GUC-00094001 IP18-00036516
Ms SAMRTHA
16-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

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 : 18/7/26

Patient Name: Ms. Samrtha Date of Birth: 16-03-2018 Age: 8yr

Gender: F Ward : OT UHID No.: 94001/26516

Date of Surgery: 18/7/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (R) Great toe debrement Nail bed Repair & Nail plate repositioning

Time in : 8:20pm Time Out : 9:05pm

	NAME	AMOUNT
1. Surgeon	Dr. Sai Suchithra	
2. Anaesthetist	Dr. Mohan	
3. Assistant Surgeon	-	
4. OT Technician	Mr. Raja	
5. Circulating Nurse	S/n Sujatha	
6. Assistant Nurse	S/n Sundari	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Record Finalized done

Signature of the Surgeon (83742)

Signature of Circulating Nurse

Order No: Order by:

Ortho

Patient Sticker

Rainbow Children's Hospital
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CONSUMABLES OF OT

Circulating staff : C/u Sugatha Technician : Mr. Raja Date : 18/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used
ET tube		
LMA		
ECG leads : A / P / N		3
HME filter : A / P / N		
Syringes : 10 cc		4
05 cc		3
02 cc		2
01 cc		1
Cautery plate : A / P / N		
IV set		1
RL		1
NS : 10ml / 100ml / 500ml / 1000ml		1/1
Fentanyl		1
Morphine		
Ketamine		
Propofol		1
Rocuronium		
Glycopyrolate		
Myopyrolate		
Ondansetron		
Pencan 25g/ Spinal Needle 22		
Bupivacaine 0.25%		
Bupivacaine 0.25%(Heavy)		
Antibiotics		
Suppositories		
Anamol : 80mg / 250mg / 170 mg		
Supridol : 100mg		
Justin : 12.5 mg / 25mg / 100mg		
Tab. Misoprost : 200mg		

Surgical Disposables	Qty Issued	Qty Used
Major Pack Ortho Pack		1
Sutures 9915		2
Gloves (7) P.F		1
7.0 S.C		2
6.5 P.F		2
Surgical blade		
NG tube		
Cautery pencil		
Koochies 7.5 P.F		2
Ointments		
Suction Catheter		
Cap, Mask		
Gauze Pack		3+1
Mop Pack		
Steristrip		2
Underpad		
Draw sheet		
Abgel		
Foleys catheter		
Urobag		
Chest Drainage Catheter		
Romodrain bag		
Bandage		
Tegaderm		
Ioban cutical 10x10		1
Double J Stent		
Vaccum Suction set		
Plastic Bed Sheet		
Betadine Solution		1
Microshield		
Cotton Balls		
Latex Gloves		5P
Ramdione Scrub		
Saral		

Disposables (Baby Side)	Qty Issued	Qty Used
Inj Vit.K		1
Cord Clamp		2
Suction Catheter		
Feeding Tube		
Vaccum Suction Set		
Surgical Gloves		
Gauze Pack		
Syringe 1ml / 2ml		
Surgical Blade # 20		
Koochies (S)		
Soft Roll 10cm		2
Elastamol 10cm		1
Articast 10cm		1
Dwater 10ml		6
Taxim 500mg		1
Taxim 250mcg		2
Justin		1
Ropin 0.2%		1
Needle 23 1½		1
~~Soft Roll 10cm~~		~~2~~
~~Elastmull 10cm~~		~~2~~

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : Ordered by :

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036516	**Ward**	4F-FOUR SHARING
Patient Name	Ms SAMRTHA	**Bed Name**	FSW 420
Age/Sex	8 Y 4 M 0 D / Female	**Order No**	18-0001729551
Date	18/07/2026 22:22	**Prescription No**	PRIP18-0627933
Payor	FAMILY HEALTH PLAN INSURANCE TPA LTD	**Dispensed Date**	18/07/2026 22:57
UHID	GUC-00094001		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	2603019005	03/29	2	128.00	256.00
2	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	1	128.00	128.00
3	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	4	100.00	400.00
4	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		2B26O326	01/30	1	21.01	21.01
5	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1D262046	03/29	1	94.55	94.55
6	SGLOVE # 7.0(SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26B5016M	01/31	2	91.00	182.00
7	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	2	205.00	410.00
8	VICRYL RAPIDE 5-0 9915W	ETHICON SUTURES-J&J	C1	0AW9173	07/30	2	885.00	1,770.00
						Total :	**1,652.56**	**3,261.56**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 18-07-2026 22:57

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	IP18-00036516	**Ward**	4F-FOUR SHARING
Patient Name	Ms SAMRTHA	**Bed Name**	FSW 420
Age/Sex	8 Y 4 M 0 D / Female	**Order No**	18-0001729557
Date	18/07/2026 22:54	**Prescription No**	PRIP18-0627930
Payor	FAMILY HEALTH PLAN INSURANCE TPA LTD	**Dispensed Date**	18/07/2026 22:55
UHID	GUC-00094001		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTIFLEX 10 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	26MA0O3	12/30	2	217.00	434.00
2	CUTICEL CLASSIC 10 X 10 (PARAFFIN)	Bbraun Medical PvtLtd	GENERAL	25CL046	09/29	1	58.00	58.00
3	ELASTOMULL 10 CMS	BSN MEDICAL		260712458	01/31	1	59.00	59.00
4	Encore Microptic gloves-6.5		H	2603019005	03/29	2	128.00	256.00
5	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	10	25.00	250.00
6	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
						Total :	**590.00**	**1,160.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 18-07-2026 22:55

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	IP18-00036516	**Ward**	4F-FOUR SHARING
Patient Name	Ms SAMRTHA	**Bed Name**	FSW 420
Age/Sex	8 Y 4 M 0 D / Female	**Order No**	18-0001729552
Date	18/07/2026 22:22	**Prescription No**	PRIP18-0627929
Payor	FAMILY HEALTH PLAN INSURANCE TPA LTD	**Dispensed Date**	18/07/2026 22:55
UHID	GUC-00094001		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	4	28.13	112.52
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	3	21.56	64.68
3	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	1	11.25	11.25
4	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
5	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	1	525.00	525.00
6	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	1	69.10	69.10
7	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
						Total :	**764.88**	**972.39**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036516	**Ward**	4F-FOUR SHARING
Patient Name	Ms SAMRTHA	**Bed Name**	FSW 420
Age/Sex	8 Y 4 M 0 D / Female	**Order No**	18-0001729558
Date	18/07/2026 22:54	**Prescription No**	PRIP18-0627931
Payor	FAMILY HEALTH PLAN INSURANCE TPA LTD	**Dispensed Date**	18/07/2026 22:56
UHID	GUC-00094001		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTICAST 10 CM 4"	BSN MEDICAL	GENERAL	25UAO16	06/28	1	1,889.00	1,889.00
						Total :	**1,889.00**	**1,889.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name

Printed Time : 18-07-2026 22:56

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	IP18-00036516	**Ward**	4F-FOUR SHARING
Patient Name	Ms SAMRTHA	**Bed Name**	FSW 420
Age/Sex	8 Y 4 M 0 D / Female	**Order No**	18-0001729556
Date	18/07/2026 22:54	**Prescription No**	PRIP18-0627928
Payor	FAMILY HEALTH PLAN INSURANCE TPA LTD	**Dispensed Date**	18/07/2026 22:54
UHID	GUC-00094001		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	6	2.58	15.48
2	JUSTIN INJ 75 MG 1 ML	Neon Laboratories Ltd	H	BDW19AIA	08/27	1	23.80	23.80
3	NEEDLE 23* 1 1 2	Dispovan		32544C	07/30	1	3.63	3.63
4	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435130	12/27	1	189.30	189.30
5	TAXIM INJ 250 MG	ALKEM LABORATORIES LTD.	H1	25462316	05/28	1	18.91	18.91
6	TAXIM INJ 500 MG	Alkem Laboratories Ltd.	H1	25180986	05/28	1	26.03	26.03
						Total :	**264.25**	**277.15**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Rainbow Children's Hospital
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PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Name of the Patient: .... GUC-00094001 Ms SAMRTHA IP18-00036516 18-03-2018 8 Y 4 M 1 D Dr. G SAI SUCHITRA (F)

UHID No: ....

Ward: ....

Date: ....

....

er: ....

n No: ....

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign

Date: ....

Time: ....

Nurse Sign

Date: ...Anitha...

Time: ....

Pharmacy Sign

Date: 19/7/26

Time: ....

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

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 1 D (F)
Dr. G SAI SUCHITRA

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		19/2/2018 @ 8.30 am					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... GUC-00094001 Ms SAMRTHA 18-03-2018 Dr. G SAI SUCHITRA 8Y4M0D (F) IP18-00036516 ..... Consultant: ..... Dept: .....

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/07/26	4pm	GR	420	
18/7	8pm	420	OT	
18/7/26		OT	4th Floor	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC	18/7/26	1729506	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/07/26	CBC, PT/APTT / INR	26023136	CK. [signature] 01101
	BT/CT		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/07/26	IV placement	(1)	1729423	CHO

ANY OTHER INFORMATION: OT

IN TIME: 8.20pm OUT TIME: 9.05am.

Procedure: (R) wound toe debridement, nail bed repair & nail plate repositing

Surgeon: Dr. Sai Sudhir

Anesthesia: Dr. Mohan.

Date: 18/7/26 Time: 8.30 am Prepared By: Sharmila 01957

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
01895			

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GUC-00094001
Ms SAMRTHA
18-03-2018
Dr. G SAI SUCHITRA
IP18-00036516
8 Y 4 M 1 D
(F)

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary		19/2/26 @ 8.30 am	Asha 15860		
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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 : IP18-00036516 **Admit Date** : 18-Jul-2026 **Admit Time** : 03:18 PM **UHID** : GUC-00094001

Patient Details :

Patient Name	: Ms SAMRTHA	**Age**	: 8 Y 4 M 0 D
Guardian	: NAGARAJAN	**DOB**	: 18-03-2018
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Saidapet Madras Chennai Tamil Nadu INDIA 600015	**Phone No**	: 7397071656
		E-mail	: n@Mm.m

Admission Details :

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

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

Contact Details :

Name : NAGARAJAN **Relationship** : Father

Contact Address : Saidapet Madras Chennai Tamil Nadu INDIA 600015 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. G SAI SUCHITRA **Specialisation** : ORTHOPEDICS

Referral Doctor : Self **Phone No** :

Co-Consultant

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

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:	**Ms SAMRTHA**	**Age :**	**8 Y 4 M 0 D**
IP No:	**IP18-00036516**	**Sex:**	**Female**
Consultant:	**Dr. G SAI SUCHITRA**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

Relationship: FATHER

Date: 18/7/26 Time: 03:18 PM

Witness Name: P. Thamarai Selvan

Witness Signature:

Patient Address:

Saidapet Madras Chennai Tamil Nadu
INDIA 600015

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 : MD. SAMRATH	UHID Number : 9400 1
Self Attendant Name : NAGARAJU	Relation : FATHER
Self Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Alleged H/o accidental fall of wooden chair on Rt (R) bigtoe & sustained injury of nailbed on 17/7/26 @ 7.30 pm at home.

Pt brought to ER, RCH.

X ray (R) foot → undisplaced # on lateral border of distal phalanx of 1st toe.

Patient Sticker

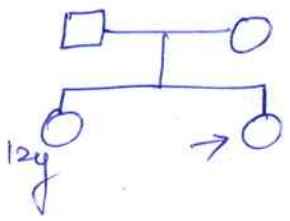
Past History : (Including details of any previous investigation or treatment)

No H/o previous admission / surgery

Birth & Neonatal History:

Term, BW – 3.2 kg, CIAB, No H/o NICU admission

Family Chart



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

(N)

Immunization History :

MMR 3 pending

Anthropometry :

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

Weight (kgs) 22 (Centile _____)

On Examination :

Temperature : 97.8 F Pulse Rate : 102 B.P. 103/66 SPO2 100

Resp.rate and type of breathing : 26

(R) big toe nail avulsed from nail bed + linear laceration @ at tip of big toe + discolouration @ toe tip +

Rash –

Lymphadenopathy –

Oedema : –

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : N

Air entry & breath sounds : B/L AE +

Any addes sounds : –

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

Cardiovascular System :

Inspection of procordium : N

Heart Sounds : S1, S2 +

Any murmur : –

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

Per Abdomen :

Inspection : N

Palpation : Soft, NO OM

Ausculation : BS +

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves : N

Motor System :

Nutriton : N

Tone: N Power N

Co-ordinator :

Posture : N

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars N

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic:

Nail avulsion of ® big toe c # of distal phalanx of ® big toe

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
BT | CT
PT | APTT | INR

Planned Management

- NPO for solids (liquids till 5pm)
- Nail bed repair @ 8.30pm
- IVF

Signature of the Doctor:

Name of the Doctor: Keerthana. D

Date & Time: 18/7/26 3.30 pm

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In: Remarks

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

Docu. No. : RCH /FRM / CLINIC...

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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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.,) : .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ 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						☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [signature]

Date & Time: 18/7/26 3.30pm

Nurse Name & Signature: C/C. Akshaya Prith / C/C. [signature]

Date & Time: 18/07/26 @ 3.30pm

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

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DRUG CHART

Date of Admission: 18/07/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7/26	8.20pm	Inj. Taxim	1gm Inj.	iv	[illegible]	PS / S/O
18/7/26	8.40pm	Inj. Insulin	32.5g iv Inj.		[illegible]	PS / SJ

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

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I.V. FLUIDS CHART

Weight. 22kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/7	5pm	IVF - 0.9% INS	IV	60					
18/7/18	8.20P	350ml RL	IV			PS SN			PS SN

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

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18-03-2018 8 Y 4 M 0 D (F)
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No. : RCH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/11/26 Time:	4pm	9pm	12am	4am
Doctor / Nurse / Family Concern?				
Temperature (°F)	97.8°F	98°F	96.2°F	97.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	110/60 (92)	100/60	98/59 (69)	106/60 (67)
Note: BP does not score in early warning scoring				
Heart Rate (Number)	100bl/mt	100bl/mt	102bl/mt	100bl/mt
Resp. Rate (bpm) (Over 1 Minute) *	22	22	26	26
Resp Rate (Number)	22bl/mt	22bl/mt	26bl/mt	26bl/mt
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	99%	99%	98%	98%
Conscious Level: Normal / Altered	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	JH	PS	Q	Q

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
18/7/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm	→ on admission				@ 4pm						
	05:00 pm	M		60ml							0	Jeey
	06:00 pm	B		60ml							0	dey
	07:00 pm			60ml						✓	0	dey
Total Intake :				120ml		Total Output :						
	08:00 pm										0	NKS
	09:00 pm									✓	0	
	10:00 pm		RT	350ml							0	R
	11:00 pm	water	50ml								0	
	12:00 am									✓	0	NKS
	01:00 am	water	100ml								0	NKS
Total Intake :		150ml				Total Output :						
	02:00 am	water	250ml							✓	0	NKS
	03:00 am										0	NKS
	04:00 am	water	100ml								0	NKS
	05:00 am										0	NKS
	06:00 am	water	200ml							✓	0	NKS
	07:00 am										0	NKS
Total Intake :		550ml				Total Output :						

Total 24 hrs. Intake	880ml

Total 24 hrs. Output	8 time urine passed

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

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	4pm	Rechived notes :-	
		child rechived from	
		ER to 4th floor. child	
		consious & oriented. child	
		activity are good IV line ⊕	
		no swelling & pain.	
		come for nail bed repair.	
		vital signs checked & Recorded	
		vitals are stable now	Jaey
		CP ++ | PP ++ | CRT 2sec.	Roodya.
		NIF- DNS 60ml/hr.	
	7pm	I/O chart maintained.	
	8pm	Handing over given to OT	
		SIN.	Jaey Roodya.
		OT Notes on 18/7/26	
18/7/26	8.20	Child details handover taken from	Sud
		SIN while receiving child conscious	O(157)
		& oriented v/s are ok consent	
		obtained Billing cleared. OT gown	
		changed child shifted to OT-2	
		at 8:20 pm on the OT table	
		to connect the Cardiac monitor	
		v/s are connected IV + connect	
		& GA was given Antibiotic was	
		given proced. Started at 8.35 pm	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094001 IP18-00036516
Ms SAMRTHA 8Y4M1D (F)
18-03-2018
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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		(R) great toe dipredment i nail bed	
		Repair & nail plate reposition	
		during the proced there is no	
		any compl. ... cath Flow v/s	
		are monitored after the proced	
		was done after child ...	
		Child Shifted to post OP	
		area with monitor PR-120b/m	
	10:30	SpO2-99% after Shifted to 4th	
		Floor. handover to 4th s/n	[signature] 01757
		← Receiving Notes →	
18/7.	10.30pm	The child defaults receiving	
		from OT to 4th floor. the	
		child is conscious and oriented.	
		Iv line present. no pain, no	[signature] 01580
		swelling. Iv line pattern.	
	12Am.	Vital signs are checked and	
		recorded vital are stable.	
		IP / PP / CRT — ++ / ++ / <3sec	[signature] 01580
	2Am	child sleeping well. no other	
		complains of ~~pain~~, vomiting.	[signature] 01580
	4AM	vital signs are checked and	
		recorded. vital are stable	
		IP / PP / CRT — ++ / ++ / <3sec	[signature] 01580

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name: ....

MRD NO: GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

Age :........ Sex: ☐ M ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 18/07/26 Time: 3:45pm

Location : (L) median(?)

Size : 22G

Cannula inserted by : S/N. Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
18/7/26	3:45pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8Pm.	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10Pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
19/[illegible]	12Am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2Am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4Am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6Am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes-date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

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

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

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

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Ms SAMRTHA IP18-00036516
18-03-2018 8 Y 4 M 0 D
Dr. G SAI SUCHITRA (F)

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: tamil Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn. No Healthcare Literacy: Yes☐ No☐

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
12/7	2pm	Treatment care	explain about treatments care	mother	No learning barrier	oral	None	verbalizes understanding	good	[illegible]

Part - III: CODES

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

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

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

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

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

Doc No. : RCH / FRM / CLINICAL / 187

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 1pm Mode of Arrival: Wheel chair Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... nil ..... Body Weight: 22 kg Kg

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

.....

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

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

Family History: ..... nil .....

.....

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

Temp.: 98.4 F HR: 90 b/mt RR: 22 b/mt BP: 100/60 mmHg

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

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

Risk of Pressure Sore (Braden Q Score 25) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0 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?) ..... 1 (sister) .....

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: ..... Jathija. B ..... Date: ..... 18/7/24 ..... Time: ..... 5pm ..... Signature .....

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10.45AM-NPO

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EMERGENCY ROOM TRIAGE FORM

wt - 22 kg

Patient's Name : Samyutha Age : 8Y Gender: ☐ Male ☑ Female

Date : 18/7/26 Time of Arrival : 1.30PM

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: 97.8°F PR: 101 BP: 103/66 (78) RR: 26 SpO_2: 100

Chief Complaints: come for procedure Nail bed repair.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2 min

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Iman

Signature of Triage Nurse : 178894

Date & Time : 18/7 @ 1.35PM.

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

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PATIENT TRANSFER FORM

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Dr. G SAI SUCHITRA

	Date & Time of Admission	Date & Time of Transfer Order
	18/07/26 @ 318pm	18/07/26 @ 4pm
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Saisuchitra	Dr. Keerthana	Further 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
9	–	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 ☐
Nail Avulsion of (R) big toe

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
CR. Akshaya mista CR. [signature] Follow	[signature]

Patient & Clinical Records Received by : [signature] 18/07/26 @ 3:20

Date & Time of Patient Received :

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sai Suchitra Date : 18/7/26

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

Start Time of Assessment: 3.30pm Weight: 22

Allergic History: .....

Chief Complaints: .....
fall injury over ® big toe

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 ☐

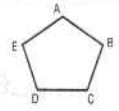
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

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

Breathing

Rate: 20 SpO_2 on FiO_2 100%
Rhythm: N
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: equal
Palpation Findings (If necessary).....

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

Circulation

HR: 102

CFT: Central <3; Peripheral <3

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 103/66 mmHg

Pulse Volume: Central 2+; Peripheral 2+

If in Shock: Compensated .....; Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: A

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 2mm; Left 2mm

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 97.8 °F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: Details inside

Treatment Planned: Details inside

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

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

Assessment done by

Name of the Doctor: Keerthana. D

Signature: .....

Date & Time: 18/7/25 3:30 PM

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/07/26 Time of arrival : 1.30pm

Chief Complaints: H/o Nail bed repair procedure @ 8.00pm. RBS: —

Height : ..... Weight : 22kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify NIL

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

☐ Character — ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NIL

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse : 10 mins

Time	Nursing Notes
18/07 5.00pm	The pt came for CR c̄ c/o. Nail bed repair
	@ 8.00pm · vitals me checked & Recorded
	c/s/b Dr. sai sucithra. To Advice the Admin
	IV line secu. blood sample sent to
	lab. procedure @ 8.00pm. NPO from
	pt shift to ward

Samples collected by: / SW Ajith   Time: / 3.45pm

Samples sent by: / SW Sanjin   Time: / 3.50pm

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 102 BP: 103/65(TS) CFT: <2sec	Shift - out from ER to: 420
RR: 16 SPO$_2$: 98%	Time of Shift - out: 4pm
GCS: 15/15 Temperature :	Handover given to: (Nurse's Name) SW Abitha
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): - IV placement done (L) melena / venflon - 22g.

