Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

UHID-

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	16/7/24 @ 8am						
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

UHID No: ..... GUC-00093926 Baby NAKSHATRA IP18-00036489 17-07-2024 1 Y 11 M 28 D (F) Dr. S. KEERTHIVASAN nsultant: ..... Dept: .....

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	9:30pm	ER	~~703~~ OT	
15.7.2026	12.50 am	OT	703	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC	15/07/26.	1727999.	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
16/7/26	Infusion pump	2am		1728126	Sig
15.7.26	Endoscopy	9.35 pm	10.25 pm	1728149	Sig
	C' Arm	9.40 pm	9.50 pm	1728150	Sig

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/7/26	IV placement	(1)	1727998	
15/7/26.	chest - x-ray.	(1)	9566	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 16/7/26 Time: 6am Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

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SURGERY DETAILS

Date : 15.7.2024

Patient Name: Baby. Nakshatra Date of Birth: 17-07-2024 Age: 1y

Gender: Female Ward : OT UHID No.: 93926/36489

Date of Surgery: 15-7-2024 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Endoscopy Foreign Body Extraction

Time in : 9.25 pm Time Out : 10.30 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Keerthivasan	
2.	Anaesthetist	: Dr. Priyadharshini	
3.	Assistant Surgeon	: -	
4.	OT Technician	: Mr. Raja	
5.	Circulating Nurse	: S/n. Sundari	
6.	Assistant Nurse	: S/n. Bharathi	

Special Equipment:

☐ Laparascopy	☑ Broncoscope (9.25 to 10.25)	☐ Harmonic	☐ Morcelator
☑ C-ARM (9.40 - 9.50)	☐ Cystoscopy	☐ Versa Point	☐ Liver Cusa
☐ Neuro Cusa	☐ Others		

Signature of the Surgeon

S. Sundari 01396
Signature of Circulating Nurse

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

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

Record further done by. Sudhir 01396

Patient Sticker

Emg ~~&~~ Foreign Body Removed

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Your Right to a Safe Delivery

CONSUMABLES OF OT

Circulating staff : ..... Technician : Mrs. Reja ..... Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.0 (welco)		1 ✓	Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3 ✓				Suction Catheter		
HME filter : A / P / N						Feeding Tube - 9F		1 ✓
Syringes : 10 cc		2 ✓				Vaccum Suction Set		
05 cc		3 ✓	Gloves			Surgical Gloves		
02 cc		2 ✓				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set ✓		1 ✓	NG tube			Koochies (S)		
RL ✓		1 ✓	Cautery pencil			Trapine		1 ✓
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			Artacil		1 ✓
			Ointments			10cm Vein - O-line		1 ✓
			Suction Catheter			Dextes 10mL		3 ✓
Fentanyl ✓		1	Cap, Mask					
Morphine			Gauze Pack		01 ✓			
Ketamine			Mop Pack					
Propofol ✓		1 ✓	Steristrip					
Rocuronium			Underpad		01 ✓			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01 ✓			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves		5pair ✓			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist 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 **CIN :** L85110TG1998PLC029914

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036489	**Ward**	7F-PVT/SUITE
Patient Name	Baby NAKSHATRA	**Bed Name**	PVT 703
Age/Sex	1 Y 11 M 29 D / Female	**Order No**	18-0001728108
Date	16/07/2026 02:23	**Prescription No**	PRIP18-0627392
Payor	SELFPAY	**Dispensed Date**	16/07/2026 02:30
UHID	GUC-00093926		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
2	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	2	28.13	56.26
3	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	3	21.56	64.68
4	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	2	11.25	22.50
5	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	1	2.58	2.58
6	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	2	2.58	5.16
7	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
8	ET TUBE - 4.0 CUFFED (WELCO LIFE)			2511222	10/28	1	891.00	891.00
9	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25J010599	09/30	1	63.00	63.00
10	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	1	525.00	525.00
11	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
12	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
13	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	SM038138	11/27	1	7.30	7.30
14	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**2,236.64**	**2,401.72**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 16-07-2026 02:30

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036489	**Ward**	7F-PVT/SUITE
Patient Name	Baby NAKSHATRA	**Bed Name**	PVT 703
Age/Sex	1 Y 11 M 29 D / Female	**Order No**	18-0001728110
Date	16/07/2026 02:23	**Prescription No**	PRIP18-0627391
Payor	SELFPAY	**Dispensed Date**	16/07/2026 02:29
UHID	GUC-00093926		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
2	UNDERPADS CARE 60 X 90 (FRIENDS)			25062026	12/30	1	205.00	205.00
3	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010294	03/31	1	811.00	811.00
						Total :	**1,116.00**	**1,116.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036489	**Ward**	7F-PVT/SUITE
Patient Name	Baby NAKSHATRA	**Bed Name**	PVT 703
Age/Sex	1 Y 11 M 29 D / Female	**Order No**	18-0001728112
Date	16/07/2026 02:34	**Prescription No**	PRIP18-0627393
Payor	SELFPAY	**Dispensed Date**	16/07/2026 02:35
UHID	GUC-00093926		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
						Total :	**25.00**	**250.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 16-07-2026 02:35

Rainbow Children's Hospital | BirthRight

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

DISCHARGE TRACKING SHEET

R- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		10 pm			
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-00093926
Baby NAKSHATRA IP18-00036489
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

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BED SIDE CHECK LIST FOR NURSES

Date:	16/7/24								
Doctor's Orders	Yes								
Carried out or not	NA								
Bed Side									
Structured Handover done	Yes								
IV Site	Yes								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	NA								
Eye Care	NA								
Mouth Care	NA								
Sterillum Bottle, Stethoscope	Yes								
Suction Bottle (Should be clean & empty)	Yes								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA								
Ventilator Tubing,(Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling,Correct Preparation)	Yes								
Chest Physio & Neb	NA								
Handed Over By Name :	E-Shan								
Signature :									
Date & Time:	16/7/24								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

Patient Name: Baby NAKSHITHRA UHID No: 93926 Bed Category: T03

AT-ADMISSION DESK:

- Explain about admission process
- Welcome Kit

SERVIGES IN WARD:

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

BILLING:

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

MANAGEMENT TEAM:

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

THANK YOU AND GET WELL SOON

Signature of patient/ patient Attendance

Signature of the Introducer

Rainbow Children's Hospital

No: 157, Anna Salai, Guindy, Chennai - 600015

Endoscopy

Patient ID	: GUC-00093926	**Visit Date**	: 15/07/2026
Patient Name	: BABY.NAKSHATRA	**Referred by**	: DR BALAKUMARAN MD
Age/Gender	: 1Yr, Female	**Consulted by**	: DR.KEERTHIVASAN MD, DM

UPPER GI ENDOSCOPY Report

Premedication : GA

Esophagus : Normal

Stomach :

Fundus : Full of food

Body : Full of food, Metallic safety pin seen embedded, Removed with rat tooth forceps

Antrum : Normal

Pylorus : Normal

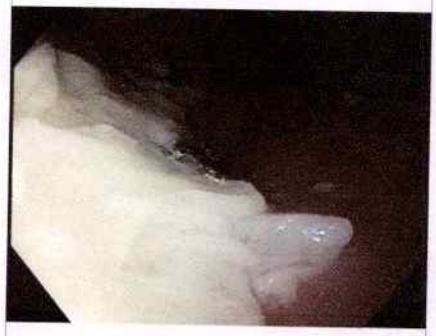
Duodenum :

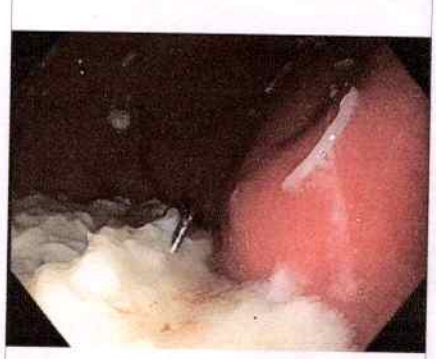
D1 : -

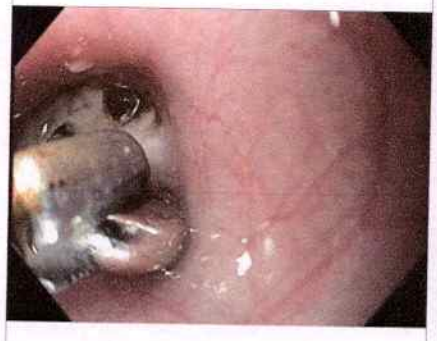
D2 : -

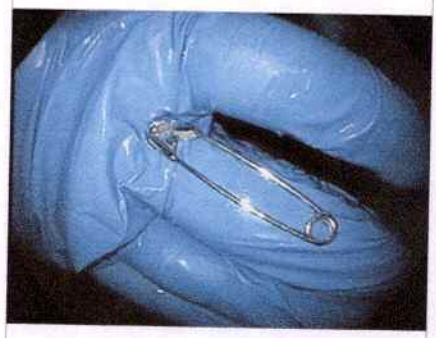
Biopsy : Not taken

Impression : Foreign body(Safety pin) ingestion, Removal done









DR.KEERTHIVASAN MD, DM

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 : IP18-00036489 **Admit Date** : 15-Jul-2026 **Admit Time** : 08:33 PM **UHID** : GUC-00093926

Patient Details :

Patient Name	: Baby NAKSHATRA	**Age**	: 1 Y 11 M 28 D
Guardian	: Mr M BALA KUMAR	**DOB**	: 17-07-2024
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 14 EB COLONY 3RD STREET 1ST CROSS Adambakkam Chennai Tamil Nadu INDIA 600088	**Phone No**	: 9003775218
		E-mail	: BALAKUMAR1808@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : Mr M BALA KUMAR **Relationship** : Father

Contact Address : 14 EB COLONY 3RD STREET 1ST CROSS Adambakkam Chennai Tamil Nadu INDIA 600088 **Phone No** : 9003775218

Signature

Doctor Details :

Doctor Name	: Dr. S . KEERTHIVASAN	**Specialisation**	: PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor	: self	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby NAKSHATRA**	**Age :**	**1 Y 11 M 28 D**
IP No:	**IP18-00036489**	**Sex:**	**Female**
Consultant:	**Dr. S . KEERTHIVASAN**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

Signature of Patient/Relative:

Name: Dr. N. Balakumar

Relationship: Father

Date: 15-07-2026 Time: 8:33

Witness Name: DSWO

Witness Signature:

Patient Address:

14 EB COLONY 3RD STREET 1ST CROSS Adambakkam Chennai Tamil Nadu INDIA 600088

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 :> Nakshatra. B	UHID Number : 93926
Self/Attendant Name : > Dr. M. Balachumar	Relation : e Father.
Self/ Attendant Signature : > M.R.L Phone Number : 9003775018	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

UHID ID: _____ _____

Department: _____ _____

Consultant: _____

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

Pediatric Multiorgan History & Physical Examination

Name: Nakshathra Age/Sex 2yrs/F

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

Accidental foreign body ingesion
-safety pin.

History of present illness :

A 2yrs female came with complaints of accidental foreign body ingestion at home around 7pm. witnessed by mother.
no c/o cough, drooling of saliva.
one episode of vomiting

chest x ray - safety pin in stomach.

Last meal - 6.45pm

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

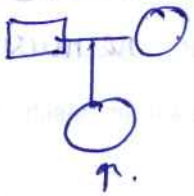
Past History : (Including details of any previous investigation or treatment)

—

Birth & Neonatal History:

Term | Elec LSCS (↓AFI) | B.wt - 3.4 kg. MSL.
NICU stay for observation | CIAB.

Family Chart



Birth & Socio Economic History:

About Father : Gynec.
About Mother :
Any additional Information :

Developmental History :

Milestones attained at appropriated age.

Immunization History :

Immunized upto age according to IAP guidelines.

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)
Weight (kgs) 11.1 kg (Centile _____)

On Examination :

Temperature : 96.7 F Pulse Rate : 127/min B.P. : _____ SPO2 99% RA
Resp.rate and type of breathing : 28/min

Rash —
Lymphadenopathy —
Oedema : —
Allergies (if any): —

(P.T.O.)

Patient Sticker

Respiratory System :

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

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

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : no murmur

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

Per Abdomen :

Inspection :

Palpation : soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Accidental foreign body ingestion - safety pin (closed)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC

~~PT/APTT~~

Chest x-ray

Planned Management

IV Fluids.

Signature of the Doctor: .....

Name of the Doctor: Dr. Chandisalega

Date & Time: 15.12.22

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-00093926 IP18-00036489
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17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 2:30am	S/B Dr. Mr.....	FB in stomach (safety pin - closed) ↓ Endoscopic removal .....
	Reviewed	
	asleep	
	PP-LF	
	On NPO	
	RS - clear	
	P/A - soft, Nontender	
	→ to start orals at 2:30pm when child is awake	
	- Cont IVF	
	→ Stop IVF by morning	
16/7/26 9.30am	S/B Dr. Kavitha	
	A - Endoscopic removal of foreign body	
	Tolerated feeds	
	No vomit.	
	Passed stool	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/E - Alert, playful	
	PPWF	
	Vitals - stable	
	P/A - Distension ⊕	
	Soft,	
	non-tender	
	Other systems - WNL	
	Plan - discharge	after D/W Dr. Keerthivasan
	S.V.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

Weight. 11.1kg Ward. OT

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature

VERIFIED BY : Name

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

I.V. FLUIDS CHART

Weight. 11.1kg Ward. ....

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/7/24	10am.	0.9% DNS	IV	40ml/hr	[signature] 19/7/24	[signature]			
15/7	11pm	100 ml RL	IV	pushed	[signature]	[signature]	15/7	[signature]	[signature]

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ ~~Not~~ known any Drug Allergies

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

Shifting From: ER Shifted to: ~~[illegible]~~ 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 : Dr. Manoma'

Date & Time : 17/7/24, 9 pm

Nurse Name & Signature: Jayanthee

Date & Time : 17/7/24 @ 8:40pm

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

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

: RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Field	Entry 1	Entry 2
Date: 16/7/26 Time:		
Doctor / Nurse / Family Concern?	10am	4am
Temperature (°F) (scale 94–104)	97.8°F	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)		
Heart Rate (Number)	128bm	120b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)		
Resp Rate (Number)	32b/m	32b/m
Resp Distress: Mod/ Severe / None / Mild		
Receiving O_2 (l/min) / O_2 Saturations (%)	98%	97%
Conscious Level: Normal / Altered		
GCS *	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

Handwritten on chart: on admission

Note: BP does not score in early warning scoring

ACTIONS
NB: Scores 3 should be recorded overleaf

Score	Action
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)

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
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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.

16/7/26.		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am	NPO									0	[illegible]
Total Intake :						Total Output :						
	02:30 am		DBF							✓		
	03:00 am										0	[illegible]
	04:00 am		DBF									
	05:00 am	H2O	10ml							✓		
	06:00 am		DBF								0	[illegible]
	07:00 am	H2O	10ml							✓		
Total Intake :	H2O 20ml + DBF (3)					Total Output :				[illegible]		

Total 24 hrs. Intake	DBF (3) + 20ml

Total 24 hrs. Output	[illegible]

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

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			N	M			
			16/7	16/7			
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4	1	1			
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	1	1			
	Forget Limitations	2					
	Oriented to own ability	1	2	2			
	History of Falls or Infant-Toddler Placed in Bed	4	9				
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	1	1			
	Within 48 hours	2					
	More than 48 hours/ None	1	-				
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3	1	1			
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		11	11			

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

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		NA	NA			
Other Intervention(s) Specify		NA	NA			
Nurse's Name:		[illegible]	[illegible]			
Signature:		[illegible]	[illegible]			
Date:		16/7/24	16/7/24			
Time:		8pm	8AM			

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

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BRADEN 'Q' SCALE

(for Paediatric use)

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

☐M ☐F IP No. :

					:	16/7	15/7	
Mobility	1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent though slight changes in body or extremity position independently.	4. No limitation: Makes frequent changes in position without assistance.		4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."		4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	
					TOTAL SCORE	27	27	
					Evaluator's Name			

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

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PHLEBITIS ASSESSMENT

Patient's Name: GUC-00093926 Baby NAKSHATRA IP18-00036489
MRD NO: 17-07-2024 1 Y 11 M 28 D (F) ...... IP No.: ......
Dr. S . KEERTHIVASAN
Age :.... Sex: ☐ M ☐ F
Consultant :............

CANNULA 1

Date : 15/7/26 Time: 9 pm
Location : (L) metadorsal
Size : 24 G
Cannula inserted by : S/N: Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
15/7	9 pm	☐Yes ✓No	☐Yes ✓No	Observe	[illegible]
	11pm	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
16/7	1 am	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
	2am	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
	5am	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
	7am	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
	8AM	☐Yes ✓No	☐Yes ✓No	Obs	[illegible]
	12pm	☐Yes ✓No	☐Yes ✓No	Obs	[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		

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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17-07-2024 1 Y 11 M 28 D (F)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/7/24 Time of arrival : 8:25 pm

Chief Complaints: Accidental ingestion of foreign body around 7 pm RBS: .....

Height : - Weight : 11.1 kg BMI : - Head Circumference (<2 years) -

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

If yes , identify NIL

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character - ☐ Location - ☐ Frequency - ☐ Duration -

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

RCH

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

If Yes Consultant Notified: NIL (Date/Time): -

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 8:40 pm

Time	Nursing Notes
8:20 pm.	patient came for ER with the compliant of accidental ingestion of foreign body. Safty pin around 7 pm, Dr. Keerthirasan sir advised to put an admission, NPO from 6:45 pm, informed OT, vital are checked all are stable, Shifted to ward.

Samples collected by: S/N

Samples sent by : S/N.

Time:

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: 127bpm. BP: — CFT: <3sec	Shift - out from ER to: OT
RR: 28bpm SPO$_2$: 100%	Time of Shift - out: 9:30pm.
GCS: 15/15 Temperature : 96.2°F.	Handover given to: (Nurse's Name) S/N. Sundharr
Pain Score: 0	
Repeat RBS (if applicable): NIL	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Iv line placement done in metacarpal line 24 G is placed

Name of the Nurse : A. Sfills

Signature of the Nurse : A. Cheery

Date & Time : 15/07/26 @ 9:00pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiraleger ..... Date : .....

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

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

Allergic History: .....

Chief Complaints: .....

Accidental foreign body ingestion

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: 28/m SpO$_2$ on FiO$_2$ 99% RA

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L RBE ⊕

Palpation Findings (If necessary) .....

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

Circulation HR: 127/mn. CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 96.7F.....

Any urgent interventions needed: ☐ Yes ☐ No

Any Rash: ☐ Yes ☐ No,

If Yes .....

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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

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

.....

.....

Labs Planned: .....

.....

.....

As per chart

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

As per chart.

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr. Chandirolega

Signature: .....

Date & Time: 15/2/26

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

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OPERATION NOTES

Surgeon : Dr. Keerthivasan		Asst. Surgeon : -	
Anesthetist : Dr. Priyadharshini		OT Nurse : S/N Bharathi	
Pre-Operative Diagnosis: SAFETY PIN INGESTION			
Surgical Procedure : FOREIGN BODY (SAFETY PIN INGESTION) REMOVAL			
Weight : 11.1 Kg	Date : 15.7.2026	Start Time : 9.25 Pm	End Time : 10.30 Pm
Post Operative Diagnosis:			
Peri-Operative Complications:			
Esophagus - ⊖			
Operation Notes:			
Findings: Stomach — Full of food			
Removed via RAT TOOTH FORCEPS			
unremarkable			
Procedure Notes:			
Amount of Blood Loss:		Blood Transfused (in ML)	
Name and Number of Surgical Specimen sent for examination:			

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

- NPO x 4 hrs
- (L) lateral position

Wound Care:

- NEBPARACETAMOL

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: ....

Signature of the Surgeon: Dr. S. Keerthivasan

Date & Time: 15.7.2026 & 10.35 pm

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
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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 : 15.7.26

Nurse Name & Signature: S. SUNDARI

Date & Time : 15.7.26 9.30 Am

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Keerthivasan
Asst. Surgeon : .....
Anaesthetist : Dr. Priyadharshini
Scrub Nurse : Mr. Bharathan

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

..... Age : ..... Gender : F
y Name : .....
Date : 15.7.26 In-time : 9.30 Pm Out-time : 10.30 Pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9.25 Pm

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. Priyadharshini

Before Skin Incision ➤➤

TIME OUT Time: 9.30 Pm

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. Keerthivasan

Before Patient Leaves Operating Room

SIGN OUT Time: 10.30 Pm

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

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

Signature : [signature]
Name : S. SUNDARI

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
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DRUG CHART

Date of Admission: 15/7/24 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 29 D (F)
Dr. S. KEERTHIVASAN

REGULAR PRESCRIPTIONS

Weight. 11.1kg Ward. OT

DRUG : NEXPRO JUNIOR SACHET

Dose	Route	Frequency	Start Date
10g	P/O	OD	16/7/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: before food

Daily Doctor's Endorsement by a Sign

Date / Time	
16/7	
8 am	AA / BS

DRUG : SYP. SUCRAFIL O

Dose	Route	Frequency	Start Date
3ml	P/O	TDS	16/7/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	
16/7	
8 am	BS / PP
2 pm	
10 pm	

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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Your Right to a Safe Delivery

PATIENT TRANSFER FORM

GUC-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

Date & Time of Admission	Date & Time of Transfer Order
15.7.2026 at 8.33 pm	16.7.2026 at 12.50 am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Keerthivasan	Dr. Priyadharshini	post of care

From Unit	To Unit	Information to Attendant
OT	7th Floor (703)	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
(Dr. Priyadharshini) S. Sundri 013906	Dr. Priyadharshini

Patient & Clinical Records Received by : [signature] @ 1 am.

Date & Time of Patient Received :

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

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

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Dr. S . KEERTHIVASAN

BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 15.7.26 **TRANSFERRED TO :**

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

GUC-00093926 IP18-00036489
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NPO from 6:45 pm.

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EMERGENCY ROOM TRIAGE FORM

Wt: 11.1kg

Patient's Name : Baby . Nakshathra . Age : 2 yrs . Gender: ☐ Male ☑ Female

Date : 15/07/26 Time of Arrival : 8:25 pm.

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.7°F PR: 127/min BP: — RR: 28bm. SpO2: 100%.

Chief Complaints: Accidental ingestion foreign body safety pin around 7pm.

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).

Signature of Triage Nurse : .....

Name of Triage Nurse : A. Sujith

Date & Time : 15/7/26 @ 8:27 pm.

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

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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

Date: 15/7/26 Time: 8.45 pm Proposed Operation: Endoscopic FB removal

Diagnosis: FB stomach - safety pin

B.P / CRT: ..... H.R: 121/min Weight: 11.1 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: ~~Egg~~ NKDA

Medical History: CVS : 1st child, full term, LSCS

RESP : B.W - 3.4 kg, NICU for observation

CNS : (NSL) (N) developmental

Renal : milestones, vaccinated till date

Hepatic / GE : Physical Activity: active child

Others : nil comorbids

Past Anaesthetic History: nil prev sx

Physical Exam:

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

Lungs : B/L AE (+)

Heart: S1S2 (+)

CNS: NFND

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : 24 G (+) Spine Exam for regional : (N)

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA (A) VL

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

CURRENT MEDICATIONS	DOSAGE
-	-

Pre-Operative Instructions:

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

.....

.....

Signature: ..... Name: Dr Purushothaman

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: 2-6 hrs	
Physical Status:	✓ Patient Identified	☑ Consent Present ✓ ☑ Chart Reviewed

H.R.: 120/min B.P / CRT: 80/50 SpO_2: 100% R.R.: 25/min Last Feed: 6.45pm

Pre-OP Diagnosis: FB Operation: Endoscopic FB removal Date: 15/5/16

Surgeon: Dr Keerthivasan Anaesthesiologist: Dr Priyadharshini Technician: Ms Raja

TIME: 9.30pm 10.30pm

N_2O / AIR / O_2 LPM: 1 : 1

HALO / ISO / SEVO: 2%

Drugs:
Inj Fent 20 mcg IV
Inj Propofol 50mg IV
Inj Atracurium 3 mg IV

Antibiotic

Suppository

Blood Loss

FIO_2 / SaO_2

$ETCO_2$: 35–40

ECG: Sinus Rhythm

Temperature

Urine Output

NOTES

Fluids / Blood: 100 ml RL

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional ☑ BP ☑ Cuff Site: ...... ☐ Art Site: ...... ☑ EKG Lead ☑ Temp Site ☑ FiO_2 Monitor ☑ Agent Monitor ☑ Pulse Oximeter ☑ Capnograph ☑ Ventilator ☐ Nerve Stimulator **Position:** (L) lateral ☐ 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: 9.30 pm OP Start: ...... OP End: ...... Leave OR: 10.30 pm **Anaesthesia:** ✓ ☐ GA ☐ Monitored Anaesthesia Care ☐ Regional **Line (Size & Location)** ☐ CVP: ...... ☐ ART: ...... ☐ IV: 24 G (L) UL ☐ IV: ...... ☐ IV:	**Induction** ☑ IV ☐ Inhal ☐ Pre O_2 ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# 4 at ...... cm ☑ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: 4% lignocaine sprayed over cords ☐ Awake ✓ ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# (2) Attempts: (1) Difficulty Why? ...... ☐ **Bilat = BS** ☐ Semi-Closed Circle ☑ Closed Circle ☐ Other	**Regional:** Extremity Specify: ...... ☐ Spinal ☐ Epidural ☐ Caudal Others: ...... Position: ...... **Site:** ...... Needle Size: ...... Depth: ...... Parasthesia ☐ Yes ☐ No Catheter at skin ...... cm Drug Name & Conc: ...... Bolus: ...... Infusion: ...... Block Level: ...... Comments: ...... Transportation to ☐ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: Dr Priya R Signature of the Doctor: [signature] 15462

Patient Sticker

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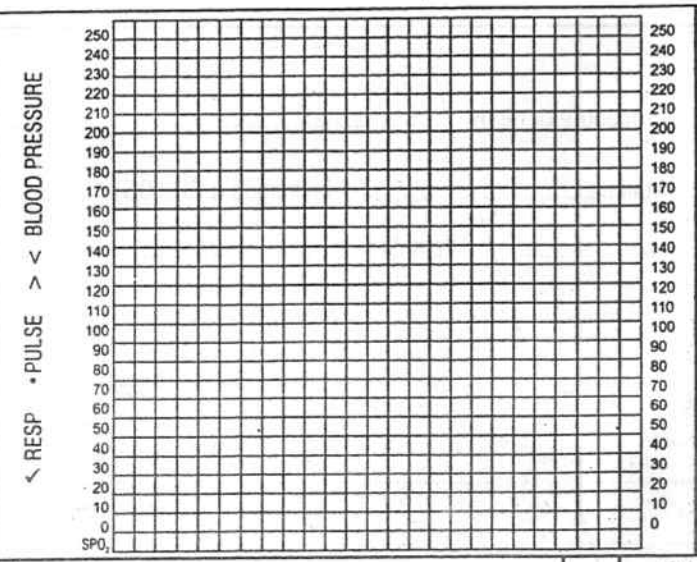
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

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

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

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/5		0/10	NPO x 2 hours	15/5/26

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

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

Anaesthesiologist Name : Dr Priya R
Anaesthesiologist Signature: 15/5/26
Date & Time: 15/5/26 10.40pm

PACU Nurse Name : .....
PACU Nurse Signature: .....
*Date & Time: .....

Transferred to Unit by (PACU): .....
Date & Time: .....

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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 : .....

CONSENT FORM FOR ANAESTHESIA

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Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

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

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

Anaesthesiologist : ..... 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 : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : ..... Name : Dr Priya Dhawan Date & Time : 15/7/24

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

GUC-00093926 IP18-00036489
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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		
6	Maintain normothermia during the surgical procedure (>36 deg C)		
	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		

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Dr. S . KEERTHIVASAN

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

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

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PRE - OPERATIVE CHECK LIST

Date: 15/7/26

Patient's Name : Baby. Nakshatra Age : 2y/F Gender : ☐ M ☐ F

Blood Group : O+ve UHID : 93926

Planned Surgery : Endoscopy Surgeon : Dr. Keerthivasan.

Anesthetist : Date & Time of Operation : 15/7/26 @ -

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name :

Billing Executive Signature :

Date & Time :

Nurse In-Charge Name : Suganthi.

Signature of Nurse In-Charge :

Date & Time : 15/7/26 @ 8:35pm.

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

CONSENT FOR UPPER GI ENDOSCOPY

Rainbow Children's Hospital

BirthRight BY RAINBOW HOSPITALS

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Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S . KEERTHIVASAN

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

Description of the Procedure

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

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

Precautions

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

Risks

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

CONSENT FOR THE PROCEDURE

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

CONSENT FOR UPPER GI ENDOSCOPY

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

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

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

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

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

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

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12. CONSENT OF PARENT / PARENT REPRESENTATIVE / SURROGATE

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

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

	Signature	Name	Date	Time
Patient Representative with relationship		SWATHILAKA P	15/7/20	9.20 PM
Witness		LEETHA P	15/7/20	9.20 PM
Doctor		Dr. Keerthivasan		
Interpreter				

(Authorization of patient/patient representative surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

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-00093926 IP18-00036489
Baby NAKSHATRA
17-07-2024 1 Y 11 M 28 D (F)
Dr. S. KEERTHIVASAN

	Date & Time of Admission	Date & Time of Transfer Order
	15/7/26 @ 8:33 pm	15/7/26 @ 9:30pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Keerthivasan.	Dr. Chandralega	further mangement
From Unit	**To Unit**	**Information to Attendant**
ER	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
15	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS 500ml	1
2.	Dr set	1
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Jayatha 01181	Dr. Manonmani

Patient & Clinical Records Received by : Sudha 013906

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

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