GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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

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SURGERY DETAILS

Date : 16/07/2026

Patient Name: Master. HariHaraselvan Date of Birth: 17/09/2014 Age: 11 Y

Gender: Male Ward : OT UHID No.: 15591/86492

Date of Surgery: 16/07/2026 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : B/L knee & plate removal

Time in : 1.85 pm Time Out : 2.45 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Kailash	
2.	Anaesthetist	: Dr. Mohanmurali / Dr. Ashwini	
3.	Assistant Surgeon	: -	
4.	OT Technician	: Mr. Thangadurai	
5.	Circulating Nurse	: Pradeepavoorayan	
6.	Assistant Nurse	: SN Sangeetha / SN Siva	

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

Signature of the Surgeon

Signature of Circulating Nurse

Record of Medical done by Risha

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

Harihara Selvam.

Patient Sticker

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CONSUMABLES OF OT

Circulating staff : Ch. Pradeepa Technician : Mr. Shyam Date : 16/1/26 Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack ortho		01	Inj Vit.K		
LMA			Sutures 2304		01	Cord Clamp		
ECG leads : A / (P) / N		3	1326		01	Suction Catheter		
HME filter : A / P / N			2317		01	Feeding Tube 10 F		1
Syringes : 10 cc ✓		6+1	P.F 6		01	Vaccum Suction Set		
05 cc ✓		4	Gloves 7½ P.F		03	Surgical Gloves		
02 cc ✓		4	~~8~~ P.F		01	Gauze Pack		
01 cc ✓			5½ P.F		01	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade 11 / 15	02	1	Surgical Blade # 20		
IV set ✓		1+1	NG tube			Koochies (S)		
RL ✓		1	Cautery pencil ✓	01		Artacil		1
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies			D. water 10ml		6
			Ointments			Ropin 0.2%		(1)
			Suction Catheter			Needle 23x 1½		1
Fentanyl ✓		1	Cap, Mask			Vein-o-line		2
Morphine			Gauze Pack	04		Amnipara 100ml		(1)
Ketamine			Mop Pack	01		KETAROLL		1
Propofol ✓		1	Steristrip	01		NS 100 ML IV		1
Rocuronium			Underpad ✓		1	Estuonal 10 cm		02
Glycopyrolate			~~Draw~~ sheet bandage	01		Estuonal 15cm		02
Myopyrolate ✓		1	Abgel			Actislose		02
Ondansetron			Foleys catheter			Gloop bandage 15		02
Pencan 25g/ Spinal Needle 22			~~Urobag~~ pinopore	01				
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set ✓		1			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	02				
			Microshield					
			Cotton Balls					
			Latex Gloves		10P			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036492		
Patient Name	Master P HARIHARASELVAN	**Ward**	8F-OT COMPLEX
Age/Sex	11 Y 9 M 29 D / Male	**Bed Name**	PRE OP 806
Date	16/07/2026 17:06	**Order No**	18-0001728452
Payor	SELFPAY	**Prescription No**	PRIP18-0627495
UHID	GUC-00015591	**Dispensed Date**	16/07/2026 17:07

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	1303356	07/27	1	45.30	45.30
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	7	28.13	196.91
4	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	4	21.56	86.24
5	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	4	11.25	45.00
6	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	6	2.58	15.48
7	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
8	INFANT FEEDING TUBE-10	ROMSONS	GENERAL	G25G010537	06/30	1	63.75	63.75
9	KETOROL INJ 30 MG 1 ML	DrReddy'sLaboratories Ltd		V260230	02/29	1	37.72	37.72
10	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
11	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
12	NEEDLE 23* 1 1 2	Dispovan		32544C	07/30	1	3.63	3.63
13	PEDIADRIPSET PLUS	ROMSONS		K26B020111	01/31	2	311.00	622.00
14	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
15	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435130	12/27	1	189.30	189.30
16	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	2	460.00	920.00
						Total :	**2,280.36**	**3,411.47**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

inted Time : 16-07-2026 17:07

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Rainbow Children's Hospital

BirthRight by Rainbow

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	IP18-00036492	**Ward**	8F-OT COMPLEX
Patient Name	Master P HARIHARASELVAN	**Bed Name**	PRE OP 806
Age/Sex	11 Y 9 M 29 D / Male	**Order No**	18-0001728451
Date	16/07/2026 17:06	**Prescription No**	PRIP18-0627496
Payor	SELFPAY	**Dispensed Date**	16/07/2026 17:08
UHID	GUC-00015591		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTICAST 7.5CM 3"	BSN MEDICAL	GENERAL	25UA022	08/28	2	1,388.00	2,776.00
2	CAUTERY PENCIL (ADVANCE)	The Advanced cadiomed	GENERAL	250824	08/28	1	1,303.00	1,303.00
3	CREPE BANDAGE 6#3(M)	3M HEALTHCARE	GENERAL	ND251012	12/29	2	426.56	853.125
4	ELASTOMULL 10 CMS	BSN MEDICAL		260712458	01/31	2	59.00	118.00
5	ELASTOMULL 15 CMS	BSN MEDICAL	GENERAL	245202005	11/29	1	87.19	87.19
6	ELASTOMULL 15 CMS	BSN MEDICAL	GENERAL	253012773	06/30	1	93.00	93.00
7	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	4	100.00	400.00
8	MONOCRYL 3-0 NW 1326	ETHICON SUTURES-J&J	C1	T6003	12/30	1	997.00	997.00
9	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642SF029	03/30	1	949.00	949.00
10	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
11	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1B260029	04/28	1	21.01	21.01
12	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1D262046	03/29	1	94.55	94.55
13	ORTHO DRAPE PACK			1010626	05/29	1	2,500.00	2,500.00
14	PrimaPore 20cm x 10cm	SMITHS & Nephew		2445B	11/29	1	135.50	135.50
15	PROTECTIVE SHEET 20X2O	Local		101O626	05/29	1	250.00	250.00
16	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	2	103.00	206.00
17	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
18	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	260300891T	05/29	3	128.00	384.00
19	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
20	STERI STRIP1 4*4IN 1546	3M HEALTHCARE		0344WE5	03/30	1	225.00	225.00
21	SURGICAL BLADE 11	Surgeon	GENERAL	O030925	08/30	2	7.10	14.20
22	SURGICAL BLADE 15	Surgeon	GENERAL	031225	11/30	1	7.67	7.67
23	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010294	03/31	1	811.00	811.00
24	VICRYL 2-0 VP 2317	ETHICON SUTURES-J&J	C1	T5052	09/30	1	888.00	888.00
25	VICRYL 2-0 VP 2404	ETHICON SUTURES-J&J	C1	T4014	03/29	1	830.62	830.625
						Total :	**11,674.21**	**14,688.87**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 16-07-2026 17:08

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

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INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036492		
Patient Name	Master P HARIHARASELVAN	**Ward**	8F-OT COMPLEX
Age/Sex	11 Y 9 M 29 D / Male	**Bed Name**	PRE OP 806
Date	16/07/2026 17:06	**Order No**	18-0001728453
Payor	SELFPAY	**Prescription No**	PRIP18-0627497
UHID	GUC-00015591	**Dispensed Date**	16/07/2026 17:08

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

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

nted Time : 16-07-2026 17:08

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PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 30 D (M)
Dr. KAILASH S

Date: 17/7/26

Gender: .....

Ward: ICU

Room No: 705

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☑ c. No pending indents are there against above patient
- ☑ d. Checked the bed side cupboard of the bed
- ☑ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign	Nurse Sign	Pharmacy Sign
Date:	Date: 17/7/26	Date: 17/7/26
Time:	Time: 2pm	Time: .....

Docu. No. : RCH /FRM / GENERAL / 117

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 30 D (M)
Dr. KAILASH S

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							
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP | GUC-00015591 IP18-00036492 Master P HARIHARASELVAN 17-09-2014 11 Y 9 M 29 D (M) Dr. KAILASH S : ..... Dept: .....

Date of Admission: ..... ischarge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/7/26	10:55 Am	ED	705	
16/7/26	12.45 PM	705	OT	
16/7/26	4.4pm	OT	7th floor	

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
16/7/26	Infusion pump	11.15 Am		1728264	P. Kam [illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
16/7/26	Dx wire placement	(1)	1728218	[signature]

ANY OTHER INFORMATION:

Patient Name: Master Harithara selvan
Surgeon Name: Dr. Kailash
Anaesthetis Name: Dr. Mohan / Dr. Ashwini
Procedure: 8 plate removal
In 1.35 pm
Out. 2.40pm.

Date: 17/7/26 Time: 2pm Prepared By: [signature] 6073

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature] 6073	7th Floor		

Rainbow Children's Hospital | BirthRight

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 30 D (M)
Dr. KAILASH S

DISCHARGE TRACKING SHEET

FLOOR- 7th Floor.

NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	17/7/26 at 2pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing		17/7/26 at 2pm			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Patient Name: Harikaraselvan.P UHID No: 15591 Bed Category: 105

AT-ADMISSION DESK:

- Explain about admission process
- Welcome Kit

SERVIGES IN WARD:

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

BILLING:

- Take billing update on daily basis at ground floor IP Billing Department (09:00AM to 06:00PM) and if any Query please reach to billing manager/IP Manager (+916379905271) (on same time.)
- If any insurance query and corporate information, please reach to ground floor insurance/ corporate desk.
- For Insurance patient give documents after admission.
- Please carry attender pass at the time of visiting patient.
- VISITING HOURS for Pediatrics (08AM -09PM & 4PM -6PM)
- VISITING HOURS for OBG (12PM -01PM & 4PM -6PM)
- Explain about concern department contact details, which mentioned bedside chart.

MANAGEMENT TEAM:

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

THANK YOU AND GET WELL SOON

Signature of patient/ patient Attendance

Signature of the Introducer

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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BED SIDE CHECK LIST FOR NURSES

Date:	16/7/26	16/7	17/7						
Doctor's Orders	yes	Yes	yes						
Carried out or not	yes	Yes	yes						
Bed Side									
Structured Handover done	yes	Yes	yes						
IV Site	yes	Yes	yes						
Central Lines	NA	NA.	NA						
Arterial Lines	NA	NA	NA						
Feeding Catheter	NA	NA	NA						
Urinary Catheter	NA	NA.	NA						
Skin Care	yes	Yes.	yes						
Eye Care	yes	Yes.	yes						
Mouth Care	yes	Yes.	yes						
Sterillum Bottle, Stethoscope	yes	Yes.	yes						
Suction Bottle (Should be clean & empty)	NA	NA.	NA						
Intubation Tray	NA	NA.	NA						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA.	NA						
Ventilator Tubing, (Any Water, Blood)	NA	NA.	NA						
Humidification	NA	NA.	NA						
Check all Infusion (Labelling, Correct Preparation)	yes	Yes.	yes						
Chest Physio & Neb	NA	NA.	NA						
Handed Over By Name :	[illegible]	NISHA	Sree[illegible]						
Signature :	P.V	[illegible]	[illegible]						
Date & Time:	16/7/26 11AM	16/7/26 8:17PM	17/7 [illegible]						
Hand Over Taken By Name :	Sowmya	[illegible]							
Signature :	[illegible]	[illegible]							
Date & Time:	16/7/26 8:17P	17/7/26 11AM							

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 : IP18-00036492 **Admit Date** : 16-Jul-2026 **Admit Time** : 09:46 AM **UHID** : GUC-00015591

Patient Details :

Patient Name	: Master P HARIHARASELVAN	**Age**	: 11 Y 9 M 29 D
Guardian	: Mr N PETCHIMUTHU	**DOB**	: 17-09-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 49, GANGAI NAGAR, URAPAKKAM, CHENNAI 603210 Urapakkam Kanchipuram Tamil Nadu INDIA 603210	**Phone No**	: 9842604535
		E-mail	: n.petchimuthu@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 101 **Ward Name** : 0F-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr N PETCHIMUTHU **Relationship** : Father

Contact Address : 49, GANGAI NAGAR, URAPAKKAM, CHENNAI 603210 Urapakkam Kanchipuram Tamil Nadu INDIA 603210 **Phone No** : 9842604535 / 9842604535

