ACTIVITY RECORD FOR BILLING

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

UHID No: ..... IP No: GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

..... Dept: .....

Date of Admission: ..... Ti ..... arge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/07	4'40pm	ER	406	Sri 17890
25/7	6.45pm	406	OT	Rakuj/020685
25/7/26	10:30 pm	OT	406	Cmct 071428

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Pre anesthesia	25/7/26	33052.	01890.
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/07	CBC, PT/APTT/INR	066 83907	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/7	C-arm	8:50pm	9:20pm	1733117	Gat
25/7/26	Infusion Pump	5.30pm	26/7/26 8AM	33191	Bari 02189

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/07	Au line placement (1)		21732972	[signature] 12/20

ANY OTHER INFORMATION: 25/7/2026:-

Procedure : (I) Distal humerus closed reduction K-wire

Surgeon : Dr. Sai suchithra

Anaesthetist : Dr. Senthil

Time in : 8.10pm Time out : 9:30pm

Date: 26/7/26 Time: 10am Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature] 6/1:32pm			

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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SURGERY DETAILS

Date : 25/7/26

Patient Name: master. R. Riythiv kathir Date of Birth: 12/09/2019 Age: 6 years

Gender: male Ward : OT UHID No.: 94296/36616

Date of Surgery: 25/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (L) distal humerus closed reduction & K-wire Fixation

Time in : 8:10 PM

Time Out : 9:30 PM

	NAME	AMOUNT
1. Surgeon	: DR. G. Saisuchitra	
2. Anaesthetist	: Dr. Senthil	
3. Assistant Surgeon	: —	
4. OT Technician	: Mr. Sudharshan	
5. Circulating Nurse	: SN. Gunadevi	
6. Assistant Nurse	: SN. Sangeetha	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator

St- 8.40 am ☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

End: 9:20 pm ☐ Neuro Cusa ☐ Others .....

(H33117)

DR. G Saisuchitra

Signature of the Surgeon

Signature of Circulating Nurse

Order No: Record binalac done by Ortho Order by: .....

GUC-00094295 IP18-00036616
Master R.RIYTHIV KATHIR
12-06-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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CONSUMABLES OF OT

Circulating staff : Sangeetha Technician : Mr. Raja Date : 25/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube ET TUBE 5.0(medico)		1	~~Major~~ Pack Ortho		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3	POP 10cm		03	Suction Catheter		
HME filter : A / P / N			Artiflex 10cm		01	Feeding Tube		
Syringes : 10 cc		1				Vaccum Suction Set		
05 cc		1	Gloves 6½ 7½ PF		01	Surgical Gloves		
02 cc			7. S. care		02	Gauze Pack		
01 cc			6½ S. care		01	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set		2	NG tube 5½ PF		01	Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		1	~~Koochies~~ Elastomul 10cm		01	Oxygen mask (P)	1	1
			Ointments			Atropin		1
			Suction Catheter			DEXA		1
Fentanyl		1	~~Cap, Mask~~ K-wire (2.0)		03	Amnepara		1
Morphine			Gauze Pack		3	cepuraxime 750 mg.		1
Ketamine			Mop Pack					
Propofol		1	Steristrip					
Rocuronium			Underpad		02			
Glycopyrolate			Draw sheet					
Myopytolate		1	Abgel					
~~Ondansetron~~ ONDOKIND		1	Foleys catheter					
Pencan 25g/ Spinal Needle 22			~~Urobag~~ C-arm cover		01			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			~~Vaccum~~ Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Dr. Sai Suchithra — Surgeon
Dr. Senthil — Anaesthesiologist
S/N. Gamel 9/7/26 — Nurse
OT Technician

Order No. : Ordered by :

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
DL NO :
CIN : L85110TG1998PLC029914

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036616	**Ward**	8F-OT COMPLEX
Patient Name	Master R.RIYTHIV KATHIR	**Bed Name**	PRE OP 806
Age/Sex	6 Y 10 M 14 D / Male	**Order No**	18-0001733154
Date	26/07/2026 00:33	**Prescription No**	PRIP18-0629229
Payor	SELFPAY	**Dispensed Date**	26/07/2026 00:33
UHID	GUC-00094296		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE	PENTA PHARMA	H	L0016006	12/27	1	787.00	787.00
2	DEXAMETHASONE INJ 2 ML	NIPRO	H	VDDUI0O8	10/27	1	10.78	10.78
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	1	28.13	28.13
4	DSYRINGE 5ML.(NIPRO)	Adilase	GENERAL	26C13K17	02/31	1	21.56	21.56
5	E.C.G ELECTRODES (PAED)	ROMSONS	GENERAL	0716O326	02/28	3	40.00	120.00
6	INTRAFLOW (AUTO STOP) ROMSONS	Neon Laboratories Ltd	H	K26B010515	01/31	2	525.00	1,050.00
7	MCT-ROF 100MG 10ML	NEON LABORATORIES LTD	H	NA1353005	10/27	1	69.10	69.10
8	MYOPYROLATE-INJ-5ML	SWISS CRITICURE		V350487	11/27	1	140.20	140.20
9	ONDOKIND INJ 4 MG 2 ML		GENERAL	BA26025	01/28	1	12.72	12.72
10	Oxygen Mask With Tubing - PeadROMSONS-FC	NEON LABORATORIES LTD	H	G26A040056	12/30	1	336.00	336.00
11	TROPINE INJ AMP0.6MG1ML			KM038118	11/27	1	7.30	7.30
						Total :	**1,977.79**	**2,582.79**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

d Time : 26-07-2026 00:33

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

DL NO :

CIN : L85110TG1998PLC029914

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036616	**Ward**	8F-OT COMPLEX
Patient Name	Master R.RIYTHIV KATHIR	**Bed Name**	PRE OP 806
Age/Sex	6 Y 10 M 14 D / Male	**Order No**	18-0001733155
Date	26/07/2026 00:33	**Prescription No**	PRIP18-0629230
Payor	SELFPAY	**Dispensed Date**	26/07/2026 00:34
UHID	GUC-00094296		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTIFLEX 10 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	26MAO13	10/30	1	212.00	212.00
2	C-ARM COVER	Surgiwere		003	02/29	1	155.73	155.73
3	ELASTOMULL 10 CMS	BSN MEDICAL		260712458	01/31	1	59.00	59.00
4	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	4	100.00	400.00
5	K-WIRE 2.0MMX 150MM	ELITE MEDICALS	GENERAL	251128	11/30	3	210.00	630.00
6	NITRILE EXAMINATION GLOVES P F- MEDIUM	Aculife Health Care Pvt.Ltd(Nirlif		ENPF030020	11/28	10	25.00	250.00
7	NS 100ML ACCULIFE - EH	RAMAN & WEIL PVT LTD		1C2613680	02/29	1	44.93	44.93
8	ORTHO DRAPE PACK	BSN MEDICAL		1010626	05/29	1	2,500.00	2,500.00
9	RAMADINE SOLUTION 10% 100 ML	ICARE (KANAM LATEX)	GENERAL	RC126036	04/28	1	103.00	103.00
10	RAPIDUR 10 CMS	ICARE (KANAM LATEX)	GENERAL	25P027	11/30	3	245.00	735.00
11	SGLOVE # 6.5 (SURGICARE)	ANSEL	GENERAL	6F103	05/31	1	91.00	91.00
12	SGLOVE # 7.0(SURGICARE)			26B5016M	01/31	2	91.00	182.00
13	SGLOVE # 7.5 POWDER FREE			2602085605	02/29	1	128.00	128.00
14	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
15	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	2	205.00	410.00
16	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010296	03/31	1	811.00	811.00
						Total :	**5,097.66**	**6,828.66**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Time : 26-07-2026 00:34

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA 600015
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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	IP18-00036616	**Ward**	4F-FOUR SHARING
Patient Name	Master R.RIYTHIV KATHIR	**Bed Name**	FSW 406
Age/Sex	6 Y 10 M 14 D / Male	**Order No**	18-0001733196
Date	26/07/2026 09:00	**Prescription No**	PRIP18-0629255
Payor	SELFPAY	**Dispensed Date**	26/07/2026 09:00
UHID	GUC-00094296		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ET TUBE -5.0 CUFFED (WELCO LIFE)	AQUITAS HEALTHCARE PVT LTD	H	250650	06/30	1	891.00	891.00
2	XORITAS 750MG INJ			H122506B	07/27	1	318.28	318.28
						Total :	**1,209.28**	**1,209.28**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Time : 26-07-2026 09:00

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 14 D (M)
Dr. G SAI SUCHITRA

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcemënt					
	INTIME	OUT TIME			
Arrangement of File by Nursing	26/5/24 10am				
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00094295 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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OPERATION NOTES

Surgeon : DR. G. Sai Suchitra	Asst. Surgeon :
Anesthetist : Dr. Senthil	OT Nurse : SIN. Sangeetha
Pre-Operative Diagnosis: Left type 3 supracondylar # humerus with pre op median nerve palsy	
Surgical Procedure : Left distal humerus closed reduction and K-wire fixation	
Weight : 23.6 kg	Date : 25/7/26
Start Time : 8:40 pm	End Time : 9:20pm
Post Operative Diagnosis:	
Peri-Operative Complications: NIL	
Operation Notes: Inj. Cefuroxime given	
Findings: Pucking over left elbow NOT tense, compartments soft Pulse well felt before and after reduction	
Procedure Notes: GA, arm supported on arm board draping done. after prepping C-arm used throughout Type 3 gartland fracture - medial displacement in coronal plane Closed reduction done and 3 lateral wires passed Stability checked throughout range, excellent A/E POP given after 3ml LA Lignocaine	
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:	1) Elevation x 48 hrs 2) Analgesia 3) Active finger movements to be encouraged.
Wound Care:	4) RTA 3 weeks for wire and cast removal + XR (17/8/26.)
Drain /Special Lines/Catheters:	5) Cast to be completed with overwrap before going home 6) Home when safe
Special Patient Positioning and Requirements:	
Nutritional Instructions:	
When to Start Mobilization:	
Special Referrals:	
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up	

Name of the Surgeon: DR. SUCHITRA (83742)

Signature of the Surgeon: .....

Date & Time: 25/7/26, 9:50pm.

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT ..... Shifted to: 4th Floor .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Inj CEFUROXIME	400 mg	IV		25/4/ 8.34PM	☐C ☑DC
2	Inj. PANTOPRAZOLE					

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 14 D (M)
Dr. G SAI SUCHITRA

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	26/4/26 @ 10AM						
Activity Sheet update by Pharmacy							

R. RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

SAFETY CHECKLIST

Surgeon : Dr. Sai Suchithra
Asst. Surgeon : –
Anaesthetist : Dr. Senthil
Scrub Nurse : S/N. Sangeetha

Patient Name : Master R. Riythiv Kathir Age : 6 y. Gender : M
UHID No. : 924295 Surgery Name :
Date : 25/7/26 In-time : 8:10pm Out-time : 9:30am

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Before Induction of Anaesthesia ➢➢

SIGN IN Time: 8:10pm

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]

Name : Dr. Senthil kumar

Before Skin Incision ➢➢

TIME OUT Time: 8:40pm

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

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

Anticipated Critical Events

Surgeon Reviews:

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

Anaesthesia Team Reviews:

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

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☑ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [signature]

Name : DR. SUCHITRA (83742)

Before Patient Leaves Operating Room

SIGN OUT Time: 9:30pm

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

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

Signature : [signature]

Name : [signature] 07/4/78

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

PATIENT TRANSFER FORM

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Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

Treating Consultant Name: DR G. Sai Suchitra	Date & Time of Admission: 25/7/26	Date & Time of Transfer Order: 25/7/26
	Transfer Ordered by: Dr. Senthil	Reason for Transfer: Further management
From Unit: OT	To Unit: 4th FLOOR	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: ① 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	Name of Person Ordered Transfer
S/N. Gnat OT UNIT	Dr. Senthil

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

BirthRight | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 25/4/26 at From OT **TRANSFERRED TO :** 4th FLOOR

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	YES	
	b.Surgical procedure & correct site verified	YES	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b.SpO_2 within safe range	YES	100%.
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	YES	
	b.No active uncontrolled bleeding	YES	
	c.Last vitals recorded before transfer	YES	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	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	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	YES	POP.
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	NA	
	b.Bed/side rails up and brakes applied	YES	
	c.Special positioning maintained as per surgery	YES	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	YES	arm pouch.
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	YES	
11	**BIOPSY/HPE SENT**	NA	
12	**Documentation**		
	a.Documentation completeness	YES	
	Transferring Nurse: _____	Asst	
	Receiving Nurse : _____		
	Signature of Incharge:		

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It takes a lot to treat the little.

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25/7/26

Kathir 7y/M

Fell while playing with another kid at school on Wednesday 22/7/26
Went to local quack for massage + splinting which caused lot of swelling in arm, ~~went~~ couldn't move his fingers. Then went to Govt. hospital where it was removed and new POP given.

O/E
(L) arm plaster removed
Skin condition OK, intact
Swelling on (L) elbow
PIN pain (+)

Radial, Ulnar intact
CRT < 2secs, pink fingers

Explained about need for surgery for both portion, to wait for nerve recovery post surgery. Explained about pre op neurological deficit to parents

XR AP Type 3 supracondylar # (L) distal humerus.

Adv

Admission
Closed reduction + K wire fixation (L) elbow ↓ GA

DR ANCHITRA (82702)

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

PRE

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Date: 25/07/26

Patient's Name : RIYTHIV Age : 6Y10M Gender : ☑ M ☐ F

Blood Group : B +ve UHID : 94296

Planned Surgery : CLOSE REDUCTION / K WIRE Surgeon : DR. SAI SUCHITRA

Anesthetist : DR. SATHISH Date & Time of Operation : 25/07/26 @ 7:00pm

Tick Appropriate Boxes

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 : M. Santhana babu

Billing Executive Signature : M. S

Date & Time : 25/07/2026 16:21pm

Nurse In-Charge Name : Shibu Debnath

Signature of Nurse In-Charge : [illegible] TH890

Date & Time : 25/07/26 @ 4:30pm

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

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PA[illegible]RM

GUC-00094296 IP18-00036616
Master R.RIYTHIV KARTHIR
12-09-2019 8Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

	Date & Time of Admission	Date & Time of Transfer Order
	25/7/26 @ 4pm	25/7/26 @ 6.45pm
Treating Consultant Name: Dr. Sai Suchitra.	Transfer Ordered by: Dr. Chandireleg a.	Reason for Transfer: further treatment
From Unit: 4th floor	To Unit: 07	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 30	Number of Imaging Films: -	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Balaji 25/7/26 @ 6.45pm	

Patient & Clinical Records Received by :

Date & Time of Patient Received : 25/7/26 at 7pm.

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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12-09-2019 6 Y 10 M 13 D (M)
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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: 4th floor Shifted to: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: Balapujangs / 030687

Date & Time : 25/7/26 @ 6.45pm

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer:		TRANSFERRED TO :
1	**Patient Identification**	YES/NO	REMARKS
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	Yes	
	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	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	No	
	c.Catheter secure & urine output recorded	NC	
	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)	NO	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NO	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	No	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	No	
	b.Epidural catheter secure, infusion checked	No	
	c.Pressure areas protected (heels/elbows)	No	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**		
10	**REPORTS AND LABS HANDED OVER**	No	
11	**BIOPSY/HPE SENT**		
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: Balaji/Orobas		
	Receiving Nurse :		
	Signature of Incharge:		

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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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	Yes.	
4	Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice	Yes.	
	INTRAOPERATIVE		
5	Using chlorhexidine gluconate and alcohol-containing skin preparatory agent in combination	Yes	
6	Maintain normothermia during the surgical procedure (>36 deg C)	Yes	
	POSTOPERATIVE		
7	Maintain and monitor blood glucose levels regardless of diabetes status between 110 and 150 mg/dl		
8	Application of incisional negative pressure wound dressing		

CONSENT FORM FOR ANAESTHESIA

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GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

Patient Name : .....
UHID NO: .....
Anaesthesiologist : .

..... Age : ..... Gender : Male ☐ Female ☐
..... Surgeon Name: .....
..... Operative procedure planned : .....

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 : RATHNAKUMAR
Relationship with Patient: FATHER.
Date & Time : 25/7/26 @ 6.45pm

Witness :
Signature : .....
Name : Balaji
Date & Time : 25/7/26 @6.45pm

Doctor (who is taking the consent) :
Signature : .....
Name : Dr T.SEMMAL KUMARI M.D
Date & Time : 25/7/26 at 7.00pm

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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

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

Instruction:

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

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

..... Left closed / open reduction & distal humerus and k-wire fixation
..... ROP Application ..... 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.

..... infection, neurovascular injury, stiffness, delayed / non-union, malunion .....

My signature on this form indicates that

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

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

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : .....

Name : RAJHAKUMAR

Relationship with Patient: FATHER

Date & Time : 25/7/26 @ 8.45pm

Witness :

Signature : .....

Name : Balaji

Date & Time : 25/7/26 @ 8.45pm.

Doctor (who is taking the consent) :

Signature : .....

Name : DR. SUCHITRA

Date & Time : 25/7/26 20:05

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

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

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

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

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

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

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

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

.....

.....

.....

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Rainbow® Children's Hospital — It takes a lot to treat the little.
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GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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

Date: .... Proposed Operation: ....

Diagnosis: ....

B.P / CRT: .... H.R: .... Weight: 22 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: – NIL –

Medical History: CVS : H/o Open Anatomical Repair for Epigastric Hernia under GA 5 month back

RESP :

Diabetes :

CNS :

Renal :

Hepatic / GE :

Physical Activity:

Others :

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE (+), No added Sounds

Heart: S1S2 (+), no murmurs

CNS: NAD

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

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: [signature] Name: Dr. T Jeevitha ... md

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No | Fasting Status: 8 hrs

Physical Status: | Patient Identified | ☐ Consent Present | ☐ Chart Reviewed

H.R: | B.P / CRT: | SpO_2: | R.R: | Last Feed:

Pre-OP Diagnosis: (1) Elbow # | Operation: Closed Reduction & K-wire fixation | Date: 25/7/26

Surgeon: ..... | Anaesthesiologist: Dr Senthilkumar | Technician: .....

TIME	8:10	8:20	8:35	8:45	9:00	9:10
N_2O /AIR /O_2 LPM						
HALO /ISO /SEVO						
Drugs:						
Inj propofol	40m					
Inj Fentanyl	40m					
Inj Atracurium	15m		5m		2.5m	
Inj Ceftriaxone			350mg			
Inj Paracetamol			2mg			
Inj. Dexin						
FiO_2 / SaO_2						
$ETCO_2$						
ECG						
Temperature						
Urine Output						
Fluids						
Blood						

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GABS

Others

☐ Equipment Checked and Functional
☑ BP
☐ Cuff Site: .....
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☑ AIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: .....
☑ Pressure Points Checked

Eye Care:
☑ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☑ Oral ☐ Nasal
ETT# 5 mm at 15 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

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

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

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

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

Name of the Doctor: Dr Senthilkumar

Signature of the Doctor: .....

