ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S . KEERTHIVASAN

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		5/7/24 @ 9AM	9/5/60				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	11.45 pm	ER	704	
5/7/26	8.00 am	OT	704	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
03/07/26.	CBC, PP2	26021179	
4/7/26.	ESR, CRP	26021269.	
4/7/26	Calprotectin	26021295	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
04/7/26	Infusion pump	12Am		1702 1422	Sd
05/7/26	Endoscopy + colonoscopy	6.33am	7.am	( )	Cat

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
03/7/26	IV line placement	(1)	721361	
04/7/26	CT Scan abdom	(1)	008972	

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 21 D (F)
Dr. S. KEERTHIVASAN

5/7/26 @ 6.30am

Endoscopy + colonoscopy

Surgeon - Dr. Keerthivasan

Anaesthetist - Dr. Ashwini

Start time - 6.33am End : 7.00am

Date: 5/7/26 Time: 5/7/26 @ 9.00am Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 21 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 05/7/2026

Patient Name: Ms. Meera Sathiyothan Date of Birth: ..... Age: 10yr/F

Gender: F Ward : 6(7th)(7th)(Endoscopy) UHID No: 16392/36312

Date of Surgery: 05/7/26 ☒ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Endoscopy + colonoscopy

Time in : 6.30 am Time Out : 7.05 am

	NAME	AMOUNT
1. Surgeon	Dr. Keerthivasan	
2. Anaesthetist	Dr. Ashwini	
3. Assistant Surgeon	—	
4. OT Technician	Mr. Sudharshan	
5. Circulating Nurse	S/N. Gunadevi	
6. Assistant Nurse	S/N. Bharathi	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Endoscopy St- 6.33 am to 7 am)
1722097

Signature of the Surgeon Dr. Keerthivasan

Signature of Circulating Nurse

Record tabulised by S/N. Gangotha

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

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

Glasses - ₹2

Clouds - ₹10

Spoon - ₹ 2

Mr 'Meera

Patient Sticker

Endoscophy + Colonoscopy

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 : Ms. Gnana Devi Technician : MR. Sudhakaran Date : 5/7/26 Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3				Suction Catheter		
HME filter : A / P / N						Feeding Tube 9Fr		1
Syringes : 10 cc		3				Vaccum Suction Set		
05 cc		2	Gloves			Surgical Gloves		
02 cc		2				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set		1	NG tube			Koochies (S)		
RL		1	Cautery pencil			Plastic Apron		1
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			Nasal Canula (1)		1
			Ointments			Atropin		1
			Suction Catheter			Ephedrine		1
Fentanyl		1	Cap, Mask			10 cm vein-o line		1
Morphine			Gauze Pack					
Ketamine			Mop Pack					
Propofol		2	Steristrip					
Rocuronium			Underpad		1			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036312		
Patient Name	Ms MEERA SATHIYOTHAN	**Ward**	7F-PVT/SUITE
Age/Sex	10 Y 1 M 21 D / Female	**Bed Name**	PVT 704
Date	05/07/2026 08:33	**Order No**	18-0001722105
Payor	CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LTD	**Prescription No**	PRIP18-0625004
UHID	ANC-00016392	**Dispensed Date**	05/07/2026 08:44

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**460.00**	**460.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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	IP18-00036312	**Ward**	7F-PVT/SUITE
Patient Name	Ms MEERA SATHIYOTHAN	**Bed Name**	PVT 704
Age/Sex	10 Y 1 M 21 D / Female	**Order No**	18-0001722107
Date	05/07/2026 08:33	**Prescription No**	PRIP18-0625005
Payor	CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LTD	**Dispensed Date**	05/07/2026 08:44
UHID	ANC-00016392		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		1010626	04/29	1	120.00	120.00
2	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
3	UNDERPADS CARE 60 X 90 (FRIENDS)			20062026	12/30	1	205.00	205.00
						Total :	**350.00**	**575.00**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

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	IP18-00036312		
Patient Name	Ms MEERA SATHIYOTHAN	**Ward**	7F-PVT/SUITE
Age/Sex	10 Y 1 M 21 D / Female	**Bed Name**	PVT 704
Date	05/07/2026 08:57	**Order No**	18-0001722117
Payor	CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LTD	**Prescription No**	PRIP18-0625008
UHID	ANC-00016392	**Dispensed Date**	05/07/2026 08:58

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	026B24K67	01/31	3	21.83	65.49
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C03K96	02/31	2	21.56	43.12
3	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B04K17	01/31	2	11.25	22.50
4	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
5	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25J010599	09/30	1	63.00	63.00
6	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	1	525.00	525.00
7	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	2	69.10	138.20
8	OXYGEN NASEL CANNULA (PEAD)	Polymed	GENERAL	G26A040028	12/30	1	255.00	255.00
9	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262078	03/29	1	69.39	69.39
10	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	SM038138	11/27	1	7.30	7.30
						Total :	**1,083.43**	**1,309.00**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

inted Time : 05-07-2026 08:58

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		5/7/16 9AM			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

No: 157, Anna Salai, Guindy, Chennai - 600015

Endoscopy

Patient ID	: ANC-00016392	**Visit Date**	: 05/07/2026
Patient Name	: MS.MEERA SATHIYOTHAN	**Referred by**	: DR SASIDHARAN MD DM
Age/Gender	: 10Yrs, Female	**Consulted by**	: DR.KEERTHIVASAN MD, DM

UPPER GI ENDOSCOPY Report

Premedication : IV SEDATION

Esophagus : Normal

OG Junction : 28 CMS

Stomach :

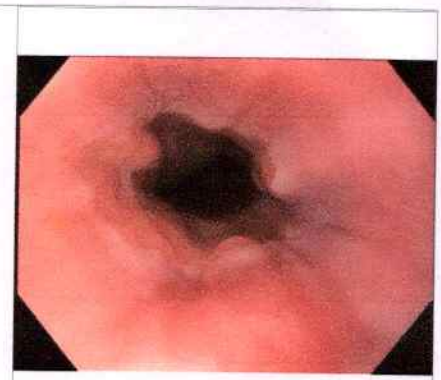
- **Fundus** : Normal
- **Body** : Normal
- **Antrum** : Normal
- **Pylorus** : Normal

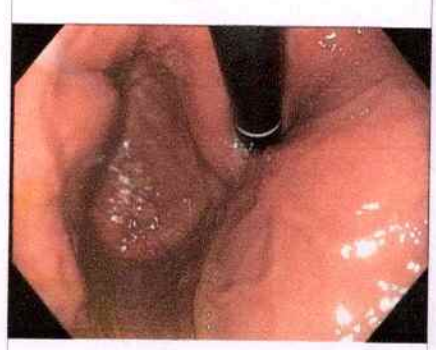
Duodenum :

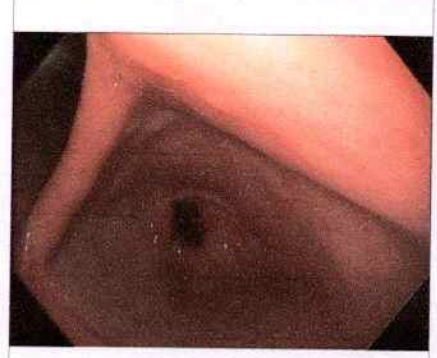
- **D1** : Normal
- **D2** : Normal

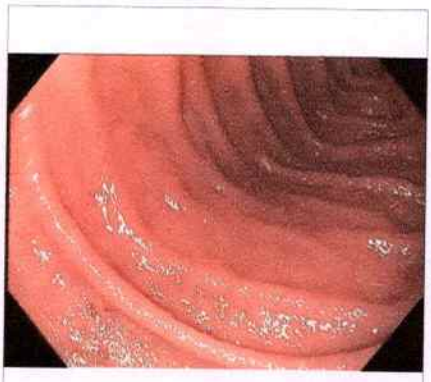
Biopsy : Taken from duodenum and antrum

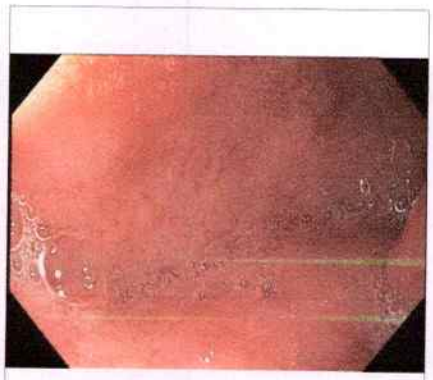
Impression : Normal mucosal study- Await HPE

