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ACTIVITY RECORD FOR BILLING

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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

UHID No : ------- --- Consultant : ---------- Dept : Pediatrics

Date of Admission : 23/7/26 Time : 6 Pm Date of Discharge : ---------- Time: ----------

Room / Bed No : O.T Ward : O.T Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26	@ 8:28 Am	ER	OT	As
23/7/26	11:15 AM	OT	112	Anp

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/7/26	coblator charges	8:50 AM	9:30 AM	3105037	Rif
	Cross checked by Kalpana [illegible]				

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
23/7/26	IV Placement	(1)	3105388	
	PAC done in OPD Basis.		3104963	
	Gloss checked by Lalpang			

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	1st floor Lalpang		

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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SURGERY DETAILS

Date : 23/7/26

Patient Name: Master A.S. Durga Bhairava, Date of Birth: 30/01/2019 Age: 7y 5m

Gender: male Ward : OT UHID No.: 207152/60812

Date of Surgery: 23/7/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : coblator assisted Tonsillectomy + Adenoidectomy (C+A)

Time in : 8:45AM Time Out : 9:45AM

		NAME	AMOUNT
1.	Surgeon	: Dr. Ajay kumar	OT charges
2.	Anaesthetist	: Dr. Bandhan	
3.	Assistant Surgeon	: -	
4.	OT Technician	: Tech. Rakesh	coblator charges
5.	Circulating Nurse	: Sr. Ruby. P	8.50am/9.38am
6.	Assistant Nurse	: Sr. Prasoona	3105037

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: 3105011/1/15 Order by: SR Jyothi

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

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VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

Patient Name

IP.No:

Ward:

DOA:

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	–	–	
2	Discharge Summary	02	–	–	
3	Nursing Initial assessment form	01	–	–	
4	Patient Trasfer Forms	02	–	–	
5	In-patient Medical Record	01	–	–	
6	Doctors Progress Sheets				
7	Nurses Progress notes	02	–	–	
8	Consultation Sheets				
9	General Consent for Treatment				
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)	01	–	–	
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes	01	–	–	
24	Nurses Clinical Presentation				
25	TPR & BP chart	01	–	–	
26	Intake and Output chart (fluid Chart)	01	–	–	
	Drug Chart (Regular prescription)	02	–	–	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	–	–	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01	–	–	
33	MLC form (in case of MLC)				
34	Patient Educatlon Form				
	OTHERS	15			
	Total No. of Pages	32			

Noted By manisha 24/1/24 @3PM

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital

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Check List for ICU Shift Outs

CASH / TPA

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

Special remarks 112

S.No	Parameters	Responsibility	Signature
1	Due clearence from **IP Billing & Financial Counselling** for the accomodation to be shifted	BILLING STAFF	
2	**Room Ready to Occupy -** Checking done for A/C , Lighting , Plumbing, Cleaning & Bedsheets	FLOOR COORDINATOR / MOD	
3	**Shift summary is prepared** or not Whether any Pharmacy Consumables are to be Replaced /Returns / Indent required **Pharmacy Clearence**	NURSING STAFF	

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060812 **Admit Date** : 23-Jul-2026 **Admit Time** : 06:00 AM **UHID** : VIH-00207152

Patient Details :

Patient Name	: Master A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA	**Age**	: 7 Y 5 M 23 D
Guardian	: Mr A.PRAVEEN	**DOB**	: 30-01-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO:3-125/87/108,SRI LAXMI NAGAR COLONY,BODUPPAL,HYDERABAD, TELANGANA. Boduppal Hyderabad Telangana INDIA 500092	**Phone No**	: 9951151852/ 9848890117
		E-mail	: entr.praveen@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 102 **Ward Name** : N 0 GF-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr A.PRAVEEN **Relationship** : S/O

Contact Address : **Phone No** : 9951151852

Signature

Doctor Details :

Doctor Name : Dr. AJAY KUMAR **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