Patient Sticker

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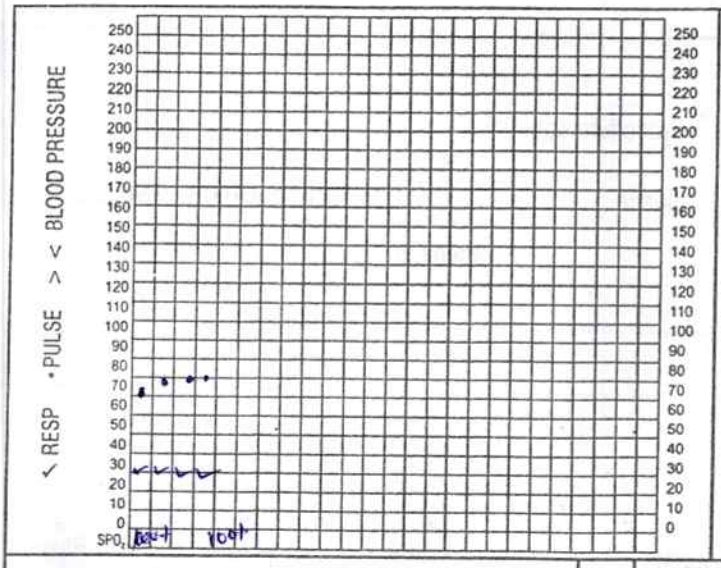
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Gunadeu Time Received : 9:30pm Time Discharged : 10:30pm



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	0	0		2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2		2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2		2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2		2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2		2	
		TOTAL	9/10	8/10	8/10		10/10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name : Dr. T. Senthilkumar M.D

Anaesthesiologist Signature: T.Snm

Date & Time: .....

PACU Nurse Name : Gunadeu

PACU Nurse Signature: SN. Gunadeu 01428

*Date & Time: 25/7/26 10:30pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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 : IP18-00036616 **Admit Date** : 25-Jul-2026 **Admit Time** : 04:00 PM **UHID** : GUC-00094296

Patient Details :

Patient Name	: Master R.RIYTHIV KATHIR		
Guardian	: Mr RATHNA KUMAR	**Age**	: 6 Y 10 M 13 D
Gender	: Male	**DOB**	: 12-09-2019
Occupation	:	**Religion**	:
Address (H)	: NO-2/116, SINGARAVELAN ST, CHINNA NEELAKARAI, CHENNAI Injambakkam Kanchipuram Tamil Nadu INDIA 600115	**Martial Status**	:
		Phone No	: 9840491381/ 9814192806
		E-mail	: rkrathinakumar@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr RATHNA KUMAR

Contact Address : NO-2/116, SINGARAVELAN ST, CHINNA NEELAKARAI, CHENNAI Injambakkam Kanchipuram Tamil Nadu INDIA 600115

Relationship : Father

Phone No :

Signature

Doctor Details :

Doctor Name : Dr. G SAI SUCHITRA

Referral Doctor : DR.METHA HOSPITAL **Specialisation** : ORTHOPEDICS

Co-Consultant : **Phone No** :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master R.RIYTHIV KATHIR**	**Age :**	**6 Y 10 M 13 D**
IP No:	**IP18-00036616**	**Sex:**	**Male**
Consultant:	**Dr. G SAI SUCHITRA**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative: R. Rathnakumar

Name: Rathna kumar
Relationship: father
Date: 25/07/2026 Time: 04:00pm
Witness Name: A. Sivasankari
Witness Signature: A. Sivasankari

Patient Address:
NO-2/116, SINGARAVELAN ST, CHINNA NEELAKARAI, CHENNAI Injambakkam Kanchipuram Tamil Nadu INDIA 600115

