

VIH-00114764 IP-00060171  
Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA

**ACTIVITY RECORD FOR BILLING**



Name: -----  
UHID No : ----- IP No : ----- Consultant : ----- Dept : Pediatrics  
Date of Admission : 29/5/20 Time : 10:46 AM Date of Discharge : ----- Time: -----  
Room / Bed No : OT Ward : OT Suggested Billable bed type : -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<u>29/5/20</u>	<u>12:00 PM</u>	<u>OT</u>	<u>OT</u>	
<u>29/5/20</u>	<u>1:00 PM</u>	<u>OT</u>	<u>Recovery</u>	

**Cross Consultation Visit**

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







VIH-00114764 IP-00060171  
Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA



### SURGERY DETAILS

Date : 29/05/26

Patient Name: Mast. Shaik Armaan Date of Birth: 25/06/2019 Age: 6y.11m.

Gender: male Ward : OT UHID No.: 114764

Date of Surgery: 29/05/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Circumcision

Time in : 1:15 PM

Time Out : 1:45 PM

	NAME	AMOUNT
1. Surgeon	Dr. Jyoti Bothra	OT charges
2. Anaesthetist	Dr. Bandha / Prishpa	
3. Assistant Surgeon		
4. OT Technician	Tech. Rakesh	
5. Circulating Nurse	Sr. Praveena / Meghna	
6. Assistant Nurse	Sr. Ratna P. / Bharani	

- Special Equipment:  Laparoscopy  Bronchoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others .....

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 3085214 / 3085215

Order by: Ruby P

3085214  
15  
CONSUMABLES  
OF OT  
Circumcision  
①



Circulating Staff : Su presume Technician : Rakesh

Anaesthesia Disposables	Qty		Surgical disposables	Qty		Disposables (Baby side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack			Inj. Vit. K		
LMA			Sutures			Cord Clamp		
ECG leads : A/P/N		3	9915.0		1	Suction Catheter		
HME filter : A/P/N						Feeding Tube		
Syringe 10 cc		3				Vaccum Suction Set		
05 cc		3	Gloves			Surgical Gloves		
02 cc			SB: 6; PF 6		2	Gauze Pack		
01 cc						Syringe 1 ml/ 2 ml		
Cautery Plate : A/P/N			Surgical blade NO. 15		1	Surgical Blade # 20		
IV set			NG tube No: 6		1	Koochies (S)		
RL			Cautery Pencil					
NS : 10ml/100 ml/ 500ml/1000ml		2	Koochies					
Capnography (P)		1	Ointments			psu to green		1
Tramépre		1	Suction Catheter					
Fentanyl			Cap. Mask		6-6			
Morphine			Gauze Pack		2			
Ketamine			Mop Pack					
Propofol		2	Steristrip					
Rocuronium			Underpad		1			
Glycopyrolate			Draw Sheet Allensb		1			
Myopyrolate			Abgel					
Ondansetron			Foleys Catheter					
Pencan 25g/Spinal Needle 22 (Paco)		1	Urobag					
Bupivacine 0.25%		1	Chest Drainage Catheter					
Bupivacine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg/250mg/170 mg			Double J Stent					
Supridol 100 mg			Vaccum Suction set					
Justin : 12.5 mg/25 mg/ 100 mg		1	Plastic Bed Sheet					
Tab. Misoprost : 200 mg			Betadine Solution		1			
Gale 6 1/2 (P.F)		1	Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Dr Jyoti Bothra Anaesthesiologist Dr. Bunde Nurse Bhavani / Ruby P OT Technician Rakesh  
 Order No. : 3085230 Ordered by : Ruby P

**RAINBOW CHILDREN'S MEDICARE LIMITED****Rainbow Children's Hospital - Secunderabad**

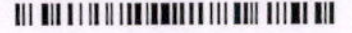
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,  
Kakaguda, Karkhana Hyderabad Telangana INDIA 500009  
Tel No : 040-42462200, Ext 2000,2001,2002

VAT TIN : 36920283145

CIN : L85110TG1998PLC029914

DL NO :

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

**INPATIENT ISSUES AGAINST ORDERS**

IP No	IP-00060171	Ward	N 0 GF-EMERGENCY
Patient Name	Master SHAIK ARMAAN	Bed Name	ER 102
Age/Sex	6 Y 11 M 4 D / Male	Order No	0003085230
Date	29/05/2026 14:07	Prescription No	PRIP-1289230
Payor	SELPAY	Dispensed Date	29/05/2026 14:08
UHID	VIH-00114764		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ALLESORB CORE TURNAROUND COVER 40x102IN			2605111	03/29	1	775.00	775.00
2	BACTOPREP SOLUTIONS 100 ML	RAMAN & WEIL PVT LTD		RTBP26002	02/29	1	229.00	229.00
3	BETADINE SOLUTION 10% 100 ML	WIN MEDICARE PVT. LTD	General	MD01426	03/28	1	103.95	103.95
4	BUPICAINE INJ VIAL 0.25% 20ML			ARBP12503	11/27	1	60.23	60.23
5	CAPNOGRAPHY NASAL CANNULA-PEAD		GENERAL	CGBMD01	03/29	1	200.00	200.00
6	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26CO3K92	01/31	3	28.13	84.39
7	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26CO3K96	02/31	3	21.56	64.68
8	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	77160326	02/28	3	34.64	103.92
9	Encore Microptic gloves- 6.5		H	26020311T	02/29	1	128.00	128.00
10	ENCORE MICROPTIC GLOVES-6 PF	ELITE MEDICALS	GENERAL	260300751T	03/29	2	128.00	256.00
11	FACE MASK-3LAYER THREADED	Sunrise		VI02012026	12/99	6	10.00	60.00
12	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	17O724	06/27	2	100.00	200.00
13	INFANT FEEDING TUBE-6	ROMSONS	GENERAL	G26A010116	12/30	1	63.00	63.00
14	JUSTIN SUPPOSITORIES 25 MG	Neon Laboratories Ltd	H	BLNP279008	10/28	1	15.46	15.46
15	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353002	07/27	2	69.10	138.20
16	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS		26FB001	01/29	10	23.43	234.30
17	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	IC261780	02/29	1	93.94	93.94
18	NS IV 10 ML AMPULE	MEDLIFE HEALTH SOLUTIONS	GENERAL	7219038	06/30	2	16.14	32.28
19	PROTO GOWN (ADULT) (PROTECTCARE)		General	VI20052026	12/30	1	450.00	450.00
20	SGLOVE # 6 (SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26C2003M	02/31	2	91.00	182.00
21	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	VYGON		030725AG	07/30	1	302.00	302.00
22	SURGEONS CAP	Mediblu	General	VI22022026	12/99	6	10.00	60.00
23	SURGICAL BLADE 15	Surgeon	GENERAL	160625	05/30	1	7.67	7.67
24	TRANSPORE 1 INCH	3M HEALTHCARE	GENERAL	R02261120	01/31	1	199.66	199.66
25	UNDERPADS 60X90 BUTTERFLY			40RW40CS15	03/28	1	140.00	140.00
26	VICRYL RAPIDE 5-0 9915W	ETHICON SUTURES-J&J C1		AW6665	04/30	1	885.00	885.00



**RAINBOW CHILDREN'S MEDICARE LIMITED**

**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

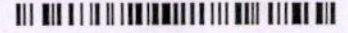
**VAT TIN :** 36920283145

**CIN :** L85110TG1998PLC029914

**DL NO :**

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

**INPATIENT ISSUES AGAINST ORDERS**



<b>IP No</b>	IP-00060171	<b>Ward</b>	N 0 GF-EMERGENCY
<b>Patient Name</b>	Master SHAIK ARMAAN	<b>Bed Name</b>	ER 102
<b>Age/Sex</b>	6 Y 11 M 4 D / Male	<b>Order No</b>	0003085230
<b>Date</b>	29/05/2026 14:07	<b>Prescription No</b>	PRIP-1289230
<b>Payor</b>	SELPAY	<b>Dispensed Date</b>	29/05/2026 14:08
<b>UHID</b>	VIH-00114764		

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<b>Total :</b>	<b>4,184.91</b>	<b>5,068.68</b>
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for RAINBOW CHILDREN'S MEDICARE LIMITED

**Receiver Name**

**Authorized Signature**

Pharmacist Name : RUBY FLORENCE VELPULA

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29242

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— 316 — bus  
— 6316 — pharmacy & car  
— 1940 — fence  
— 1120 — in  
— 2020 — pig

<b>Name</b>	Master SHAIK ARMAAN	<b>UHID</b>	VIH-00114764
<b>Father/Guardian</b>	Mr SHAIK NIYAMATULLAH	<b>Age/Gender</b>	6 Y 11 M 4 D/Male
<b>Address</b>	HNO 12-14-269/6/A LALAPET SECBAD, Lalapet, Hyderabad, Telangana, INDIA, 500017		
<b>IP No</b>	IP-00060171	<b>Admission Date</b>	29-05-2026
<b>Ref Doctor</b>	Self	<b>Discharge Date</b>	29-05-2026

## DISCHARGE SUMMARY

### **Consultant:**

**Dr. JYOTI BOTHRA**

DNB, MCh (Pediatric Surgery), FMAS

SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY

### **Diagnosis: Religious Circumcision**

### **Surgical Procedure: Circumcision done on 29.05.2026**

**History:** Master SHAIK ARMAAN is a 6 Y 11 M 4 D boy presented with history of religious circumcision. For the above complaints, he was admitted at Rainbow Children's Hospital for surgical management.

**Examination:** He was afebrile, maintaining saturations at room air and was hemodynamically stable. Heart rate was 87/min, BP 100/60 mmHg and RR - 24/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Neurologically, he was conscious and oriented. Other systemic examination was normal.

Weight on admission : 24.5 kgs.

**Management:** He was admitted in the ward.

<b>Name</b>	Master SHAIK ARMAAN	<b>UHID</b>	VIH-00114764
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**Surgical Procedure: Circumcision done on 29.05.2026**

**Operative Notes :**

- Circumcision done with sleeve method .
- Hemostasis confirmed.

**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. Sitz bath twice a day for 10 days, daily bath
3. T - Bact ointment for local application twice a day for 10 days.
4. Kindly consult with Dr. Jyoti Bothra, Consultant Pediatric Surgeon, after 10 days in OPD with prior appointment (This consultation will be charged).

**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](http://www.rainbowhospitals.in)**

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

Name

Master SHAIK  
ARMAAN


UHID

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

  
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

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

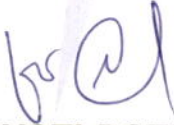
Name : SHAIK ARMAAN

Signature : 

Relationship with patient : MOTHER

This summary has been explained by : Ruby

Summary prepared by: Dr. Shivam  
Typist : Kalyan



  
**Registrar/Resident/C.M.O**

**Dr. JYOTI BOTHRA**

DNB, MCh (Pediatric Surgery), FMAS  
SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY  
TSMC/FMR/02962

VIH-00114764 IP-00060171

Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA

**DEFEC**

**MEDICAL CASE SHEET**

Patient N



IP. No :

Ward :

DOD :



Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1	✓	✓	
2	Discharge Summary	2			
3	Nursing Initial assessment.	1	✓	✓	
4	Patient Transfer form	2	✓	✓	
5	In-patient Medical record	1	✓	✓	
6	Doctors progress sheets	1	✓	✓	
7	Nursing plan of care and handover sheets	1	✓	✓	
8	Consultation sheet	-	-	-	
9	General consent for treatment	1	✓	✓	
10	Consent for Surgery	1	✓	✓	
11	Consent for blood transfusion - ANESTHESIA	1	✓	✓	
12	Consent for chemotherapy	-	-	-	
13	Consent for high risk	-	-	-	
14	Consent for Restraint	-	-	-	
15	LAMA consent	-	-	-	
16	Consent for special procedure/Sedation	-	-	-	
17	Consent for Formula feed	-	-	-	
18	Consent for MTP	-	-	-	
19	Consent for Radiological Investigations	-	-	-	
20	Consent for HIV test	-	-	-	
21	Anaesthesia notes (Pre Anaesthesia & post)	1	✓	✓	
22	Neonatal Admission/Delivery/Physical Exam	1	✓	✓	
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)	1	✓	✓	
31	Drug chart (Regular Prescription)	1	✓	✓	
32	Investigation Values (result sheet)	1	✓	✓	
33	Nebulization chart	-	-	-	
34	Nutritional review chart	-	-	-	
35	Intensive care unit (ICU Charts)	-	-	-	
36	Consent for Admission in PICU/NICU	-	-	-	
37	The Humpty dumpty scale	1	✓	✓	
38	Braden Q Scale	1	✓	✓	
39	Bed-side check list - PAW ASSESSMENT FORM	1	✓	✓	
40	PICU bed formula Dilution feeds - THROUGH BOTTLES	1	✓	✓	
41	Gastro monitoring chart - SBI	1	✓	✓	
42	Rch ED doctors note - BILLING POLICY	1	✓	✓	
43	BP Monitoring chart - ATTENDING INFORMATION	1	✓	✓	
44	RBS monitoring chart - ADMISSION & ESTIMATION BIP	1	✓	✓	
45	ADMISSION CARD	1	✓	✓	

Total No. of Pages

31

Signature and Date

*[Handwritten Signature]*  
29/5/26

## ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

**ADMISSION SHEET**

**Registration Details :**



**Admission No :** IP-00060171

**Admit Date :** 29-May-2026

**Admit Time :** 10:46 AM **UHID :** VIH-00114764

**Patient Details :**

**Patient Name :** Master SHAIK ARMAAN

**Age :** 6 Y 11 M 4 D

**Guardian :** Mr SHAIK NIYAMATULLAH

**DOB :** 25-06-2019

**Gender :** Male

**Religion :**

**Occupation :**

**Martial Status :** Single

**Address (H) :** HNO 12-14-269/6/A LALAPET SECBAD Lalapet Hyderabad Telangana INDIA 500017

**Phone No :** 9177632838

**E-mail :** na123@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 SHAIK NIYAMATULLAH

**Relationship :** S/O

**Contact Address :** HNO 12-14-269/6/A LALAPET SECBAD Lalapet Hyderabad Telangana INDIA 500017

**Phone No :** 9177632838 / 9908786657

*Signature*  
Signature

**Doctor Details :**

**Doctor Name :** Dr. JYOTI BOTHRA

**Specialisation :** PEDIATRIC SURGERY

**Referral Doctor :** Self

**Phone No :**

**Co-Consultant :**

**Payment Details :**

**Deposit Amount :** 0.00

**Payment Mode :** Cash

**Payor Name :** SELFPAY

Patient Name : Mast. Master SHAIK ARMAAN UHID : VIH-00114764 IPD : IP-00060171 Gender : Male Age : 6 Y 11 M 4 D

VIH-00114764 IP-00060171  
Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA

Patie



### NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/5/26 Time of arrival : 10:46am  
Chief Complaints: clpt came for Surgery circumcision RBS: -  
Height : 125cm Weight : 21.5kg BMI : - Head Circumference (<2 years) : -  
Allergies:  Yes  No  Medications  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

<p><b>RISK FOR FALL:</b></p> <p><input type="checkbox"/> If patient is &lt; 6 years tick below fall risk intervention directly</p> <p><input checked="" type="checkbox"/> If Patient is &gt; 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Uses furniture for support <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>Bedrest / immobile <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Weak <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Impaired <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li>Escort while ambulating <input type="checkbox"/></li> <li>Assist Patient <input type="checkbox"/></li> <li>Educate patient and family on fall precautions/prevention <input checked="" type="checkbox"/></li> </ul>	<p><b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li>Mobility Problem <input type="checkbox"/></li> <li>Walking Problem <input type="checkbox"/></li> <li>Developmental Delay <input type="checkbox"/></li> <li>Musculoskeletal Congenital Abnormality <input type="checkbox"/></li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p>.....</p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li>Underweight <input type="checkbox"/></li> <li>Overweight <input type="checkbox"/></li> <li>Feeding Problem <input type="checkbox"/></li> <li>Special diet <input type="checkbox"/></li> <li>Special feeding method <input type="checkbox"/></li> </ul> <p><b>Inform consultant for positive criteria</b></p>
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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?) 1 sister  
Time of initial assessment completed by ER Nurse : 10:49am

Patient Name : Mast. Master SHAIK ARMAAN UHID : VIH-00114764 IPD : IP-00060171 Gender : Male Age : 6 Y 11 M 4 D

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

Time	Nursing Notes
10:42am	⇒ Patient came to ER
10:45am	⇒ vitals checked and Reassessed
10:48h	⇒ Doctor has seen the patient, admission done
10:50am	⇒ Npo from today morning 6:30 am (Roti)
11:00am	⇒ iv placement done
11:10am	⇒ Blood samples collected and sented to lab
12:00pm	⇒ Patient shifted to OT.

Samples collected by: } S.S. Kajal  
 Samples sent by: } S.S. Kiran

Time: } 11:00am  
 Time: } 11:10am

**Medication given in ER:**

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 79b/min BP: 104/72(75) FT: 135cc RR: 24b/min SPO <sub>2</sub> : 98.1 GCS: 15/15 Temperature: 97.2F Pain Score: 0 Repeat RBS (if applicable):	Shift - out from ER to: OT Time of Shift - out: 29/5/2020 12:00pm Handover given to: S.r. Marya (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any):


iv placement done

Name of the Nurse: S.S. Renuthy

Signature of the Nurse: *[Signature]*

Date & Time: 29/5/2020 12pm

# PATIENT TRANSFER FORM

Patient Name / I.P. No.		Date & Time of Admission	Date & Time of Transfer Order
VIH-00114764 IP-00060171 Master SHAIK ARMAAN 25-06-2019 6 Y 11 M 4 D (M) Dr. JYOTI BOTHRA 		29/05/26 @ 10:46 AM	29/05/26 @ 2 PM
		Transfer ordered by	Reason for Transfer
		Dr. Baurdha	postoperative care.
From Unit	To Unit	Information to attendant	
OT	Recovery Room	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in clinical file	Number of Imaging films	Personal belongings including clinical documents. If any handed over to attendant	
(26)	nil	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
If yes, what ?			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / notes written by Doctor :			
Dr. Jyoti Bothra			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
Sr. Ruby.P		Dr. Baurdha	
Patient & Clinical records received by :			
Sr. Mava			
Date & Time of Patient Received:			
29/05/26 2 PM			


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

VIH-00114764 IP-00060171 Master SHAIK ARMAAN 25-06-2019 6 Y 11 M 4 D (M) Dr. JYOTI BOTHRA 		Date & Time of Admission 29/5/26 @ 10:45 pm	Date & Time of Transfer Order 29/5/26 @ 12:00 pm
Consulting Consultant Name		Transfer Ordered by Dr. Shivam.	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over <i>OPD file given. Shivam</i>			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Swagatika / <i>[Signature]</i>		Name of Person Ordered Transfer Dr. Shivam	
Patient & Clinical Records Received by : <i>Klan? 29/5/26 @ 12 pm</i>			
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<sup>®</sup>  
Children's  
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

VIH-00114764 IP-00060171  
Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA



Patient Name: \_\_\_\_\_

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

**Chief Presenting Complaints & Duration (Chronologically)**

Child came for religious  
~~1000 messages~~ circumstances  
preparation

**History of present illness :**

NPO status  
Solid : 6:30am  
Liquid : 6:30am



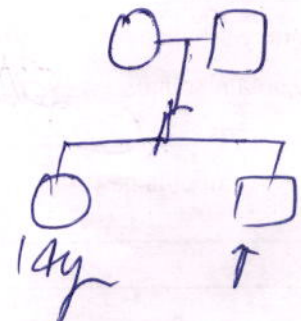
### Pediatric Multiorgan History & Physical Examination

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

NOTHING

**Birth & Neonatal History:**

F7/NUD/CLEAR/4kg  
NO H/O NRO Admin



**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_  
Any additional Information : \_\_\_\_\_

**Developmental History :**

Normal for Age

**Immunization History :**

Vaccination done for Age



### Pediatric Multiorgan History & Physical Examination

**Anthropometry :**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_  
Weight (kgs) ) 24.5/0 (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 97.28 Pulse Rate : 87/m B.R. 102/8/86 SPO2 98%  
Resp. rate and type of breathing : 24

Rash \_\_\_\_\_  
Lymphadenopathy \_\_\_\_\_  
Oedema : \_\_\_\_\_  
Allergies (if any): \_\_\_\_\_

**Respiratory System :**

Inspection (any s/o distress) : \_\_\_\_\_  
Air entry & breath sounds : BIBAS (N)  
Any addes sounds : \_\_\_\_\_  
Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

**Cardiovascular System :**

Inspection of procordium : \_\_\_\_\_  
Heart Sounds : S1S2 (N)  
Any murmur : \_\_\_\_\_  
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_  
Palpation : \_\_\_\_\_  
Ausculation : \_\_\_\_\_  
Spine : \_\_\_\_\_ External Genitalia : \_\_\_\_\_  
Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

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

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Motor System:

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

#### Reflexes :



DTR

Superficials:

Plantars \_\_\_\_\_

#### Sensory System :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bladder / Bowel : \_\_\_\_\_

#### Clinical Summary & Diagnostic:

Religious circumcision  
please for  
circumcision



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_  
\_\_\_\_\_

Desired goals of the treatment : \_\_\_\_\_  
\_\_\_\_\_

**Planned Labs:**

\_\_\_\_\_

CBE ✓

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Planned Management**

\_\_\_\_\_

- NPO

- Shift to 07

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Noted by Sr. Linton 210  
29/5/26 @ 12pm

Signature of the Doctor: \_\_\_\_\_

Name of the Doctor: Dr. Shivan

Date & Time: 29/5/26 10:50

Signature of the Consultant: \_\_\_\_\_

Name of the Consultant: \_\_\_\_\_

Date & Time: \_\_\_\_\_



1

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>29/5/26</u>	S/B Dr. Jyoti	
	S/O Cocoon	
	Stable	
	<u>Adv</u>	
	Can be W/C	





### NURSING SHIFT HAND OVER FORM

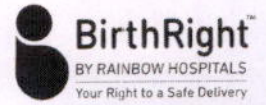
SITUATION	Diagnosis: -	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure: Circumcision	Post OP Day:						
BACKGROUND	Date	29/5/20	29/5/20					
	Shift	Morning	PM					
	Medical Condition (Any special condition to be noted):	-	-					
	Diet:	NPO	NBN					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA					
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.2p	98.6p				
		Res:	25b/m	24b/m				
		SpO <sub>2</sub> :	99%	99%				
		Pulse:	105b/m	90b/m				
		BP:	106/70(83)	112/60				
		LOC:	-	Comins				
	Fall Risk Score:	(ii)	15					
Pain Score:	0	1						
Skin Integrity	Intact	Intact						
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-					
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	NPO	NBN					
	Critical Lab Test / Values:	-	-					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	Dependent	Dependent						
Post Operative Procedure Special Orders: -								
Handed Over By Name :		Swagath Rayana						
Signature / ID :		[Signature]						
Date:		29/5/20						
Time:		@ 12:00 PM						
Taken Over By Name :		Mana Ruby						
Signature / ID :		[Signature]						
Date:		29/5/20						
Time:		2 PM						

## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):							
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mast. Shaik Armaan Gender:  Male  Female Age : 6 yrs

UHID No : 114764 Date : 29/5/26

**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)

R. Circumcision

upon Shaik Armaan  
(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  
Name of the doctor performing surgery

**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: Dr. Jyoti Bothra

**Consentee :**  
Signature :  
Name :  
Date & Time :

**Patient Attendant :**  
Signature :  
Name : Sharan  
Relationship with Patient: Father  
Date & Time : 29/5/26, 12:30pm

**Witness :**  
Signature :  
Name : SHAIK DILSHAD  
Date & Time : 29/5/26, 12:30pm

**Doctor (who is taking the consent) :**  
Signature :  
Name : Dr. Jyoti Bothra  
Date & Time : 29/5/26, 12:30pm

**CONSENT FORM FOR GENERAL /  
REGIONAL ANAESTHESIA /  
MONITORED ANESTHESIA CARE**

Patient Name : SHAIK ARMAAN Age : 6yrs Gender : Male  Female   
UHID NO: V14 00 114764 Surgeon Name: Dr. Jyoti  
Anaesthesiologist : Dr. Madhav  
Operative procedure planned : Circumcision

**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 and 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 Acidosis
- Incapacitating Chronic 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 SHAIK ARMAAN the above mentioned operation / Diagnostic / Therapeutic procedures Circumcision

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 anaesthesiologist 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 : SHAIK DILSHAD

Name : SHAIK DILSHAD

Relationship with Patient : MOTHER

Date & Time : 25/05/2026

**Witness :**

Signature : SAT SHARAM

Name : SAT SHARAM

Date & Time : 25/05/2026

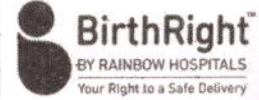
**Doctor (who is taking the consent) :**

Signature : Dr. P. Madhav

Name : Dr. P. Madhav

Date & Time : 25/05/26

Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**



Name: Shaik Arman Age: 6 yrs Sex: F UHID.No: V1400114764  
 Date: 25/05/26 Time: 04:40 pm Proposed Operation: Circumcision  
 Diagnosis: Phimosis  
 B.P / CRT: 110/70 H.R: 84 Weight: 24.4 kgs 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/Angio: .....
PT: .....	K: .....	LDH: .....	T3: .....	Other: .....
PTT: .....	Ca++: .....	Alk phos: .....	T4: .....	
INR: .....	Mg++: .....	Amylase: .....	TSH: .....	
	Cl-: .....	SGOT/SGPT: .....		

Allergies: NKDA

Medical History: CVS: (-)  
 RESP: Diabetes: (-)  
 CNS:  
 Renal:  
 Hepatic / GE: Physical Activity: Good  
 Others:

Past Anaesthetic History: Nil Significant

**Physical Exam:**

Airway: MF 1 2 3 4 Mouth Opening: adequate Mentohyoid Distance: (N) Neck: (N) Teeth: (N)  
 Lungs: BAE ⊕ clear Heart: S1 ⊕ S2 ⊕  
 CNS: NAD

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

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE

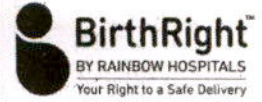
- Pre-Operative Instructions:**
- DVT Prophylaxis :
  - NIL ORAL  $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions:

CBP on Cannulation

Signature: [Signature] Name: Dr P Medhavi



# ANAESTHESIA CHART



## Pre Induction Assessment:

Change in Patient Condition:  Yes  No      Fasting Status: Adequate

Physical Status:  Patient Identified       Consent Present       Chart Reviewed

H.R.: 70/min      B.P / CRT: 80/40      SpO<sub>2</sub>: 100%      R.R.: 18/mm      Last Feed: \_\_\_\_\_

Pre-OP Diagnosis: \_\_\_\_\_      Operation: Circumcision      Date: 29/5/20

Surgeon: Dr Jyoti Bothra      Anaesthesiologist: Shilpa      Technician: Rakesh

TIME	Antibiotic	Suppository	Blood Loss	NOTES
N <sub>2</sub> O /AIR /O <sub>2</sub> LPM				
HALO /SO /SEVO				
Drugs:				
<u>PROPOFOL 50 + 50 + 50mg</u>				
<u>FENTANYL 50ug</u>				
<u>MEDA 0.5mg</u>				
FiO <sub>2</sub> / SaO <sub>2</sub>				
<u>100 / 100</u>				
ETCO <sub>2</sub>				
<u>35</u>				
ECG				
<u>ST</u>				
Temperature				
Urine Output				
Fluids: Blood				
B.P				
V Systolic				
A 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: \_\_\_\_\_

Art Site: \_\_\_\_\_

EKG Lead

Temp Site

FIO<sub>2</sub> 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: 11:50pm

OP Start: \_\_\_\_\_

OP End: 11:50pm

Leave OR: 11:50pm

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP: \_\_\_\_\_

ART: \_\_\_\_\_

IV: \_\_\_\_\_

IV: \_\_\_\_\_

IV: \_\_\_\_\_

Induction

IV       Inhal

Pre O<sub>2</sub>       BSI

Others: nasal prongs

Mask       SGA

Airway       Oral       Nasal

ETT# \_\_\_\_\_ at \_\_\_\_\_ cm

Oral       Nasal       Cuff

Tracheostomy       Topical

Drug: \_\_\_\_\_

Awake       Direct Vision

Video Laryngoscopy       Stylette / Bougie

Fiberoptic

Blade# \_\_\_\_\_ Attempts: \_\_\_\_\_

Difficulty Why? \_\_\_\_\_

Bilat = BS

Semi-Closed Circle

Closed Circle

Other

Regional:

Extremity      Specify: \_\_\_\_\_

Spinal       Epidural       Caudal

Others: \_\_\_\_\_

Position: See of 0.257

Site: supravacine

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 ENA

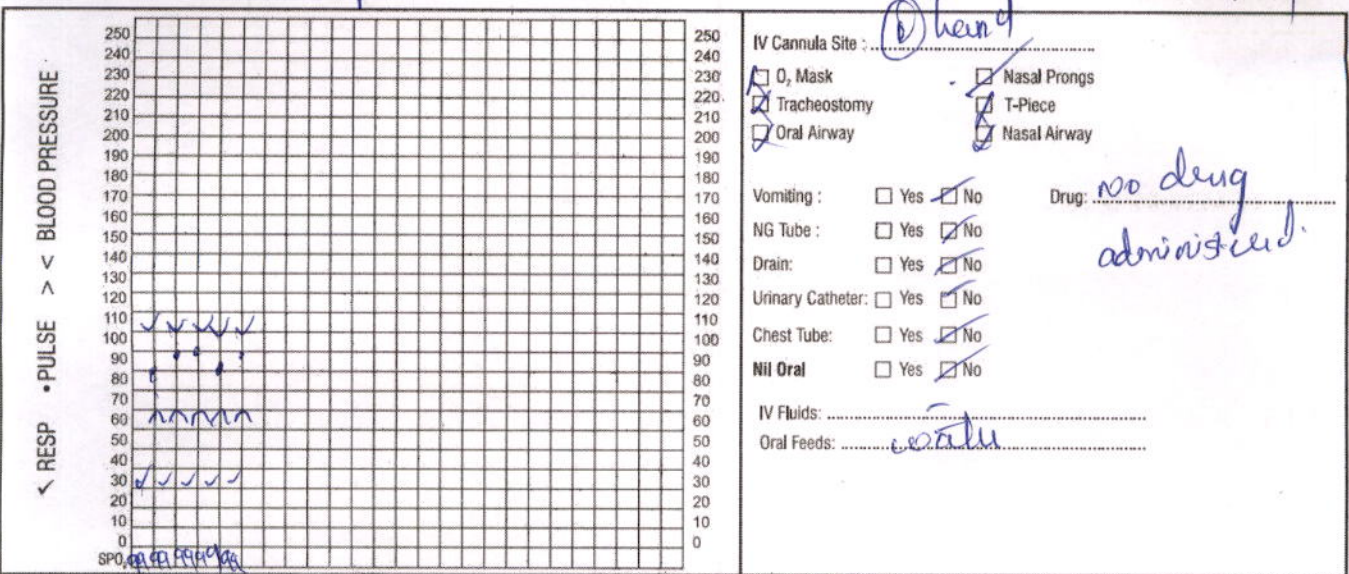
Name of the Doctor: Dr Shilpa

Signature of the Doctor: \_\_\_\_\_



**POST-ANAESTHESIA CARE UNIT RECORD**

Received in PACU by : Ruby P Time Received : 2pm Time Discharged : 5pm



IV Cannula Site : Hand

O<sub>2</sub> Mask  Nasal Prongs  
 Tracheostomy  T-Piece  
 Oral Airway  Nasal Airway

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

IV Fluids : water  
 Oral Feeds : water

Drug : no drug administered

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

**PAIN ASSESSMENT AND MANAGEMENT FORM**

Date	Time	Pain Score	Intervention	Signature
<u>29/5/26</u>	<u>2:30pm</u>	<u>0</u>	<u>-</u>	<u>[Signature]</u>

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Anaesthesiologist Name : Dr. Banda  
 Anaesthesiologist Signature : [Signature]  
 Date & Time : 29/5/26 5pm  
 PACU Nurse Name : Ruby P  
 PACU Nurse Signature : [Signature]  
 Date & Time : 29/5/26 5pm

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

Transferred to Unit by (PACU): Ruby  
 Date & Time: 29/5/26 @ 5pm

Patient Sticker

Department of Anaesthesiology  
**EPIDURAL ANALGESIA RECORD**

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....



## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  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: ..... BIR ..... Shifted to: ..... OT .....

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

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shivam / .....

Date & Time : 29/5/20 @ 10:45 AM. .....

Nurse Name & Signature: Suganya / .....

Date & Time : 29/5/20 @ 10:45 AM. .....

Patient Name : Mast. Master SHAIK ARMAAN UHID : VIH-00114764 IPD : IP-00060171 Gender : Male Age : 6 Y 11 M 4

VIH-00114764 IP-00060171  
 Maaster SHAIK ARMAAN  
 25-06-2019 6 Y 11 M 4 D (M)  
 Dr. JYOTI BOTHRA



wt:- 24.5kg  
 Ht:- 125cm  
 Gender:  Male  Female

### EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. Shaik Armaan Age : 6yrs

Date : 29/5/26 Time of Arrival : 10:42am

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: 95.5F PR: 87b/m BP: 107/55(86) RR: 24b/m SpO<sub>2</sub>: 98%

Chief Complaints: cto pt came for surgery circumcison

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS	
Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking	Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding	Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable: <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input checked="" type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 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]  
 Signature of Parent / Guardian  
 Triage Completion Time : 10:45am

### 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

Name of Triage Nurse : Swagatika

Date & Time : 29/5/26 @ 10:45am

Docu. No. : RCH/FRM / CLINICAL / 085

**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).

[Signature]  
 Signature of Triage Nurse :

PRE - OPERATIVE CHECK LIST

VIH-00114764 IP-00060171

Master SHAIK ARMAAN  
25-06-2019 6 Y 11 M 4 D (M)  
Dr. JYOTI BOTHRA

Date: 29/5/20

Patient's Name

Age: Gender:  M  F

Blood Group



I.P. No.: 060171

Planned Surgery: Circumcision Surgeon: Dr. Jyothi Bothra

Anaesthetist: Date & Time of Operation: 29/5/20 @ 12:30

Tick appropriate boxes :

To be filled by Nurse Incharge / Senior Nurse :

S.No.	Instructions	YES	NO
1	Weight checked and recorded? wt - 24.50 kgs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2	Is the patient fasting for over 6 hours pre-operatively?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3	Check Pre-OP investigations & Results (CBP, Blood Group, BT, CT, PT/APTT, Viral Screening, CXR etc.) Discuss with Registrar / Consultant	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4	Enema given / Bowel Preparation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5	Remove all ornaments, etc and sterile gown given	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6	Is Blood arranged as required?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7	If Blood has been ordered - is Blood bag read?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8	IV Cannula to be placed / IV fluids if indicated	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9	Pre Anaesthetic consultation with anesthesiologist	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10	Pre medications given? (Sedative / etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11	Skin Preparation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operation Surgeon only)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13	Other (if any)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NOTE: If any of above is ticked "No" Discuss with the registrar / Consultant immediately

Date: 29/5/20 Time: @ 10:45

Dr. Kiran  
Signature of Nurse in-charge

# SURGICAL SAFETY CHECKLIST

VIH-00114764 IP-00060171  
 Master SHAIK ARMAAN  
 25-06-2019 6 Y 11 M 4 D (M)  
 Dr. JYOTI BOTHRA

Surgeon : Dr. Jyoti Bothra  
 Asst. Surgeon : Dr. Shiva  
 Anaesthetist : Dr. Ravi/ Bharani  
 Scrub Nurse : Dr. Ravi/ Bharani



Age : 6yr Gender : Male  
 Jery Name : Circumcision  
 Date : 29/08/26 In-time : 1:15pm Out-time : 1:45pm



## Before Induction of Anaesthesia >>

SIGN IN	Time: <u>1:15pm</u>
<b>Patient Has Confirmed</b>	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Site Marked</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
<b>Anaesthesia Safety Check Completed</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pulse Oximeter on Patient &amp; Functioning</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Patient have a:</b>	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Difficult Airway / Aspiration Risk?</b>	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>	
Yes, and Adequate Intravenous Access and Fluids Planned	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Shiva</u>	

## Before Skin Incision >>

TIME OUT	Time: <u>1:15pm</u>
<b>Confirm all team members have introduced themselves by Name and Role</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure <u>→ Circumcision</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anticipated Critical Events</b>	
<b>Surgeon Reviews:</b>	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>→ Done</u> <u>→ 30mins</u> <u>→ 5ml</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Anaesthesia Team Reviews:</b>	
Are There Any Patient-specific Concerns? <u>→ None</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Nursing Team Reviews:</b>	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <u>→ Yes</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Is Essential Imaging Displayed?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>G. Praveena</u>	

## Before Patient Leaves Operating Room

SIGN OUT	Time: <u>1:45pm</u>
<b>Nurse Verbally Confirms with the Team:</b>	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>To Surgeon, Anaesthetist and Nurse:</b>	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Jyoti Bothra</u>	

# Rainbow Children's Medicare Ltd.

# 3-7-222 & 3-7-223, Sy. No. 51 & 54, Opp. New Karkhana Police Station

Karkhana Main Road, Kakaguda, Secunderabad - 500009.

Tel : +91-40-4246 2200, 2789 5050, 2789 6060.

GST: 36AABCR4014M1ZE email: vrchbilling@rainbowhospitals.in

CIN: L85110TG1998PLC029914 www.rainbowhospitals.in



## OPERATION THEATER NOTES

<b>Patient's Name : Master SHAIK ARMAAN</b>	<b>Age : 6 Y 11 M 4 D</b>	<b>Gender : Male</b>
<b>UHID : VIH-00114764</b>	<b>I.P. NO. 00060171</b>	<b>WEIGHT : 24.5kgs</b>
<b>Surgeon : Dr. JYOTI BOTHRA</b>	<b>Asst surgeon : Dr</b>	
<b>Anaesthetist : Dr Rama Brunda</b>	<b>OT Nurse : S/N</b>	
<b>Surgical Procedure : CIRCUMCISION</b>		
<b>Indications for Surgery : Religious Circumcision</b>		
<b>Anaesthesia - GA</b>		
<b>PRE-OPERATIVE PREPARATION-</b> Betadine skin preparation		
<b>OPERATIVE NOTES:</b> - Circumcision done with sleeve method . - Hemostasis confirmed.		
<b>Discharge Orders:</b> 1. Diet as advised. 2. Sitz bath twice a day for 10 days, daily bath 3. T - Bact ointment locally twice a day for 10 days 4. Syp. Crocin-DS (5ml/240mg) 5ml twice daily after food for 3 days. 5. Kindly consult Dr. Jyoti Bothra, Consultant Pediatric Surgeon, after 10 days in OPD with prior appointment (This consultation will be charged).		

**Consultants Surgeon's Name**

Dr. JYOTI BOTHRA

**Date :** 29/05/20

**Consultant Surgeon's Signature**

**Time :**



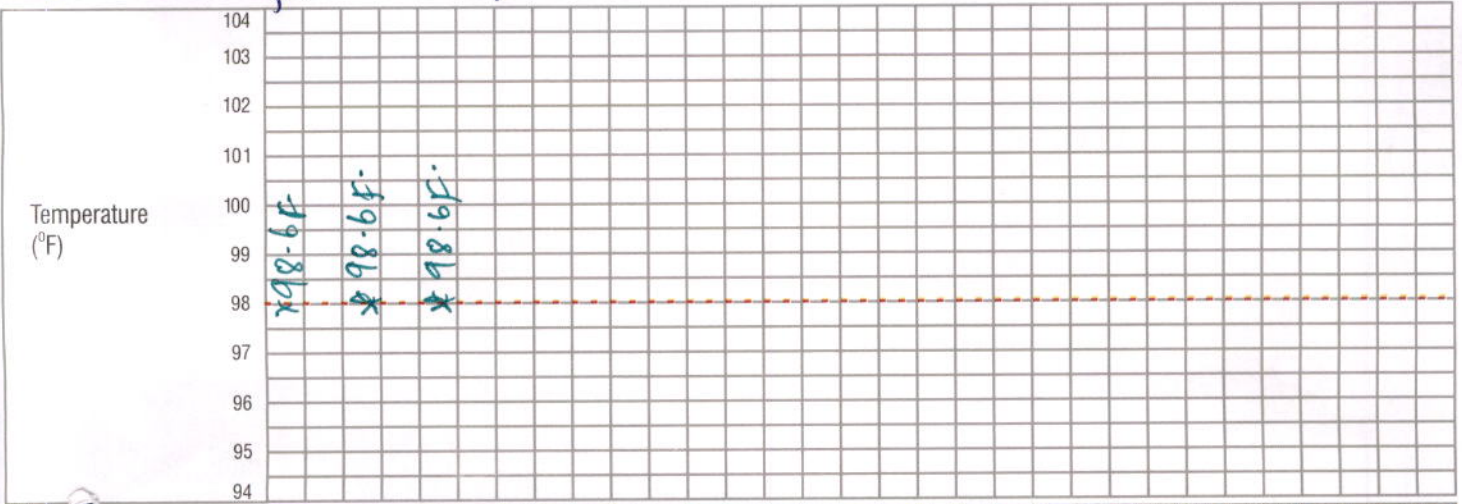
Patient



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/6/20 Time: 12 1 2 3

Doctor / Nurse / Family Concern? M M M



Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110	110	112	115
	100			
	90			
	80			
	70	60	59	70
	60			
	50			

Note:  
 BP does not score  
 in early  
 warning scoring

Heart Rate (Number) 109 112 94

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

Resp Rate (Number) 19 24 20

Resp Distress	Mod/ Severe			
	None / Mild			
Receiving O <sub>2</sub> (l/min)				
O <sub>2</sub> Saturations (%)		98	97	97
Conscious Level	Normal	NA	NA	NA
	Altered			
GCS *		15	15	15

TOTAL SCORE			
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	M	A	J

- ACTIONS**
- 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.

# 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)

VIH-00114764 IP-00060171  
 Master SHAIK ARMAAN  
 25-06-2019 6 Y 11 M 4 D (M)  
 Dr. JYOTI BOTHRA



# 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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am	NBM									07		
	11:00 am	NBM									07		
	12:00 pm	NBM									07		
	01:00 pm	NBM									07		
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm	NBM									0		
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**





**REGULAR PRESCRIPTIONS**

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

<b>DRUG :</b> <u>gabapentin</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					





VIH-00114764 IP-00060171  
 Master SHAIK ARMAAN  
 25-06-2019 6 Y 11 M 4 D (M)  
 Dr. JYOTI BOTHRA



# RESULT SHEET



Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
i.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					

