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Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: 25/7/26

Name of the Patie: GUC-00005068 Baby J ARADHYA IP18-00036594 25-06-2018 8 Y 0 M 29 D (F) Dr. S. KEERTHIVASAN

UHID No: .....

Gender: .....

Ward: .....

Room No: 607

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: 25/7/26	Date: 25/7/26
Time:	Time: 01:18 PM	Time: .....

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

Rainbow Children's Hospital

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

DISCHARGE TRACKING SHEET

)OR- 6TH 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			25/7/18				

ACTIVITY RECORD FOR BILLING

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Name: .....

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

UHID No: ..... IP No: .... Dept: .....

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26.	7.18 pm	ER	6OT	
24/7/26	11.15 pm	6th Floor	7th Flr	
24/7/26	2 pm	7th floor	6th floor	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	pre anesthesia check-up	24/7/26	1732170	
2.				
3.	Dr. Nataraj	24/7/26	To be raised	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
23/7/26	CBC, PT, APTT, INR	26023727	
	SGPT, SGPT		17/07
24/7/26	1) Duodenum (small) (Gastroscopy biopsy) 2) Antrum	26023808	
24/7/26	Biopsy Bone marrow Aspiration	26023808	
24/7/26	Bone marrow Aspiration Reporting	26023812	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/7/26	Infusion pump	6am	24/7/26 @ 7pm	1732178	Clayy 01/7/26
24/7/26	Endoscopy + Colonoscopy	11:40am	12:10pm	1732302	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/7/26.	IV placement	(1)	1732085	

ANY OTHER INFORMATION:

Procedure Name: Endoscopy + Colonoscopy + Bone marrow Test

Surgeon Name: Dr. Keerthivasan + Dr. Natrajan

Anaesthetist Name: Dr. Mohan, Dr. Priyadharshini

Anaesthesia: IV sedation

In time: 11:30Am out time: 12:30pm

Date: 25/7/26 Time: .....

Prepared By: 60787.

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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SURGERY DETAILS

Date : 24/7/26

Patient Name: Baby. J. Aradhya Date of Birth: 25/6/2018 Age: 24

Gender: Female Ward : Endoscopy room UHID No. 0606 8/36594

Date of Surgery: 24/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Endoscopy + colonoscopy + Bone Marrow Test

Time in : 11:30 Am Time Out : 12:30pm

	NAME	AMOUNT
1. Surgeon	: Dr. Keerthivasan, Dr. Natrajan	
2. Anaesthetist	: Dr. mohan, Dr. priyadharshini	
3. Assistant Surgeon	:	
4. OT Technician	: Mr. Shyam, Mr. prasanth	
5. Circulating Nurse	: S/N. Thanu	
6. Assistant Nurse	: S/N. Bharath.	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☒ Others Endoscopy start time: 11:40 Am End time: 11:50 Am
Colonoscopy start time: 11:50 Am End time: 12:10pm.

Signature of the Surgeon

(1732302).
Signature of Circulating Nurse

Order No: Order by:

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

Patient Sticker

Endo + Colonoscopes

CONSUMABLES OF OT

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Circulating staff : .... Technician : Prasanth / Shyam Date : 24/1/26 Time : ....

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

Surgeon Anaesthesiologist Nurse OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036594	**Ward**	6F-PRIVATE
Patient Name	Baby J ARADHYA	**Bed Name**	PVT 607
Age/Sex	8 Y 0 M 29 D / Female	**Order No**	18-0001732321
Date	24/07/2026 13:12	**Prescription No**	PRIP18-0628980
Payor	SELFPAY	**Dispensed Date**	24/07/2026 13:13
UHID	GUC-00005068		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	3	28.13	84.39
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	2	21.56	43.12
3	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	1	11.25	11.25
4	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	3	2.58	7.74
5	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
6	EFIPRES INJ 30 MG 1 ML	NEON LABORATORIES LTD	H	1231096	02/28	1	45.90	45.90
7	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	1	525.00	525.00
8	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	2	69.10	138.20
9	OXYGEN NASEL CANNULA (PEAD)	Polymed	GENERAL	G25FO40115	05/30	1	255.00	255.00
10	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
11	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**1,528.36**	**1,760.44**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

inted Time : 24-07-2026 13:13

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	IP18-00036594		
Patient Name	Baby J ARADHYA	**Ward**	6F-PRIVATE
Age/Sex	8 Y 0 M 29 D / Female	**Bed Name**	PVT 607
Date	24/07/2026 13:12	**Order No**	18-0001732320
Payor	SELFPAY	**Prescription No**	PRIP18-0628979
UHID	GUC-00005068	**Dispensed Date**	24/07/2026 13:12

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		1010726	06/29	1	120.00	120.00
2	D WATER IV 1000 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	1D262317	03/29	1	107.61	107.61
3	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	2	100.00	200.00
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
5	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
						Total :	**557.61**	**882.61**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

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C-00005068 IP18-00036594
by J ARADHYA
06-2018 8 Y 0 M 29 D (F)
. S. KEERTHIVASAN

DISCHARGE TRACKING SHEET

FLOOR- 6th Floor NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	9.Am.		Seal Dissp		
	INTIME	OUT TIME			
Arrangement of File by Nursing	8.30 Am	9.35 Am	Seal Dissp		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S . KEERTHIVASAN

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OPERATION NOTES

Surgeon : Dr. Keerthivasan	Asst. Surgeon : –
Anesthetist : Dr. Mohan, Dr. priyadharshini	OT Nurse : S/N. Bharathi
Pre-Operative Diagnosis:	
Surgical Procedure : OGD + colonoscopy ↓ GA.	

Weight :	Date : 24/7/26	Start Time :	End Time :

Post Operative Diagnosis:

Peri-Operative Complications: OGD scopy — E - ⊖, St - Ⓝ, DL - Few lymph nodes; Colonoscopy — Poor preparation, - Rectum sigmoid, Small HF Ⓝ.

Operation Notes:

Findings:

Procedure Notes:

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

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

Name of the Surgeon: .....

Signature of the Surgeon: .....

Date & Time: .....

