Rainbow Children's Hospital

(2)

UHID- GUC-00093625 Baby AKHILAN 01-01-2022 Dr. G SAI SUCHITRA 4 Y 6 M 8 D (M) IP18-00036386

HARGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	9/7/26 @ 12.10pm						
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

UHID No: ..... IP No: ..... Dept: .....

Date of Admission: ..... Ti ..... arge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	11.50pm	ER	708	
9/7/26.	11.50am	07	4th floor	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	P AC	8/7/26	1724209	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
8/7/26.	CBC, PT/APTT, Blood grouping	26021949	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
	Infusion pump	9/9/26 9am	9/7/26 @	1724421	Soup
		9/7/26	12pm		01am

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/7/26	IV line placement	(1)	1724211	[illegible]
8/7/26	POP Upper limb	(1)	1724207	[illegible]
	X-ray - WRIST AP	(1)	9196	[illegible]
	X-Ray WRIST Lateral	(1)	9196	[illegible]

ANY OTHER INFORMATION:

Type 1 Monteggia variant with M/3 ulnar fracture [illegible] Cond] closed Reduction.
In time - 9:15 Am
Out time - 9:45 A.
Surgeon - [illegible]
Anaesthetist - Dr. Mohan

Date: 9/7/26 Time: 12:10pm Prepared By: [illegible]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[illegible]			

GUC-00093626 IP18-00036386
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SURGERY DETAILS

Date : 9/7/26

Patient Name: Baby. Akhilan Date of Birth: 1/1/2022 Age: 4yrs

Gender: Male Ward : OT UHID No.: 93626 / 36386

Date of Surgery: 9/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Type 1 Montaggia variant with M/3 ulnar fracture (Lt) – done procedure

Time in : 9:15 Am Time Out : 9:48 Am

	NAME	AMOUNT
1. Surgeon	Dr. Sai Suchithra	
2. Anaesthetist	Dr. Mohan.	
3. Assistant Surgeon	~~Dr~~	
4. OT Technician	Mr. Thayam.	
5. Circulating Nurse	CWN Sam	
6. Assistant Nurse	S/N Aruna.	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others ....

Record Finalized done.

Dr. Sai Suchitra
Signature of the Surgeon

Signature of Circulating Nurse

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

Docu. No. : RCH /FRM / GENERAL / 114

Patient Sticker

ortho case
POP

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CONSUMABLES OF OT

Circulating staff : C/N. Sasi Technician : .... Date : 9/7/26 Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used
ET tube		
LMA		
ECG leads : A / (P) / N		3
HME filter : A / P / N		
Syringes : 10 cc ✓		3
05 cc ✓		3
02 cc ✓		3
01 cc		
Cautery plate : A / P / N		
~~IV set~~ Drip set (P)		1
RL ✓		1
NS : 10ml / 100ml / 500ml / 1000ml		
Fentanyl ✓		1
Morphine		
Ketamine		
Propofol ✓		1
Rocuronium		
Glycopyrolate		
Myopyrolate ✓		1
Ondansetron		
Pencan 25g/ Spinal Needle 22		
Bupivacaine 0.25%		
Bupivacaine 0.25%(Heavy)		
Antibiotics		
Suppositories		
Anamol : 80mg / (250mg) / 170 mg		1
Supridol : 100mg		
Justin : 12.5 mg / 25mg / 100mg		
Tab. Misoprost : 200mg		

Surgical Disposables	Qty Issued	Qty Used
~~Major~~ Pack ortho		01
Sutures		
POP 10 cm		03
soft roll 10cm		01
Gloves 6 1/2 PF		01
7 1/2 PF		01
7. S. C		01
Surgical blade 15		01
~~NG tube~~ Blade		
Cautery pencil		
~~Koochies~~ Bandage 6 inch		01
Ointments		
Suction Catheter		
Cap, Mask		
Gauze Pack R / O		1 / 1
Mop Pack		
Steristrip		
Underpad ✓		1
Draw sheet		
Abgel		
Foleys catheter		
Urobag		
Chest Drainage Catheter		
Romodrain bag		
Bandage		
Tegaderm		
Ioban		
Double J Stent		
Vaccum Suction set		
Plastic Bed Sheet		
Betadine Solution		
Microshield		
Cotton Balls		
Latex Gloves		10
Ramdione Scrub		(100)
Saral		

Disposables (Baby Side)	Qty Issued	Qty Used
Inj Vit.K		
Cord Clamp		
Suction Catheter		
Feeding Tube 9F		1
Vaccum Suction Set ✓		1
Surgical Gloves		
Gauze Pack		
Syringe 1ml / 2ml		
Surgical Blade # 20		
Koochies (S)		
Atracil		(1)
D. water 10ml		3
25% D 100ml		(1)
10 cm Ext-string (M)		(1) 01

Dr. Sai Suchithra — Surgeon
Dr. Mohan — Anaesthesiologist
S/N Geet — Nurse
Mr. Bullei — OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

VAT TIN : 33AABCR4014M1ZK **CIN :** L85110TG1998PLC029914

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036386	**Ward**	8F-OT COMPLEX
Patient Name	Baby AKHILAN	**Bed Name**	MICU 805
Age/Sex	4 Y 6 M 8 D / Male	**Order No**	18-0001724388
Date	09/07/2026 10:35	**Prescription No**	PRIP18-0626010
Payor	SELFPAY	**Dispensed Date**	09/07/2026 10:37
UHID	GUC-00093625		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	SGLOVE 7.0(POWDER FREE)	ANSEL	GENERAL	260300831T	03/29	1	128.00	128.00
						Total :	**128.00**	**128.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036386	**Ward**	8F-OT COMPLEX
Patient Name	Baby AKHILAN	**Bed Name**	MICU 805
Age/Sex	4 Y 6 M 8 D / Male	**Order No**	18-0001724386
Date	09/07/2026 10:35	**Prescription No**	PRIP18-0626009
Payor	SELFPAY	**Dispensed Date**	09/07/2026 10:36
UHID	GUC-00093625		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARM SLING POUCH (M)	Local	GENERAL	SAS020525	04/30	1	450.00	450.00
2	ARTIFLEX 10 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	26MA0O3	12/30	1	217.00	217.00
3	BANDAGE # 6 INCH	Muttu	GENERAL	ASBO34	12/30	1	34.00	34.00
4	Encore Microptic gloves-6.5		H	260501801T	05/29	1	128.00	128.00
5	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	1	123.00	123.00
7	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
8	ORTHO DRAPE PACK			1010626	05/29	1	2,500.00	2,500.00
9	RAPIDUR 10 CMS	BSN MEDICAL		25P027	11/30	3	245.00	735.00
10	SGLOVE # 7.0(SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26B5016M	01/31	1	91.00	91.00
11	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	2602085605	02/29	1	128.00	128.00
12	UNDERPADS CARE 60 X 90 (FRIENDS)			20062026	12/30	1	205.00	205.00
13	VACCUME SUCTION SET	ROMSONS	GENERAL	G26C010430	02/31	1	543.00	543.00
						Total :	**4,789.00**	**5,504.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA 600015
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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	IP18-00036386	**Ward**	8F-OT COMPLEX
Patient Name	Baby AKHILAN	**Bed Name**	MICU 805
Age/Sex	4 Y 6 M 8 D / Male	**Order No**	18-0001724387
Date	09/07/2026 10:35	**Prescription No**	PRIP18-0626008
Payor	SELFPAY	**Dispensed Date**	09/07/2026 10:36
UHID	GUC-00093625		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
2	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	1B26O748	01/27	1	22.03	22.03
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	026B24K67	01/31	2	21.83	43.66
4	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	1	28.13	28.13
5	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C03K96	02/31	3	21.56	64.68
6	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	3	11.25	33.75
7	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	3	2.58	7.74
8	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
9	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25J010599	09/30	1	63.00	63.00
10	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
11	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
12	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP291047	11/28	1	22.31	22.31
13	PEDIADRIPSET PLUS	ROMSONS		G26C020226	02/31	1	311.00	311.00
14	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
15	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**1,328.13**	**1,500.74**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 09-07-2026 10:36

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

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

GUC-00093626 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
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OPERATION NOTES

Surgeon : Dr. SUCHITHRA .	Asst. Surgeon : —
Anesthetist : Dr. mohan / Dr. priyadharshini	OT Nurse : S. [illegible]
Pre-Operative Diagnosis:	
Surgical Procedure : ~~[illegible]~~ Type 1 Monteggia variant with M/3 ulnar fracture (closed) - Closed reduction	

Weight : 15.8	Date : 9/7/26	Start Time : 9:15 A	End Time : 9:45 A

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: ↓ GA c patient supine, arm on arm board

Findings: Anterior subluxed radial head
Volar apex ulna - long oblique fracture

Radial head reduced with a pop
as ulna deformity corrected
Radial head stable throughout all

Procedure Notes:
movements - Checked ↓ fluoro
Ulna stable after reduction and
hence decision for casting only

Reduction well maintained in cast

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

(P.T.O.)

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency: 1) Elevation 2) Active finger movements 3) Home today
Wound Care: 4) R/A 1 week for check XR - 16/7/26. 5) Serial XR for first 2 weeks to check reduction
Drain /Special Lines/Catheters:
Special Patient Positioning and Requirements:
Nutritional Instructions:
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No
Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: Dr. SUCHITRA

Signature of the Surgeon: .....

Date & Time: .....

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

SAFETY CHECKLIST

Surgeon : Dr. Sabarinathan
Asst. Surgeon : —
Anaesthetist : Dr. Mohan.
Scrub Nurse : Staff Nurse.

Patient Name : Baby. Akhilan Age : 4Y Gender : Male
UHID No. : 93626 Surgery Name : Hernia Repair
Date : 9/1/26 In-time : 9:15AM Out-time : 9:45AM

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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? ☑No
- Yes, & Equipment / Assistance Available ☐Yes ☑No

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

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

Signature .....
Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

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

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

Anticipated Critical Events

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

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

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

Signature :.....
Name : Dr. RSCHITRA

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 :.....

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... Shifted to: .....

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	Pcetap	25mg	PR	Stat	9/1	☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : 9/7/22 @

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

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PATIENT TRANSFER FORM

GUC-00093626 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

	Date & Time of Admission [illegible] @ 11:30 pm	Date & Time of Transfer Order [illegible] @
Treating Consultant Name Dr. Sai [illegible]	Transfer Ordered by Dr. [illegible]	Reason for Transfer Further [illegible]
From Unit OT	To Unit [illegible]	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File [illegible]	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring [signature]	Name of Person Ordered Transfer Dr. [illegible]
Patient & Clinical Records Received by : [signature] 019052	
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

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BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: **TRANSFERRED TO :**

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Y	
	b.Surgical procedure & correct site verified	Y	
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	X	
	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)	N/A	
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	N/A	
	b.Epidural catheter secure, infusion checked	N/A	
	c.Pressure areas protected (heels/elbows)	N/A	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	N/A	
10	**REPORTS AND LABS HANDED OVER**	✓	
11	**BIOPSY/HPE SENT**		
12	**Documentation**		
	a.Documentation completeness	Y	
	Transferring Nurse: _____		
	Receiving Nurse : _____		
	Signature of Incharge:	✓	

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Baby Akhilan Age: 4 Sex: M UHID.No :

Date: 8/7/26 Time: 11.15 am Proposed Operation: closed reduction

Diagnosis: (A) forearm fracture.

B.P / CRT: H.R: 138/min Weight: 15.8kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

SpO2 - 100%.

Laboratory Data:

Hgb: 10.6	Glucose:	Protein:	HIV:	X-Ray:	
PCV:	Urea:	Alb:	HBS Ag:	ECG:	
WBC: 9320	Creat:	Total Bill:	HCV:	2D Echo:	
Plate: 324000	Na:	Dir. Bill:	Blood group: A+ve	Stress/Anglo:	
PT: 15.3	K:	LDH:	T3	Other:	
PTT: 26.4	Ca++:	Alk phos:	T4		
INR: 1.10	Mg++:	Amylase:	TSH		
	Cl -:	SGOT/SGPT:			

Allergies: NKDA

Medical History: CVS: 2nd born, full term, B.W - 2.5kg. NVD

RESP: M/o NICU admission Diabetes: 3 days for resp. distress

CNS: vaccinated till date

Renal: (N) developmental milestones.

Hepatic / GE: Physical Activity: active child.

Others :

Past Anaesthetic History: nil prev sx.

Physical Exam:

Airway: MP (1) 2 3 4 Mouth Opening: 4deg Mentohyoid Distance: (N) Neck: (N) Teeth: (N)

Lungs: B/L AE (+)

Heart: S1 S2 (+)

CNS: NAD.

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: Ante Cubital Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: Name: Dr Priyadharshini

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: 7 hrs

Physical Status: Patient Identified ✓ ☐ Consent Present ✓ ☑ Chart Reviewed

H.R: 120/min | B.P / CRT: 80/60 | SpO_2: 100% | R.R: 25/min | Last Feed:

Pre-OP Diagnosis: .... Operation: closed reduction + GA Date: 9/7/26

Surgeon: Dr Sri Suchitra ...... Anaesthesiologist: Dr ... / Dr Priya Technician: Mr ...

TIME	9.15am	9.45am
N_2O / AIR / O_2 LPM	1:1	
HALO / SO / SEVO	3%	
Drugs:	Inj Propofol 40mg IV; Inj Fentanyl 20 mcg IV; Inj Atracurium 3mg IV; Inj Glycopyrrolate 1.5ml IV	
FIO_2 / SaO_2	0.5	
$ETCO_2$	40-45	
ECG	sinus rhythm	
Temperature		
Urine Output		
Fluids / Blood	100ml 1/2 DNS	

Antibiotic

Suppository: Para 250mg PR

Blood Loss

NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (chart scale 0–240)

Tourniquet on Time / Tourniquet off Time / Throat Pack In / Throat Pack Out

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site:
☑ Art Site:
☑ EKG Lead
☑ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 9.15am
OP Start:
OP End:
Leave OR: 9.45am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV:
☐ IV: 22 G (R) ...
☐ IV:

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

☐ Mask ☑ SGA & igel
☐ Airway ☐ Oral ☐ Nasal
ETT# ...... at ...... cm
☑ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

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

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

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

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

Name of the Doctor: Dr Priya
Signature of the Doctor: [signature]

Patient Sticker

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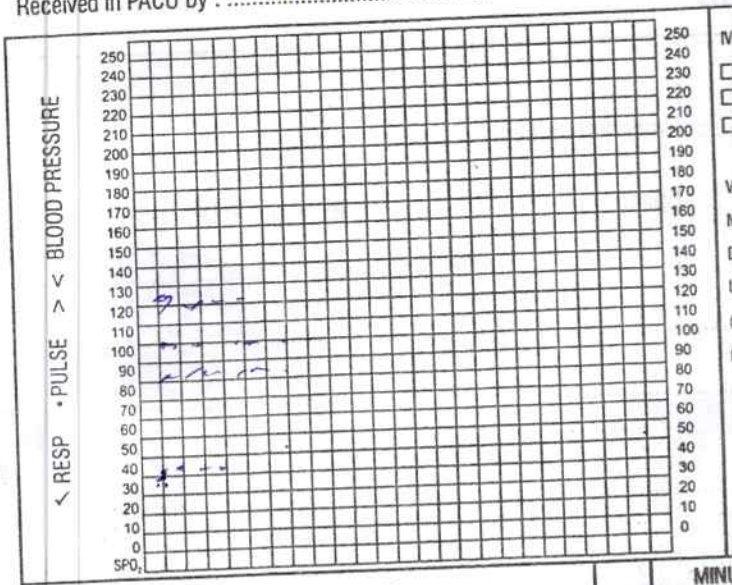
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : S. Sailaja Time Received : 9:40 AM Time Discharged : .....



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/7		2/10	NPO x 2 hours	

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : S. Sailaja

PACU Nurse Signature: .....

*Date & Time: 9/7/24 @

Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: 7/7/24 @

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

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

UHID NO: .....

... Surgeon Name: .....

Anaesthesiologist : ..... Operative procedure planned : .....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : HYPOTENSION, BRADYCARDIA DESATURATION, PONV

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

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

Patient / Patient Attendant :

Signature : .....

Name : NIVEDHITHA MOHAN

Relationship with Patient: MOTHER

Date & Time : 9/7/2026 at 9 AM

Witness :

Signature : .....

Name : E. Priyanka

Date & Time : 9/7/2026 at 9 AM

Doctor (who is taking the consent) :

Signature : ..... Name : Dr Priyanka Date & Time : 9/7/26.

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

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Informed Consent for Surgery or Special Procedure

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

Patient Name : ..... Age : ..... Gender : .....

UHID / IP No: .....

INSTRUCTION

This consent form should be signed by patient (if an adult 18 years or older) or by 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)..... LEFT Forearm closed/ open reduction +/- TENS fixation and POP application ..... upon .....
(Name of the Patient).

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

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

I have been explained that the following complications though rare are possible and will not hold the Surgeon, Anaesthesiologist or the hospital staff responsible for any untoward event there of.
..... infection, neurovascular injury, delayed/non union, loss of reduction, need for surgeries late, stiffness, cost complications .....

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 and consent to the performance of the operation or procedure.

Consignee:
Signature : .....
Name: BALASUBRAMANIAN
Date & Time: 09/07/2026

Relative
Signature : .....
Name: N.VEDHITHA.M
Relationship with patient: ☑ MOTHER ☐

Witness:
Signature : .....
Name: E. Priyanka
Date & Time: 9/7/2026 at 9:45 am

Signature : .....
Date & Time: 09/07/26, 9:45 am.
Name of Doctor: DR. SUCHITRA

GUC-00093625 Baby AKHILAN 01-01-2022 4 Y 6 M 8 D IP18-00036386

GUC-00093625
Baby AKHILAN
01-01-2022

IP18-00036386

4 Y 6 M 8 D (M)

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

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BED SIDE CHECK LIST FOR NURSES

Date:									
Doctor's Orders									
Carried out or not									
Bed Side									
Structured Handover done									
IV Site									
Central Lines									
Arterial Lines									
Feeding Catheter									
Urinary Catheter									
Skin Care									
Eye Care									
Mouth Care									
Sterillum Bottle, Stethoscope									
Suction Bottle (Should be clean & empty)									
Intubation Tray									
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline									
Ventilator Tubing,(Any Water, Blood)									
Humidification									
Check all Infusion (Labelling,Correct Preparation)									
Chest Physio & Neb									
Handed Over By Name :									
Signature :									
Date & Time:									
Hand Over Taken By Name :									
Signature :									
Date & Time:									

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BABY: AKHILAN 00093625	8/7/2026 at 11:30PM	9/7/2026 9AM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
DR. U. Sai Suchitra.	Dr. Sai Suchitra.	Surgery Tx
From Unit	**To Unit**	**Information to Attendant**
4TH FLOOR 708	OT (Report)	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
	1	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 ☐

child IVF 40ml/h. DNS.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
E. Ponjanka	Dr. Chandralega 9/7/26

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

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

Rainbow Children's Hospital

I PREVENTION CHECKLIST

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

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: 9. AM' Shifted to: 9.5 AM'

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : .....

PRE - OPERATIVE CHECK LIST

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Date: 9/7/26

Patient's Name : Baby. Athilan Age : 4yrs Gender : ☑ M ☐ F

Blood Group : UHID : 91625

Planned Surgery : Greenstick # ⓔ Forearm Displaced Surgeon : Dr. Saj Suchitra

Anesthetist : Date & Time of Operation : 9/7/26 at 8am

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : Nurse In-Charge Name : S. Nirmala

Billing Executive Signature : Signature of Nurse In-Charge :

Date & Time : Date & Time : 9/7/26 6AM 6AM

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036386 **Admit Date** : 08-Jul-2026 **Admit Time** : 10:36 PM **UHID** : GUC-00093625

Patient Details :

Patient Name	: Baby AKHILAN	**Age**	: 4 Y 6 M 7 D
Guardian	: BALA SUBRAMANIAM	**DOB**	: 01-01-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO:E-3F,VGN IMPERIA PHASE 1, 3RD MAIN ROAD, MAHALAKSHMI NAGAR,PERUMAL AGARAM Tiruverkadu Chennai Tamil Nadu INDIA 600077	**Phone No**	: 4086669049/ 9962063564
		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 : BALA SUBRAMANIAM **Relationship** : Father

Contact Address : NO:E-3F,VGN IMPERIA PHASE 1, 3RD MAIN ROAD, MAHALAKSHMI NAGAR,PERUMAL AGARAM Tiruverkadu Chennai Tamil Nadu INDIA 600077 **Phone No** : 9962063564

Signature

Doctor Details :

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

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby AKHILAN**	**Age :**	**4 Y 6 M 7 D**
IP No:	**IP18-00036386**	**Sex:**	**Male**
Consultant:	**Dr. G SAI SUCHITRA**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name:

Relationship:

Date: Time:

Wittness Name:

Wittness Signature:

Patient Address:

NO:E-3F,VGN IMPERIA PHASE 1, 3RD MAIN ROAD, MAHALAKSHMI NAGAR, PERUMAL AGARAM Tiruverkadu Chennai Tamil Nadu INDIA 600077

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BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

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

Patient Name :	UHID Number :
Self/Attendant Name :	Relation :
Self/ Attendant Signature : Phone Number : 9962063564	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: Baley Abdulai Age/Sex 4Y8S/M

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

Green stick fracture left arm

History of present illness :

A 4Yos old male came with complaints of accidental fall while playing in restaurant around 9.45pm, resulting in fracture of left forearm

- Deformity ⊕.
- Range of movements ↓
- peripheral pulses felt

no c/o fever, cough, cold.
no c/o vomiting, loose stools, Abd pain.

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Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

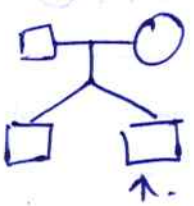
Past History : (including details of any previous investigation or treatment)

—

Birth & Neonatal History:

Telem | NVD | B. wt 2.5kg | CIAB,
TTNB - NICU stay for - 3 days

Family Chart



Birth & Socio Economic History:

About Father : —
About Mother : G NCM
Any additional information : —

Developmental History :

Mile stones attained at appropriate age.

Immunization History :

Immunized upto age according to NIS

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)
Weight (kgs) 15.8kg (Centile _____)

On Examination :

Temperature : 98.4F Pulse Rate : 128/min B.P. — SPO2 100% RA.
Resp.rate and type of breathing : 28/min

Rash —
Lymphadenopathy —
Oedema : —
Allergies (if any): —

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur :

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

Per Abdomen :

Inspection : (N)

Palpation : soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

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Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

Re

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Green stick # ② forearm displaced.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
PT
APTT
INR
Blood grouping.

Planned Management

Above elbow cast application
NPO as per anesthetist orders.
monitor vitals
W/F finger movements, colour, pulses.

Signature of the Doctor:

Name of the Doctor: Dr. Chandiraleg.

Date & Time: 8/7/26

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

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

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:

☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:

☐ Educational Topic/s: .....

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
Dr. G SAI SUCHITRA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/2024 6.08 AM	S/B Dr. chandirakalage.	
	child reviewed.	
	sleeping.	
	NPO from 2 o clock	
	on IV Fluids.	
	O/E	
	afebrile	
	CVS-S1S2 (+)	
	RS-B/L AE (+)	
	P/A - soft	
	Left forearm - Above elbow backslab (+)	
	able to move fingers	
	pink in colour.	
	pulses felt.	
		Adv:
		- shift to OT on call
	[signature] 19/2024	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00093625 IP18-00036386
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RESULT SHEET

A1 positive

Date	9/1/26					
Time						
Hb	10.6					
PCV	31					
RBC	3.92					
WBC	9320					
N/L	63/29					
Platelets	3,24,000					
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	15.3/1.10					
APTT	26.4.					
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ......ER...... Shifted to: ......708......

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ......[signature] ......

Date & Time : ......8/7/26......

Nurse Name & Signature: ......[signature] [signature]......

Date & Time : ......8/7/2026 at 11pm......

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

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: 7th floor Shifted to: CDR

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : .....

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DRUG CHART

Date of Admission: 8/7/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

DRUG : SYP. PARACETAMOL				Date / Time
Dose: 4.5ml	Route: PO	Frequency: SOS	Start Date: 8/7/26	
Doctor's Signature: 19/7/26	Valid Period	Pharm.		
Additional Instructions: 250mg/5ml QGH If pain Present				

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

Patient Sticker

I.V. FLUIDS CHART

Weight. 15 8kg Ward. .....

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
8/7/16	8pm	0.9% DNS	IV	50 ml/hr					
9/7	9:20pm to 7:40am	1% DRL 100 ml	IV	clotted		9:20pm	9/7		9:40pm

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

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01-01-2022 4 Y 6 M 7 D (M)
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Doc. No. : RCH/ FRM / CLINICAL / 125

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Admission 8/7/22 at 11am

Parameter	12am	4am
Date: 8/7/22 Time:	12am	4am
Doctor / Nurse / Family Concern?		
Temperature (°F) (104–94)	97.8°F	98.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	BP 96/62	BP 97/58
Note: BP does not score in early warning scoring		
Heart Rate (Number)	122	100
Resp. Rate (bpm) (Over 1 Minute) * (70–10)	26	24
Resp Rate (Number)	26	24
Resp Distress: Mod/ Severe / None / Mild	Nor?	Nor?
Receiving O_2 (l/min)		
O_2 Saturations (%)	100	99
Conscious Level: Normal / Altered		
GCS *		
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials		

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : .....

1. 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	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
9/7/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am	On Admission				9/7/26				11:50 am		
	01:00 am	H2O	NO								0	NO
Total Intake :		NO				Total Output :						
	02:00 am	N									0	NO
	03:00 am										0	NO
	04:00 am	b									0	NO
	05:00 am										0	NO
	06:00 am	0								Discharge	0	NO
	07:00 am										0	NO
Total Intake :						Total Output :						

Total 24 hrs. Intake	50	Total 24 hrs. Output	Nil

Docu. No. : RCH /FRM / CLINICAL / 092

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NURSING SHIFT HAND OVER FORM

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

Patient Sticker

NURSING CARE RECORD

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: .....

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							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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

Patient Sticker

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

Patient Sticker

NURSING CARE RECORD

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Date: .....

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							
Afternoon							
Night							

Patient Sticker

NURSES NOTES

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

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Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

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Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:.. GUC-00093625 IP18-00036386 Baby AKHILAN

MRD NO:.......... 01-01-2022 4 Y 6 M 7 D (M) Dr. G SAI SUCHITRA

Age :.................. 1 ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 8/7/26 Time: 11:30 pm

Location : (R) metadorsal

Size : 22G

Cannula inserted by : S/N Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
8/7/26	11:30 pm	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	2 am	☐Yes ☑No	☐Yes ☑No	Obser	[illegible]
	6 am	☐Yes ☑No	☐Yes ☑No	Obser	[illegible]
	8 am	☐Yes ☑No	☐Yes ☑No	obser	[illegible]
	10 am	☐Yes ☑No	☐Yes ☑No	Obr	[illegible]
	12 pm	☐Yes ☑No	☐Yes ☑No	Obr	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes-date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

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

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

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

GUC-00093625
Baby AKHILAN
01-01-2022
Dr. G SAI SUCHITRA
IP18-00036386
4 Y 6 M 8 D
(M)

Rainbow® Children's Hospital
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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 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					
	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					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation/ Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1					
	Sedatives (Excluding						

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Baby AKHILAN
01-01-2022 4 Y 6 M 8 D (M)
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THE HUMPTY DUMPTY SCALE 9/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	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	1				
	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					
	Forget Limitations	2	.				
	Oriented to own ability	1	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	3				
	Patient Placed in Bed	2	2				
	Outpatient Area	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		15				

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:		[illegible]				
Signature:		[signature]				
Date:		9/7				
Time:		8pm				

Patient Sticker

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
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	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
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	Forget Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	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						

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:						
	Signature:						
	Date:						
	Time:						

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/-	9am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	NH	[signature]
				☐ 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		

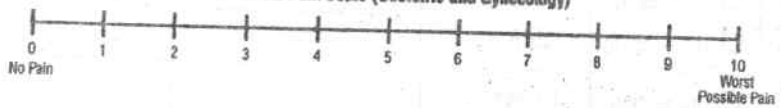
Re-assessment Frequency:

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

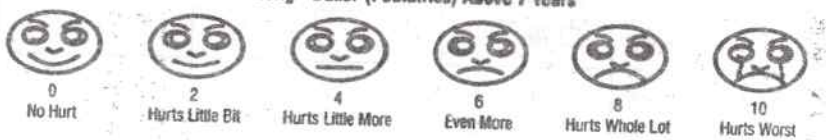
(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	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 HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Patient Sticker

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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		

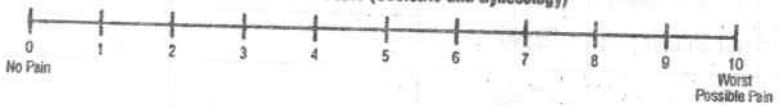
Re-assessment Frequency:

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

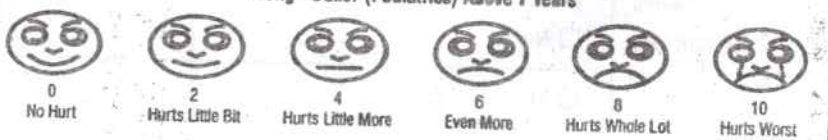
(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	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)
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GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4Y6M8D (M)
Dr. G SAI SUCHITRA

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BRADEN 'Q' SCALE

				Date : 01/01			
				Time : 11			
Mobility	**1. Completely immobile:** 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			
FRICTION-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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
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			
				TOTAL SCORE	20			
				Evaluator's Name				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • 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	• Use the Same Protocol as for **"At Risk"** Patients • 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	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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Patient Sticker

BRADEN 'Q' SCALE

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				Date :				
				Time :				
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				TOTAL SCORE				
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GUC-00093625 IP18-00036386
Baby AKHILAN (M)
01-01-2022 4 Y 6 M 8 D
Dr. G SAI SUCHITRA

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Green stone & Dispaurep

Arrival Time: 12am Mode of Arrival: Walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil

Body Weight: 158 Kg

Height: ...... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Family History: Nil

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

If yes please list, ...

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

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

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

Observations: Weight: 158kg Length: ...... Head Circumference (< 2 years): ......

Temp.: 97.6°F HR: 110/m RR: 22 BP: 110/70

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

Fall Risk Assessment: ☐ Yes ☑ No Score: 12 ...... (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28 ......) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

(P.T.O)

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

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

Nurse's Name: ..... Date: 9/7/20 Time: 6am Signature

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Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

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EMERGENCY ROOM TRIAGE FORM

Wt : 15.8 kg

Patient's Name : Baby. Akhilan. Age : 4 yrs. Gender: ☑ Male ☐ Female

Date : 8/7/26. Time of Arrival : 10:05 pm.

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

Source of Information : ☑ Parents ☐ Others (Specify) ..... Nil.

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 96.5°F. PR: 138/min BP: ..... RR: 22/min SpO_2: 100%.

Chief Complaints: Accidental fall down from floor. 1 hour the (L) Hand.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 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 : A. Jyothi

Signature of Triage Nurse : .....

Date & Time : 08/7/26 @ 10:07 pm.

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

AE Back slate.
10 layers.

PATIENT TRANSFER FORM

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GUC-00093625 IP18-00036386
Baby AKHILAN
01-01-2022 4 Y 6 M 7 D (M)
Dr. G SAI SUCHITRA

Date & Time of Admission	Date & Time of Transfer Order
8/7/26 10:36pm	8/7/26 11:30pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Sai Suchitra	Dr. Chandralega	Further Management

From Unit	To Unit	Information to Attendant
BR	Tos	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
(13)	op baers cheetxray	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 ☐

Displaced green stick # (L) Forearm

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr. Chandralega 8/7/26

Patient & Clinical Records Received by : Sreemani

Date & Time of Patient Received : 8/7/26 at 11:58 pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

GUC-00093625 IP18-00036386
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiraleka Date : .....

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

Start Time of Assessment: ..... Weight: .....

Allergic History: .....

Chief Complaints: .....
displaced green stick #

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: –

Medication History: –

Relevant Investigations: –

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 28/min SpO₂ on FiO₂ 100% RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AR (+)
Palpation Findings (If necessary).....

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

Circulation HR: 128/min CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: ..... 98 F .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

.....

As per chart

.....

.....

.....

.....

Treatment Planned: .....

.....

As per chart

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr. Chandrakala G.

Signature: .....

Date & Time: 8/7/20

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: ..... 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. Plan
4. Pain Management
5. Informed Consent
6. Medication / Therapy (safety, effects/ side effect, interactions)
7. Discharge Medication
8. Infection Control Measures
9. Diagnostic Test / Procedures
10. Nutrition / Diet
11. Fall Risk Education
12. Safe use of Medical Equipment / Implantable Devices Safety
13. Patient's / Family Rights
14. 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		

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

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

Mechanism/s to overcome barrier/s:

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

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

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