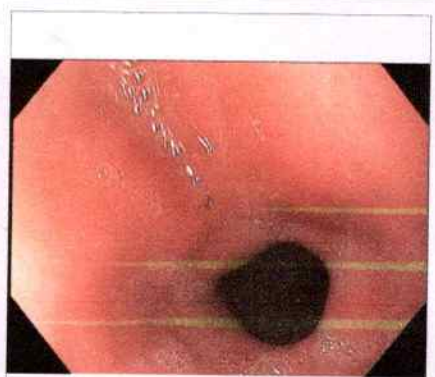












DR.KEERTHIVASAN MD, DM

Rainbow Children's Hospital

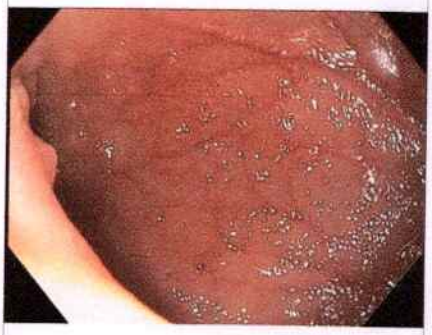
No: 157, Anna Salai, Guindy, Chennai - 600015

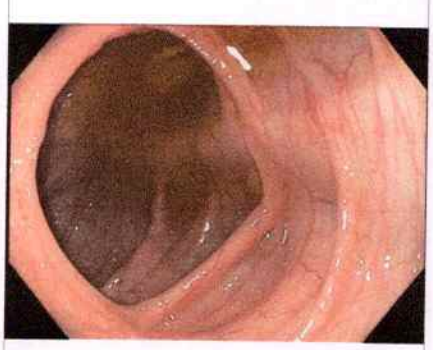
Endoscopy

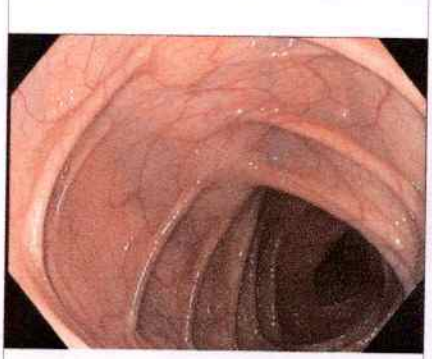
Patient ID	: ANC- 00016392	**Visit Date**	: 05/07/2026
Patient Name	: MS.MEERA SATHIYOTHAN	**Referred by**	: DR SASIDHARAN MD DM
Age/Gender	: 10Yrs, Female	**Consulted by**	: DR.KEERTHIVASAN MD, DM

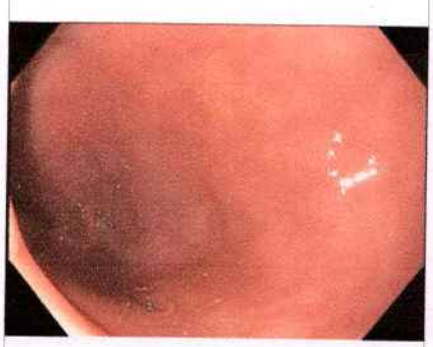
Colonoscopy Report

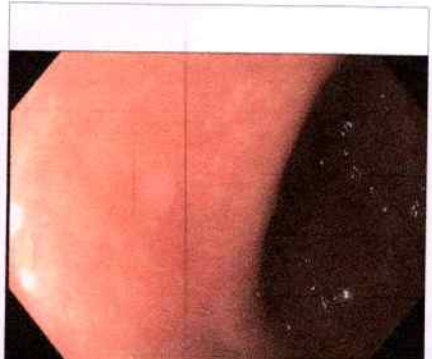
Premedication	:	**IV SEDATION**
P/R	:	Nil
Preparation	:	Normal
Anal Canal	:	Normal
Rectum	:	Few healing erosions seen, Flat subcentimetric polyp seen, Biopsy polypectomy done
Sigmoid Colon	:	Normal
Descending Colon	:	Normal
Splenic Flexure	:	Normal
Transverse Colon	:	Normal
Hepatic Flexure	:	Normal
Ascending Colon	:	Normal
IC Valve	:	Seen till terminal ileum, Normal mucosa
ceacum	:	Normal
Biopsy	:	A- Ileum, B- Cecum/ AC/TC, C- Rectosigmoid, D-Flat polyp
Impression	:	Healing colitis, Sessile polyp- Await HPE

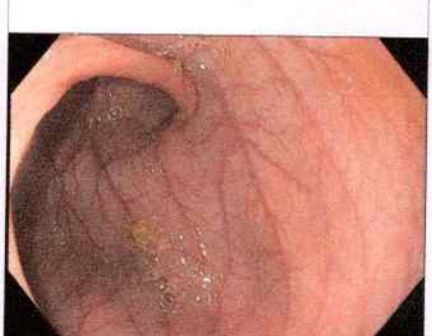












DR.KEERTHIVASAN MD, DM

PRE - OPERATIVE CHECK LIST

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 4/7/26

Patient's Name : Ms. Meera Sathiyaman Age : 10yr. Gender : ☐ M ☑ F

Blood Group : ..... UHID : 3631

Planned Surgery : Colonoscopy Surgeon : Dr. Keerthivasan

Anesthetist : ..... Date & Time of ~~Operation~~ Procedure : 4/7/26 @ 6.30 AM

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : M. Santhana bala

Billing Executive Signature :

Date & Time : 04/07/2026 17.40

Nurse In-Charge Name :

Signature of Nurse In-Charge :

Date & Time :

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	3/7/26	4/7/26								
Doctor's Orders	yes	yes								
Carried out or not	yes	yes								
Bed Side										
Structured Handover done	yes	yes								
IV Site	yes	yes								
Central Lines	NA	NA								
Arterial Lines	NA	NA								
Feeding Catheter	NA	NA								
Urinary Catheter	NA	NA								
Skin Care	yes	yes								
Eye Care	yes	yes								
Mouth Care	yes	yes								
Sterillum Bottle, Stethoscope	yes	yes.								
Suction Bottle (Should be clean & empty)	NA	NA								
Intubation Tray	NA	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA								
Ventilator Tubing, (Any Water, Blood)	NA	NA								
Humidification	NA	NA								
Check all Infusion (Labelling, Correct Preparation)	NA	NA								
Chest Physio & Neb	NA	NA								
Handed Over By Name :	[illegible]	[illegible]								
Signature :	607728	019158								
Date & Time:	3/7/26 @ 8pm	4/7/26 8pm								
Hand Over Taken By Name :	[illegible]									
Signature :	019151									
Date & Time:	4/7/26									

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036312 **Admit Date** : 03-Jul-2026 **Admit Time** : 11:04 PM **UHID** : ANC-00016392

Patient Details :

Patient Name	: Ms MEERA SATHIYOTHAN	**Age**	: 10 Y 1 M 19 D
Guardian	: Mr DR.K . SATHIYOTHAN	**DOB**	: 14-05-2016
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 267, SAI THIRUMALA NAGAR, Meleripakkam Kanchipuram Tamil Nadu INDIA 603003	**Phone No**	: 9884044457/
		E-mail	: sathiyothan@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 DR.K . SATHIYOTHAN **Relationship** : Father

Contact Address : 267, SAI THIRUMALA NAGAR, Meleripakkam Kanchipuram Tamil Nadu INDIA 603003 **Phone No** : 9884044457

Signature

Doctor Details :

Doctor Name : Dr. S . KEERTHIVASAN **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms MEERA SATHIYOTHAN**		
IP No:	**IP18-00036312**	**Age :**	**10 Y 1 M 19 D**
Consultant:	**Dr. S . KEERTHIVASAN**	**Sex:**	**Female**
		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 [redacted] of the patient.

