

GUC-00093526

Baby ATHARVA GUPTA

14-04-2022

Dr. DHINESH BALAJI J D

IP18-00036728

4 Y 3 M 20 D

(M)



Rainbow
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Hospital

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DISCHARGE TRACKING SHEET

DATE: 3/2/26

Name of Consultant :

Floor :

UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time		10:10 AM	mg	
2	Arrangement of File by Nurses			02/06/26	
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				



OPERATION NOTES

Surgeon : Dr. Dhinesh Balaji J D Asst. Surgeon :
 Anesthetist : Dr. Sathish OT Nurse : Sr. Sangeetha

Pre-Operative Diagnosis: @ parotid abscess

Surgical Procedure :
 Incision and drainage

Weight : 19.5 kg Date : 3/8/26 Start Time : 8.15 am End Time : 8.40 am

Post Operative Diagnosis: Findings:

Peri-Operative Complications: - Superficial abscess - @ parotid region
 - 3-4 ml pus with panniculitis @
 - Deep fascia - intact

Operation Notes:

Findings:

Procedure:
 - LMA GA, Pt in supine position,
 - I&D was done
 - thorough lavage was given
 - hemostasis was secured

Procedure Notes: - Draining was placed.

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

(A) pus for c/s
 (B) tissue for HPE

POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

POST OP ORDERS (19 kg)

Wound Care:

① Syp. AUGMENTIN DVO (200mg / 5ml)
5ml - 0 - 5ml x 5 days② Syp. P250 (250mg / 5ml)

Drain /Special Lines/Catheters:

5ml - 5ml - 5ml x 3 days

- Discharge today

Special Patient Positioning and Requirements:

- Review in OPD
to be after (7) days

Nutritional Instructions:

E D.

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: Dr. Dhruv Bhatnagar J.DSignature of the Surgeon: [Signature]Date & Time: 03/08/26 9am

SAFETY CHECKLIST

Surgeon : Dr. Dhinesh Balaji
Asst. Surgeon :
Anaesthetist : Dr. Sathish
Scrub Nurse : S/w Sangeetha

Patient Name : Baby Atharva Gupta Age : Gender :
UHID No. : 93526 Surgery Name : J.E.D
Date : 3.18.26 In-time : Out-time :

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Before Induction of Anaesthesia >>

SIGN IN		Time:.....
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 : <u>[Signature]</u>		
Name : <u>Dr. Sathish</u>		

Before Skin Incision >>

TIME OUT		Time:.....
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 : <u>[Signature]</u> (Reg no: 116801)		
Name : <u>Dr. Dhinesh Balaji J.D</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
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 :		

1. $\log_{10} 100 = 2$
 2. $\log_{10} 10 = 1$
 3. $\log_{10} 1 = 0$
 4. $\log_{10} 0.1 = -1$
 5. $\log_{10} 0.01 = -2$

6. $\log_{10} 0.001 = -3$
 7. $\log_{10} 0.0001 = -4$
 8. $\log_{10} 0.00001 = -5$
 9. $\log_{10} 0.000001 = -6$
 10. $\log_{10} 0.0000001 = -7$

11. $\log_{10} 0.00000001 = -8$
 12. $\log_{10} 0.000000001 = -9$
 13. $\log_{10} 0.0000000001 = -10$
 14. $\log_{10} 0.00000000001 = -11$
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 20. $\log_{10} 0.00000000000000001 = -17$

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 25. $\log_{10} 0.0000000000000000000001 = -22$

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 38. $\log_{10} 0.00000000000000000000000000000000001 = -35$
 39. $\log_{10} 0.000000000000000000000000000000000001 = -36$
 40. $\log_{10} 0.0000000000000000000000000000000000001 = -37$



SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia >>

SIGN IN	Time:.....
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 : <i>[Signature]</i>	
Name : <i>Dr. Prateek R</i>	

Before Skin Incision >>

TIME OUT	Time:.....
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 :	

Before Patient Leaves Operating Room

SIGN OUT	Time:.....
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 :	

Handwritten notes at the top of the page, possibly a date or reference.

Handwritten notes in the upper middle section.

Handwritten notes in the middle section.

Handwritten notes in the lower middle section.

Handwritten notes at the bottom of the page.

Handwritten notes on the left side of the page.

Handwritten notes in the bottom center.

Handwritten notes in the bottom right area.

Handwritten notes in the bottom right corner.

PRE - OPERATIVE CHECK LIST

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Patient's Name : Baby. ATHARAV Date: 3/8/26
Age : 473m Gender : ☒ M ☐ F
Blood Group : B(+) UHID : GIUC - 93526
Planned Surgery : I & D Surgeon : DR. Dhinesh Balaji
Anesthetist : DR. Sathish Date & Time of Operation : 3/8/26 @ 9 AM

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 available	☒	☐	☐
16.	Other (if any)	☒	☐	☐

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

Billing Clearance taken

Billing Executive Name : [Signature]

Billing Executive Signature : [Signature]

Date & Time : 3/8/26 @ 7:30 AM

Nurse In-Charge Name : Sushadip

Signature of Nurse In-Charge : [Signature]

Date & Time : 3/8/26 @ 7:30 AM

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: _____ Age: _____ Sex: _____ UHID.No: _____

Date: 2/8/26 Time: 8am Proposed Operation: I & D

Diagnosis: (R) parotid abscess

B.P / CRT: _____ H.R: _____ Weight: 20kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:
Hgb: _____ Glucose: _____ Protein: _____ HIV: _____ X-Ray: _____
PCV: _____ Urea: _____ Alb: _____ HBS Ag: _____ ECG: _____
WBC: _____ Creat: _____ Total Bil: _____ HCV: _____ 2D Echo: _____
Plate: _____ Na: _____ Dir. Bil: _____ Blood group: _____ Stress/Angio: _____
PT: 14.6 K: _____ LDH: _____ T3 _____ Other: _____
PTT: 28.5 Ca++: _____ Alk phos: _____ T4 _____
INR: 1.0 Mg++: _____ Amylase: _____ TSH _____
Cl -: _____ SGOT/SGPT: _____

Allergies: _____

Medical History: CVS: NCD / Term / 3.16kg / C7A8

RESP: _____ Diabetes: (R) developmental diabetes

CNS: vaccinated till date

Renal: _____

Hepatic / GE: _____ Physical Activity: active child

Others: nil comorbid

Past Anaesthetic History: nil prev

Physical Exam:

Airway: MP (2) 3 4 Mouth Opening: Adeq Mento-hyoid Distance: (2) Neck: (R) Teeth: (2)

Lungs: R/L HE (+)

Heart: 2.5 (+)

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:

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: Dr. Pooja Bhatnagar

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:

90/min

B.P / CRT:

80/50

SpO₂:

100%

R.R:

20/min

Last Feed:

Pre-OP Diagnosis:

① femoral abscess

Operation:

I & O

Date: 2/8

Surgeon:

Dr. Querk

Anaesthesiologist:

Dr. Sathya / Dr. Purnima

TIME

H₂O / AIR / O₂ LPM

HALO / SO / SEVO

Drugs:

1g Bupivacaine 50 mg IV
1g Bupivacaine 50 mg IV

Antibiotic

Suppository

Blood / SS

NOTES

FiO₂ / SaO₂ETCO₂

ECG

Temperature

Urine Output

Fluids

Blood

B.P

V Systolic

A Diastolic

X Mean

* Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

200 ml

LAB Values

☒ Equipment Checked and Functional☒ BP☒ Cuff Site:☒ Ar Site:☒ EKG Lead☒ Temp Site☒ FIO₂ Monitor☒ Agent Monitor☒ Pulse Oximeter☒ Capnograph☒ Ventilator☒ Nerve Stimulator

Position:

☒ Pressure Points Checked

Eye Care:

☒ Goggles☒ Tape☒ Padding☒ Awake

Temp:

☐ HME☐ Cling Film☐ Huggers's☐ Other☐ Fluid Warmer☐ OH Warmer☐ Cotton Wool

Times:

Anaes Start:

OP Start:

OP End:

Leave OR:

Anesthesia:

☒ GA☐ Monitored Anaesthesia Care☐ Regional

Line (Size & Location)

☐ CVP:☐ ART:☐ IV:☐ IV:☐ IV:☐ IV:☐ IV:☐ IV:

Induction

☒ IV☐ Pre O₂☐ Others☐ Inhal☐ RSI☐ Mask☐ Airway☐ ETT#☐ Oral☐ Tracheostomy☐ Drug:☐ Awake☐ Video Laryngoscopy☐ Fiberoptic☐ Blade#☐ Attempts:☐ Difficulty Why?☐ Bilat = BS☐ Semi-Closed Circle☐ Closed Circle☐ Other☐ Other☐ Other☐ Other☐ Other

Regional:

Extremity

☐ Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia

Catheter at skin

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:

Specify:

☐ Epidural☐ Caudal

Depth:

Yes

No

cm

cm

cm

cm

cm

cm

cm

cm

cm

cm

cm

cm

cm

Patient Sticker

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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: C/A S. J. L.Time Received: 8:30 AMTime Discharged: 9:50 AM

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 PULSE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 RESP	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)					
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0			IN	MINUTES			OUT	SCORING INTERPRETATION 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:
ACTIVITY			2	30	60	90	2	
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0			2				2	
RESPIRATION			2				2	
BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0			2				2	
CIRCULATION			2				2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0			2				2	
CONSCIOUSNESS			2				2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0			2				2	
COLOR			2				2	
TOTAL			10				10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/8		0/10	npox & hemo	<u>[Signature]</u>

 Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS
Anaesthesiologist Name: [Signature]Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: S. J. L.PACU Nurse Signature: [Signature]*Date & Time: 3/8/26 @ 8:50

Reassessment Frequency:

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

Transferred to Unit by (PACU): S. J. L.Date & Time: 3/8/26 @ 9:50

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

CONSENT FORM FOR ANAESTHESIA



Patient Name : Age : Gender : Male ☐ Female ☐

UHID NO: Surgeon Name:

Anaesthesiologist : SATHISH CHANDRAN Operative procedure planned : Jackson and Drainage

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- | | | | |
|---|---------------------------------------|---|--|
| ☐ Heart disease | ☐ Hypertension | ☐ Diabetes mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : | | | |

- 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 anaesthesia.

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 anaesthesiologist 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 : [Signature]

Name : Rakesh Kumar

Relationship with Patient : Father

Date & Time : 03/08/21

Witness :

Signature : [Signature]

Name : Pradeep

Date & Time : 3/8/21

Doctor (who is taking the consent) :

Signature : [Signature]

Name : SATHISH CHANDRAN

Date & Time : 4/8/21

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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)

Incision and drainage

..... 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, delayed wound healing,

Salivary leak

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. Dhivresh Balasi J.D

Consentee :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : Pankaj Kumar

Name : Pankaj Kumar

Relationship with Patient: Father

Date & Time : 30 Aug 2026 @ 8:03 AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : Dr. Dhivresh Balasi J.D

Name : Dr. Dhivresh Balasi J.D

Date & Time : 03/08/26 8 AM

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

நோயாளியின் பெயர் : வயது : பாலினம்: ஆண் ☐ பெண் ☐

UHID எண் : தேதி:

நீபந்தனைகள்:

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 இந்தப் படிவத்தில் 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.

.....

.....

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்க்கண்டவற்றை குறிக்கிறது:

1. இந்தப்படிவத்தில் கொடுக்கப்பட்டுள்ள தகவல்களை நான் படித்துப் புரிந்துகொண்டேன்.
2. மேலே குறிப்பிட்ட அறுவை சிகிச்சை அல்லது சிகிச்சை செயல்முறையில் உள்ள மேற்குறிப்பிட்ட சிக்கல்கள் ஆகியவற்றோடு இதுவுள்ள 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 பெற்றுள்ளேன்.
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:.....

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

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

GUC-00093526 IP18-00036728

Baby ATHARVA GUPTA

14-04-2022 4 Y 3 M 20 D (M)

Dr. DHINESH BALAJI J D



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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: *et* Shifting to: *4th floor*

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	<i>2 Arginine</i>	<i>100mg</i>	<i>iv</i>	<i>stat</i>		☐ C ☒ DC
2	<i>paracet suppository</i>	<i>250mg</i>	<i>PR</i>	<i>stat</i>		☐ 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. Mohan* Date & Time : *3/8/26 @ 8:50* Nurse Name & Signature: *S. S. Suth* Date & Time : *3/8/26 @ 8:50*

04+

RECEIPT

DATE: _____

TO: _____
FROM: _____
AMOUNT: _____

RECEIVED		PAID	
1	1000	1	1000
2	1000	2	1000
3	1000	3	1000
4	1000	4	1000
5	1000	5	1000
6	1000	6	1000
7	1000	7	1000
8	1000	8	1000
9	1000	9	1000
10	1000	10	1000

RECEIVED BY: _____

DATE: _____

AMOUNT: _____

SIGNATURE: _____

DATE: _____

RECEIVED BY: _____

GUC-00093526 IP18-00036728
 Baby ATHARVA GUPTA
 14-04-2022 4 Y 3 M 20 D (M)
 Dr. DHINESH BALAJI J D



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.....ICATION 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: ward

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	INS ALIMENTIN	600ug	IV	stat	2/8	☒ C ☐ DC
2	PARACETAMOL SUPP 320mg 20mg	20mg	PR	stat	3/8	☐ 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

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature : *[Signature]*

Date & Time : 2/8/25 5am 21 Pm

Nurse Name & Signature :

Date & Time :

Old April

Medication Dr

Prescription

Chronic Care

1
2
3
4
5
6
7
8
9
10

medication history record

medication history record

medication

medication

medication

medication

Medication History Record

Medication History Record

Medication History Record

Medication History Record

Medication History Record

Medication History Record

medication history record

PATIENT TRANSFER FORM

GUC-00093526 IP18-00036728
Baby ATHARVA GUPTA
14-04-2022 4 Y 3 M 20 D (M)
Dr. DHINESH BALAJI J D



Date & Time of Admission <i>31.08/26.07.18a</i>		Date & Time of Transfer Order <i>31.08/26</i>
Treating Consultant Name <i>Dr. Dhinesh Balaji</i>	Transfer Ordered by <i>Dr. Satish</i>	Reason for Transfer <i>Further management</i>
From Unit <i>OT</i>	To Unit <i>420</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>IP file - 1</i>	Number of Imaging Films <i>-</i>	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 <i>S/o Suresh 01750</i>	Name of Person Ordered Transfer <i>Dr. Satish</i>
Patient & Clinical Records Received by : <i>[Signature]</i> 10PM	
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

ATTENT TRANSFER FORM

From: _____
To: _____
Date: _____

By: _____
For: _____
Reason: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____



Date & Time of Transfer: 3/8/26		07 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		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		Yes	
4 Pain Assessment			
a. Pain score assessed & analgesia given		Yes	
b. Reassessment done		Yes	
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		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		No	
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		No	
b. Epidural catheter secure, infusion checked		No	
c. Pressure areas protected (heels/elbows)		Yes	
9 BLOOD AND BLOOD PRODUCTS TRANSFUSED		No	
10 REPORTS AND LABS HANDED OVER		No	
11 BIOPSY/HPE SENT		No	
12 Documentation			
a. Documentation completeness		Yes	
Transferring Nurse: Shw. Suthouren			
Receiving Nurse:			
Signature of Incharge:			

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036728 Admit Date : 03-Aug-2026 Admit Time : 07:18 AM UHID : GUC-00093526

Patient Details :

Patient Name	: Baby ATHARVA GUPTA	Age	: 4 Y 3 M 20 D
Guardian	: Mr PANKAJ KUMAR	DOB	: 14-04-2022
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: VGN MINERVA, BLOCK - K 2, FLAT-T2, THIRD FLOOR, GURUSKLAMY ROAD, NOLAMBUR Maduravoyal Tiruvallur Tamil Nadu INDIA 600095	Phone No	: 8348842198/ 7302943776
		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 PANKAJ KUMAR Relationship : Father
Contact Address : VGN MINERVA, BLOCK - K 2, FLAT-T2, THIRD FLOOR, GURUSKLAMY ROAD, NOLAMBUR Maduravoyal Tiruvallur Tamil Nadu INDIA 600095 Phone No : 8348842198


Signature

Doctor Details :

Doctor Name : Dr. DHINESH BALAJI J D Specialisation : PEDIATRIC SURGERY
Referral Doctor : ~~Dr. Raj Kumar~~ Phone No :
Co-Consultant : (infectious diseases)

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby ATHARVA GUPTA

Age : 4 Y 3 M 20 D

IP No: IP18-00036728

Sex: Male

Consultant: Dr. DHINESH BALAJI J D

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 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:

Relationship:

Date:

Time:

Witness Name:

Witness Signature:

Patient Address:

VGN MINERVA, BLOCK - K 2, FLAT-T2,
THIRD FLOOR, GURUSKLAMY ROAD,
NOLAMBUR Maduravoyal Tiruvallur
Tamil Nadu INDIA 600095

BILLING POLICY

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

DECLARATION

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

Patient Name :	UHID Number :
Self/Attendant Name :	Relation :
Self/ Attendant Signature :	Name & Signature of Financial Counselor
Phone Number :	

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**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

GUC-00093526 IP18-00036728

Baby ATHARVA GUPTA

14-04-2022 4 Y 3 M 20 D (M)

Dr. DHINESH BALAJI J D

UHID ID: _____



Department: _____

Consultant: _____

Name: _____ Age/Sex _____

Chief Presenting Complaints & Duration (Chronologically)

C/O: Right parotid swelling
warmth over zygomatic

C/D: level on 8th x 2deg
a month later

initially treated as OPD

7. oval antibody

Still symptoms persisted
hence planned for Sx

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

Nil

Birth & Neonatal History:

NVD | Term | 3.1kg | CIAB | NVCV

Family Chart



Birth & Socio Economic History:

About Father :

⊕

About Mother :

⊕

Any additional Information :

Developmental History :

⊕

Immunization History :

uptodate

IAP Schedule

Anthropometry :

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

Weight (kgs) 13.7kg (Centile _____)

On Examination :

Temperature : 97°F Pulse Rate : 102/min B.P. _____ SPO2 100% LRA

Resp.rate and type of breathing : ⊕

Rash ⊕

Lymphadenopathy ⊕

Oedema : ⊕

Allergies (if any): ⊕

Respiratory System :

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

Air entry & breath sounds : vllc

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1, S2

Any murmur : (N)

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

Per Abdomen :

Inspection : (N)

Palpation : soft

Ausculation : BS

Spine : (N) External Genitalia : (N)

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

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutriton : (N)

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

(7)

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

dx: (R) parotid abscess
y planned

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Coagulation profile (R)
drawn

Planned Management

To sit
Anesthetic given

NPO from 12AM

Signature of the Doctor:

C. D. Gentry

Name of the Doctor:

C. D. Gentry

Date & Time:

7:30 AM

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:

☐ Medication	☐ Yes	☐ No	Remarks
☐ 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:

Date:

Department:

Shift:



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[illegible]



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Date & Time	Progress Notes	Doctor's Order
3/8/20	S/B Dr. Maroma child received from OT Afebnh alert PP-HF, psych w deep extant wild roase 0 L → movement → ords as adamed - Syp. Breachel (cso'i) Olav 1500	Ⓡ protid abcm. SP 12D

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

GUC-00093526

IP18-00036728

Baby ATHARVA GUPTA

14-04-2022

4 Y 3 M 20 D

(M)

Dr. DHINESH BALAJI J D



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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						



DRUG CHART

Date of Admission: 03.08.2026 Drug Allergies: ☒ 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:				

Signature
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 19.5 kg Ward.

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				

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/8	8:10 ^{am}	LNT AUGMENTIN	600mg	IV	<i>RA</i>	SP SM
2/8	8:30 ^{am}	PADA SUPPOSITORY	25mg	PR	<i>RA</i>	SM SM



Weight. 19.5 kg. Ward.

[illegible]

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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)

GUC-00093526 IP18-00036728
 Baby ATHARVA GUPTA
 14-04-2022 4 Y 3 M 20 D (M)
 Dr. DHINESH BALAJI J D



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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.

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am	water 20ml												
	11:00 am	Received from OT												
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake														
Total 24 hrs. Output														

10/1/79

10/1/79

10/1/79

10/1/79

10/1/79

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10/1/79



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>ISP</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Surgery / Procedure: <u>-</u>		Post OP Day: <u>POD #0</u>					
BACKGROUND	Date	<u>3/8/26</u>						
	Shift	<u>M</u>						
	Medical Condition (Any special condition to be noted):	<u>Noted</u>						
	Diet:	<u>Soft diet</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>						
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp: <u>97.8 F</u>						
		Res: <u>26 b/min</u>						
		SpO ₂ : <u>99%</u>						
		Pulse: <u>124 b/min</u>						
		BP:						
		LOC: <u>15/15</u>						
		Fall Risk Score:						
	Pain Score:	<u>0/10</u>						
	Skin Integrity							
Recommendations	Safety Needs:	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Physiotherapy:	<u>-</u>						
	Others Specify:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Special Diet:	<u>Soft diet</u>						
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
ADL (Dependent / Non Dependent):	<u>Dependent</u>							
Post Operative Procedure Special Orders:		<u>-</u>						
Handed Over By Name :		<u>Bali</u>						
Signature / ID :		<u>Balest</u>						
Date:		<u>3/8/26</u>						
Time:		<u>1.30 pm</u>						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

GUC-00093526

IP18-00036728

Baby ATHARVA GUPTA

14-04-2022 4 Y 3 M 20 D (M)

Dr. DHINESH BALAJI J D



NURSING CARE RECORD

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Date: 18/8/26

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10am	To maintain good nutritional status.	11am	→ Assess the child's condition → No chart maintained → Encourage oral fluids	Maintained good nutritional status	Reassessed done.	Balraj
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

Date:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



NURSES NOTES



☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/8/26	7:50 AM	OT NOTES ON 03/08/26 child details handover taken ER S/N while receiving child conscious & oriented v/s are monitored child consent obtained Billing cleared. child IV line pattern shifted to OT-1 at 8:00 AM. ON the OT table to connect to cardiac monitor. & CRW was given. Antibiotic was given IVF ON FLOW. procedure started at 8:00 AM & Incision & Drainage. During the procedure there is no any complaint. after the procedure was done after the procedure child Extub. child shifted to Post Op area.	
	10:00 AM	Receiving Notes. child received from OT to 4th floor. child details handing over taken from OT staff. child is conscious. IV line present and patency oral started. No vomiting	Singh 01/757.
	10:30 AM	child today discharge. File send to Billing	Bakshi 20088

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker



NURSES NOTES

- ☐ No Known Drug Allergies
☐ Drug Allergies

[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker



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- ☐
- Drug Allergies

[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker



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NURSES NOTES

- ☐
- No Known Drug Allergies

- ☐ Drug Allergies

[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

PHLEBITIS ASSESSMENT

CANNULA 1

Date: 3/8/26 Time: 2.10.

Location : 1st Metacarpal

Size :

Cannula inserted by : Dr. Sahu

[illegible]

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

Patie GUC-00093526 IP18-00036728
Baby ATHARVA GUPTA
14-04-2022 4 Y 3 M 20 D (M)
Dr. DHINESH BALAJI J D

MRD



1 No.:.....

Age: _____ Sex: ☐ M ☐ F

Consultant :.....

CANNULA 2

Date : _____ Time: _____

Location :

Size :

Cannula inserted by :

[illegible]

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 :

[illegible]

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 :

[illegible]

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

GUC-00093528

IP18-00036728

Baby ATHARVA GUPTA

14-04-2022

4 Y 3 M 20 D

(M)

Dr. DHINESH BALAJI J D



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	3/8				
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total			12				

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓				
Call device within reach		✓				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate lighting		✓				
Wheel chair support		✓				
Other Intervention(s) Specify						
Nurse's Name:		Balaji				
Signature:		Balaji				
Date:		3/8				
Time:		10am				



PAIN ASSESSMENT FORM

Date	Time	core (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/8/26	10am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	N/I	Balaji/Poste
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

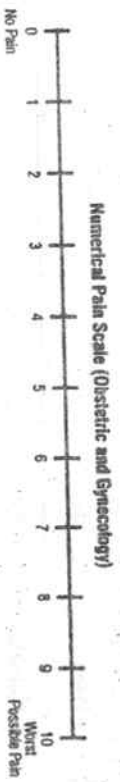
Re-assessment Frequency:

- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

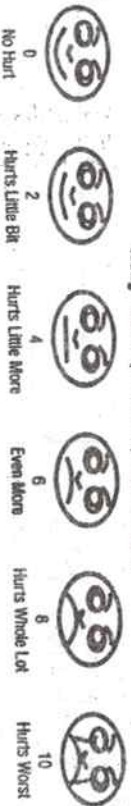
PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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



Wong - Baker (Pediatrics) Above 7 Years



Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

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

GUC-00093526 IP18-00036728

Baby ATHARVA GUPTA

14-04-2022 4 Y 3 M 20 D (M)

Dr. DHINESH BALAJI J D

BRADEN 'Q' SCALE

Rainbow
Children's
Hospital
Take care to keep the littleBirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe DeliveryDate : 3/8
Time : 10a

Mobility	Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4		
Activity The degree of physical activity	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
FRICION-SHEAR Friction. Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	24	
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	Balaji	

20208

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	⑩ Use same protocol as for "High Risk" Patients ⑩ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: English

Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak

Willingness to Learn: ☒ Yes ☐ No

Healthcare Literacy: ☐ Yes ☒ No



Identified Education Needs:

- | | | | | | | | | | | | | |
|--------------|-----------------------|--------------------|---------------------|--|-------------------------|-------------------------------|---------------------------------|---------------------|-------------------------|--|-------------------------------|-------------------|
| 1. Diagnosis | 2. Treatment and Care | 3. Pain Management | 4. Informed Consent | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 6. Discharge Medication | 7. Infection Control Measures | 8. Diagnostic Test / Procedures | 9. Nutrition / Diet | 10. Fall Risk Education | 11. Safe use of Medical Equipment / Implantable Devices Safety | 12. Patient's / Family Rights | 13. Risk / Safety |
|--------------|-----------------------|--------------------|---------------------|--|-------------------------|-------------------------------|---------------------------------|---------------------|-------------------------|--|-------------------------------|-------------------|

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/8/20	10am	Infection control measures	Explained about hand wash and hand hygiene methods.	Father	No	Oral	None	Verbalized understanding - dig	Good	Balraj 50685

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) _____

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify) _____
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify _____
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding:

1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review
-----------------------------	-------------------------------	-----------------

1. *Chlorophyll*
 2. *Carotenoids*
 3. *Xanthophylls*
 4. *Phycobilins*

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1. *Chlorophyll*
 2. *Carotenoids*
 3. *Xanthophylls*
 4. *Phycobilins*



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

 Date: 03. Aug. 2026 Time of arrival: 7.00am

 Chief Complaints: I & B RBS: ✓

 Height: 5 Weight: 19.5/kg BMI: 7 Head Circumference (<2 years) -

 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: -

 If yes, identify -

 Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character - ☐ Location - ☐ Frequency - ☐ Duration -

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
- Uses furniture for support

☐ Yes ☒ No

☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
- ☒ Assist Patient
- ☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

 Psychological Screening: ☒ No Significant Findings

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

 If Yes Consultant Notified: - (Date/Time): 03. Aug. 26.

 Social History: Lives With Parents

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

 Time of Initial assessment completed by ER Nurse: 7.00am

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

Time	Nursing Notes
7.15am	Pt Come for Surgical procedure D.D
	Monitored vital signs & recorded.
	Dr. Deepak assessed and admitted
	IV placement Done. NPO. 12.00am - Solids
	5.30.am liquid. Blood group. B ⁺ ve.
	Shifted for further management

Samples collected by: J N/A

Time: 3 N/A

Samples sent by:

Medication given in ER:

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

Condition of patient at time of shift - out :

HR: 102b/min BP: CFT: 330cc
RR: 26b/min SPO₂: 99% RA.
GCS: 15/15 Temperature: 96.9°F
Pain Score: 0
Repeat RBS (if applicable): 0011

Details of Shift - out

Shift - out from ER to: OT
Time of Shift - out: 7.40 AM
Handover given to: S/N
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): N/A

Name of the Nurse: Godwin Sarin

Signature of the Nurse: [Signature] 01/03/21

Date & Time: 08. Aug. 2026 @ 7.30AM



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor :

Date :

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

Start Time of Assessment:

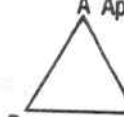
Weight:

Allergic History:

Chief Complaints:

Pediatric Assessment Triangle

A Appearance - TICLS



C Circulation

☐ Normal

☐ Abnormal

B Breathing

☐ ↑ WOB

☐ ↓ WOB

☐ Normal

☐ Gasping / Apnea

☐ Pallor

☐ Cyanosis

☐ Mottling

☐ Bleeding

Initial Physiological Status: ☐ Stable ☐ Unstable

☐ Life Threatening

☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

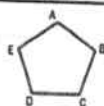
If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment



Airway



☐ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No

If Yes



Breathing

Rate:

SpO₂ on FiO₂

Rhythm:

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry:

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

**Circulation**

HR:

CFT ☐ Central
☐ Peripheral Any urgent interventions needed: ☐ Yes ☐ No

BP: mmHg

Pulse Volume: ☐ Central
☐ Peripheral If in Shock: ☐ Compensated
☐ Hypotensive Muffled Heart Sound: ☐ Yes ☐ NoEngorged Neck Veins: ☐ Yes ☐ NoMurmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of
Heart Failure: ☐ Yes ☐ No

If Yes

**Disability**

GCS: 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.:

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:**Treatment Planned:**Need for Oxygen: ☐ Yes ☐ NoIf yes Low Flow ☐High Flow ☐PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by

Name of the Doctor:

Signature:

Date & Time:

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

PATIENT TRANSFER FORM

GUC-00093526 IP18-00036728

Baby ATHARVA GUPTA

14-04-2022 4 Y 3 M 20 D (M)

Dr. DHINESH BALAJI J D



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time of Admission 03. Aug. 2026 @ 7.12 AM		Date & Time of Transfer Order 03. Aug. 2026 @ 7.40 AM
Treating Consultant Name Dr Dhinesh	Transfer Ordered by Dr. Deepak.	Reason for Transfer Further Management.
From Unit ER.	To Unit OT	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File Total 8 sheets 14.	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 ☐ Dr. R. Parvathidevi		
Name & Signature of Person who is Transferring [Signature] 01/01/24		Name of Person Ordered Transfer C. J. Arora
Patient & Clinical Records Received by :		
Date & Time of Patient Received :		

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

Signature

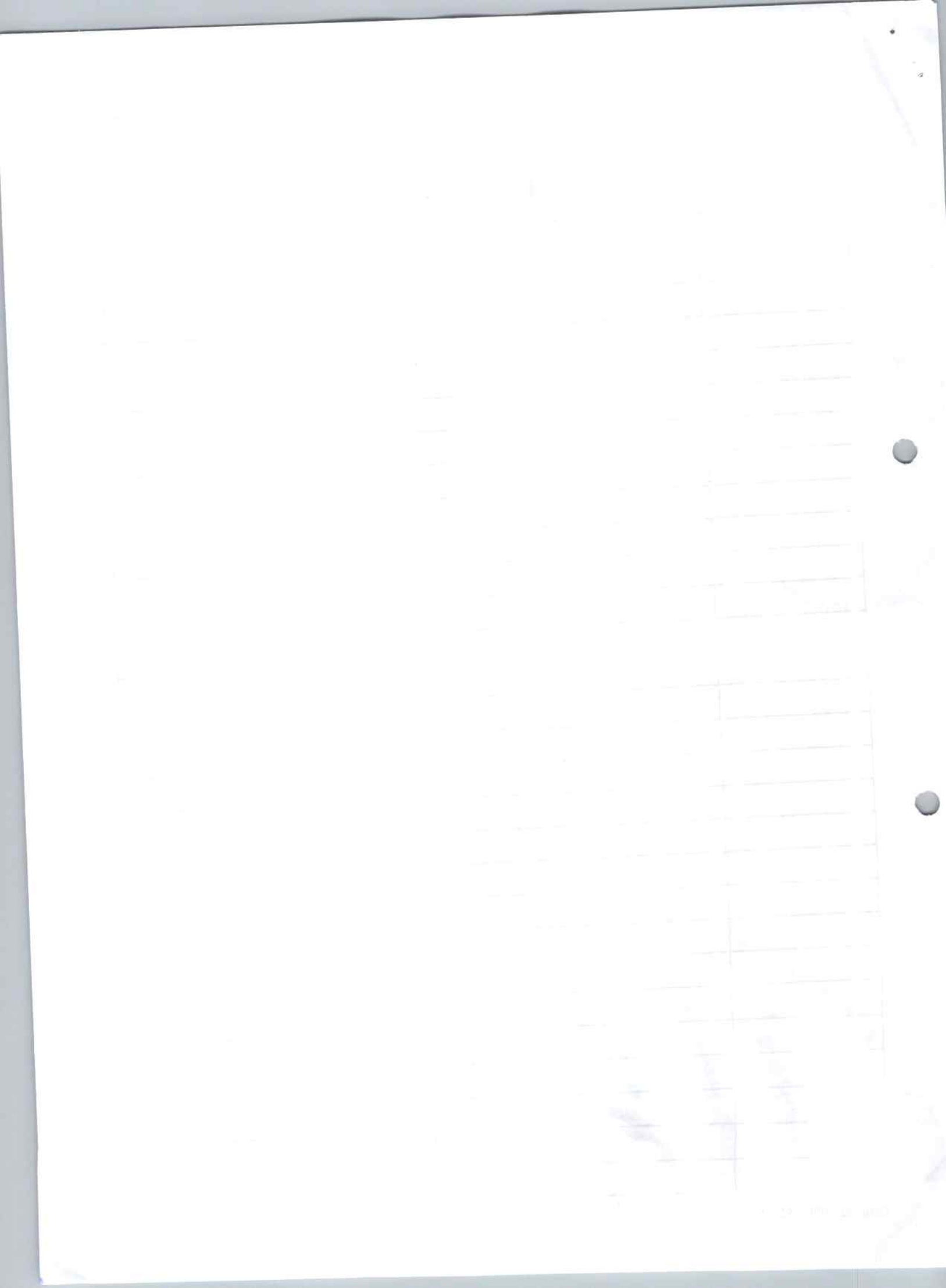
Da Dymosy

Wiederholung



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby, Atharva Gupta Age: 4 yrs. Gender: ☒ Male ☐ Female
 Date: 08. Aug. 2022 Time of Arrival: 7:00 AM
 Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☒ Not known
 Source of Information: ☐ Parents ☐ Others (Specify):
 Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance
 Initial Vital Signs: Temp: 96.2° PR: 102 bpm BP: CH RR: 26 /m SpO₂: 100% P/A
 Chief Complaints: (P) Paroxysmal apnoeas D & D.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal
☐ Sick Looking

Circulation / Colour

☒ Normal

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable:

☐ Not - Life - Threatening

☐ Life - Threatening

Triage Classification

- ☐ Level 1: Resuscitation
☐ Level 2: EMERGENT: Life or limb threatening
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
☐ Level 4: LESS URGENT: Significant illness but not life threatening
☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

- ☐ Immediate
☐ < 15 min
☐ 30 min
☒ 60 min
☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 2 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: Radwin Savin

Date & Time: 08. Aug. 2022 @ 7:05am

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

Signature of Triage Nurse: [Signature]

Patient Sticker

SURGERY DETAILS

Date : 3/8/26

Patient Name: Baby Atharva Gupta Date of Birth: 14-04-2022 Age: 4 yr

Gender: M Ward: OT UHID No: 93526/36728

Date of Surgery: 3/8/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : INCISION AND DRAINAGE

Time In : 8.0 am

Time Out : 8.55 a.

