

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 11 D (F)
Dr. NANDHINI G



(Rainbow
Children's
Hospital

DISCHARGE TRACKING SHEET

D- FLOOR-

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		02/7/21 6pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G



Name:

UHID No: Consultant: Dept:

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	8:30am	7 th floor	OT	[Signature]
20/7/26	1pm	OT	7 th floor	[Signature]

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. prahald	21/7/26	To be raise	[Signature]
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

[illegible]

[illegible]

Procedure Name: left pyeloplasty
 Surgeon Name: Dr. Nandhini
 Assist Surgeon Name: Dr. Dinesh
 Anaesthetist Name: Dr. Ashwin, Dr. Mohan
 Anaesthesia: GA
 In time: 8:35 AM Out time: 11 AM
 Date: 22/7/2021 Time: 8 AM Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------



SURGERY DETAILS

Date : 20/7/26

Patient Name: Baby Athulya Ezhamvaluthi Date of Birth: 10/06/2021 Age: 5Y

Gender: Female Ward: OT UHID No.: 01426/36536

Date of Surgery: 20/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Left pyeloplasty

Time in : 8:35 AM

Time Out : 11 AM

	NAME	AMOUNT
1. Surgeon	Dr. Nandhini	
2. Anaesthetist	Dr. Ashwini, Dr. Mohan	
3. Assistant Surgeon	Dr. Dinesh	
4. OT Technician	Mr. Shyam	
5. Circulating Nurse	C/N. Thanushya	
6. Assistant Nurse	S/N. Sasi, S/N. Suganthi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No:

Order by:

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

Patient Sticker

② Pyloroplasty



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSUMABLES OF OT

 Circulating staff : Thammy Technician : Prasanth/Shyru Date : 20/7/26 Time :

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube <u>5.0 CURVED (used)</u>		1	Major-Pack <u>minor</u>		1	Inj Vit.K		
LMA		1	Sutures <u>5048</u>		1	Cord Clamp		
ECG leads : A/P/N		3	<u>2305</u>		1	Suction Catheter		
HME filter : A/P/N			<u>2303</u>		1	Feeding Tube <u>GER/SFR</u>		1
Syringes : 10 cc		4	<u>2437</u>		1	Vaccum Suction Set		
05 cc		3	Gloves <u>6 1/2 P.F</u>		1	Surgical Gloves		
02 cc		2	<u>7 1/2 P.F</u>		2	Gauze Pack		
01 cc		1	<u>5 1/2 P.F</u>		1	Syringe 1ml / 2ml		
Cautery plate : A/P/N		1	Surgical blade <u>15</u>		1	Surgical Blade # 20		
IV set <u>Drip Set (P)</u>		1	NG tube			Koochies (S)		
RL		1	Cautery pencil		1	<u>ARTACIL</u>		1
NS : 10ml / 100ml / 500ml / 1000ml		1/2	Koochies			<u>TROPIN</u>		1
<u>D-waxer 10ml</u>		6	Ointments			<u>VASOCON</u>		1
<u>DEXMID 50mg</u>		1	Suction Catheter			<u>VEN-O-LINE 10cm</u>		1
Fentanyl		1	Cap, Mask			<u>VENFLOW 22G</u>		1
Morphine			Gauze Pack <u>plg/210</u>		3/1	<u>NEEDLE 20G</u>		1
Ketamine			Mop Pack		1	<u>Syringe 20ml</u>		1
Propofol		1	Steristrip			<u>ureteral stent</u>		
Rocuronium			Underpad		1	<u>4FR 16cm</u>		1
Glycopyrolate			Draw sheet			<u>Longel</u>		1
Myopyrolate		1	Abgel					
Ondansetron			Foleys catheter <u>Silicon(10)</u>		1			
Pencan 25g/ Spinal Needle 22			Urobag		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
<u>TAXIM 1g</u>		1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		2			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		1			
<u>D25 1-100ml</u>		1	Microshield					
<u>DSY 20cc</u>		1	Cotton Balls					
<u>18G NEEDLE</u>		1	Latex Gloves		repairs			
<u>ROPIN 0.2M</u>		1	Ramdone Scrub					
<u>NEEDLE 20G</u>		1	Saral					

Surgeon Dr. NandhiniAnaesthesiologist Dr. Mohan

Nurse

OT Technician

Order No. : Ordered by :

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



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS



IP No IP18-00036536 Ward 7F-PVT/SUITE
Patient Name Baby ATHULYA EZHAMVALUTHI Bed Name PVT 703
Age/Sex 5 Y 1 M 10 D / Female Order No 18-0001730136
Date 20/07/2026 12:32 Prescription No PRIP18-0628163
Payor SELFPAY Dispensed Date 20/07/2026 12:47
UHID ANC-00001486

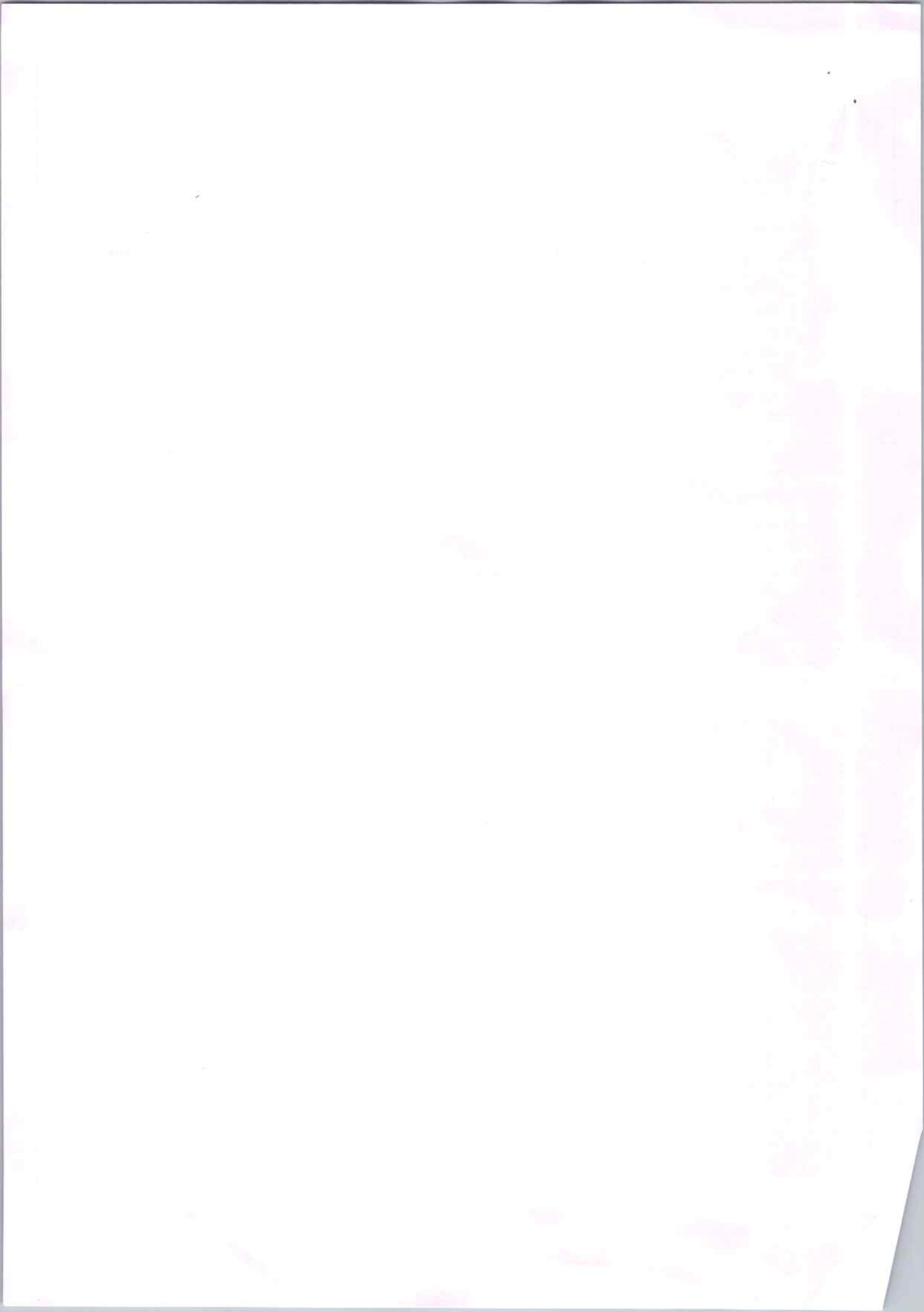
S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
2	DEXTOMID INJ 50 MCG 0.5 ML	Neon Laboratories Ltd		1257022	11/27	1	383.40	383.40
3	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	WE432B001	04/29	1	21.51	21.51
4	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	4	28.13	112.52
5	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	3	21.56	64.68
6	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	2	11.25	22.50
7	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	6	2.58	15.48
8	INFANT FEEDING TUBE-5	ROMSONS	GENERAL	G25K010189	10/30	1	63.00	63.00
9	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25J010599	09/30	1	63.00	63.00
10	LOX 2% JELLY 30 GM	NEON LABORATORIES LTD	H	L1816	01/28	1	34.58	34.58
11	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
12	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
13	NEEDLE 18 * 1 1 2	Dispovan	GENERAL	08634D	01/31	1	3.38	3.38
14	NEEDLE 20 G	Dispovan		50532D	11/30	1	2.66	2.66
15	NEEDLE 20 G	Dispovan		50532D	11/30	1	2.66	2.66
16	PEDIADRISET PLUS	ROMSONS		K26B020111	01/31	1	311.00	311.00
17	PREGELLED SURGICAL PLATES PEAD (ADVANCE)	The Advanced cadiomed	GENERAL	2412122406	12/26	1	562.50	562.50
18	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
19	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435130	12/27	1	189.30	189.30
20	TAXIM INJ 1 GM	Alkem Laboratories Ltd.	H1	26180121	07/28	1	42.67	42.67
21	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	SM038138	11/27	1	7.30	7.30
22	VASOCON INJ 1MG1ML	NEON LABORATORIES LTD		KP85439	02/27	1	13.04	13.04
23	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26C010503	02/31	1	419.00	419.00
24	VENFLON I -22G	BECTON DICKINSON (BD)	GENERAL	5288174	09/30	1	321.00	321.00
Total :							2,827.96	2,979.62

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



**RAINBOW CHILDREN'S MEDICARE LIMITED****Rainbow Children's Hospital - Guindy**

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

VAT TIN : 33AABCR4014M1ZK**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	IP18-00036536	Ward	7F-PVT/SUITE
Patient Name	Baby ATHULYA EZHAMVALUTHI	Bed Name	PVT 703
Age/Sex	5 Y 1 M 10 D / Female	Order No	18-0001730135
Date	20/07/2026 12:32	Prescription No	PRIP18-0628165
Payor	SELPAY	Dispensed Date	20/07/2026 12:49
UHID	ANC-00001486		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	CAUTERY PENCIL (ADVANCE)	The Advanced cadiomed	GENERAL	250824	08/28	1	1,303.00	1,303.00
2	DOUBLE J STENT 4 F 16 CM	Blue neem		2024256927	10/29	1	741.00	741.00
3	Encore Microptic gloves- 6,5		H	2603019005	03/29	1	128.00	128.00
4	FOLEY'S CATHETER 10 FR (SILICON)	ROMSONS	GENERAL	0G24HO11162F	07/29	1	1,295.00	1,295.00
5	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	3	100.00	300.00
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	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642SF029	03/30	1	949.00	949.00
9	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
10	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirilif		1B260029	04/28	1	21.01	21.01
11	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1D262046	03/29	2	94.55	189.10
12	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
13	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	260300891T	05/29	2	128.00	256.00
14	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
15	SURGICAL BLADE 15	Surgeon	GENERAL	031225	11/30	1	7.67	7.67
16	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
17	UROBAG (ADULT) - URODYNE		GENERAL	K26BO50008	12/30	1	395.00	395.00
18	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010294	03/31	2	811.00	1,622.00
19	VICRYL 3-0 VP 2437	ETHICON SUTURES-J&J C1		T5050	08/30	1	663.00	663.00
20	VICRYL 4-0 NW 2305	ETHICON SUTURES-J&J C1		T5005	09/30	1	564.00	564.00
21	VICRYL 5-0 VP 2303	ETHICON SUTURES-J&J C1		T5011	05/30	1	584.00	584.00
Total :							10,157.23	11,615.78

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

VAT TIN : 33AABCR4014M1ZK

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	IP18-00036536	Ward	7F-PVT/SUITE
Patient Name	Baby ATHULYA EZHAMVALUTHI	Bed Name	PVT 703
Age/Sex	5 Y 1 M 10 D / Female	Order No	18-0001730149
Date	20/07/2026 12:47	Prescription No	PRIP18-0628164
Payor	SELPAY	Dispensed Date	20/07/2026 12:48
UHID	ANC-00001486		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	~~DEXTO MID IN 1.50 MG 0.5 ML~~	Neon Laboratories Ltd		1257022	11/27	1	383.40	383.40
2	DSYRINGE 20 ML WITH LEUR LOCK	NIPRO	GENERAL	25B05K11	01/30	1	42.00	42.00
3	ET TUBE -5.0 CUFFED (WELCO LIFE)			250650	06/30	1	891.00	891.00
4	~~TAXIMIN 1 GM~~	Alkem Laboratories Ltd.	H1	26180121	07/28	1	42.67	42.67
Total :							1,359.07	1,359.07

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

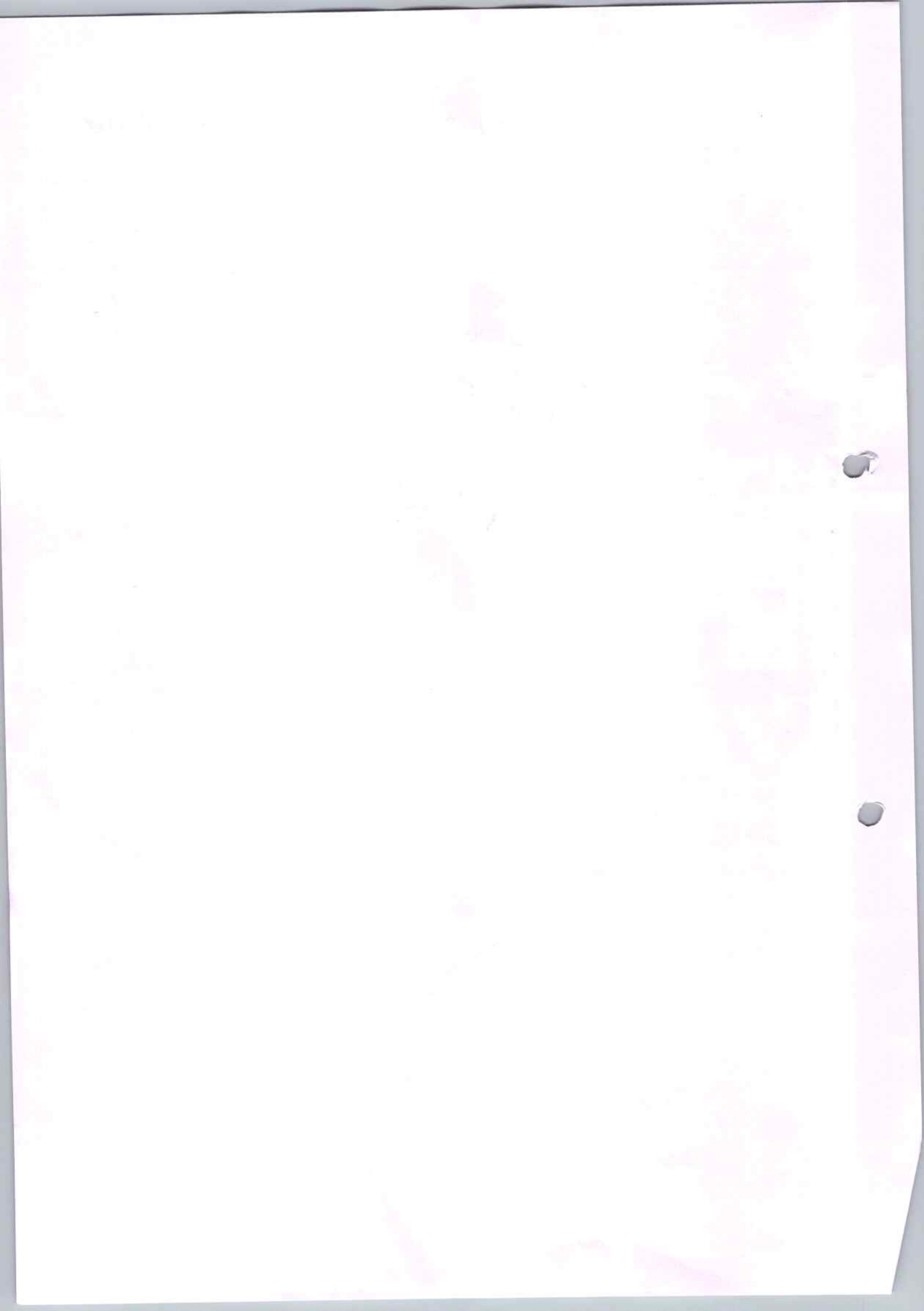
ANC-00001486 IP18-00036536
 Baby ATHULYA EZHAMVALUTHI
 10-06-2021 5 Y 1 M 12 D (F)
 Dr. NANDHINI G



DISCHARGE TRACKING SHEET

FLOOR- 7TH FLOOR NAME OF CONSULTANT- Dr. Nandhini

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
	22/7/2026				
Discharge Announcement	22/7/26 at: 10.45 AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		22/7/26 at 10.00 AM	Sup Sora		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					





Patient Name	Baby ATHULYA EZHAMVALUTHI	Patient Ph.No	9677216973
Age	5 Y 1 M 11 D	Requisition No	R2618-009834
Gender	Female	Collected on	21-07-2026 11:43 AM
IP / Bill No.	IP18-00036536	Received On	21-07-2026 11:49 AM
UHID No.	ANC-00001486	Reported On	21-07-2026 11:49 AM
Ref. Doctor	NANDHINI G	Ward / Bed No	

ULTRASOUND SCREENING**USG - LOCAL AREA****FINDINGS**

Mild - moderate residual left hydronephrosis noted with APD measuring around 10.5 mm and PT - 13.5 mm.

DJ stent insitu.

No e/o perinephric collection.

Impression**Suggested clinical correlation****Dr. PRASANNA KUMARAVEL**

MBBS, MDRD
Reg No: 92729

Print Date/Time : 21-07-2026 11:49 AM

Printed By : SURIYA N

Page: 1 of 1

Note: Clinically correlate, Kindly discuss if necessary

Rainbow Children's Medicare Limited

CHENNAI : No. 157 to 160, Anna Salai, Near Little
Mount Metro Station, Guindy, Tamil Nadu - 600015

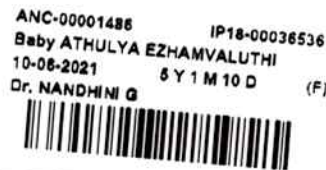
SHOLINGANALLUR : No. 493/42A2B, OMR ECR
Link Road, Chennai, Tamilnadu - 600119

For Appointments call: 1800 2122

CIN : L85110TG1998PLC029914

info@rainbowhospitals.in

www.rainbowhospitals.in



Patient Name: _____

Bed Category: 703 .

AT-ADMISSION DESK:

- Explain about admission process
- Welcome Kit

SERVIGES IN WARD:

- Explain about room facility like how to use the patient COT, Nursing Bell, important contact details.
- Room cleaning and wash room cleaning will be done regularly.
- Patient bed sheet & clothes will be changed every day morning.
- If patient got shifted to OT, please enquire with nursing station to get further updates
- Wash room hot water will be available round the clock
- For patient food please reach to Dietician / F&B Call @ (2203)
- Don't keep waste in the sink or other drains
- Food for the patient strictly as per the advice in-house dietician
- No outside food is allowed for patients
- Fruit juices, coconut water, salads, are available in canteen
- Patients' Rights & Reasonability explain to the family.
- Only 2 attender's allowed inside the room with patient.

BILLING:

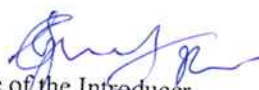
- Take billing update on daily basis at ground floor IP Billing Department (09:00AM to 06:00PM) and if any Query please reach to billing manager/IP Manager (+916379905271) (on same time.)
- If any insurance query and corporate information, please reach to ground floor insurance/corporate desk.
- For Insurance patient give documents after admission.
- Please carry attender pass at the time of visiting patient.
- VISITING HOURS for Pediatrics (12PM -1PM & 4PM -5PM)
- VISITING HOURS for OBG (08AM -09AM & 4PM -5PM)
- Explain about concern department contact details, which mentioned bedside chart.

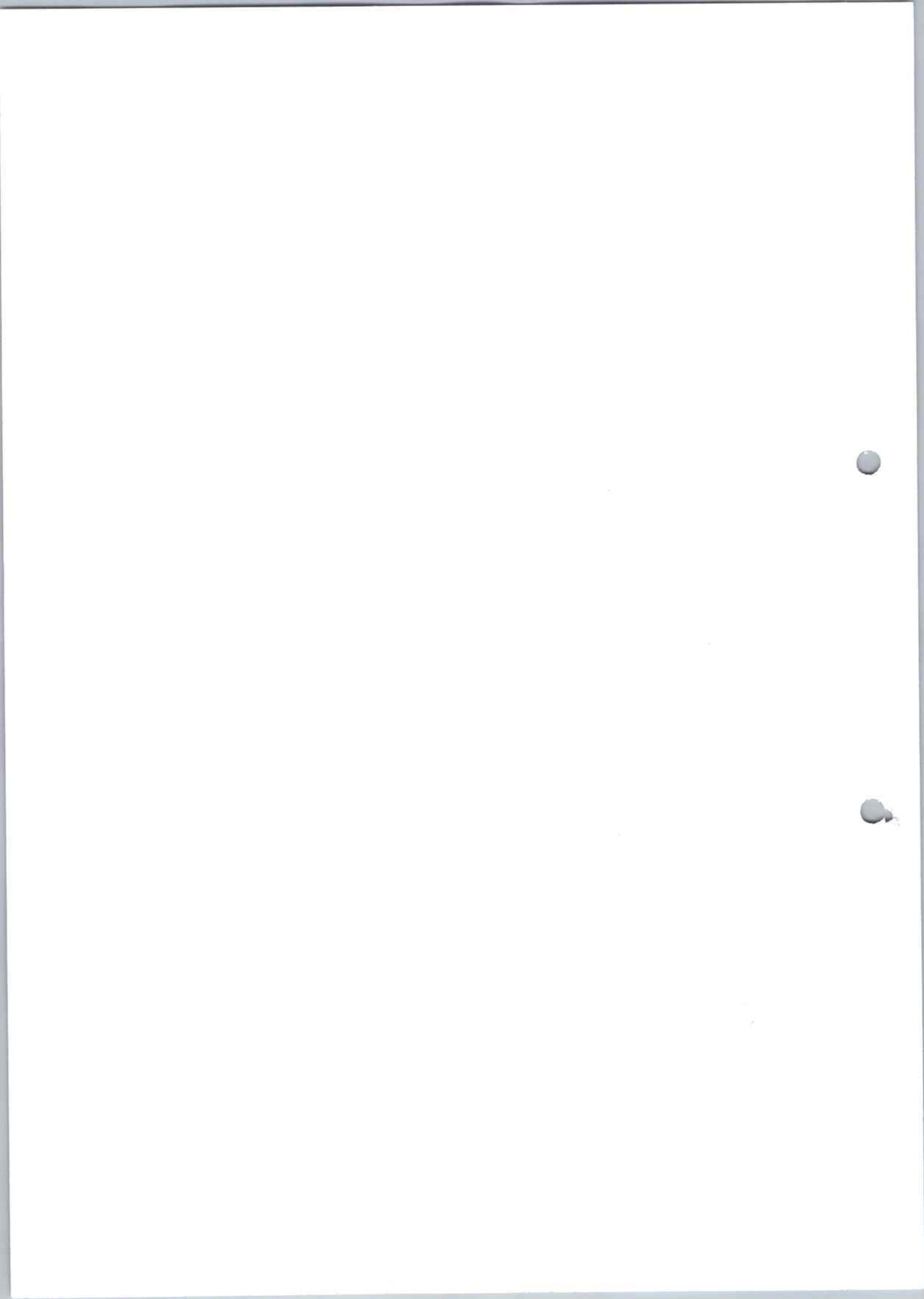
MANAGEMENT TEAM:

- Team will meet everyday morning to look after the patient welfare and collect patient feedback on hospital services & MOD (+91 6379905263) available round the clock.
- Please give your valuable feedback before leaving the hospital at the time of discharge, it would be helpful to improve our services.

THANK YOU AND GET WELL SOON


Signature of patient/ patient Attendance


Signature of the Introducer





ADMISSION SHEET

Registration Details :



Admission No : IP18-00036536

Admit Date : 20-Jul-2026

Admit Time : 06:14 AM UHID : ANC-00001486

Patient Details :

Patient Name : Baby ATHULYA EZHAMVALUTHI

Age : 5 Y 1 M 10 D

Guardian : Mr EZHAMVALUTHI M

DOB : 10-06-2021

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : 39/66 bharathidasan east stret cauvery
nagar Saidapet Madras Chennai Tamil Nadu
INDIA 600015

Phone No : 9677216973

E-mail : ezhamvaluthi@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : ER 101

Ward Name : 0F-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr EZHAMVALUTHI M

Relationship : Father

Contact Address : 39/66 bharathidasan east stret cauvery nagar
Saidapet Madras Chennai Tamil Nadu INDIA
600015

Phone No : 9677216973

Signature

Doctor Details :

Doctor Name : Dr. NANDHINI G

Specialisation : PEDIATRIC SURGERY

Referral Doctor : DR. NANDHINI G

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby ATHULYA EZHAMVALUTHI

Age : 5 Y 1 M 10 D

IP No: IP18-00036536

Sex: Female

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:

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.
(Rivers 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: > EZHAMVALUTHI MANOHARAN

Relationship: > FATHER

Date: 20-07-2026

Time: 06:14

Witness Name: 

Witness Signature: 

Patient Address:

39/66 bharathidasan east stret
cauvery nagar Saidapet Madras
Chennai Tamil Nadu INDIA 600015

BILLING POLICY

- ▶ **Billing Cycle:** - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- ▶ Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- ▶ 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- ▶ As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT/ RTGS/ Demand Draft and Online Payment.
- ▶ In the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's/ Corporate won't be applicable.
- ▶ If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- ▶ Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- ▶ Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- ▶ Patient/ Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- ▶ TPA Insurance Processing Fee applicable for all Insurance Cases.
- ▶ In our hospital there is "No Discounts Policy". Kindly co-operate.
- ▶ No Duplicate: Second copy of OP or IP bill will be issued.
- ▶ In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- ▶ If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- ▶ Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/ Insurance Company at later stage.
- ▶ For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- ▶ It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- ▶ Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- ▶ Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- ▶ All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- ▶ Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HHS. 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 : ATHULYA EZHAMVALUTHI	UHID Number : 1486
Self Attendant Name : EZHAMVALUTHI MANOHARAN	Relation : FATHER
Self Attendant Signature : [Signature] Phone Number : 9677216973	Name & Signature of Financial Counselor [Signature]



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G



Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Antenatally detected BL Pcs dilatation.
L > R

History of present illness :

① PUJO - on phexin 5ml HS

No w/o UTI in the past.

BBD ② - on laxatives.

Flup Vsh Abcd.

	RRid	APD	Urid	APD	hwt
2021	5	-	6	8cm	8m
2022	5.8	-	6.9	10cm	8m
2023	6.2	-	7.2	1cm	10m
2024	6.7	-	7.1	1.5cm	10m
2025 (Feb)	7.4	-	8.2	1.4cm	1.1cm
2025 (June)	7.3	-	8.3	1cm	1.2cm
2026 (July)	7.8	-	9.2	3cm	1.1cm

EC scan ②

487-

② (IR) ②

517-

s/o ② PUJO

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

No h/o previous admission

Birth & Neonatal History:

Term / LSCS / Birth - 2.54 kgs
 CIAB / No NICU stay

Family Chart**Birth & Socio Economic History:**

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Dev. (N)

Immunization History :

Vaccinated upto date acc. to IAP schedule

Anthropometry :

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

Weight (kgs) 16.2 kgs (Centile _____)

On Examination :

Temperature : 96.8 F Pulse Rate : 126/min B.P. 99/65 SPO2 99%

Resp. rate and type of breathing : (76) min Hg

Rash _____ Alert, active
 Lymphadenopathy _____ PPWF, pulse volume - good

Oedema : CRT - 3 sec.

Allergies (if any): _____

Respiratory System :Inspection (any s/o distress) : NGB (N)Air entry & breath sounds : B/c NRBs (+)Any added sounds : -Relevant data from outside (Chest X-Ray, ABG, etc.,) -**Cardiovascular System :**Inspection of precordium : -Heart Sounds : S1S2 (+)Any murmur : -Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : -**Per Abdomen :**Inspection : -Palpation : Soft, Non-tender, no organomegaly, fecal mass palpableAuscultation : -Spine : (N) External Genitalia : (N)Relevant data from outside (CT, USG etc.,) -**Central Nervous System :**Level of Consciousness : AVPU/GCS score : GCS 15/15Cranial Nerves : -**Motor System :**Nutrition : (N)Tone : (N) Power : >3/5Co-ordinator : (N)Posture : (N)Involuntary Movements : -

Patient Sticker

Reflexes :

DTR

Plantars

Superficials:

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

② RU50 - for ④ Pyeloplasty

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
RPR
coagulation profile / OP

Planned Management

NPO ← solids - 9pm (yesterday night)
liquids - 6am (today)

Continue NPO

Signature of the Doctor:

Name of the Doctor:

Date & Time:

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

1. Anticipated Date of Discharge:

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

☐ Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status:

☐ Self Care

☐ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

☐ Medication

☐ Yes

☐ No

☐ Bathing

☐ Yes

☐ No

☐ Eating

☐ Yes

☐ No

☐ Walking

☐ Yes

☐ No

☐ Dressing

☐ Yes

☐ No

☐ Toileting

☐ Yes

☐ No

Remarks

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:

(F)

Receiving
Over
Doctor

DOCTOR'S SHIFT CHANGE HANDOVER FORM



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date:

Department:

Shift:

[illegible]

NANDHINI G



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

20/7/20
2.30pm

S/Pr. Chandiralege.

D - (L) PUS dysfunction
(L) pismembraneous cycloplasty

child reviewed
dilett, active
No pain (+)
Tolerating clear liquids well
O/E

Afebrile
C/S - S/S (+)
R/S - R/LAR (+)
P/A - soft, RSP

Antibiotics - draining
Adm

- Monitor vitals
- Drugs as per chart
- Prevalad sim-sim

SP
19/2/24

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
~~2/17/20~~ ~~2PM~~	S/N 2h. transition Per day - @ pyclop with skin clear RA 4/1 PVC - 1 heart tr - 2000 / 4 hr.	Int to can Huz + Int. iv Ans
~~1/1/20~~ ~~4/1/20~~		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/17/26 9:20 AM	S/B DR. DEEPAN	
	ASIA: (L) PUJO	
	↳ SIP (L) Pyeloplasty	
	Child reviewed	
	Child has c/o: mild cough	
	no c/o: fever, runny nose	
	Oral diet taken well - NO vomiting	
	Child did not pass any stool / Flatus passed	
	Off: Child is asleep, afebrile	
	CVS: S1S2 ⊕	
	PE: VAS ⊕	Catheter
	PTA: Soft INT	insitu
	IBS ⊕	↓
	CNS: NFAD	hematuria resolving
	LE:	
	→ Dressing intact ⊕	
	→ NO SOAKAGE at present	
		Continue apnea check
		Monitor vitals / sensor
		Cath

Date & Time	Progress Notes	Doctor's Order
2/17/26 Wash	S/A J.A. manifestation Ipoos - @ cytoplasmic viral stain. wsp = 4.24 / ug / L Hemorrhagic Chancre, in ch warts / fever PA Mt Bsch.	
		@ drink → food — EVF / IV pitalup — IV Abx. — IV pa / enox
	Abx pc mt } @ B → 1.8.26	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/17/16 4:40 PM	S/B DR. DEFRANK	
	ASIS: (L) PUJO	
	S/P: (L) diaphragmatic pyeloplasty	
	Child reviewed	
	Child has c/o: pain over IV line site Surgical site	
	O/E: child is alert, afebrile	
	CVS: S1S2 (P)	
	Rx: VBS (P)	
	PIA: SPT INT	
	CNS: (NFN)	(Jmy)
		8am - 1:00 pm
	L/E:	V/O = 650ml
	- Dressing intact	I - 570ml
	- NO drainage	
	GNS @ 20ml/h	Stool passed Rz
	Amikacin 250mg $\rightarrow$ D ₁	To monitor vital / monitoring
	Cefotaxime 800mg $\rightarrow$ D ₂	To monitor urine output
		To continue as per chest cxs

IP18-00036536

10-06-2021

5 Y 1 M 12 D

(F)

Dr. NANDHINI G



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



PHYSICIAN'S NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 11 D (F)



ATION FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

21/7/26
12 Noon

S/B Dr. Prasad

~~check at 11:30 AM~~

At PwT: → pre surgery

At kid: 9-2cm

P-T: 0.9 - 1.4cm

APD 3cm

DT PA: At T Max 18mm

No drainage : 5ml

Good uptake

P

Ans @ 2ml / hr

To Cont antibiotic

Post surgery

Mild H HX: APD 1cm

BT 5cm

Not passed stool

Sys Domestic
3ml → 3ml

Dolaplex Supp 1 sh

Pan 20mg 10

Consultant :

Name : Signature: F. Date & Time :