Name of the Nurse : CK Akshaya pristh

Signature of the Nurse : CK [signature]

Date & Time : 18/07/26 @ 3.30pm

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18-03-2018 8Y4M0D (F)
Dr. G SAI SUCHITRA

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OPERATION NOTES

Surgeon : Dr. Sai Suchitra	Asst. Surgeon : –
Anesthetist : Dr. Mohan	OT Nurse : S/N Sundari
Pre-Operative Diagnosis:	(R) Great toe nail bed laceration + open distal phalangeal #
Surgical Procedure :	(R) Great toe debridement, nail bed repair and nail plate repositioning

Weight : 22 kg.	Date : 18/1/26	Start Time : 8.35pm	End Time : 8.35pm

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Findings:

↓ GA, patient supine, under tourniquet control, sterile draping done
(iv Taxim at induction)
(R) Great toe nail avulsion
Nail bed transverse ~~fold~~ full width laceration with hematoma
Open distal phalangeal #

Procedure Notes:

Thorough wash given. No loose fragments
Nail bed repaired with 5-0 rapide vicryl
Nail plate repositioned. Drill holes made
Below knee back slab given till toes.

Amount of Blood Loss: –	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:	1) Elevation of limb x 72 hrs 2) Heel weight bearing (R) LL 3) T-Augmentin 625 mg BD x 7 days at discharge
Wound Care:	4) Home Tomorrow 5) R/A 10 days for wound check 28/7/26
Drain /Special Lines/Catheters:	
Special Patient Positioning and Requirements:	
Nutritional Instructions:	
When to Start Mobilization:	
Special Referrals:	
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up	

Name of the Surgeon: DR SUCHITRA

Signature of the Surgeon:

Date & Time: 18/7/26, 21:25

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT Shifted to: 4th Floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	2 CEFOTAXIME	1gm	IV	STAT	18/3/18	☐C ☐DC
2	2. DICLOFENAC	37.5mg	IV/IM	STAT	18/3/18	☐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 : 18/3/18

Nurse Name & Signature: 18/3/18 9.30 pm

Date & Time : 18/3/18 @ 9.30pm

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

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

SAFETY CHECKLIST

Surgeon : Dr. Sai Suchitra
Asst. Surgeon : —
Anaesthetist : Dr. Mohan
Scrub Nurse : S/r. Sundari

Patient Name : M/S. Samartha Age : 8yr Gender : F
UHID No. : 94001 Surgery Name : Circumcision Toe
Date : 18/7/26 In-time : 8.35pm Out-time : 9.05pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8.36pm

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. Ram. (83116)

Before Skin Incision ➤➤

TIME OUT Time: 8.38pm

Confirm all team members have introduced themselves by Name and Role	☑Yes ☐No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☑Yes ☐No
Correct Site	☑Yes ☐No
Correct Procedure	☑Yes ☐No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	☐Yes ☑No ☐NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	☐Yes ☑No ☐NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☑Yes ☐No ☐NA
Is Essential Imaging Displayed?	☐Yes ☑No ☐NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☑Yes ☐No

Signature : 
Name : DR SUCHITRA 83742

Before Patient Leaves Operating Room

SIGN OUT Time: 8.58pm

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 : Sujith

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PATIENT TRANSFER FORM

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8Y 4M 0D (F)
Dr. G SAI SUCHITRA

	Date & Time of Admission: 18/7/26 @ 3.15pm	Date & Time of Transfer Order: 18/7/26 @ 10.30pm
Treating Consultant Name: Dr. Sai Suchitra	Transfer Ordered by: Dr. Mohan	Reason for Transfer: Further Management
From Unit: OT	To Unit: 4th Floor	Information to Attendant: Yes ☒ No ☐
Number of Sheets in Clinical File: IP tile-1	Number of Imaging Films: -	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☒ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N Sufi 0195	Dr. Mohan

Patient & Clinical Records Received by : S.N. Angel 0188 @ 10.30pm

Date & Time of Patient Received :

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

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

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 18/7/26 OT TRANSFERRED TO: 4th Floor

	Patient Identification	YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b.Surgical procedure & correct site verified	yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	No	
	b.SpO_2 within safe range	yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	No	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	yes	
	b.No active uncontrolled bleeding	NO	
	c.Last vitals recorded before transfer	yes	
	d.Central line hubs are closed	NO	
	e.Dressing Intact	yes	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	yes	
	b.Reassessment done	yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	yes	
	b.All drains fixed, output noted	NO	
	c.Catheter secure & urine output recorded	NO	
	d.Splints/casts/traction devices stabilized	yes	
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	NO	
	b.Bed/side rails up and brakes applied	yes	
	c.Special positioning maintained as per surgery	yes	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NO	
	b.Epidural catheter secure, infusion checked	NO	
	c.Pressure areas protected (heels/elbows)	yes	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NO	
10	**REPORTS AND LABS HANDED OVER**	NO	
11	**BIOPSY/HPE SENT**	NO	
12	**Documentation**		
	a.Documentation completeness	yes	
	Transferring Nurse: S/N Sugatha 01458		
	Receiving Nurse :		
	Signature of Incharge:		

RCH/GDY/FRM/CLINICAL/598

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

PRE - OPERATIVE CHECK LIST

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Date: 18/07/26

Patient's Name : Ms. SAMRTHA Age : 8Y4M Gender : ☐ M ☑ F

Blood Group : A +ve UHID : 94001

Planned Surgery : NAIL AVULSION OF ® BIGTOE Surgeon : DR. SAI SUCHITRA

Anesthetist : Dr. Sathish Date & Time of Operation : 18/07/26

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : SURYA S Nurse In-Charge Name : Anitha

Billing Executive Signature : Signature of Nurse In-Charge :

Date & Time : 18/7/26 1:15pm Date & Time : 18/7/26 @ 4pm

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

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 18/1/26 @8pm

4200 **TRANSFERRED TO :** OT

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

Transferring Nurse: Balaraj/000685

Receiving Nurse : S/N Sujatha 15571

Signature of Incharge:

Department of Anaesthesiology

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PRE-ANAESTHETIC EVALUATION

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

Date: 18/11/26 Time: 6.30pm, Proposed Operation: (R) Lt Pyeloplasty bed repair

Diagnosis: washbed 19yr

B.P / CRT: 95/60 H.R: 86/min Weight: 22kgs. ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 13.5	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 3.5L	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT: 14.6	K:	LDH:	T3	Other:
PTT: 28.2	Ca++:	Alk phos:	T4	
INR: 1.07	Mg++:	Amylase:	TSH	
87u(R)	Cl -:	SGOT/SGPT:	**Allergies:** - Nil	

Medical History: CVS :

Diabetes :

RESP :

CNS : 2m anaesthesia

Renal :

Physical Activity:

Hepatic / GE :

Others :

Past Anaesthetic History:

Physical Exam:

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

Lungs :

Heart: Chr / norm.

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: .... Name: Dr. [illegible] (NNTO)

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No ✓ | Fasting Status: adequate

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

H.R.: 97/min | B.P / CRT: 94/60 | SpO_2: 100% | R.R.: 18/min | Last Feed:

Pre-OP Diagnosis: .... | Operation: (B) LL Adductor release [illegible] | Date: 18/7

Surgeon: Dr. [illegible] | Anaesthesiologist: [illegible] | Technician: [illegible]

TIME
N_2O / AIR / O_2 LPM
HALO / ISO / SEVO — MAC 0.8
Drugs:
1. Fentanyl — 30 mcg
2. Propofol — 50, 20
3. Tazocin — 1gm [illegible]
4. Diclofenac — 12.5 mg [illegible]

FIO_2 / SaO_2 — 100
$ETCO_2$ — 35, 35, 30
ECG
Temperature
Urine Output

Fluids / Blood — 100 ml — 350 ml

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

Tourniquet 20 min

Antibiotic
Suppository
Blood Loss
NOTES

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:
OP Start:
OP End:
Leave OR:

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV: ✓ (R) [illegible]
☐ IV: 24G [illegible]
☐ IV:

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

☐ Mask ☐ SGA ✓ 2.5 [illegible]
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .... Attempts: ....
Difficulty Why?

