GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		1pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP No: ..... GUC-00055334 IP18-00036730 ..... Dept: .....

Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/8/26	9.10aM	ER	418	
3/8/26	10am.	418	OT	
3/8/26	12.45Pm.	OT	418	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC	03/07/26	OT	
2.	[redacted]	[redacted]	[redacted]	[redacted]
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/8/26	Cystoscopy	10.55a.	11.10a	1736518	[signature] 0.1757

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
03/08/26	RV line Placement	1	OT	Sugandh

ANY OTHER INFORMATION: 3/8/26

IN TIME: 1045 - OUT TIME: 1130 hrs.

Procedure: Cystoscopy & DJ Stent removal

Surgeon: Dr. Nandini.

Anesthetist: Dr. Mohan.

Date: 03/08/26 Time: 1950 hrs. Prepared By: Sr Sujata

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
03/8/26			

Patient Sticker

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SURGERY DETAILS

Date : 3/8/26

Patient Name: Mast tharun kantL Date of Birth: 4/06/2009 Age: 17 y

Gender: M Ward : OT UHID No.: 55334/36730

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

Name of the Surgery : Cystoscopy Stent Removal

Time in : 10.55a. Time Out : 11.10a

	NAME	AMOUNT
1. Surgeon	Dr. Anand Viraj	
2. Anaesthetist	Dr. Mohan.	
3. Assistant Surgeon	—	
4. OT Technician	Mr. Thangam.	
5. Circulating Nurse	Ms. Sugantl.	
6. Assistant Nurse	Mr. Sugantl.	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☑ Cystoscopy (10.55a-11.10a) ☑ Versa Point 1736518 ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Record filled done

Signature of Circulating Nurse

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

INJ. PIPTAZ 2.25g @ 1V
@ 11am

Patient Sticker

DJ Stent Removal

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CONSUMABLES OF OT

Circulating staff: S/N Sugandhi Technician: Mr. Thangam Date: 3/8/26 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+3	✓				Suction Catheter		
HME filter: A / P / N						Feeding Tube		
Syringes : 10 cc ✓	3H	✓				Vaccum Suction Set		
05 cc ✓	3	✓	Gloves 5.5 PT	1	✓	Surgical Gloves		
02 cc ✓	3	✓	6.5 PT	1	✓	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set ✓	2	✓	NG tube			Koochies (S)		
RL ✓	1	✓	Cautery pencil			Venflon 22g	1	✓
NS : 10ml / 100ml / 500ml / (1000ml) ✓	1		Koochies			10cc ME~		(1)
			Ointments			D. Water 10ml		1
			Suction Catheter			Revotaz 2.25g		(1)
Fentanyl ✓	1		Cap, Mask			25% D 100ml		(1)
Morphine			Gauze Pack ✓	2		20ml syringe		(1)
Ketamine			Mop Pack			Airway 1 size		(1)
Propofol ✓	2	✓	Steristrip					
Rocuronium			Underpad ✓	2				
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 Protek					
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 Lox Jelly	1	✓			
			Latex Gloves 2	5P	✓			
			Ramdione Scrub					
			Saral					

Dr. Nandu

Surgeon

Dr. M...