Signature

Doctor Details :

Doctor Name : Dr. KAILASH S **Specialisation** : ORTHOPEDICS

Referral Doctor : self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master P HARIHARASELVAN**	**Age :**	**11 Y 9 M 29 D**
IP No:	**IP18-00036492**	**Sex:**	**Male**
Consultant:	**Dr. KAILASH S**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/~~Relative~~:

Name: Petchimuthu

Relationship: Father

Date: 16/07/2026 Time: 9.47 Am

Witness Name: Parthiban

Witness Signature:

Patient Address:

49, GANGAI NAGAR, URAPAKKAM,
CHENNAI 603210 Urapakkam
Kanchipuram Tamil Nadu INDIA
603210

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BILLING POLICY

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

DECLARATION

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

Patient Name : Master. P. Hariharaselvan	UHID Number : GUC-00015591
Self/Attendant Name : N. PETCHIMUTHU (Father)	Relation : Father
Self/ Attendant Signature : Phone Number : 9842604535	Name & Signature of Financial Counselor

भारत सरकार

भारतीय विशिष्ट पहचान प्राधिकरण
भारत सरकार
Unique Identification Authority of India
Government of India

आधार

பதிவேட்டு எண்/Enrolment No.: 2043/31511/23219

Harihara Selvan (ஹரிஹர செல்வன்)

S/O: Petchimuthu, 9 Ground Floor eb opp, lakshmi nagar, Nandivaram - Guduvancheri, Kancheepuram, Tamil Nadu - 603202

Date: 18/10/2016

உங்கள் ஆதார் எண்/ Your Aadhaar No.:

9972 4155 5007

எனது ஆதார், எனது அடையாளம்.

1947 | help@uidai.gov.in | www.uidai.gov.in

தகவல்

- ஆதார் அடையாளத்திற்கான சான்று, குடியுரிமைக்கு அல்ல.
- அடையாள சான்றை ஆன்லைன் ஆதன்டிகேஷன் மூலமாகப் பெறவும்.
- இது எலக்ட்ரானிக் செயல்முறை மூலம் தயாரிக்கப்பட்ட கடிதமாகும்.

குறிப்பு: குழந்தைக்கு 5 வயதாகும்போது பயோமெட்ரிக் சிறப்பம்சங்களை பதிவு செய்யுங்கள்.

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- To establish identity, authenticate online.
- This is electronically generated letter.

Note: Children on attaining 5 years of age need to provide biometric information.

Digitally signed by DS UNIQUE IDENTIFICATION AUTHORITY OF INDIA 01
Date: 2016.10.18 10:05:37 IST

- ஆதார் நாடு முழுவதிலும் செல்லுபடியாகும்.
- ஆதார் ஆதார் பெறுவதற்கு ஒரே ஒரு முறை மட்டுமே நீங்கள் விண்ணப்பத்தை பூர்த்தி செய்து பதிவு செய்ய வேண்டிய அவசியம் ஏற்படும்.
- தயவுசெய்து உங்களின் சமீபத்தைய புதிய மொபைல் நம்பர் மற்றும் e-மெயில் முகவரியை பதிவு செய்யவும். இதனால் உங்களுக்கு பல்வேறு வசதிகளை பெற்றுக் கொள்ளும் சௌகரியம் கிடைக்கும்.

- Aadhaar is valid throughout the country.
- You need to enrol only once for Aadhaar.
- Please update your mobile number and e-mail address. This will help you to avail various services in future.

भारत सरकार
GOVERNMENT OF INDIA

ஹரிஹர செல்வன்
Harihara Selvan
பிறந்த நாள்/ DOB: 17/09/2014
ஆண் / MALE

9972 4155 5007

எனது ஆதார், எனது அடையாளம்.

AADHAAR
भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

முகவரி:
தந்தை / தாய் பெயர்:
பேட்ச்சிமுத்து, 9 க்ரௌன்ட் ப்லோர் எப் ஒப்ப், லட்சுமி நகர், நந்திவரம்-கூடுவாஞ்சேரி, காஞ்சிபுரம், தமிழ் நாடு - 603202

Address:
S/O: Petchimuthu, 9 Ground Floor eb opp, lakshmi nagar, Nandivaram - Guduvancheri, Kancheepuram, Tamil Nadu - 603202

9972 4155 5007

MERA AADHAAR, MERI PEHACHAN

Rainbow®
Children's
Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

UHID ID: _____ _____

Department: _____ _____

Consultant: _____

Docu. No. : RCH /FRM / GENERAL / 065

(P.T.O.)

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

Pediatric Multiorgan History & Physical Examination

Name: Mast. Hari Hara Selvan. Age/Sex 11yrs/M.

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

Osteoporosis c B/L genu valgus
s/p: proximal medial Tibial plating done on 23/1/25.

History of present illness :

A 11yrs male came with complaints of known case of Bilateral genu valgus, Bilateral proximal medial Tibial plating done planned for plate removal.
no c/o fever, cough, cold
no c/o vomiting, loose stools
no c/o sorethroat, ear discharge.

NPO - from 7.30 AM.

Patient Sticker

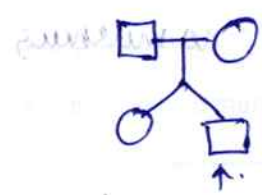
Past History : (including details of any previous investigation or treatment)

H/o Admission for hemivault remodelling & vessels.
for ~~plagiocephaly~~ scapho[cephaly]
Admitted for B/L proximal medial tibial plating
in 2025.

Birth & Neonatal History:

NVD | Term | B.wt - 3.1kg | no NICU stay.

Family Chart



Birth & Socio Economic History:

About Father : YNCM.

About Mother :

Any additional information :

Developmental History :

milestones attained at appropriate age.

Immunization History :

Immunized upto age according to IAP guidelines.

Anthropometry :

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

Weight (kgs) 30.1kg (Centile ______)

On Examination :

Temperature : 96.5°F Pulse Rate : 89/min B.P. 103/67 mmHg SPO2 100% RA

Resp.rate and type of breathing : 22/min

Rash —

Lymphadenopathy —

Oedema :

Allergies (if any): —

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : (N)

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

Any addes sounds : no added sounds

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : no murmurs

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

Per Abdomen :

Inspection : (N)

Palpation : soft, non tender

Ausculation :

Spine : External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticke

GUC-00015591 IP18-00036492
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17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

Reflexes :

DTR **Superficials:**

Plantars Flexors

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Osteoporosis c B/L Genu valgus s/p: B/L Proximal medial Tibial plating
Plan: Plate removal

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

IV Fluids
Inj. cefotaxime - To arrange
NPO from 7.30 AM. → To be given in OT preoperatively
Shift to OT on call.

Signature of the Doctor: .....

Name of the Doctor: Dr. Chandralega

Date & Time: 16/7/2018

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: .....

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

(1)

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/18. 10:00PM	Δ: S/P B/L proximal medial Tibial platy - removal.	
	child muid	
	Afebrile	
	No c/o pain	
	child stable	
	clinicly well	
	vitals stable.	
	RS: clear CVS: S1 S2 (+)	
	CNS: NFND PA: soft (NT) - no mass	
		Advice
		1) Continue as charted.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/25 9:10 AM	S/B Dr. Deepak	
	Dx:- Osteopetrosis c B/L genu valgus	
	↓	
	S/P:- B/L Proximal medial Tibial plating	
	↓	
	now S/p Plate removal	
	Child reviewed	
	Child has no new concerns	
	no fever / vomiting	
	O/E:	
	Child is alert, active	
	CVS: S1S2	Vitally stable
	RS: VBS	
	P/A: Soft	
	CNS: NAD	
	Parathyroid - 50	
	Vit D3 - 13 ↓	D1 → Inj Cefotaxime 1g IV BD
		To Monitor vitals / seizures
		To W/O any fever / Pain
		Dr. 16/6/25

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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RESULT SHEET

Date	16/7/26					
Time						
Hb	11.9					
PCV	36					
RBC	4.77					
WBC	7870					
N/L	53/37					
Platelets	3,39,000					
CRP						
ESR	2					
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg	9.1					
Phosphate /PHO_4	/4.8					
Urea						
Creatinine						
ALP	164					
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
parathyroid	50					
vit D3	13					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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DRUG CHART

Date of Admission: 16/7/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				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:				

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

REGULAR PRESCRIPTIONS

Weight. 30.1kg Ward. 7th floor.

DRUG : Inj CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	q12h	16/7

Name & Signature of the Doctor Starting the Drugs: 2033

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 2 am, 8 pm

DRUG : Inj PARA

Dose	Route	Frequency	Start Date
500mg	IV	Q6H	16/7

Name & Signature of the Doctor Starting the Drugs: 2033

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 16/7, 8 am, 2 pm, 10 pm

DRUG : T. CRYMORAL FORTE

Dose	Route	Frequency	Start Date
1 tab	PO	1—0—1	16/7

Name & Signature of the Doctor Starting the Drugs: 2033

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 7 am, 7 pm

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Dr. KAILASH S

Weight. 30.11kg Ward. ....

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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/7/26	—	INJ. CEFOTAXIME	1GM	IV	[signature] 19124	—
16/7/26	1:35PM	INJ. CEFOTAXIME	1g	iv	S. [signature] 10348	[signature]
16/7/26	2:30PM	INJ. PARACIP	450mg	iv	S. [signature] 10348	[signature]
16/7/26	3:40 PM	INJ. KETONOV	15mg	Slow iv in 100ml NS	S. [signature] 10348	[signature]

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

I.V. FLUIDS CHART

Weight. 30.1kg 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
16/7/26	11.15 AM	0.9% NS	IV	70ml/hr	19/12/24	P.K V.A	~~16/7/26~~		
16/7/26	2PM	RL-10	iv	10ml/kg/hr	S. Sathish 101348	M M	S. Sathish 101348 16/7/26		
16/7/26	2.45 PM	RLS-100ml	iv	100ml	S. Sathish 101348	M M	16/7/26 S. Sathish 101348		

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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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: 705

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Chandiralega [signature] 19/7/24

Date & Time : 16/7/26

Nurse Name & Signature: M. Arthi [signature]

Date & Time : 16/7/26 @: 10 Am.

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

Doc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7/26 Time: 11AM. 4PM. 8PM 12AM 4AM.

Doctor / Nurse / Family Concern?

Temperature (°F)	96.2°F	98.2°F	97.2°F	97.5°F	98°F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	110/60	110/60	110/60	100/67	98/60 (68)	96 (78)
Heart Rate (Number)	72bpm	112	110	88bpm	90bpm	100bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	28bpm	28	28	28bpm	26bpm	20bpm
Resp Distress (Mod/ Severe / None / Mild)	✓	✓	✓			
Receiving O_2 (l/min)	RA	RA	RA	RA	RA	RA
O_2 Saturations (%)	99%	99%	99%	100%	97%	99%
Conscious Level (Normal / Altered)						
GCS *	15/15	15	15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	PB	PB	PB	PB	PB	PB

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Dr. KAILASH S

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FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake Route: Mouth	I.V	N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
16/7/26	08:00 am											
	09:00 am											
	10:00 am	Admission										
	11:00 am	N		70ml							0	P.L
	12:00 pm	P		70ml							0	P.L
	01:00 pm	O		70ml							0	P.L
Total Intake: 210ml						Total Output: NIL						
	02:00 pm	RL		700ml							0	[illegible]
	03:00 pm	N		NESTOP							0	[illegible]
	04:00 pm	P									0	[illegible]
	05:00 pm	O									0	[illegible]
	06:00 pm	Tc water	200							200	0	[illegible]
	07:00 pm	H2O	50							100	0	[illegible]
Total Intake: 250ml + 700						Total Output: 300ml						
	08:00 pm											
	09:00 pm	H2O	150ml							200ml	0	[illegible]
	10:00 pm	milk	200ml	70								
	11:00 pm			70							0	[illegible]
	12:00 am	H2O	50ml	70						[illegible]		
	01:00 am			70								
Total Intake: 350ml						Total Output: 1+ mic - 200ml						
	02:00 am			70								
	03:00 am			70								
	04:00 am	H2O	20	70						[illegible]	0	[illegible]
	05:00 am			70								
	06:00 am	milk	200ml	DC						350	0	[illegible]
	07:00 am			DC								
Total Intake: 220 ml						Total Output: 1+ mic → 350ml						

Total 24 hrs. Intake	1590ml.	Total 24 hrs. Output	1+ mic - 850ml

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .... NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Admission Notes	
16/7/26	11.00Am	child Admission from ER to 7th Floor. child is general condition good, Admission for B/L plate Removal, NPO from 9.30Am, Anaesthesia OP basic, Billing Clearance done, IVF - Fomihova, tain OT give, wt - 30.1kg Plan for 1 Am, shifting 12.45Pm	P. Kavira 607261
	12.00pm	child vitals checked and Recorded. [12pm / CP ++ / PP ++ / CFT <2sec]	P. Kavi 607261
	12.50Pm	child details handover given to OT staff	P. Kavira 607261
16/7/26	at 1.15 pm	OT Notes patient received from 7th Flood. patient conscious and oriented patient vitals are stable. BP - 100/60mmHg, HR - 72 b/mt. SpO2 - 100%. patient shifted to OT - II for surgery. under aseptic technique. General anaesthesia is given. under General anaesthesia procedure plate removal is done (PTO)	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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☐ No Known Drug Allergies
☐ Drug Allergies .... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/20		patient shifted to recovery room	
		patient vitals are monitored.	
		BP - 120/80 mmHg, HR - 72 b/mt,	
		SpO2 - 100, patient shifted to	
		ward, patient file handed over	
	2.40 pm.	the ward staff	[signature]
		Receiving notes	
16/7/20	2:40pm	child details, Hand over taken	
		from OT staff. child conscious	
		Oriented, child vitals are stable.	
		child NPO break at 5pm,	
		child post op. Order, Inj. Taxim 0.5	
		IV 12Hrly (3doses), Inj. para. 300mg	
		IV Tds, T. chymo. fort BD, IVF	
		Stop, IV line patters. →	[signature] 607308
	3pm	child vitals are stable.	
		Maintained I/O chart. →	[signature]
	4pm	child vitals are stable.	60...
		no other complaints, No c/o	
		pain, child sleeping well.	
		4pm / CP ++ / PP ++ / CRT <2sec →	[signature] 607...
	5pm	child NPO break. H2O	
		given no c/o vomiting, maintained	
		I/O chart. →	[signature] 607308
	6pm	child no other complaints.	
		maintained I/O chart →	[signature] 60730

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26	7:30pm	child details Handover given to night duty staff.	[signature]
		Night Duty Notes.	
	7:30pm	Handover received from Evening Duty staff child active and oriented. IV line present. IVF 0.9% DNS - 70ml/hr on flow. post op order. Inj-paracetamol-500mg 8th hourly Inj - Taxim 1gm BD. T- Chymoral fort - BD. drug chart order not there. Informed Dr. Lucky sir told came and.	[signature]
	9pm	checked vital sign and recorded. PP ++ CP ++ CRT <3sec. Vital sign is stable.	[signature]
	10.30 pm	Inj-Para 500mg given as per Dr. Kailash sir post operative orders.	[signature]
17/7/26	2am	checked vital sign and Recorded. PP ++ CP ++ CRT <3sec.	
	2am	Inj- Taxim 1gm given as per Dr. Kailash sir post operative orders.	[signature]
	4am	Checked vital sign and recorded. PP ++ CP ++ CRT <3sec	[signature]

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue nots.	
17/7	7am	Due medication. was given.	
		As per drug chart order.	ns/0950
		I/O chart was maintaining.	
	7:30 am	The child details handing	
		over given to morning duty staff	ns/0930
		— Morning duty on 17/7/2018	
	7:30 am	Child report taking over from	
		(N) duty.	[illegible]
	8am	child was afebrile taking orally	
		& passing urine vital signs are	
		stable maintained I/O chart	
		due medication given as per	
		orders	[illegible]
	10am	No other special complaint	
		at present voiding freely	
		No urine pattern [illegible]	
		[illegible]	[illegible]
	12pm	Vital signs are checked &	
		recorded maintained I/O chart	
		And has no specific complaint	
		at present has no oozing	
		bleeding from the operative	
		site	[illegible]
	1:30pm	Pt report handing over to (E)	
		duty staff	[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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OPERATION NOTES

Surgeon : Dr. Kailash		Asst. Surgeon : —	
Anesthetist : Dr. Moha		OT Nurse : Sr. Sangeetha / MN Siva	
Pre-Operative Diagnosis: B/L Genu valgum c 8-plates in situ			
Surgical Procedure : B/L Knee 8-plate removal			
Weight :	Date : 16/7/2026	Start Time : 1.35 Pm	End Time : 8.40 Pm.
Post Operative Diagnosis:			
Peri-Operative Complications:			

Operation Notes: ↓SAP, ↓S.A.P Caudal anesthesia,

Findings: Pt. in supine position, surgical parts prepared. T control to (L) thigh, through previous scar

Procedure Notes: plate was exposed. 8-plate with 2 screws removed. Hemostasis seen & wound closed in layers. Compression dressing done. Similar procedure done on (R) side.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

(P.T.O.)

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

Adv

Wound Care:

Inj. Taxim 1g IV 12hrly (3 doses)

Drain /Special Lines/Catheters:

Inj. Tab 500mg IV 1-1-1

Special Patient Positioning and Requirements:

T-Chymoral forte 1-0-1

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: (Dr KAILAS HS)

Signature of the Surgeon:

Date & Time: 16/7

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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: ..... OT ..... Shifted to: ..... Wardside .....

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. CEFOTAXIME	1g	iv	stat	16/7/26 1:30 PM	☐C ☐DC
2	INJ. PARACIP	450mg	slow iv	stat	16/7/26 2:30PM	☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Ashwini S ..... S. Ashwini 101348

Date & Time : ..... 16/7/26 2 PM .....

Nurse Name & Signature: ..... Pradeepaveerarajan / 20002 .....

