ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 31/07/26

Patient Name: Mr. A. Tamilanban Date of Birth: 19/10/2004 Age: 21 Y

Gender: Female Ward : OT UHID No.: 02258/36692

Date of Surgery: 31/07/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Right canaloplasty & GA

Time in : 10:50AM Time Out : 2:00PM

	NAME	**AMOUNT**
1. Surgeon	: DR. Nithya. R	Mail sent for
2. Anaesthetist	: DR. mohan / DR priyadharsini	Charges regarding
3. Assistant Surgeon	: Dr NSL	BURS usage kindly
4. OT Technician	: Mr. Technician	Charge it as divided
5. Circulating Nurse	: GN Sangeetha	Charges &
6. Assistant Nurse	: S/N. Arunadevi	Nerve Stimulator

Microscope (11:55 AM – 1:30pm) (1735459)

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator

☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

☐ Neuro Cusa ☐ Others ....

DR. Nithya. R
Signature of the Surgeon

Signature of Circulating Nurse

Recd finalized by S/N [illegible]

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

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

Small Biopsy 26024537.

Mr. Tamilanban

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

CONSUMABLES OF OT

Circulating staff : C/o Sangeetha Technician : Mr. Thangam Date : .... Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used
ET tube 6.5 Caffed		04
LMA		
ECG leads : (A) (P) / N	3+2	
HME filter : A / P / N		
Syringes : 10 cc		2/5
05 cc		3+1
02 cc		3
01 cc		
Cautery plate : (A) (P) / N	1	2
IV set		1+1
RL		2
NS : 10ml / (100ml) / 500ml / 1000ml	1	1
Dsyringe 20ml		1
Fentanyl		1
Morphine		
Ketamine		
Propofol		5
Rocuronium		
Glycopyrolate		
Myopyrolate		1
Ondansetron		
Pencan 25g/ Spinal Needle 22		
Bupivacaine 0.25%		
Bupivacaine 0.25%(Heavy)		
Antibiotics		
Bandage roll 15cm		1+1
Suppositories		
Anamol : 80mg / 250mg / 170 mg		
Supridol : 100mg		
Justin : 12.5 mg / 25mg / 100mg		
Tab. Misoprost : 200mg		
camera cover		1
X O scopy cover		(1)
Inj: Adrenaline		1+1
~~Inj: Dexa~~		1

Surgical Disposables	Qty Issued	Qty Used
~~Major~~ Pack minor	(1)	
Sutures 3(0 vicryl 2?)		1+1
Gloves P.F 6.5		3
P.F 7		2
Surgical blade 15		1
NG tube		
Cautery pencil		1
Koochies		
Ointments		
Suction Catheter		
Cap, Mask		1+1
Gauze Pack R/O		
Mop Pack		
Steristrip		
Underpad		1
Draw sheet		
Abgel		1
Foleys catheter		
Urobag		
Chest Drainage Catheter		
Romodrain bag		
Bandage		
Tegaderm		
Ioban		
Double J Stent		1
Vaccum Suction set		
Plastic Bed Sheet		1
Betadine Solution		
Microshield		
Cotton Balls		10p
Latex Gloves		
Ramdione Scrub		
Saral		

Disposables (Baby Side)	Qty Issued	Qty Used
Inj Vit.K		
Cord Clamp		
Suction Catheter		
Feeding Tube		
Vaccum Suction Set		
Surgical Gloves		3
Gauze Pack plain		
Syringe 1ml / 2ml		
Surgical Blade # 20		
Koochies (S)		
Inj Xylocaine adrenaline		1
needle 23G 1½		1
needle 26 x 1½		1
protective sheet		1
Ruto gown		1+1
Dressing pad 40x40		1
Anaesthesia circuit (A)		1
D water 10ml		5
Dexa		3+1
200 cm Extension		(2)
100 cm Three way extension		1
Soft Roll 15 cm		(3)
10cm Vein-O-line		01
50ml Syringe		02
Artacil		02
Dexmedetomidine 50mcg		02
Amnopara		01
Augmentin 1.2g		(1)
Dressing pad 10x10		(4)
D water 100ml		1
Inj: Levipil 5ml		1
DNS 500ml		(1)

Surgeon | Anaesthesiologist | Nurse | OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

