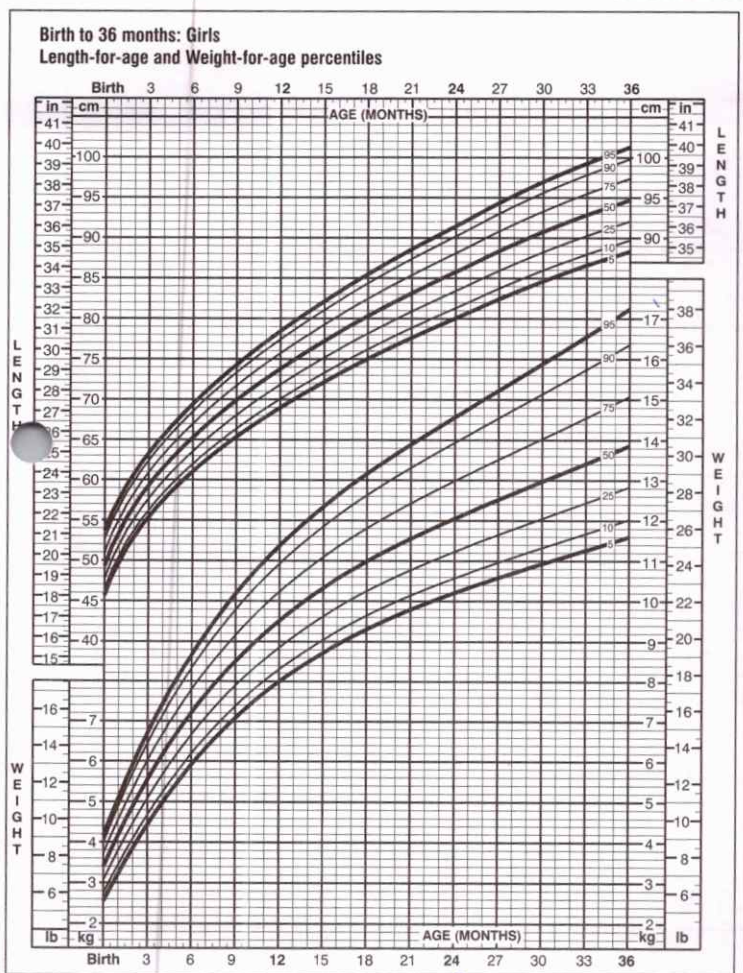
Food Allergies: N/D Veg/Non-veg Non Veg

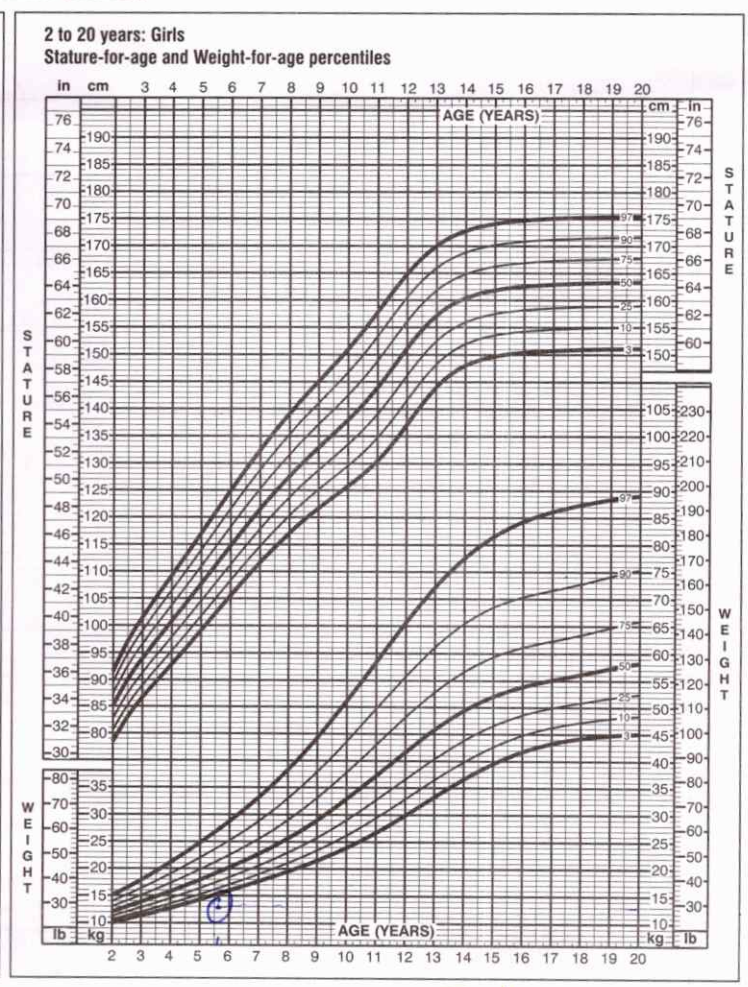
Diagnosis: Face Laceration.

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Shaheer

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sabiya Zaheen Dietician's Signature Sabiya

Daily Notes: