GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 30/7/26

Patient Name: Baby. S. Ananya Date of Birth: 21/3/2023 Age: 3yr

Gender: Female Ward : OT UHID No.: 94485 / 36684

Date of Surgery: 30/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : closed Reduction + percutaneous kwire Fixation (R) Humerus

Time in : 2:30pm Time Out : 3:30pm.

	NAME	AMOUNT
1. Surgeon	: Dr. Sai Suchitra	
2. Anaesthetist	: Dr. mohan	
3. Assistant Surgeon	:	
4. OT Technician	: Mr. Raja, Mr. Sudhakshan	
5. Circulating Nurse	: C/N: Thanushya	
6. Assistant Nurse	: S/N: Sika:	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☑ C-ARM (2:45pm 1735057 3:10pm) ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Round finalized by Sr. Sangeetha 607871.

Signature of the Surgeon

Signature of Circulating Nurse

Order No: ..... Order by: .....

Patient Sticker

K-wire

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CONSUMABLES OF OT

Circulating staff: Vrann   Technician: Puja   Date: 30/7/21   Time: ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack [illegible]		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / (P) / N		3				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		3				Vaccum Suction Set		
05 cc		2	Gloves PF 7½		02	Surgical Gloves		
02 cc			S.C 7		01	Gauze Pack		
01 cc			5½ PF		1	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set Dripset		1	NG tube			Koochies (S)		
RL		1	Cautery pencil			POP 10 cm		02
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			Elastomull 10cm		02
			Ointments			D water 10ml		3
			Suction Catheter			10cm Vein-O-Line		1
Fentanyl		1	Cap, Mask			Soft Roll 10cm		1
Morphine			Gauze Pack		04	Xoritas 750mg		1
Ketamine			Mop Pack			C-Arm cover		1
Propofol		1	Steristrip			K-wire 1.8		2
Rocuronium			Underpad					
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					
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon   Anaesthesiologist   Nurse   OT Technician

Order No. : ....   Ordered by : ....

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

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	IP18-00036684	**Ward**	8F-OT COMPLEX
Patient Name	Baby S ANANYA	**Bed Name**	PRE OP 807
Age/Sex	3 Y 4 M 9 D / Female	**Order No**	18-0001735046
Date	30/07/2026 16:21	**Prescription No**	PRIP18-0629993
Payor	SELFPAY	**Dispensed Date**	30/07/2026 16:22
UHID	GUC-00094485		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	3	28.13	84.39
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	2	21.56	43.12
3	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	3	2.58	7.74
4	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	20326S08G	05/28	3	32.34	97.02
5	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	1	69.10	69.10
6	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP291047	11/28	1	22.31	22.31
7	PEDIADRIPSET PLUS	ROMSONS		G26A020267	12/30	1	311.00	311.00
8	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
9	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
10	XORITAS 750MG INJ	AQUITAS HEALTHCARE PVT LTD	H	H122506B	07/27	1	318.28	318.28
						Total :	**1,335.14**	**1,482.80**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 30-07-2026 16:22

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA 600015
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6	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP291047	11/28	1	22.31	22.31
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9	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
10	XORITAS 750MG INJ	AQUITAS HEALTHCARE PVT LTD	H	H122506B	07/27	1	318.28	318.28
						Total :	**1,335.14**	**1,482.80**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

rinted Time : 30-07-2026 16:22

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	IP18-00036655	**Ward**	8F-OT COMPLEX
Patient Name	Baby ANVIKA V	**Bed Name**	PRE OP 806
Age/Sex	7 Y 0 M 15 D / Female	**Order No**	18-0001734663
Date	29/07/2026 22:24	**Prescription No**	PRIP18-0629978
Payor	SELFPAY	**Dispensed Date**	30/07/2026 15:15
UHID	SNC-00019260		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	CAMERA COVER	Diamond Medicare	GENERAL	O04	02/29	1	57.80	57.80
						Total :	**57.80**	**57.80**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

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
DL NO :
CIN : L85110TG1998PLC029914
Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036684	Ward	6F-PRIVATE
Patient Name	Baby S ANANYA	Bed Name	PVT 602
Age/Sex	3 Y 4 M 9 D / Female	Order No	18-0001735101
Date	30/07/2026 18:56	Prescription No	PRIP18-0630045
Payor	STAR HEALTH AND ALLIED INSURANCE CO LTD	Dispensed Date	30/07/2026 18:56
UHID	GUC-00094485		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	K-Wire 1.8mm x 300mm			A251	02/28	2	260.00	520.00
						Total :	260.00	520.00

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

rinted Time : 30-07-2026 18:56

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PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: 31/7/26

GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

Gender: F

Room No: 609/

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign	Nurse Sign	Pharmacy Sign
Date:	Date: 31/7/26	Date: 31/7/26
Time:	Time: 8.30am	Time:

Docu. No. : RCH /FRM / GENERAL / 117

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	31/7/23 at 8Am		Anuply Das				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

tant: ..... Dept: .....

Date of Admission: .....

of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/7/26.	1:40pm.	ER	602	
30/7/26	2pm	602	OT	
30/7/26	4:35pm.	OT	602	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC	30/7/26	1738496	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
30/7/26.	~~CBC, PT/APTT/INR~~	26024423	
30/7/26	RBS	26024422	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
30/7/26	C-Arm	2:45 pm	3:10 pm	1735037	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
30/7/26	IV line placement	(1)	1134964	

ANY OTHER INFORMATION:

Procedure Name: closed + Percutaneous K wire Fixation
Right humerus.
Surgeon Name: Dr. Sai Suchitra
Anaesthetist: Dr. mohan.
Anaesthesia: I/V GA
In time: 2:30pm out time: 3:30pm

Date: 31/7/26 Time: 8AM Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- 6th Floor ~~NAME~~ NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing	31/3/26 @ 10.15 am	31/3/26 @ 10.30 am	Renuka OPD		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP18-00036684 **Admit Date** : 30-Jul-2026 **Admit Time** : 12:57 PM **UHID** : GUC-00094485

Patient Details :

Patient Name	: Baby S ANANYA	**Age**	: 3 Y 4 M 9 D
Guardian	: Mr SHAKTHIVEL SAMBANDAM	**DOB**	: 21-03-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 52/100 L B ROAD ADYAR Adyar Chennai Tamil Nadu INDIA 600020	**Phone No**	: 9884131308
		E-mail	: S.SHAKTHIVEL@LIVE.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 SHAKTHIVEL SAMBANDAM **Relationship** : Father

Contact Address : 52/100 L B ROAD ADYAR Adyar Chennai Tamil Nadu INDIA 600020 **Phone No** : 9884131308

S. Shakthivel
Signature

Doctor Details :

Doctor Name : Dr. G SAI SUCHITRA **Specialisation** : ORTHOPEDICS

Referral Doctor : DR G SHARAVANAN **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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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:	**Baby S ANANYA**	**Age :**	**3 Y 4 M 9 D**
IP No:	**IP18-00036684**	**Sex:**	**Female**
Consultant:	**Dr. G SAI SUCHITRA**	**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: > S. Shathu

Name: > SHANTHAVEL SAMBANDAM

Relationship: > FATHER

Date: 30-07-2026 Time: 12:57

Witness Name: BINU

Witness Signature:

Patient Address:
52/100 L B ROAD ADYAR Adyar
Chennai Tamil Nadu INDIA 600020

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

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 : > S. ANANYA	UHID Number : 94485
Self/Attendant Name : > K. YAZHINI	Relation : > Mother
Self/ Attendant Signature : > K. Ananya Phone Number : > 9123592016	Name & Signature of Financial Counselor

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

GUC-00094485
Baby S ANANYA IP18-00036684
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: ______________________ Age/Sex ______

Information given by: ______________________ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

C/o -> fall from bed
yesterday

History of present illness :

H/o -> fall from bed yesterday
evening.
↓
Had swelling of Arm
pain
↓
X-ray -> done at outside -> type 3
supracondylar fracture.
↓
planned for.

- Able to move fingers
- NPO from Night 10pm
- No h/o fever, cough/cold
- No h/o seizure/wheeze/any other medical
illness
- Not on any medication
- No h/o drug allergy

Patient Sticker

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

No past admission

Birth & Neonatal History:

1st child / NVD / No NICU stay /
B.Wt – 2.75 kg /

Family Chart

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

(N)

Immunization History :

upto Age

Anthropometry :

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

Weight (kgs) 15.3 kg (Centile ______)

On Examination :

Temperature : 98°F Pulse Rate : 123/min B.P. 108/84 mm SPO2 97% RA

Resp.rate and type of breathing : 30 bpm

LE

Rash (R) Arm swelling (+)

Lymphadenopathy above elbow.

Oedema : Able to move finger

Allergies (if any): Distal pulse well felt

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS (+)

Any addes sounds : BLAE (-)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur : No 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 : Alert, GCS-15

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: (R) Type 3 - Supracondylar fracture planned for closed reduction, k-wire fixation

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs: RBS - 89 mg/dl

CBC
PT/APTT/INR

Planned Management

- NPO
- procedure at 2pm
- IVF

Signature of the Doctor:

Name of the Doctor: Dr. Manoma

Date & Time: 20/7/26, 12 pm

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 Facilty 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-00094485
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA
IP18-00036684 A (1)

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30/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/B Dr. Suchitra (ORTHOPAEDIC SURGEON)	
30/7/26 12:15	Fell from cot at home yesterday (29/7/26)	
	Went to local hospital today morning	
	Came here for further management	
	O/E (R) arm supported in arm sling	
	Swelling, Tenderness around (R) elbow	
	Radial, Ulnar, Median — neurology intact	
	CRT < 2 secs	
	XR c/o type 3 supracondylar fracture (R) humerus	
	Plan	
	Maintain NPO	
	CRP & k wire (R) distal humerus	↓ GA today 2:00 pm
	CBC, PT/APTT	
	T/c F.	
	Dr. SUCHITRA (83742)	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/24 5:10PM	S/B Dr. Deepak	
	Ao. (R) Supracondylar Humerus # Gartland-3	
	Child reviewed	
	Received from OT	
	O/E:	
	alert, afebrile	
	CVS: S1S2 (P)	
	RS: NVBS (+)	
	P/A: soft	
	CNS: NFND	Stools / Urine / not passed
	L/E:	
	(R) POP applied	
	CRT < 3 secs	
	All fingers mobile	
	→ Advise to break NPO at 6pm after discussing c̄ Sai Suchitra ma'am	
	→ To start IVF 0.9% DNS 50ml/hr	
	To monitor for finger movements	
	CRT	
	To monitor vitals monitoring	

[signature] 10PM

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

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Dr. G SAI SUCHITRA

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/7/26		
9pm	S/B Dr. Manna	
	Reviewed	
	Afebrile	
	(R) POP → in place	
	Able to move fingers	
	pain - less, CRT < 2 sec	
	pink.	
	PP - HE	
	tolerated orals	
	R.	
	→ Cont same	
	- Syp. Paro (101)	
[signature]		

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 30/7/26 Drug Allergies: NIL ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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: Syp. Pa 500				Date/Time	30/7	31/7
Dose: 5ml	Route: P/o	Frequency: QGH	Start Date: 30/7/26	9.30 pm	SS	5.30 am
Doctor's Signature:	Valid Period:	Pharm.			AA	AA
Additional Instructions: 4t pain (P)						SS

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:						

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 15.3kg Ward. 6th rdo

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

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

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

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

Patient Sticker	Weight. .... Ward. ....

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
						PT
30/7/26	2:40pm	[illegible]	[illegible]	IV	[illegible]	SK / PT
30/7/26	3:20pm	Paracetamol	250mg	PR	[illegible]	SK

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I.V. FLUIDS CHART

Weight. 15.3 kg Ward. [illegible]

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
30/7/26	12pm	0.9 % DNS	IV	50 ml/hr	[illegible]	[illegible] / SD	30/7/26 @5:20 pm		[illegible]
30/7/26	2:30 pm	200 ml 1-1 [illegible]	iv	250 ml	[illegible]	PT / [illegible]	30/7/26	[illegible]	PT / [illegible]

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

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

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/26 Time: 1.50pm 4pm 8pm 12am 4am

Doctor / Nurse / Family Concern?

Temperature (°F): 98.5 | 98.6°F | 98.5°F | 98.0 | 97.8°F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 118/mt | 120b/m | 110 b/m | 112bm

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

Resp Rate (Number): 28/mt | 28b/m | 28b/m | 28bm

Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	RA 98%	RA 99%	100%	98%	98%
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	[illegible]	✓	[illegible]	[illegible]	[illegible]

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.

30/7/26		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	Recd		from		PR	at	1.50 pm			0	[illegible]
	01:00 pm	Npo		50ml						nil		
Total Intake :		Npo + 50ml				Total Output : Nil						
	02:00 pm										0	[illegible]
	03:00 pm		Npo	250ml								
	04:00 pm										0	[illegible]
	05:00 pm											
	06:00 pm	H2O	20ml							✓	0	[illegible]
	07:00 pm		Levipil	100mg								
Total Intake :			350ml			Total Output : 1 time						
	08:00 pm	H2O	25ml									
	09:00 pm									✓	0	[illegible]
	10:00 pm	H2O	20ml								0	[illegible]
	11:00 pm									✓		
	12:00 am										0	[illegible]
	01:00 am	H2O	30ml									
Total Intake :		75ml				Total Output : 2 time						
	02:00 am									✓	0	[illegible]
	03:00 am											
	04:00 am	H2O	20ml								0	[illegible]
	05:00 am											
	06:00 am									✓	0	[illegible]
	07:00 am	H2O	30ml									
Total Intake :		50ml				Total Output : 2 time						

Total 24 hrs. Intake	525ml	Total 24 hrs. Output	5 time

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Dr. G SAI SUCHITRA

NURSES NOTES

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☑ ~~No Known~~ Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On Admission note.	
20/7/24	1.50pm	Child Received from ER	
		to 6th Floor child details	
		hand over from ER staff	
		child came from K wire	
		Fixation procedure @ 2pm.	
		IV line pattern is health	[signature]
		and observed.	
	1.55pm	Child vitals checked	
		and Recorded. vitals Normal	
		4 | ff. | CFT	
		++ | ff | Less	
		child IV fluids is 0.9%	[signature]
		NS - 50 ml/hr. on flow	
	2pm.	Child shift to OT.	
		Hand over given from	[signature]
		OT staff	
		OT Notes	
30/7/26	2pm	⇒ child received from 6th floor	
		Child conscious and oriented.	
		⇒ Anaesthesia given by Dr. mohan.	
		under GA.	
		⇒ surgery done by Dr. Sai suchitra	
		under Aseptic precaution.	[signature]
		⇒ K wire Fixation done.	
		⇒ Antibiotic given Inj supacef 700mg.	
		intraoperative	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
30/7/26	3:30 pm	=> child shifted to Recovery area.	
		=> child conscious.	60781
	4:35 pm	=> child shifted to 6th floor	
		Child handover to 6th floor staff	6078
		child received from OT	
	5.30 pm	2hours NPO, child	
		vital signs checked	
		& Recorded. CP PP CRT feel feel <3	
	5.30 pm	Tc water given, kanji	
		had no vomiting complain	
		P250 5ml TDS others	
		no medication	
30/8/26	6pm	Tommorrow plan discharge 20/8/26, cast removed	
		plan maintain	
		I/O charts.	
		others no complaint	
		child details on urolysis	
		no need IVF fluids.	
	7.30 pm	Child details handover	
		given to night duty	
		Staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night duty notes.	
30/7/26	7.30pm	child details hand over taken form evenig duty staff. child consious & active.	Seu 01ssq2
	8pm.	child vitals checked & recorde temp is normal. CP ++ / PP ++ / CRT <3sec	Seu 01ssq2
	9pm.	child compiaints pain is more.	
	9.30pm	child medication syp-P250 5ml given. →	Seu 01ssq2
	10pm	child IV line (F) IV line observed & healy. no other compiaints →	
	12am	child vitals checked & recor temp is normal. CP ++ / PP ++ / CRT <3sec	
		I/O chart maintaind →	Seu 01ssq2
	2am	child sleeping well. no other compiaints →	Anu 0200
	4AM	→ child vital signs checked and record. vitals are stable. PP ++ / CP ++ / CRT <3sec	Anu 0200
	6AM	→ child intake and output maintained & record.	Anu 0200

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26	7.30pm	→ child detail hand over given to morning duty SIN	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name:..
MRD NO:........ GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA
Age :.............. ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 30/7/26 Time: 12pm.
Location : (L) metacarpel
Size : 22G.
Cannula inserted by : S/N Shibu

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
30/7/26.	12pm.	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
30/7/21	12:30pm	☐Yes ☑No	☐Yes ☑No	patterne	[illegible]
	4pm	☐Yes ☑No	☐Yes ☐No	obseo	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observ	ss/ow
21/7	12 Am	☐Yes ☑No	☐Yes ☑No	observ	ss/ow
	4Am	☐Yes ☑No	☐Yes ☑No	observ	ss/ow
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

CANNULA 2

Date : Time:
Location :
Size :
Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

NOTE : ✱ To be assessed within 30 minutes of insertion.
✱ Every 2 hours if on fluid infusion.
✱ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)........ Next page

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes-date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

NOTE : ❋ To be assessed within 30 minutes of insertion.
❋ Every 2 hours if on fluid infusion.
❋ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)

0	1	2	3	4	5
IV site appears healthy	ONE of the following is evident: ❋ Slight pain near I.V. site or slight redness near I.V site	TWO of the following is evident: ❋ Pain near I.V. Site ❋ Erythema ❋ Induration	ALL of the following is evident: ❋ Pain along path of cannula ❋ Erythema ❋ Induration	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord ❋ Pyrexia
OBSERVE CANNULA	OBSERVE CANNULA	RESITE / REMOVE CANNULA	RESITE / REMOVE CANNULA CONSIDER TREATMENT	RESITE / REMOVE CANNULA CONSIDER TREATMENT	INITIATE TRETMENT RESITE / REMOVE CANNULA

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: (R) Supracondylar Fracture
Arrival Time: 2.50pm Mode of Arrival: Carrying Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 15.3 Kg

..... Height: ..... cm

.....

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

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

Family History: Nil

.....

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

If yes please list, ...

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

.....

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

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

Observations: Weight: 15.3kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.5°F HR: 118bl/m RR: 30br/m BP: 105/76(71)

Pain Score: 2/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)

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

Risk of Pressure Sore (Braden Q Score 27) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With ..... Parents .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Mothers .....

Nurse's Name: ..... Date: 2017/26 Time: 2 Pm Signature

BG → B(+)

NPO → 8:30 pm

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wt → 15.3 kg

TRIAGE FORM

Patient's Name : ANANYA Age : 3y4m Gender: ☐ Male ☐ Female

Date : 30/07/20 Time of Arrival : 11:30 am.

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: 98 F PR: 123 BP: 108/84 (73) RR: 30 SpO2: 97%

Chief Complaints: H/O K-wire fixation

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 : 8 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 : Shibu Debnath.

Signature of Triage Nurse : SD

Date & Time : 30/07/20 @ 11:32 am.

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

11:40Am - Syp. Ibugesic - 5ml

Syp. P250 - 5ml

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/7/26 Time of arrival : @11:30am

Chief Complaints: K-wire fixation. RBS: 84 mg/dl

Height : – Weight : 15.3kg BMI : – Head Circumference (<2 years) –

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

If yes , identify –

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

–

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: Yes. (Date/Time): 30/7/26 at 11:30AM.

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse : 15 mins

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

Time	Nursing Notes
11:30am	patient came to ER for c/o.
	Procedure K-wire fixation.
	closed reduction. After investigation
	Dr. Sai sukitha advised for admission
	vitals are checked and recorded.
	IV line placement done samples are
	collected and sended to lab patient shifted
	to ward.

Samples collected by: G/N Shibu Time: 12pm.

Samples sent by : G/N praveen 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: 120 BP: 100/80 mmHg CFT: <3sec	Shift - out from ER to: 6.02
RR: 30 SPO_2 : 100%	Time of Shift - out: 1:40pm
GCS: 15/15 Temperature : 98°F	Handover given to: G/N Shehnaz (Nurse's Name)
Pain Score: 6/10	
Repeat RBS (if applicable): 84 mg/dl.	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done. ⓓ metacarpal 22G.

Name of the Nurse : Praveen Signature of the Nurse :

Date & Time : 30/11/20 at 11:32am.

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Docu. No. : RCH /FRM /

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

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKA ☐ 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: GOT

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. Manoma

Date & Time : 30/7/26, 12 p.m

Nurse Name & Signature: praveen

Date & Time : 30/7/26 at 12pm

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
30/9/26.	12pm	84 mg/dl	—	

Docu. No. : RCH /FRM / CLINICAL / 185

PATIENT TRANSFER FORM

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Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

Date & Time of Admission	Date & Time of Transfer Order
30/7/26 at 12:57pm	30/7/26, 1:40pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Sai Suchitra	Dr. Manoranjan	Further management

From Unit	To Unit	Information to Attendant
ER	602	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS 500ml	(1)
2.	Intrapion	(1)
3.		
4.		
5.		

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

(R) type III Supracondylar fracture, planned for closed reduction and K-wire fixation

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Praveen Kumar	Dr. Manoranjan

Patient & Clinical Records Received by :

Date & Time of Patient Received : 30/7/26 @1:50pm

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

Unavailable Bed | Nurse not Available | Available Bed not ready

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Dr. G SAI SUCHITRA

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OPERATION NOTES

Surgeon : Dr. Sai suchitra	Asst. Surgeon :
Anesthetist : DD mohan	OT Nurse : S/N. Siva.
Pre-Operative Diagnosis: Right Type 3 Gartland Supracondylar humerus fracture	
Surgical Procedure : Closed reduction + percutaneous k-wire fixation (R) humerus	
Weight :	Date : 30/7/26 Start Time : 2:45pm End Time : 3:20pm
Post Operative Diagnosis:	
Peri-Operative Complications:	
Operation Notes:	
Findings: ↓ LMA, patient supine, arm supported on arm board, draping done. C-arm used throughout Closed reduction done and found to be satisfactory.	
Procedure Notes: 2 lateral divergent 1.8mm k-wires passed and cut and bent. ↓ stability check A/E back slab given.	
Amount of Blood Loss:	Blood Transfused (in ML)
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:	1) Limb Elevation & Encourage active finger movements 2) Analgesia 3) Home tomorrow
Wound Care:	4) R/V 3 weeks for XR + K wire and Cast removal 20/8/26
Drain /Special Lines/Catheters:	5) Cast completion before discharge
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: 30/7/26, 15:20