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

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

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

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

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

Signature of Patient/Relative:>

Name: > Dr. K. SATHIYOTHAN

Relationship: > Father

Date: 03-07-2026 Time: 11:04

Witness Name: Arun

Witness Signature:

Patient Address:
267, SAI THIRUMALA NAGAR,
Meleripakkam Kanchipuram Tamil Nadu INDIA 603003

BILLING POLICY

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

DECLARATION

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

Patient Name : > S.R. Meera Sathyalan	UHID Number : 18392
Self/Attendant Name : > Dr. K. Sathyalan.	Relation : > Father
Self/ Attendant Signature : > Phone Number : > 9884044457.	Name & Signature of Financial Counselor

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F) _____
Dr. S . KEERTHIVASAN

Department: _____ _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: Age/Sex

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

=> C/o loose stools for 1 month, semisolid.
blood stained, ↑sed frequency
mucous ⊕, ~8 episodes/day, ass. c̄ pain ⊕
=> C/o abdominal pain on & off for 1 month

=> H/o weight loss ⊕ (1kg in 1month)

USG (2/6/26) - Gas filled colonic loops upto recto sigmoid Jn

Patient Sticker

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

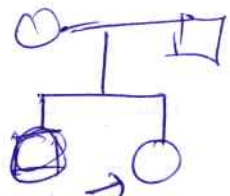
No H/o previous admission

Birth & Neonatal History:

Term | LSCS | 3kg | CIAB

No NICU stay

Family Chart



H/o IBD in aunt & ileal atresia in Cousin.

Birth & Socio Economic History:

About Father : NCM

About Mother :

Any additional Information :

Developmental History :

Appropriate for age.

Immunization History :

up to date as per IAP

Anthropometry :

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

Weight (kgs) 23kg (Centile _____)

On Examination :

Temperature : 98.6F. Pulse Rate : 85/min B.P. 98/76 (85) SPO2 100% @ RA

Resp.rate and type of breathing : 24/min, regular

Rash

Lymphadenopathy No

Oedema :

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BL CAE (+)

Any addes sounds : No added sounds

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : $S_1 S_2$ (+)

Any murmur : No murmurs

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

Per Abdomen :

Inspection : Soft, No distention, No HSM

Palpation : BS (+)

Ausculation :

Spine : External Genitelia : (N)

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : NFND

Cranial Nerves :

Motor System :

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Chronic diarrhoea ↓ evaluation - ? IBS-D
admitted for Colonoscopy

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
RP2
Fecal calprotectin

Planned Management

INJ. XONE
INJ. METROGYL
INJ. PAN
IVF (DNS) maintenance
Plan for OGD & Colonoscopy on sunday

Signature of the Doctor: .....

Name of the Doctor: Dr. S. Mahalakshmi

Date & Time: 03/07/26, 11 PM

Signature of the Consultant: .....

Name of the Consultant: .....

Date & Time: .....

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In:

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(1)

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

Date & Time	Progress Notes	Doctor's Order
4/7/4v 10:15 AM	S/B Dr. DEEPAK	
	Dsw: Chronic diarrhea ↓ Evaluation	
	↓	
	? IBD	
	? IBS-D	
	Child has a H/o: loose stools 6 episodes - 8 episodes per day for past 1 month	
	c̄ associated	
	blood in stools on & off	
	C/o: vomiting - 2-3 episodes	
	No associated: fever	
	O/E: Child is alert, afebrile,	
	CVS: S1S2 ⊕	
	RS: NVBS ⊕	
	P/A: soft / NT TENDERNESS generalized	
	CNS: NFND	

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

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

Date & Time	Progress Notes	Doctor's Order
		Rx
	To plan CECT Abdomen	
	↓	
	NPO from now	
	↓	
	Oral contrast at 2.30 PM	
	↓	
	DO CECT Abdomen	
	↓	
	Only clear liquids after CECT	
	↓	
	then prep for OGD & Colonoscopy	
	6 PM - 400ml Colo prep	
	↓	
	Tr Emeset at 8:00 PM	
	↓	
	10 PM - 400ml Colo prep	
		↓
	NPO from 12:00 AM	
	To monitor	vitals / urine output / sensorium
	→ Dulcoflex Suppository 1mg PR at 12:00 PM	
	→ To collect	Fecal calprotectin
		Cx

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(12)

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

Date & Time	Progress Notes	Doctor's Order
4/7/20 3:25PM	S/B Dr. Deepak	
	Aw: Chronic diarrhoea ↓ evaluation	
	Child reviewed	
	Child is taking oral contrast	
	C/O: intermittent Abd pain	
	O/E:	
	Child is active, alert, afebrile	
	CVS: S1S2 ⊕	
	RS: VBS ⊕	
	P/A: Soft	
	CNS: NFND	
Rx		
	To do CECT	
	↓	
	Preparation for OGD & colonoscopy as per advice	
Rx		
	To monitor vitals / GCS	
	To do Fecal calprotein	
	To trace CRP, ESR	
	To do CECT now	
	[signature]	

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

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

Date & Time	Progress Notes	Doctor's Order

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

Date & Time	Progress Notes	Doctor's Order

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

Date & Time	Progress Notes	Doctor's Order

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

Date & Time	Progress Notes	Doctor's Order

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

Date & Time	Progress Notes	Doctor's Order

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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	23/7/26					
Time						
Hb	12.5					
PCV	36					
RBC	4.55					
WBC	5,900					
N/L	22/67					
Platelets	4,17,000					
CRP						
ESR						
PCT						
RBS	109					
Na	140					
K	4.1					
Cl	103					
(Ca/Mg	1.22					
Phosphate / HCO_3^-	/23					
Urea	17					
Creatinine	0.42					
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-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

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: ER Shifted to: F04

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	T. RIFAGUT	200mg	P/O	1—0—1	3/7/26 8 AM	☑C ☐DC
2	T. COLOSPA-X		P/O	½-0-½	3/7/26 8 AM	☑C ☐DC
3	CAP. VSL-3		P/O	0—0—1	3/7/26 8 PM	☑C ☐DC
4	NEXPRO SACHET	20mg	P/O	1—0—1	3/7/26 8 AM	☑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. S. Mahalakshmi

Date & Time : 03/7/26, 11PM

Nurse Name & Signature: Subhadip Cq

Date & Time : 3/7/26 & 11.30 PM

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S . KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 3/7/26 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:				

Signature .....

VERIFIED BY : Name .....

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

REGULAR PRESCRIPTIONS

Weight. 23.4 kg Ward. 7th floor

DRUG: TAB. RIFAGUT (200mg)				Date / Time	4/7	5/7
Dose	Route	Frequency	Start Date	9 AM	P.K / S.S	
1 tab	P/O	BD	3/7/26			
Name & Signature of the Doctor Starting the Drugs: [signature]						
Additional Instructions:				9 PM	NS / AA	
Daily Doctor's Endorsement by a Sign						

DRUG: TAB. COLASPAX				Date / Time	4/7	5/7
Dose	Route	Frequency	Start Date	7 AM	P.K / S.S	
1/2	P/O	BD	3/7/26			
Name & Signature of the Doctor Starting the Drugs: [signature]						
Additional Instructions:				7 PM	NS / AA	
Daily Doctor's Endorsement by a Sign						

DRUG: CAP. VSL-3				Date / Time	4/7
Dose	Route	Frequency	Start Date		
1	P/O	H/S	3/7/26		
Name & Signature of the Doctor Starting the Drugs: [signature]				9 PM	NS / AA
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG: NEXPRO SACHET (1 sachet (20mg))				Date / Time
Dose	Route	Frequency	Start Date	
1	P/O	BD	3/7/26	w/h
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions: 1/2 hr B/F				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN (F)
14-05-2016 10 Y 1 M 19 D
Dr. S . KEERTHIVASAN

I.V. FLUIDS CHART

Weight. 23.4kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
04/7	12AM	IVF DNS	IV	60	[signature]	SM/VA			
5/7/26	6:30 Am	RL	iv	300ml	S. Vasli 101348	[signature]	5/7/26	S. Vasli 101348	[signature]

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 23.4 kg Ward ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Dt.
1.1g	IV	Q12H	3/7/26

Date/Time: 04/7, 5/7 — 12PM, 12PM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : INJ. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
920mg	IV	Q8H	3/7/26

Date/Time: 04/7 — 2AM, 10AM, 6PM — Stop

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : INJ. PAN

Dose	Route	Frequency	Start Dt.
20mg	IV	OD	

Date/Time: 3/7, 04/7, 5/7 — 11:30 pm, 6AM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : I. EMESET

Dose	Route	Frequency	Start Dt.
2.5mg	IV	Q8H	4/7

Date/Time: 4/7, 5/7 — 6 am, 2 pm, 10 pm

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S . KEERTHIVASAN

(1)

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

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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date 3/7/26. Time:

		12 PM	4 AM
Doctor / Nurse / Family Concern?			
Temperature (°F)	104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94	97.6 F	97.8 F
Heart Rate (bpm) and Blood Pressure (mmHg) *	190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50	100/60 (64)	100/62 (64)
Note: BP does not score in early warning scoring			
Heart Rate (Number)		100b/m	100b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 / 60 / 50 / 40 / 30 / 20 / 10		
Resp Rate (Number)		28b/m	28b/m
Resp Distress	Mod/ Severe		
	None / Mild	✓	✓
Receiving O_2 (l/min)			
O_2 Saturations (%)		99% RA	98% RA
Conscious Level	Normal		
	Altered		
GCS *		15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0
Pain Score		0	0
Observer's Initials		[illegible]	[illegible]

On Admission

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.