VAT TIN : 33AABCR4014M1ZK CIN : L85110TG1998PLC029914

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735526
Date	31/07/2026 16:16	**Prescription No**	PRIP18-0630201
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:17
UHID	ANC-00002258		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE		H	L0016006	12/27	1	787.00	787.00
2	ANAESTHESIA OPEN CIRCUIT -ADULT	Starmed		20260505	05/29	1	1,734.00	1,734.00
3	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	130359	08/27	1	45.30	45.30
4	Augmentin 1.2 G Inj	Glaxo SmithKline Pharmaceuticals L	H	DB00084A	09/27	1	151.21	151.21
5	DEXAMETHASONE INJ 2 ML	PENTA PHARMA	H	VDDUI0O8	10/27	4	10.78	43.12
6	DEXTOMID INJ 50 MCG 0.5 ML	Neon Laboratories Ltd		1257022	11/27	2	383.40	766.80
7	DRESSING PADS 40X40(2 NOS)12 PLY STERILE	Bapuji Surgicals		0M2544O23	03/29	1	418.00	418.00
8	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	7	28.13	196.91
9	DSYRINGE 20ML(NIPRO)	NIPRO	GENERAL	026B11K32	01/31	1	61.00	61.00
10	DSYRINGE 50 ML LUER SLIP NIPRO	NIPRO	GENERAL	026B12K41	01/31	2	204.36	408.72
11	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	4	21.56	86.24
12	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	3	11.25	33.75
13	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	5	2.58	12.90
14	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	20326S08G	05/28	3	32.34	97.02
15	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
16	EPICETAM INJ 500MG5ML	Neon Laboratories Ltd	H	V667146	02/28	1	121.80	121.80
17	ET TUBE - 6.5 MM WITH CUFFED-HELMIER		General	G26B010147	01/31	1	399.00	399.00
18	HIGH PRESSUR EXTENTION 200CM-ROMSONS	ROMSONS	GENERAL	K26E01O376	04/31	2	435.00	870.00
19	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	2	525.00	1,050.00
20	LOX WITH ADRENALINE INJ 2 % 30 ML	Neon Laboratories Ltd	H	SU1478523	02/27	1	33.60	33.60
21	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	5	69.10	345.50
22	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
23	NEEDLE 23* 1 1 2	Dispovan		32544C	07/30	1	3.63	3.63
24	NEEDLE 26 1 1 2INCH	Dispovan	GENERAL	01654R	12/30	1	3.38	3.38
25	PREGELLED SURGICAL PLATES(ADULT)	Erbee	GENERAL	2510302409	10/27	1	1,275.00	1,275.00
26	PREGELLED SURGICAL PLATES PEAD (ADVANCE)	The Advanced cadiomed	GENERAL	2412122406	12/26	2	562.50	1,125.00
27	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	2	69.84	139.68
28	THREE WAY EXTENCTION 100 CM (B.D)	BECTON DICKINSON (BD)	GENERAL	K26D010689	03/31	1	464.00	464.00
29	VASOCON INJ 1MG1ML	NEON LABORATORIES LTD		0075	02/27	2	13.04	26.08
30	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00

Printed Time : 31-07-2026 16:17

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	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735526
Date	31/07/2026 16:16	**Prescription No**	PRIP18-0630201
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:17
UHID	ANC-00002258		

Total :	**8,506.00**	**11,418.84**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 31-07-2026 16:17

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	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735525
Date	31/07/2026 16:16	**Prescription No**	PRIP18-0630202
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:18
UHID	ANC-00002258		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ABGEL 20X10	Sutures India	GENERAL	R110325	11/28	1	151.00	151.00
2	BANDAGE # 6 INCH	Muttu	GENERAL	ASBO34	12/30	2	34.00	68.00
3	CAMERA COVER	Diamond Medicare	GENERAL	O04	02/29	1	57.80	57.80
4	CAUTERY PENCIL (ADVANCE)	The Advanced cadiomed	GENERAL	250824	08/28	1	1,303.00	1,303.00
5	DRESSING PAD 10X10 STERILE	Bapuji Surgicals	GENERAL	M2544034	06/29	4	223.00	892.00
6	D WATER IV 1000 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	2602074015	05/28	1	258.80	258.80
7	Encore Microptic gloves-6.5		H	2603019005	03/29	3	128.00	384.00
8	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	2	128.00	256.00
9	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641150	06/29	3	100.00	300.00
10	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2545O21	11/29	2	123.00	246.00
11	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
12	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1C2613680	02/29	2	44.93	89.86
13	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1D262046	03/29	1	94.55	94.55
14	O-SCOPE DRAPE E214-LARGE	Surgiwere		02406DC0	05/29	1	552.19	552.19
15	PROTECTIVE SHEET 20X2O	Local		1010326	12/29	1	250.00	250.00
16	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010726	06/29	2	250.00	500.00
17	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
18	SURGICAL BLADE 15	Surgeon	GENERAL	031225	11/30	1	7.67	7.67
19	UNDERPADS CARE 60 X 90 (FRIENDS)			18072026	12/30	1	205.00	205.00
20	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010296	03/31	1	811.00	811.00
21	VICRYL 3-0 VP 2437	ETHICON SUTURES-J&J	C1	T5050	08/30	2	663.00	1,326.00
						Total :	**5,512.94**	**8,355.87**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 31-07-2026 16:18

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	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735531
Date	31/07/2026 16:26	**Prescription No**	PRIP18-0630203
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:26
UHID	ANC-00002258		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTIFLEX 15 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	24MA037	12/30	4	290.62	1,162.50
						Total :	**290.62**	**1,162.50**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 31-07-2026 16:27

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	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735530
Date	31/07/2026 16:26	**Prescription No**	PRIP18-0630204
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:28
UHID	ANC-00002258		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DNS 500ML BOTTLE-NIRLIFE	NIRLIFE HEALTH CARE		5BI0085	06/28	1	43.52	43.52
						Total :	**43.52**	**43.52**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 31-07-2026 16:28

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	IP18-00036692	**Ward**	8F-OT COMPLEX
Patient Name	Mr A.TAMILANBAN	**Bed Name**	PRE OP 806
Age/Sex	21 Y 9 M 12 D / Male	**Order No**	18-0001735538
Date	31/07/2026 16:50	**Prescription No**	PRIP18-0630205
Payor	SELFPAY	**Dispensed Date**	31/07/2026 16:50
UHID	ANC-00002258		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	MINOR OT PEDIATRIC DRAPE			20260715	07/29	1	1,800.00	1,800.00
						Total :	**1,800.00**	**1,800.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Receiver Name

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 31-07-2026 16:51

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE TRACKING SHEET

DATE : 1/8/26

Name of Consultant :

Floor :

UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time	8.30AM			
2	Arrangement of File by Nurses				
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

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 : IP18-00036692 **Admit Date** : 31-Jul-2026 **Admit Time** : 07:21 AM **UHID** : ANC-00002258

Patient Details :