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Dr. G SAI SUCHITRA

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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: OT Shifted to: 602

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	Paracetamol	250mg	PR	STAT	30/7/26 @ 3:20 pm	☐ C ☑ DC
2	Inj. SUPACEF	750mg	IV	STAT	30/7/26 @ 2:40 pm	☐ 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 : [signature]

Date & Time : 2/20/2026 0315

Nurse Name & Signature: Thanuly. [signature]

Date & Time : 30/7/26 @ 4:35 pm

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sai Suchitra
Asst. Surgeon : -
Anaesthetist : Dr. Mohan.
Scrub Nurse : S/N. Siva.

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..... Age : ..... Gender : .....
ry Name : .....
2.20pm Out-time : 3:30pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:32 pm.

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 : .....

Before Skin Incision ➤➤

TIME OUT Time: 2:35 pm.

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 : ..... (P3742)

Before Patient Leaves Operating Room

SIGN OUT Time: 3:30pm.

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

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

Signature : .....

Name : S/N. Siva.

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PATIENT TRANSFER FORM

GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

	Date & Time of Admission: 30/7/26 @ 12:57pm	Date & Time of Transfer Order: 30/7/26 @ 4:35pm
Treating Consultant Name: Dr. Sai Suchitra	Transfer Ordered by: Dr. Mohan.	Reason for Transfer: For further management
From Unit: OT	To Unit: 602	Information to Attendant: Yes ☒ No ☐
Number of Sheets in Clinical File: 1 Ip 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
60789	Dr. Mohan.

Patient & Clinical Records Received by :

Date & Time of Patient Received : 30/7/26 @ 5pm.

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-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 30/4/26 @ 4:35pm OT **TRANSFERRED TO :** 6th 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	Yes	
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	NA	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NA	
	b.Reassessment done	NA	
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	NA	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	NA	
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:		
	Receiving Nurse :		
	Signature of Incharge: For		

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: S ANANYA Age: ..... Sex: ..... UHID.No : .....

Date: 30/7/26 Time: ..... Proposed Operation: Supracondylar Fracture

Diagnosis: .....

B.P / CRT: ..... H.R: 100/min Weight: 15.3 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12	Glucose:	Protein:	HIV:	X-Ray:	
PCV:	Urea:	Alb:	HBS Ag:	ECG:	
WBC:	Creat:	Total Bill:	HCV:	2D Echo:	
Plate: 3 lakhs	Na:	Dir. Bill:	Blood group:	Stress/Anglo:	
PT:	K:	LDH:	T3	Other: Inves pending	
PTT: WNL	Ca++:	Alk phos:	T4		
INR:	Mg++:	Amylase:	TSH		
	Cl -:	SGOT/SGPT:			

Allergies: NKA

Medical History: CVS :

RESP : Diabetes :

CNS : H/o Fall in bed

Renal : No H/o Wheezy / Runny nose / Fever

Hepatic / GE : Physical Activity:

Others : No H/o prev surg

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE (P)

Heart: S1S2 (P)

CNS: WNL

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:

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:

To do Hb% Platelets PT, APTT

Signature: ..... Name: SANANYA

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status: [illegible]	
Physical Status:	Patient Identified	☐ Consent Present	☐ Chart Reviewed

H.R: [illegible]	B.P / CRT: 90/[illegible]	SpO_2: [illegible]	R.R: [illegible]	Last Feed: [illegible]

Pre-OP Diagnosis: .... Operation: .... Date: 30/[illegible]

Surgeon: Dr. [illegible] Anaesthesiologist: Dr. [illegible] Technician: [illegible]

TIME
N_2O / AIR / O_2 LPM
HALO / ISO / SEVO [illegible]
Drugs:

- SUPANAF? [illegible] (IV)
- PROPOFOL 50mg
- FENTANYL 30mcg
- PARACETAMOL 250mg [illegible]

FiO_2 / SaO_2 — 100 — 100 — 100
$ETCO_2$
ECG — [illegible] — [illegible] — [illegible]
Temperature
Urine Output

Fluids / Blood: 1 [illegible] — 1[illegible] [illegible]

Antibiotic
Suppository
Blood Loss
NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

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: [illegible]
☐ Art Site: ....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine

☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 2:20pm
OP Start: ....
OP End: 3:15pm
Leave OR: ....

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ SGA 2 [illegible]
☐ 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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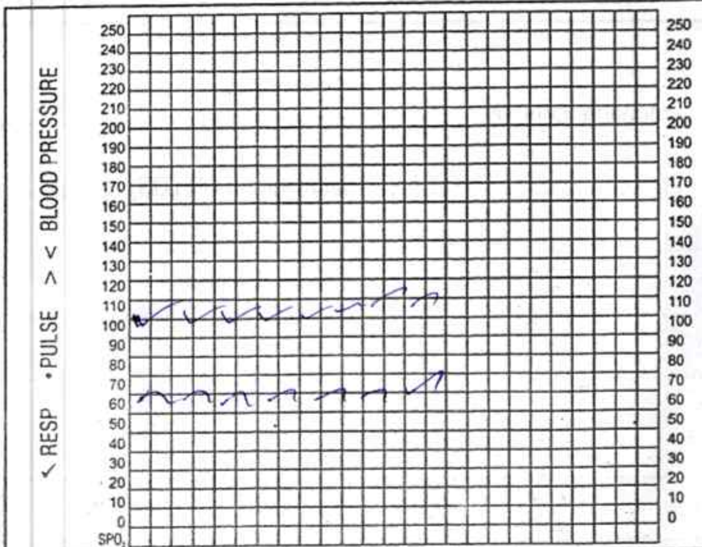
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Thanu   Time Received: 3:30 pm   Time Discharged: 4:35pm



IV Cannula Site: ....

☐ O₂ 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	10/10					

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			[illegible]	
			Syp Paracetamol 150mg PO.	

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

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

PACU Nurse Name: Thanu
PACU Nurse Signature: ....
*Date & Time: 30/7/26 @ 3:30 pm

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

Transferred to Unit by (PACU): ....
Date & Time: 30/7/26 @ 4:35 pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

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

UHID NO: .... Surgeon Name: .....

Anaesthesiologist : SATHISH CHANDRA Operative procedure planned : K wire fixation (RT) Elbow

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, dehydration.

- 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 : K. Jyothi

Name : MRS YAZHINI

Relationship with Patient: Mother

Date & Time : 30/7/26

Witness :

Signature : K. Jyothi

Name : .....

Date & Time : 30/7/26

Doctor (who is taking the consent) :

Signature : ..... Name : SATHISH Date & Time : 30/7/26

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

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)

..... Right distal humerus closed / open reduction and K wire fixation + POP application upon .....

(Name of the Patient)

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

I have been explained 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.

..... Infection, bleeding, neurovascular injury, stiffness, plate complications, delayed or malunion, compartment syndrome, K wire loosening .....

My signature on this form indicates that

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

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

Consentee :

Signature : ..... K. Yazhini

Name : Mrs. YAZHINI

Date & Time : 30/7/26, 14:15.

Patient Attendant :

Signature : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : 30/7/26 @ 14:15 pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. S Chetna

Date & Time : 30/7/26, 14:15

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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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.

.....

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.....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-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

Rainbow Children's Hospital | BirthRight

SSI PREVENTION CHECKLIST

S.No	INTERPRETATION	PERFORMED	
	PREOPERATIVE		
1	Do not remove hair at the surgical site unless the presence of hair will affect the procedure. Use clipper if necessary	NIA	
2	Decolonize surgical patients with skin antiseptic(Chlorhexidine bath /wipes)	NIA	
3	Antibiotic prophalaxis given within 60mts prior to skin incision	NIA	
4	Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice	NIA	
	INTRAOPERATIVE		
5	Using chlorhexidine gluconate and alcohol-containing skin preparatory agent in combination	Yes	
6	Maintain normothermia during the surgical procedure (>36 deg C)	Yes.	
	POSTOPERATIVE		
7	Maintain and monitor blood glucose levels regardless of diabetes status between 110 and 150 mg/dl		
8	Application of incisional negative pressure wound dressing		

Shibu Debnath

Shw / 17890

RCH/GDY/FRM/CLINICAL/322

GUC-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer: 30/07/23 @ 2pm		**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	N/A	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	N/A	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	N/A	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	N/A	
	e.Dressing Intact	N/A	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	N/A	
	b.All drains fixed, output noted	N/A	
	c.Catheter secure & urine output recorded	N/A	
	d.Splints/casts/traction devices stabilized	N/A	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	N/A	
	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	Yes	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	Yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	N/A	
	b.Epidural catheter secure, infusion checked	N/A	
	c.Pressure areas protected (heels/elbows)	N/A	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	N/A	
10	**REPORTS AND LABS HANDED OVER**	Yes	
11	**BIOPSY/HPE SENT**	N/A	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: Shibu Debnath		
	Receiving Nurse : TCOT 6072021		
	Signature of Incharge: Shibu Debnath		

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-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

	Date & Time of Admission	Date & Time of Transfer Order
	30/7/26 at 12.57 pm	30/7/26 at 2pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Sai Suchitra	Dr. Sai Suchitra	Further management
From Unit	**To Unit**	**Information to Attendant**
bo2	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
Case sheet	op file	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
OTN	Dr. Sai Suchitra

Patient & Clinical Records Received by : 601891

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-00094485 IP18-00036684
Baby S ANANYA
21-03-2023 3 Y 4 M 9 D (F)
Dr. G SAI SUCHITRA

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Your Right to a Safe Delivery

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: 602 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 : .....

