GUC-00077361
Ms JOSHITHA
23-05-2011
Dr. NANDHINI G
IP18-00036708
15 Y 2 M 9 D
(F)

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		12pm					
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: .....

UHID No: ..... IP No: GUC-00077361 IP18-00036708 ..... Dept: .....

Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Date of Admission: ..... Tin ..... arge: ..... Time: .....

Room / Bed No: ..... Ward: ..... llable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/10/24	8:40AM	ER	4/8	
1/8/24	9:30 AM	4/8	OT	
1/8/24	12:10pm	OT	4/8	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/3/26.	2 V-placement	(1)	OT	
1/3/26	IV Placement	(1)	5953	

ANY OTHER INFORMATION: OT

IN TIME: 10:22 OUT TIME: 11:15 a.

Procedure: Seton. Placement

Surgeon: Dr. N and Lini

Anasthetist: Dr. Mohan

Infusion pump used only 3 hrs 3.30pm — 6.30 pm.

Date: 1/3/26 Time: 12pm Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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SURGERY DETAILS

Date : 1/8/26

Patient Name: Ms. Joshitha Date of Birth: 23/05/2011 Age: 15yr

Gender: Female Ward : OT UHID No.: 77361/36708

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

Name of the Surgery : Setan Replacement

Time in : 10:20 Am Time Out : 11:15 am.

	NAME	AMOUNT
1. Surgeon	: Dr. Nandhini	
2. Anaesthetist	: Dr. mohan, Dr. Jayadharshini	
3. Assistant Surgeon	: -	
4. OT Technician	: Mr. Thangam, Mr. Raja	
5. Circulating Nurse	: C/N. Sangeethanushya	
6. Assistant Nurse	: S/N. Sangeetha	

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

6018 9/1
Signature of Circulating Nurse

Signature of the Surgeon Record findlas done

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

Stenter placement.

Patient Sticker

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CONSUMABLES OF OT

Date : 1/8/26. Time : ....

Circulating staff : Sanjeeth Technician : Raj

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

	Surgical Disposables	Qty Issued	Qty Used
	Major Pack		
	Sutures [illegible]		⊘
3 ✓	Prolene 240 P		1 ✓
5 ✓			
3 ✓	Gloves 5½ p.f		3 ✓
2 ✓	6 p.F		1 ✓
1 ✓			1 ✓
	Surgical blade 15		
1+1 ✓	NG tube		
1 ✓	Cautery pencil		
12	Koochies		
	Ointments		
	Suction Catheter		
1.	Cap, Mask		
	Gauze Pack plain		24 ✓
	Mop Pack		
2 ✓	Steristrip		1 ✓
	Underpad		
	Draw sheet		
	Abgel		
	Foleys catheter		
	Urobag		
	Chest Drainage Catheter		
	Romodrain bag		
	Bandage		
	Tegaderm		
	Ioban		
1 ✓	Double J Stent		
	Vaccum Suction set		
	~~Plastic Bed Sheet~~ Apron		4+1 ✓
	Betadine Solution		1 ✓
	Microshield		
	Cotton Balls		
	Latex Gloves		5 pair ✓
	Ramdione Scrub		
	Saral		

Disposables (Baby Side)	Qty Issued	Qty Used
Inj Vit.K		
Cord Clamp		
Suction Catheter 10F		1 ✓
Feeding Tube ✗ ~~10F~~		
Vaccum Suction Set		
Surgical Gloves		
Gauze Pack		1 ✓
Syringe 1ml / 2ml		
Surgical Blade # 20		
Koochies (S)		
Paraffin Gauze 10×30		1 ✓
Cevistat 1.5G		1 ✓
10cm Vein-O-line		1 ✓
Metrogel 100mL		1 ✓
Ropin 0.2%		1 ✓
Dexa		1 ✓
Trac		1 ✓
Duwater 10mL		1 ✓
Amne Para 100mL		1 ✓

Surgeon Anaesthesiologist Nurse OT Technician

Ordered by : ....

Order No. : ....

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	IP18-00036708	**Ward**	4F-FOUR SHARING
Patient Name	Ms JOSHITHA	**Bed Name**	FSW 418
Age/Sex	15 Y 2 M 9 D / Female	**Order No**	18-0001735886
Date	01/08/2026 12:39	**Prescription No**	PRIP18-0630367
Payor	SELFPAY	**Dispensed Date**	01/08/2026 12:42
UHID	GUC-00077361		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	NEOMOL SUPPOSITORIES 80 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP486016	04/28	1	6.99	6.99
						Total :	**6.99**	**6.99**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Receiver Name

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	IP18-00036708		
Patient Name	Ms JOSHITHA	**Ward**	4F-FOUR SHARING
Age/Sex	15 Y 2 M 9 D / Female	**Bed Name**	FSW 418
Date	01/08/2026 12:39	**Order No**	18-0001735885
Payor	SELFPAY	**Prescription No**	PRIP18-0630368
UHID	GUC-00077361	**Dispensed Date**	01/08/2026 12:47