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

Doc. No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

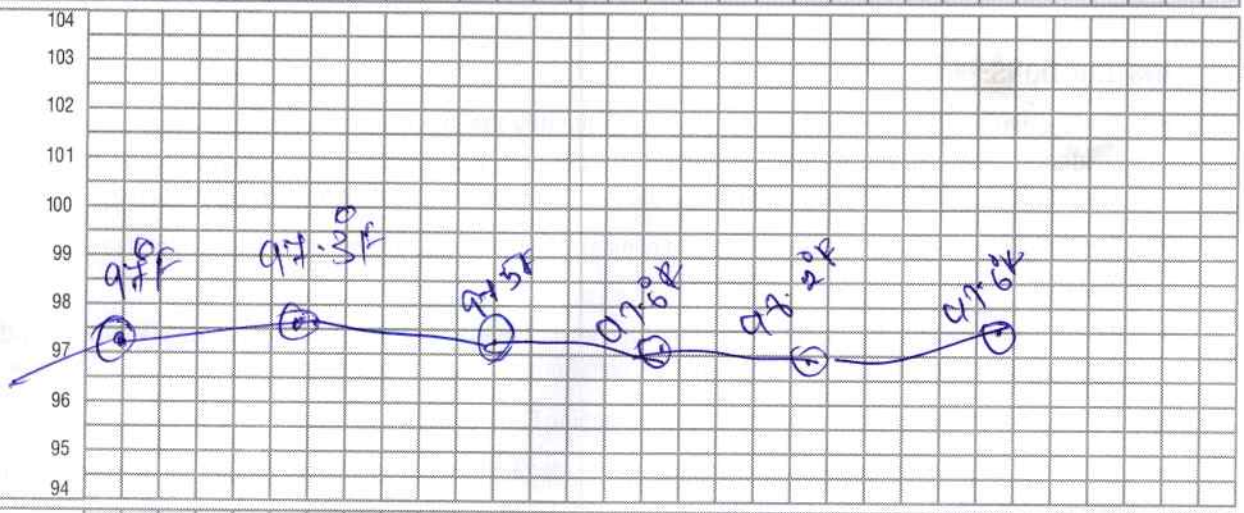
Rainbow® Children's Hospital — It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

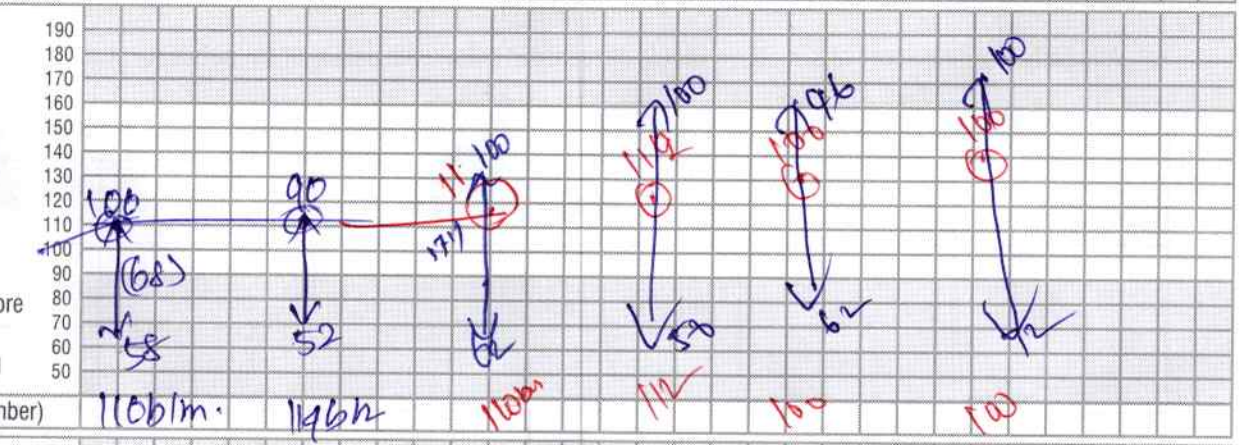
Date: 21/7/16 Time:	8am	12pm.	4pm	8pm	12am	4am
Doctor/Nurse/Family Concern?						

Temperature (°F)



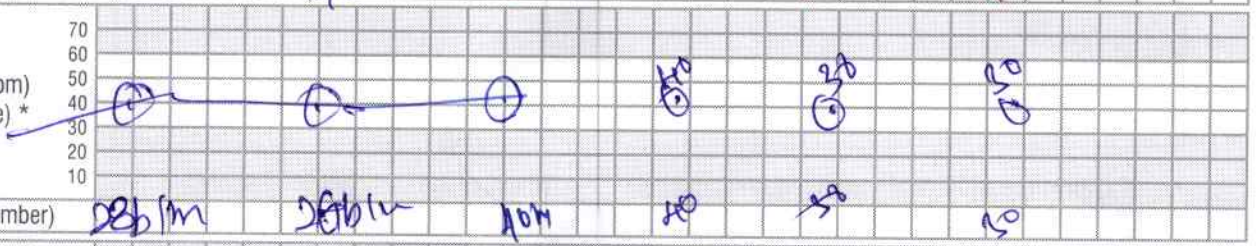
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)	110b/m.	114b/m	110b/m	112	100	100

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



Resp Rate (Number)	28b/m	26b/m	40/m	40	30	30
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)	RA	RA	RA	RA	RA	RA
O_2 Saturations (%)	96%	99%	99% (RA)	100	100	100
Conscious Level: Normal / Altered	✓					
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	AA	AA	AA	AA	AA	AA

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 incharge and PICU /NICU fellow or PICU/NICU 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.

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(1)

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : (1)

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

3/7/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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	H20	50	60						100	0	Sw
Total Intake :		50 + 60 = 110ml				Total Output : 100ml						
	02:00 am			60							0	Sw
	03:00 am	H20	50	60						100	0	Sw
	04:00 am			60							0	Sw
	05:00 am	H20	50	60							0	Sw
	06:00 am	H20	100	60						100	0	Sw
	07:00 am	H20	100	60							0	Sw
Total Intake :		300 + 360 = 660ml				Total Output : 200ml						

on Admission

Total 24 hrs. Intake	770ml

Total 24 hrs. Output	300ml

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 2

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.

4/7/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Motion, ~~Diarrhoea~~	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	H2O	60ml	60			✓			✓	0	SN
	09:00 am			60								
	10:00 am	TC	200ml	60			✓			✓	0	SN
	11:00 am	N		60								
	12:00 pm	P		DC			✓			✓	0	SN
	01:00 pm	O		DC.						✓		
Total Intake :		200ml + 240ml				Total Output :				4 time		
	02:00 pm			60ml							0	SN
	03:00 pm			DC						Self	0	SN
	04:00 pm	H2O	150ml	60ml			✓				0	SN
	05:00 pm			60ml						Self	0	SN
	06:00 pm	Colopm	200ml	60ml			✓				0	SN
	07:00 pm		200ml	60ml			✓			Self	0	SN
Total Intake :		550ml + 300ml = 850ml				Total Output :				3 time self voi		
	08:00 pm	Colopm	100	60			✓			✓	0	SN
	09:00 pm	Colopm	200	DIL			✓			✓	0	SN
	10:00 pm	Colopm	100	DIL			✓			✓	0	SN
	11:00 pm	Colopm	200	60			✓				0	SN
	12:00 am	Colopm	100	60			✓			✓	0	SN
	01:00 am	N		60							0	SN
Total Intake :		700 + 240 = 940				Total Output :				4 time		
	02:00 am	P		60							0	SN
	03:00 am	O		60							0	SN
	04:00 am	N		60							0	SN
	05:00 am			60							0	SN
	06:00 am	P		60						✓	0	SN
	07:00 am	O		60							0	SN
Total Intake :		360				Total Output :				1 time		SN

Total 24 hrs. Intake	2,950 ml	Total 24 hrs. Output	12 time

100ml stool - 1 time

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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: 3/7/2026

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	8pm	Improve knowledge and promote.	9pm	teach medication regimen and follow up care encourage queries to clarity	Improved Knowledge to some extend	Reassessment was done	607733

Docu. No: RCH /FRM / CLINICAL / 148

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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: 4/7/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	maintain good nutritional status.	8:30 am	maintain good nutritional status	IVF 0.9% NS -50ml/hr on flow	Reassessment done	[signature]
Afternoon	1.30pm	- Assess the child general condition - teach the parent how to prevent infection	5pm	- Assessed the child general condition - taught the parent how to prevent infection	taught the parents how for prevent infection	Parents aware of infection	[signature]
Night	8pm	Maintain fluid balance	10pm	Assessed the general condition vital signs are checked & recorded maintain I/O chart	IV fluid on flow	maintaining I/O chart	[signature]

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(1)

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		ADMISSION NOTES	
3/7/2026	11:45pm	Child admission in ER to 7th floor. Child is concious and oriented. Complaints of loose stool for 1 month, abdominal pain on & off for 1 month	607728
4/7/26	12:00pm	vitals was checked and recorded. IVF was connected 60ml/hr. RL no other complaints. Due medication was given. Inj done	607728
	2:00pm	due medication was given. Inj metrodinazole was given no other complaints	607728
	4:00pm	Baby vital was checked and recorded maintain I/O chart no other complaints	607728
	6:00pm	Due medication was given no other complaints	607728
	7:00am	maintain I/O chart and recorded	607728
	7:30am	Child details handing over given by morning duty staff	607728

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Morning Duty Staff.	
4/7/26	7.30pm	Handover Received from Night Duty Staff. Child is active and alert. IV line present. IVF 0.9% DNS bone 1hr on flow.	[illegible]
	8am	Checked vital sign and Recorded.	
	10.15am	Dr. Keerthivasan sir came and seen the patient advice. Now patient NPO. plan CECT with abdomen. plan oral contrast at 2.30pm plan / need to shift CECT at 3pm. 1pm need to give inj-Emeset 2.5mg. plan colonoscopy tomorrow.	[illegible] D1990
	12pm	patient IV line out inform Dr. Deepak sir advice put new IV line. sample CRP, ESR. sended to lab.	[illegible] 019058
	1pm	Monitored I/O chart and Recorded	
	1.30pm	Handover given to evening duty staff	[illegible] 019058

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening duty on 4/7/20	
4/7/20	1.30pm	Child details handing over taken from Morning duty staff. Child conscious and Oriented. IV line pattern. IVF 0.9% NS 60ml/h On flow of the child →	[signature]
	2pm	Oral Contrast 250ml given to Oral route. IV line pattern →	[signature]
	4pm	Vital signs checked and Recorded →	[signature]
		(table below)	
	4.30pm	CE-CT done to patient. Report awaited. Oral started 50ml water →	[signature]
	6pm	Coloprep 400ml Started to give Coloprep. IVF 0.9% NS 60ml/h on of the patient →	[signature]
	7.30pm	patient details handing over On Night duty staff →	[signature]
		← Night duty on 4/7/20 →	
	7.30pm	Patient Report taking over from E duty staff —	[signature]
	8pm	Patient was conscious & oriented, her vital signs are checked & Recorded. Maintained I/O chart	

	CP	PP	CFT
4pm	++	++	<2sec

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
5/7/26	9pm	Inj Emest [illegible] IV mix gm	
		as per order —	[signature]
	10pm	Colopray 172 ā 400ml voided	
		as per order IVF connected	
		as per order loose stool ⊕	
		IV line ⊕ general condition	
		is fair —	[signature]
	12pm	Duroprep 5mg P/R kept	
		as per order IV fluid as	
		on flows pt patient sleeping	
		well	[signature]
	2Am	has no special complaint at	
		present voiding freely general	
		condition is fair —	[signature]
	4am	vital signs are checked & recorded	
		maintained IV during —	[signature]
	6am	morning care given as per	
		due medication given as per order	
		given general condition is fair	[signature]
	6¹⁵pm	pt shift to endoscopy	
		[illegible] pt was received	
		conscious well vital sign are	
		checked & recorded —	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION NOTES

Surgeon : Dr. Keerthivasan	Asst. Surgeon : —
Anesthetist : Dr. Ashwini	OT Nurse : S/N. Bharathi
Pre-Operative Diagnosis:	
Surgical Procedure : OGD + Colonoscopy under IV sedation	

Weight :	Date : 5/7/26	Start Time : 6.33 am	End Time : 7.00am

Post Operative Diagnosis:

OGD scopy

Peri-Operative Complications: → Biopsies from

E – (N) Duodenum

Operation Notes: Await HPE S – (N) Antrum

Findings: D1, D2 → Normal

LGI scopy – TI – (N)

Cecum – (N)

TC/AC – (N)

Procedure Notes: DC/Sigmoid – (N)

Await HPE Rectum – Few erosion (+)

Flat polyp.

Biopsy polypectomy (+) done

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

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: - NPO x 2hrs - Sift diet
Wound Care:
Drain /Special Lines/Catheters:
Special Patient Positioning and Requirements:
Nutritional Instructions:
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No
Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: Dr Keerthivasan

Signature of the Surgeon: .....

Date & Time: 5/7/26 7:30 am

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Keerthivasan
Asst. Surgeon : —
Anaesthetist : Dr. Ashwini
Scrub Nurse : S.N. Bharathi

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

Patient : ..... Gender : .....
UHID : .....
Date : .....
Out-time : 7.50am

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: 6.30am

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 : S. Ashwini 16/3/18
Name : DR. ASHWINI.S

Before Skin Incision ➤➤

TIME OUT Time: 6.40 am

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

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

Anticipated Critical Events

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

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

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

Signature : .....
Name : Dr. Keerthivasan

Before Patient Leaves Operating Room

SIGN OUT Time: 7am

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑Yes ☐No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA
- The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA
- Whether there are any Equipment Problems to be addressed ☐Yes ☑No ☐NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑Yes ☐No

Signature : 16/3/18
Name : .....

Doc. No. : RCH / FRM / CLINICAL / 111

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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: 7th Endoscopy Shifted to: 704

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : DR. ASHWINI S S. Ashwini 101348

Date & Time : 5/7/26 6:30 AM

Nurse Name & Signature: Gunadevi

Date & Time : 5/7/26 7:00 am

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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

Date & Time of Admission	Date & Time of Transfer Order
4/7/26	5/7/26 . 7.55 am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Keerthivasan	Dr. Ashwini	Procedure done

From Unit	To Unit	Information to Attendant
7th (7H)	7th Floor	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/Nr. Cauct	Dr. Ashwini

Patient & Clinical Records Received by :

Date & Time of Patient Received : 5/7/26 8 am

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-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

BirthRight Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 5/7/26 7th (711) room **TRANSFERRED TO :** 7th floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b.Surgical procedure & correct site verified	yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NO	
	b.SpO_2 within safe range	yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
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	yes	
	b.Reassessment done	yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NA	
	b.All drains fixed, output noted		
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	yes	
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	yes	
	b.Bed/side rails up and brakes applied	yes	
	c.Special positioning maintained as per surgery	yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	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**	NO	
11	**BIOPSY/HPE SENT**	yes	
12	**Documentation**		
	a.Documentation completeness	yes	
	Transferring Nurse: Gnat		
	Receiving Nurse :		
	Signature of Incharge:		

CONSI ... R GI ENDOSCOPY

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S . KEERTHIVASAN

Patient Name **Sex:** M / F
Consultant: d & Bed No.: **UHID:**

Description ... the Procedure

Lower GI Endoscopy is a visual examination of the lining of the colon or large intestine. A long, flexible tube (Colonoscope) is passed through the rectum and into the colon. Colonoscopy refers to examination of the entire length of the colon while in Sigmoidoscopy the distal part of the large intestine is visualized. Through the tube, the doctor will be able to look for any abnormalities that may be present. If necessary, small tissue samples (biopsies) can be taken for laboratory analysis. Polyps (abnormal growths of tissues) can also be removed using an electric snare wire and areas of bleeding can be treated by internal injection or the application of heat.

You / Your child will be made to lie on the left side and sometimes an intravenous sedative may be given. The doctor will pass the colonoscope through the anus into the rectum and advance it through the colon. You / Your child may experience some abdominal cramping and pressure from the air which is introduced into your colon. This is normal and will pass quickly. You may be asked to change position during the examination and you / your child will be assisted by a nurse. The examination takes on an average, 15 to 30 minutes.

Precautions

- To allow a clear view, the colon must be completely free of waste material. You / Your child must follow the instructions given by the doctor to ensure adequate bowel preparation
- You must inform the doctor or nurse if you/ your child have any allergies or have had previous endoscopic procedures or surgeries and bring all previous reports.
- You / Your child must remove your eyeglasses.

Risks

Colonoscopy can result in complications, such as reactions to medications, perforation (tear) of the intestine and bleeding. These are very rare (less than 1 in 1000 examinations), but may require urgent treatment including, rarely, surgery. The possibility of complications is increased when the scope is used for treatment, such as the removal of polyps.

CONSENT FOR THE PROCEDURE

1. My questions and concerns about my /my child's conditions, the procedure, cost, risks, and treatment options have been discussed with the doctor and answered to my satisfaction.
2. I have been advised of my / my child's medical conditions, the benefits and reason for the procedure as indicated by the clinical observations and/or diagnostics performed, the risks of not having the procedure, alternative tests I could have and their risks.
3. I recognize that no guarantees have been made regarding likelihood of success or outcomes and also whether the procedure will give the doctor any further information and that further tests may be needed. I also give consent for treatment through the scope if the situation warrants it.
4. I authorize Dr. _____ and such assistants and associates as may be selected by him/her to perform any part of the above procedure upon my self / my child.
5. As with any procedure, I am aware that risks such as blood loss, infection, change in blood pressure, heart failure, anesthetic/allergic reactions, etc. may arise necessitating attention. Therefore, besides consenting to the performance of the procedure, I also consent and authorise the rendering of such other care and treatment as my Doctor or his designee reasonably believes necessary.
6. I understand that biopsy tissue taken during this procedure will be kept for tests for a period of time.

7. I consent and agree to the administration of sedation by Dr. ______________________ or the performance of this procedure. I am aware of the risks of the sedation and also consent to supplementation with any other mode of anaesthesia if necessary.
8. I have informed the Doctor of all my / my child's previous illnesses, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I shall not hold the Hospital or the Doctor responsible for the consequences which may arise from the non-disclosure of the same.
9. I give my consent for the administration of blood product transfusion during this procedure if required. I have been informed that despite careful screening in accordance with national and international regulations, there are rare instances of threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown for which screening tests do not exist. I also understand that unpredictable reactions may occur which include but are not limited to rash and shortness of breath, shock and in rare occasions death.
10. I consent to the photography or television of the procedure to be performed for the purpose of advancing medical education; or its publication in scientific journals provided my /my child's identity is not revealed by the pictures or descriptions in the accompanying texts. I also consent to and authorize the presence of and observation of this procedure by qualified observers, as may be authorized by the Rainbow childrens Hospitals Chennai and its regulatory laws and agencies.
11. I have been explained biological sample (Blood, Body Fluids, tissue) collected from my body for diagnostics tests or surgical resection along with the data may be given without disclosing my identity by Rainbow Doctor to research scientists affiliated with Rainbow childrens hospital for diagnostic or therapeutic research purpose. This will happen only if there is any sample leftover after its intended medical use. There will be no additional sample collected. This research use may not benefit me but will help in better understanding of disease and better treatment for other patients in future. I understand that I will not benefit from any potential commercial value that may result from this research and development activity. I have the option to disallow the research use of the left-over sample.

Please put a tick in the box below, if you do not agree to allow research use of the left-over sample:

☐ I do not agree to allow research use of the left-over samples ---

12.CONSENT OF PATIENT/ PARENT REPRESENTATIVE / SURROGATE

Having understood the above I give my consent for me/ my child undergoing the above said procedure at Rainbow childrens Hospitals, Chennai and absolve the said Hospital, its doctors and the staff in the event of any complication.I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and thereby consent to this procedure.I, ______________________ (name/relationship to the patient), therefore, consent for the procedure to performed on me/ my child

	Signature	Name	Date	Time
Patient Representative with relationship	R. Aruthi	Dr R. Renati	5/7/26	6.35am
Witness	Divy	Dr. K. Sathyapriya	5/7/26	6.35am
Doctor	[signature]	Dr. Keerthivasan	5/7/26	6.35am
Interpreter				

(Authorization of patient/patient representative / surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

CONSE] ANC-00016392 IP18-00036312 ENDOSCOPY

Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

Patient Name **Sex:** M / F
Consultant: **& Bed No.:** **UHID:**

Description of the Procedure

Upper GI endoscopy or oesophago gastroduodenoscopy (OGD) is a visual examination of the lining of the oesophagus, stomach and the first part of the intestine (duodenum). This is performed by passing a long flexible tube through the mouth. The doctor will be able to look for any abnormalities which may be present. If necessary small tissue samples (biopsies) can be taken during the examination for detailed laboratory analysis.

Treatment can also be done through the endoscope. This includes dilatation and/or stenting of narrowed areas, removal of polyps and swallowed objects and treatment of bleeding vessels and ulcers by injection or the application of heat, and procedures such as banding. You / Your child will have to lie on your left side and a guard will be placed to protect your teeth and the scope. A local anaesthetic may be sprayed on your throat to make it numb and occasionally you /your child may be given a sedative injection. The doctor will then pass the scope through your mouth and down the throat while you make a swallowing movement. The instrument will not affect you / your child breathing or cause pain. The examination takes about five minutes on an average.

Precautions

1. You / Your childs stomach must be empty so do not eat or drink anything after midnight.
2. If you / your child are undergoing the procedure in the afternoon, you / your child can have a light breakfast before 8 AM and clear liquids till 11 AM and nil after that.
3. You must inform the doctor or nurse if you / your child have any allergies or have had previous endoscopic procedures or surgeries. Please bring all previous reports.
4. You / Your child must remove your eyeglasses and dentures.

Risks

Endoscopy can result in complications, such as reactions to medications, perforation (tear) of the food passage and bleeding. These are very rare (less than 1 in 1000 examinations), but may require urgent treatment including, rarely, surgery. The possibility of complications is increased when the scope is used for treatment.

CONSENT FOR THE PROCEDURE

1. My questions and concerns about my / my child's condition, the procedure, cost, risks, and treatment options have been discussed with the doctor and answered to my satisfaction.
2. I have been advised of my / my child's medical condition, the benefits and reason for the procedure as indicated by the clinical observations and/or diagnostics performed, the risks of not having the procedure, alternative tests I could have and their risks.
3. I recognize that no guarantees have been made regarding likelihood of success or outcomes and also whether the procedure will give the doctor any further information and that further tests may be needed. I also give consent for treatment through the scope if the situation warrants it.
4. I authorize Dr. _____ and such assistants and associates as may be selected by him/her to perform any part of the above procedure upon myself / mychild.
5. As with any procedure, I am aware that risks such as blood loss, infection, change in blood pressure, heart failure, anesthetic/ allergic reactions, etc., may arise necessitating attention. Therefore, besides consenting to the performance of the procedure, I also consent and authorize the rendering of such other care and treatment as my Doctor or his designee reasonably believes necessary.
6. I understand that biopsy tissues taken during this procedure will be kept for tests for a period of time.
7. I consent and agree to the administration of sedation by Dr._____ for the performance of this procedure. I am aware of the risks of the sedation and also consent to supplementation with any other mode of anaesthesia if necessary.

CONSENT FOR UPPER GI ENDOSCOPY

8. I have informed the Doctor of all my / mychild's previous illnesses, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I shall not hold the Hospital or the Doctor responsible for the consequences which may arise from the non-disclosure of the same.

9. I give my consent for the administration of blood product transfusion during this procedure if required. I have been informed that despite careful screening in accordance with national and international regulations, there are rare instances of life-threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown for which screening tests do not exist. I also understand that unpredictable reactions may occur which include but are not limited to rash and shortness of breath, shock and in rare occasions death.

10. I consent to the photography or television of the procedure to be performed for the purpose of advancing medical education, or its publication in scientific journals provided my / mychild's identity is not revealed by the pictures or descriptions in the accompanying texts. I also consent to and authorize the presence and observation of this procedure by qualified observers, as may be authorized by the Rainbow childrens Hospitals Chennai and its regulatory laws and agencies.

11. The investigation samples (blood or tissue) obtained for diagnostic tests from you may be used by research scientists or scientists affiliated with Rainbows research for the advancement of medical sciences to serve humanity for better preventive or therapeutic purpose. This will happen only if there is any sample left over after its intended medical use. Similarly, data associated with your treatment can be shared with research scientists without disclosing your identity. This research will not benefit you financially but may help in better understanding of diseases and better treatment for future patients.

You have the option to disallow us from such research use of your sample and data.

I confirm that I have read and understood the information and I consent to participate.

.....

12. CONSENT OF PARENT / PARENT REPRESENTATIVE / SURROGATE

Having understood the above I give my consent for me / mychild's undergoing the above said procedure at Rainbow childrens Hospitals, Chennai and absolve the said Hospital, its doctors and the staff in the event of any complication. I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and thereby consent to this procedure.

I ,----------(name / relationship to the patient)therefore, consent for the procedure to performed on me / my child.

	Signature	Name	Date	Time
Patient Representative with relationship		Dr. R. Renuthi	05/7/26	6.20 am
Witness		D. S. SATHIYAN	5/7/26	6.20 am
Doctor		Dr. Keerthivasa	5/7/21	6.20 am
Interpreter				

(Authorization of patient/patient representative surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

PATIENT TRANSFER FORM

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

	Date & Time of Admission	Date & Time of Transfer Order 05/7/26 at 6:15 pm
Treating Consultant Name Dr. Keerthivasan	Transfer Ordered by Dr. Keerthivasan	Reason for Transfer further procedure
From Unit 4th Floor	To Unit Endosurgery Room	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File five	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
S. Meera Mohan	Dr. Keerthivasan

Patient & Clinical Records Received by : Carol

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

Ref No : F / HW / CON / SP / 06

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

BirthRight by Rainbow

CONSENT FOR SPECIAL PROCEDURES AND SEDATION

Patient Name : ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

Gender : M ☐

Age : ..... De

Date : .....

I ..DR. SATHIYOTHAN..... S/DW/O .....

hereby consent for the procedure of ..UPPER GASTROINTESTINAL ENDOSCOPY + COLONOSCOPY.....

.For my patient / myself named ..... UHID NO .....

The doctors have clearly explained to me in language known to me about the following possible complications of the procedure: ..HYPOTENSION / BRADYCARDIA.....

The doctors have explained to me about the alternative to the procedure as : .....

During the procedure myself / my patient will receive intravenous medications for sedation using the following medications : ..INJ. FENTANYL , INJ. PROPOFOL.....

I have been explained about possible complication of sedation such as: fall in blood pressure ☐✓
Fall in heart rate ☐✓ suppression of spontaneous breathing ☐✓, others.....

I have been explained about the alternative to the sedatives as : ..GENERAL ANAESTHESIA.....

I have understood the matter mentioned above and give consent for the procedure as well as sedation.

Name of the Doctor performing the procedure : ..DR. K. KEERTHIVASAN.....

Name of the Doctor administering the sedation:..DR. ASHWINI.S.....

Patient Attendant :

Signature : .....

Name : ..DR. S. SATHIYOTHAN.....

Relationship with Patient: ..FATHER.....

Date & Time : ..5/07/26 6:25 AM.....

Witness :

Signature : .....

Name : ..Dr. R. Renuka.....

Date & Time : ..5/7/26 6:25 am.....

Doctor (who is taking the consent) :

Signature : .....

Name : ..DR. ASHWINI.S.....

Date & Time : ..5/7/26 6:20 AM.....

Departme[nt]
PRE-ANA[ESTHETIC]

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 21 D (F)
Dr. S. KEERTHIVASAN

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Name: .... Sex: .... UHID.No: ....

Date: 5/7/26 Time: 5:10AM Proposed Operation: UGI endoscopy + colonoscopy

Diagnosis: chronic diarrhoea for evaluation

B.P / CRT: 110/54mmHg H.R: 95/min Weight: 23 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.5g/.	Glucose: 109	Protein:	HIV:	X-Ray:
PCV: 36	Urea:	Alb:	HBS Ag:	ECG:
WBC: 5900	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4.17L	Na: 140	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K: 4.1	LDH:	T3	Other:
PTT:	Ca++: 1.22	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-: 103	SGOT/SGPT:	**Allergies:** NKDA.	

Medical History: CVS: Diabetes:

RESP: No fever / URI / LRI.

CNS:

Renal: Physical Activity: admission

Hepatic / GE: term / LSCS delivery / B.W = 3 kg / immunised till date

Others: Ⓝ developmental milestones

Past Anaesthetic History: No H/o previous SA

Physical Exam: Ⓝ built Teeth: No loose tooth

Airway: Ⓝ MP 1 ② 3 4 Mouth Opening: adequate Mentohyoid Distance: Ⓝ Neck: movt Ⓝ

Lungs: B/L NVBS +, clear

Heart: S_1S_2 +

CNS: NFND

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: 22G Spine Exam for regional: Ⓝ

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ~~☐ LMA~~ iv sedation

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

Last oral intake @ 8PM

CURRENT MEDICATIONS	DOSAGE
T. Rifagut	
T. colospa	
Nexpro	
Inj: ceftriaxone 1.1g iv	

Pre-Operative Instructions:
1. DVT Prophylaxis:
2. NIL ORAL — Water / ORS 2 Hours; Others 6 Hours ✓
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

Signature: Dr. Ashwini 101848 Name: DR. ASHWINI. S

Docu. No.: RCH/FRM/CLINICAL/044

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 21 D (F)
Dr. S. KEERTHIVASAN

ANAESTHESIA CHART

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

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: > 6 hrs

Physical Status: I Patient Identified ✓

☑ Consent Present ✓ ☐ Chart Reviewed

H.R: 95/min B.P / CRT: 96/56 mmHg SpO_2: 99–100% R.R: 16/min

Pre-OP Diagnosis: chronic diarrhoea for evaluation

Last Feed: 8PM

Surgeon: Dr. Keerthivasan Operation: UGI endoscopy + colonoscopy Date: 5/7/26

Anaesthesiologist: Dr. Ashwini Technician: Ms. Prashanth

TIME: 6:30AM — 7Am

N_2O/AIR / O_2, LPM: @ 5L/min via nasal cannula

HALO / ISO / SEVO

Drugs:

Inj: fentanyl 40 µg iv

Inj: propofol 60mg + 20 + 10 + 10mg iv

Antibiotic

Suppository

FiO_2 / SaO_2 — 100% →

$ETCO_2$

ECG — NSR →

Temperature

Urine Output

Blood Loss

Fluids / Blood — RL – iv 300ml →

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 10, 0

(Charted: systolic ~100, heart rate ~80, diastolic ~40)

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: (R) calf
☑ Art Site:
☑ EKG Lead
☐ Temp Site
☐ FiO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: (L) lateral
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 6:30AM
OP Start:
OP End:
Leave OR: 7Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP
☑ ART
☑ IV: 22G (L) hand
☐ IV
☐ IV

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

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

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

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

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

Transportation to
☑ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: DR. ASHWINI.S

Signature of the Doctor: [signature]