GUC-00005058 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: Endoscopy room (7th floor) Shifted to: 6th floor.

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 24/7/26 @ 12 pm

Nurse Name & Signature: Thanu

Date & Time : 24/7/26 @ 2pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Keerthivasan
Asst. Surgeon :
Anaesthetist : Dr. Mohan, Dr. Priyadh
Scrub Nurse : S/N. Bharathi

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

Age : Gender :
Surgery Name : Endoscopy + Colonoscopy
11:30AM Out-time : 12:30 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:32 AM

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

Site Marked ☐Yes ☐No ☑NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

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

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

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

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

Signature : 12.6.18
Name : Dr. Mohan, Dr. priyadharshini

Before Skin Incision ➤➤

TIME OUT Time: 11:40 AM

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

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

Anticipated Critical Events

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

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

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

Signature :
Name : Dr. Keerthivasan

Before Patient Leaves Operating Room

SIGN OUT Time: 12:30 pm

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 :
Name : S/N. Bharathi

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

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 24/7/26 @ 2pm **TRANSFERRED TO :** 6th floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	Yes	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	Yes	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	Yes	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	NA	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NA	
	b.Reassessment done	NA	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	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	Yes	
	c.Special positioning maintained as per surgery	NA	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	NA	
11	**BIOPSY/HPE SENT**	Yes	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: _____		
	Receiving Nurse : _____		
	Signature of Incharge:		

PATIENT TRANSFER FORM

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GUC-00006068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

	Date & Time of Admission: 23/7/26 @ 5:41 pm	Date & Time of Transfer Order: 24/7/26 @ 2pm.
Treating Consultant Name: Dr. S. Keerthivasan	Transfer Ordered by: Dr. Mohan.	Reason for Transfer: For Further Management
From Unit: Endoscopy room (4th floor)	To Unit:	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 1 IP file	Number of Imaging Films: –	Personal belongings including clinical documents. If any handed over to attendant. Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
607871	Dr. Mohan.

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

PRE - OPERATIVE CHECK LIST

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Date: 24/7/26

Patient's Name : Baby. Aradhya. Age : 8Y Gender : ☐ M ☑ F

Blood Group : O+ve UHID : 05068.

Planned Surgery : Endoscopy + colonoscopy + BM aspiration. Surgeon :

Anesthetist : Date & Time of Operation : 24/7/26 @ 11 am

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	YES	NO	NA
1.	Weight checked and recorded?	☑	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☑	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☑	☐	☐
4.	Enema given / Bowel Preparation	☑	☐	☐
5.	Remove all ornaments, etc and sterile gown given	☑	☐	☐
6.	Is Blood arranged as required?	☐	☑	☐
7.	If Blood has been ordered - is Blood bag ready?	☐	☑	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☑	☐	☐
9.	Pre Anesthetic consultation with anesthesiologist	☑	☐	☐
10.	Pre Medications Given? (Sedatives / etc)	☐	☑	☐
11.	Skin Preparation	☑	☐	☐
12.	Site is marked	☐	☑	☐
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 : Delli Babu.C Nurse In-Charge Name : Serajul

Billing Executive Signature : Delli Signature of Nurse In-Charge : Serajul

Date & Time : 24/07/26 @ 2:52pm Date & Time : 24/7/26 @ 11 am

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PRESCRIPTION FORM FOR SCHEDULE X DRUGS

Date: 24/7/26

UHID No: 00005068

Gender: Female

Date of Birth: 25-06-2018 Age: 8y Ward: 6th Floor

Name of the Patient: ARADHYA . J

Treating Doctor's Name : Dr. Keerthivasan Regd. No: 95834

S.No	Name of Drug	Quantity
1	Inj - Ketamine 2 ml (100 mg) / 5 ml (250 mg	①
2	Tab. Methylphenidate (Inspiral SR) 10 mg	
3	Tab. Methylphenidate (Inspiral) 5 mg	

Others if any: ....

Prescribing Doctor:

Signature: [signature]

Name: LUVANINENI 203377

Date & Time: 24/7/26, 10:10AM

Issued by (Pharmacist):

Signature: [signature]

Name: [illegible]

Date & Time: 24/7/26 @ 10.26 am.

Note: Please fill all the fields. All fields are mandatory, Incomplete forms can be rejected.

Docu. No: RCH /FRM / CLINICAL / 134

Birthright | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: **TRANSFERRED TO :**

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

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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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: 6th Floor Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. Tonoferon	5ml	P/O	1-0-0		☐C ☐DC
2	Syp. Reconesv	5ml	P/O	1-0-0		☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 24/7/24 @ 10:30AM

Nurse Name & Signature: Sanjay

Date & Time : 24/7/24 @

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
	23/7/26 @ 5.41pm	24/7/26 @ 11 am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Keerthivasan	Dr. Deepak.	Further Management.
From Unit	**To Unit**	**Information to Attendant**
6th Floor.	7th Floor.	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
Case 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
Serajit (signature)	Dr. Deepak.

Patient & Clinical Records Received by : (signature) 601871

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

Departmer
PRE-ANA

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

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

Date: 24/7/26 Time: 7:30AM Proposed Operation: UGI endoscopy + colonoscopy + BM aspiration

Diagnosis: Chronic anemia & chronic constipation for evaluation

B.P / CRT: 99/62 mmHg H.R: 101/min Weight: 18.8 Kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 8.6g%	Glucose:	Protein:	HIV:	X-Ray:
PCV: 28	Urea:	Alb:	HBS Ag:	ECG:
WBC: 6100	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.08L	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS :

RESP : No fever | URI | LRI. Diabetes :

CNS : ? Febrile seizures at 7 months Age.

Renal :

Hepatic / GE : NVD | preterm baby | 32 weeks GA/B.W = 1.69 Kg | Physical Activity:

Others : No NICU admission | speech delay (+) | immunised till date

Past Anaesthetic History: No H/o previous Sx.

Physical Exam: (N) built

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

Lungs : B/L NVBS (+) clear

Heart: S1S2 (+) No murmur.