Patient Name	: Mr A.TAMILANBAN	**Age**	: 21 Y 9 M 12 D
Guardian	: M.ARUL	**DOB**	: 19-10-2004
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: G1, 410, KG SIGNARU CIITY, ADAYALAMPATTU, MADURAVOYAL, CHENNAI Maduravoyal Tiruvallur Tamil Nadu INDIA 600095	**Phone No**	: 9884226213
		E-mail	: TAMILARUVI01@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 : M.ARUL **Relationship** : Father

Contact Address : G1, 410, KG SIGNARU CIITY, ADAYALAMPATTU, MADURAVOYAL, CHENNAI Maduravoyal Tiruvallur Tamil Nadu INDIA 600095 **Phone No** : 9884226213 / 9444275853

Signature

Doctor Details :

Doctor Name : Dr. NITHYA R **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : Rainbow Website **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:	**Mr A.TAMILANBAN**	**Age :**	**21 Y 9 M 12 D**
IP No:	**IP18-00036692**	**Sex:**	**Male**
Consultant:	**Dr. NITHYA R**	**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: M. Arvc

Relationship: FATHER

Date: 31/07/26 Time: 07:21 AM

Witness Name: R. Thangavel Shan

Witness Signature:

Patient Address:

G1, 410, KG SIGNARU CIITY,
ADAYALAMPATTU, MADURAVOYAL,
CHENNAI Maduravoyal Tiruvallur
Tamil Nadu INDIA 600095

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 : Mr A. TAMILARASAN	UHID Number : ARC-0000225 8
Self/Attendant Name : Mr ARUL	Relation : FATHER
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

k/c/o → Cerebral palsy
GDD.
Admitted for (R) EAC - cholesteatoma.

History of present illness :

k/c/o → Global developmental delay, seizure disorder from 1½ yr of Age on multiple AED

Now admitted for (R) EAC - cholesteatoma.
planned (R) ear Condoplasty

→ H/o → Recent (R) AOM, (R) Ear discharge
discharge to have (R) EAC cholesteatoma
planned for (R) EAC condoplasty

- No h/o fever/cough/cold
- last seizure 6 months back
- good drug compliance

- Morning dose of AED given at 8 am
- NPO from 9 pm.

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

CT/MRI brain → b/l diffuse cortical atrophy.

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

Admitted multiple times f seizure

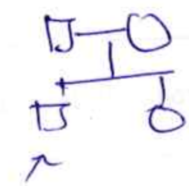
28/7/26 → Hb-14.2 PT-14.0
RBC-4.24 INR-1.0
Plt-1.6A. APTT-34
TC-9.18.

Operated for penile Hypospadias L G A in 2013.
b/l

Birth & Neonatal History:

1st child / c-section / B.W-1.3kg /
Late preterm / NICU stay x 28 days,
Suckling CIAB / On MV x 7 days
/ ? Cerebral edema

Family Chart



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

wheelchair dependent
Global developmental delay, GMFCS-V
Speaks incomplete word.

Immunization History :

upto Age.

Anthropometry :

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

Weight (kgs) 31.15 (Centile ______)

On Examination :

Temperature : 97.9°F Pulse Rate : 82/min B.P. ______ SPO2 100% RA

Resp.rate and type of breathing : 24/min

Microcephaly (P)

Rash Hyperpigment on Flexion contracture in
Elbow, legs both limbs

Lymphadenopathy

(R) Ear → Reddened

Oedema : granulation tissue (P)

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS (P)

Any addes sounds : B/L AE (E)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (P)

Any murmur : No mur.

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 : Alert, GCS-E4V4(?)bar/sem (?)

Cranial Nerves :

Motor System :

Nutriton :

Tone: ↑ in all 4 limbs Power best obtained > 3/5

Co-ordinator : Sparing (?)

Posture :

Involuntary Movements : Nil

ANC-00002258 IP18-00036692
Mr A. TAMILANBAN
P 19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

Reflexes .

DTR brisk

Plantars (R) Extn, (L) Neutral.

Superficials:

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:
Global developmental delay ? seizure disorder.
(R) EAC - cholesteatoma → planned for (R) MR candoplasty.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

IV Line
- RBS - 98 mg/dl

Planned Management

- NPO
- IVF
- Shift to OT as per schedule.

Signature of the Doctor:

Name of the Doctor: Dr. Manoraj

Date & Time: 31/7/26, 8 am

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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OPERATION NOTES

Surgeon : DR. Nithya. R	Asst. Surgeon :
Anesthetist : DR - Muthan / DR priyadharsini	OT Nurse : S/N. Gunadevi
Pre-Operative Diagnosis: (R) EAC Cholesteatoma	
Surgical Procedure : (R) Canaloplasty U/GA	
Weight : 31.1 kg / Date : 31/07/26	Start Time : 10:50 AM / End Time : 2:00 PM
Post Operative Diagnosis: (R) EAC Cholesteatoma with [illegible] erosion	
Peri-Operative Complications:	
Operation Notes: — Ch	
Findings: - Canaloplasty done	
Procedure Notes: — Cholesteatoma lining the EAC [illegible] the inferior wall [illegible] below [illegible] Exposing [illegible] facial nerve.	
Amount of Blood Loss: < 1 ml	Blood Transfused (in ML) —
Name and Number of Surgical Specimen sent for examination: HPE	

Doc. No. : RCH / FRM / CLINICAL / 099

(P.T.O.)