Date & Time : ..... 16/7/2026 at. 2.0 Pm .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. kailash
Asst. Surgeon : —
Anaesthetist : Dr. Mohanmurah
Scrub Nurse : Sr. Sangeetha / Sr. Siva

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Age : 11y Gender : M.
Name : 8 plate removal
Out-time : 2.45pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 1:32pm

Patient Has Confirmed

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

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

Before Skin Incision ➤➤

TIME OUT Time: 1:40pm

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 : [signature]
Name : Dr. kailash

Before Patient Leaves Operating Room

SIGN OUT Time: 2.45pm

Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☑ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☑ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☐ Yes ☑ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☑ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	☐ Yes ☑ No

Signature : [signature]
Name : Sr. sangeetha / Sr. siva.

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

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
16/7/26 at 9:40pm	16/7/2026 at 3pm

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

From Unit	To Unit	Information to Attendant
OT	4th floor.	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
one file	–	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
Sri Pradeepn Veerayan Wards	Dr. Mohanmurali

Patient & Clinical Records Received by : Sri 16/7/26 at 3pm

Date & Time of Patient Received :

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

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

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

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

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PHLEBITIS ASSESSMENT

Patient's Name:..

MRD NO: GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

Age :..... D.:.................... Sex: ☐ M ☐ F

Consultant:..

CANNULA 1

Date : 16/7/26 Time: 10:00 AM

Location : Ⓛ Metacarpal

Size : 22 G Venflon

Cannula inserted by : S/N: Praveen

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
16/7/26	10:00 AM	☐Yes ☑No	☐Yes ☑No	patten	[illegible]
	12 pm	☐Yes ☑No	☐Yes ☑No	observe	RB
		☐Yes ☐No	☐Yes ☐No		
16/7/26	2 pm	☐Yes ☑No	☐Yes ☑No	[illegible]	[illegible]
	4 pm	☐Yes ☑No	☐Yes ☑No	[illegible]	[illegible]
	6 pm	☐Yes ☑No	☐Yes ☑No	observe	Sy
	8 pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10 pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
17/7	12 Am	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	2 am	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	4 am	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	6 am	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	8 am	☐Yes ☑No	☐Yes ☑No	Observ	Sw
	10 am	☐Yes ☑No	☐Yes ☑No	Observed	Sw
	12 pm	☐Yes ☑No	☐Yes ☑No	Observed	Sw
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	11Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	P.Kan...
16/7/26	5pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature]
16/7/26	10pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature] 01280
17/7/26	4Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature] 01280
17/7/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	NIL	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

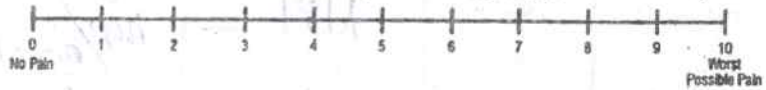
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within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

(P.T.O)

Docu.No: RCH /FRM / CLINICAL / 152

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 drawn 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,	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, 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO, less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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BRADEN 'Q' SCALE

(1)

				Date : 16/7	16/7	16/7	17/7/14
				Time : M	E	N	M
Mobility	**Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	3	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	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	1	1
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	24	24	24	24
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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WELL'S CRITERIA FOR ASSESSING DVT

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

S.No	Assessment Criteria	Score	Date: 16/7 Time: 11Am	Date: 16/7 Time: 2pm	Date: 16/7. Time: 8PM	Date: 17/7 Time: M	Date: Time:	Date: Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0		
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0		
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0		
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0		
	Total Score		0	0	0	0		
	Signature of the Nurse		[signature]	[signature]	[signature]	[signature]		

Intervention: [signature] Nil

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

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

Docu. No. : RCH /FRM / CLINICAL / 128

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WELL'S CRITERIA FOR ASSESSING DVT

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

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

Intervention: _____

_____

_____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

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

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THE HUMPTY DUMPTY SCALE

M E N M

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			16/7	16/7	16/7	17/7	
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	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	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total		10	10	10	10	

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		X	X	NA	X	
	Other Intervention(s) Specify		X	X	NA	X	
	Nurse's Name:		RDS	SD	ALISHA		
	Signature:						
	Date:		16/7	16/7	16/7	17/7	
	Time:		11AM	2pm	8pm	8am	

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

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

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
16/7/26	11Am	yes	explian about Room orientation	Mother	No	oral	None	yes	good	[illegible]
17/7/26	1am	yes	Nutritional pattern	mother	NO	oral	None	yes	good	SN [illegible]

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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Master P HARIHARASELVAN (M)
17-09-2014 11 Y 9 M 29 D
Dr. KAILASH S

PRE - OPERATIVE CHECK LIST

Date: 16/7/26

Patient's Name : Hariharaselvan Age : 11y 9m Gender : ☒ M ☐ F

Blood Group : B+ve UHID : GUC - 00015591

Planned Surgery : 8 plate removal Surgeon : Dr. Kailash.

Anesthetist : Dr. Priyadharshini Date & Time of Operation : 16/7/26 at 1:30pm.

Tick Appropriate Boxes
To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : Dilli balan. C Nurse In-Charge Name : Praveenkumar.

Billing Executive Signature : Nurse In-Charge :

Date & Time : 16/07/2026 10:04pm Signature of Nurse In-Charge : Date & Time : 16/7/26 at 10 Am

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

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Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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	yes	
8	Application of incisional negative pressure wound dressing	yes	

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer: 16/7/26 @		TRANSFERRED TO : OT
1	**Patient Identification**	YES/NO	REMARKS
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b.Surgical procedure & correct site verified	yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b.SpO_2 within safe range	yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	yes	
	b.No active uncontrolled bleeding	NA	
	c.Last vitals recorded before transfer	yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	NA	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NA	
	b.Reassessment done	NA	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NA	
	b.All drains fixed, output noted	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	NA	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	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	NA	
	c.Special positioning maintained as per surgery	NA	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**		
10	**REPORTS AND LABS HANDED OVER**		
11	**BIOPSY/HPE SENT**		
12	**Documentation**		
	a.Documentation completeness		
	Transferring Nurse: ______________	[signature]	
	Receiving Nurse : ______________	[signature]	
	Signature of Incharge:		

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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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)

.....