Nurse Name & Signature: .....

Date & Time : 30/3/23 at 2pm

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

Rainbow Children's Hospital

BirthRight by Rainbow

Laboratory Report

PatientName	:	Baby S ANANYA	Patient Ph.No	:	9884131308
Age/Gender	:	3 Y 4 M 9 D/ Female	Requisition No	:	GU26024422
Bill No	:		Received On	:	
UHID No	:	GUC-00094485	Reported On	:	
Ref.Doctor	:	Dr. G SAI SUCHITRA	Ward / Bed No	:	6F-PRIVATE / PVT 602

RANDOM BLOOD GLUCOSE(POCT)

TEST RESULT STATUS: Report Entered

Test	Result	Unit	Reference Range
RANDOM BLOOD GLUCOSE	84	mg/dl	70 - 140

----------End of the Report----------

Rainbow Children's Hospital

BirthRight by Rainbow

Laboratory Report

PatientName	: Baby S ANANYA	**Patient Ph.No**	: 9884131308
Age/Gender	: 3 Y 4 M 9 D/ Female	**Requisition No**	: GU26024423
Bill No	:	**Received On**	: 30/07/2026 01:27 PM
UHID No	: GUC-00094485	**Reported On**	:
Ref.Doctor	: Dr. G SAI SUCHITRA	**Ward / Bed No**	: 6F-PRIVATE / PVT 602

PROTHROMBINE TIME & ACTIVATED PROTHROMBINE TIME

TEST RESULT STATUS: Report Entered

Test	Result	Unit	Reference Range
PT	15.4	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
APTT	33.8	Seconds	
INR	1.11		
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

Rainbow Children's Hospital

BirthRight by Rainbow

Laboratory Report

PatientName	: Baby S ANANYA	**Patient Ph.No**	: 9884131308
Age/Gender	: 3 Y 4 M 9 D/ Female	**Requisition No**	: GU26024423
Bill No	:	**Received On**	: 30/07/2026 01:27 PM
UHID No	: GUC-00094485	**Reported On**	:
Ref.Doctor	: Dr. G SAI SUCHITRA	**Ward / Bed No**	: 6F-PRIVATE / PVT 602

COMPLETE BLOOD PICTURE

TEST RESULT STATUS: Report Entered

Test	Result	Unit		Reference Range
ABSOLUTE NEUTROPHIL COUNT		10^9/L		1.5 - 8.5
MONOCYTES	10	%		4 - 10
PLATELET COUNT	314	10^9/L		150 - 450
MCV	80	fL		75 - 87
EOSINOPHILS	1	%		1 - 6
ATYPICAL LYMPHOCYTES				
BANDS		%		0 - 14
DISCLAIMER				
MPV	7.8	fL		6.5 - 10
MCHC	34	g/dL		32 - 36
PERIPHERAL SMEAR				
PDW-CV		%		10.0 - 17.9
ABSOLUTE MONOCYTE COUNT		10^9/L		0.28 - 0.78
INTERPRETATION				
MYELOCYTES				
RDW-CV	11.7	%		11.5 - 15
NEUTROPHILS	55	%	H	23 - 45
HEMOGLOBIN	12.0	g/dL		11.5 - 15.5
Differential Count				
ATYPICAL CELLS				
WBC COUNT	10.50	%		
BASOPHILS		10^9/L		5.5 - 15.5
ABSOLUTE EOSINOPHIL COUNT		%		0 - 1
BLASTS		10^9/L		0.17 - 0.47
PROMYELOCYTES		%		
P-LCR				
METAMYELOCYTES		%		11.0 - 45.0
PCV/HCT	35	VOL%		34 - 40
ABSOLUTE LYMPHOCYTE COUNT		10^9/L		2 - 10
MCH	27	pg/cells		24 - 30
RBC COUNT	4.36	10^12/L		3.9 - 5.3
LYMPHOCYTES	34	%	L	35 - 65
PCT		%		0.108 - 0.282