Patient Sticker

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN (M)
19-10-2004 21 Y 9 M 12 D
Dr. NITHYA R

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POST-[illegible] FORM

Post-Operative Monitoring Parameters /Frequency: vitals monitoring interval for 8 hours
Wound Care: –
Drain /Special Lines/Catheters: –
Special Patient Positioning and Requirements: Left lateral position
Nutritional Instructions: NPO till fully awake - water, soft diet
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: NITHYA R

Signature of the Surgeon: [signature]

Date & Time: 31/7/26 2:00pm

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/7/20	POST OP ORDERS	
	(1) INJ AUGMENTIN 700 mg IV Q8H	
	(2) INJ PAN 40 mg IV OD	
	(3) INJ DEXA 4 mg IV Q8H	
	(4) INJ PARACETAMOL 500 mg IV Q6H	
	(5) SYP ~~SINAREST~~ TMINIC 5ml - 0 - 5ml	
	NID 1h 6012	
31/7/20 5PM	S/B - Dr Yuvaraj	
	Child c K/c/o Cerebral Palsy, GDD,	
	underwent (R) EAC - Choleatoplasty under GA.	
	had episode of ? seizures @ OT post procedure	
	for few mins - ? Absence seizure	

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CNS - base line sensorium	⊕
	voutabl.	
	no seizures	
	CVS - S1S2 no murmur.	
	PA - Soft, non tender.	
	RS - Clear, Conducted sounds ⊕.	
	Advs	
	- continue medication as charted.	
	- watch for seizure.	
		TDY.

Patient Sticker

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RESULT SHEET

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

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Docu.

ANC-00002258 IP18-00036692
Mr A. TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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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: (420)

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. ENCORATE	7.5ml	P/o	BD	31/7/26 8am	☑C ☐DC
2	T. LEVIPIL	250g	P/o	1/2 BD	31/7/26 8am	☑C ☐DC
3	T-FRISIUM	5g	P/o	BD	31/7/26 8am	☑C ☐DC
4	T-LAMITOR	11/2 —0 — 2		BD	31/7/26 8am	☑C ☐DC
5	T. BENAPON	40g	P/o	OD	30/7/26 9pm	☑C ☐DC
6	T-JUSDET	1000 IU	P/o	OD	30/7/26. 9pm	☑C ☐DC
7	T-METHYL COBALAMINE	500g		P/o OD	30/7/26 1pm	☑C ☐DC
8	T. FOLATE	5g	P/o	OD	30/7/26 1pm	☑C ☐DC
9	Syp. TONOFERON	5ml	P/o	OD	30/7/26. 1pm	☑C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [signature] Dr. Manoven

Date & Time: 31/7/26, 8am

Nurse Name & Signature: J. [signature]

Date & Time: 31/7/26 @ 8am

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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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: 420 Shifted to: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: Jalaj/020685

Date & Time : 31/7/26 @ 10am

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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DRUG CHART

Date of Admission: 31-7-26. Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

REGULAR PRESCRIPTIONS

Weight. 31.2kg Ward. .....

DRUG : Syp ENCORATE

Dose	Route	Frequency	Start Date
7.5ml	P/o	BD	31/7

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	31/7/18
9am	✓
9pm	PSD ✓

DRUG : T. LEVIPIL

Dose	Route	Frequency	Start Date
250mg	P/o	BD	31/7

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	31/7/18
9am	✓
9pm	Wtl

DRUG : T. FRISIUM

Dose	Route	Frequency	Start Date
5mg	PO	BD	31/7

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	31/7/18
9am	✓
9pm	PSA ✓

DRUG : T. LAMITOR

Dose	Route	Frequency	Start Date
	P/O	BD	31/7

Name & Signature of the Doctor Starting the Drugs: TY

Additional Instructions: 1½ - 0 - 2

Daily Doctor's Endorsement by a Sign

Date / Time	31/7/18
9am	✓
9pm	PSA ✓

Patient Sticker

Weight. 31.2kg Ward. .....

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
31/7	11.15am	INJ AUGMENTIN	900mg	IV	RA 1546	
31/7	12.55pm	INJ DEXA	3mg	IV	RA 1546	
31/7	1.30pm	INJ PARACIP	900mg	IV	RA 1546	
31/7	3.45pm	INJ LEVIPIL	500mg	IV	RA 1546	

ANC-00002258
Mr A.TAMILANBAN IP18-00036692
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

I.V. FLUIDS CHART

Weight. 31.2 kg Ward. ....

Date	Time	Composition of IV 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
31/7/26	8:30 am	0.9 % DNS	IV	70 ml/hr	[illegible]	[illegible]	31/7/26		[illegible]
31/7	10.50am - 2pm	700 ml RL	IV	over 2.5 hrs	[illegible]	[illegible]	31/7	[illegible]	[illegible]

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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REGULAR PRESCRIPTIONS

Sheet No: ..... Weight ..... Ward .....

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

DRUG : T. BENADON

Dose	Route	Frequency	Start Dt.
40mg	P/O	OD	31/7

Date/Time: 31/7/18 — 10am NG

Name & Signature of the Doctor Starting the Drugs: TY

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T. JUSDEE

Dose	Route	Frequency	Start Dt.
1000 IU	P/O	OD	31/7

Date/Time: 31/7/18 — 2pm NG

Name & Signature of the Doctor Starting the Drugs: TY

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T. METHYL COBALAMINE

Dose	Route	Frequency	Start Dt.
500mg	P/O	OD	31/7

Date/Time: 31/7/18 — 2pm NG

Name & Signature of the Doctor Starting the Drugs: TY

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Syp TONOFERON

Dose	Route	Frequency	Start Dt.
5ml	P/O	OD	31/7

Date/Time: 31/7/18 — 10 AM NG

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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REGULAR PRESCRIPTIONS

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

DRUG : Inj. AUGMENTIN

Dose	Route	Frequency	Start Dt.
100mg	IV	QID	31/7

Name & Signature of the Doctor Starting the Drugs: T-Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	31/7	1/8
11 Am		
7 pm	CS SA	
3 Am		

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	OD	31/7

Name & Signature of the Doctor Starting the Drugs: T-Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	31/7	1/8
6 Am	bm CS SA	PSA RS

DRUG : Inj DEXAMETHASONE

Dose	Route	Frequency	Start Dt.
4mg	IV	QID	31/7

Name & Signature of the Doctor Starting the Drugs: RJ

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	31/7	1/8
6 Am		PSA RS
2 pm		
10 pm	PSA RS	

DRUG : Inj PARACETAMOL

Dose	Route	Frequency	Start Dt.
500mg	IV	QID	31/7

Name & Signature of the Doctor Starting the Drugs: RJ

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	31/7	1/8
8 Am		SA
2 pm		
8 pm	PSA RS	
2 Am		SA

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

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REGULAR PRESCRIPTIONS

Weight .... Ward ....

Sheet No: ....

DRUG : Syp T-MINIC

Dose	Route	Frequency	Start Dt.
7ml	P/o	BD	31/7

Date / Time: 31/7/18 — 8 Am [illegible]; 8 Pm [illegible]

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

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19-10-2004
Dr. NITHYA R

M / CLINICAL / 127

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 31/7

Time	9am	11am	1pm	3pm	4pm	8pm	12am	4am
Doctor / Nurse / Family Concern?								
Temperature (°F)	97.5F	98°F	98°F	98°F	98°F	98F	98.2F	98.1F
Heart Rate (bpm) and Blood Pressure (mmHg) *	102/75	100/70	100/70	100/70	100/72	110/60	101/73	105/73
Heart Rate (Number)	88 b/mt	88 b/m	88 b/m	88 b/m	82 b/m	84 b/mt	78 b/mt	80 b/m
Resp. Rate (bpm) (Over 1 Minute) / Resp Rate (Number)	18 b/mt	18 b/m	18 b/m	18 b/m	18 b/m	20 b/mt	22 b/mt	22 b/m
Resp Distress: Mod/Severe / None/Mild	✓	✓	✓		✓	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	99%	99%	99%	100%	96%	100%	99%
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓	✓	✓	
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0
Observer's Initials	VB	V	V	V				

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge nurse to be informed and continue hourly observations... 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.

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 1

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

31/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	→ child	received	from	ER.	to	4th	Floor			0	Baby
	09:00 am		NT DNS 70ml							✓	0	Baby
	10:00 am		70ml									
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :				140ml		Total Output :				1 time urine passed		
	02:00 pm									✓	0	Amma
	03:00 pm			RL 700ml							0	
	04:00 pm									✓	0	
	05:00 pm	N		60ml						✓	0	
	06:00 pm	P		60ml						✓	0	
	07:00 pm	O		60ml								
Total Intake :				180ml		Total Output :				4 times urine passed		
	08:00 pm	Ajo	30ml	60ml						✓	0	RF
	09:00 pm	Dan	10ml	60ml							0	RF
	10:00 pm	Hea	20ml	60ml						✓	0	RF
	11:00 pm			60ml						✓	0	RF
	12:00 am			DC							0	RF
	01:00 am			DC						✓	0	RF
Total Intake :		60ml +		240ml		Total Output :				4 time urine passed		
	02:00 am									✓	0	RF
	03:00 am										0	RF
	04:00 am									✓	0	RF
	05:00 am										0	RF
	06:00 am									✓	0	RF
	07:00 am	Ajo										
Total Intake :		40ml				Total Output :				4 time urine passed		

Total 24 hrs. Intake	760ml

Total 24 hrs. Output	13 time urine passed

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes	
31/7/26	8.50am	The child received from ER to 4th floor. Child details handing over taken from ER staff. Child is conscious. IV line present & patency.	
		IVF NS 50ml - 7ml/hr on flow	Balaji/staff
	9am	Vital Signs checked & Recorded	
		Vitals are stable	
		CP | PP | CRT ↓ | ↓ | <3sec	
		Plan: (R) Ear Canuloplasty	
		Child is on NPO →	Balaji/staff
	10am	Child shifted to OT →	Balaji/staff
		OT Notes	
31/7/26	10Am.	patient hand over taken from 4th FLOOR staff. while receiving the patient is conscious & oriented. Vitals checked & recorded pulse: 88bpm, BP=100/70mmHg	
	10:50Am	Temp: (N), SpO2 = 100%, R = 18b/m	
	10:55Am	General Anaesthesia given by	
	11:15Am	DR. mohan. Antibiotic prophylaxis	
		Inj: Augmentin 600mg at 11:15Am	
	11:25Am	procedure started by DR. Nithya	
		procedure went on well. vitals	
		on monitory. procedure	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
31/7/26		done. Cranial count inserted Skin closed. patient shifted from OT to OT recovery at 2:00pm. patient had vomiting sensation. patient getting sleep.	
	3:45pm	Inj: Leripil 500mg given patient awake. CBG = 96. because Dr Nutan advised to started DNS = 50ml/hr. patient shifted to 4th Floor.	
	4:00pm	(1) small cotton ball present in the surgical site. Tomorrow to be dressing & remove the cotton ball ordered by DR. Nithya DR. Nithya will do the dressing. patient shifted to 4th FLOOR. patient	
	5pm	documents & details handover given to 4th Floor staff	
		Receiving Notes on 31/7/26	
	5pm	The child received from the OT staffs.	
		The child is consious and active	
		vitals are checked and recorded	
		temp is normal	PP ++ / CP ++ / CRT <2s
	6pm	Administer the medication as prescribed	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
31/7	9am	Treatment & care	Explain about treatment and care.	Father	No	Oral	None	Verbalizes understanding	good	Backup

Part - III: CODES

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

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

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

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
31/7/26	8:35 am	98 mg/dl	-	

Docu. No. : RCH /FRM / CLINICAL / 185

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19-10-2004
Dr. NITHYA R

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PRE - OPERATIVE CHECK LIST

Date: 31/07/26

Patient's Name : TAMILANBAN Age : 21 yrs Gender : ☑ M ☐ F

Blood Group : UHID : ANC - 2258

Planned Surgery : EAR CANALPLASTY Surgeon : DR. NITHYA

Anesthetist : DR. ASHWINI Date & Time of Operation : 31/07/26 @ 10:30am

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	☐	☑	☐
6.	Remove all ornaments, etc and sterile gown given	☑	☐	☐
7.	Is Blood arranged as required?	☑	☐	☐
8.	If Blood has been ordered - is Blood bag ready?	☑	☐	☐
9.	IV Cannula to be placed / IV fluids if Indicated	☑	☐	☐
10.	Pre Anesthetic consultation with anesthesiologist	☐	☑	☐
11.	Pre Medications Given? (Sedatives / etc)	☑	☐	☐
12.	Skin Preparation	☑	☐	☐
13.	Site is marked	☑	☐	☐
14.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☑	☐	☐
15.	Implants are available	☐	☑	☐
16.	Equipment is available			
	Other (if any)			

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

Billing Clearance taken Nurse In-Charge Name : NITH

Billing Executive Name : Delli babu. C Signature of Nurse In-Charge :

Billing Executive Signature : Date & Time : 31/07/26 @ 10.0am

Date & Time : 31/07/26 @ 9:16am

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

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mr. Tamilanban Age: 21 Sex: M UHID.No :

Date: 28/7/26 Time: 12.10 pm Proposed Operation: (R) ear canaloplasty

Diagnosis: (R) ear cholesteatoma

B.P / CRT: H.R: Weight: 31 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: O+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies: —

Medical History: CVS : K/c/o cerebral palsy

RESP : Diabetes :

CNS : H/o seizures x 1 year on Rt. last episode 6 months back.

Renal :

Hepatic / GE : Physical Activity: wheel chair bound.

Others : Multiple hospital admissions for seizures (+).

Past Anaesthetic History: H/o proximal penile hypospadias repair & GA in 2018, V/E

Physical Exam: B/L vasectomy for epididymo orchitis in 2018, V/E

Airway: MP 1 2 3 4 could not be assessed. Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : B/L AE (+)

Heart: S1S2 (+)

CNS:

LSCS, 1st child, B.W - 900 gms, 28 days of NICU admission, pre term, phototherapy given for neonatal jaundice vaccinated till date. Global developmental delay.

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

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

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

CURRENT MEDICATIONS	DOSAGE
T. Levipil	250mg.
T. Frisium	5mg.
T. Lamitor	50mg.

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:
   - To continue antiepileptics on the day of OT
   - To do CBC, PT, PTT, INR

Signature: Name: Dr Priyadharshini.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No			Fasting Status: 7 hrs
Physical Status:	Patient Identified ✓	☐ Consent Present	☐ Chart Reviewed

H.R: 74/min	B.P / CRT: 70/40	SpO_2: 100	R.R: 16/min	Last Feed:	
Pre-OP Diagnosis: (R) ear cholesteatoma	Operation: (R) canaloplasty	Date: 31/7			
Surgeon: Dr Nidhya	Anaesthesiologist: Dr Mohan / Dr Priya	Technician: Mr Divin			

TIME: 10.50am | 11.50am | 12.50pm | 1.50pm | 2pm

N₂O /AIR /O₂ LPM: 50% FiO2

HALO /SO /SEVO

Drugs:

Inj Propofol 50mg IV F/b 100mg/hr IV infusion
Inj Fentanyl 50mcg IV
Inj Atracurium 15mg IV
Inj Dexmedetomidine 10 mcg IV F/b 6mg/hr IV infusion
Inj Paracetamol 900mg IV
Inj Neostigmine 2.5mg IV
Inj Glycopyrrolate 2mL IV

Inj Augmentin 900mg IV

Antibiotic
Suppository
Blood Loss
NOTES

FiO₂ / SaO₂: 0.5
ETCO₂: 35-38
ECG: sinus rhythm (bradycardia)
Temperature
Urine Output

Fluids: IOR + 200ml RL
Blood

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: supine
☐ Pressure Points Checked

Eye Care:
- ☐ Oint.
- ☑ Tape
- ☐ Padding
- ☐ Awake

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

Times:
Anaes Start: 10.50am
OP Start: 11.35am
OP End:
Leave OR:

Anaesthesia:
- ☑ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP:
- ☐ ART:
- ☐ IV: 22 Gr (L) UL.
- ☐ IV
- ☐ IV

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

- ☐ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
- ETT: 6.5 at 20 cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug: 4% lignocaine spray

- ☐ Awake ☑ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade#: 3 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
☐ PICU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr Priya
Signature of the Doctor:
15/6/22

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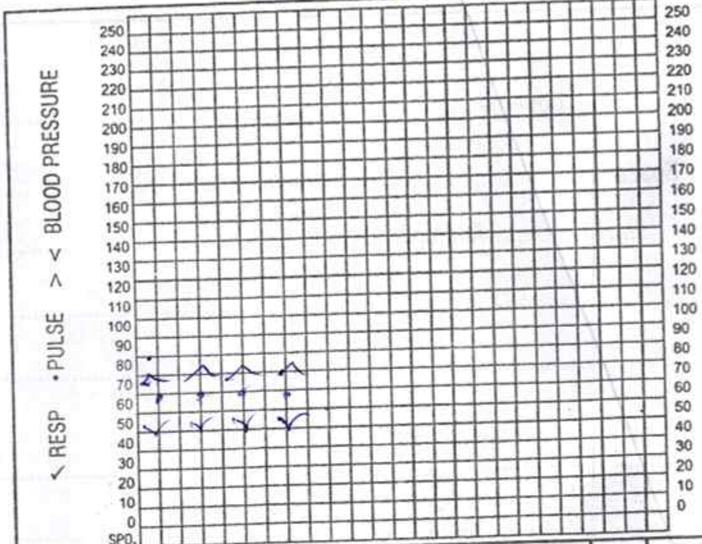
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : S/N Sangeetha Time Received : 3:30pm Time Discharged : 5:00pm.



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
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
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

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
31/7	2pm	0/10	NPO x @ hours till 10 Pm	[signature] 154622
			IVF [illegible] @ 50ml/hr	
			Monitor vitals.	
			T. Paracetamol (Powder form) 500mg TDS.	

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

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

Anaesthesiologist Name : Dr Pooja
Anaesthesiologist Signature: [signature] 154622
Date & Time: 31/7/26 2pm.

PACU Nurse Name : S/N. Sangeetha
PACU Nurse Signature: [signature] 020337
Date & Time: 31/7/26 at 3:30pm

Transferred to Unit by (PACU): S/N Sangeetha 020337
Date & Time: 31/7/26 at 5:00pm.

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PRO

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BY RAINBOW HOSPITALS
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ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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

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

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

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

Right Canaloplasty +/- mastoid Exploration + Meatoplasty upon ....
(Name of the Patient)

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

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

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

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

Bleeding, Infection

My signature on this form indicates that

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

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

Consentee :

Signature : ....

Name : ....

Date & Time : ....

Witness :

Signature : [signature]

Name : Sr. Sangeetha

Date & Time : 31/7/26 at 10:32 Am

Patient Attendant :

Signature : [signature]

Name : M. Arun

Relationship with Patient: Father

Date & Time : 31/7/26 at 10:30 Am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr Nithya R

Date & Time : 31/7/26 10:30 am

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

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

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

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

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

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

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

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

.....

.....

.....

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

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

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

ANC-00002258 IP18-00036692
Mr A. TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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SSI PREVENTION CHECKLIST

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer: 31/7/26 @ 10am	420 YES/NO	TRANSFERRED TO: OT REMARKS
1	**Patient Identification**	Yes.	
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes'	
	b.Surgical procedure & correct site verified		
2	**Airway & Breathing**	No	
	a.Oxygen delivery (mask/cannula/ventilator) secured	yes	
	b.SpO₂ within safe range	No	
	c.If ETT: position confirmed, ties secure, cuff inflated	yes	
3	**Circulation & Hemodynamic Stability**	yes	
	a.IV lines secured & infusion running correctly	No	
	b.No active uncontrolled bleeding	yes	
	c.Last vitals recorded before transfer	No	
	d.Central line hubs are closed	NO	
	e.Dressing Intact		
4	**Pain Assessment**	NO	
	a.Pain score assessed & analgesia given	NO.	
	b.Reassessment done		
5	**Wound, Dressings & Drains**	NO	
	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		
6	**Medications Pre & Post-Op Orders**	yes.	
	a.Medications due time noted	yes	
	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	NO.	
	c.Pressure areas protected (heels/elbows)	~~No~~	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	yes	
10	**REPORTS AND LABS HANDED OVER**	Na	
11	**BIOPSY/HPE SENT**		
12	**Documentation**	Yes	
	a.Documentation completeness		
	Transferring Nurse: [signature]		
	Receiving Nurse : [signature]		
	Signature of Incharge: [signature]		

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

SAFETY CHECKLIST

Surgeon : DR. Nithya. R
Asst. Surgeon : +
Anaesthetist : DR. mohan / DR. Anju
Scrub Nurse : SN. Amaradevi

Patient Name : Mr. A. Tamilanban Age : 21 Y Gender : M
UHID No. : 02258 Surgery Name : Rt. Tonsilectomy
Date : 31/07/26 In-time : 10:50 AM Out-time : 5:00 PM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:55 AM

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

Site Marked ☑ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : .....
Name : DR. mohan

Before Skin Incision ➤➤

TIME OUT Time: 11:25 AM

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

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

Anticipated Critical Events

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

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

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

Signature : .....
Name : DR. Nithya. R

6 Type ISO 11140 — STEAM — Green = Sterilized — SV: 121°C - 15 min. 134°C - 3,5 min. — Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 — Sterintech

Before Patient Leaves Operating Room

SIGN OUT Time: .....

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

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

Signature : .....
Name : SN. Amaradevi

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: (R) EAV Cholesteatoma

Arrival Time: 6:50am Mode of Arrival: Wheelchair Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 31.1 Kg

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

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Multiple admission for seizure	-	

Family History: .....

.....

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

If yes please list, ...

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

.....

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

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

Observations: Weight: 31.1kg. Length: ..... Head Circumference (< 2 years): .....

Temp.: 97.5°F HR: 88 b/mt RR: 18 b/mt BP: 102/75 mm Hg

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 22) (Document in the Braden Q Assessment Sheet)

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

Character of Pain - Location - Frequency - Duration -

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to Mother

Nurse's Name: Balapriyanga Date: 31/7/26 Time: 9am Signature

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

NPO 9.30pm-S
5.45AM-SL

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EMERGENCY ROOM TRIAGE FORM

wt - 31.1kg

Patient's Name : Mr. Tamilan Ban Age : 21Y Gender: ☐ Male ☐ Female

Date : 31/7/26 Time of Arrival : 7.15AM

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.9°F PR: 82 BP: - RR: 24 SpO_2: 100

Chief Complaints: Come for procedure (R) canaloplasty. / cold (+)

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 : 2min

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Iman

Signature of Triage Nurse : .....

Date & Time : 31/7/26 @ 7.20AM

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

ANC-00002258 IP18-00036692
Mr A. TAMILANBAN
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 31/7/26 Time of arrival : 7:10 AM

Chief Complaints: Plan for Procedure (R) ear canaloplasty RBS: 98 mg/dl

Height : – Weight : 31.2 kg BMI : – Head Circumference (<2 years) –

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

If yes , identify –

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

☐ Character – ☐ Location – ☐ Frequency – ☐ Duration –

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☐ No
Ambulatory Aids:		
• Wheelchair	☑ Yes	☐ No
• Uses furniture for support	☐ Yes	☐ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☐ No
• Weak	☐ Yes	☐ No
• Impaired	☑ Yes	☐ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

–

–

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: YES (Date/Time): –

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 7:15 AM

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

Time	Nursing Notes
7:30am	Pts came for ER C/O Plan for Procedure
	(R) eag. Canaloplasty.
	Vital Sigs @ Checked & recorde.
	S/b Dr. Mahalakshmi Inform to Dr. Nithya.
	Adviced for Admission. IV line
	Placement done. OP Basic Blood Samples
	collected ~~Report~~ Report. Pts Shift to Ward.
	OP File given to parents.

Samples collected by: / Time: /

Samples sent by : / Time: /

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 82 b/M BP: 107/67 (72) CFT: <1sec	Shift - out from ER to: .....
RR: 26 b/M SPO_2 : 100 %	Time of Shift - out: .....
GCS: 13/15 Temperature : 97.9°F	Handover given to: .....
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

.....

Name of the Nurse : M. Jyothi Signature of the Nurse : .....

Date & Time : 31/7/26 @ 7:15 AM

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Nithya Date : 21/7/26

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

Start Time of Assessment: ...... Weight: 31 kg

Allergic History: ......

Chief Complaints:

Ⓡ EAC - cholesteatoma
planned for Ⓡ Ex canaloplasty.

Pediatric Assessment Triangle

A Appearance - TICLS Ⓝ

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

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

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ......

Significant Past History: ......

Medication History: ......

Relevant Investigations: ......

Primary Assessment

Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ......

Breathing

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

Rhythm: ......

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: ......

Palpation Findings (If necessary) ......

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ......

Circulation

HR: ....

CFT
- Central ....
- Peripheral ....

Any urgent interventions needed: ☐ Yes ☐ ~~No~~

If Yes ....

BP: .... mmHg

Pulse Volume:
- Central ....
- Peripheral ....

If in Shock:
- Compensated ....
- Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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.: ....

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: ....

Attached

Treatment Planned: ....

Attached

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. Marwa

Signature: [signature]

Date & Time: 31.7.20, 8 a.

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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PATIENT TRANSFER FORM

ANC-00002258 IP18-00036692
Mr A. TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

	Date & Time of Admission	Date & Time of Transfer Order
	31/7/26 @: 7:21AM	31/7/26 @: 8:50 am
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Nithya	Dr. Manonmani	Futher management
From Unit	To Unit	Information to Attendant
ER	(420)	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
(10)	Nil	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐
GDD c seizure disorder, (E) EAC cholesteatoma

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
J. Queen Mary. Ajith	Dr. Manonmani

Patient & Clinical Records Received by : Balu / 0685 31/7/26 @ 8.50am

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

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PATIENT TRANSFER FORM

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

	Date & Time of Admission	Date & Time of Transfer Order
	31/7/26 @ 7.21am	31/7/26 @ 10am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Nithya.	Dr Yuvaraj.	For procedure.
From Unit	**To Unit**	**Information to Attendant**
420	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	CT Screening (R)	(1).
2.	IP file	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Balaji/020688 31/7/26@ 10am.	

Patient & Clinical Records Received by : 020330

Date & Time of Patient Received : 31/7/26 at 10 AM.

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 31/07/26 at From: OT TRANSFERRED TO: 4th Floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b.SpO_2 within safe range	Yes	102 %
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	Yes	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	Yes	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	Yes	
	b.All drains fixed, output noted		
	c.Catheter secure & urine output recorded		
	d.Splints/casts/traction devices stabilized		
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	Yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	Yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NA	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	Yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	Yes	
11	**BIOPSY/HPE SENT**		
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse:		
	Receiving Nurse :		
	Signature of Incharge:		

RCH/GDY/FRM/CLINICAL/598

CONSENT FORM FOR ANAESTHESIA

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ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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 : ..... Date & Time : .....

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

PATIENT TRANSFER FORM

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ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

Date & Time of Admission	Date & Time of Transfer Order
31/7/26 at 7:21Am.	31/7/26 at 5:00Pm.

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
DR. Nithya. R.	DR. Mohan.	Farther management

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

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

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SIN. Sangeetha 020328	DR. Mohan

Patient & Clinical Records Received by : 01560 31/7/26

Date & Time of Patient Received : 5:12

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

ANC-00002258 IP18-00036692
Mr A.TAMILANBAN
19-10-2004 21 Y 9 M 12 D (M)
Dr. NITHYA R

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ AUGMENTIN	900mg	IV	stat	31/7/26 11.15am	☐C ☐DC
2	INJ DEXAMETHASONE	3mg	IV	stat	31/7/26 12.50pm	☐C ☐DC
3	INJ PARACETAMOL	900mg	IV	stat	31/7/26 1.30pm	☐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 Renja

Date & Time : 31/7/26 at 1:30pm

Nurse Name & Signature: Sr. Sangeetha

Date & Time : 31/07/26 at at 1:30pm