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

Regional:
Extremity — Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: .... Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc:
Bolus: local infiltration
Infusion:
Block Level: R1F, block
Comments: 0.2 Ropin 5ml.
Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor:
Signature of the Doctor: [illegible]

[illegible]

Patient Sticker

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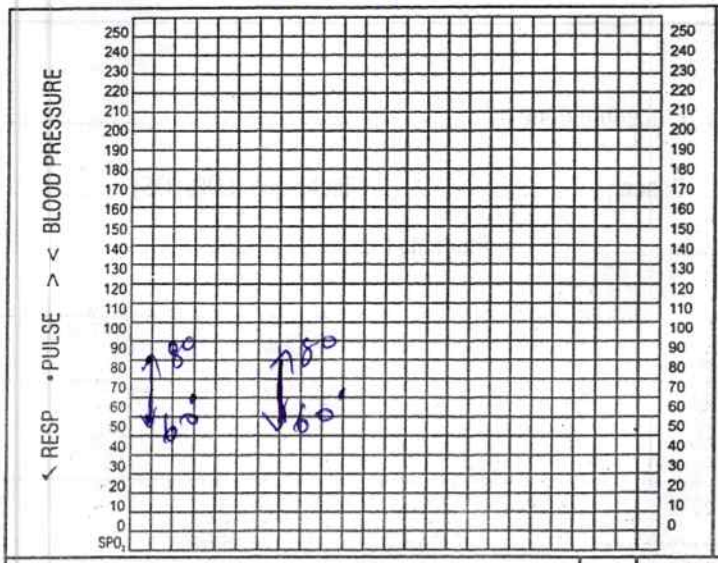
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : C/N Sujatha Time Received : 9.05 pm Time Discharged : .....



IV Cannula Site : .....

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

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

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			NPO x 2 hrs.	
			Monitor VITALS	
			T-Paracetamol 25mg IV	

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

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: 8/7/26

PACU Nurse Name : S/N Sujatha
PACU Nurse Signature: .....
Date & Time: 18/7/26 @9.05 pm

Reassessment Frequency:

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

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

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT F GUC-00094001 IP18-00036516 **:SIA**

Ms SAMRTHA

18-03-2018 8 Y 4 M 0 D (F)

Dr. G SAI SUCHITRA

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

UHID NO: .... Surgeon Name: ......Dr. Saisuchitra

Anaesthesiologist : ......Dr. M Ram...................... Operative procedure planned : ....Nail bed repair (R) LL Big toe.

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : Hypotension, desaturation, bradycardia

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [signature]

Name : M. Bhuvaneswari.

Relationship with Patient: ....

Date & Time : 18/07/26 6:30pm.

Witness :

Signature : ....

Name : ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature : [signature] Name : [signature] (8711b) Date & Time : 18/7/16 6:30pm

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDUR

GUC-00094001
Ms SAMRTHA
18-03-2018 8Y 4M 0D (F)
Dr. G SAI SUCHITRA
IP18-00036516

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Patient Name : .....

☐ 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)

Debridement, nail bed repair, nail plate reposition of (R) great toe + POP application (below knee)

(Name of the Patient)

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

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

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

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

infection, neurovascular deficit, stiffness, delayed / non union, disfigurement in shape, texture, colour of new nail, deformity

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 : M. Bhuvaneswari

Date & Time : 18/07/2026 02 Pm

Patient Attendant :

Signature : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : Fathiza

Date & Time : 18.7.26

Doctor (who is taking the consent) :

Signature : .....

Name : DR SUCHITRA

Date & Time : 18/7/26 20:00

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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

UHID எண் : ..... தேதி: .....

நீபந்தனைகள்:

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:.....

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8 Y 4 M 0 D (F)
Dr. G SAI SUCHITRA

Rainbow Children's Hospital | BirthRight

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)	NO	
3	Antibiotic prophalaxis given within 60mts prior to skin incision	NO.	
4	Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice	NO	
	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		

GUC-00094001 IP18-00036516
Ms SAMRTHA
18-03-2018 8Y4M0D (F)
Dr. G SAI SUCHITRA

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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.
(Exampie: 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: Balapriyanga Doctors

Date & Time : 18/7/26 @ 8pm

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

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PA[GUC-00094001 IP18-00036516 Ms SAMRTHA 18-03-2018 8Y4M0D (F) Dr. G SAI SUCHITRA]RM

	Date & Time of Admission	Date & Time of Transfer Order
	18/7/26 @ 3.18pm	18/7/26 @ 4pm.
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Sai Suchithra	Dr. Mahalakshmi.	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.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Balu(?) / 020685	

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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