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	CUTICEL CLASSIC 10 X 30 (PARAFFIN)	BSN MEDICAL	GENERAL	24CL065	08/28	1	58.12	58.125
2	DISPOSABLE APRONS STERILE XL	Mediblue		15072026	06/29	2	120.00	240.00
3	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	4	100.00	400.00
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	011	12/28	10	18.75	187.50
5	PROLENE 1 NW 840	ETHICON SUTURES-J&J	C1	V4007	07/29	1	470.00	470.00
6	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
7	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
8	SGLOVE 5.5 SIGNATURE			250905391T	09/28	3	117.00	351.00
9	SURGICAL BLADE 15	Surgeon	GENERAL	031225	11/30	1	7.67	7.67
10	UNDERPADS CARE 60 X 90 (FRIENDS)			18072026	12/30	1	205.00	205.00
						Total :	**1,327.55**	**2,150.30**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

rinted Time : 01-08-2026 12:47

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	IP18-00036708	**Ward**	4F-FOUR SHARING
Patient Name	Ms JOSHITHA	**Bed Name**	FSW 418
Age/Sex	15 Y 2 M 9 D / Female	**Order No**	18-0001735905
Date	01/08/2026 13:13	**Prescription No**	PRIP18-0630372
Payor	SELFPAY	**Dispensed Date**	01/08/2026 13:15
UHID	GUC-00077361		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE		H	L0016006	12/27	1	787.00	787.00
2	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	130359	08/27	1	45.30	45.30
3	CEVISTAT 1.5G INJ		H1	IALQ5005A	09/27	1	361.88	361.88
4	DEXAMETHASONE INJ 2 ML	PENTA PHARMA	H	VDDUI0O8	10/27	1	10.78	10.78
5	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	5	28.13	140.65
6	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)	GENERAL	6106011	03/31	1	24.00	24.00
7	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	25GO2K57	06/30	3	21.56	64.68
8	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	2	11.25	22.50
9	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	3	2.58	7.74
10	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
11	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	2	525.00	1,050.00
12	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	2	69.10	138.20
13	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
14	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435134	03/28	1	189.30	189.30
15	SUCTION CATHETER 10 ROMSONS	ROMSONS	GENERAL	K25I010716	08/30	1	85.00	85.00
16	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**2,730.72**	**3,576.87**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA 600015
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INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036708		
Patient Name	Ms JOSHITHA	**Ward**	4F-FOUR SHARING
Age/Sex	15 Y 2 M 9 D / Female	**Bed Name**	FSW 418
Date	01/08/2026 13:13	**Order No**	18-0001735906
Payor	SELFPAY	**Prescription No**	PRIP18-0630370
UHID	GUC-00077361	**Dispensed Date**	01/08/2026 13:15

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
						Total :	**100.00**	**100.00**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

ted Time : 01-08-2026 13:15

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	IP18-00036708	**Ward**	4F-FOUR SHARING
Patient Name	Ms JOSHITHA	**Bed Name**	FSW 418
Age/Sex	15 Y 2 M 9 D / Female	**Order No**	18-0001735907
Date	01/08/2026 13:14	**Prescription No**	PRIP18-0630371
Payor	SELFPAY	**Dispensed Date**	01/08/2026 13:15
UHID	GUC-00077361		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ACUGYL 500MG INJ		H1	1A260008	04/28	1	22.03	22.03
						Total :	**22.03**	**22.03**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Receiver Name

Pharmacist Name : GRACE PAUL RAJAN

UC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Rainbow® Children's Hospital
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DISCHARGE TRACKING SHEET

DATE : 18/26.

Name of Consultant :

Floor :

UHID :

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

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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OPERATION NOTES

Surgeon : Dr. Nandhini	Asst. Surgeon : –
Anesthetist : Dr. Mohan	OT Nurse : S/N. Sangeetha
Pre-Operative Diagnosis:	
Surgical Procedure : – Recurrent Perianal Abscess – Seton Replacement.	

Weight : 35.5 kg	Date : 01/08/2026	Start Time : 10.25 am.	End Time : 11.40 am.

Post Operative Diagnosis:
—

Peri-Operative Complications: —

Operation Notes: [illegible] lithotomy position

Findings:
previous Seton Suture Buried in
– the tract.
– granulation site in ® gluteal
region opened c̄ clean cut
& infected granulation scooped out.

Procedure Notes:
– Big mucosal side rent identified
& old suture knot removed,
– Thorough H2O2 / Betadine lavage given
– new seton placed c̄ 20 prolene
(2 knots)

Amount of Blood Loss: & Caprenia	Blood Transfused (in ML) [illegible] given.

Name and Number of Surgical Specimen sent for examination:
Nil

Doc. No. : RCH / FRM / CLINICAL / 099 (P.T.O.)

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

Adv
1) NPO till 12noon

Wound Care:

2) IV Supacef / metrogyl
1.5gm / 100ml 8th

Drain /Special Lines/Catheters:

3) T. P500mg tds

Special Patient Positioning and Requirements:

4) T. vit C 500mg bd

Nutritional Instructions:

5) T. ZID 50mg od

When to Start Mobilization:

6) T. Satrogyl ō - 3days
& syp.

Special Referrals:

7) Rituximab infusion cs

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

New plan today

Any Other Post-Operative Care Needed including Required Follow Up

8) Discharge today

Name of the Surgeon: Dr. Nandhini

Signature of the Surgeon: [signature]

Date & Time: 01|08|2026 B5287

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT Shifted to: 4th floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ PARACETAMOL	500mg	IV	STAT	1/8/26 @ 1:20pm	☐C ☑DC
2	INJ CEFTRIAXONE	1.3g	IV	STAT	1/8/26 10:30Am	☐C ☑DC
3	INJ EMESET	500mg	IV	STAT	1/8/26 @ 10:30pm	☐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. [signature] (8A116)

Date & Time: 01/08/2026

Nurse Name & Signature: S/N. Thanushiya

Date & Time: 01/8/2026 @ 12:10pm.

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Nandhini
Asst. Surgeon :
Anaesthetist : Dr. mohan & Dr. priya
Scrub Nurse : SN. Sangeetha

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Patient UHID Date :

Age : 15y Gender : F
: Sefan placent
Out-time : 11:15 am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:22 Am

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

Site Marked ☐Yes ☑No ☐NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

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

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

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

Signature :
Name :

Before Skin Incision ➤➤

TIME OUT Time: 10:24 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 :

Before Patient Leaves Operating Room

SIGN OUT Time:

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

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

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

Signature :
Name :

PATIENT TRANSFER FORM

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GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Nandhini	01/08/2026 @ 7:50AM	01/08/2026 @ 12:10PM
Transfer Ordered by	**Reason for Transfer**	
Dr. mohan.	Further management	
From Unit	**To Unit**	**Information to Attendant**
OT	4th Floor (418)	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/N. Thanushiya	Dr. mohan.

Patient & Clinical Records Received by : nurse/OT 1/8/26 @ 12.15 Pm

Date & Time of Patient Received :

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

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

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 01/08/26 @ 12:10pm **TRANSFERRED TO :** 4th floor.

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

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

PR

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Date: 1/8/26

Patient's Name: Ms. Joshitha Age: 15yrs2m Gender: ☐ M ☑ F

Blood Group: B positive UHID:

Planned Surgery: Sohn placement Surgeon: Dr. Nandhini

Anesthetist: Dr. Sathish Date & Time of Operation: 1/8/26 at 9:45am

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	☐	☑	☐
	Remove all ornaments, etc and sterile gown given	☐	☑	☐
6.	Is Blood arranged as required?	☐	☑	☐
7.	If Blood has been ordered - is Blood bag ready?	☐	☑	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☐	☑	☐
9.	Pre Anesthetic consultation with anesthesiologist	☐	☑	☐
10.	Pre Medications Given? (Sedatives / etc)	☐	☑	☐
11.	Skin Preparation	☐	☑	☐
12.	Site is marked	☐	☑	☐
13.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☐	☑	☐
14.	Implants are available	☐	☑	☐
15.	Equipment is avaialble	☐	☑	☐
16.	Other (if any)	☐	☑	☐

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

Billing Clearance taken

Billing Executive Name :

Billing Executive Signature: [signature]

Date & Time :

Nurse In-Charge Name : Sahaya...

Signature of Nurse In-Charge : [signature]

Date & Time : 1/8/26 at 7.50am

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

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Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Your Right to a Safe Delivery

Department of Anaesthesiology

ANAESTHESIA ASSOCIATES

PREANAESTHETIC EVALUATION

Date : Time :

Name :

Proposed Operation seton replacement + removal of granulation tissue

Age :

Preoperative Diagnosis

Sex :

B.P	H.R	R.R	Temp	Height	Weight	Physical Status
					35.5kg	1 (2) 3 4 5

I.P. No. :

LABORATORY DATA

Hgb	9.9.	Glucose		Protien		HIV	
PCV		Urea		Alb		HBS Ag	
WBC		Creat		Total Bill		HCV	
Plate	2.37	Na		Dir. Bill		Blood group	
PT		K		LDH		Other	
PTT		Ca++		Alk phos			
INR		Mg++		Amylase			

X-Ray Other:
ECG
2D Echo
Stress/Anglo

Allergies : —.

Medical History : CVS:

RESP: K/C/O Crohn's disease on Rx.

CNS: Diabetes :

Renal:

Hepatic /GE: APD+/-

Others:

Past Anaesthetic History: H/O seton placement S GA, ULE

Physical Exam

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

Lungs:

Heart: NAD

CNS: Pupils : E V M

Others : Pallor : +/- Venous Access Site 22G (P) Spine Exam for regional : N

ANAES. PLAN : MAC/REGIONAL/GA-ETT/LMA Proposed Post-op Plain relief: Peri -op. plan explained to patient Y/N

WILL TAKE BLOOD YES/NO	PREGNANT YES/NO LMP	

CURRENT MEDICATIONS:

PRE - OPERATIVE INSTRUCTIONS:

1. DVT Prophylaxis
2. NBM form :
3. Informed Consent Standard / High Risk

IMMEDIATE PRE-ANESTHESIA EVALUTION

H.R.:..... SaO2 :.....

R.R.:..... Last Feed :.....

B.P./C.R.T. :.....

Signature :.....

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Patient ID :

Department of Anaesthesiology
AXON ANAESTHESIA ASSOCIATES
EPIDURAL ANALEGESIA 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 :

Any other Issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge/Shifting ordered by (Name, Signature, date and time)

CONSENT FOR

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

A

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

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

Anaesthesiologist : Dr. Nandan. Operative procedure planned : Lichen Sclerosus

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : Hypertension, Dyslipidemia, Bradycardia.

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

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

Patient / Patient Attendant :

Signature : P. Suprava

Name : P. SUPRAJA

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : Thushiya.

Date & Time : 01/08/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Nandan.

Date & Time : 01/8/26 9.30am.

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

INFORMED CO... SPECIAL PROC... RY OR

GUC-00077361
Ms JOSHITHA
23-05-2011
Dr. NANDHINI G
IP18-00036708
15 Y 2 M 9 D (F)

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

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

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

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

..... Selon Placenta .....

..... upon .....

(Name of the Patient)

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

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

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

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

..... Nausea / Injury .....