	Master A.S DURGA BHAIRAVA		
Name	RUDRAUNSH SHOURYA	**UHID**	VIH-00207152
Father/Guardian	Mr A.PRAVEEN	**Age/Gender**	7 Y 5 M 23 D/Male
Address	H.NO:3-125/87/108,SRI LAXMI NAGAR COLONY, BODUPPAL, HYDERABAD, TELANGANA., INDIA, 500092		
IP No	IP-00060812	**Admission Date**	23-07-2026
Ref Doctor		**Discharge Date**	24-07-2026

DISCHARGE SUMMARY

Consultant: Dr. AJAY KUMAR
Pediatric ENT
CONSULTANT EAR NOSE & THROAT SURGEON
10524

Diagnosis: Grade-III adenoids + tonsils

S/P- Coblation assisted adenoidectomy + tonsillectomy under GA done on 23.07.2026.

History: Master A. S. DURGA BHAIRAVA RUDRAUNSH SHOURYA is a 7 Y 5 M 23 D boy presented inability to breath, mouth breathing, recurrent cold and cough, frequent waking spells. For the above complaints, he was admitted at Rainbow Children's Hospital for surgery.

Examination: He was afebrile, maintaining saturations at room air and hemodynamically stable. Heart rate was 96/min, blood pressure 100/60 mmHg and respiratory rate - 26/min. Grade-III adenoids + tonsils present.

Weight on admission : 26.1 kgs.

Name	Master A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA	**UHID**	VIH-00207152

Management: He was admitted in the ward.
Procedure : Coblation assisted adenoidectomy + tonsillectomy under GA done on 23.07.2026

Operative Notes :
- Under general anesthesia.
- Coblation assisted adenoidectomy done.
- Coblation assisted tonsillectomy done.
- Hemostasis ensured.

Post Operative notes : Post operative period was uneventful. He was started orally on liquid feeds which he accepted and tolerated well and he is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Advice:
1. Diet as advised.
2. Syrup Augmentin-ES, 5ml (8am-8pm) for 7 days (Refrigerate after reconstitution).
3. Syrup Ascoril-D, 5ml (9am-9pm) for 5 days.
4. Nasivion-P nasal drops, 3 drops in each nostril, (6am-2pm-10pm) for 7 days.
5. Syrup Combiflam, 7ml, (7am-3pm-11pm) (after food) for 5 days.
6. Tablet Pantoprazole (20mg) 1 tablet (at 7pm) (empty stomach) for 7 days.
7. Syrup Prednisolone (5ml=5mg), 5ml (9am-9pm) (after food) for 3 days.
8. Betadine throat gargle, 2 teaspoons in 1/2 glass of chilled water (gargle & spit out) (7am-3pm-11pm) for 1 week.
9. Kindly consult Dr. Ajay Kumar, Consultant ENT Surgeon, after 7 days in OPD with prior appointment.

Name	Master A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA	**UHID**	VIH-00207152

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To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

In Case of Emergency for increasing breathing difficulty, dullness or high fever, Contact 040-42462200 Extn: 2010 (or) 7337357870.

If any IV antibiotics - will be given in Emergency Room between 6am - 7am for morning dose, between 2pm - 3pm for afternoon dose and between 10pm - 11pm for evening dose (Outside IV medication shall not be allowed with in the hospital as per the hospital protocol).