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

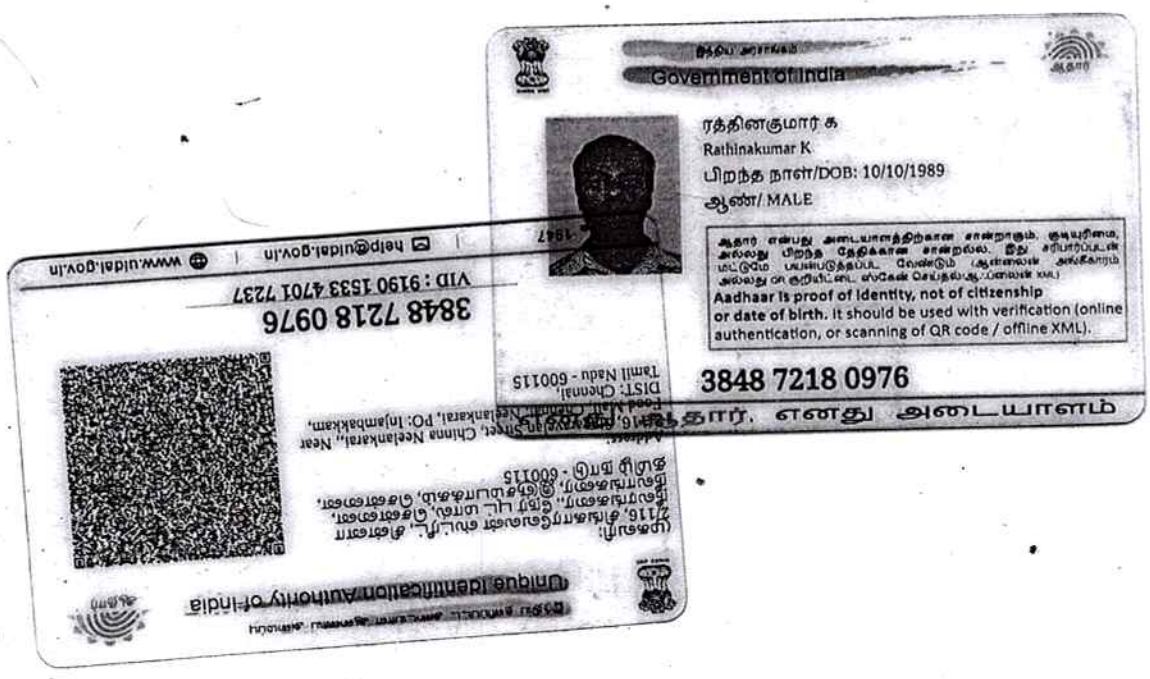
- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation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

DECLARATION

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

Patient Name : Master: Rythir kathir	UHID Number : GVC-0009429 6
Self/Attendant Name : RATHNAKUMAR	Relation : father
Self/ Attendant Signature : M. Rathnakumar Phone Number : 9840491381.	Name & Signature of Financial Counselor A. Qu

RCH/GDY/FRM/CLINICAL/426


Government of India
ரத்தினகுமார் க
Rathinakumar K
பிறந்த நாள்/DOB: 10/10/1989
ஆண்/ MALE
Aadhaar is proof of identity, not of citizenship
or date of birth. it should be used with verification (online
authentication, or scanning of QR code / offline XML).
3848 7218 0976
ஆதார், எனது அடையாளம்
Unique Identification Authority of India
VID : 9190 1533 4701 7237
help@uidai.gov.in
www.uidai.gov.in

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

H/o accidental fall while playing at school on 22/7/26 c/b c/o swelling over (R) elbow. Went to local quack for massage & splinting c/b ↑ in swelling + & inability to move his fingers. Then went to GH where new POP was applied.

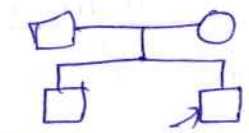
Patient Sticker

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

H/o supraumbilical epigastric hernia. do Open anatomical repair & GA done in Feb' 2026 in Mehta hospital.

Birth & Neonatal History:

Family Chart



11y

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History : (N)

Anthropometry :

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

Weight (kgs) 23.6 kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 136 B.P. 100/79 SPO2 99%.

Resp.rate and type of breathing : 24

Rash – Swelling over (L) elbow +

Lymphadenopathy – PIN palsy +

Oedema : – Radial & ulnar nerve - intact

Allergies (if any): peripheral pulses - well felt

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : N

Air entry & breath sounds : B/L AE +

Any addes sounds : –

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

Cardiovascular System :

Inspection of procordium : N

Heart Sounds : S_1, S_2 +

Any murmur : no murmur

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

Per Abdomen :

Inspection : N, scar +

Palpation : Soft, no OM

Ausculation : BS +

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves : N

Motor System :

Nutriton : N

Tone: N Power N

Co-ordinator :

Posture : N

Involuntary Movements :

Sticker

Superficials: N

m : N

owel :

Summary & Diagnostic: Type 3 supracondylar # ① distal humerus c PIN palsy

diatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓

PT/APTT/INR ✓

Planned Management

NPO

IVF

Closed reduction & K wire fixation of ① elbow ↓ GA

Signature of the Doctor:

Name of the Doctor: Keerthana D

Date & Time: 25/4/26 4 pm

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

Docu.

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 14 D (M)
Dr. G SAI SUCHITRA

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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						

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.,) : .....

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DRUG CHART

Date of Admission: 25/07 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

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

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

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

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

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR (M)
12-09-2019 6 Y 10 M 13 D
Dr. G SAI SUCHITRA

REGULAR PRESCRIPTIONS Weight. 23.6 kg Ward. ....

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

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

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

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

Patient Sticker

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/7	8.34pm	Inj- Ceftriaxone	400 mg	IV		
25/7	8:50pm	Inj PARACETAMOL	400 mg	IV		
25/7	8.30pm	Inj- Dexamethasone	4 mg	IV		
25/7	8.33pm	Inj. Emeset	2 mg	IV		

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Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
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I.V. FLUIDS CHART

Weight. 23.6kg 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
25/7	5.30pm	0.9% DNS	IV	65	[signature]	Baluf [signature]			
25/7	8:20 pm	10 RL	IV		[signature]	[signature]	25/7 26	[signature]	[signature]

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

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: RCH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/1/26 Time: 5.30pm 8pm 10.30PM 12AM 4AM

Doctor / Nurse / Family Concern?

Temperature (°F)

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

Note: BP does not score in early warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		98%	98%	98%	99%
Conscious Level	Normal / Altered	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials					

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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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.

Date	Time	Intake: Nature of Fluid	Intake Route: Mouth	Intake Route: I.V	Intake Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
25/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	→ Child Received from ER to 4th floor ←										
	06:00 pm	Np		65ml	65					0	0	[signature]
	07:00 pm	o		65ml						✓	0	[signature]
Total Intake :		130ml				Total Output : 1time urine passed						
	08:00 pm	RL		500ml							0	[signature]
	09:00 pm										0	[signature]
	10:00 pm										0	[signature]
	11:00 pm	N		65ml							0	[signature]
	12:00 am	P		65ml							0	[signature]
	01:00 am	O		65ml							0	[signature]
Total Intake :		195ml				Total Output : Nil						
	02:00 am	N		65ml							0	[signature]
	03:00 am	P		65ml							0	[signature]
	04:00 am	O		65ml							0	[signature]
	05:00 am			65ml							0	[signature]
	06:00 am	water	50ml	65ml						✓	0	[signature]
	07:00 am	TC water	200ml	65ml							0	[signature]
Total Intake :		250ml + 390ml				Total Output : 1 time urine passed						

Total 24 hrs. Intake	965

Total 24 hrs. Output	2 times urine passed

Docu. No. : RCH /FRM / CLINICAL / 092

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← Receiving Note →	
25/7	4pm	The child details receiving from ED sh77 to 4th floor. sh77. The child is conscious and oriented IV line present. no pain, no swelling, IV line patten.	
	5pm	Vital. sign are checked and recorded. vital are stable.	

CP	PP	CRT
++	++	<2sec

	6pm	Pt child was maintain nopain complain of pain, vomiting
	6.45pm	The child details handing over given to OT sh77, the child shifted to OT sh77.
		OT
25/7/26	7:00Am	Patient hand over taken from 4th FLOOR staff. while receiving the patient is conscious and oriented. pulse: 100bpm. R.R = 20b/m, BP: 100/60 mmHg, Temp (N). SPO2: 100%. General Anaesthesia
	8:15pm	given by DR. Senthil kumar procedure started by DR. G. Sai Suchitra. procedure went on well. vitals on monitoring. patient procedure

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ......

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/7/26	9. pm	done Gauze count corrected.	
		Baby shifted from OT to	
		OT recovery. patient awake	
		arm pouch (+) patient shifted	
		from OT recovery to 4th Floor.	
		patient documents & details	
		hand over given to 4th FLOOR	Amet
	10:30pm	Staffs	[illegible]
	10:40P.	The child recieved from	
		OT to 406. The child	
		details handing over	
		taken from evening	
		Duty staff. child is	
		on NPO child is	
		conscious and oriented	[signature]
		child is on room air	02189
	10.45	vital signs are checked	
	pm	and recorded. vital signs	
		are stable. CP ++ / PP ++ / CRT <3sec	[signature] 02189
	11pm	IV fluids 0.9% DNS	
		65ml/hr on flow.	
26/7/21	12Am	vital signs are checked	
		and recorded. vital signs	
		are stable	
		CP ++ / PP ++ / CRT <3sec	[signature] 02179

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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INTERDISCIPLINARY PAT... ...TION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
25/7	5pm	treatment & care.	Explained about treatment & care.	mother.	no	oral.	none	verbalizes understand	Good	n8/[illegible]
26/7/26	8AM	Falls' educt	Explained the points to fall risk educt. put the side rails	Mother	no	Oral	none	verbalizes underst	Good	[illegible]

Part - III: CODES

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

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

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

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

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

Doc No. : RCH / FRM / CLINICAL / 187

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4 PM Mode of Arrival: self Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: 23.6 Kg

..... Height: ..... cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

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: 23.6. Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.6 F HR: 106A RR: 28bA. BP: 105/60

Pain Score: 0/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 19) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): 25/7/26 @ 4:45 pm.

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 ..... parents .....

Nurse's Name: ..... Date: 25/7/26 Time: 4:45 pm Signature

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sai Suchithra Date : 25/4/26

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

Start Time of Assessment: 4 PM Weight: 23.6 kg

Allergic History: .....

Chief Complaints:
C/o swelling q ① elbow

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: 24 SpO_2 on FiO_2 99%
Rhythm: N
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: equal
Palpation Findings (If necessary).....

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

Circulation

HR: 105

CFT — Central: <3 — Peripheral: <3

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 100/79 mmHg

Pulse Volume: Central 2+ — Peripheral 2+

If in Shock: Compensated ..... — Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: A

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size — Right 2mm — Left 2mm

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 98.2°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

Details inside

Treatment Planned: .....

Details inside

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: Keerthana D

Signature: .....

Date & Time: 25/7/26 4pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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Patient's Name:..

MRD NO:............ GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)

Age :.................. Dr. G SAI SUCHITRA I ☐ F

Consultant :..........

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 25/07/25 Time: 8:40pm

Location : (R) metacarpals

Size : 22G

Cannula inserted by : R/N Shibu.

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
25/07	pallern 4.00pm	☐Yes ☐No	☐Yes ☐No	poth	[illegible]
25/07	6:00pm	☐Yes ☐No	☐Yes ☐No	Observed	[illegible]
25/07	8:00pm	☐Yes ☐No	☐Yes ☐No	Observ.	[illegible]
	10pm	☐Yes ☐No	☐Yes ☐No	Observed	[illegible]
26/7	12am	☐Yes ☐No	☐Yes ☐No	Observed	[illegible]
	2am	☐Yes ☐No	☐Yes ☐No	Observed	[illegible]
	4am	☐Yes ☐No	☐Yes ☐No	Observed	[illegible]
	6am	☐Yes ☐No	☐Yes ☐No	Observed	[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		

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

PATIENT TRANSFER FORM

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

GUC-00094296 IP18-00036616 Master R.RIYTHIV KATHIR 12-09-2019 6 Y 10 M 13 D (M) Dr. G SAI SUCHITRA	Date & Time of Admission 25/07 @ 4:00pm	Date & Time of Transfer Order 25/07 @ 4:40pm
Treating Consultant Name Dr. Suchitra	Transfer Ordered by Dr. Keerthakar.	Reason for Transfer Treatment
From Unit ER	To Unit 406	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File (12)	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	0.9% DNS 500 ml →	(1)
2.	Infrafix →	(1)
3.		
4.		
5.		

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

Ⓛ Supracondylar #

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shibu 17890	Preethi

Patient & Clinical Records Received by : Batton 25/7/26

Date & Time of Patient Received : 615 pm @ 6.30 pm

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

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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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 : .....

Date & Time : 25/7/26 4pm

Nurse Name & Signature: .....

Date & Time : 25/07/26 @ 4pm

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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Dr. G SAI SUCHITRA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/07/2019 Time of arrival : 3:28 pm

Chief Complaints: H/O closure reduction RBS: 84 mg/dl.

Height : — Weight : 22.6 kg BMI : — Head Circumference (<2 years) .....

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

If yes , identify nil

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 8/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

☐ Character while playing ☐ Location L hand ☐ Frequency on & off ☐ Duration 4 days

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With Parents

Siblings in household ☑ Yes ☐ No (if yes How Many?) 01

Time of Initial assessment completed by ER Nurse : 3:38 pm

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

Time	Nursing Notes
4pm	patient come to the ER with the H/o fall down @ 22/07/24. now procedure close reduction. monitored the vital signs. Recorded Dr. kunthavi madam. IV line placement done. Blood sample collected and pt shifted to the ward.

Samples collected by: S/N Shibu Time: 4:10pm.

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 108/m BP: 100/79 (83) CFT: <3 sec RR: 24/m SPO$_2$: 100% GCS: 15/15 Temperature : 98.2 F Pain Score: 2/10 Repeat RBS (if applicable): 84 mg/dl	Shift - out from ER to: 406 Time of Shift - out: 4:40pm. Handover given to: S/N Angel. (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done. (R) metacarpals 22G.

Name of the Nurse : Shibu Debnath Signature of the Nurse : Shi 17890

Date & Time : 25/07/24 @ 4:10pm

(NPO - 11:00 am)

GUC-00094296 IP18-00036616
Master R.RIYTHIV KATHIR
12-09-2019 6 Y 10 M 13 D (M)
Dr. G SAI SUCHITRA

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wt 23.6 kg.

EMERGENCY ROOM TRIAGE FORM

Patient's Name : RIYTHIV KATHIR Age : 7y Gender: ☐ Male ☑ Female

Date : 25/07/25 Time of Arrival : 3:25 pm

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2 F PR: 132/m BP: 100/79 (85) RR: 24/m SpO_2: 99%

Chief Complaints: H/O came for procedure (close reduction)

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☑ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2 min.

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 : Shibu Debnath

Signature of Triage Nurse : .....

Date & Time : 25/07/25 & 3:27 pm

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