.....

..... 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.

.....

.....

.....

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 : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : P Kala

Name : P. Kalaiswati

Relationship with Patient: mother

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:.....

CONSENT FORM FOR ANAESTHESIA

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

UHID NO: ..... Surgeon Name: Dr Kailash

Anaesthesiologist : Dr Arun Operative procedure planned : Plate removal

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 : Aspiration, dehydration, bleeding, 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. Kale

Name : P. Kalleshwari

Relationship with Patient: Mother

Date & Time : 16/7/26 @ 1.00 pm

Witness :

Signature : P. Kaur308

Name : P. Kaur308

Date & Time : 16/7/26 @ 1.00 pm

Doctor (who is taking the consent) :

Signature : ✓

Name : Dr Arun (Dr Arun)

Date & Time : 16/7/26 @ 1.00 pm

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

GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

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

Allergy / Adverse Reaction: NIL

Body Weight: 30.1 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	B/L proximal Needle cast tibial plate	

Family History: NIL

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

If yes please list, ...

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

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

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

Observations: Weight: 30.1Kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.20F HR: 92b/m RR: 28b/m BP: 110/60

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

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

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

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

FUNCTIONAL SCREENING:

☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to ..... Mother .....

Nurse's Name: ..... SIN KANIMOZHI Date: 16/7/26 ..... Time: 11 AM Signature .....

procedure: 1:30pm.
Npo: 9:30Am.

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EMERGENCY ROOM TRIAGE FORM

Wt: 30.1kg

Patient's Name : Harihara selvan. Age : 11y. Gender: ☑ Male ☐ Female

Date : 16/7/26. Time of Arrival : 9:40Am.

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 96.5°F PR: 89. BP: 103/67(73) RR: 22. SpO_2: 100%.

Chief Complaints: procedure: 8 plate removal. K/c/o Osteopetrosis.

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

P. Kala
Signature of Parent / Guardian

Triage Completion Time : 2 mins.

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location:

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Praveen.

Signature of Triage Nurse : [signature]

Date & Time : 16/7/26 @ 9:52 Am

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 16/07/26 Time of arrival : 9:40AM

Chief Complaints: Came for procedure plate Removal RBS: –

Height : 137CM Weight : 30.7kg 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 : 9:55AM

Time	Nursing Notes
10:00 AM	Pts came for procedure plan for Plate
	Removal.
	Checked vital sigs & recorded.
	S/By Dr. Kailash Adviced for Admission.
	NPO - from 7:30 AM. 16/7/26.
	IV line placement done.
	Pts was stable shift to ward.
	OP file given to parents

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: 89 b/m BP: 103/67 (73 CFT: <3 sec	Shift - out from ER to: 705
RR: 22 b/m SPO$_2$: 100 %	Time of Shift - out: 10.55 AM
GCS: 15/15 Temperature : 96.5°F	Handover given to: (Nurse's Name) S/N
Pain Score: 0/10	
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done

(R) Metacarpal 22G Venflon 16/7/26 @ 10:00 AM

Name of the Nurse : N. Aarthi Signature of the Nurse : [signature]

Date & Time : 16/7/26 @ 10:00 Am

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiralega

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

Date : 16/7/24

Start Time of Assessment: .....

Allergic History: .....

Weight: .....

Chief Complaints: .....

Plate removal

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: Staphylococcal

Medication History: –

Relevant Investigations: –

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 22/min SpO₂ on FiO₂ 100% RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L UAE+
Palpation Findings (If necessary) .....

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

(P.T.O.)

Circulation

HR: 89/min CFT [Central ..... Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 103/67 ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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

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

Signs of Neurological compromise .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: 96.5F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned: .....

As per chart

Treatment Planned: .....

As per chart

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

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

Assessment done by

Name of the Doctor: Dr. Chandiralega

Signature: .....

Date & Time: 26/7/24

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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Docu. No. : RCH /FRM / CLIN

CTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

PATIENT TRANSFER FORM

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Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
	16/7/26 @ 9.46 Am	16/7/26 @ 1.00pm
	Transfer Ordered by	Reason for Transfer
Dr. KAILASH	Dr. Deepak	Further Mangement
From Unit	To Unit	Information to Attendant
705	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?
Ip Files	—	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Inj. Taxim 1gm	1
2.	D-Syringe 10ml	1
3.	Poly Flush	3ml
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
P. Kaumozhi 60726	DR. DEEPAK

Patient & Clinical Records Received by : Radhganarayan / [signature]

Date & Time of Patient Received : 16/7/2026 at. 1.15pm

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

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mast Hariharaselvan Age: 11 Sex: M UHID.No: 15591

Date: 11/7/26 Time: 1pm Proposed Operation: 8 plate removal

Diagnosis: B/L genu valgus.

B.P / CRT: .... H.R: .... Weight: 29.7kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 11.9	Glucose:	Protein:	HIV: NR	X-Ray: 28/9/2020
PCV:	Urea:	Alb:	HBS Ag: NR	ECG: (N)
WBC: 7870	Creat:	Total Bill:	HCV: NR	2D Echo: LVEF
Plate: 339000.	Na:	Dir. Bill:	Blood group: B+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++: 9.1	Alk phos: 164	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

K/c/o osteopetrosis

Allergies: NKDA

Medical History: CVS: 2nd born, NVD, B.W - 3.1 kg, cried

RESP: immediately after birth. Diabetes: no NICU admission,

CNS: (N) developmental milestones

Renal: vaccinated till date.

Hepatic / GE: no known comorbidities Physical Activity: active child.

Others: H/O Remirault remodelling & correction of scaphocephaly

Past Anaesthetic History: ↓ GA in 2020 - ICU admission × 2 days

Physical Exam: H/O B/L proximal medial tibial plating in 2025, u/

Airway: MP 1 2 (3) 4 difficult airway anticipated Mouth Opening: adequate Mentohyoid Distance: (N) Neck: restricted extension Teeth: crowding of teeth, partially edentulous

H/O blood transfusions (+)

Lungs: B/L AE (+)

Heart: S1S2 (+)

CNS: NFND

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

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

CT brain feb 2026, (N) ... brain, good growth.