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

Name : Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by : Dr. Shrikar
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

Dr. AJAY KUMAR
Pediatric ENT
CONSULTANT EAR NOSE & THROAT SURGEON
10524

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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Nursing Admission Assessment Form For Pediatrics

Diagnosis: Adenotonsillectomy

Arrival Time: 11.15pm Mode of Arrival: By wheel chair Admitting From: ☐ ER ☐ OPD ☐ Direct - OT

Allergy / Adverse Reaction: -

Body Weight: 26.12 Kg

Height: - cm

Past Medical History: Obtained From ☐ Patient ☑ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Family History: Nil

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, -

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: -

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☐ None ☑ Yes, If Yes, fill reconciliation form

Observations: Weight: 26.12 kg Length: - Head Circumference (< 2 years): -

Temp.: 98.6 F HR: 114 b/m RR: 22 b/m BP: 96/56 (68) bpm hg

Pain Score: 0 Specify Site: - (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain - Location - Frequency - Duration -

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
- ☐ Special Feeding Method
- ☐ Feeding Problem
- ☐ Special diet
- ☐ No Abnormality Detected

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 ..... parents .....

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

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... parents .....

Nurse's Name: ..... Anitha ..... Date: ..... 2/3/17 ..... Time: ..... 11:30AM ..... Signature

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00207152 IP-00060812 Master A.S DURGA BHAIRAVA 30-01-2019 7 Y 5 M 23 D (M) Dr. AJAY KUMAR	23/1/26 @ 6:00AM	23/1/26 @ 11:15 AM
	Transfer Ordered by Dr. Bavardha.	Reason for Transfer Post operative care
From Unit OT	To Unit ICU	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 26	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Ruby. P	Dr. Bavardha.

Patient & Clinical Records Received by :
Sr. Anitha

Date & Time of Patient Received : @ 11.25 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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00207152 IP-00060812 Master A.S DURGA BHAIRAVA 30-01-2019 7 Y 5 M 23 D (M) Dr. AJAY KUMAR	23/7/26 @ 6:00 AM	23/7/26 @ 8:20 AM
	Transfer Ordered by Dr. Sameesa	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 21	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Aschitha	Dr. Sameesa

Patient & Clinical Records Received by : Prasanna

Date & Time of Patient Received : 23/7/26 8:20 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

Patient Name : Mast[illegible]GA BHAIRAVA RUDRAUNSH SHOURYA UHID : VIH-00207152 IPD : IP-000608[illegible] : 7 Y 5 M 23 D

IP-00060812
VIH-00207152
Master A.S DURGA BHAIRAVA (M)
7 Y 5 M 23 D
30-01-2019
Dr. AJAY KUMAR

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

EMERGENCY ROOM TRIAGE FORM

wt - 26.12 Kg.

Patient's Name : Mast. Rudraunsh Age : 7y 5months Gender: ☑ Male ☐ Female

Date : 23/7/26 Time of Arrival : 5:49Am.

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: 98.4°F PR: 96bl/m BP: 102/61 (73) RR: 26bl/m SpO2: 98%

Chief Complaints: C/O. Came for Surgery (Adenotonsillectomy)

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 : @ 5:53Am.

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 : Suvagatika

Signature of Triage Nurse : .....

Date & Time : 23/7/26 @ 5:53Am.

Patient Name : Mast. A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA UHID : VIH-00207152 IPD : IP-00060812 Gender : Male Age : 7 Y 5 M 23 D

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 23/7/26 Time of arrival : 5:55 Am.

Chief Complaints: C10. Came for Surgery (Adenotonsillectomy) - RBS: .....

Height : 125cms Weight : 26.12Kgs. BMI : — Head Circumference (<2 years) —

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

If yes , identify —

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0 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 Parents.

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

Time of Initial assessment completed by ER Nurse : @ 6:03 Am.

Patient Name : Mast. A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA UHID : VIH-00207152 IPD : IP-00060812 Gender : Male Age : 7 Y 5 M 23 D

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

Time	Nursing Notes
@5:45Am	Patient come to ER.
5:53Am	* Vitals checked & recorded.
6:00Am	* Dr-Sameera Seen the patient,
6:05Am	* Last. Food - Yesterday night @ 9:00 pm , Liquid @ 4:00 Am.
6:10Am	* Doctor advice for admission. Admission done.
	* IV placement done. * 8AM Test given in ER
8:20Am	* Patient Shifted to OT.

Samples collected by: — Nill — Time: — Nill —

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 98 b/m BP: 104/62 CFT: <2sec.	Shift - out from ER to: OT
RR: 25 b/m SPO$_2$: 99%	Time of Shift - out: @ 23/7/26 @ 8:20 AM
GCS: 4,5,6 Temperature : 98.1°F	Handover given to: Sr. Saraswathi (Nurse's Name)
Pain Score: 0	By SL Architha
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Architha Signature of the Nurse : AS

Date & Time : 23/7/26 @ 8:20 AM

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

UHID ID: _____

Department: _____

Consultant: _____

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

Pediatric Multiorgan History & Physical Examination

Name : Rudranath. Age/Sex 7½/M

Information given by: Mother. Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

c/o recurrent cough & cold
∴ 1 year
mouth breathing ∴ 3 months.

History of present illness :

Mast. Rudranath is a 7½ y. old male child presented with H/o recurrent cough & cold
∴ 1 year

→ H/o mouth breathing ∴ 3 months.

For the above complaint, he was admitted at RCH for surgical management.

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

Pediatric Multiorgan History & Physical Examination

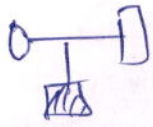
Past History : (Including details of any previous investigation or treatment)

Nil significant

Birth & Neonatal History:

F/T / LSCS / B'wt: (N) / BC1AB/

no neonatal issues



Birth & Socio Economic History:

About Father : Class - V

About Mother :

Any additional Information :

Developmental History :

Appr. for age.

Immunization History :

Immunized till date.

(P.T.O.)

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Master A.S DURGA BHAIRAVA
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Dr. AJAY KUMAR

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 26.12 kg (Centile _____)

On Examination :

Temperature : 98.4 F Pulse Rate : 96/min. B.P. 102/61 (73) mil Hg SPO2 98% RA

Resp.rate and type of breathing : 26/min

Rash

Lymphadenopathy — WD — Grade 3 adenoids

Oedema : — " " tonsils.

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BAE (+)

Any addes sounds : clear

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur : no murmurs.

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) :

Per Abdomen :

Inspection

Palpation : soft, no organomegaly

Ausculation :

Spine : External Genitelia :

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

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Dr. AJAY KUMAR

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : conscious.

Cranial Nerves : Intact

Motor System:

Nutriton :

Tone: Power 5/5 all limbs

Co-ordinator : (N)

Posture :

Involuntary Movements :

Reflexes : ++ | ++ / ++ | ++

DTR **Superficials:**

Plantars

Sensory System : (N)

Bladder / Bowel :

Clinical Summary & Diagnostic:

Grade 3 adenoids + Grade 2 tonsils.
Obstructive sleep adenoidectomy + tonsillectomy & GA

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: N/A.

Desired goals of the treatment : Perform the surgery.

Planned Labs:

INVESTIGATIONS ON OPD BASIS.

Noted by SN [illegible] 23/7/26 @ 9:40 Am

Planned Management

→ NBM OVERNIGHT
→ INJ. AUGMENTIN
→ PROCEDURE AT 8.30 AM
→ PAC DONE

Signature of the Doctor: [signature]

Name of the Doctor: Dr. Sameera

Date & Time: 23.7.26, 7.00AM.

Signature of the Consultant: ...

Name of the Consultant: ...

Date & Time: ...

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☑ Not Known; If Yes Specify: —			
	Surgery / Procedure: Adenotonsillectomy			Post OP Day: —			
BACKGROUND	Date / Shift	22/6 ER	23/4 M	23/7 M	23/7 E	23/7/26 N	
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil	Nil	
	Diet:	NPO	NBM	cold diet	cold diet	cold diet	
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Vital Signs: Temp:	98°F	98.6F	98.4F	98.6F	98.6°F	
	Res:	24 b/m	22 b/m	24 b/m	22 b/m	24 b/m	
	SpO_2:	99%	99%	98%	99%	99%	
	Pulse:	94 b/m	82 bpm	96 b/m	100 b/m	105 b/m	
	BP:	104/62 (77)	100/62 mmHg	96/64 mmHg	102/62 (71)	103/78 (64)	
	LOC:	conscious	conscious	conscious	conscious	conscious	
	Fall Risk Score:	3'		13	13	13	
	Pain Score:	0'	0	0	0	0	
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	
Recommendations	Safety Needs:	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	Nil	—	Nil	Nil	Nil	
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Special Diet:	NPO	—	Nil	Nil	Nil	
	Critical Lab Test / Values:	Nil	—	Nil	Nil	Nil	
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Non Dependent	dependent	Dependent	Dependent	Dependent	
Post Operative Procedure Special Orders:		—	—	Nil	Nil	nil	
Handed Over By Name :		Architha	Sr. Ruby	Anitha	Anitha	Manisha	
Signature / ID :		A 102062	91885	[signature]	[signature]	905045	
Date:		23/4/26	23/4/26	23/7	23/7	24/7/26	
Time:		@ 8:20am	@ 11:15AM	@ 2pm	@ 8pm	@ 8AM	
Taken Over By Name :		Parsone	Anitha	Anitha	Manisha		
Signature / ID :		[signature]	[signature]	[signature]	905045		
Date:		23/7/26	23/7	23/7	23/7/26		
Time:		@ 8:20am	@ 11.20am	@ 2pm	@ 8pm		

Noted by Manisha 24/7/26 @ 8AM

Patient Sticker

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NURSING SHIFT HAND OVER FORM

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

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30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 23/7/26

To Be Filled In By Assigned Nurse:

Department: ENT Duration of Procedure : 1hr

Name of Surgeon: Dr. Ajay Kumar Date of Admission : 23/7/26

Bundle Care Criteria: (Tick (√) if done)

		Staff Signature
1.	Antibiotic given prior to surgery? ☐ Yes ☐ No ☐ Single Dose Antibiotic Or ☐ Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision? ☐ Yes ☐ No Name of the Antibiotic: inj. Amoxycillin After test dose	
2.	Hair Removal ☐ Yes ☐ No If Yes: ☐ Surgical Clipper Department where Hair Removed: ☐ Ward ☐ Operating Room ☐ Other: ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☐ Axilla (Goal: 36-37°C)	
4.	Name of doctor or staff administering the antibiotic: Dr. Rakesh Date & Time of antibiotic administration: 23/7/26 @ 8:45 AM Date & Time procedure started: 23/7/26 @ 8:45 AM	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Rudraansh Adhuty Age : 7y Gender : Male ☑ Female ☐

UHID NO: 207152 Surgeon Name: Dr Ajay kumar

Anaesthesiologist : Dr Sunidhi

Operative procedure planned : Adenotonsillectomy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : laryngospasm, Bronchospasm

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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 : PRAVEEN ADURTY

Relationship with Patient: Father

Date & Time : 20/7/16, 7pm

Witness :

Signature : .....

Name : BHAVANA. A

Date & Time : 20/7/16 7pm

Mother

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Srinidhana

Date & Time : 20/7/16, 7pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mast. A. S. Durga Bhairava Gender: ☑ Male ☐ Female Age : 7yr

UHID No : 207152 Date : 23/7/26

Instruction:

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

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

coblation assisted tonsillectomy + Adenoidectomy + GA

upon

(Name of the Patient)

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

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

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

Bleeding

My signature on this form indicates that

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

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

Consentee :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : [signature]

Name : PRAVEEN ADURTY

Relationship with Patient: Father

Date & Time : 23/7/26, 8.25am

Witness :

Signature : [signature]

Name : A. Sai Bhavana

Date & Time : 23/4/26, 8:25 am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Ajay Kumar