101348

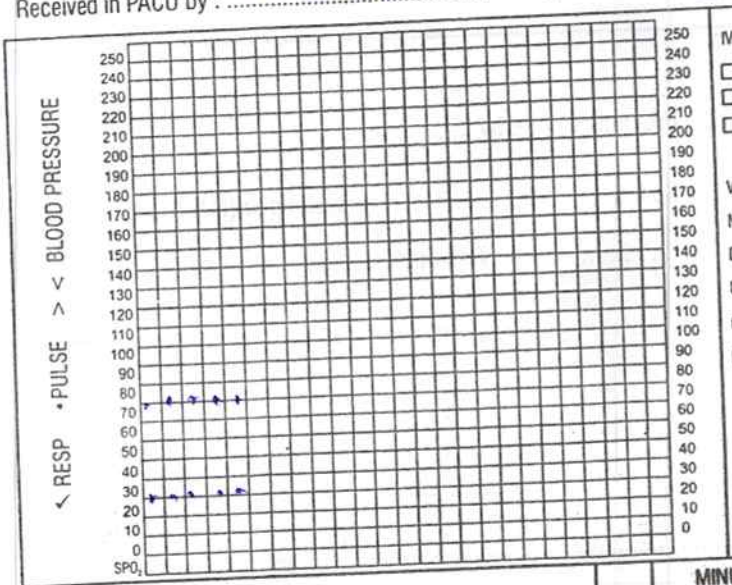
ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 21 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RE UNIT RECORD

Received in PACU by : Anuradha Time Received : 7.30 am Time Discharged : .....



IV Cannula Site : .....

- ☐ O2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

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

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

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
5/7/26	7.30 Am	0/10	NPO X 2 hrs.	S. Ashwin 101348
			other medications as advised	

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

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

Anaesthesiologist Name : DR. ASHWIN. S
Anaesthesiologist Signature: S. Ashwin 101348
Date & Time: 5/7/26 7:30 Am
PACU Nurse Name : Anuradha
PACU Nurse Signature: Anuradha
*Date & Time: 5/7/26

Transferred to Unit by (PACU): .....
Date & Time: .....

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(1)

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

HE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 3/7 N	DATE 4/7 M	DATE 4/7 E	DATE 5/7 M	DATE 5/7 M
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	[illegible]				
	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
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1		1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4		4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	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	1	1	1	1
	Total		14/15	16	16	16	1[illegible]

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
Other Intervention(s) Specify		×	×	NA	×	NA
Nurse's Name:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:		3/7/21	4/7/21	4/7/21	5/7/21	5/7/21
Time:		10 pm	8 am.	3 pm	8 pm	8 am

Docu. No. : RCH /FRM / CLINICAL / 005

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(2)

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	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					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

BRADEN 'Q' SCALE

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight by Rainbow Hospitals — Your Right to a Safe Delivery

				Date :	13/7	[illegible]	[illegible]	4/7
				Time :	N	[illegible]	E	M
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	24	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BRADEN 'Q' SCALE

					Date : 5/7/26			
					Time : M			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	28			
				Evaluator's Name				

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

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

(1)

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/26	12:00	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature] 60772
4/7/26	4:00	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature] 60772
4/07/26	8am	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	[signature]
4/7/26	2pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature]
4/7/26	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	Nil	[signature]
5/7/26	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	Nil	[signature]
5/7/26	8AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

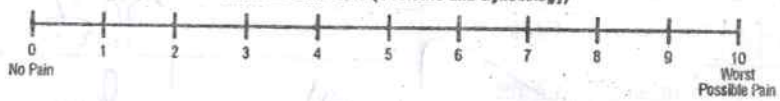
Re-assessment Frequency:

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

(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:....... ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
MRD NO:................ 14-05-2016 10 Y 1 M 19 D (F)
Dr. S . KEERTHIVASAN
Age :.................... V I F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 03/7/26 Time: 11:20pm.
Location : (R) metacarpal
Size : 22G.
Cannula inserted by : S/N praveen.

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
3/7/26	11:20pm	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
4/7/26	2:00am	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
	4:00am	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
	6:00am	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
	8 am	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	10 am	☐Yes ☑No	☐Yes ☑No	Obsv	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	Obsv	[illegible]
4/7/26	2pm	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	"	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	"	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
5/7/26	12am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

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

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

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

wt: 23.4 kg

Patient's Name : Ms. Meera Sathiyothan Age : 10y.
Gender: ☐ Male ☑ Female
Date : 03/7/26 Time of Arrival : 10:50 pm.
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: 95.8° PR: 85 BP: 98/46(25) RR: 24 SpO_2: 98
Chief Complaints: plan: Endoscopy + colonoscopy

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking
Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding
Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
Triage Completion Time : 2min.

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☐ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☐ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☐ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
☐ The patient should be given a surgical mask immediately, if not already wearing one.
☐ Both patient and triage staff should perform hand hygiene.
☐ The staff should use PPE (as appropriate).

Signature of Triage Nurse : .....

Name of Triage Nurse : Praveen
Date & Time : 03/7/26 at 10:51 pm.

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

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]neral Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:45PM Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil

Body Weight: 23 Kg

Height: ..... cm

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

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

Family History: Nil

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

If yes please list, Nil

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: 23 Length: - Head Circumference (< 2 years): .....

Temp.: 98.0°F HR: 100bpm RR: 28bpm BP: 100/64

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 20 (Document in the Humpty Dumpty Sheet)

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

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

Character of Pain Nil Location Nil Frequency Nil Duration Nil

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

(P.T.O)

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With ..... Nil .....

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 ..... Father .....

Nurse's Name: ..... Date: 04/7/26 Time: 12AM Signature 6073

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/7/26 Time of arrival : 10.50 PM

Chief Complaints: C/O Plan Endoscopy & colonoscopy procedure RBS: -

Height : - Weight : 23.4kg BMI : - Head Circumference (<2 years) -

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

If yes , identify -

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With Parents.

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

Time of Initial assessment completed by ER Nurse : 10.55pm

Time	Nursing Notes
10.50 pm	* patient came in ER, came for procedure Endoscopy + colonoscopy
	* vital signs check & recorded.
	* patient Scened by DR. Mahalakshmi maam & Advised Admission under DR. keerthivasan sir.
	* Iv placement & Blood sample collected
	* shift to the ward.

Samples collected by: S/N praveen — Time: 11.35pm

Samples sent by: S/N Subhadip — Time: 11.40 pm

Medication given in ER:

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

Condition of patient at time of shift - out:

HR: 89 b/m BP: 98/76 (83) CFT: <3 sec

RR: 20 b/m SPO_2: 99% R/A

GCS: 15/15 Temperature: 96.7°F

Pain Score: 0/10

Repeat RBS (if applicable): —

Details of Shift - out

Shift - out from ER to: 704

Time of Shift - out: 11.50 PM

Handover given to: S/N (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Iv placement (R) metacarpal 22 G

Name of the Nurse: Subhadip

Signature of the Nurse:

Date & Time: 3/7/26 & 11.40 pm

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S . KEERTHIVASAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Date : .....

Admitting Doctor : .....

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

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

Allergic History: .....

Chief Complaints: .....

.....

.....

.....

.....

.....

.....

.....

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

Significant Past History: .....

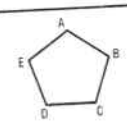
Medication History: .....

Relevant Investigations: .....

.....

.....

Primary Assessment



Airway

☐ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

Breathing

Rate: ..... SpO_2 on FiO_2 .....

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

.....

(P.T.O.)

Circulation

HR: .....

CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: ..... AVPU: .....

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☐ Hemodynamically Stable

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

.....

Labs Planned: .....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: .....

Signature: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 20 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/7/21	12:00 am	Informed Consent	provided psychological support	parents	No barrier	Oral	Now	verbalised understanding	good	60338

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

Doc No. : RCH / FRM / CLINICAL / 187

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

ANC-00016392 IP18-00036312
Ms MEERA SATHIYOTHAN
14-05-2016 10 Y 1 M 19 D (F)
Dr. S. KEERTHIVASAN

Date & Time of Admission	Date & Time of Transfer Order
3/7/26 @ 11.09 pm	3/7/26 @ 11.45 pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Keerthivasan.	Dr. Mahalakshmi	Further management

From Unit	To Unit	Information to Attendant
ER	704	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

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

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

Chronic diarrhoea ↓ evaluation

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Praveen Dr 15949.	15465

Patient & Clinical Records Received by : S. madhumitha 607363 at 11.45pm.

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