GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

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SURGERY DETAILS

Date : 21/7/26

Patient Name: Master. Senthazhalan Date of Birth: 30/5/2016 Age: 10Y

Gender: M Ward : OT UHID No.: 78290

Date of Surgery: 21/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : MINOR SURGERY

Time In : 8:20 pm Time Out : 8:45 pm

	NAME	AMOUNT
1. Surgeon	: Dr. Abirami krithiga	
2. Anaesthetist	: Dr. mohan	
3. Assistant Surgeon	: —	
4. OT Technician	: mr. Sudarshan	
5. Circulating Nurse	: s/N Risna	
6. Assistant Nurse	: s/N Gunadevi	

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: Record finalize done by Risna 007721 Order by:

Patient Sticker

Eme suturing :-

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CONSUMABLES OF OT

Circulating staff : Risna Technician : Mr Sudhakar Date : 21/7/25 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major Pack~~			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3	5-0 rapid		1	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		1				Vaccum Suction Set		
05 cc		1	Gloves 6 1/2 PF		02	Surgical Gloves		
02 cc		1				Gauze Pack		
01 cc		1				Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set	2	1	NG tube			Koochies (S)		
RL	4	1	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
			Ointments					
			Suction Catheter					
Fentanyl		1	Cap, Mask					
Morphine			Gauze Pack		2			
Ketamine			Mop Pack					
Propofol		1	Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet		01			
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Pmr done

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : Ordered by :

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK **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	IP18-00036566	**Ward**	4F-FOUR SHARING
Patient Name	Master K.S SENTHAZHALAN	**Bed Name**	FSW 420
Age/Sex	10 Y 1 M 21 D / Male	**Order No**	18-0001730999
Date	21/07/2026 21:44	**Prescription No**	PRIP18-0628492
Payor	SELFPAY	**Dispensed Date**	21/07/2026 21:45
UHID	GUC-00078290		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		1010726	06/29	1	120.00	120.00
2	Encore Microptic gloves-6.5		H	2603019005	03/29	2	128.00	256.00
3	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	2	100.00	200.00
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
5	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1B260029	04/28	1	21.01	21.01
6	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
7	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
8	VICRYL RAPIDE 5-0 9915W	ETHICON SUTURES-J&J	C1	0AW9173	07/30	1	885.00	885.00
						Total :	**1,587.01**	**2,040.01**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 21-07-2026 21:46

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK **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	IP18-00036566	**Ward**	4F-FOUR SHARING
Patient Name	Master K.S SENTHAZHALAN	**Bed Name**	FSW 420
Age/Sex	10 Y 1 M 21 D / Male	**Order No**	18-0001731000
Date	21/07/2026 21:44	**Prescription No**	PRIP18-0628491
Payor	SELFPAY	**Dispensed Date**	21/07/2026 21:45
UHID	GUC-00078290		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	1	28.13	28.13
2	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)	GENERAL	6072541	02/31	1	24.00	24.00
3	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	1	21.56	21.56
4	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	1	11.25	11.25
5	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
6	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	1	525.00	525.00
7	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
8	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
						Total :	**788.88**	**868.88**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

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GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTA

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		22/7/26 @10am.	Balaur		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
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OPERATION NOTES

Surgeon : Dr. ABIRAMI	Asst. Surgeon : —
Anesthetist : Dr. MOHAN	OT Nurse : S/N Guna
Pre-Operative Diagnosis: (R) eyebrow laceration	
Surgical Procedure : – Wound debridement & Minor suture	

Weight : 38 kg	Date : 21/7/20	Start Time : 8:25pm	End Time : 8:40pm

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Findings: – U/ LMA + local anaesthesia.
– wound debrided & suturing done.
2 5-0 RAPID vicryl

Procedure Notes: dressing done

Adv
1. NPO x 1hour
2. cont. inj. cefo 20m IV BD
3. DC today
Supp T. Taxim dosage 1-0-1 } 3days
Syp. P.[illegible] 5ml 1-1-1

Amount of Blood Loss: Blood Transfused (in ML)
– R/w on Friday

Name and Number of Surgical Specimen sent for examination:

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:
Wound Care:
Drain /Special Lines/Catheters:
Special Patient Positioning and Requirements:
Nutritional Instructions:
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No
Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: .....

Signature of the Surgeon: .....

Date & Time: .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... OT ..... Shifted to: ..... 4th Flow .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 21/7/18

Nurse Name & Signature: ..... 21/7/18 .....

Date & Time : ..... 21/7/18 .....

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

SURGICAL SAFETY CHECKLIST

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Surgeon : Dr. Abirami
Asst. Surgeon : —
Anaesthetist : Dr. Mohan
Scrub Nurse : Sis Gune

... Age : ..... Gender : .....
lame : Suturing
Date : 21.7.18 In-time : 8:12pm Out-time : 8:40pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:22p

Patient Has Confirmed
- Identity ☑Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☑Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☑No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature : .....
Name : Zuhan

Before Skin Incision ➤➤

TIME OUT Time: 8:24p

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑Yes ☐No ☐NA

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

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

Signature : .....
Name : Dr. Abirami

Before Patient Leaves Operating Room

SIGN OUT Time: 8:40p

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 : Reisa

PATIENT TRANSFER FORM

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GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

	Date & Time of Admission: 21/7/26 @ 4:32pm	Date & Time of Transfer Order: 21/7/26 @ 10pm
Treating Consultant Name: Dr. Abirami Krithiga	Transfer Ordered by: Dr. mohan	Reason for Transfer: For further management
From Unit: OT	To Unit: 4th Floor	Information to Attendant: ~~Yes~~ ☐ No ☐
Number of Sheets in Clinical File: 1 Bp file	Number of Imaging Films: ———	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ ~~No~~ ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature]	Dr. mohan

Patient & Clinical Records Received by : [signature] 01 Priya

Date & Time of Patient Received : 22/7/26 @ 10pm

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

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 21/7/26 @ 10 pm OT **TRANSFERRED TO :** 4th floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	Yes	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	Yes	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	Yes	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	Yes	
	b.All drains fixed, output noted	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	NA	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	Yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	Yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NA	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	NA	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	NA	
11	**BIOPSY/HPE SENT**	NA	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse:	BOTH	
	Receiving Nurse :		
	Signature of Incharge:		

for Prisni BOTH

Laboratory Report

Master K.S SENTHAZHALAN	9789354158
10 Y 1 M 21 D	GU26023496
Male	21-07-2026 05:18 PM
IP18-00036566	21-07-2026 05:30 PM
GUC-00078290	
Dr. ABIRAMI KRITHIGA J	0F-EMERGENCY / ER 101

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED
HEMOGLOBIN (Colorimetry)	13.2	g/dL		11.5 - 15.5
RBC COUNT (DC detection method)	4.78	10^12/L		4 - 5.2
PCV/HCT (Calculated)	38	VOL%		35 - 45
MCV (Calculated)	80	fL		77 - 95
MCH (Calculated)	28	pg/cells		25 - 33
MCHC (Calculated)	34	g/dL		32 - 36
RDW-CV (Calculated)	11.9	%		11.5 - 15
PLATELET COUNT (DC Detection Method)	277	10^9/L		150 - 450
MPV (Calculated)	9.0	fL		6.5 - 10
WBC COUNT (DC Detection Method)	10.26	10^9/L		4.5 - 13.5
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**65**	**%**	H	33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	**27**	**%**	L	28 - 48
MONOCYTES (Microscopy, Leishman stain)	6	%		4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	2	%		1 - 4

This is an interim report. The final report will be released after 24 hours

PRE - OPERATIVE CHECK LIST

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Date: 21/7/26

Patient's Name : master. santhaz kalan Age : 10 Y/M Gender : ☐ M ☐ F

Blood Group : A+ve UHID : 78290

Planned Surgery : eyebrow tomato Surgeon : Dr. Abirami karthick.

Anesthetist : Dr. mohan Date & Time of Operation : 21/7/26 @ 2pm

Tick Appropriate Boxes
To be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	YES	NO	NA
1.	Weight checked and recorded?	☑	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☑	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☐	☑	☐
4.	Enema given / Bowel Preparation	☐	☑	☐
5.	Remove all ornaments, etc and sterile gown given	☐	☐	☑
6.	Is Blood arranged as required?	☐	☐	☑
7.	If Blood has been ordered - is Blood bag ready?	☑	☐	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☑	☐	☐
9.	Pre Anesthetic consultation with anesthesiologist	☐	☑	☐
10.	Pre Medications Given? (Sedatives / etc)	☐	☑	☐
11.	Skin Preparation	☑	☐	☐
12.	Site is marked	☑	☐	☐
13.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☐	☐	☑
14.	Implants are available	☑	☐	☐
15.	Equipment is avaialble	☐	☐	☑
16.	Other (if any)			

NOTE: if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance taken

Billing Executive Name : M. Santhana babu Nurse In-Charge Name : Jothika

Billing Executive Signature : M. S Signature of Nurse In-Charge : Jothika

Date & Time : 21/07/26 18.25 Date & Time : 21/7/26 2pm

Doc. No. : RCH / FRM / CLINICAL / 107

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Rainbow Children Hospital
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Patient Name : .... Gender: ☐ Male ☐ Female Age : .....

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

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

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

.....

..... MINOR SURGERY

..... upon Mr. Senthazhalan

(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 about the reuse of single use device after appropriate reprocessing. If required during the surgery or procedure in consonance with good clinical practices.

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 / infection

.....

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. ABIRAMI

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : .....

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

நோயாளியின் பெயர்:..... வயது:..... பாலினம்: ஆண்☐ பெண்☐

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

இந்த ஒப்புதல் படிவத்தில் நோயாளி (18 வயதுக்கு மேற்பட்டவராக இருந்தால்) அல்லது நோயாளி மைனராக இருந்தால் (Minor) அல்லது தகவலறிந்து தகவலின் அடிப்படையில் முடிவு எடுக்கும் திறன் இல்லாதவராக இருந்தால், பெற்றோர் / பாதுகாவலர் கையொப்பமிடவேண்டும். இந்த தகவலை நீங்கள் பெற்றுள்ளீர்களா என்பதையும், உங்களுக்கு பரிந்துரைக்கப்பட்ட அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சை நடைமுறைக்கு உங்கள் சம்மதத்தை அளித்துள்ளீர்களா என்பதை சரிபார்ப்பதே இந்தப் படிவத்தின் நோக்கமாகும்.

பின்வரும் செயல்பாடுகள் அல்லது சிகிச்சை நடைமுறைகளை செயல்படுத்துவதற்கு இதன்மூலம் நான் முழுஒப்புதல் அளிக்கிறேன் (மருத்துவ சுருக்கங்களைப் பயன்படுத்தவேண்டாம்/தொழில்நுட்ப சொற்களைத் தவிர்க்கவும்).

.....மேற்கொள்ளவுள்ள மருத்துவசெயல் முறைகளில் உள்ள நன்மைகள் மற்றும் இதன் தேவை காரணம் குறித்தும் எனக்கு அறிவுறுத்தப்பட்டுள்ளது. மருத்துவப்பயிற்சி என்பது ஒரு அறிவியல் மட்டுமன்றி ஒரு கலை என்பதை நான் அறிவேன், எனவே மருத்துவ சிகிச்சையின் வெற்றி அல்லது சிகிச்சையினால் குணமாகும் சாத்தியக்கூறு குறித்து எந்த உத்தரவாதமும் இல்லை அல்லது செய்யமுடியாது என்பதை ஒப்புக்கொள்கிறேன். நோயாளியின் (எனது) நிலை, பரிந்துரைக்கப்பட்ட அறுவை சிகிச்சை மற்றும் அதன் விளைவு குறித்த எனது கேள்விகளுக்கு இந்தப்படிவத்தில் அறுவை சிகிச்சை நிபுணர் கையொப்பமிடுவதற்கு முன்பே, நான் திருப்தி அடையும் வகையில் பதிலளிக்கப்பட்டுவிட்டது.

அறுவைச் சிகிச்சை அல்லது மருத்துவ நடவடிக்கையின் போது தேவையானால், நல்ல மருத்துவ நடைமுறைகளுக்கு ஏற்ப, ஒருமுறை பயன்படுத்தும் கருவிகளை சரியான முறையில் மறுசெயலாக்கி மீண்டும் பயன்படுத்தலாம் என்பதை எனக்கு விளக்கியுள்ளனர்.

இந்த அறுவை சிகிச்சை செயல்முறையில் உள்ள அபாயங்கள் மற்றும் இதற்கு உள்ள நியாயமான மாற்று சிகிச்சைகள் மற்றும் மாற்று சிகிச்சையில் தொடர்புடைய அபாயங்கள், பக்கவிளைவுகள் மற்றும் சிகிச்சையை தொடராமல் இருப்பதால் ஏற்படக்கூடிய விளைவுகள் குறித்து எனக்கு விளக்கப்பட்டது.

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

பின்வரும் சிக்கல்கள் அரிதானவை என்றாலும் சாத்தியமுள்ளது என்று எனக்கு விளக்கப்பட்டது. எனவே எந்தவொரு அசம்பாவிதத்திற்கும் அறுவை சிகிச்சைநிபுணர், மயக்கமருந்து நிபுணர் அல்லது மருத்துவமனை ஊழியர்களை நான் பொறுப்பாக்கமாட்டேன்.

.....

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இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

1. இந்தப்படிவத்தில் கொடுக்கப்பட்டுள்ள தகவல்களை நான் படித்துப் புரிந்துகொண்டேன்.
2. மேலே குறிப்பிட்ட அறுவை சிகிச்சை அல்லது சிகிச்சை செயல்முறையில் உள்ள மேற்குறிப்பிட்ட சிக்கல்கள் ஆகியவற்றோடு இதிலுள்ள அபாயங்கள், நன்மைகள் மற்றும் பிறதகவல்களை எனது மருத்துவர் எனக்குப் போதுமான அளவு விளக்கினார்.
3. எனது அறுவை சிகிச்சை நிபுணரிடம் கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு அளிக்கப்பட்டது. அறுவை சிகிச்சை அல்லது மருத்துவசெயல்முறை குறித்து நான் விரும்பும் அனைத்து தகவல்களையும் பெற்றுள்ளேன.
4. அறுவை சிகிச்சை அல்லது மருத்துவ நடைமுறையைச் செயல்படுத்துவதற்கான ஒப்புதலை நான் வழங்குகிறேன்.

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer: 2/7/26. 420	**TRANSFERRED TO :** OT.	
1	**Patient Identification**	**YES/NO**	**REMARKS**
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes.	
	b.Surgical procedure & correct site verified	Yes.	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NO	
	b.SpO_2 within safe range	yes.	
	c.If ETT: position confirmed, ties secure, cuff inflated	NO	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	yes	
	b.No active uncontrolled bleeding	NO	
	c.Last vitals recorded before transfer	yes	
	d.Central line hubs are closed	No	
	e.Dressing Intact	NO.	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NO	
	b.Reassessment done	NO.	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NO	
	b.All drains fixed, output noted	NO	
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	NO	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	NO	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	yes	
	c.Emergency meds given in OT (time & dose documented)	NO.	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NO	
	b.Bed/side rails up and brakes applied	NO	
	c.Special positioning maintained as per surgery	No	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NO	
	b.Epidural catheter secure, infusion checked	NO	
	c.Pressure areas protected (heels/elbows)	No	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NO	
10	**REPORTS AND LABS HANDED OVER**	yes.	
11	**BIOPSY/HPE SENT**	NO.	
12	**Documentation**		
	a.Documentation completeness	Yes.	
	Transferring Nurse: Balaji/ 01068		
	Receiving Nurse : S/N Suthi 01957		
	Signature of Incharge:		

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NIL ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... A20 ..... Shifted to: ..... OT .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

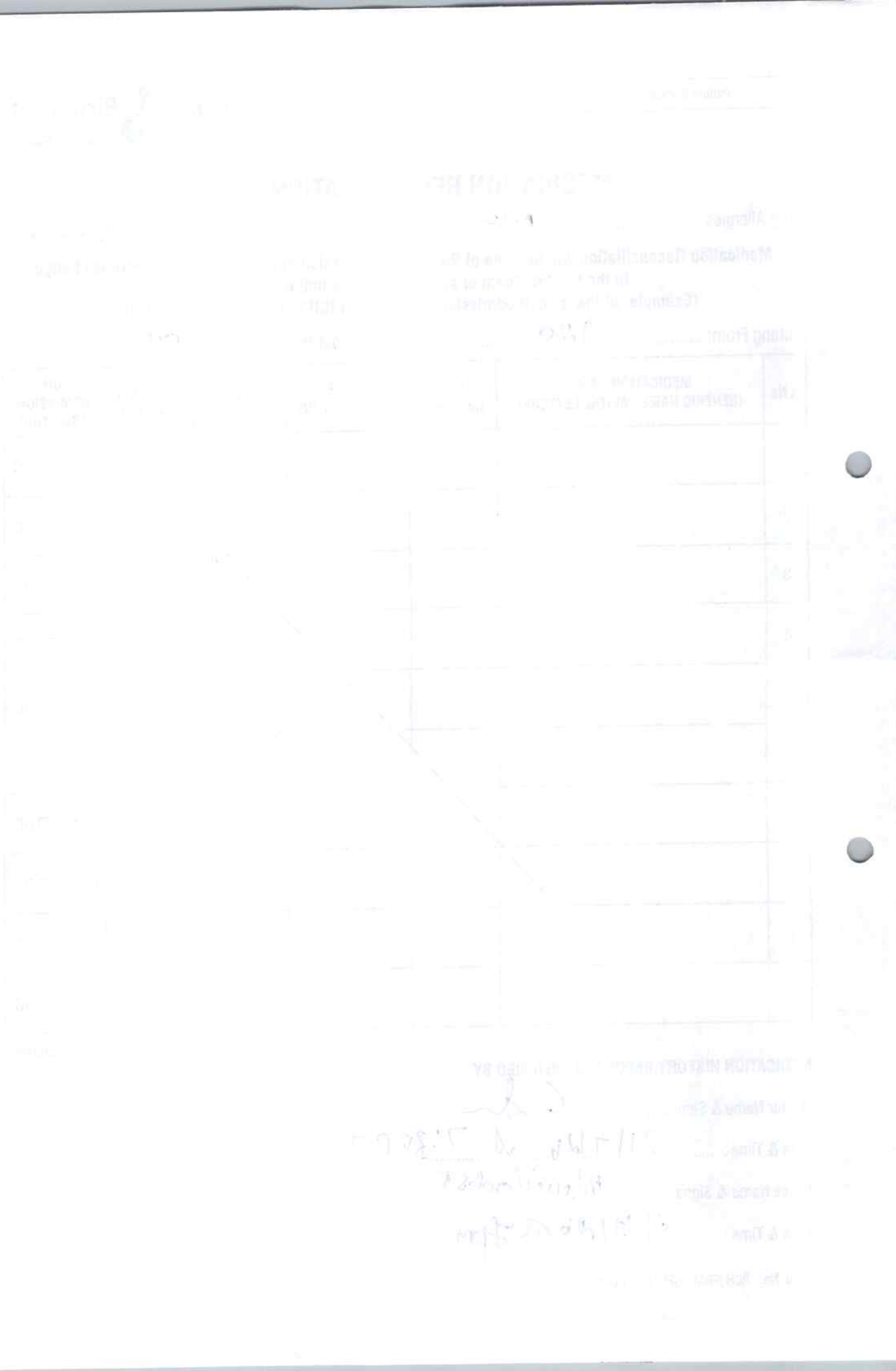
Doctor Name & Signature : .....

Date & Time : 21/7/26 @ 7:30 PM

Nurse Name & Signature: Balaraj/ORD85

Date & Time : 21/7/26 @ 7pm

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



PATIENT TRANSFER FORM

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GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Date & Time of Admission	Date & Time of Transfer Order
21/7/26 @ 4.32pm	21/7/26 @ 7.30pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Abirami	Dr. Deepak.	For procedure.

From Unit	To Unit	Information to Attendant
420	OT	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Baburaj 020685	

Patient & Clinical Records Received by : S/r Sujatha

Date & Time of Patient Received : 21/7/26 @ 7-40pm

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

CONSENT F GUC-00078290 IP18-00036566 Master K.S SENTHAZHALAN 30-05-2016 10 Y 1 M 21 D (M) Dr. ABIRAMI KRITHIGA J SIA

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

UHID NO: ..... Surgeon Name: ..... Dr. Mahesh .....

Anaesthesiologist : ..... Dr. Indra ..... Operative procedure planned : ..... hand surg .....

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 : ..... Hypertension, diabetes .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : .....

Name : D. KARTHIKAYAN

Relationship with Patient: FATHER

Date & Time : 21/7/26 @ 5:30pm

Witness :

Signature : .....

Name : Sangeetha

Date & Time : 21/7/26 @ 7pm

Doctor (who is taking the consent) :

Signature : ..... Name : Dr. Indra Date & Time : 21/7/26.

Docu. No. : RCH / FRM / CLINICAL / 021

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Department of Anae[sthesia]
PRE ANAESTHET[IC]

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Name: .... Sex: .... UHID.No : ....

Date: 21/12/26 Time: 5.30pm Proposed Operation: [illegible]

Diagnosis: (R) eyebrow laceration.

B.P / CRT: 100/7 H.R: 95/min. Weight: 38kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 13.2	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.7	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:** – nil –	

Medical History: CVS :

RESP :

Diabetes :

CNS :

Renal : No comorbidities

Physical Activity:

Hepatic / GE :

Others :

Past Anaesthetic History: H/o circumcision on April 2021 uneventful.

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth: loose teeth (R) upper lateral incisor.

Lungs : S1 S2 / LAM

Heart:

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site: —

Spine Exam for regional : —

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

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: last fed 2.30pm, NPO – 6hrs.

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: [signature] Name: [signature]

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status:	
Physical Status:	Patient Identified ✓	☑ Consent Present	☐ Chart Reviewed
H.R:	B.P / CRT:	SpO_2:	R.R:
Pre-OP Diagnosis:	Operation:	Date:	Last Feed:
Surgeon:	Anaesthesiologist:	Technician:	

TIME

N$_2$O /Air 70 LPM

HALO /ISO /SEVO

Drugs:

FIO$_2$ / SaO$_2$

ETCO$_2$

ECG

Temperature

Urine Output

Fluids

Blood

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

☐ Equipment Checked and Functional
☐ BP
☐ Cuff Site:
☐ Art Site:
☐ EKG Lead
☐ Temp Site
☐ FIO$_2$ Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position:

☐ 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:
OP Start:
OP End:
Leave OR:

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV:
☐ IV
☐ IV:

Induction
☐ IV ☐ Inhal
☐ Pre O$_2$ ☐ RSI
☐ Others

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

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

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

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor :
Signature of the Doctor :

Patient Sticker

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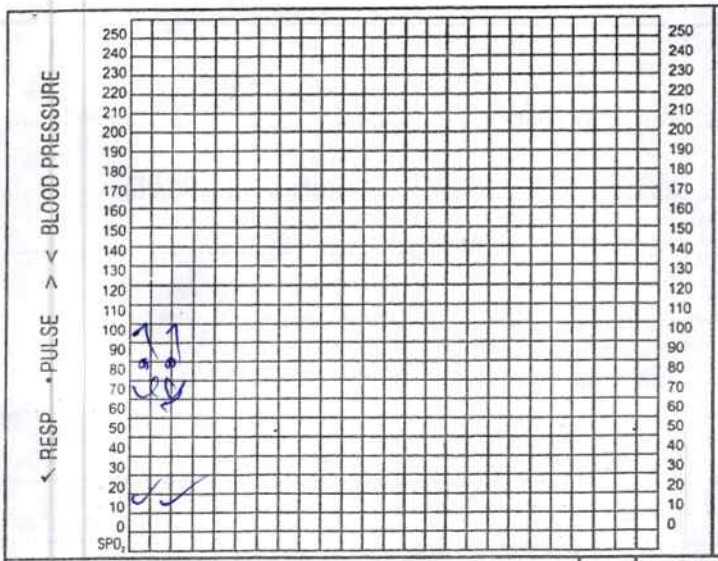
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Risna Time Received : 8:45pm Time Discharged : .....



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			Npo × 2 hrs.	
			T: Paracetamol 500mg do	
			Monitor vitals	

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

Reassessment Frequency:

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: 21/7/26

PACU Nurse Name : Risna

PACU Nurse Signature: .....

Date & Time: 20/7/26

Transferred to Unit by (PACU): 4th flow

Date & Time: 21/7/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

Rainbow Children's Hospital

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Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036566 **Admit Date** : 21-Jul-2026 **Admit Time** : 04:32 PM **UHID** : GUC-00078290

Patient Details :

Patient Name	: Master K.S SENTHAZHALAN	**Age**	: 10 Y 1 M 21 D
Guardian	: Mr D.KATHIRAVAN	**DOB**	: 30-05-2016
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO 23 OFFICERS COLONY 1ST CROSS STREET ADAMBAKKAM Adambakkam Kanchipuram Tamil Nadu INDIA 600088	**Phone No**	: 9789354158
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 101 **Ward Name** : 0F-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr D.KATHIRAVAN **Relationship** : Father

Contact Address : NO 23 OFFICERS COLONY 1ST CROSS STREET ADAMBAKKAM Adambakkam Kanchipuram Tamil Nadu INDIA 600088 **Phone No** : 9789354158

Signature

Doctor Details :

Doctor Name : Dr. ABIRAMI KRITHIGA J **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master K.S SENTHAZHALAN**	**Age :**	**10 Y 1 M 21 D**
IP No:	**IP18-00036566**	**Sex:**	**Male**
Consultant:	**Dr. ABIRAMI KRITHIGA J**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name: kathiravan
Relationship: Father
Date: 21/07/2026 Time: 4.32 pm
Wittness Name: [illegible]
Wittness Signature:

Patient Address:
NO 23 OFFICERS COLONY 1ST CROSS STREET ADAMBAKKAM Adambakkam Kanchipuram Tamil Nadu INDIA 600088

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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 9eapplicable.
- 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 arid 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 : Master. K.S.Senthazhalan.	UHID Number : GUC-00078290
Self/Attendant Name :	Relation : Father
Self/ Attendant Signature :	Name & Signature of Financial Counselor
Phone Number : 9789354158	

भारत सरकार

आधार

இந்திய அரசாங்கம்

Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 2726/51150/52569

To
செந்தழலன் க. செள
Senthazhalan K. S
C/O: Kathiravan. D
No. 23, Jansi Chris Nestle,
Officers Colony 1st Main Road,
Adambakkam
Kancheepuram Tamil Nadu - 600088
9042001383

Signature Not Verified
Digitally signed by GOVERNMENT OF INDIA
UNIQUE IDENTIFICATION AUTHORITY OF INDIA 05
Date: 2023.08.29 23:05:12 UTC

உங்கள் ஆதார் எண் / Your Aadhaar No. :

6408 5914 3021

VID : 9123 3236 9165 1118

எனது ஆதார், எனது அடையாளம்

Issue Date: 29/08/2023

இந்திய அரசாங்கம்

Government of India

ஆதார்

செந்தழலன் க. செள
Senthazhalan K. S
பிறந்த நாள்/DOB: 31/05/2016
ஆண்/ MALE

6408 5914 3021

VID : 9123 3236 9165 1118

எனது ஆதார், எனது அடையாளம்

Government of India

AADHAAR

தகவல் / INFORMATION

- ஆதார் என்பது அடையாளச் சான்று, குடியுரிமைக்கான சான்று அல்ல
- ஆதார் தனித்துவமானது மற்றும் பாதுகாப்பானது.
- பாதுகாப்பான QR குறியீடு/ஆ்ப்லைன் XML / ஆன்லைன் அங்கீகாரத்தைப் பயன்படுத்தி அடையாளத்தைச் சரிபார்க்கவும்
- ஆதார் கடிதம், பிவிசி கார்டுகள், இ ஆதார் மற்றும் எம் ஆதார் போன்ற அனைத்து வகையான ஆதார்களும் சமமாக செல்லுபடியாகும். 12 இலக்க ஆதார் எண்ணுக்கு பதிலாக மெய்நிகர் ஆதார் அடையாளத்தை (VID) பயன்படுத்தலாம்.
- 10 ஆண்டுகளுக்கு ஒரு முறையாவது ஆதாரை புதுப்பிக்கவும்
- பல்வேறு அரசு மற்றும் அரசு சாரா பலன்கள் / சேவைகளைப் பெற ஆதார் உங்களுக்கு உதவுகிறது
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்.
- ஆதார் சேவைகளைப் பெற உங்கள் ஸ்மார்ட் போன்களில் எம் ஆதார் செயலியைப் பதிவிறக்கவும்
- பாதுகாப்பை உறுதிப்படுத்த ஆதார் / பயோமெட்ரிக்ஸ் லாக் / அன்லாக் அம்சத்தைப் பயன்படுத்தவும்
- ஆதார் கோரும் நிறுவனங்கள் உரிய ஒப்புதலைப் பெற வேண்டும்
- **Aadhaar** is a proof of identity, not of citizenship.
- **Aadhaar** is unique and secure.
- Verify identity using secure QR code/offline XML/online Authentication.
- All forms of **Aadhaar** like **Aadhaar** letter, PVC Cards, **eAadhaar** and **mAadhaar** are equally valid. Virtual **Aadhaar** Identity (VID) can also be used in place of 12 digit **Aadhaar** number.
- Update **Aadhaar** at least once in 10 years.
- **Aadhaar** helps you avail various Government and Non- Government benefits/services.
- Keep your mobile number and email id updated in **Aadhaar**.
- Download **mAadhaar** app on smart phones to avail **Aadhaar** Services.
- Use the feature of lock/unlock **Aadhaar**/biometrics to ensure security.
- Entities seeking **Aadhaar** are obligated to seek due consent.

Download Date: 29/08/2023

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Unique Identification Authority of India

ஆதார்

முகவரி:
கேர் ஆப்: கதிரவன். தே, எண். 23, ஜான்சி கிரிஸ் நெஸ்ட்லி,, ஆபிசர்ஸ் காலனி 1வது மெயின் ரோடு,, ஆதம்பாக்கம், காஞ்சிபுரம், தமிழ் நாடு - 600088

Address:
C/O: Kathiravan. D, No. 23, Jansi Chris Nestle,, Officers Colony 1st Main Road,, Adambakkam, Kancheepuram, Tamil Nadu - 600088

6408 5914 3021

VID : 9123 3236 9165 1118

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PEDIATRIC IN-PATIENT MEDICAL RECORD

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Pediatric Multiorgan History & Physical Examination

Name: Mast. Senthazhalan Age/Sex 10 yrs/M.

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Accidental fall and hit over right eye brow

History of present illness :

A 10yrs old came with complaints of Accidental hit over right eye brow with door following which the child laceration of eye 5x2cm.
no c/o vomiting, loss of consciousness
no c/o seizure
Cough (+)
no c/o fever, loose stools,

Patient Sticker

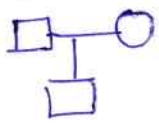
Past History : (Including details of any previous investigation or treatment)

circumcision done on ~~may~~ April 2025.

Birth & Neonatal History:

NVD | Term | B. wt - 3kg | no NICU stay.

Family Chart



Birth & Socio Economic History:

About Father : NCM.

About Mother :

Any additional Information :

Developmental History :

milestones attained at appropriate age.

Immunization History :

Immunized upto age according to ~~IAP~~ guidelines

Anthropometry :

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

Weight (kgs) 38kg. (Centile _____)

On Examination :

Temperature : 97.2F Pulse Rate : 90/min B.P. 104/67 mm Hg SPO2 99-1-RA

Resp.rate and type of breathing : 22/m.

Rash –

Lymphadenopathy –

Oedema : –

Allergies (if any): –

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : (N)

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

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Accidental hit over @ eyebrow.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

LFT

Planned Management

Procedure at 8pm.
Anaesthetist to see
IV Fluids

Signature of the Doctor:

Name of the Doctor: Dr. Chandiraleka

Date & Time: 21/7/22

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

NOTE: * To be completed by a Doctor within (24) hours of admission.

1. Anticipated Date of Discharge: .....

2. Destination Post Discharge: ☐ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

   ☐ Needs Assistance In:

			Remarks
☐ Medication	☐ Yes	☐ No	.....
☐ Bathing	☐ Yes	☐ No	.....
☐ Eating	☐ Yes	☐ No	.....
☐ Walking	☐ Yes	☐ No	.....
☐ Dressing	☐ Yes	☐ No	.....
☐ Toileting	☐ Yes	☐ No	.....

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: .....

   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/20 11:30PM	SIB Dr. DEEPAK	
	Assis: (R) Eyebrow Laceration	
		Wound debridement + minor suturing
	Child reviewed Child asleep	
	CVS: S1S2 (+) RS: VBS (+) P/A: soft CNS: NFND	
	LE: -> Dressing intact -> NO leakage	
		Rx -> Continue as per chart -> TV monitor vitals & observation
		Sign

Patient Sticker

418

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It takes a lot to treat the little.

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Stick

(4)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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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						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

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DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: NKC ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

Weight. 38kg Ward. A 20

DRUG :	Inj CEFAZOLIN		
Dose	Route	Frequency	Start Date
400mg	IV	Q8H	2/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time		
22/7		
12	PM	
AM	MA	
8	VB	
AM	BL	
4		
PM	D1	

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Patient Sticker

Weight 38/9 Ward. 420

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 38kg Ward. 420

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
21/7	6pm	0.9% DNS	IV	80ml/hr	[signature] 19124	[signature] 006681			
21/7/16	8:30 pm	200ml RL	IV	200 ml	[signature]	[signature] GD	22/7	[signature]	[signature] GD

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: A20

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

** C- Continue, DC - Discontinue*

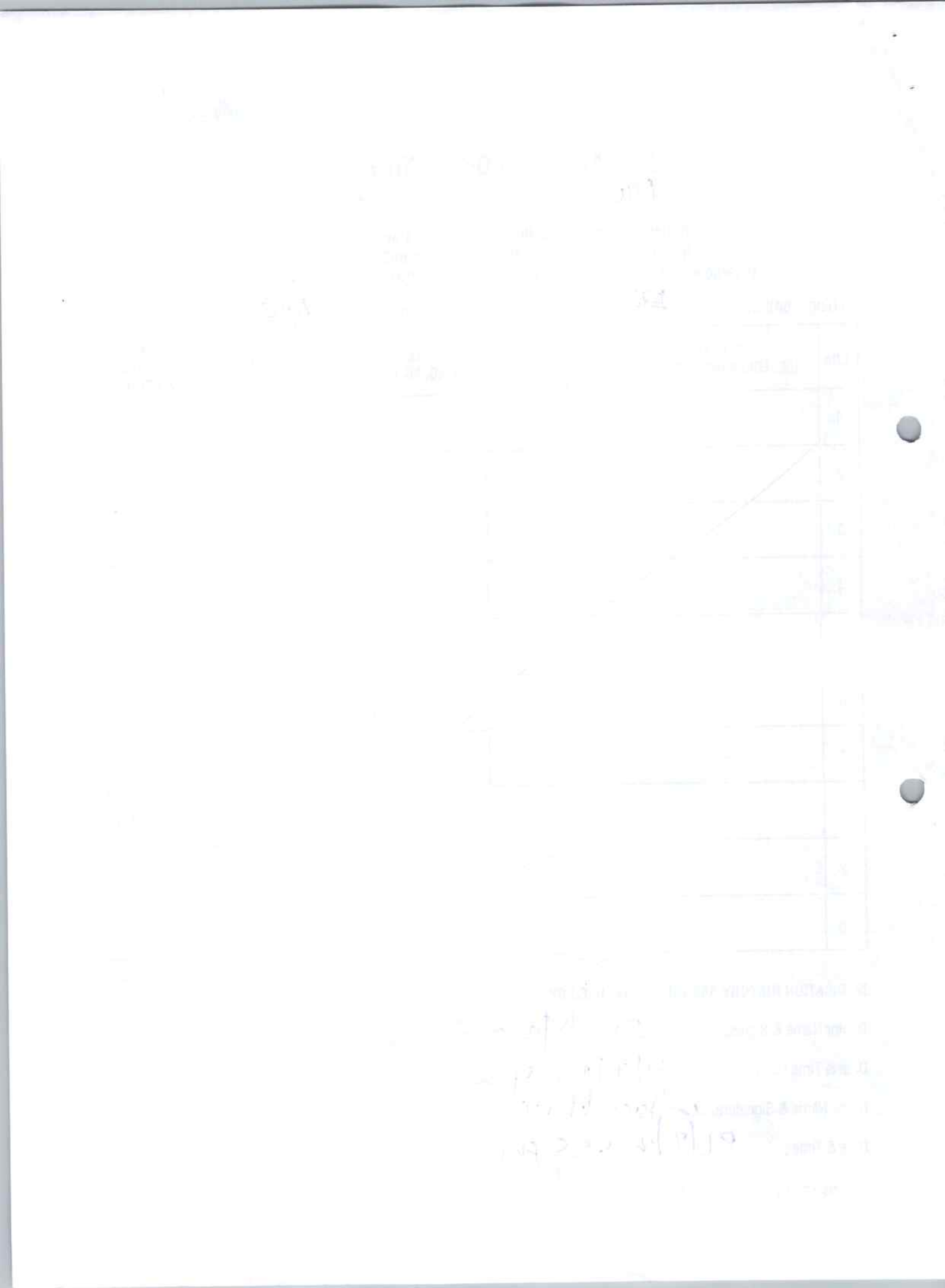
MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Maanasa

Date & Time : 21/7/24, 5pm

Nurse Name & Signature:

Date & Time : 21/7/24 05PM



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CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time:	5.30pm	9pm	11pm	4am.	
Doctor / Nurse / Family Concern?					

Temperature (°F)

	98.4°F	98.6°F	98.6°F	98.4°F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

	105 (71) 62	100 85 70	102 69 86	92 (60) 32
Heart Rate (Number)	110 bpm - 85 bpm	92 bpm	88 bpm	

Resp. Rate (bpm) (Over 1 Minute) *

	20			
Resp Rate (Number)	24 bpm	20 bpm	22 bpm	20 bpm	20 bpm

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		98%	99%	98%	99%	99%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0
Pain Score		0	0	0	0	0
Observer's Initials		VB	RR	PV	PM	PM

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.

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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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FLUID CHART

Sheet No. : 1

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.

21/17.		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			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	→ child received from ER to 4th floor										
	06:00 pm	NPO		IVFDNS 80ml							0	Bali
	07:00 pm			80ml							0	Bali
Total Intake :				160ml		**Total Output :** NIL						
	08:00 pm											
	09:00 pm			RL 200ml						—	0	
	10:00 pm									—	0	
	11:00 pm			80ml							0	
	12:00 am			80ml							0	
	01:00 am			80ml						✓	0	
Total Intake :				240ml		**Total Output :** Nil						
	02:00 am			80ml							0	
	03:00 am	Tab Dol	Tab Dol	80ml							0	
	04:00 am			80ml							0	
	05:00 am			80ml							0	
	06:00 am			RL							0	
	07:00 am	Tab Dol	Tab Dol	RL						✓	0	
Total Intake :		20ml + 320ml				**Total Output :** Nil						

Total 24 hrs. Intake	80 + 240 + 750ml	Total 24 hrs. Output	2 Nil Urine

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Accidental hit (R) eyebrow.

Arrival Time: 5:15pm Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 38 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: —

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: 38 KG Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.4°F HR: 110 b/mt RR: 24 b/mt BP: 105/62 (71) mmHg

Pain Score: Nil Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 9 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 25) (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 ..... Family Members. .....

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 ..... Mother. .....

Nurse's Name: ..... Balapriyanga Date: ..... 2/1/17 ..... Time: ..... 6pm ..... Signature

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/07/26 Time of arrival : 4.00pm

Chief Complaints: H/o. Accidental Fall down - (R) eyebrow Laceration RBS: .....

Height : ..... Weight : 38kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: N/C

If yes , identify N/C

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0/10 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

N/C

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: N/C (Date/Time): —

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 10 mins

Time	Nursing Notes
21/07 4.00pm	The ptalen came for ER c c/o. Accidental
	fall c/o con (RT) eye brow - Laceration.
	vitals are checked & Recorded. C/s/b Dr.
	Keerthana informed to Dr. Abirami. plan
	for primary suturing @ 8.00pm & sedation.
	IV line given. blood sample sent
	Pt shifted to room.

Samples collected by: S/N. Saniyas Time: 4.58pm

Samples sent by : Time:

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: 90bpm BP: 104/67 mmHg CFT: 4350C	Shift - out from ER to: 420
RR: 22bpm. SPO₂: 99% RA	Time of Shift - out: 5:20pm
GCS: 15/15 Temperature : 97.2F	Handover given to: S/N. Anuja (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): NIL	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done. (L) median vein Jelco/Venflon - 22G

Name of the Nurse : CK. Aesheeya ms Signature of the Nurse : CK [signature]

Date & Time : 21/07/26 @ 5.25pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandrasekar Date : 21/7

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: 38kg

Allergic History: .....

Chief Complaints: .....

Accidental fall & hit

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: –

Medication History: –

Relevant Investigations: –

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Breathing

Rate: 22/m SpO_2 on FiO_2 99% RA

Rhythm: .....

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AAE (+)

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Circulation

HR: 90/min CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 104/67 mmHg

Pulse Volume: [Central ..... / Peripheral .....]

If in Shock: [Compensated ..... / Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU: .....

Pupils: [Responsive ☐ Non-Responsive ☐ / Size [Right ..... / Left .....]]

Active Seizures: ☐ Yes ☐ No Sugars: .....

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: 97-2F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: .....

.....

.....

Labs Planned: .....

.....

As per chart

.....

.....

.....

.....

Treatment Planned: .....

.....

As per Chart

.....

.....

.....

.....

Need for Oxygen: ☐ Yes ☐ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by

Name of the Doctor: Dr. Chandiraleka

Signature: .....

Date & Time: 21/7/26

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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EMERGENCY ROOM TRIAGE FORM

Wt: 38 kg

Patient's Name : Mst. SENTHAZHALAN Age : 10 yrs. Gender: ☑ Male ☐ Female

Date : 21/07/26 Time of Arrival : 4.00pm

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): NIL ☐ Not known

Source of Information : ☐ Parents ☐ Others (Specify) NIL

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.2 F PR: 90/min BP: 109/67(80) RR: 22/min SpO_2: 99% Laceration

Chief Complaints: H/O. Accidental fall down. - (RT) Eyebrow.

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 : 3 min

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 : C/C. Akshaya Mistry

Signature of Triage Nurse : C/C

Date & Time : 21/07/26 @ 4.05pm

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

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

Date & Time of Admission	Date & Time of Transfer Order
21/7/26 @ 3:42pm	21/7/26 @ 5:20pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Abirami Krithiga	Dr. chandraleya	further mgmt

From Unit	To Unit	Information to Attendant
ER	420	Yes ☐ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
(5)	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	NS 500ml	(1)
2.	RL set	(1)
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Syed	Dr. Mamta.

Patient & Clinical Records Received by : Kathiga / 30/7/26

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

GUC-00078290 IP18-00036566
Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

Master K.S SENTHAZHALAN
30-05-2016 10 Y 1 M 21 D (M)
Dr. ABIRAMI KRITHIGA J

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

Docu. No. : RCH /FRM / CLINICAL / 162

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor