Rainbow Children's

GUC-00091054 IP18-00036586

Baby H YUGAN

08-07-2022 4 Y 0 M 15 D (M)

Dr. NANDHINI G

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing			12.45 pm				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

Name: ..... GUC-00091064 Baby H YUGAN IP18-00036586 .....

08-07-2022 4 Y 0 M 15 D (M)

Dr. NANDHINI G

UHID No: ..... Consultant: ..... Dept: .....

Date of Admission: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23.07.2026	7:35am	ER	512	
23/7/26	6:45AM	512	OT	
23/7/26	11.20am	OT	512	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION: OT

IN TIME : 9:05am OUT TIME: 10: am

PROcedure: B/L Ligation PV SAC

Surgeon : Dr. Nandhini

Anasthetist: Dr. Mohan / Dr. Priyadharshini

Date: 23/7/24 Time: 2.9.[illegible] Prepared By: S/N Sujatha 019509

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

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

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SURGERY DETAILS

Date : 23/1/26

Patient Name: Baby yugan Date of Birth: 08-07-2022 Age: 4 yr

Gender: M Ward : OT UHID No.: 91064/36586

Date of Surgery: 23/1/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : B/L Ligation PrSAe

Time In : 9.05 am. Time Out : 10.0 am

	NAME	AMOUNT
1. Surgeon	: Dr. Nandhini	
2. Anaesthetist	: Dr. Mohan	
3. Assistant Surgeon	: -	
4. OT Technician	: Mr. Prasanth	
5. Circulating Nurse	: Chr. Sugathi	
6. Assistant Nurse	: S/N Agalya.	

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

Record finalizd. done.

Signature of the Surgeon

R 01559
Signature of Circulating Nurse

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

OT-II B/L Hernia.

Patient Sticker

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CONSUMABLES OF OT

Circulating staff : Cla. Sujatha Technician : prasanth.B Date : 23/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major Pack~~ paediatric minor		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / (P) / N		3	3.0 vicryl (R.B) (2437)		1	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		4+				Vaccum Suction Set		
05 cc		2+	Gloves 7.0, 6.5		01/01	Surgical Gloves		
02 cc		01	5.5 pf		1	Gauze Pack		
01 cc			6.5 pf		1	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade 15		1	Surgical Blade # 20		
~~IV set~~ Drip set		01	~~NG tube~~ 7.0 S.C		1	Koochies (S)		
RL		01	~~Cautery pencil~~ 8.0 S.C		1	Vein-D-line 10cm		01
NS : 10ml / (100ml) / 500ml / 1000ml		2	Koochies			Taxim 1g		01
			Ointments			ROPin 0.2-1-		01
			Suction Catheter			20G Needle		02
Fentanyl		01	Cap, Mask		*	D-25-1- 100ml		01
Morphine			Gauze Pack ✓		3/1	20ml syringe		01
Ketamine			Mop Pack			22G venflon		01
Propofol		01	Steristrip			D Water 10ml		02
Rocuronium			Underpad ✓		1	Atropine		01
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			~~Urobag~~ Skin Marker		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / (250mg) / 170 mg		01	Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic ~~Bed Sheet~~ Apron		1			
Tab. Misoprost : 200mg			Betadine Solution ✓		1			
5ml Syringe		1	Microshield					
			Cotton Balls					
			Latex Gloves ✓		5P			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : Ordered by : 01/07/26

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	IP18-00036586	**Ward**	8F-OT COMPLEX
Patient Name	Baby H YUGAN	**Bed Name**	PRE OP 808
Age/Sex	4 Y 0 M 15 D / Male	**Order No**	18-0001731859
Date	23/07/2026 11:46	**Prescription No**	PRIP18-0628801
Payor	MEDI ASSIST INSURANCE TPA PVT LTD	**Dispensed Date**	23/07/2026 11:52
UHID	GUC-00091064		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DERMARK PEN ROMSON	ROMSONS	GENERAL	G25I01O30O	08/30	1	331.00	331.00
2	DISPOSABLE APRONS STERILE XL	Mediblue		1010726	06/29	1	120.00	120.00
3	Encore Microptic gloves-6.5		H	2603019005	03/29	2	128.00	256.00
4	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	1	128.00	128.00
5	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	4	100.00	400.00
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	1	123.00	123.00
7	MINOR OT PEDIATRIC DRAPE			20260604	06/29	1	1,800.00	1,800.00
8	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
9	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1B260029	04/28	2	21.01	42.02
10	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
11	SGLOVE # 7.0(SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26B5016M	01/31	1	91.00	91.00
12	SGLOVE # 8.0 (SURGI CARE)	KANAM LATEX	GENERAL	22C3394KV	02/27	1	75.00	75.00
13	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
14	SURGICAL BLADE 15	Surgeon	GENERAL	031225	11/30	2	7.67	15.34
15	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
16	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010294	03/31	1	811.00	811.00
17	VICRYL 3-0 VP 2437	ETHICON SUTURES-J&J	C1	T5050	08/30	1	663.00	663.00
						Total :	**4,848.68**	**5,530.36**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 23-07-2026 11:52

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	IP18-00036586	**Ward**	8F-OT COMPLEX
Patient Name	Baby H YUGAN	**Bed Name**	PRE OP 808
Age/Sex	4 Y 0 M 15 D / Male	**Order No**	18-0001731858
Date	23/07/2026 11:46	**Prescription No**	PRIP18-0628800
Payor	MEDI ASSIST INSURANCE TPA PVT LTD	**Dispensed Date**	23/07/2026 11:51
UHID	GUC-00091064		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	WE432B001	04/29	1	21.51	21.51
2	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	4	28.13	112.52
3	DSYRINGE 20ML(NIPRO)	NIPRO	GENERAL	026B11K32	01/31	1	61.00	61.00
4	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	3	21.56	64.68
5	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	1	11.25	11.25
6	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	2	2.58	5.16
7	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
8	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
9	NEEDLE 20 G	Dispovan		50532D	11/30	1	2.66	2.66
10	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP291047	11/28	1	22.31	22.31
11	PEDIADRIPSET PLUS	ROMSONS		K26B020111	01/31	1	311.00	311.00
12	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
13	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435130	12/27	1	189.30	189.30
14	TAXIM INJ 1 GM	Alkem Laboratories Ltd.	H1	26180237	09/28	1	42.94	42.94
15	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	KM038118	11/27	1	7.30	7.30
16	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
17	VENFLON I -22G	BECTON DICKINSON (BD)	GENERAL	5288174	09/30	1	321.00	321.00
						Total :	**1,681.48**	**1,891.57**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 23-07-2026 11:51

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULT/

GUC-00091054 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

5th floor

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		12:45 pm			
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-00091064 IP18-00036586
Baby H YOGAN 4 Y 0 M 15 D (M)
08-07-2022
Dr. NANDHINI G

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OPERATION NOTES

	Asst. Surgeon : –
Surgeon : Dr. Nandhini	OT Nurse : Sr. Agalya.
Anesthetist : Dr. Mohan	
Pre-Operative Diagnosis: (R) encysted Hydrocele of cord / (L) Inguinal Hernia	
Surgical Procedure : B/L ligation PV sac.	
Weight : 14 kg	Date : 23/1/26 / Start Time : 9.20am / End Time : 9.50am
Post Operative Diagnosis: } nil	
Peri-Operative Complications:	
Operation Notes: – B/L inguinal skin crease incision	
Findings: – (R) Thin sac c̄ encysted fluid / (L) Thick sac c̄ Rubmocele	
Procedure Notes: – B/L ligation PV sac done – B/L internal Ring narrowed. – B/L PV sac opened out. – wound closed in layers c̄ 3-0 vicryl	
Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination: —	

(P.T.O.)

Doc. No. : RCH / FRM / CLINICAL / 099

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency: Adv
Wound Care: 1) ~~apply~~ till 10.30 Am.
Drain /Special Lines/Catheters: 2) Inj. calpol (250mg/5ml) 5ml tds — 2dy
Special Patient Positioning and Requirements:
Nutritional Instructions: 3) mark. diet / ap
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No
Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: .....

Signature of the Surgeon: .....

Date & Time: .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

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

Shifting From: OT Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ TAXIM	700mg	IV	Stat	23/1/26 9.05	☐C ☑DC
2	PARA SUPPOSITORY	250mg	PR	Stat	23/1/26 10.50	☐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] Dr. Priya

Date & Time : 23/1/26.

Nurse Name & Signature: S/N Sugantha 019507

Date & Time : 23/1/26

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

GUC-00091064 IP18-00036586
Baby H YUQAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

SAFETY CHECKLIST

Surgeon : Dr. Nandhini
Asst. Surgeon :
Anaesthetist : Dr. Mohan
Scrub Nurse : S/N Ajalya

Patient Name : Baby Yugan Age : 4yr Gender M
UHID No. : 91064 Surgery Name : B/L Hernia
Date : 23/1/26 In-time : 9.05a.m. Out-time : 10.00a.m.

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9.06a.m.

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

Site Marked ☐Yes ☐No ☐NA
Anaesthesia Safety Check Completed ☑Yes ☐No
Pulse Oximeter on Patient & Functioning ☑Yes ☐No
Does Patient have a:
- Known Allergy? ☐Yes ☑No

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

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

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

Signature :
Name : Dr Bujair R

Before Skin Incision ➤➤

TIME OUT Time: 9.08a.m.

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 Nandhini

Before Patient Leaves Operating Room

SIGN OUT Time: 9.55a.m.

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 : 9.55a
Name : Sruthi

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PATIENT TRANSFER FORM

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

	Date & Time of Admission	Date & Time of Transfer Order
	23/1/26 @ 6.50 a	23/1/26 @ 11.20 am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Nandhini	Dr. Mohan	Further Manag.
From Unit	**To Unit**	**Information to Attendant**
OT	512	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
IP file-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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N Sugathi	019507

Patient & Clinical Records Received by : [signature] O2cer

Date & Time of Patient Received : 23/1/26 at 1:30 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

Docu. No. : RCH /FRM / CLINICAL / 102

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Dr. NANDHINI G

BirthRight | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 23/7/26 OT **TRANSFERRED TO :** 5th Floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NO	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NO	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	NO	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	Yes	
	e.Dressing Intact		
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	Yes	
	b.All drains fixed, output noted	NO	
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	NO	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	Yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	Yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NO	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	Yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NO	
	b.Epidural catheter secure, infusion checked	NO	
	c.Pressure areas protected (heels/elbows)	NO	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NO	
10	**REPORTS AND LABS HANDED OVER**	NO	
11	**BIOPSY/HPE SENT**		
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: S/N Sujith 019509		
	Receiving Nurse :		
	Signature of Incharge:		

Rainbow Children's Hospital - Guindy
Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu,
INDIA ,600015.
044-40122444, info@rainbowhospitals.in

PatientName	: Baby H YUGAN	**Outpatient No.**	: 2607-009333
Age/Gender	: 4 Y 0 M 11 D/ Male	**Admit Date**	: 19-07-2026
Ward/Bed	:	**Discharge Date**	: 19-07-2026

Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-07-2026 12:00
BLOOD GROUP	A1		
RH (D) TYPE	POSITIVE		

Dr. LAWANYA G, MD, MBBS
Reg No : 80624

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-07-2026 12:00
HEMOGLOBIN (Colorimetry)	12.4	g/dL		11.5 - 15.5
RBC COUNT (DC detection method)	4.61	10^12/L		3.9 - 5.3
PCV/HCT (Calculated)	37	VOL%		34 - 40
MCV (Calculated)	79	fL		75 - 87
MCH (Calculated)	27	pg/cells		24 - 30
MCHC (Calculated)	34	g/dL		32 - 36
RDW-CV (Calculated)	12.9	%		11.5 - 15
PLATELET COUNT (DC Detection Method)	313	10^9/L		150 - 450
MPV (Calculated)	8.8	fL		6.5 - 10
WBC COUNT (DC Detection Method)	11.51	10^9/L		5.5 - 15.5
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**47**	**%**	H	23 - 45
LYMPHOCYTES (Microscopy, Leishman stain)	38	%		35 - 65
MONOCYTES (Microscopy, Leishman stain)	10	%		4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	5	%		1 - 6

Dr. LAWANYA G, MD, MBBS
Reg No : 80624

Investigation	Result	Unit	Biological Reference Interval
PROTHROMBINE TIME & ACTIVATED PROTHROMBINE TIME (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-07-2026 12:00
PT (Optical Clot Detection)	13.9	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
044-40122444, info@rainbowhospitals.in

PatientName	: Baby H YUGAN	**Outpatient No.**	: 2607-009333
Age/Gender	: 4 Y 0 M 11 D/ Male	**Admit Date**	: 19-07-2026
Ward/Bed	:	**Discharge Date**	: 19-07-2026

Investigation	Result	Unit	Biological Reference Interval
INR	0.99		
APTT (Optical Clot Detection)	41.9	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

Lanya.

Dr. LAWANYA G, MD, MBBS

Reg No : 80624

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

Birthright Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 23/7/22 at 8.40AM TRANSFERRED TO : OT

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b.Surgical procedure & correct site verified	yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NO	
	b.SpO_2 within safe range	yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NO	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	NO	
	b.No active uncontrolled bleeding	NO	
	c.Last vitals recorded before transfer	yes	
	d.Central line hubs are closed	NO	
	e.Dressing Intact	NO	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NO	
	b.Reassessment done	NO	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NO	
	b.All drains fixed, output noted		
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	NO	
6	**Medications Pre & Post-Op Orders**	NO	
	a.Medications due time noted	~~yes~~	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	yes	
	c.Emergency meds given in OT (time & dose documented)	yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	~~yes~~	
	b.Bed/side rails up and brakes applied	yes	
	c.Special positioning maintained as per surgery		
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NO	
	b.Epidural catheter secure, infusion checked	NO	
	c.Pressure areas protected (heels/elbows)	NO	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NO	
10	**REPORTS AND LABS HANDED OVER**	NO	
11	**BIOPSY/HPE SENT**	NO	
12	**Documentation**		
	a.Documentation completeness	yes	
	Transferring Nurse:		
	Receiving Nurse : S/N Suganthi 019501		
	Signature of Incharge:		

PATIENT TRANSFER FORM

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GUC:-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

Date & Time of Admission	Date & Time of Transfer Order
23/7/26 at 6:50 AM	23/7/26 at 8:40 AM

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Nandhini	Dr. Chandrayoga.	Further Treatment.

From Unit	To Unit	Information to Attendant
512	OT	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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
R & Thulasi 23/7/26 at 8:42	

Patient & Clinical Records Received by : S/N Suganth 01757 @8:40 am

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-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Baby. Yugan Age: 4yrs 8months UHID.No : 91064

Date: 19/7/26 Time: 12:20PM Proposed Operation: B/L ligation of PV sac

Diagnosis: B/L Hydrocoele

B.P / CRT: ..... H.R: ..... Weight: 13.9 Kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.4.	Glucose:	Protein:	HIV:	X-Ray:	
PCV:	Urea:	Alb:	HBS Ag:	ECG:	
WBC:	Creat:	Total Bill:	HCV:	2D Echo:	
Plate: 3.13.	Na:	Dir. Bill:	Blood group: A1+Ve	Stress/Anglo:	
PT: 13.9.	K:	LDH:	T3	Other:	
PTT: 41.9.	Ca++:	Alk phos:	T4		
INR: 0.99.	Mg++:	Amylase:	TSH		
	Cl -:	SGOT/SGPT:			

Allergies: NKDA

Medical History: CVS : No comorbids

RESP : No fever / URI / cough (+) / running nose (+)

CNS :

Renal :

Diabetes :

Hepatic / GE : Born NVD / full term / B.W = 3.26kg / No NICU admissions

Others : (N) developmental milestones / immunised till date.

Physical Activity:

Past Anaesthetic History: No H/o previous Sx

Physical Exam:

Airway: (N) MP 1 (2) 3 4 Mouth Opening: adequate Mentohyoid Distance: (N) Neck: move (N) Teeth: No loose teeth

Lungs : B/L NVBS (+), clear

Heart: S1S2 (+), No murmurs

CNS: NFND

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site : 22G / 24G Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE
—	NIL —

Pre-Operative Instructions:

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

a) collect CBC, PT, APTT & INR.

Signature: 10/8/26 Name: DR. ASHWINI S.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: 6 hrs for solids

☑ Chart Reviewed

Physical Status: Patient Identified ☑ ☑ Consent Present

Last Feed:

H.R: 105/min B.P / CRT: 80/55 SpO₂: 100% R.R: 30/min

Operation: B/L hernia repair Date 22/7/26

Pre-OP Diagnosis:

Anaesthesiologist: Dr Mohan / Dr Priya Paediatrician:

Surgeon: Dr Naudhini

TIME	9.10am ... 10am
N_2O / AIR / O_2 LPM	2 : 2
HALO / ISO / SEVO	2%
Drugs:	Inj Fentanyl 15 mcg IV; Inj Propofol 30mg IV; 11
FIO_2 / SaO_2	
$ETCO_2$	
ECG	SR
Temperature	
Urine Output	
Fluids / Blood	150 ml RL

Antibiotic: Inj Taxim 700 mg IV

Suppository: Para 250 mg PR

Blood Loss

NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (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: 9.10am
OP Start:
OP End:
Leave OR: 10am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☑ SGA 2 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: 15ml 0.2%
Site: Ropin
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] 152622

Patient Sticker

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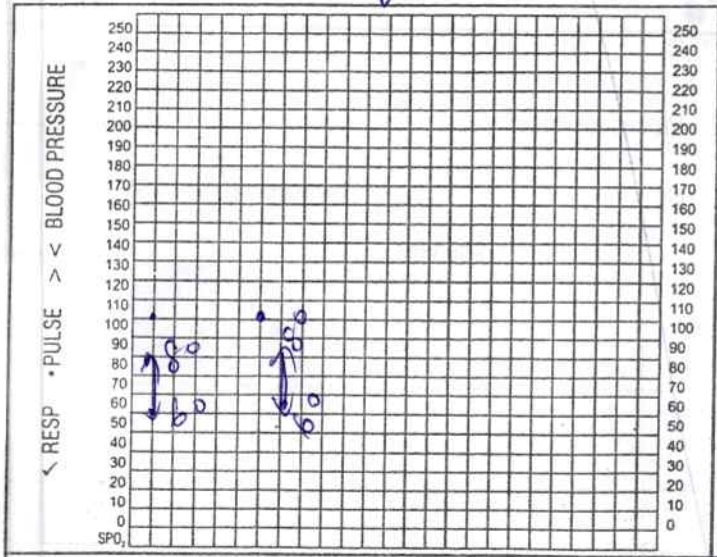
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : C/N Sugandhi Time Received : 10.0am Time Discharged : 11.20 am



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	2				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
23/7		0/10	NPO x 2 hours	

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

Anaesthesiologist Name : Dr Priya. P
Anaesthesiologist Signature: .....
Date & Time: 23/7/26 10.20am.

PACU Nurse Name : S/N Sugandhi
PACU Nurse Signature: .....
Date & Time: 23/7/26 @10.0am

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) S/N Sugandhi
Date & Time: 23/7/26 @ 11.20 a.

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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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Patient Name : .... GUC-00091064 IP18-00036586 Baby H YUGAN 08-07-2022 4 Y 0 M 15 D (M) Dr. NANDHINI G .... Age : .... Gender : Male ☐ Female ☐

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

Anaesthesiologist : ... . Operative procedure planned : B/L HERNIA REPAIR

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, PONV, desaturation

- 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 : [signature]

Name : ....

Relationship with Patient: ....

Date & Time : ....

Witness : C. N. [signature]

Signature : ....

Name : ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature : [signature] Name : Dr Periyadharshini Date & Time : 23/7/26 8.45 am

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

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INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : GUC-00091064 IP18-00036586 Baby H YUGAN 4 Y 0 M 15 D (M) 08-07-2022 Dr. NANDHINI G .... Gender: ☐ Male ☐ Female Age : ....

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

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

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

.... (R) emptied Hydro .... upon .... (L) Hernia .... B/L Ligation pr Sac

(Name of the Patient)

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

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

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

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

.... Bleeding / Infection ....

My signature on this form indicates that

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

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

Consentee :

Signature : [signature]

Name : ....

Date & Time : ....

Witness :

Signature : ....

Name : ....

Date & Time : ....

Patient Attendant :

Signature : [signature]

Name : ....

Relationship with Patient: ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature : [signature]

Name : ....

Date & Time : ....

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

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

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

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

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

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

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.....அதனால்.....

.....நோயாளியின் பெயர்.....

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

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இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

Rainbow Children's Hospital | BirthRight

SSI PREVENTION CHECKLIST

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

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

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

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 : IP18-00036586 **Admit Date** : 23-Jul-2026 **Admit Time** : 06:50 AM **UHID** : GUC-00091064

Patient Details :

Patient Name : Baby H YUGAN
Guardian : ..
Gender : Male
Occupation :
Address (H) : Chennai. Chennai Tamil Nadu INDIA 600001

Age : 4 Y 0 M 15 D
DOB : 08-07-2022
Religion :
Martial Status :
Phone No : 8296764672
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 : ..
Contact Address : Chennai. Chennai Tamil Nadu INDIA 600001

Relationship : Father
Phone No : 8296764672

Signature

Doctor Details :

Doctor Name : Dr. NANDHINI G
Referral Doctor : DR.RAGHURAM
Co-Consultant :

Specialisation : PEDIATRIC SURGERY
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby H YUGAN**	**Age :**	**4 Y 0 M 15 D**
IP No:	**IP18-00036586**	**Sex:**	**Male**
Consultant:	**Dr. NANDHINI G**	**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 care 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:
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: FATHER

Date: 23/07/26 Time: 06:30 Am.

Witness Name: P Thamarai Selvan

Witness Signature:

Patient Address:

Chennai. Chennai Tamil Nadu INDIA 600001

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 : Baby M. YUVAN.	UHID Number : 91064
Self/Attendant Name :	Relation : FATHER
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

UHID ID:

Department:

Consultant:

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

Pediatric Multiorgan History & Physical Examination

Name: Baby H yugan Age/Sex 3½ YRS

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

(R) Hydrocele.
(L) mild inguinal hernia

History of present illness :

A 3yrs 6 months old male came with complaints of swelling in right groin, not increased in size since 6 days evaluated and found to have (R) hydrocele, left ~~right~~ inguinal hernia & planned for ligation of PVSac
no c/o fever, cough, cold.
no c/o vomiting, loose stools.

USG Abdomen : (N) study
USG Scrotum : Large encysted (R) hydrocele
mild left inguinal hernia

Bld - A/Positive	PT - 13.9
Hb - 12.4	INR - 0.99
RBC - 4.67	APTT - 41.9
PCV - 37	
TC - 11.5/	
N/L - 47/38	

Patient Sticker

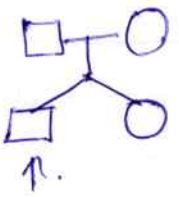
Past History : (Including details of any previous investigation or treatment)

—

Birth & Neonatal History:

NVD | Term | B.wt 3.26 kg | no NICU stay

Family Chart



Birth & Socio Economic History:

About Father : 2nd child

About Mother :

Any additional Information :

Developmental History :

Milestones attained at appropriate age

Immunization History :

Immunized upto age according to IAP guidelines.

Anthropometry :

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

Weight (kgs) 14/6g (Centile _____)

On Examination :

Temperature : 97.2F Pulse Rate : 170/min B.P. 93/52mm Hg 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) : (N)

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

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium : (N).

Heart Sounds : S1S2 (+)

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 :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

B/L Inguinal hernia,
Ligation of PV sac

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

OPD Basics

Planned Management

1

Signature of the Doctor:

Name of the Doctor: Dr. Chandralega

Date & Time: 22/7/24

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In: Remarks

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC:-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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2

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PROGRESS NOTES AND DOCTOR'S ORDER

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PROGRESS NOTES AND DOCTOR'S ORDER

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DRUG CHART

Date of Admission: 23.07.2022 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

GUC-00091064 IP18-00036586
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REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/7	9.15 am	INJ TARIM	100 mg	IV	RH	PS
						AM
23/7	9.50 am	PARA SUPPOSITORY	250mg	PR	RH	PS
						AM

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I.V. FLUIDS CHART

Weight. ..... 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
23/7	9.45 pm	1/2 D/RL 150ml	IV	Limited	H	PS ACN	23/7	H	PS ACN

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

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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: ER. Shifted to: 5/2

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Chandiralege

Date & Time : 23/7 @ 7.00 am

Nurse Name & Signature: Godwin Savio OBIGH

Date & Time : 23.07.2022 @. 7.00 am.