Anaesthesiologist

Pmrdan

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	IP18-00036730	**Ward**	4F-FOUR SHARING
Patient Name	Master THARUN KANTH S	**Bed Name**	FSW 418
Age/Sex	17 Y 1 M 30 D / Male	**Order No**	18-0001736529
Date	03/08/2026 12:32	**Prescription No**	PRIP18-0630639
Payor	SELFPAY	**Dispensed Date**	03/08/2026 12:32
UHID	GUC-00055334		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AIRWAY-1 70 MM (WHITE)	ROMSONS		1156O424	03/29	1	234.00	234.00
2	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	WE432B001	04/29	1	21.51	21.51
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	4	28.13	112.52
4	DSYRINGE 20 ML WITH LEUR LOCK	NIPRO	GENERAL	25B05K11	01/30	1	42.00	42.00
5	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	25GO2K57	06/30	3	21.56	64.68
6	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	1	11.25	11.25
7	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	4	2.58	10.32
8	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	20326S08G	05/28	3	32.34	97.02
9	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
10	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26D010228	03/31	2	577.00	1,154.00
11	LOX 2% JELLY 30 GM	Neon Laboratories Ltd	H	L1839	02/28	1	34.58	34.58
12	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	2	69.10	138.20
13	REVOTAZ INJ 2.25 GM 20ML	Alkem Laboratories Ltd.	H	25444732	11/27	1	204.61	204.61
14	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1E262785	04/29	1	69.84	69.84
15	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
16	VENFLON I -22G	BECTON DICKINSON (BD)	GENERAL	6022278	12/30	1	321.00	321.00
						Total :	**2,169.50**	**3,095.53**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036730	**Ward**	4F-FOUR SHARING
Patient Name	Master THARUN KANTH S	**Bed Name**	FSW 418
Age/Sex	17 Y 1 M 30 D / Male	**Order No**	18-0001736530
Date	03/08/2026 12:32	**Prescription No**	PRIP18-0630640
Payor	SELFPAY	**Dispensed Date**	03/08/2026 12:33
UHID	GUC-00055334		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	2604O1201T	03/29	1	128.00	128.00
2	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	2	100.00	200.00
3	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	011	12/28	10	18.75	187.50
4	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
						Total :	**363.75**	**632.50**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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DISCHARGE TRACKING SHEET

DATE : 3/8/20

Name of Consultant :

Floor :

UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time	1.10pm		na actual	
2	Arrangement of File by Nurses				
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

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Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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CONSULTATION FORM

Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

.....

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Consultant :

Name : ..... Signature : ..... Date & Time : .....

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Patie 04-08-2009 17 Y 1 M 30 D (M)
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ERATION NOTES

Surgeon : Dr. Nandhini		Asst. Surgeon : –	
Anesthetist : Dr. Mohan		OT Nurse : S/n Suganth.	
Pre-Operative Diagnosis:			
Surgical Procedure : – Post Renal transplant – cystoscopy / stent Removal			
Weight : 44.4 kg	Date : 3/8/26	Start Time : 10.45 a.m.	End Time : 11.20 a.
Post Operative Diagnosis: –			
Peri-Operative Complications: –			
Operation Notes: – closed in lithotomy position			
Findings: – Transplant kidney – DJ Stent (low end) seen in Bladder			
Procedure Notes: – Clear urine Bladder – DJ Stent Removed in toto			
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: 1) NPO till 11.30 Am

Drain /Special Lines/Catheters: 2) all nephro drug to cont

Special Patient Positioning and Requirements: 3) IV piptaz - 2.58gm stat

Nutritional Instructions:

When to Start Mobilization: 4) Plan discharge today

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: ....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Nandhini
Asst. Surgeon : —
Anaesthetist : Dr. Mohan
Scrub Nurse : S/N. Sugantha

Patient Name : Mast. Tharun [illegible] Age : 17 yr Gender : M
UHID No. : 55334 Surgery Name : Cys [illegible]
Date : 3/8/21 In-time : 10:45 Out-time : 11:20

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Before Induction of Anaesthesia ➢➢

SIGN IN Time: 10:46

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 : [signature] 15/ubr
Name : Dr. Priya R

Before Skin Incision ➢➢

TIME OUT Time: 10:48

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

Correct Patient (Check ID Band)	☑Yes ☐No
Correct Site	☑Yes ☐No
Correct Procedure	☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:

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

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns?	☐Yes ☑No ☐NA

Nursing Team Reviews:

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

Signature : [signature]
Name : Dr. Nandhini

Before Patient Leaves Operating Room

SIGN OUT Time: 11:18

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient?	☑Yes ☐No

Signature : [signature] 01957
Name : Sujith

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

INFORMED CONSENT FOR SURGERY OR SPECIAL P

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GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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

Date : ....

UHID No : ....

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

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)
.... U/S Sx / DJ Stent Removal ....
.... upon ....
(Name of the Patient)

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

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

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

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

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

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

Consentee :
Signature : V. Srikantha
Name : V. SRIKANTHAN
Date & Time : ....

Patient Attendant :
Signature : V. Srikantha
Name : V. SRIKANTHAN
Relationship with Patient: ....
Date & Time : ....

Witness :
Signature : [signature]
Name : Sruthi
Date & Time : 3/8/20

Doctor (who is taking the consent) :
Signature : [signature]
Name : ....
Date & Time : ....

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

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

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

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

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

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

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

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

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இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

PRE

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

Date: 3/8/26

Patient's Name : Tharunkanth Age : 17yrs Gender : ☑ M ☐ F

Blood Group : O positive UHID :

Planned Surgery : RT Stent Removal Surgeon : Dr. Nandhini

Anesthetist : Dr. Sathish Date & Time of Operation 3/8/26 at 10am

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 Valli-C Nurse In-Charge Name : [illegible]

Billing Executive Signature : [illegible] Signature of Nurse In-Charge : [illegible]

Date & Time : 03/02/26 @ 8.46am Date & Time : 3/8/2026 at 8am

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

Departm
PRE-AN

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

Date: ..... Time: ..... Proposed Operation: DJ stent removal

Diagnosis: Post renal transplant status

B.P / CRT: 120/70 H.R: 80 Weight: 44.4 kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 9.6	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea: 10.	Alb:	HBS Ag:	ECG:
WBC:	Creat: 0.88	Total Bill:	HCV:	2D Echo:
Plate: 105	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K: 5.1	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: —

Medical History: CVS :

RESP : Diabetes :

CNS :

Renal : H/o renal transplant recipient.

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History: on multiple antihypertensives.

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adeq Mentohyoid Distance: N Neck: N Teeth: N

Lungs : B/L AE+

Heart: S1S2+

CNS: NFND

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site: Axillary Spine Exam for regional : N

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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: ..... Name: Dr Pavithra

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

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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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Dr. NANDHINI G

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

UHID NO: .....

..... Surgeon Name: .....

Anaesthesiologist : ..... Operative procedure planned : DJ STENT REMOVAL

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : .....

- 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 : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : 3/8/26

Doctor (who is taking the consent) :

Signature : ..... Name : ..... Date & Time : 3/8/26 10:45 A.M.

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Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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PATIEN... ANDOVER CHECKLIST

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

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04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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SSI PREVENTION CHECKLIST

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

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 3/8/26 @ 4/8 TRANSFERRED TO: 07

		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	NO	
3	Circulation & Hemodynamic Stability		
	a.IV lines secured & infusion running correctly	NO	
	b.No active uncontrolled bleeding	NO	
	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	NO	
5	Wound, Dressings & Drains		
	a.Surgical dressing intact	NO	
	b.All drains fixed, output noted		
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	NO	
6	Medications Pre & Post-Op Orders		
	a.Medications due time noted	NO	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes.	
	c.Emergency meds given in OT (time & dose documented)		
7	Equipment Safety & Transport Preparedness		
	a.Oxygen cylinder full & ambu bag at bedside	NO	
	b.Bed/side rails up and brakes applied	NO	
	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	Yes.	
11	BIOPSY/HPE SENT	NO	
12	Documentation		
	a.Documentation completeness	Yes	
	Transferring Nurse: Pali[illegible]		
	Receiving Nurse : S/N [illegible]		
	Signature of Incharge:		

RCH/GDY/FRM/CLINICAL/598

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 : IP18-00036730 **Admit Date** : 03-Aug-2026 **Admit Time** : 08:09 AM **UHID** : GUC-00055334

Patient Details :

Patient Name	: Master THARUN KANTH S	**Age**	: 17 Y 1 M 30 D
Guardian	: Mr SRIKANTHAN V	**DOB**	: 04-06-2009
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO 17, ARUMUGAM NAGAR, BHARANI ST Velacheri Chennai Tamil Nadu INDIA 600042	**Phone No**	: 8939292602
		E-mail	: NO@GAMIL.COM

Admission Details :

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

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

Contact Details :

Name : Mr SRIKANTHAN V **Relationship** : Father

Contact Address : NO 17, ARUMUGAM NAGAR, BHARANI ST Velacheri Chennai Tamil Nadu INDIA 600042 **Phone No** : 9710142630 / 8939292602

V. Srikanth

Signature

Doctor Details :

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

Referral Doctor : FRIENDS **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.16

Payment Mode : Cash **Payor Name** : SELFPAY

Rainbow Children's Hospital - Guindy
Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master THARUN KANTH S**	**Age :**	**17 Y 1 M 30 D**
IP No:	**IP18-00036730**	**Sex:**	**Male**
Consultant:	**Dr. NANDHINI G**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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: V. Srikanth

Name:

Relationship:

Date: Time:

Wittness Name:

Wittness Signature:

Patient Address:

NO 17, ARUMUGAM NAGAR, BHARANI
ST Velacheri Chennai Tamil Nadu
INDIA 600042

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BILLING POLICY

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

DECLARATION

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

Patient Name : Master . THARUN KUMAR S	UHID Number : 55334
Self/Attendant Name : Mr. SRIKANTHAN. V.	Relation : FATHER
Self/ Attendant Signature : Phone Number : T V. Srikanth	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

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Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Child E Previous HD :
Live Related Renal transplant
1° kidney disease
Tubulointerstitial disease
HTN - On Antihypertensive
↓
now admitted after renal

Child had RV c/o. fever

Child is on TAC

Patient Sticker

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

Multiple Admission for Renal disease

Birth & Neonatal History:

LSCS | TERM | 3.25kg | CIAB | NVNICU

Family Chart

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History : upto date ↓IAP upto 5yrs

Anthropometry :

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

Weight (kgs) 44.4kg (Centile _____)

On Examination :

Temperature : afebrile Pulse Rate : 72/min B.P. 124/73 (86) SPO2 94% on RA

Resp.rate and type of breathing : (R)

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

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

Air entry & breath sounds : VBS (+)

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection : (N)

Palpation : Soft NT

Ausculation : BS (+)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Dco- Post Renal transplant
4 Stent removal

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

Signature of the Doctor: C.D

Name of the Doctor: C.D Gupta

Date & Time: 3/8/20

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: .....

Patient Sticker

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/8/26 1:45pm	S/B Dr. Nandhi mam, S/B Dr. Manama	
	S/p DJ stent removal	
	Revised	
	Alert, active	BP-126/85 mmHg
	passed urine, mild pain	
	No hematuria	
	stated orally	
	PP-wt	
	P/a - soft, Non tender	
	Rx	
	→ (D) today	
	- T-Taxim-O 200	1-0-1 x 3 days
	- to stop septran	
	- USG abdomen after	1 week
[signature]		

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

Rainbow Children's Hospital
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RESULT SHEET

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

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Patie

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: AIB

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. PANCRAFT	1	P/O	1-2-1		☐C ☐DC
2	T. MMF S	360-0-180	P/O	360-0-180		☐C ☐DC
3	T. OMNACORTIL	15mg	P/O	1-0-0		☐C ☐DC
4	T. VANGANCYCLOVIR 450		P/O	1/2/ thrice a week		☐C ☐DC
5	T. BOSENTAN	62.5	P/O	1/2-0-0		☐C ☐DC
6	T. EMVAS	2.5mg-0-5mg	P/O	2.5mg-0-5mg		☐C ☐DC
7	T. SHELCAL	1	P/O	1-0-1		☐C ☐DC
8	T. MAGVIJN	1	P/O	1-0-1		☐C ☐DC
9	T. SEPTRAN DS		P/O	0-0-1		☐C ☐DC
10						☐C ☐DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 3/8/26

Nurse Name & Signature: ..... Ajith

Date & Time : 3/8/26 @ 8:10am

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ PIPTAZ	2.25g	IV	STAT	3/8 11am	☐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 : [signature] Dr Piyush R

Date & Time : 3/8/26 11.20am

Nurse Name & Signature: S/n Sujatha.

Date & Time : 3/8/26 @ 11:20 am

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

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Manoj

Date & Time : ..... 3/04/26, 9:50 a

Nurse Name & Signature: ..... Balaraj 620885

Date & Time : ..... 3/8/26 @ 10am

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

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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DRUG CHART

Date of Admission: 3/8/16 Drug Allergies: NKA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Signature .....

VERIFIED BY : Name .....

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. 44.8kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

Weight. 44.4kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/8	10.50am	INJ MIPTAZ	2.25g	IV		PJ
						PJ

Signature .....

VERIFIED BY : Name .....

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
2/8	7:20	RL 1	IV	[illegible]	[signature]	PS / PS	3/8	[signature]	PS / PS

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

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

M / CLINICAL / 127

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

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BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

...Y WARNING SCORE: CHILDREN'S UNIT

Date : 3/2/26 Time: 9am · 12pm · 12.45pm

Doctor / Nurse / Family Concern?

	9am	12pm	12.45pm
Temperature (°F) (104–94)	98.8°F	98.8°F	97°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	115/61 (79)	110/80	120/65 (76)
Heart Rate (Number)	80 bpm	80 b	78 bpm / 78 bpm
Resp. Rate (bpm) (Over 1 Minute) (70–10)	20	20	20
Resp Rate (Number)	20 b/m	20 b	20 b/mt
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	99%	98%
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]	VB

Note: BP does not score in early warning scoring

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 3	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 4	: Shift in charge AND PICU fellow or PICU consultant to be informed.
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed. Then irrespective of rest of the score, the Nurse MUST inform the PICU team.

* 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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Dr. NANDHINI G

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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.

3/8		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	→	Child received from ER to 4th Floore									
	09:00 am	NPO.									0	Baby
	10:00 am										0	
	11:00 am										0	
	12:00 pm	water		500ml							0	
	01:00 pm										0	Baby
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Plan: DT shunt removal — Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: .....

Surgery / Procedure: — Post OP Day:

BACKGROUND

Date / Shift	3/8 M.					
Medical Condition (Any special condition to be noted):	Noted					
Diet:	NPO					

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	RA					
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.5 F					
Res:	20b/mt					
SpO_2:	98b/mt					
Pulse:	80b/mt					
BP:	115/61					
LOC:	15/15					
Fall Risk Score:						
Pain Score:	0/10.					
Skin Integrity	27 Feb					

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	—					
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	NPO					
Critical Lab Test / Values:	—					
Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	Dependent					
Post Operative Procedure Special Orders:	—					
Handed Over By Name :	Baby staff					
Signature / ID :						
Date:	3/8/26.					
Time:	1.30pm					
Taken Over By Name :						
Signature / ID :						
Date:						
Time:						

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NURSING SHIFT HAND OVER FORM

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

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NURSING CARE RECORD

Date: 3/8/26

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	To prevent infections.	10am	Assess the child's condition → Monitor vitals. → Follow hand wash method wear mask	Infections - Prevented	Reassessment done	Balaji
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

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Master THARUN KANTH S
Patient 04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies .... Nil ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes.	
3/8	9.10am	Child received from ER to	
		4th floor. Child details	
		handing over taken from	
		ER staff. No IV line.	
		Vital signs checked and	
		recorded. Vitals are stable.	
		CP ++ / PP ++ / CRT <3sec	
		Child is on NPO from 10pm	
		Today plan DJ Shunt removal	
		@ 10am →	Balaji/010488
	10am	Child shifted to OT.	Balaji/010488
	10:00	OT Notes on 3/8/26	
3/8/26		Child details handover taken	
		from S/N while receiving child.	
		Conscious & oriented. V/S are	
		monitored. Billing · clear ·	
		consent obtained. Child	
		OT gown changed shifted	
		to OT-2 at 10:45 am. On	
		the OT table to connect	
		the cardiac monitors. LMA	
		was given. IVF connected after	
		the procedure was started	
		cystoscopy DJ Stent Removal	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		during the proced there	
		is no cry Cough V/S are	
		monitored after the child	
		Extubated child shifted to	
		post op are after child	
	12.45pm	put shifted to 4th floor	
		handover to 4th floor S/N.	
		Receiving Notes.	
3/8	12.45pm	Child received from OT to	
		4th floor. Child details handing	
		over taken from OT Staff child	
		is conscious. IV line present with	
		patency. Vital signs checked	
		and recorded. Vitals are stable	
		CP / PP / CRT	
		++ / ++ / <3sec →	Baby [illegible]
		Vitals informed to Dr. Manorama	
		Seen the Advised to	
		give medication as per	
		doctor's order.	
		Dr. Nandhini seen the	
		child Advised to discharge	
		Stop - Septran, Added Janew.	
		Other medication as prescribed	
		order to follow. VSY	
		screening after 1 week	
	1.PM	file sending to billing.	[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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Patient's Name:..
MRD NO:......... GUC-00055334 IP18-00036730 Room No : ....
Master THARUN KANTH S
Age :............... 04-06-2009 17 Y 1 M 30 D (M) M ☐ F
Dr. NANDHINI G
Consultant :... ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 3/8/26 Time: 10-45.
Location : Rt hand
Size : 22 G
Cannula inserted by : Dr. Mohan

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
3/8/26	10-45	☐Yes ☑No	☐Yes ☑No	Obser	R.
	12pm	☐Yes ☑No	☐Yes ☑No	Patten.	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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PAIN ASSESSMENT FORM

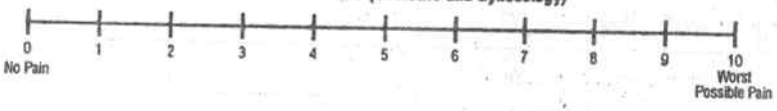
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/8/26	9am	0/10	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	Bali 020685
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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BRADEN 'Q' SCALE

				Date : 3/8			
				Time : 9am			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
				TOTAL SCORE	25		
				Evaluator's Name	Baby		

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	⓫ Regular Turning Schedule ⓬ Enable as much activity as possible ⓭ Protect the heels ⓮ Use pressure redistribution surfaces ⓯ Manage moisture, friction and shear ⓰ Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	⓱ Use the Same Protocol as for **"At Risk"** Patients ⓲ Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	⓳ Follow the same protocol as for **"Moderate Risk"** Patients ⓴ In addition to regular turning schedule ㉑ Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	㉒ Use same protocol as for **"High Risk"** Patients ㉓ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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04-05-2006 17 Y 1 M 30 D
Dr. NANDHINI G

...MPTY DUMPTY SCALE M

PARAMETER	CRITERIA	SCORE	DATE 3/8	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1				
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1				
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1				
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	2					
	One of the Meds listed above	1	1				
	Other Medications / None	Total	8				

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

Intervention:						
Bed in low position		✓				
Call device within reach		✓				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate lighting		✓				
Wheel chair support		—				
Other Intervention(s) Specify						
Nurse's Name:		Lalit				
Signature:						
Date:		8				
Time:		9pm				

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECO

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/8/26	9am	Infection control measures	Explained about handwash methods	Father	NO	Oral	None	Verbalizes understanding	good	Balu

Part - III: CODES

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

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

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

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

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

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Plan : DJ Stent removal
Arrival Time: 9.10am Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction — Body Weight: 44.4 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Multiple admission -	-	RCH.

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: 44.4kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.5°F HR: 80 bpm RR: 20 bpm BP: 115/61 (71)

Pain Score: 5 Specify Site: 0/10. (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 25) (Document in the Braden Q Assessment Sheet)

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

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

(P.T.O)

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to Father

Nurse's Name: Balapeesaya Date: 3/8/26 Time 10am Signature

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
8/8/26 @ 8.04am	3/8/26 @ 9.10am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Nandhini.	Dr. Deepak.	Further Management
From Unit	**To Unit**	**Information to Attendant**
ER	4B	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
18	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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Ajith	

Patient & Clinical Records Received by : Babu Varghese 3/8/26 @ 9.10am

Date & Time of Patient Received :

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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Docu. No.

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/08/26 Time of arrival : 8:05 am

Chief Complaints: Planned for DJ. Stent Removal RBS: .....

Height : ..... Weight : 44.4kg 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?) .....

Time of Initial assessment completed by ER Nurse : 8:10 am

(P.T.O.)

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

Time	Nursing Notes
8:18 am	patient came for ER with the complaint of planned for DJ stent removal, Dr. Nandhini mam advised to put an admission, NPO from 8pm, informed OT, vitals are checked all are stable, shifted to ward

Samples collected by: S/N — Nil — Time: Nil

Samples sent by : S/N — Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 72 BP: 124/72 CFT: < 2sec	Shift - out from ER to: OT (4F18
RR: 20 SPO_2: 99%	Time of Shift - out: 9:10am
GCS: 15/15 Temperature : 97.5F	Handover given to: (Nurse's Name) SN Bala
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Nil

Name of the Nurse : A. Ajith

Signature of the Nurse : [signature]

Date & Time : 3/8/26 @ 8:20am

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : ..... Date : .....

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

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

Allergic History: .....

Chief Complaints: .....

.....

.....

.....

.....

.....

.....

.....

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

.....

.....

Primary Assessment

Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

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

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

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

(P.T.O.)

Circulation

HR: .....

CFT — Central ..... / Peripheral .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central ..... / Peripheral .....

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right ..... / Left .....

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

.....

.....

Labs Planned: .....

.....

.....

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.....

.....

.....

Treatment Planned: .....

.....

.....

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.....

.....

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

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

Assessment done by

Name of the Doctor: .....

Signature: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

Blood Grp: O+

NPO - Solids - 8pm, water 10pm

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Wt: 44.4 kg.

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Tharunkanth Age : 17yrs Gender: ☑ Male ☐ Female

Date : 3/8/26 Time of Arrival : 8.05am

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Posted 10am

Initial Vital Signs: Temp: 97.8F PR: 72 BP: 124/73(86) RR: 20 SpO_2: 98%.

Chief Complaints: plan for DJ Stent Removal

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

V. Srikanth
Signature of Parent / Guardian

Triage Completion Time : 8.10am

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 : Sanjeep [signature]

Signature of Triage Nurse : Sanjeep [signature]

Date & Time : 3/8/26 at 8.10am

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

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PATIENT TRANSFER FORM

GUC-00055334 IP18-00036730 Master THARUN KANTH S 04-06-2009 17 Y 1 M 30 D (M) Dr. NANDHINI G	Date & Time of Admission 3/8/2620 8.09am	Date & Time of Transfer Order 3/8/2600 10am
Treating Consultant Name Dr. Nandhini	Transfer Ordered by Dr. Manonmani.	Reason for Transfer For procedure.
From Unit 408	To Unit OT	Information to Attendant Yes ✓ No ☐
Number of Sheets in Clinical File –	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

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 Balumi / 020685	Name of Person Ordered Transfer

Patient & Clinical Records Received by : S/N Subr

Date & Time of Patient Received : 3/8/24 @ 10am

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

Docu. No. : RCH /FRM / CLINICAL / 102

PATIENT TRANSFER FORM

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GUC-00055334 IP18-00036730
Master THARUN KANTH S
04-06-2009 17 Y 1 M 30 D (M)
Dr. NANDHINI G

Date & Time of Admission	Date & Time of Transfer Order
3/8/26 @ 8.09a.	3/8/26 @ 12.40pm

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

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

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

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N Sruthi 01957	Dr Mohan.

Patient & Clinical Records Received by : Babu/Doctor 3/8/26 @ 12.40pm.

Date & Time of Patient Received :

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

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

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

OT TRANSFERRED TO : 4th Floor

	Date & Time of Transfer: 3/8/26	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	NO	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	yes	
	b.No active uncontrolled bleeding	NO	
	c.Last vitals recorded before transfer	yes	
	d.Central line hubs are closed	NO	
	e.Dressing Intact	yes	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	yes	
	b.Reassessment done	yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	yes.	
	b.All drains fixed, output noted	NO	
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	NO	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	yes	
	c.Emergency meds given in OT (time & dose documented)	yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	yes	
	b.Bed/side rails up and brakes applied	yes	
	c.Special positioning maintained as per surgery	yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NO	
	b.Epidural catheter secure, infusion checked	NO	
	c.Pressure areas protected (heels/elbows)	yes	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NO	
10	**REPORTS AND LABS HANDED OVER**	NO	
11	**BIOPSY/HPE SENT**	NO	
12	**Documentation**		
	a.Documentation completeness	yes	
	Transferring Nurse: S/N Sujatha 01450		
	Receiving Nurse : Balaraju/00687		
	Signature of Incharge: [signature]		