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

CURRENT MEDICATIONS	DOSAGE
T. vitamin D.	

Pre-Operative Instructions:

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

Signature: [signature] 15/10/25 Name: Dr Priyadharshini R

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No — Fasting Status: > 6 hrs

Physical Status: II — Patient Identified ✓ — ☑ Consent Present — ☑ Chart Reviewed

H.R.: 75/min — B.P / CRT: 96/54 mmHg — SpO₂: 99–100% — R.R: 16/min — Last Feed: 7 AM

Pre-OP Diagnosis: B/L genu valgum S/p plating — Operation: B/L LL screw removal — Date: 15/7/26

Surgeon: Kailash — Anaesthesiologist: Dr. M. Ravi Ashwini — Technician: Shyam Azad

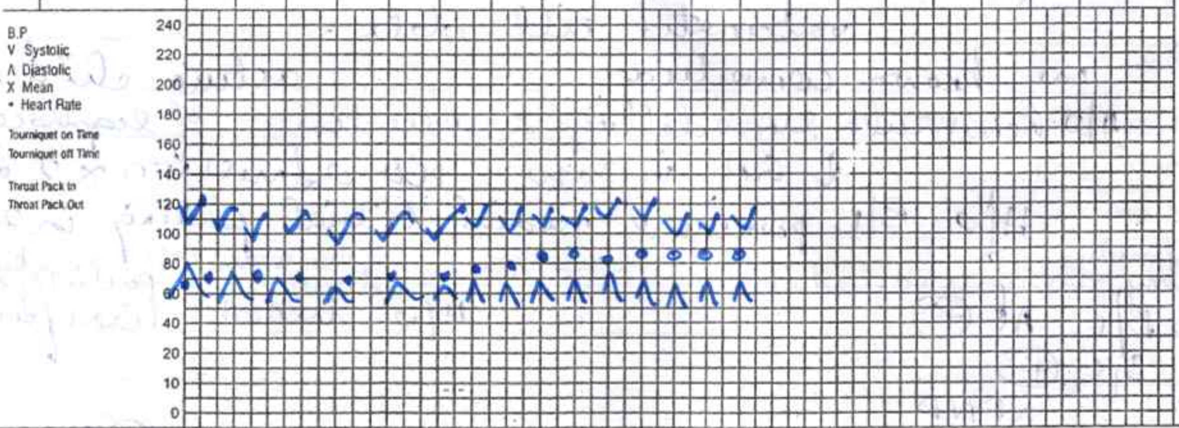
TIME	1:35 PM		3 PM
N_2O / AIR / O_2 LPM	1:1 →		
HALO / ISO / SEVO	MAC 0.6 →		
Drugs:			
Inj. Fentanyl	40 mcg		
Inj. Propofol	60 mg		
Inj. Tramadol	For Ventilation / Inj. paracip 450 mg IV		
Inj. atracurium 10 mg + 5 mg IV			
Reversal: Inj. Neostigmine 1.5 mg + Inj. glycopyrolate 0.3 mg IV			
FiO_2 / SaO_2	100	100	100 — 100% — 100%
$ETCO_2$			
ECG	35	35	37 — 36–35
Temperature			
Urine Output	SR	SR	SR — NSR
Fluids / Blood	10 RL →	NS – 100 ml →	

Antibiotic: Inj. cefotaxime 1 g IV

Suppository

Blood Loss

NOTES



LAB Values: ABG / GRBS / Others

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

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 1:45 PM
OP Start:
OP End:
Leave OR: 3 PM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☑ Regional

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

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

☑ Mask ☑ SGA
☐ Airway ☑ Oral ☐ Nasal
ETT# 3 LMA placed
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# Attempts:
Difficulty Why?

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

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☑ Caudal
Others:
Position: (R) lateral position
Site: Sacral hiatus
Needle Size: 26 G Depth:
Parasthesia ☐ Yes ☑ No — USG
Catheter at skin: guidance 20 ml of
Drug Name & Conc: 0.2% ropivacaine after
Bolus:
Infusion: negative aspiration of
Block Level: blood / CSF.
Comments:

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

Name of the Doctor: DR. ASHWINI
Signature of the Doctor: [signature] 101348

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Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Pradeep Time Received : 2.45pm Time Discharged : 3.45pm

✓ RESP > < BLOOD PRESSURE • PULSE

SPO2	Chart	
250		250
240		240
230		230
220		220
210		210
200		200
190		190
180		180
170		170
160		160
150		150
140		140
130		130
120	^ ^ ^	120
110		110
100	• • •	100
90		90
80	^ ^ ^	80
70		70
60		60
50		50
40		40
30		30
20		20
10		10
0		0

IV Cannula Site : ....

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

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

IV Fluids: ....
Oral Feeds: ....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
16/7/20	3pm	0/10	NPO x 2hr iv antibiotic as advised Syp. P250 6ml tds	S. Ashwini 101348

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

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

Anaesthesiologist Name : DR. ASHWINI S
Anaesthesiologist Signature: S. Ashwini 101348
Date & Time: 16/7/20 3pm

PACU Nurse Name : Pradeepaveeranyan
PACU Nurse Signature: [signature] 62021
Date & Time: 16/7/20 at 2.45pm

Transferred to Unit by (PACU): [signature] 62021
Date & Time: 16/7/2020 at 3.45pm

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

PATIENT TRANSFER FORM

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GUC-00015591 IP18-00036492
Master P HARIHARASELVAN
17-09-2014 11 Y 9 M 29 D (M)
Dr. KAILASH S

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Kailash	16/7/26 @ 9.46 AM	16/7/26 @ 10.55 AM
Transfer Ordered by	**Reason for Transfer**	
Dr. Kavitha	Further Management	
From Unit	**To Unit**	**Information to Attendant**
ER	705	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
(10)	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 ☐

osteopetrosis c B/L genu valgus S/P B/L proximal medial tibial plating done planned for plate removal

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Praveen	Dr. Chandralega 19/7/26

Patient & Clinical Records Received by : P. Kanimozhi 607261

Date & Time of Patient Received : 16/7/26 @ 18.00 ABK

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