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



RESULT SHEET

0 POSITIVE

Date	15-7-20				
Time	(At RCH)				
Hb	13.1				
PCV	38				
RBC	4.52				
WBC	13,000				
N/L/M	45/48/6				
Platelets	3-90				
CRP					
ESR					
PCT					
RBS	89				
Na	141				
K	4.3				
Cl / HCO ₃ ⁻	105 / 25				
Ca/Mg	1.20				
Phosphate					
Urea	20				
Creatinine	0.54				
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	16.3 / 1.18				
APTT	26.6				
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..) :

ANC-00001486 IP18-00036536
 Baby ATHULYA EZHAMVALUTHI
 10-06-2021 5 Y 1 M 10 D (F)
 Dr. NANDHINI G



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

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

RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc..) :

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: 703

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	SYP. COPHALEXIN	(250mg/ml)	q/c	oo-sm	11/7/26	☐ 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. Karthika

Date & Time: 20/7/26 6:40 am

Nurse Name & Signature: Rishy

Date & Time: 20/7/26 @ 7:am



DRUG CHART

Date of Admission: 20/7/26 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:																
DRUG :				Date Time												
Dose	Route	Frequency	Start Date													
Doctor's Signature		Valid Period	Pharm.													
Additional Instructions:																



REGULAR PRESCRIPTIONS

Weight 16.2 Ward 7th floor

DRUG : <u>INJ. CEFOTAXIME</u>				Date	Time
Dose	Route	Frequency	Start Date		
<u>800mg</u>	<u>IV</u>	<u>Q8H</u>	<u>20/7</u>	<u>1 am</u>	<u>20/7</u>
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INJ. AMIKACIN</u>				Date	Time
Dose	Route	Frequency	Start Date		
<u>250mg</u>	<u>IV</u>	<u>Q24H</u>	<u>20/7</u>	<u>4 pm</u>	<u>20/7</u>
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INJ. PARACETAMOL</u>				Date	Time
Dose	Route	Frequency	Start Date		
<u>170mg</u>	<u>IV</u>	<u>Q8H</u>	<u>20/7</u>	<u>10 am</u>	<u>20/7</u>
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INJ. EMESE 7</u>				Date	Time
Dose	Route	Frequency	Start Date		
<u>1.5mg</u>	<u>IV</u>	<u>Q8H</u>	<u>20/7</u>	<u>10 am</u>	<u>20/7</u>
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

IP18-00036536

ANC-00001486
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D

10-06-2021

5 Y 1 M 10 D

(F)

Dr. NANDHINI G



Weight. Ward.

Date > Time		Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
Dose		Dose		Dose	
Dr. Sign.		Dr. Sign.		Dr. Sign.	
Dose		Dose		Dose	
Dr. Sign.		Dr. Sign.		Dr. Sign.	
Dose		Dose		Dose	
Dr. Sign.		Dr. Sign.		Dr. Sign.	
Dose		Dose		Dose	
Dr. Sign.		Dr. Sign.		Dr. Sign.	
Dose		Dose		Dose	
Dr. Sign.		Dr. Sign.		Dr. Sign.	

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

STAT / ONCE ONLY DRUGS

[illegible]

Weight. Ward.

[illegible]

Ra' ANC-00001486 IP18-00036536
 Ch Baby ATHULYA EZHAMVALUTHI
 Ho 10-06-2021 5 Y 1 M 10 D (F)
 Dr. NANDHINI G

Ref. No.: F / HW / DC / RP / INPR / 05.a



I.P. No. Sheet No. Wards Weight (kg)

REGULAR PRESCRIPTIONS

DRUG : INJ. PANTOPRAZOLE

Dose 20mg Route IV Frequency OD Start Dt. 20/7

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose Route Frequency Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose Route Frequency Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose Route Frequency Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

CIN : U85110 TG1998 PTC029914



3

20h to 20h to 20h to 20h to 20h to

MEDICATION CHART AUDIT CHECKLIST - IP

	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
DRUG NAME	I.V. Cefotaxim	I.V. Amikacin	I.V. Paracetamol	I.V. Fentanyl	I.V. Pantoprazole		
FREQUENCY	TPS	OD	TPS	TPS	OD		
DOCTORS							
1. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/WRONG UNIT OF MEASUREMENT							
4. NO/WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES	✓	✓	✓	✓	✓		
11. NON-USAGE OF GENERIC NAMES	✓	✓	✓	✓	✓		
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINT YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED)).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							

MEDICATION CHART AUDIT CHECKLIST - IP

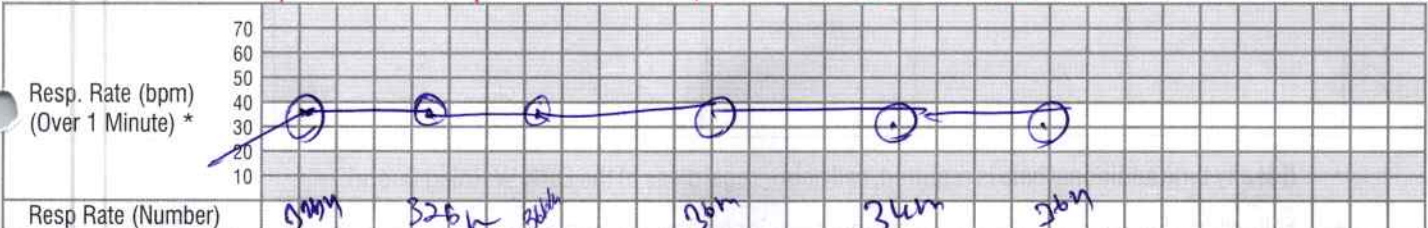
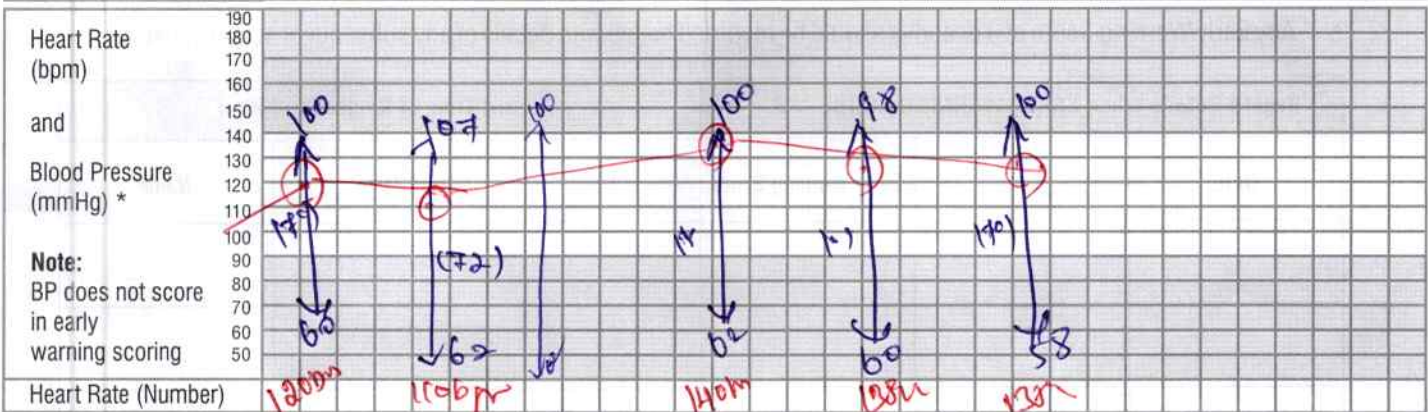
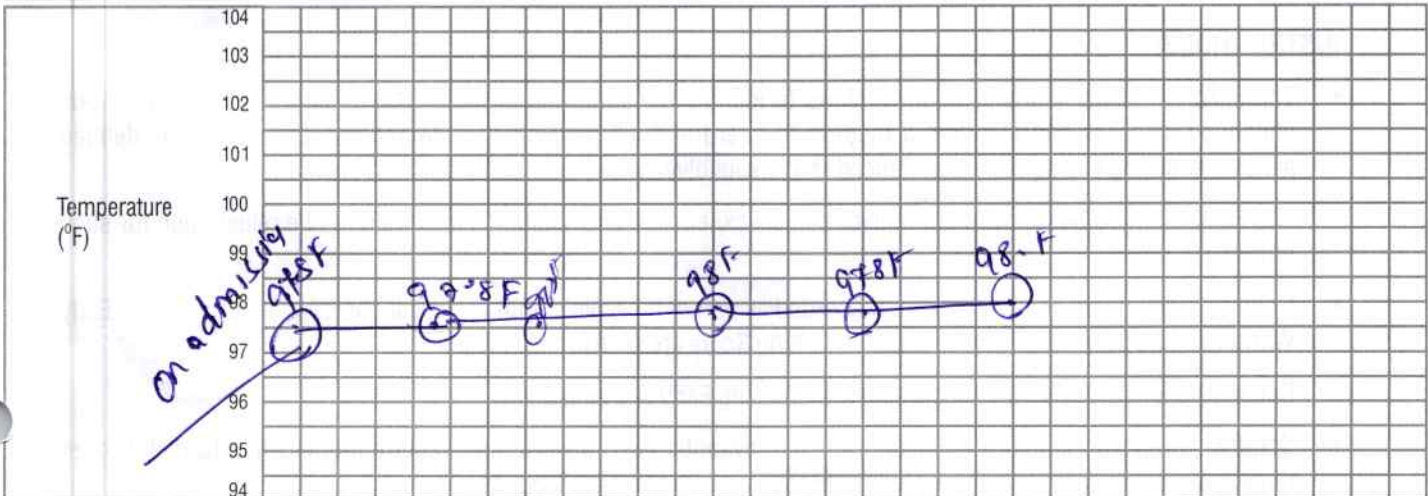
	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
DRUG NAME							
FREQUENCY							
DOCTORS							
1. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/WRONG UNIT OF MEASURE							
4. NO/WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES							
11. NON-USAGE OF GENERIC NAMES							
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7/22 Time: 4:15 PM
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	99%	99%
O ₂ Saturations (%)	99%	99%
Conscious Level	Normal	Altered
GCS *	15	15
TOTAL SCORE	0	0
Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	AN	AN

ACTIONS	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.

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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 09/7/20	Time: 8 AM	12 PM	4 PM	8 PM	12 AM	4 AM
Doctor / Nurse / Family Concern?						
Temperature (°F)						
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring						
Heart Rate (Number) 143 bpm, 120 bpm, 132 bpm, 150 bpm, 150 bpm, 200 bpm						
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number) 28 bpm, 30 bpm, 30 bpm, 150 bpm, 150 bpm, 200 bpm						
Resp Mod/ Severe Distress None / Mild Receiving O₂ (l/min) O₂ Saturations (%) Conscious Level Normal / Altered GCS *						
TOTAL SCORE Number of shaded boxes Pain Score Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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)

ANC-00001486 IP18-00036536
 Baby ATHULYA EZHAMVALUTHI
 10-06-2021 5 Y 1 M 10 D (F)
 Dr. NANDHINI Q



1



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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

On admission @ ER to the floor
 NPO
 NPO
 NPO



FLUID CHART

Sheet No. : 2

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
26	08:00 am	NPO									0	✓	
	09:00 am										0	✓	
	10:00 am	NPO	250ml								0	✓	
	11:00 am	NPO	100ml						5		0	✓	
	12:00 pm	NPO							150ml		0	✓	
	01:00 pm	NPO	10ml								0	✓	
Total Intake :			360ml			Total Output :					180ml		
	02:00 pm										0	✓	
	03:00 pm	TC	100ml	50							0	✓	
	04:00 pm			50							0	✓	
	05:00 pm	H2O	50ml	50							0	✓	
	06:00 pm			50							0	✓	
	07:00 pm			50					210ml		0	✓	
Total Intake :			150ml + 250ml			Total Output :					210ml		
	08:00 pm			50ml							0	✓	
	09:00 pm	H2O	100ml	50ml							0	✓	
	10:00 pm	H2O	50ml	50ml							0	✓	
	11:00 pm			50ml							0	✓	
	12:00 am			50ml					200ml		0	✓	
	01:00 am			50ml							0	✓	
Total Intake :			150ml + 300 = 450ml			Total Output :					200ml		
	02:00 am			50ml							0	✓	
	03:00 am			50ml							0	✓	
	04:00 am			50ml							0	✓	
	05:00 am			50ml							0	✓	
	06:00 am	H2O	100ml	50ml							0	✓	
	07:00 am			50ml					150ml		0	✓	
Total Intake :			100ml + 300 = 400ml			Total Output :					150ml		
Total 24 hrs. Intake		1610 ml											
Total 24 hrs. Output		700ml											



FLUID CHART

Sheet No. : 5

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.

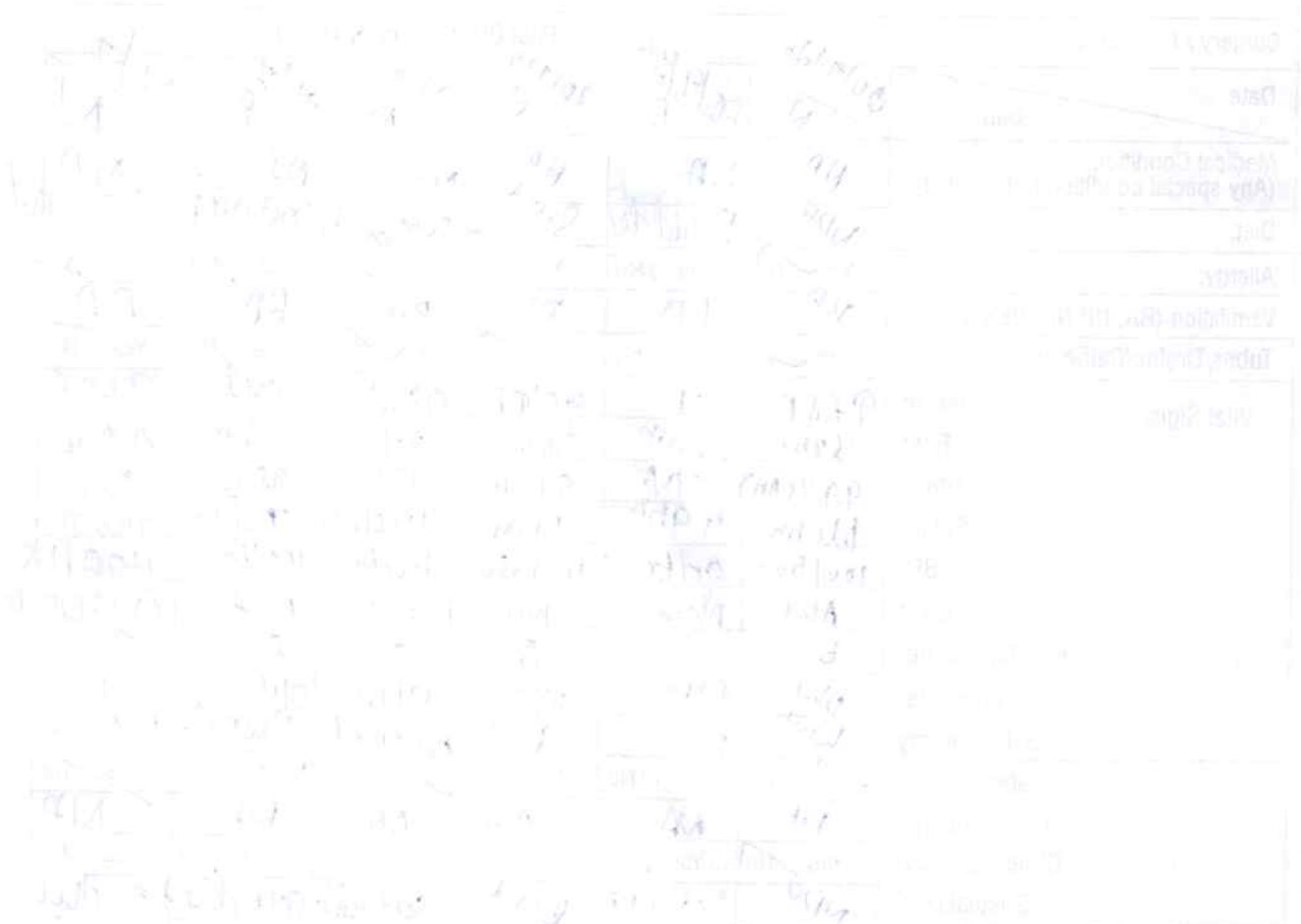
Date		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
21/2/26												
	08:00 am	H ₂ O	100ml	50ml							0	V.A
	09:00 am	H ₂ O	100ml	50ml							0	V.A
	10:00 am			DL							0	V.A
	11:00 am	Soup	100ml	DL					300ml		0	V.A
	12:00 pm	Juice	50ml	50ml							0	V.A
	01:00 pm	H ₂ O	50ml	50ml					300ml		0	V.A
Total Intake : 400ml + 170ml = 570ml					Total Output : 650ml							
	02:00 pm	H ₂ O	50ml	20							0	A.
	03:00 pm	H ₂ O	50ml	20							0	A.
	04:00 pm	H ₂ O	50ml	20					350		0	A.
	05:00 pm	H ₂ O	50ml	20							0	A.
	06:00 pm	H ₂ O	50ml	20							0	A.
	07:00 pm	H ₂ O	50ml	20					350		0	A.
Total Intake : 150 - 300ml + 120ml = 420ml					Total Output : 700ml							
	08:00 pm			20							0	A
	09:00 pm	H ₂ O	100ml	20							0	A
	10:00 pm	H ₂ O	50ml	20					300ml		0	A
	11:00 pm			20							0	A
	12:00 am			20							0	A
	01:00 am			20					600ml		0	A
Total Intake : 150 + 120 = 270ml					Total Output : 600ml							
	02:00 am			20							0	A
	03:00 am			20							0	A
	04:00 am			20							0	A
	05:00 am			DL							0	A
	06:00 am			DL					100ml		0	A
	07:00 am	Baby In		P.C							0	A
Total Intake :					Total Output : 100ml							
Total 24 hrs. Intake			1260ml			Total 24 hrs. Output			2050ml			

NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>Pyloplasty done.</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known	
		Surgery / Procedure:		If Yes Specify: <u>N/A</u>	
		Post OP Day: <u>Day - 1</u>			
BACKGROUND	Date	20/9/20	20/9/20	20/9/20	21/9/20
	Shift	N	E	N	M
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA
ASSESSMENT	Diet:	NPO	Liquid diet	Soft diet	Soft diet
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 97.8 F	Temp: 98.0 F	Temp: 98.0 F	Temp: 97.8 F
	Res: 32bpm	Res: 22bpm	Res: 36bpm	Res: 30bpm	
	SpO ₂ : 99% (am)	SpO ₂ : 99%	SpO ₂ : 99% (am)	SpO ₂ : 98%	
	Pulse: 140bpm	Pulse: 119bpm	Pulse: 140bpm	Pulse: 130bpm	
	BP: 100/60	BP: 90/60	BP: 100/60	BP: 100/60	
	LOC: A&V	LOC: Alert	LOC: A&V	LOC: Alert	
Recommendations	Fall Risk Score:	8	8	8	8
	Pain Score:	0/10	0/10	0/10	0/10
	Skin Integrity:	Intact	Intact	Intact	Intact
	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:	NA	NA	NA	NA
Recommendations	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	NPO	Soft diet	Soft diet	Soft diet
	Critical Lab Test / Values:	-	-	-	-
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	
Post Operative Procedure Special Orders:					
Handed Over By Name :		E. Srinivas			
Signature / ID :		[Signature]			
Date:		20/9/20			
Time:		8pm			
Taken Over By Name :		S. Madhavi			
Signature / ID :		[Signature]			
Date:		21/9/20			
Time:		8am			

WIRING SHIP BA

Wiring Diagram



NC-00001488 IP18-00038536
 Baby ATHULYA EZHAMVALUTHI
 0-08-2021 8 Y 1 M 10 D (F)
 R. NANDHINI G

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING CARE RECORD

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	7:45 PM	- Assess the child's Genie condition - provide psychological support to child	7:30 AM	- Assessed the child's Genie condition - Provided psychological support to patient	provided psychological support to Pt	child feel better.	PS



NURSING CARE RECORD

Date: 20/7/20

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	8am	Assess the child's general condition & provide psychological support to patient	9am	Assess the child's general condition & provide psychological support to patient	provided to psychological support to pt	Re-assessment was done	J. boathu
Afternoon	2pm	maintain teeth good nutritional status	2:30 pm	maintained good nutritional status.	monitored AIO chart and recorder	Reassessment done	By al
Night	7:30pm	- Assess the child's general condition. - Provide painkillers as per doctor's order	10:00pm	- Assessed the child's general condition. - Provided painkillers as per doctor's order	provided painkillers as per doctor's order	child feels better	L



NURSES NOTES

☒ No known Drug Allergies

☐ Drug Allergies N/A

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving notes on 20/11/22	
	7:15 PM	Child Received from ER to 7 th floor. Child conscious and oriented. Child detail handy Over taken from S/N Rishi	
		① Puro - for ② Pyeloplasty plan @ 9:30 AM plan. Vital signs checked and Recorded.	
		Temp - 97.6 F; Pulse - 128 bpm, BP 100/60 (80) ~, RR - 32 bpm, SpO2 - 98%	
		Diluting clearance done Op with (R)	AK
		plan shifting root @ 8:30 AM →	
	7:30 AM	Child leave NPO from today @ 6 AM. Child detail handy	
		On On (M) diet shift →	AK
		MORNING RURY	
	7:30 AM	Baby detail feeding over taken from night duty staff	
		Baby wear stable admission on	
		7:30 AM. Baby planned for	
		shifted to 8:30 AM on OT.	1/60714
	8:00 AM	vitals were checked and recorded maintain go chart.	1/60714
		Shifting notes	
	8:30 AM	child shifted to 7 th floor to OT. 8:30 AM handing over sign by OT Staff	1/60714

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies *Nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>OT notes</u>	
<i>20/12/26</i>	<i>8:30am</i>	<i>=> child received to pre op area. child ID Band, consent checked.</i>	<i>[Signature]</i>
	<i>8:35 am</i>	<i>=> child received to OT.</i>	<i>[Signature]</i>
		<i>=> Anaesthesia given by Dr. Ashwini Dr. Mohan. under General Anaesthesia.</i>	
		<i>=> Surgery done by Dr. Nandhini.</i>	
		<i>=> painting and draping done under aseptic precaution.</i>	
		<i>=> Ureteral stent Insert (Size 4FR Length 16cm)</i>	
		<i>=> Instrument count, Gauze count mop count, pennant count checked and correct.</i>	<i>[Signature]</i>
		<i>=> Foley's catheter (Silicon) insitu urine drain clear.</i>	
<i>11am</i>		<i>=> Child shifted to recovery area. child vital signs stable. Tem. 98.6°F HR: 92b/m SpO2: 97% RR: 30b/m.</i>	
<i>11:00pm</i>		<i>=> child shifted to 7th floor. child handed over to 7th floor staff.</i>	<i>[Signature]</i>
		<u>RECEIVING NOTE</u>	
<i>11:00pm</i>		<i>Pt received from OT to 7th floor. Baby wear CBB</i>	
		<i>drp fluid not mentioned, NPO</i>	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies *Nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		break on 11:00pm, Stunt were placed on left armra. <i>Nil</i>	
		IV line a pattern. no other Complaint - Dr. prahla	
		Sis opinion not mentioned	<i>60332</i>
		Date.	
	1:10pm	Break & nipo Sues a sip of water. no other complaint of ~~working~~	<i>60332</i>
	1:30pm	Baby detail handing over given by evening duty staff.	<i>60332</i>
		Evening Duty Note.	
	1:30pm	Handover Received from morning Duty staff. Urid Ps active and Accented IV line present. DR. O. N. DRS - 0 Pica some/hr on flow. CBD Present & silicon catheter. Dr. prahla sis opinion. there.	<i>60332</i>
	2:30pm	Dr. Nandhini nann came and seen the Patient advice to continue IV antibiotic and I fluid. tomorrow born HB, PCV.	<i>60332</i>
	4pm	Checked vitell sign and recorded	<i>60332</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies N.D.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		hematuria present Inform to Dr. Uday Vignesh sir. advice remaining Dr. prahlad sir opinion. message.. Dr. prahlad sir message send. Sir seen the message on But Not Reply. again Inform Dr. Uday Vignesh sir. came and seen the Baby advice to continue. IV fluid. Dr. Uday Vignesh sir told prahlad sir not pickup phone. if sir replay need to follow Dr. prahlad sir orders.	
	5:30pm	Baby complaining pain. Inj. para long given for pain relief.	
	6pm	Administered due medication as per chart were output - 20ml.	
	7pm	Monitored input and output chart and Recorded	
	7:30pm	Handover given to night duty staff	
	7:30pm	Night duty on 20/12/22 Patient details handy over taken from evening duty staff Child active and good	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE								
20/7/20		Child is on soft diet. urine drained well hematuria present in the urine. IVF-0.9% h/m 50m/L on flow of the child. IV line pattern	Shk								
	8pm	vital sign checked and Recorded.	Shk								
		<table border="1"> <tr> <td></td><td>CP</td><td>PP</td><td>FT</td></tr> <tr> <td>8pm</td><td>+</td><td>+</td><td>une</td></tr> </table>		CP	PP	FT	8pm	+	+	une	
	CP	PP	FT								
8pm	+	+	une								
	10pm	One medication given as per Doctor's orders Dr. Luched for seen the child advised by continue as per chart Discharged his opinion tomorrow, w/7 tachycardia, 116, PRV, RPR cl/mban	Shk								
21/7/20	12pm	vital sign checked and Recorded. IVF-0.9% h/m 50m/L on flow of the child	Shk								
	1pm	Tj. cefotaxime 500mg given IV flow.	Shk								
	2pm	Child sleeping well. posture comfortable position.	Shk								
	4pm	maintain Intake and output chart. vital sign checked and Recorded	Shk								

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☒ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE												
21/7/21		<table border="1"> <tr> <td></td> <td>CP</td> <td>PP</td> <td>IFT</td> </tr> <tr> <td>12hr</td> <td>+</td> <td>++</td> <td>12cc</td> </tr> <tr> <td>4hr</td> <td>+</td> <td>++</td> <td>2cc</td> </tr> </table>		CP	PP	IFT	12hr	+	++	12cc	4hr	+	++	2cc	
	CP	PP	IFT												
12hr	+	++	12cc												
4hr	+	++	2cc												
	6pm.	Morning care is given. The medication given as per doctor's order. Hb. pr. Electrolyte sample sent to Lab.													
	7:30pm.	Child detail handing over to morning duty staff.													
	11:00pm	MORNING DUTY Child detail, handing over taken from night duty staff. Child was stable and conscious and oriented, Child on CRP. not passed motion. 50ml/hr Antibiotic was taken as IV medication.													
	8:00am	Vitals were checked and recorded maintain T/O chart no other complaint. feed taken minimal amount.													
	9:00am	Medication was given as per drug order.													
	10:00am	<table border="1"> <tr> <td>10hr</td> <td>CP</td> <td>PP</td> <td>IFT</td> </tr> <tr> <td></td> <td>++</td> <td>++</td> <td>2cc</td> </tr> </table>	10hr	CP	PP	IFT		++	++	2cc					
10hr	CP	PP	IFT												
	++	++	2cc												

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

— NO KNOWN Drug Allergies

□ Drug Allergies: Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	10:30am	Dr. Nandhini mam came to see the children advice to continue IVP, pain and chest injection to do abdomen screening	60228
	11:00am	child shifted to USG abdomen for Dr. Nandhini mam advice	60228
	12:00pm	Dr. Phetelal Sir came to see the pt. as advised to keep bowel, IVP 20ml/hr was advised. vital was checked and recorded. neta No chart	60228
	1:00pm	Urine was drained 30ml child was stable IVP on 20ml/hr	60228
	1:30pm	Child details handing over given by evening duty staff	60228
		Evening Duty notes.	
	1:30pm	Handover received from morning duty staff. Child is active and oriented. IVP present. CBD present & IVP 0.9%. DVS 20ml/hr on flow.	
	2pm	Administered due medication as	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/20	4pm	Rel chart and Recorded. Checked vital signs and Recorded. PP P CR H ++ 10sec	Joey on
	6pm	Administered due medication as per chart and Recorded.	
	7pm	monitored input and output chart and Record.	Joey on.
	7:30pm	Handover given to night duty staff	Joey a
		NIGHT DUTY ON 21/7 child Conditional and details handman child is conscious vitals H.D stable	
	8AM	Assessment vitals H.D stable. IV F.O. DNS 20ml.	
	10pm	Medication will be given. the Drug choice	
	11pm	Encourage Oral liquids.	
	12pm	Provide comfortable position and call Ampicillin.	
	2AM	Child is sleeping well to fall	
	4AM	Antibiotics and Medication given as per the order	
	5AM	Personal and Oral care given Done	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



OPERATION NOTES

Surgeon : <u>Dr. Nandhini</u>		Asst. Surgeon : <u>Dr. Dinesh</u>	
Anesthetist : <u>Dr. Ashwini, Dr. Mohan</u>		OT Nurse : <u>S/N. Sasi, S/N. Suganthi</u>	
Pre-Operative Diagnosis:			
Surgical Procedure : <u>① Dismembrans pyeloplasty</u>			
Weight :		Date : <u>20/7/26</u>	Start Time : <u>9:05 AM</u> End Time : <u>10:50 AM</u>
Post Operative Diagnosis:			
Peri-Operative Complications: <u>m</u>			
Operation Notes: <u>① flank incision / Extraperitoneal approach.</u>			
Findings: <u>① dilated pelvis / narrow PUJO</u>			
<u>② Dismembrans & dilated @ ureter</u>			
<u>③ pelvis closed @ 4-5 mm.</u>			
Procedure Notes: <u>Pyeloplasty done</u>			
<u>5-6 mm ring leaving 6 for 16 mm.</u>			
<u>DJ stent in situ</u>			
<u>Hemostasis verified / water leak verified</u>			
<u>wound closed in layers</u>			
Amount of Blood Loss: <u>-</u>		Blood Transfused (in ML) <u>30/40</u>	
Name and Number of Surgical Specimen sent for examination:			
<u>Bladder catheter</u>		<u>① 10-15 mm</u>	
		<u>② 10-15 mm</u>	

Patient Sticker

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

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

POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters / Frequency:

Adm

1)

mpa hll

12 noon

Wound Care:

2)

Int' h catm

Drain / Special Lines / Catheters:

3)

N Abx

Taxim / Amikacin

Special Patient Positioning and Requirements:

4)

iv paracip 300mg bds

Nutritional Instructions:

5)

iv enent 2mg bds

When to Start Mobilization:

6)

iv par 40mg bds

Special Referrals:

7)

mark hll / up

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

8) 2. prabed dms f6

Name of the Surgeon:

Signature of the Surgeon:

Date & Time:



URINARY CATHETER BUNDLE CHECK LIST

6

Type
ISO 11140

STEAM

Green =
Sterilized

Man.: 2025 - 06
 Exp.: 2030 - 06
 Ref.: 106.303.0500
 Lot.: 14176

SV: 121°C - 15 min.
 134°C - 3,5 min.

Steritech

rthRight
 AINBOW HOSPITALS
 Right to a Safe Delivery

Date of Insertion:

20/7/26

Date of Removal:

22/7/26 @ 11.15 AM

Parameters	Date	Shift Time	20/7/26 Morning	20/7/26 PM	20/7/26 N	21/7/26 M	21/7/26 N	22/7/26 M	22/7/26 M
Need for the Catheter			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Is the line removed as Policy?			☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Onset of New Fever			☒ Yes ☒ No	☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Tham	Soumya	Soumya	P. Kavya	Soumya	Soumya	P. Kavya
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

Patient's Name:

ANC-00001486 IP18-00036536

MRD NO:..

Baby ATHULYA EZHAMVALUTHI

10-06-2021

5 Y 1 M 10 D

(F)

Dr. NANDHINI G

Age :



☐ M ☐ F

Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 20/7/26

Time: 8:40 AM

Location : Cefalic vein

Size : 22G

Cannula inserted by : Dr. Ashwini

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
20/7/26	9 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
20/7/26	11 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
20/7/26	1 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	3 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	5 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	7 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
20/7	8 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	10 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
21/7	12 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	2 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	4 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	6 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	10 AM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	12 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	2 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	4 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	6 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	8 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	10 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	12 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	2 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	4 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	6 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	8 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	10 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK
	12 PM	☐ Yes ☒ No	☐ Yes ☒ No	Obs	OK

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		

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date :

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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

CANNULA 4

Date :

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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

NOTE : * To be assessed within 30 minutes of insertion.

* Every 2 hours if on fluid infusion.

* Every 4 hours if only on IV medication.

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

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

Category	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.
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.
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.
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.
Friction-Shear 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 flip up completely during move. Maintains good position in bed or chair at all times.
Nutritional Usual food intake pattern	1. Very Poor: NPO or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
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.

Highest Risk: 7 | High Risk: 8-16 | Mild Risk: 17-21 | No Risk: 22-3

No Fisk: 22-3

No Fisk: 22-3

No Fisk: 22-3

Sample	Depth	Soil Type	Moisture	Temperature	Notes
1	0-10 cm	Loam	15%	15°C	
2	10-20 cm	Silt	12%	14°C	
3	20-30 cm	Clay	10%	13°C	
4	30-40 cm	Sand	8%	12°C	
5	40-50 cm	Gravel	5%	11°C	
6	50-60 cm	Loam	18%	16°C	
7	60-70 cm	Silt	14%	15°C	
8	70-80 cm	Clay	11%	14°C	
9	80-90 cm	Sand	9%	13°C	
10	90-100 cm	Gravel	6%	12°C	

Soil Analysis Report
 Date: 10/25/2023
 Location: Garden Plot, 7011



BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name :

Age.....

ANC-00001486

IP18-00036536

Baby ATHULYA EZHAMVALUTHI

No.: F/HW/BRD-Q/NSG/04

10-06-2021

6 Y 1 M 10 D

(F)

Dr. NANDHINI Q



Date : <u>21/7</u> <u>27/7</u> <u>22/7</u>				
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.
'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 waking hours.
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.
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.
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 lift up completely during move. Maintains good position in bed or chair at all times.
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
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.
TOTAL SCORE				
Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-3



PAIN ASSESSMENT FORM



Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/11/21	10:05 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
20/11/21	3 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
20/11/21	8 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
21/11/21	2 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
21/11/21	8 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
21/11/21	9 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
22/11/21	8 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
22/11/21	9 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.
22/11/21	8 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr.

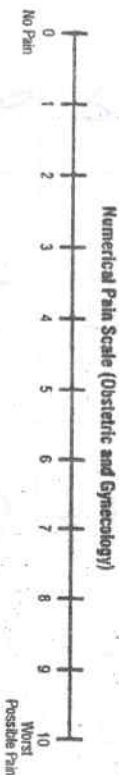
Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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



Wong - Baker (Pediatrics) Above 7 Years



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

Assessment Criteria	Sedation		Mentel	1	Pain / Agitation
	-2	-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- 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 Hyperventilation 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



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:

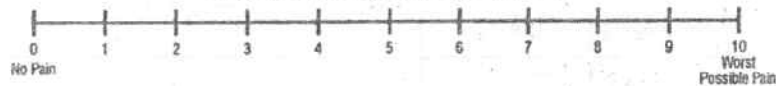
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Wong - Baker (Pediatrics) Above 7 Years





THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2017	2017	2017	2017	2017
	3 to less than 7 years old	3	2	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	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	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	2	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					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	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	1	1	1	1	1
Total			8	8	8	8	8

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		NA	NA	NA	X	X
Other Intervention(s) Specify		NA	NA	NA	X	X
Nurse's Name:		Edna	Edna	Edna	P. Lee	Ch
Signature:		Ph	Ph	Ph	P. Lee	Ch
Date:		2017/6/10	2017/6/10	2017/6/10	2017/6/10	2017/6/10
Time:		7:00 AM	8 PM	8 PM	8 AM	2 PM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			M				
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	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					
	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	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	1				
Total			8				

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		x					
Nurse's Name:		SD					
Signature:		SD					
Date:		2/7					
Time:		8pm					

1992 152



WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			20/7	20/7	20/7	21/7	21/7	22/7
			Time:	Time:	Time:	Time:	Time:	Time:
			7M	2PM	8P	8AM	2PM	8PM
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0	0	0
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0	0	0
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0	0	0
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0	0	0
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0	0	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0	0	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0	0	0
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0	0	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0	0	0
Total Score			0	0	0	0	0	0
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

Intervention: _____

High Risk = >2 Score
 Moderate Risk = 1-2 Score
 Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			Time:	Time:	Time:	Time:	Time:	Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1						
2	Bedridden recently >3 days or major surgery within four weeks	1						
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1						
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1						
5	Entire leg swollen (Assess for both legs)	1						
6	Localized tenderness along the deep venous system (Assess for both legs)	1						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1						
9	Previously documented DVT (Assess for both legs)	1						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2						
Total Score								
Signature of the Nurse								

Intervention: _____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

NOTE 2



NOTES



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Arrival Time: 7-10pm Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction: nil Body Weight: 16.2 Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>born - @ pugo</u>	<u>nil</u>	<u>nil</u>

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: 16.4 Length: Head Circumference (< 2 years):

Temp.: 97.8 F HR: 120 bpm RR: 32 bpm BP: 100/60 mm

Pain Score: 0 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☒ No Score: 8 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 24) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: nil Location: Frequency: nil Duration: nil

FUNCTIONAL SCREENING: ☐ No Abnormalities Detected
☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected
☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: me (Date/Time): 12/1

Social History: Lives With me

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse's Name: Q/12/2017/120 Date: 2017/12/0 Time:

Signature [Signature]

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

ANC-00001486

IP18-00036536

Baby ATHULYA EZHAMVALUTHI

10-06-2021

5 Y 1 M 10 D

(F)

Dr. NANDHINI G



BirthRight
an's al
at the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☒ No ☐

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/7/20	7:15M	None	NPO explained to Parent	Mother	None	Oral	None	Verbal	None	B.
21/7/20	8AM	Yes	Explain about oral Intake	Mother	None	Oral	None	Verbal	Good	P.R. 60920
22/7/20	8AM	Yes	explain about oral Intake	Mother	None	Oral	None	Verbal	Good	S.D. 60930

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								

ҚАЗАҚСТАН РЕСПУБЛИКАСЫНЫҢ БІЛІМ ЖӘНЕ ҒЫЛЫМ МИНИСТРЛІГІ

Аты	Топы	Жасы	Сыныбы	Түп бағасы	Қосымша бағасы	Барлығы
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50

Аты	Топы	Жасы	Сыныбы	Түп бағасы	Қосымша бағасы	Барлығы
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50

Аты	Топы	Жасы	Сыныбы	Түп бағасы	Қосымша бағасы	Барлығы
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50

Аты	Топы	Жасы	Сыныбы	Түп бағасы	Қосымша бағасы	Барлығы
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50

Аты	Топы	Жасы	Сыныбы	Түп бағасы	Қосымша бағасы	Барлығы
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50
Аманжол	10	15	10	10	10	50

PATIENT TRANSFER FORM

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI (F)
10-08-2021 5 Y 1 M 10 D
Dr. NANDHINI G



Treating Consultant Name Dr. Nandhini		Date & Time of Admission 20/7/26 @ 6:14am	Date & Time of Transfer Order 20/6/26 @ 8:30am
Transfer Ordered by Dr. Nandhini		Reason for Transfer for further procedure	
From Unit 7m floor	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File \$1 file	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring U. Arisani 607728		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : KCP 607728			
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

1. 10/10/10

Patient Name

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Nandhini
Asst. Surgeon : Dr. Dinesh
Anaesthetist : Dr. Ashwini, Dr. Mohan
Scrub Nurse : S/N. Sasi, S/N. Suganthi

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. Nandhini G


Age : Gender :
y Name : Lt. Pyeloplasty
8:35 am Out-time : 11 AM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN	Time: <u>8:40 AM</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☒ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☐ Yes ☐ No ☒ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature :	
Name :	

Before Skin Incision >>

TIME OUT	Time: <u>9:05 AM</u>
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 : <u>Dr. Nandhini</u> <u>65282</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>11 AM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☒ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No	
6 Type ISO 11140 STEAM Green = Sterilized Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 SV: 121°C - 15 min. 134°C - 3,5 min. 	
Signature :	
Name : <u>S/N. Sasi, S/N. Suganthi</u>	



Office of
Public Health
and Safety

Division of
Prevention and
Control

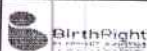
Center for
Disease Control
and Prevention

Atlanta, Georgia
30333

72-110411

10-10-72

10-10-72
Dr. [illegible]
[illegible]



PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 20/7/26 @ 1pm

TRANSFERRED TO: 7th floor

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

PATIENT TRANSFER FORM

ANC-00001488 IP18-00036536

Baby ATHULYA EZHAMVALUTHI

10-06-2021

5 Y 1 M 10 D

(F)

Dr. NANDHINI G



Date & Time of Admission 2017/26 @ 6:14am	Date & Time of Transfer Order 2017/26 @ 1pm.
Treating Consultant Name Dr. Nandhini G	Transfer Ordered by Dr. Mohan
Reason for Transfer For further management	
From Unit OT	To Unit 7th floor
Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 1 IP file	Number of Imaging Films -
Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒	If yes, what ?

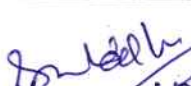
Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring 	Name of Person Ordered Transfer Dr. Mohan
---	--

Patient & Clinical Records Received by :

 607367 at 1pm

Date & Time of Patient Received :

2017/26 @ 11:00pm 607367

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

ANC-00001486

IP18-00036536

Baby ATHULYA EZHAMVALUTHI

10-06-2021

8 Y 1 M 10 D

(F)

Dr. NANDHINI G



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

Shifting From: OT

Shifting to: 1st floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	<u>2. TATAM</u>	<u>500mg</u>	<u>iv</u>	<u>STAT</u>	<u>20/7/26</u> <u>@ 8:50 AM</u>	☐ C ☒ DC
2	<u>2. Paracetamol</u>	<u>500mg</u>	<u>PR</u>	<u>STAT</u>	<u>20/7/26</u> <u>@ 9:30 AM</u>	☐ 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: [Signature]

Nurse Name & Signature: Tharu [Signature]

Date & Time: 20/7/26 @ 1pm.

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



PRE - OPERATIVE CHECK LIST

lirthRight

/ RAINBOW HOSPITALS

It takes a lot to treat the little. Your Right to a Safe Delivery

Date: 20/07/26

Patient's Name: BABY ATHULYA EZHAMVALUTHI^{H1} Age: 5Y Gender: ☐ M ☒ F

Blood Group: O+ve UHID: ANC-00001486

Planned Surgery: PYLOROPLASTY Surgeon: DR. NANDHINI

Anesthetist: DR. DHINESH Date & Time of Operation: 20/7/26 @ 9am

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	YES	NO	NA
1.	Weight checked and recorded? 16.2 kg	☒	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☒	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☒	☐	☐
4.	Enema given / Bowel Preparation	☐	☒	☐
5.	Remove all ornaments, etc and sterile gown given	☒	☐	☐
6.	Is Blood arranged as required?	☐	☒	☐
7.	If Blood has been ordered - is Blood bag ready?	☐	☒	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☐	☒	☐
9.	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐
10.	Pre Medications Given? (Sedatives / etc)	☐	☒	☐
11.	Skin Preparation	☒	☐	☐
12.	Site is marked	☒	☐	☐
13.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☒	☐	☐
14.	Implants are available	☐	☒	☐
15.	Equipment is available	☒	☐	☐
16.	Other (if any)	☐	☒	☐

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

Billing Clearance taken

Billing Executive Name: _____ Nurse In-Charge Name: Rishmi

Billing Executive Signature: _____ Signature of Nurse In-Charge: _____

Date & Time: _____ Date & Time: 20/7/26 2 PM

1000

100

© 2004 Blackwell Publishing Ltd *Journal of Internal Medicine* 255: 103–110

10

CONSENT FORM FOR ANAESTHESIA

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G

Patient Name :

Age : Gender : Male ☐ Female ☐

UHID NO:

Surgeon Name: Dr. Nandhini

Anaesthesiologist :

Operative procedure planned : ① pyloroplasty

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- ☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : HYPOENSION / BRADYCARDIA / PONS
• 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 anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

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

Patient / Patient Attendant :

Signature : Vasanthapriya

Name : Vasanthapriya

Relationship with Patient : Mother

Date & Time : 20/7/20 @ 8:20 AM

Witness :

Signature : Ezhamvaluthi M

Name : Ezhamvaluthi M

Date & Time : 20/7/20 @ 8:20 AM

Doctor (who is taking the consent) :

Signature : Dr. Ashwin

Name : DR. ASHWINI

Date & Time : 20/7/20

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

8:30 AM

8:30 AM

28-11-1971

g. 10/5/48

10/15/2015

Handwritten: $\frac{1}{2} \log 10$

Handwritten signature: *W. J. ...*

② hydrolysis

Mr. H. H. H. H.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Athulya Ezhamvaluthi Age: 5Y Sex: F UHID.No: 1986

Date: 15/7 Time: 4.00pm Proposed Operation: Pyeloplasty

Diagnosis: PUJ obstruction

B.P / CRT: 107/62 mmHg H.R: 126 Weight: 16.3kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>13.1g/l</u>	Glucose: <u>89</u>	Protein: _____	HIV: _____	X-Ray: _____
PCV: <u>38</u>	Urea: <u>20</u>	Alb: _____	HBS Ag: _____	ECG: _____
WBC: <u>13.00</u>	Creat: <u>0.54</u>	Total Bill: _____	HCV: _____	2D Echo: _____
Plate: <u>3.9L</u>	Na: <u>141</u>	Dir. Bill: _____	Blood group: <u>O+</u>	Stress/Angio: _____
PT: <u>16.3 sec</u>	K: <u>4.3</u>	LDH: _____	T3: _____	Other: _____
PTT: <u>26.6 sec</u>	Ca++: <u>1.2</u>	Alk phos: _____	T4: _____	
INR: <u>1.18</u>	Mg++: _____	Amylase: _____	TSH: _____	
	Cl-: <u>105</u>	SGOT/SGPT: _____		

Allergies:

Medical History: CVS:

RESP:

CNS:

Renal:

Hepatic / GE:

Others:

Past Anaesthetic History:

Physical Exam:

Airway:

Lungs:

Heart:

CNS:

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: Acute

Spinal 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:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL: ☒ Standard ☐ High Risk
- Informed Consent: ☒ Discussed with Patient
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

To do CBE, PT, PTT, INR.

Signature: [Signature] Name: Dr. Pujadharini

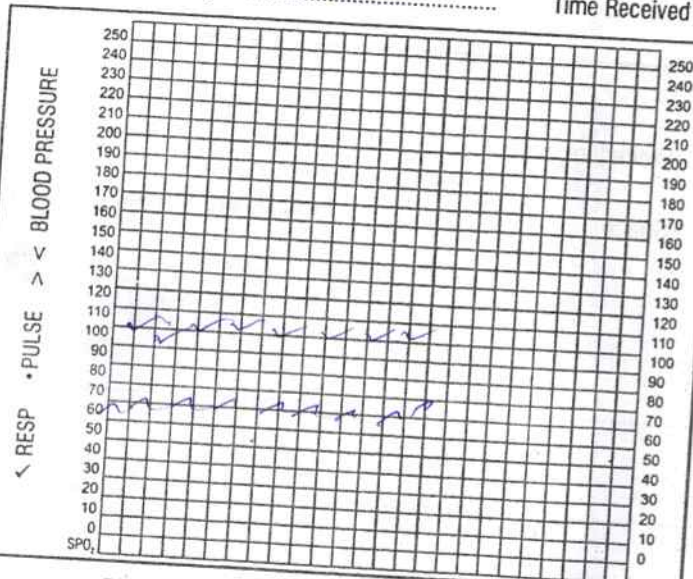
Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Thanu

Time Received : 11 AM

Time Discharged :



IV Cannula Site :
☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No

Drug:

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids:

Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	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 move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2				
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2					
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	2	2				
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2				
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			9	10	12			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			MPo - 1/10	
			Moxib rub	
			1g. Paracetamol 200mg PO	

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☒ NRS

Anaesthesiologist Name : Dr. Ravi

Anaesthesiologist Signature: [Signature]

Date & Time: 20/7/26 @ 11 AM

PACU Nurse Name : Thanu

PACU Nurse Signature: [Signature]

Date & Time: 20/7/26 @ 11 AM

Reassessment Frequency:

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

Transferred to Unit by (PACU): TC

Date & Time: 20/7/26 @

Patient Sticker

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by
Technique (LOR/LOS)

Date: Time:
CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)
Attempts :

CSE /Spinal /Epidural
Depth:
Position: Attempts:
Catheter at Skin:

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)	Maternal	Comments
----	----------	----------

[illegible]

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 :

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



ANC-00001486 IP18-00036536
Baby ATHULYA EZHAMVALUTHI
10-08-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G

Patient Name :

Gender: ☐ Male ☐ Female

Age :

UHID No :



Date :

Instruction:

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

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

Disembowel Nephrectomy

upon

(Name of the Patient)

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

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

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

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

Mr. Vash / Nandini / Nisha

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 : Vasanthi A

Name : Vasanthi A

Date & Time : 20/7/26 @ 8:20 AM

Patient Attendant :

Signature : Ezhamvaluthi M

Name : Ezhamvaluthi M

Relationship with Patient : Father

Date & Time : 20/7/26 @ 8:20 AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : Nandini G

Name : Nandini G

Date & Time :

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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 இந்தப் படிவத்தில் அறுவை சிகிச்சை நிபுணர் கையொப்பமிடுவதற்கு முன்பே, நான் திருப்தி அடையும் வகையில் பதிலளிக்கப்பட்டுவிட்டது.

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

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

.....அதனால்.....
.....நோயாளியின் பெயர்.....

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

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்க்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு :

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....



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 prophylaxis given within 60mts prior to skin incision	yes NA	
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		



PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 20/7/26 @ 2:30 AM		TRANSFERRED TO: OT	
1	Patient Identification	YES/NO	REMARKS
	a. Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b. Surgical procedure & correct site verified	yes	
2	Airway & Breathing		
	a. Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b. SpO ₂ within safe range	yes	
	c. If ETT: position confirmed, ties secure, cuff inflated	NA	
3	Circulation & Hemodynamic Stability		
	a. IV lines secured & infusion running correctly	NA	
	b. No active uncontrolled bleeding	NA	
	c. Last vitals recorded before transfer	yes	
	d. Central line hubs are closed	NA	
	e. Dressing Intact	NA	
4	Pain Assessment		
	a. Pain score assessed & analgesia given	NA	
	b. Reassessment done	NA	
5	Wound, Dressings & Drains		
	a. Surgical dressing intact	NA	
	b. All drains fixed, output noted	NA	
	c. Catheter secure & urine output recorded	NA	
	d. Splints/casts/traction devices stabilized	NA	
6	Medications Pre & Post-Op Orders		
	a. Medications due time noted	yes	
	b. Pre & Post-op instructions (NPO, position, mobilization) communicated	yes	
	c. Emergency meds given in OT (time & dose documented)	yes	
7	Equipment Safety & Transport Preparedness		
	a. Oxygen cylinder full & ambu bag at bedside	NA	
	b. Bed/side rails up and brakes applied	NA	
	c. Special positioning maintained as per surgery	NA	
8	High-Risk Patient Safety (if applicable)		
	a. Chest tube: underwater seal below chest level	NA	
	b. Epidural catheter secure, infusion checked	NA	
	c. Pressure areas protected (heels/elbows)	NA	
9	BLOOD AND BLOOD PRODUCTS TRANSFUSED		
10	REPORTS AND LABS HANDED OVER		
11	BIOPSY/HPE SENT		
12	Documentation		
	a. Documentation completeness		
	Transferring Nurse: _____		
	Receiving Nurse: _____		
	Signature of Incharge: _____		

[Handwritten signature]
 10/07/26



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Nandhini

Date : 20/7/20

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

Start Time of Assessment: 6 am

Weight: 16.2 kgs

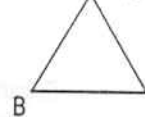
Allergic History: _____

Chief Complaints: _____

① PUJO -
for Pycloplasty ②

Pediatric Assessment Triangle

A Appearance - TICLS Alert



C Circulation ☒ Normal

☐ Abnormal

B Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☐ Pallor ☐

☐ Cyanosis ☐

☐ Mottling ☐

☐ Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening ☐

☐ Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☐ No

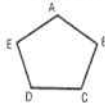
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway



☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Breathing

Rate: 28/min

SpO₂ on FiO₂ RA 100%

Rhythm: regular

Retractions: ☒ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: equal

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 126/min

CFT ☐ Central ☒ Peripheral 23x20

Any urgent interventions needed: ☐ Yes ☒ No

BP: mmHg

Pulse Volume: ☐ Central ☒ Peripheral good

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

If Yes

.....

.....

.....

.....



Disability

GCS: 15/15

AVPU: Alert

Any urgent interventions needed: ☐ Yes ☒ No

Pupils: ☐ Responsive ☒ Non-Responsive ☐
Size ☐ Right ☒ Left 13mm

Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

If Yes

.....

.....

.....

.....

Exposure



Temp: 96.8°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:

Treatment Planned:

Mentioned inside

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. Kantho

Signature: [Signature]

Date & Time: 20/7/26 6:15pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 20/7/26 Time of arrival: @ 6:00 am
Chief Complaints: Came for pyloroplasty RBS: -
Height: - Weight: 16.2 kg 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
- Uses furniture for support

☐ Yes ☒ No
☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No
☐ Yes ☒ No
☐ Yes ☒ No
☐ Yes ☒ No

Mental Status: Forgets limitations

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): -

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse: 30 mins

Time	Nursing Notes
6:10am	child came for emergency planned for pyeloplasty. vitals maintained in normal limits. Anaesthesia given and blood test done by OPD. Baseline s/s DR. Kanitha discussed to DR. Nandhini advised to admission for further management. MPO from 6:00 am, child blood group is positive. child shift to ward.

Samples collected by: I

Time: I

Samples sent by: I

Time: I

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>126</u> BP: <u>94/65</u> CFT: <u>22ACC</u> RR: <u>26</u> SPO ₂ : <u>99%</u> GCS: <u>15/15</u> Temperature: <u>97.5</u> Pain Score: <u>0/10</u> Repeat RBS (if applicable): <u>-</u>	Shift - out from ER to: <u>703</u> Time of Shift - out: <u>7AM</u> Handover given to: <u>s/s Lowmija</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse: Rishu

Signature of the Nurse: Rishu (1020336)

Date & Time: 20/7/26 @ 6:30am



NPO: 8:30pm
Liquid: 6:00AM

Blood: $\rightarrow$ a positive

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

wt. 16.85kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby: Athulya Ezhamvaluthi Age: 5yrs. Gender: ☐ Male ☒ Female
Date: 09.07.2026 Time of Arrival: 6:00AM

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

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

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 96.8°F PR: 126b/min BP: 99/65/76 RR: 26b/min SpO₂: 99% on

Chief Complaints: come for procedure @ pyloroplasty

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	☐ Stable
☒ Normal	☒ Normal	☐ Unstable:
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening
Circulation / Colour	☐ Decreased	☐ Life - Threatening
☐ Normal	☐ Gasping / Apnea	
☐ Abnormal		
☐ Bleeding		

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: 9:00

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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:
- 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: Godwin Sarin

Signature of Triage Nurse: [Signature]

Date & Time: 09.07.2026 @ 6:05 AM

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

PATIENT TRANSFER FORM

ANC-00001486 IP18-00036536

Baby ATHULYA EZHAMVALUTHI
10-06-2021 5 Y 1 M 10 D (F)
Dr. NANDHINI G



Date & Time of Admission <i>20/7/26 @ 6.5 AM</i>		Date & Time of Transfer Order <i>20/7/26 @ 7.15 AM</i>
Treating Consultant Name <i>DR. Nandhini</i>	Transfer Ordered by <i>DR. Udaya Thir</i>	Reason for Transfer <i>further Management</i>
From Unit <i>ER</i>	To Unit <i>703</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>10</i>	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 ☐ <i>for (C) Pyeloplasty</i>		
Name & Signature of Person who is Transferring <i>Rishi</i> <i>[Signature]</i>		Name of Person Ordered Transfer <i>Rishi</i> <i>[Signature]</i>
Patient & Clinical Records Received by : <i>[Signature]</i>		
Date & Time of Patient Received : <i>20/7/26 7:15 AM</i>		

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