CNS: NFND

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : 2nd Rt Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE
Syp. Fe	

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: S. Akhil Name: DR. ASHWINI.S

101348

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: >6hrs
Physical Status:	Patient Identified ✓	☑ Consent Present	☑ Chart Reviewed

H.R: 75/min | B.P / CRT: 84/50mmHg | SpO_2: 100% | R.R: 16/min | Last Feed:

Pre-OP Diagnosis: chronic anemia + constipation | Operation: VG Therapy, colonoscopy, BM aspiration | Date: 24/7/26

Surgeon: Dr Keerthivasan / Dr Nataraj Evaluation | Anaesthesiologist: Dr Mohan / Dr Priya | Technician: Mr. Shyam

TIME: 11.25am | 12.20pm

N_2O /AIR /O₂ LPM: 2L/min

HALO /SO /SEVO

Drugs:

Inj Propofol for 20ml 20mg IV + 20mg + 20mg IV

Inj Fentanyl 50mg IV

Inj Ketamine 20mg IV.

FIO_2 / SaO_2

$ETCO_2$

ECG: SR

Temperature

Urine Output

Fluids / Blood: 300ml RL

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: (A) 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: 11.25am
OP Start: .....
OP End: .....
Leave OR: 12.20pm

Anaesthesia:
☐ GA IV sedation
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: 22G (L) VL
☐ IV .....
☐ IV: .....

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

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

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

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

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

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

Name of the Doctor: Dr Priya
Signature of the Doctor: [signature]

Patient Sticker

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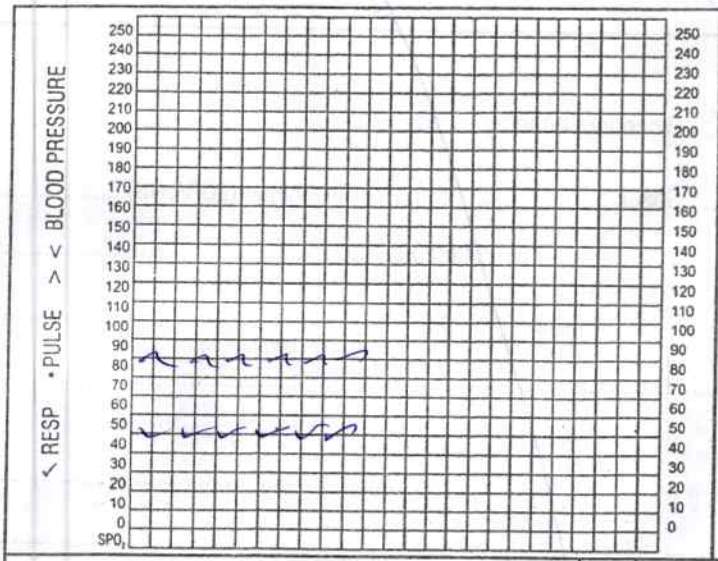
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Thanu Time Received : 12:30pm Time Discharged : 2pm



IV Cannula Site : .....

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

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

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
24/7		0/10	NPO x 2 hours	ISHA

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 Ranjan
Anaesthesiologist Signature: ISHA
Date & Time: 24/7/26

PACU Nurse Name : Thanu
PACU Nurse Signature:
*Date & Time: 24/7/26 @ 12:30pm

Transferred to Unit by (PACU):
Date & Time: 24/7/26 @ 2pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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CONSENT FOR SPECIAL PROCEDURES

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S . KEERTHIVASAN

Patient Nam .... Gender: ☐ Male ☐ Female

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

I .... S/D/W/O ....

Here by give consent for procedure of : ....

For my patient, Named : ....

The doctors have clearly explained to me that the procedure has following possible complications:

.... [illegible] ....

....

....

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

....

....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: ....

Patient Attendant :

Signature : R. A[illegible]

Name : R. ABIRAMI

Relationship with Patient: MOTHER

Date & Time : 24. 07. 2026

Witness :

Signature : ....

Name : ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature : ....

Name : [illegible]

Date & Time : 24.[illegible]

CONSENT FOR ANAESTHESIA

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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

UHID NO: ..... Surgeon Name: Dr. Keerthivasan

Anaesthesiologist : Dr. Mohan / Dr. Rathish Operative procedure planned : U.G.I endoscopy + colonoscopy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : hypotension / Bradycardia

- 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 : R. Abirami

Name : R. ABIRAMI

Relationship with Patient: MOTHER

Date & Time : 24-07-2026

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : S. Ashwini 101348 Name : DR. ASHWINI.S Date & Time : 24/7/26 7:30AM

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

CONSENT FOR UPPER GI ENDOSCOPY

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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

Description of the Procedure

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

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

Precautions

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

Risks

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

CONSENT FOR THE PROCEDURE

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

CONSENT FOR UPPER GI ENDOSCOPY

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

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

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

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

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

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

.....

12. CONSENT OF PARENT / PARENT REPRESENTATIVE / SURROGATE

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

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

	Signature	Name	Date	Time
Patient Representative with relationship	R. Abi	R. ABIRAMI	24/7/26	11 AM
Witness				
Doctor		Dr. Keerthivasan	24/7/26	11 AM
Interpreter				

(Authorization of patient/patient representative surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S . KEERTHIVASAN

CONSENT FOR LOWER GI ENDOSCOPY

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

Description of the Procedure

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

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

Precautions

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

Risks

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

CONSENT FOR THE PROCEDURE

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

7. I consent and agree to the administration of sedation by Dr. _____ or the performance of this procedure. I am aware of the risks of the sedation and also consent to supplementation with any other mode of anaesthesia if necessary.

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

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

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

11. I have been explained biological sample (Blood, Body Fluids, tissue) collected from my body for diagnostics tests or surgical resection along with the data may be given without disclosing my identity by Rainbow Doctor to research scientists affiliated with Rainbow childrens hospital for diagnostic or therapeutic research purpose. This will happen only if there is any sample leftover after its intended medical use. There will be no additional sample collected. This research use may not benefit me but will help in better understanding of disease and better treatment for other patients in future. I understand that I will not benefit from any potential commercial value that may result from this research and development activity. I have the option to disallow the research use of the left-over sample.

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

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

12.CONSENT OF PATIENT/ PARENT REPRESENTATIVE / SURROGATE

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

	Signature	Name	Date	Time
Patient Representative with relationship	R. [illegible]	R. ABIRAMI	24/7/26	11 AM
Witness				
Doctor	[illegible]	Dr. Keerthivasan	24/7/26	11 AM
Interpreter				

(Authorization of patient/patient representative / surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

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 : IP18-00036594 **Admit Date** : 23-Jul-2026 **Admit Time** : 05:41 PM **UHID** : GUC-00005068

Patient Details :

Patient Name	: Baby J ARADHYA		
Guardian	: T JEGANATHAN	**Age**	: 8 Y 0 M 29 D
Gender	: Female	**DOB**	: 25-06-2018
Occupation	:	**Religion**	:
Address (H)	: D/6, NEW SI QUARTERS, NORTH RAJA STREET Alandur Reopened W E F 6 6 05 Chennai Tamil Nadu INDIA 600016	**Martial Status**	:
		Phone No	: 9790884783
		E-mail	: mailmejegan.t@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM **Bed No** : PVT 607 **Ward Name** : 6F-PRIVATE

Room No : PVT 607 **Admission Type** : First Visit

Contact Details :

Name : T JEGANATHAN

Contact Address : D/6, NEW SI QUARTERS, NORTH RAJA STREET Alandur Reopened W E F 6 6 05 Chennai Tamil Nadu INDIA 600016

Relationship : Father

Phone No : 9790884783

Signature

Doctor Details :

Doctor Name : Dr. S . KEERTHIVASAN

Referral Doctor : self

Co-Consultant : Dr. NATARAJ PALANIAPPAN

Specialisation : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 25000.00

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:	**Baby J ARADHYA**	**Age :**	**8 Y 0 M 28 D**
IP No:	**IP18-00036594**	**Sex:**	**Female**
Consultant:	**Dr. S . KEERTHIVASAN**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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: R. Alij

Name: Jeganathan
Relationship: Father
Date: 23/07/2026 Time: 5'41
Witness Name: Jeevith
Witness Signature:

Patient Address:
D/6, NEW SI QUARTERS, NORTH RAJA STREET Alandur Reopened W E F 6 6 05 Chennai Tamil Nadu INDIA 600016

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 : ARDHYA	UHID Number : Guc-0005068
Self/Attendant Name : Jeganathan	Relation : Father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

भारत सरकार

आधार

இந்திய அரசாங்கம்

Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 2193/11809/01982

To
அபிராமி ரத்தினம்
ABIRAMI RATHINAM
D/O: Rathinam
D NO P4/6
A 4 AREA
THERMAL QUARTERS
METTUR DAM
Mettur
Salem Tamil Nadu - 636401
6374594927

Signature valid

Digitally signed by UNIQUE IDENTIFICATION AUTHORITY OF INDIA
Date: 2022.04.07 06:07:30 UTC

உங்கள் ஆதார் எண் / Your Aadhaar No. :

3782 5728 0321

VID : 9101 9545 9082 7532

எனது ஆதார், எனது அடையாளம்

Issue Date: 11/01/2014

இந்திய அரசாங்கம்

Government of India

அபிராமி ரத்தினம்
ABIRAMI RATHINAM
பிறந்த நாள்/DOB: 31/05/1992
பெண்/ FEMALE

3782 5728 0321

VID : 9101 9545 9082 7532

எனது ஆதார், எனது அடையாளம்

Government of India

AADHAAR

தகவல்

- ஆதார் அடையாளத்திற்கான சான்று. குடியுரிமைக்கு அல்ல.
- பாதுகாப்பான QR குறியீடு/ ஆப்லைன் XML / ஆன்லைன் அங்கீகாரத்தைப் பயன்படுத்தி அடையாளத்தை சரிபார்க்கவும்
- இது எலக்ட்ரானிக் செயல்முறை மூலம் தயாரிக்கப்பட்ட கடிதமாகும்.

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code/ Offline XML/ Online Authentication.
- This is electronically generated letter.

- ஆதார் நாடு முழுவதிலும் செல்லுபடியாகும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா சேவைகளை எளிதில் பெற ஆதார் உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்
- mAadhaar செயலியைப் பயன்படுத்தி உங்கள் ஸ்மார்ட் போனில் ஆதாரை எடுத்துச் செல்லுங்கள்

- Aadhaar is valid throughout the country.
- Aadhaar helps you avail various Government and non-Government services easily.
- Keep your mobile number & email ID updated in Aadhaar.
- Carry Aadhaar in your smart phone – use mAadhaar App.

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

Download Date: 07/04/2022

முகவரி:
D/O: ரத்தினம், களண் பி4/6, ஏ4 ஏரியா,
தெர்மல் குடியிருப்பு, மேட்டூர் அணை,
மேட்டூர், சேலம்,
தமிழ் நாடு - 636401

Address:
D/O: Rathinam, D NO P4/6, A 4 AREA,
THERMAL QUARTERS, METTUR DAM, Mettur,
Salem,
Tamil Nadu - 636401

3782 5728 0321

VID : 9101 9545 9082 7532

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00005068 IP18-00036594 _____
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
UHID ID: _____ Dr. S . KEERTHIVASAN _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: ARADHYA Age/Sex 8 yrs / F

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

C/o persistent anemia since 18 months of age
Had C/o chronic constipation since 1yr of age.
Now came for admission for Endoscopy + Colonoscopy

History of present illness :

Child has H/o chronic anemia i drop in Hb. Since 18 months of age.

H/o chronic constipation since 1yr of age
No H/o passage of frank blood in stools / melena (Bloody - Blackish Tarry stools)

No H/o Aversion to foods / NO H/o allergic to specific foods
Talks normal diet

No prev H/o rashes / pustular lesions / recurrent infections

Now, Has come for Endoscopy / Colonoscopy, Iron Transfusion + Bone marrow aspiration

H/o No H/o passage of Blood in stools (occult blood ⊕)
→ Anti TTG - Neg (
→ IgA levels - ⊖

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

Past Hi ...details of any previous investigation or treatment)

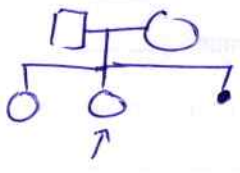
H/o prev Blood transfusions (2-3) times previously at 2yr/3yrs & 5yrs of age respectively

H/o prev Admission for viral fevers. 3yrs of age.

Birth & Neonatal History:

Preterm / NVD / Preterm / NO NICU stay / 1.698kgs

Family Chart NCM.



Birth & Socio Economic History:

About Father : NO H/o Anemia/related disorders in parents.

About Mother : (P).

Any additional Information :

Developmental History : delayed speech till 2 Yrs yrs.

Immunization History :

Immunized till 9 months of age / Currently has catchup vaccinations.

Anthropometry :

Head Circum (cms) 47cm (Centile) Height (cms): 110cms (Centile) (< 3rd centile) -2.42

Weight (kgs) 18.8kgs (Centile 10th centile).

On Examination :

Temperature : 98.1°F Pulse Rate : 101/min B.P. 99/62 mmHg SPO2 100% @RA.

Resp.rate and type of breathing : 20/min

Rash Pallor +

Lymphadenopathy (P). PP-well for

Oedema : non-pitting

CRT < 3sec

Allergies (if any): NO Allergies

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : NVBS / No added sounds

Any addes sounds : _____

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

_____

_____

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 + / No murmur

Any murmur : _____

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

_____

_____

Per Abdomen :

Inspection : _____

Palpation : Soft NT, no organomegaly

Ausculation : _____

Spine : (N) External Genitelia : (N)

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

_____

_____

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutriton : (N)

Tone: (N) Power 5/5

Co-ordinator : _____

Posture : -

Involuntary Movements : -

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Patient Dr. S. KEERTHIVASAN

Reflexes :

DTR 2+

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Chronic anemia under Evaluation /
Chronic Constipation ([illegible]

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
Coagulation profile
SGOT
SGPT

To arrange for Bone marrow
Needle (13) [5cm]
[3 EDTA
2 Heparin] tubes to be kept ready

Planned Management

NPO from 6AM.
1) Tomorrow morning 11 am
for endoscopy / colonoscopy
& plan for BM aspiration / Biopsy along (with endoscopy).
2) Clear liquids
Transparent
PEGLEC (50ml/kg) 12AM to 2AM.
1 peglec (138g in 2L water)
[500ml]
3) Inj EMESET 2mg IV Stat
4) DULCOFLEX 2 tablet(s) < 10PM / 5AM.

Signature of the Doctor: Lucky [signature] 203377

Name of the Doctor: LUCKY.VAGNESH

Date & Time: 23/7/26, 6:10 PM.

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In:

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B. Dr. Luckymlwton	
23/7/18 8:00PM		
	Child seemed	
	Afebrile	
	No other complaints	
	on clear liquids	
	vitals : stable	
	RS : clear CNS : NFND	
	CVS : S1 S2 ⊕ / No murmur PA : soft	
	CBC	
	8.8 > 6820 < 2.35; 50/41	
	RBC – 4.37	
		Adv
	PT : 13 OT/PT : [30/25]	1) Anaesthetist to see
	APTT : 37.7	for sedation for
	INR : 0.92	endoscopy / colonoscopy & Bone marrow biopsy
		2) Shift to Endoscopy at
	To give PEGLEC (137g in 2202)	11 AM
	↓	3) NPO from 6 AM
	(500ml). to give	4) IVF 55ml/hr 0.9 DNS
		at 6:00AM (onwards)
	[signature]	5) monitor vitals
	2033 hrs	6) Dulcoflex at 10PM, 5AM Supp P/R

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 9am	S/B Dr Kavitha	
	Δ - Chronic Iron deficiency anaemia, Chronic Constipation ↓ evaluation, Short stature ? GI bleed	
	Admitted for Colonoscopy, Upper GI Endoscopy, BM evaluation.	
	O/E - Alert, active, Pallor (+). Microcephaly, ? crowded teeth, Dental caries, ? Chipmunk facies (+)	
	PPWF, CRT < 3 secs, Pulse volume - good. Vitals - stable.	
	Stool → occult blood (+ve)	
	P/A - soft, non-tender, no organomegaly	
	CVS - S1S2 (+), no murmurs	
	RS - B/L NVBS (+)	
	CNS - [illegible] sensorium (N) NFND	
	Colon preparation - passed stools 4-5 episodes, watery once - mixed c̄ black stools	
	NPO from 6am.	
		Advice NPO / IVF

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

[signature] Plan - Iron transfusion
Shift endoscopy suite room

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 12:00pm	c/s/b Dr. NATARAJ / Dr. Pavan / Dr. Gokul / Dr. Ajay	
	BONE MARROW ASPIRATION + BIOPSY IGA	
	↓ strict aseptic conditions	
	Bone marrow Aspiration f/b biopsy taken from posterior superior iliac spine	
	Smears + EDTA + Heparin samples taken	
	procedure uneventful	
	samples to be sent :-	
	(i) BM aspirate & biopsy for morphology to r/o sideroblastic anemia.	
	(ii) To preserve EDTA & heparin sample	
	iii) To give Inj-FCM.	
		198607
24/7/26 3pm	c/s/b Dr. Pavan / Dr. Gokul / Dr. Ajay	
	1) Inj Ferric carboxymaltose 300mg in 150ml NS IV over 2hrs.	
	2) W/F reactions (chills, Anaphylaxis)	

198607

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/1/26 4pm	S/B Dr. Kavitha	
	Child alert. Tolerated liquids.	
	PPWF, Pulse volume - good	
	CRT < 3sec	
	Pallor (+)	
	Vitals - Stable	
	P/A - Soft,	
	Distension (+)	
	non-tender.	
	Other systems - WNL	
		Plan
		1) (N) Diet
		2) To give Inj. FCM 300mg in 150ml NS today
		3) Monitor vitals / P/O / sensorium.
		4) W/f reactions during injection.
		Dr. Kavitha

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

23/7/26
MCV - 65
MCH - 20
MCHC - 3
RDW - 15.7

Date	26/6/26	23/7/26				
Time						
Hb	8.6	8.8				
PCV	28	28				
RBC	4.33	4.37				
WBC	6100	6820				
N/L/M/E	51/39/8/2	50/41/7/2				
Platelets	2.08	2.35				
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT		25				
T.Bill/Conj		30				
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR		13/0.92				
APTT		37.1				
CSF Protein / Sugar						
Cells						
N/L						

(P.T.O)

Date	30/6/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood	(+ve)					
Iron - 13						
UIBC - 420						
TIBC - 433						
TTh (IgA) - (-ve)						
IgA - 118						

Culture and Sensitivities : 30/6/26 P. smear - MCHC Anaemia

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

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DRUG CHART

Date of Admission: 23/7/20 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 / 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 ....

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25-06-2018 8 Y 0 M 28 D (F)
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REGULAR PRESCRIPTIONS

Weight. 18.8 kg Ward. 608

DRUG : Syp TONOFERON				Date / Time	24/7, 25/7
Dose	Route	Frequency	Start Date		
5ml	PO	1-0-0	23/7		8AM, WH, SS/65
Name & Signature of the Doctor Starting the Drugs: (CB/F). Ludyright 20337					
Additional Instructions: 80mg/5ml					
Daily Doctor's Endorsement by a Sign					

DRUG : Syp MELONEAV				Date / Time	24/7, 25/7
Dose	Route	Frequency	Start Date		
5ml	PO	1-0-0	23/7		8AM, WH, SS/65
Name & Signature of the Doctor Starting the Drugs: Ludyright 20337					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

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

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Weight. 18.8kg Ward. 607

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

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

VERIFIED BY : N... Signature ...

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/7/26	7 pm	Inj EMESET	2mg	IV	Lenlyjith 203370	[illegible]
23/7	10 PM	DULCOFLEX	(PR) 5mg	P/R	Lenlyjith 203370	[illegible]
24/7	5AM	DULCOFLEX	(PR) 5mg	P/R	Lenlyjith 203370	[illegible]
24/7	9.20am	PROCTOLYSIS ENEMA	100ml	P/R	Lenlyjith 203370	[illegible]

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Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

I.V. FLUIDS CHART

Weight. 18.8kgs. 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
24/7	12:00AM to 2:00AM.	PEGLEC (138g in 2litre water) ↓				[signature] 0100	24/7/26 @-2am		[signature] 0100
		To give 500ml	PO		Ludgeph 20337				
24/7	6:10am	RVF 0.9DNS	55ml/hr IV		Ludgeph 20332	Sby MM			
24/7	11:35 AM	RL 200ml	rushed IV	rushed	[signature]	PT BR	24/7	[signature]	PT BR.
24/7/26	5:30pm	Inj. FERRIC CARBOXY MALTOSE 300mg in 150 ml NS (2mg/ml)	i.v over 2 hours	75	[signature] 7284	Jey 0700	24/7/26 @-8pm		[signature] 0700

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

Patient Sticker

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MEDICATION RECONCILIATION FORM

Drug Allergies: NK ☑ 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: 607

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. NEOCONERV	5ml	PO	1—0—0	23/7/26 7:30am	☑C ☐DC
2	Syp. TONOFERON (80mg/5ml)	5ml (BLF)	PO	1—0—0	23/7/26 7:30am	☑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 : Lindaygith 2037?

Date & Time : 23/7/26 6:00PM

Nurse Name & Signature: A. Aleena Kurup Ajith

Date & Time : 23/7/26 @ 6pm

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

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Doc. No. : RCH/ FRM / CLINICAL / 126 (1)

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date 23/7/26 Time: 8pm 12pm 4pm

Doctor / Nurse / Family Concern?

Temperature (°F) — 104 103 102 101 100 99 98 97 96 95 94

98°F 97.8°F 98.2°F

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

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

99 (63) 57 | 100 (42) 58 | 105 (43) 62

Heart Rate (Number) 106 b/m | 110 b/m | 115 b/m

Resp. Rate (bpm) (Over 1 Minute) * — 70 60 50 40 30 2 1

Resp Rate (Number) 26 b/m | 24 b/m | 23 b/m

Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	room air / 100%	100%	100%
Conscious Level: Normal / Altered	✓	✓	✓
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]

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

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

Patient Sticker

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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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(2)

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 : 24.7.26 Time:	8pm	12pm	4pm	8pm	12am	4am
Doctor / Nurse / Family Concern?	S					

Temperature (°F)

96.2°F | 97.4°F | 97.8°F | 97.5°F | 97.2°F

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

Note: BP does not score in early warning scoring

Heart Rate (Number)	138bpm	108bpm	110bpm	115bpm	112bpm
BP	102 (65) 57	90 (66) 58	84 49	90 56	94 68

Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	38b/min	26b/m	24b/m	22b/m	25b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	97%	97%	98%	98%	98%
Conscious Level: Normal / Altered	Conscious	Conscious	Conscious	Conscious	Conscious
GCS *	Alert	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	S				

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.
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* 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

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Date	Time	Early Warning Score	Date	Time	Name

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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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FLUID CHART

Sheet No. : (1)

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

23/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm		Admission on ER.									
Total Intake :						**Total Output :**						
	08:00 pm	milk	100ml									
	09:00 pm	H_2O	50ml									
	10:00 pm	juice	50ml							✓	0	N
	11:00 pm	H_2O	100ml				✓				0	N
	12:00 am											
	01:00 am	H_2O	50ml							✓	0	N
Total Intake :			350 ml			**Total Output :**				U-2 ; M-1		
	02:00 am											
	03:00 am	H_2O	50ml								0	N
	04:00 am	H_2O	10ml				✓			✓		N
	05:00 am										0	N
	06:00 am	NPO		55ml			✓					
	07:00 am	NPO		55ml						✓	0	N
Total Intake :			60ml + 110ml			**Total Output :**				U-2 ; M-2		