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

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Patient's Name: GUC-00091064 IP18-00036586
Baby H YUGAN
MRD NO: 08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G
Age :...... Sex: ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 23/1/26 Time: 8.15 a.

Location : (R)

Size : 22 GA

Cannula inserted by Dr. Mohan

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
23/1/26	8.15 a	☐Yes ☑No	☐Yes ☑No	Observe	[illegible] 2195?.
	10 AM	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	12 pm	☐Yes ☑No	☐Yes ☑No	Observ	
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

Blood group - A positive

8pm - solid
6AM - liquid

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Wt - 14 kg

TRIAGE FORM

Patient's Name : BABY : Yugan Age : 4YRS Gender: ☑ Male ☐ Female

Date : 23/7/26 Time of Arrival : @ 6:45AM

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.2 F PR: 117 BP: 93/53(65) RR: 28 SpO_2: 100%

Chief Complaints: came for B/L ligation of pv sac

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 mins

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 : Rishi

Signature of Triage Nurse : Rishi (030336)

Date & Time : 23/7/26 @ 6:47am.

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

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandrakala Date : 23/7/22

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

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

Allergic History: .....

Chief Complaints: .....

B/L Inguinal hernia

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/m SpO_2 on FiO_2 99:1 RA

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE (+)

Palpation Findings (If necessary).....

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

Circulation

HR: 117/min CFT — Central .... / Peripheral ....

BP 93/53 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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

Disability

GCS: 15/15 AVPU: ....

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right .... / Left ....

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

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

Exposure

Temp.: 97.2F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned: ....

As per chart

Treatment Planned: ....

As per chart

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

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

Assessment done by

Name of the Doctor: Dr. Chandiralega

Signature: [signature]

Date & Time: 23/7/21

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

GUC-00091064 IP18-00036586
Baby H YUGAN
08-07-2022 4 Y 0 M 15 D (M)
Dr. NANDHINI G

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 03.07.2026. Time of arrival : 6.45pm

Chief Complaints: B/L Hernia Repair. RBS: .....

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

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

If yes , identify .....

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

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☑ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): 03.07.2026.

Social History: Lives With Parents

Siblings in household ☑ Yes ☐ No (if yes How Many?) 01.

Time of Initial assessment completed by ER Nurse : 6.55pm

Time	Nursing Notes
7.00AM	Child Come for procedure. B/L Hernia Repair
	Monitored Vital Signs & Recorded.
	NPO Since. 8.00pm Solids, 6.am Liquids
	Dr. Chandhiralaga assessed and admitted
	under. Dr. Nandhini
	Shifted for further Management.

Samples collected by: Nil

Samples sent by : Nil

Time: Nil

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 117 BP: 93/15 CFT: <3SEC	Shift - out from ER to: 5/2
RR: 28 SPO$_2$: 100% RA.	Time of Shift - out: 7:35 am
GCS: 15/15 Temperature : 97.2°F	Handover given to: (Nurse's Name) A/N Thulasi
Pain Score: 0	
Repeat RBS (if applicable): –	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): ←

Name of the Nurse : Galwin Jasia Signature of the Nurse : [signature] 01613'

Date & Time : 23. 07. 2026 @ 7.00pm

PATIENT TRANSFER FORM

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	Date & Time of Admission: 23.07.2026 @ 6.50 AM	Date & Time of Transfer Order: 23.07.2026 @ 7:35 PM
Treating Consultant Name: Dr Nandhini	Transfer Ordered by: Dr. Chandhiralega	Reason for Transfer: further Management
From Unit: ER	To Unit: 5/2	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: Total sheets 14	Number of Imaging Films: —	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

B/L Inguinal hernia

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
016134	Dr Chandiralega 19m

Patient & Clinical Records Received by :

Date & Time of Patient Received : 23/7/26 at 7.40 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

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Docu. No. : RCH /FRI

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