My signature on this form indicates that

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

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

Consentee :

Signature : P. Suprata

Name : P. SUPRATA

Date & Time : .....

Patient Attendant :

Signature : P. Suprata

Name : P. SUPRATA

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : .....

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

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

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

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

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

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

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

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

.....

.....

.....

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Rainbow Children's Hospital | BirthRight

SSI PREVENTION CHECKLIST

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

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: OP

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: Jothi

Date & Time : 2/3/24 9.00 h

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

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PATIENT TRANSFER FORM

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Date & Time of Admission	Date & Time of Transfer Order
01/08/26 @ 7.50AM	01/8/26 @

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Nandhini	Dr. Nandhini	further management

From Unit	To Unit	Information to Attendant
418	OT	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
IP - file	Nil	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

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

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

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 : IP18-00036708 **Admit Date** : 01-Aug-2026 **Admit Time** : 07:50 AM **UHID** : GUC-00077361

Patient Details :

Patient Name	: Ms JOSHITHA	**Age**	: 15 Y 2 M 9 D
Guardian	: Mr SREEHARI	**DOB**	: 23-05-2011
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: D.PUVAM VELLOR A C Nagar Nellore Andhra Pradesh INDIA 524002	**Phone No**	: 9662430930
		E-mail	: no@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr SREEHARI **Relationship** : Father

Contact Address : D.PUVAM VELLOR A C Nagar Nellore Andhra Pradesh INDIA 524002 **Phone No** : 9662430930

Signature

Doctor Details :

Doctor Name : Dr. NANDHINI G **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : DR. NANDHINI G **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.14

Payor Name : SELFPAY

Rainbow Children's Hospital

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Rainbow Children's Hospital - Guindy

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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms JOSHITHA**	**Age :**	**15 Y 2 M 9 D**
IP No:	**IP18-00036708**	**Sex:**	**Female**
Consultant:	**Dr. NANDHINI G**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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: P. Supriya

Name:

Relationship:

Date: Time:

Witness Name:

Witness Signature:

Patient Address:

D.PUVAM VELLOR A C Nagar Nellore
Andhra Pradesh INDIA 524002

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

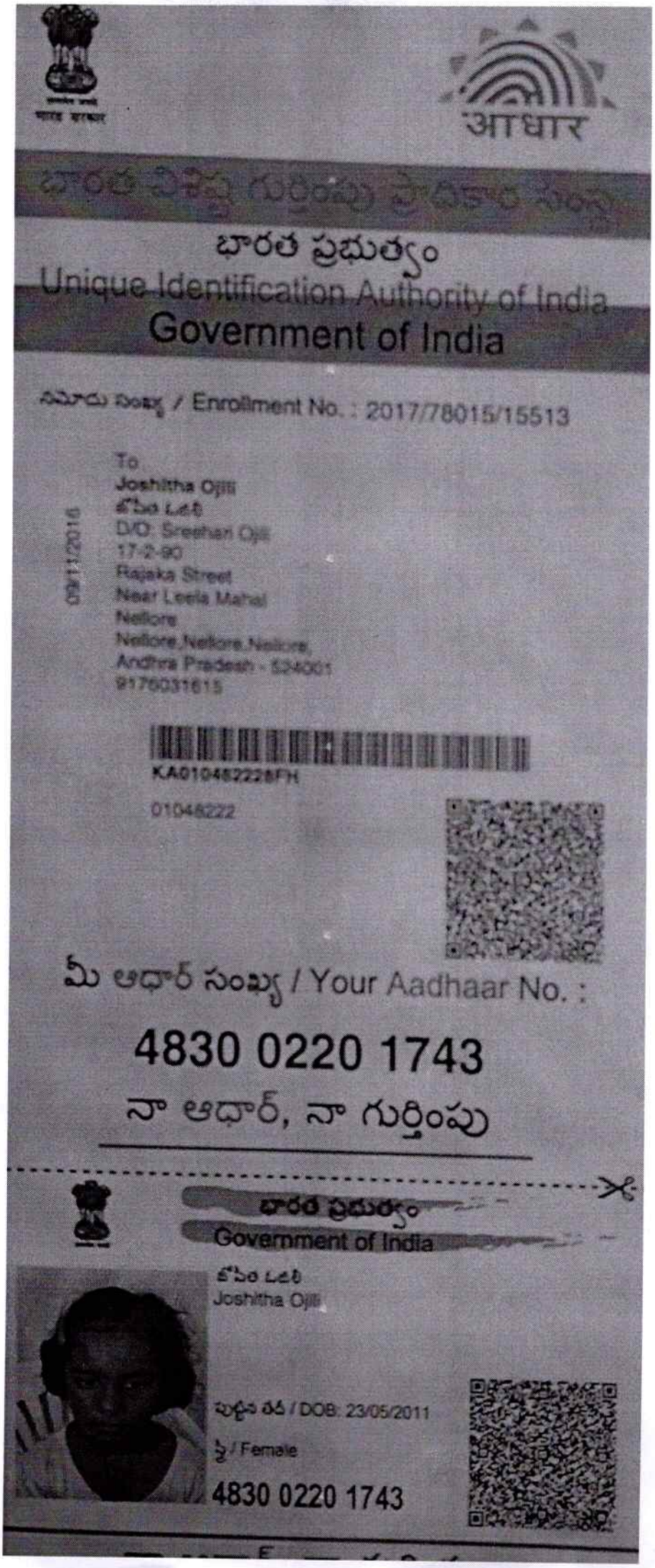
BILLING POLICY

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

DECLARATION

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

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



ఆధార్

భారత ప్రభుత్వం
Unique Identification Authority of India
Government of India

నమోదు సంఖ్య / Enrollment No. : 2017/78015/15513

To
Joshitha Ojili
కోసం ఓజి
D/O: Sreehari Ojili
17-2-90
Rajaka Street
Near Leela Mahal
Nellore
Nellore,Nellore,Nellore,
Andhra Pradesh - 524001
9176031615

KA01048222BFH

01048222

మీ ఆధార్ సంఖ్య / Your Aadhaar No. :

4830 0220 1743

నా ఆధార్, నా గుర్తింపు

భారత ప్రభుత్వం
Government of India

కోసం ఓజి
Joshitha Ojili

పుట్టిన తేది / DOB: 23/05/2011

స్త్రీ / Female

4830 0220 1743

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Docu. No. : RC

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

GUC-00077361
Ms JOSHITHA
23-05-2011
Dr. NANDHINI G
IP18-00036708
15 Y 2 M 9 D
(F)

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K/C/O Fistulating CD(Crohn's disease) admitted for seton replacement & granulation tissue removal.

History of present illness :

A child ē K/C/O TB'D (Crohn's). | Recurrent perianal fistula

received ≠ doses of infliximab.

during 2nd episode (16.2.26) → seton was placed ē drainage

Now c/o swelling in the fistula site. x 4 days.

NO fever | pain

O/E: infected granulation tissue @ fistula site.

ē partial buried suture inside

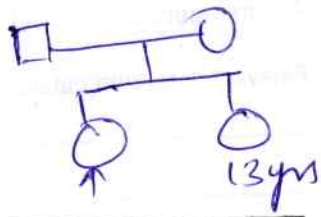
Patient Sticker

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

Birth & Neonatal History:

LSCS | Full Term | CIAB | BW - 3kg.
No NICU stay

Family Chart



Birth & Socio Economic History:

About Father : NCM

About Mother :

Any additional information :

Developmental History : Dev - (N)

Immunization History : as per IAP | NIS Last vaccine @ 10yrs

Anthropometry :

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

Weight (kgs) 35-5 (Centile _____)

On Examination :

Temperature : 97.2°F Pulse Rate : 88/min B.P. 110/72(82) SPO2 98%.

Resp.rate and type of breathing : 20/min

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): Not Known

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S_1S_2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection :

Palpation : soft, not tender ; no OM

Ausculation : BS (+)

Spine : External Genitelia : infected granulation tissue @ fistula side on (R) buttock & perineal suture burned under

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power : 5/5 in all 4 limbs

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR 2+

Superficials: +

Plantars ↓

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Δ - Recurrent Fistulating Crohn's disease for seton replacement & removal of granulation tissue.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

① NPO

② seton replacement + granulation tissue removal.

③ shift to OT @ 9.45am

Signature of the Doctor:

Name of the Doctor: Dr. Gayathri

Date & Time: 1/8/26

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/8/26.	S/B Dr. Manmai	
	Received from OT	
	Alert, PP-WF	
	peripheries	
	No vomit	
	D/w - Dr. Somashekar sir.	
	INFLIXIMAB → infusion	
	Premedication →	~~paracetamol~~
		Inj. Avil 1cc IV stat
		Inj. Hydrocortisone - ~~100~~ 75 mg IV stat
	↓	
	- Take 10ml of diluent and add to the vial containing dry powder infliximab.	
	- do not inject diluent into the powder directly, put on sides of the vial.	
	- Do not shake, gently roll between palms.	
	- Withdraw the dissolved solution of IFX (175mg) and inject into 250ml N.S.	

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

Ms. Joshitha
15Y/F

Patient Sticker

GIUC:- 77361

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Start IVF in one hand 0.9% DNS @ 30 ml/hr	other hand Inj. Infliximab 175 mg in 250 ml NS over 3 hrs.
	→ monitor for adverse reactions, vitals.	
1/8 / 2pm	S/B [illegible]	
	[illegible]	
	mild [illegible] → Bld [illegible]	
	no plan [illegible]	
	[illegible]	
	[illegible]	

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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outside (corp)

RESULT SHEET

Date	31/7					
Time						
Hb	9.9					
PCV	31.1					
RBC	3.75					
WBC	4400					
N/L	60/28					
Platelets	2.37L					
CRP	3.38					
ESR	24					
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	13					
SGOT	16					
T.Bill/Conj	0.18/0.10					
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.,) : .....

Patie

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

Rainbow® Children's Hospital
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NKA ..... ☐ 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: ..... 417 .....

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: Dr. Nagaveni

Doctor Name & Signature : .....

Date & Time : 1/8/26

Nurse Name & Signature: .....

Date & Time : 1/8/26 at 8AM

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

Patient Sticker

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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DRUG CHART

Date of Admission: 1/8/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				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 .....

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. 35.5kg .... Ward. ....

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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
1/8	10:30 AM	INJ SUPACEF	1.5g	IV		PT / SG
1/8	11 A.M.	INJ METROGYL	500mg	IV		PT / SG
1/8	11.15 am	INJ PAN	40mg	IV		PT / SG
1/8/26	2.30 pm	Inj Avil	1cc	IV	1	RV / RA
1/8/26	2.30 pm	Inj Hydrocortisone	75mg	IV	2	RV / RA

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of Fluid (If infusion, mention ml./hr = mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
1/8	10:30 AM	RL 1000	IV	Control			1/8		
		~~RL 1000~~	~~IV~~		~~[illegible]~~				
1/8/26	3:30 pm	INT INFLIXIMAB 175mg in 250ml NS over 3 hrs	IV	80 ml/hr					

Signature .....

VERIFIED BY : Name .....

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TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart

GUC-00077361
Ms JOSHITHA
23-05-2011
Dr. NANDHINI G
IP18-00036708
15 Y 2 M 9 D
(F)

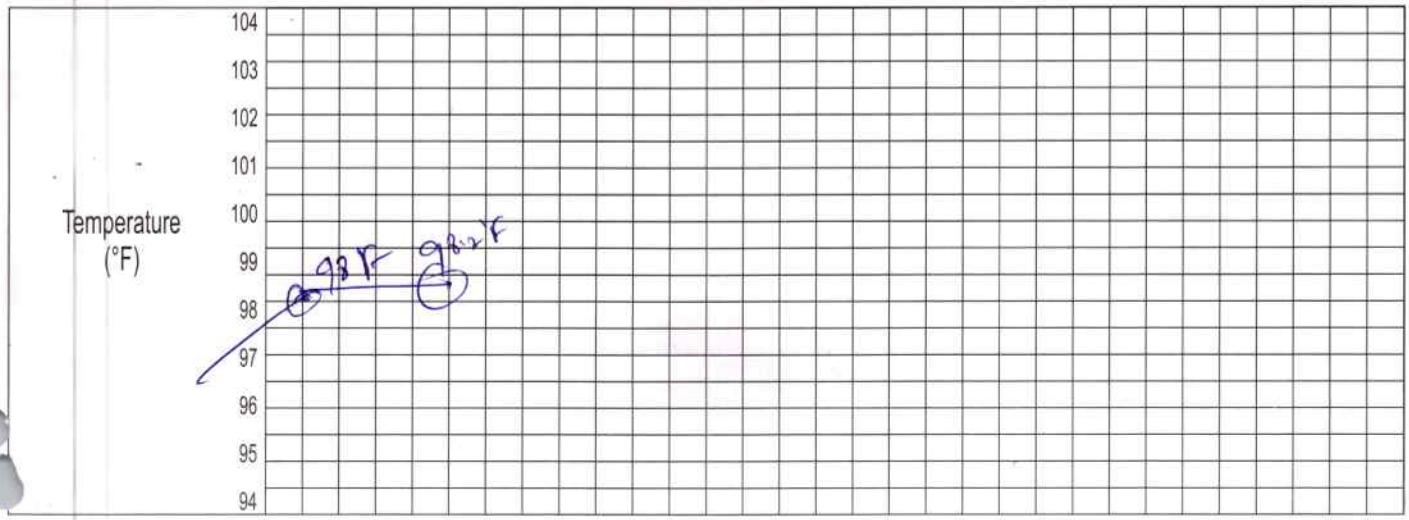
Patient Na .....
Date of Bi .....

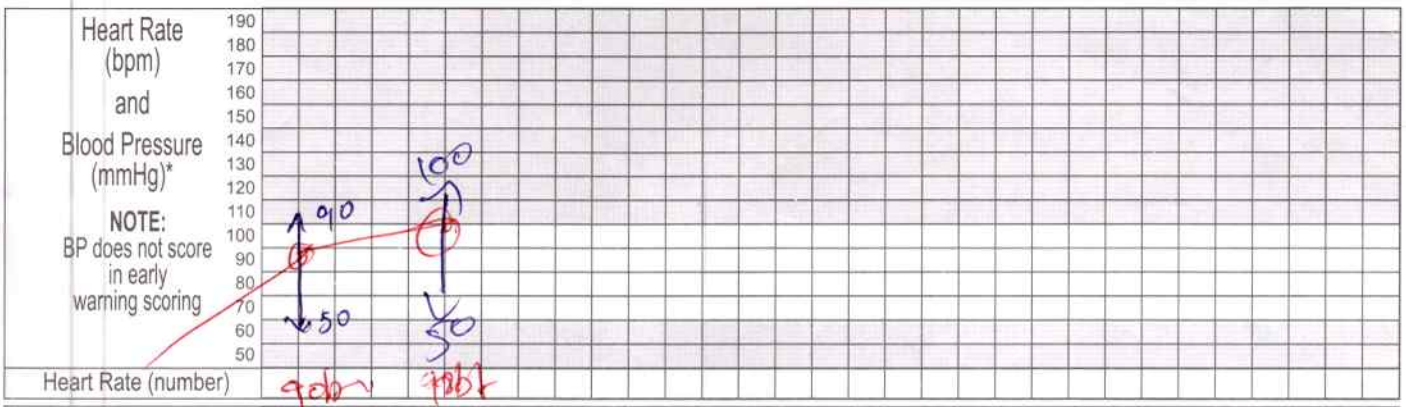
– / EWS / 04

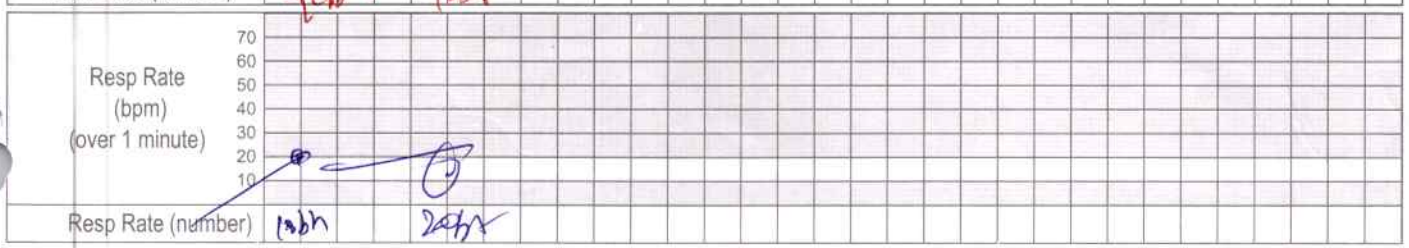
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/3/24 Time: 8am 12:30pm

Doctor/ Nurse/ Family Concern?







Resp. Mod/Severe Distress None/Mild	✓	✓
Receiving 02 (L/min) 02 saturations (%)	99%	98%
Conscious Normal Level Decreased	✓	✓
GCS *	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0
Observer's initials	[illegible]	[illegible]

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 8PM) 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.

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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FLUID CHART

Sheet No. : 6

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.

1/7/17		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	NPO								✓	NO	JY
	09:00 am	NPO									Ryles	JY
	10:00 am	NPO		500ml							0	JY
	11:00 am	NPO									0	JY
	12:00 pm	NPO									0	JY
	01:00 pm	Water + Tea	10+200								0	JY
Total Intake :		210ml				**Total Output :**				1 Time urine passed		
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Recurrent Fistulating Crohn's disease.			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	1/8/26 M	1/8/26 E				
	Medical Condition (Any special condition to be noted):	Noted	Noted				
	Diet:	NPO	~~Soft diet~~				
ASSESSMENT	Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA				
	Tubes/Drains/Catheter:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F	98.2°F				
	Res:	18bt	20 b/m				
	SpO_2:	99%					
	Pulse:	98bt					
	BP:	100/50					
	LOC:	Conv.	consciou				
	Fall Risk Score:						
	Pain Score:	0/10	0/10				
	Skin Integrity	—	—				
Recommendations	Safety Needs:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—				
	Others Specify:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NPO	~~Soft diet~~				
	Critical Lab Test / Values:	—	—				
	Other Special Orders / Medications:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependt	Dependant				
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		Nytha.	Sasi				
Signature / ID :							
Date:		1/8/26	1/8/26				
Time:		@1.30pm	@7.30pm				
Taken Over By Name :		Agitha					
Signature / ID :							
Date:		1/8/26					
Time:		@1.30pm					

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM

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

Patient Sticker

NURSING CARE RECORD

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

Date: 1/8/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☑ ~~Prevent~~ 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	08 9am	to prevent infection.	9am	to Assess the general condition to monitor vital signs to maintain hand hygiene.	Infection will be prevented	Reassessment was done.	[illegible] 012
Afternoon	1.30 Pm	maintain Personal hygiene		Assessed child condition monitored vitals maintained I/O chart maintained hand hygiene	maintained Personal hygiene	Reassessment Done	[illegible] 028973
Night							

Docu. No: RCH /FRM / CLINICAL / 148

Patient Sticker

NURSING CARE RECORD

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

Date: .....

Goals

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

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

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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 .... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/8/26		Rechived notes:	
	8 am	Child rechived	
		from ER to 4th floor	
		come for seton replacement,	
		child consious & oriented	
		child activity are good	
		no fu time.	
		vital signs checked & recorded	
		vitals are stable now	
		CP ++ | PP ++ | CRT <3	
	9.30 am	child shifted to OT	
		handing over given to	
		OT. Sister	[signature] 020041
		OT Notes	
1/8/26	9:30 Am	Child received from 4th floor to	
		pre op. area.	
	10:20 Am	→ child shifted to OT. While	[signature]
		reciving ID Band consent	607891
		Checked.	
		⇒ Anaesthesia given by Dr. Mohan	
		under GA	
		→ surgery done by Dr. Nandhini	
		→ child shifted to 4th floor	[signature]
	12:10 pm	Child handover to 4th floor	
		Staff.	60789

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

Rainbow Children's Hospital
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Your Right to a Safe Delivery

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ......Nil......

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		confirm nots	
1/2/26	12.15pm	The child details receive from OT staff to 4th floor. The child is conscious and oriented IV line present. no pain, no swell. IV the pattern.	[illegible] 01150
	1pm	I/O chart was maintain. no other complain of pain, vomit. vital signs are stable.	[illegible] 01150
	1.30pm	The child details handing over given to evening duty staff	[illegible] 01159
1/2/26		Evening Duty	
	1.30pm	The child details handing over taken from morning duty staff. child conscious and oriented. child is on room air. IV line present. IV line patten.	[signature] 021893
	2pm	No any other complaints child is stable. vitals are stable. Inj. Avil, Inj. Hydrocort given	
	3.30pm	New IV line inserted. Inj. Infliximab 175mg in 250ml NS over 3hrs 80ml/hr on flow. IV fluids RL 30ml/hr on flow.	[signature] 021893

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00077361
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

IP18-00036708

NURSES NOTES

Rainbow® Children's Hospital
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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
1/8/26	4Pm	vital signs are checked and recorded. vitals are stable	

CP	PP	CRT
++	++	<2s

02189

	4.30pm	the child is stable. no any other complaints Dr. Nandini mam advised to discharge the patient file sending to billing	02189

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

☐ No Known Drug Allergies

☐ Drug Allergies .....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name: ....
MRD NO:...... GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G
Age :............ ☐ M ☐ F
Consultant :..............................

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 1/8/26 Time: 10 AM
Location :
Size : 24.
Cannula inserted by : Dr. Mohan

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
1/8/26	10 AM	☐Yes ☑No	☐Yes ☑No	6hr	Ku
	12pm	☐Yes ☑No	☐Yes ☑No	4hr	TC
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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 : 1/8/26 Time: 3.20 pm
Location : (R) metacarpal
Size : 22'G
Cannula inserted by : S/N - Abithalakshmi

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
1/8/26	3.20pm	☐Yes ☑No	☐Yes ☑No	Patten	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	Patten	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

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23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

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THE HUMPTY DUMPTY SCALE M E

PARAMETER	CRITERIA	SCORE	DATE 1/8	DATE 2/8	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	1	1			
Gender	Male	2					
	Female	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			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	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			
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			
	Total		1/8	1/8			

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

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate lighting		✓	✓			
	Wheel chair support		NA	NA			
	Other Intervention(s) Specify		NA	NA			
	Nurse's Name:		Megha	Soni			
	Signature:						
	Date:		1/8	1/8			
	Time:		9a	8p			

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

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BRADEN 'Q' SCALE

					Date :	18/26	19/8/24	
					Time :	09	18	
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	
"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	3	
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	
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	
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 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	
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.		3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	
					TOTAL SCORE	27	27	
					Evaluator's Name	MS		

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	⓫ Regular Turning Schedule ⓬ Enable as much activity as possible ⓭ Protect the heels ⓮ Use pressure redistribution surfaces ⓯ Manage moisture, friction and shear ⓰ 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	⓱ Use the Same Protocol as for **"At Risk"** Patients ⓲ 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	⓳ Follow the same protocol as for **"Moderate Risk"** Patients ⓴ In addition to regular turning schedule ㉑ 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	㉒ Use same protocol as for **"High Risk"** Patients ㉓ 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

Patient Sticker

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PAIN ASSESSMENT FORM

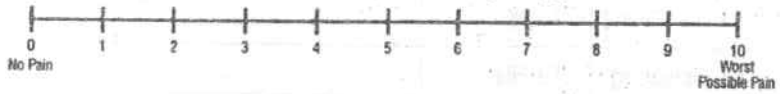
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/8/26	8⁴⁰ am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	[illegible]	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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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
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		
18/26	9am	Treatment & care	Explained about treatment & care	Mother	no	Oral	non.	verbalizes comfort	Good	[signature]

Part - III: CODES

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

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

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

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

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

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PATIENT TRANSFER FORM

GUC-00077361 IP18-00036708 Ms JOSHITHA 23-05-2011 15 Y 2 M 9 D (F) Dr. NANDHINI G	Date & Time of Admission 1/8/21 7:50am	Date & Time of Transfer Order 1/8/21 8:40am
Treating Consultant Name Dr. Nandhini	Transfer Ordered by Dr. Gayathri	Reason for Transfer Procedure.
From Unit ER	To Unit 417	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 04	Number of Imaging Films Nil	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 ☐
Δ - Fistulating crohns disease for seton replacement.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shiba [signature] 10810	[signature] 165359.

Patient & Clinical Records Received by : Jothi [signature] 02004

Date & Time of Patient Received : 1/8/21 @ 8:40am

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

Patie

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 1/08/26 Time of arrival : 7:40pm

Chief Complaints: H/O came for seton replacement RBS: —

Height : — Weight : 35.3 kg BMI : — Head Circumference (<2 years) .....

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

If yes , identify .....

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 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 : 7:50pm .....

(P.T.O.)

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

Time	Nursing Notes
8pm	patient came to the ER with the H/O
	seton replacement. monitored the vital
	signs. recorded. Dr. cgayathri mam.
	IV line placement done. and pt shifted
	to the ward.

Samples collected by: nil — Time: nil

Samples sent by : — Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 88/m BP: .... CFT: < 3 sec	Shift - out from ER to: 418
RR: 18/m SPO$_2$: 98% RA	Time of Shift - out: 8.40pm
GCS: 15/15 Temperature : 97.2°F	Handover given to: (Nurse's Name) SN Latika
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): —

—

Name of the Nurse : Shibu Debnath Signature of the Nurse : [signature] 17880

Date & Time : 1/01/20 @ 8pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Gayathri Date : 1/8/26.

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

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

Allergic History: .....

Chief Complaints: .....

Δ - Fistulizing crohns disease.

for seton replacement

Pediatric Assessment Triangle

A Appearance - TICLS ..... awake & alert

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 .....

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: 15/15 AVPU: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: afebrile

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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

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

.....

.....

Labs Planned: .....

.....

.....

as per chart

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr Gaynor

Signature: .....

Date & Time: 1/8/21

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

GUC-00077361 IP18-00036708
Ms JOSHITHA
23-05-2011 15 Y 2 M 9 D (F)
Dr. NANDHINI G

B positive WPD - 6:30 am - 8pm

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: 35.5kg

Patient's Name : Joshitha Age : 15yrs 2m Gender: ☐ Male ☑ Female

Date : 01/08/26 Time of Arrival : 7:40 pm

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Posted : 9.45 am

Initial Vital Signs: Temp: 97.2F PR: 88 BP: 110/72 (82) RR: 20 SpO_2: 98%

Chief Complaints: plan for Seton placement

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 : 7.40 pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Soniya

Signature of Triage Nurse : Soniya

Date & Time : 01/8/2026 at 7.42 am

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