Date & Time : 23/7/26, 9:25 am

Docu. No. : RCH /FRM / CLINICAL / 027

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Dr. AJAY KUMAR

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OPERATION NOTES

Surgeon : Dr. Ajay kumar.	Asst. Surgeon :

Pre-Operative Diagnosis: Gr 3 Adenoids + Tonsils

Surgical Procedure :
coblator assisted Tonsillectomy + Adenoidectomy + GA

Indications for Surgery :

Date : 23/7/26	Start Time : 8:45AM	End Time : 9:45AM

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Operation Notes:
+ GA
coblator assisted Tonsillectomy + Adenoidectomy done
Haemostasis ensured

NBM till 12:30 PM
coldwater / cold milk / fruit juice / coconut water / ORS / icecream after 12:30 PM

Inj Vovran 7.5 mg in 25 ml NS IV tid.
Inj Paracetamol 300 mg IV tid
Inj Esomeprazole 25 mg IV OD
Inj Dexamethasone 2.5 mg IV BD
Inj Augmentin 800 mg IV BD
Accard-D syp 5 ml BD
Nasivion - P nasal drop 3 drop 3 times a day
Inj [illegible] SOS

Name of the Surgeon: Dr. Ajay Kumar.

Signature of the Surgeon: ....

Date & Time: 23/4/[illegible]

SURGICAL SAFETY CHECKLIST

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30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

Surgeon : Dr. Ajay kumar
Asst. Surgeon :
Anaesthetist : Dr. Basavaraju
Scrub Nurse : Sr. Parameswari

..... Age : ..... Gender : .....
...ry Name : Adenotonsillectomy
Date : 23/1/26 In-time : 8:45am Out-time : 9:45am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:30am

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 23/1

Before Skin Incision ➤➤

TIME OUT Time: 8:45am

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, 1hr Anticipated Blood Loss? Bleeding 2aml ☑ Yes ☐ No ☐ NA

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

Nursing Team Reviews: laryngospasm
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☑ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : Ruby

Name : Ruby

Before Patient Leaves Operating Room

SIGN OUT Time: 9:45am

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 Ajay kumar

Doc. No. : RCH / FRM / CLINICAL / 111

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H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master A.S DURGA BHAIRAVA RUDRAUNSH SHOURYA**	**Age :**	**7 Y 5 M 23 D**
IP No:	**IP-00060812**	**Sex:**	**Male**
Consultant:	**Dr. AJAY KUMAR**	**Ward/Bed No:**	**N 0 GF-EMERGENCY/ER 102**

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 urance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the e 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.
ceivers 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: Praveen

Relationship: father

Date: 23/7/26 Time: 6:00 Am

Witness Name:

Witness Signature:

Patient Address:

H.NO:3-125/87/108,SRI LAXMI NAGAR COLONY,BODUPPAL,HYDERABAD, TELANGANA. Boduppal Hyderabad Telangana INDIA 500092

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BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card / Debit Card / NEFT / RTGS / Demand Draft and Online Payment.
- In 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 / Corporate won't be applicable.
- If the Surgery / Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate / Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non – Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- 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 enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : A. S DURGA BHAIRAVA RUDRAUMSH SHAURYA.	UHID Number : 207152
~~Self~~/Attendant Name : PRAVEEN KADURTY	Relation : Father.
Self / Attendant Signature : Phone Number : 9951151852.	Name & Signature of Financial Counselor VICKY

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

H/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

LY WARNING SCORE: CHILDREN'S UNIT

Date : 23/7/26

Time:	8	9	10	11	12	2	4	6	8	9	11	1	3	5
Doctor / Nurse / Family Concern?	Am	Am	Am	Am	PM	PM	PM	PM	PM	PM	PM	AM	AM	AM
Temperature (°F)	98.6	98.6	98.6	98.6		98.4°F	98.6°F	98.6°F	98.6°F	98.6°F	98.6°F	98.6°F	98.6°F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	100/62 (63)	101/64 (57)	102/65 (60)	100/66 (65)		102/56 (62)					105/78 (64)			
Heart Rate (Number)	91	101	88	92		102	100	110	111	103	107	112	105	108
Resp. Rate (bpm) (Over 1 Minute) * / Resp Rate (Number)	22	24	23	21		24	26	28	22	23	24	21	26	28
Resp Distress (Mod/ Severe; None / Mild)	✓	✓	✓	✓		N	N	N	N	N	N	N	N	N
Receiving O_2 (l/min)														
O_2 Saturations (%)	99	99	99	99		99	98	99	98	99	98	99	99	99
Conscious Level (Normal; Altered)	✓	✓	✓	✓		N	N	N	N	N	N	N	N	N
GCS *	15	15	15	15		15	15	15	15	15	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0		0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0		0	0	0	0	0	0	0	0	0
Observer's Initials	L	R	R	R		A	A	A	A	M	M	M	M	M

Note: BP does not score in early warning scoring

Noted By Manisha 24/7/26 @ 5PM

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
23/7/26	08:00 am		NBM	RL 250 ml							0	ally
	09:00 am		NBM								0	
	10:00 am											
	11:00 am		icecream								1	
	12:00 pm		water							✓	0	Anitha 23/7 @1pm
	01:00 pm										1	
Total Intake :						**Total Output :**						
23/7	02:00 pm		icecream									
	03:00 pm									✓	1	
	04:00 pm		water									
	05:00 pm		Juice								0	
	06:00 pm									✓		Anitha 23/7 @7pm
	07:00 pm										1	
Total Intake :						**Total Output :**						
	08:00 pm		Juice									
	09:00 pm									✓	1	
	10:00 pm											
	11:00 pm		ice cream								0	manisha
	12:00 am									✓		
	01:00 am										1	
Total Intake :						**Total Output :**						
24/7/26	02:00 am		water									
	03:00 am										1	
	04:00 am											
	05:00 am										0	manisha 24/7/26 @5am
	06:00 am										1	
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Noted by manisha 24/7/26 @5pm

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

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

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30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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Sheet No: ..... + K CLAVULANATE

REGULAR PRESCRIPTIONS

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

DRUG : INJ. AMOXYCILLIN	Dose	Route	Frequency	Start Dt.	Date / Time
	800mg	IV	8th hrly	23/7	23/7 6 AM

Name & Signature of the Doctor Starting the Drugs: Dr

Additional Instructions: 20-30mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : SYP AMLODIL-D +	Dose	Route	Frequency	Start Dt.	Date / Time
	5ml	P/O	12th hrly	23/7	23/7 6 AM

Name & Signature of the Doctor Starting the Drugs: Dr Smile.

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : NASIVION-P NASAL DROPS	Dose	Route	Frequency	Start Dt.	Date / Time
	3 DROPS	P/N	8th hrly	23/7	23/7 6 AM

Name & Signature of the Doctor Starting the Drugs: Dr Smile..

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :	Dose	Route	Frequency	Start Dt.	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dr. Rishika Clinical Pharmacologist

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

(P.T.O.)

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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 ▾

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 ....

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

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Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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DRUG CHART

Date of Admission: 23|7|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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

VIH-00207152 IP-00060612
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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
23/7	8:45AM	RINGER LACTATE	IV	250ml/HR	B		23/7	B	

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

VIH-00207152 IP-00060812
Master A.S DURGA BHAIRAVA
30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/7	8:45AM	INJ AMOXICILLIN / CLAVULANATE	800 mg	IV		
				After Test Dose		
23/7	8:50AM	SUPP. DICLOFENAC	25mG	P/R		
23/7	8:45AM	INJ. DEXAMETHASONE	2.5mG	IV		
23/7	8:45AM	INJ. TRANEXAMIC ACID	375mG	IV		
23/7	9AM	INJ. PARACETAMOL	375mG	IV		

Verified by Dr. Rishika Clinical Pharmacologist 23/2/26

30-01-2019 7 Y 5 M 23 D (M)
Dr. AJAY KUMAR

REGULAR PRESCRIPTIONS Weight. 26.12 kg Ward. OT

DRUG : INJ DICLOFENAC SODIUM

Dose	Route	Frequency	Start Date
7.5mg	I/V	8th hly	23/7

Name & Signature of the Doctor Starting the Drugs: Dr Sunita

Additional Instructions: 7.5mg in 25ml NS

Date/Time: 23/7 — 6 AM ✓ — 2 PM ✓ — 10 PM Gay

Daily Doctor's Endorsement by a Sign

23/7/26 Verified Dr. Rishika Clinical Pharmacologist 11:45 AM

DRUG INJ PARACETAMOL

Dose	Route	Frequency	Start Date
300mg	I/V	8th hly	23/7

Name & Signature of the Doctor Starting the Drugs: Dr Sunita

Additional Instructions: 10ml/kg/dose

Date/Time: 23/6 — 6 AM ✓ — 2 PM ✓ — 10 PM Gay

Daily Doctor's Endorsement by a Sign

23/7/26 Verified Dr. Rishika 11:45 AM

DRUG : INJ. ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
25mg	I/V	OD	23/7

Name & Signature of the Doctor Starting the Drugs: Dr Sunita

Additional Instructions: 1mg/kg/dose

Date/Time: 23/7 — 6 AM ✓ — 2 PM ✓

Daily Doctor's Endorsement by a Sign

23/7/26 Verified Dr. Rishika 11:45 AM

DRUG : INJ. DEXAMETHASONE

Dose	Route	Frequency	Start Date
2.5mg	I/V	12th hly	23/7

Name & Signature of the Doctor Starting the Drugs: Dr Sunita

Additional Instructions:

Date/Time: 23/7 — 6 AM ✓ — 6 PM ✓

Daily Doctor's Endorsement by a Sign

23/7/26 Verified Dr. Rishika 11:45 AM

ESTIMATION SLIP

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date: 20/07/26 UHID/IP No.: VIH-207152 Sl. No.: 29313

Name of Patient: Mast Rudraunsh Age: 7yy Gender: M

Father's / Husband's Name: Mr. praveen Corporate/Occupation: Pvt emp.

Address: Uppay Phone: 9951151852 Email:

Procedure/Plan: Adeno tonsillectomy DOS: 23/07/26

MODE OF PAYMENT: ☑ SELF ☐ TPA : CASH ☐ GIPSA : ☐ OTHER

TARIFF INFORMATION: Dr. Ajay kumar

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges			1	7	12	Noon 70			
	Doctor's Fee			1	7		12 Noon Billing			
	L. Tax			12,900						

PARTICULARS	AMOUNT (₹)	
Surgeon's / Anesthetist's Fee / O.T Charges	1,10,000/-	
O.T Consumables	4,000/-	Subject to approval by TPA/Insurance Company
Instrument Charges	8,000/-	Not Covered by TPA/Insurance Company
Pharmacy, Consumables & Investigations	→	As per actual – Not Included In Estimation

Equipment Charges				
	Monitor: 1,500/-	Oxygen:	Infusion Pump/Syringe Pump: 900/-	
	Ventilator	*Conventional:*	*HFO-SLE 5000:*	*HFO-Sensormedix:*
	Phototherapy	*Single Surface:*	*Double Surface:*	*Triple Surface:*

Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc.	→ As per actual – Not Included In Estimation
Package NHA-1,500/-	MRD-2,500/- Consultant-250/Day
Others 5% IDA, 5% GST	EVAC probe-27,900/-
Initial Minimum Deposit 1,60,000/-	

REMARKS :

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

DECLARATION

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

Signature of the Client | Signatory Relationship | Signature of the Financial Counselor