	NAME	AMOUNT
1. Surgeon	Dr. Dwijen Barasi J.D	
2. Anaesthetist	Dr. Sathish	
3. Assistant Surgeon	-	
4. OT Technician	Mr. Shyam	
5. Circulating Nurse	Ch. Sangeetha	
6. Assistant Nurse	S/n Sangeetha	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No:

Order by:

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Patient Sticker

IBD CONSUMABLES OF OT

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Circulating staff : Technician : Date : Time :

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube			Major Pack <i>manu pack</i>		1	Inj Vit.K		
LMA <i>2 Size</i>		1	Sutures			Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube <i>9F</i>		1
Syringes : 10 cc		3+2				Vaccum Suction Set		
05 cc		3	Gloves <i>6 P-F</i>		1	Surgical Gloves		
02 cc		2	<i>T.S.P.F</i>		1	Gauze Pack		
01 cc			<i>T.P.F</i>		1	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade <i>11</i>		1	Surgical Blade # 20		
~~W set~~ <i>Drip Set</i>		1	NG tube			Koochies (S)		
RL		1	Cautery pencil			<i>Verilon 22G</i>		1
NS : 10ml / 100ml / 500ml / 1000ml		2	Koochies			<i>Acquimentin 1.5G</i>		1
			Ointments			<i>Dewates 10ml</i>		3
			Suction Catheter			<i>10cm Vein-O-Line</i>		1
Fentanyl		1	Cap, Mask			<i>Nozzle 16G</i>		1
Morphine			Gauze Pack <i>plain</i>		4			
Ketamine			Mop Pack					
Propofol		1	Steristrip					
Rocuronium			Underpad		1			
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		1	Double J Stent					
Supridol : 100mg			Vaccum Suction set		1			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		1			
			Microshield					
			Cotton Balls					
			Latex Gloves		Sp			
			Ramdione Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : Ordered by :

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

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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	IP18-00036728	Ward	8F-OT COMPLEX
Patient Name	Baby ATHARVA GUPTA	Bed Name	PRE OP 807
Age/Sex	4 Y 3 M 20 D / Male	Order No	18-0001736451
Date	03/08/2026 10:24	Prescription No	PRIP18-0630601
Payor	SELF PAY	Dispensed Date	03/08/2026 10:27
UHID	GUC-00093526		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	1	128.00	128.00
2	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	4	100.00	400.00
3	MINOR OT PEDIATRIC DRAPE			20260715	07/29	1	1,800.00	1,800.00
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	011	12/28	10	18.75	187.50
5	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		2C260795	02/29	2	44.93	89.86
6	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126048	06/28	1	103.00	103.00
7	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
8	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	2602085605	02/29	1	128.00	128.00
9	SURGICAL BLADE 11	Surgeon	GENERAL	11C040226	01/31	1	7.67	7.67
10	UNDERPADS CARE 60 X 90 (FRIENDS)			18072026	12/30	1	205.00	205.00
11	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010296	03/31	1	811.00	811.00
Total :							3,474.35	3,988.03

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Rainbow
Children's
Hospital



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 IP18-00036728

Patient Name Baby ATHARVA GUPTA

Age/Sex 4 Y 3 M 20 D / Male

Date 03/08/2026 10:24

Payor SELF PAY

UHID GUC-00093526

Ward 8F-OT COMPLEX

Bed Name PRE OP 807

Order No 18-0001736450

Prescription No PRIP18-0630600

Dispensed Date 03/08/2026 10:27

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Augmentin 1.2 G Inj	Glaxo SmithKline Pharmaceuticals L	H	DB00084A	09/27	1	151.21	151.21
2	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	5	28.13	140.65
3	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	25GO2K57	06/30	3	21.56	64.68
4	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	2	11.25	22.50
5	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	3	2.58	7.74
6	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25K010618	10/30	1	63.00	63.00
7	LMA 2.0(Auragain)			11F24M0072	12/27	1	3,770.00	3,770.00
8	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	1	69.10	69.10
9	NEEDLE 16 G 1.5INC	Dispovan		52524C	11/30	1	5.32	5.32
10	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP291047	11/28	1	22.31	22.31
11	PEDIADRISET PLUS	ROMSONS		G26A020267	12/30	1	311.00	311.00
12	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1E262785	04/29	1	69.84	69.84
13	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
14	VENFLON I -22G	BECTON DICKINSON (BD)	GENERAL	5317423	10/30	1	321.00	321.00
Total :							5,306.30	5,478.35

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