Total 24 hrs. Intake	410ml + 110 ml	Total 24 hrs. Output	U-4 ; M-3

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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	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: ~~Diarrhoea~~ Motion	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am			55ml							0	SS/Ou
	09:00 am			55ml			✓					
	10:00 am			55ml							0	SS/Ou
	11:00 am		NPO	30ml			✓				0	
	12:00 pm		NPO								0	
	01:00 pm		NPO								0	
Total Intake :			465 ml			**Total Output :**						
	02:00 pm											
	03:00 pm										0	Du
	04:00 pm			55ml								
	05:00 pm	H2O	50ml	55ml							0	
	06:00 pm	Kaupi	100ml	10ml						✓		
	07:00 pm	H2O	50ml	75ml							0	
Total Intake :		200 ml + 195 ml				**Total Output :**	Urine					
	08:00 pm			75ml								
	09:00 pm	H2O	50ml	Stop							0	Sufoney
	10:00 pm									✓		
	11:00 pm	H2O	50ml								0	Sufoney
	12:00 am											
	01:00 am										0	Sufoney
Total Intake :		100ml + 75ml				**Total Output :**	U-1					
	02:00 am											
	03:00 am	H2O	30ml								0	Sufoney
	04:00 am											
	05:00 am	H2O	20ml								0	Sufoney
	06:00 am											
	07:00 am	H2O	50 ml								0	Sufoney
Total Intake :		100 ml				**Total Output :**	—					

Total 24 hrs. Intake	400ml + 735ml (Urine)	Total 24 hrs. Output	U-2; M-2

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

NURSING CARE RECORD

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 23/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon		→		On admission	←		
Night	7-3pm	Encourage oral ~~fee~~ hydration.		Monitor intake & Output. → Encourage oral feeds.	Child intake is better	Child clinically better & well.	Sen/ OHP2

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BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

NURSING CARE RECORD

Date: 24/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Reduce risk of hospital acquired and wound infection.	10am	Maintain strict hygiene. → Educate patient to do maintain hygiene	Child parents maintained hygiene	Child clinically better & well.	[signature]
Afternoon	2pm	Ensure adequate nutrition and hydration	3pm	To provide more oral liquids	To provided more oral liquids	Child was stable	[signature]
Night	8pm	Ensure adequate nutrition and hydration.	9pm	→ To provide more oral liquids	→ patient intake and output is good	→ patient clinically stable	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S . KEERTHIVASAN

(1)

NURSES NOTES

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

☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Admission on ER.	
23/7/26	7.15pm	child details hand over	
		taken form ER staff. child	Sen
		c/o - chronic anemia 4 month	[illegible]
		of age. chronic constipation	
		1year age. child w line	
		(+) w line observed & hey.	
	8pm	child vitals : checked & recon	
		tap is normal. CP +1 / PP +7 / CRT <	Sen [illegible]
		child clear liquid diet only	
		from night. child tomorrow	
		endoscopy + colonoscy. →	
	8.10pm	child details hand over	
		given to the night duty	
		staff. →	Sen [illegible]
		Night Duty Notes.	
23/7/26	8.10pm	→ Patient handover taken	
		by evening duty S/N →	Ramy
		→ Patient clinically stable.	[illegible]
		→ Checked vital signs	
		→ Patient vitals is stable.	
		→ c CRT <3sec / CP ++ / PP ++	
		→	Ramy [illegible]
	10pm	→ Monitored D/O chart	
		→ Maintain recording reports	
		→ Patient clinically stable →	Ramy [illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Supository dulcoflex	
		5mg administered as	
		per drug Chart order	
24/7	12am	→ peglec powder mixed	
		in 2 litter of water	
		and Given 500ml For	
		2 hours before 2am	[signature]
	2am	→ Monitored I/O Chart	01H [illegible]
		→ Maintain secondary deposit	
	4am	→ checked vital signs	
		→ patient vitals is stable.	
		CRT <3sec / CP ++ / PP ++	[signature]
	5am	→ administered 5mg	[illegible]
		dulcoflex supository	
		as per drug Chart order	
	6am	→ IV Fluids 55ml/hr	
		Connected as per drug	
		Chart order	[signature]
	7am	→ patient passed 3 times	[illegible]
		only Motion	
		→ Patient clinically stable	
	7.30 am	→ Patient handover given	
		to morning duty S/N	[signature] [illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
Dr. S. KEERTHIVASAN

(2)

NURSES NOTES

Rainbow Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Morning duty Notes.	
24/7/26	7:30am	child details hand over taken form night duty	
		Staff. child consious & active	Sel
	8am	child vitals checked & record	ous
		temp is normal. CP ++ | PP ++ | CRT <2sec	
		child NPO is there.	
	9am.	Dr. Keerthivasan sir called &	
		advaised to give Enema 100ml.	
	9:20am	Enema 100 ml given. →	Sel
	10am	child IV fluids DNS 55ml/h	
		give. →	Sel ous
		child	
	11:15am	child shifted to 7th floor	
		hand over given to the	
		7th floor staff. →	Sel ousp
24/7/26		OT Notes ON 24/7/26	
	11:15am	Child details handover taken	Suth 0195
		from S/N. while receiving child	
		Conscious & Oriented v/s are	
		stable OT gown changed. Consent	
		obtained Billing cleared. after	
		Child. Shifted to Endoscopy Room	
		On the table to connect the	
		Cardiac monitor v/s are [illegible]	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH /FRM / CLINICAL / 089

Patient Sticker

NURSES NOTES

Rainbow Children's Hospital — It takes a lot to treat the little.
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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		E recorded PR-78b/m, Spo2-100%	
		procedure started at Endoscopy+	
		Colonoscopy was done during	
		the procedure. V/S are stable.	60784
		PR-98b/m, Spo2-100%. Bp-110/70	
		after specimen taken. Child [illegible]	
		v/s are mon. Stable post op, are	
		Child Shift to ward 601	
		E handover to 6th floor Sl.	
24/7/26	2pm	=> Bone marrow Aspiration	Sujith 01557
		done by Dr Natrajan	
		=> Child Shifted to	
		6th floor. Child handover to	
		6th Floor staff.	60784
		Evening duty Notes	
24/7/26	3pm	→ patient received from OT	
		patient detail hand over taken	
		from OT staff, patient colonoscopy +	
		Endoscopy done + Bone marrow	
		aspiration done. Bone marrow	
		aspiration biopsy (done)	[signature]
	4pm	→ vital signs checked and	
		record. Vitals are stable	
		PP / CP / CRT	
		++ / ++ / <3sec	[signature]
		→ patient intake & output	
		chart maintained & record.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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BirthRight™
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Patient's Name: GUC-00005068 IP18-00036594 Baby J ARADHYA
MRD NO:....... 25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN
Age :............ ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 23/7/2b Time: ~~4:14~~ 5:20 pm
Location : (1) metadorsal
Size : 22G
Cannula inserted by : S/N Suganthira

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
23/7	5:20pm	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
	7pm	☐Yes ☐No	☐Yes ☐No	Observe	S1/OU
	11pm	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
24/7	3am	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
	6am	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
	8am	☐Yes ☐No	☐Yes ☐No	Observe	S1/OU
	10am	☐Yes ☐No	☐Yes ☐No	Observe	S1/OU
	4pm	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
24/7	6pm	☐Yes ☐No	☐Yes ☐No	Observe	[illegible]
	8pm	☐Yes ☐No	☐Yes ☐No	healthy	S1/[illegible]
25/7	12am	☐Yes ☐No	☐Yes ☐No	healthy	S1/[illegible]
	4am	☐Yes ☐No	☐Yes ☐No	healthy	S1/[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 29 D (F)
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Your Right to a Safe Delivery

Nursing General Admission Assessment Form For Pediatrics

Diagnosis: chronic constipation.

Arrival Time: 7.15 PM Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil

Body Weight: 18.8 Kg

Height: .... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
K/c/o - Anemia.	–	3 year of age. viral fever

Family History: –

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: 18.8 kg Length: .... Head Circumference (< 2 years): ....

Temp.: 98 °F HR: 104 b/m RR: 26 b/m BP: 99/57 (60)

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

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

Risk of Pressure Sore (Braden Q Score 27) (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
☐ Developmental Delay
☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

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?) .....

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: Sayful. Date: 23/7/26 Time: 8pm Signature

PATIENT TRANSFER FORM

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GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

Date & Time of Admission	Date & Time of Transfer Order
23/7/26 @ 5:41 pm	23/7/26 @ 7:15 pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Keerthivasan.	Dr. Lucky Vignesh	further management
From Unit	**To Unit**	**Information to Attendant**
ETC	007	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
15	NIL	Yes ☑ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Chronic anemia under Evaluation / Chronic constipation - for Endoscopy / Colonoscopy

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
J. Aravind for Ajith	Lucky Vignesh 23/7/26

Patient & Clinical Records Received by : Seen

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

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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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. KeerthiVasan / ~~Dr. Nithin~~ Date : 23/7/26.

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

Start Time of Assessment: ..... Weight: 18.8kgs

Allergic History: No Allergies

Chief Complaints:
- C/o Chronic constipation since 1yr of age
- C/o Chronic anemia since 11 months of age

Pediatric Assessment Triangle

A Appearance - TICLS Alert / Active

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: Prev no multiple transfusions (Chronic anemia), prev. HBV

Medication History: -

Relevant Investigations: -

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 18/min SpO_2 on FiO_2 100% @RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BLAE ⊕ / No added sounds
Palpation Findings (If necessary).....

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

(P.T.O.)

Circulation

HR: l

CFT — Central .... — Peripheral ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

BP: 99/62 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: Alert

Pupils: — Responsive ☑ Non-Responsive ☐ — Size — Right .... — Left ....

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

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Exposure

Temp.: ....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

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

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

Labs Planned: As charted

Treatment Planned: As charted

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: Lurdupriya 20337

Signature: Lu. [illegible]

Date & Time: 23/7/26, 6:48PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

GUC-00005068 IP18-00036594
Baby J ARADHYA
25-06-2018 8 Y 0 M 28 D (F)
Dr. S. KEERTHIVASAN

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 23/07/26 Time of arrival : 5:30pm.

Chief Complaints: came for Endoscopy & colonoscopy. RBS: .....

Height : ..... Weight : 18.8 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify ..... NIL .....

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

..... NIL .....

.....

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: ..... NIL ..... (Date/Time): .....

Social History: Lives With ..... Parents .....

Siblings in household ☐ Yes ☐ No (if yes How Many?) ..... 1 .....

Time of Initial assessment completed by ER Nurse : ..... 5:45 pm .....

Time	Nursing Notes
23/7/26 @ 5:40pm	patient came for ER with the planned for Endoscopy + colonoscopy. Dr. Keerthi-vasan sir advised to put admission. Dr Nataraj sir is co-consultant, NPO from 6am, Morning 11am procedure, Bone marrow needle should be arranged, informed OT, samples containes are ready before the procedure, shifted to ward.

Samples collected by: S/N Jyothi — Time: 6:45pm

Samples sent by: S/N Suganthira. — Time: 6:47pm

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: 110/min. BP: Low CFT: <2sec	Shift - out from ER to: ward
RR: 26/min. SPO_2: 100%	Time of Shift - out: 7:15 pm
GCS: 15/15 Temperature: 98.2°F	Handover given to: S/N Jacintha. (Nurse's Name)
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 in (1) metadoxal 2.2g is placed

Name of the Nurse: S/N Jyothi — Signature of the Nurse:

Date & Time: 23/7/26 @ 8:6:20pm

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EMERGENCY ROOM TRIAGE FORM

Wt · 18.8 kg.

Patient's Name : Baby. Aradhya. Age : 8y/F

Date : 23/7/26. Time of Arrival : 5:30pm

Gender: ☐ Male ☑ Female

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: 98.1F PR: 101bpm BP: 99/62 (70) RR: 26bpm SpO_2: 100% RA

Chief Complaints: c/o. endoscopy & colonoscopy.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☑ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2mins

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 : Gayathri.

Date & Time : 23/7/26 @ 5:30pm

Signature of Triage Nurse : .....

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

Patient Sticker

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature