

ANC-00006446 IP28-00004476
Master S.N.THARUN CHAKRAVARTHI
28-10-2020 5 Y 7 M 0 D (M)
Dr. NITHYA R



Hospital
To Save a Life to Save the World

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE TRACKING SHEET

UHID : FLOOR: CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing				
Activity Sheet updated by Pharmacy	4:00 PM	4:03 PM		

ACTIVITY RECORD FOR BILLING



Name: ANC-00006446 IP28-00004476
 Master S.N. THARUN CHAKRAVARTHI
 UHID No: 28-10-2020 5 Y 7 M 0 D (M)
 Dr. NITHYA R
 Date of Admission:
 Room / Bed No: Ward: Suggested Billable bed type:
 Consultant: Dept:
 Date of Discharge: Time:



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	6:50 AM	ER	OT	[Signature]
28/5/26	9:20 AM	OT	post up	S. D. [Signature]
28/5/26	11 AM	post up	OT	S. D. [Signature]

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ANC-00006446 IP28-00004476
Master S.N.THARUN CHAKRAVARTHI
28-10-2020 5 Y 7 M 0 D (M)
Dr. NITHYA R



SURGERY DETAILS

Date : 28/05/26
Patient Name: MASTER S. NITHARUN CHAKRAVARTHI Date of Birth: 28/10/2020 Age: 5 Y
Gender: MALE Ward: M-FLOOR UHID No.: 6446/4476
Date of Surgery: 28/05/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery : Coblation Assisted adenotomylectomy LOR

Time in : 7:35 AM Time Out : 9:20 AM

	NAME	AMOUNT
1. Surgeon	DR. NITHYA R	
2. Anaesthetist	DR. NAHALAKSHMI	
3. Assistant Surgeon		
4. OT Technician	MR. SUMITH /	
5. Circulating Nurse	MS. EZHIL	
6. Assistant Nurse	MS. SHANKAR /	

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others Coblator (2000 ₹)

Nithya
Signature of the Surgeon

[Signature]
Signature of Circulating Nurse

Order No:

Order by:



Adenotonsillectomy



CONSUMABLES OF OT

Circulating staff : *MS. FZHIL* Technician : *Sumitha sharma* Date : *28/10/2025* Time : *7:30 AM*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <i>5.0 Floxometallic</i>		01	Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A/P/N		03	<i>protective sheet</i>	01		Suction Catheter		
HME filter : A/P/N			<i>protogoon</i>	02		Feeding Tube <i>BF</i>	01	
Syringes : 10 cc		04	Gloves <i>P.F 6.0</i>	01		Vaccum Suction Set		
05 cc		02	<i>P.F 6 1/2</i>	01		Surgical Gloves		
02 cc		01				Gauze Pack		
01 cc		01				Syringe <i>1ml/2ml 20ml</i>	02	
Cautery plate : A/P/N			Surgical blade			Surgical Blade # 20		
IV set <i>podia drip set</i>		01	NG tube			Koochies (S)		
RL		01	Cautery pencil			<i>dwaler</i>	04	
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			<i>100cm extension</i>	01	
<i>Inj Dextrose 25%</i>		01	Ointments			<i>(P) O2 mask</i>	01	
<i>Needle 16G</i>		01	Suction Catheter			<i>Jy - Serial</i>	01	
Fentanyl			Cap, Mask			<i>ET Tube 5.0 (cuffed)</i>	01	
Morphine			Gauze Pack	05		<i>Needle 24G</i>	01	
Ketamine			Mop Pack	01				
Propofol		01	Steristrip					
Rocuronium			Underpad	01		<i>500 ml</i>	01	
Glycopyrolate			Draw sheet			<i>NS 1000 ml</i>	02	
Myopyrolate		01	Abgel			<i>artamin drops</i>		
Ondansetron			Foleys catheter			<i>pendant ep-dp</i>	01	
Pencan 25g/ Spinal Needle 22			Urobag			<i>Neuro surgical</i>		
Bupivacaine 0.25%			Chest Drainage Catheter			<i>padding</i>	01	
Bupivacaine 0.25% (Heavy)			Romodrain bag			<i>2x40</i>		
Antibiotics			Bandage			<i>Bandage 4 inch</i>	01	
<i>Inj. Augmentin 600mg</i>		02	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg		01	Double J Stent					
Supridol : 100mg			Vaccum Suction set	03				
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
<i>Inj. dexatomid</i>		01	Microshield					
<i>Inj. Amepressa</i>		01	Cotton Balls					
<i>Inj. Artacil</i>		01	Latex Gloves			<i>10 pair</i>		
<i>Inj. dexatil</i>		01	Ramdione Scrub					
			Saral					

Dr. Nithya
Surgeon

Dr. meha
Anaesthesiologist

J. S. ...
Nurse

C. S. ...
OT Technician

Order No. :

Ordered by :

1. Introduction
 2. Methodology
 3. Results
 4. Discussion
 5. Conclusion

1. Introduction
 2. Methodology
 3. Results
 4. Discussion
 5. Conclusion

Year	1990	1991	1992	1993	1994	1995
1						
2						
3						
4						
5						

1
 2
 3
 4
 5

1. Introduction
 2. Methodology
 3. Results
 4. Discussion
 5. Conclusion

Year	1990	1991	1992	1993	1994	1995
1						
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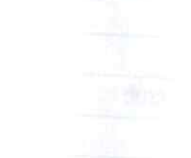
Year	1990	1991	1992	1993	1994	1995
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Year	1990	1991	1992	1993	1994	1995
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Year	1990	1991	1992	1993	1994	1995
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Year	1990	1991	1992	1993	1994	1995
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Year	1990	1991	1992	1993	1994	1995
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2						
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4						
5						



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Anna Nagar



Old Survey No.230/7A part, Town Survey No.8, Pillaiyar Koil Street,
Thirmangalam Anna Nagar West Chennai Tamil Nadu INDIA 600040
Tel No : 044-69289928

VAT TIN :

CIN :

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	IP28-00004476	Ward	5F-PRE/POST
Patient Name	Master S.N.THARUN CHAKRAVARTHI	Bed Name	PRE & POST OP 503
Age/Sex	5 Y 7 M 0 D / Male	Order No	28-0000147264
Date	28/05/2026 10:00	Prescription No	PRIP28-0069229
Payor	SELPAY	Dispensed Date	28/05/2026 10:01
UHID	ANC-00006446		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BANDAGE # 4 INCH	Muttu	GENERAL	ASB032	12/30	1	22.50	22.50
2	GAUZE 7.5X7.5 12 PLY (5 NOS)	Bapuji Surgicals	GENERAL	M2641087	04/29	1	100.00	100.00
3	GAUZE 7.5X7.5 12 PLY (5 NOS)	Bapuji Surgicals	GENERAL	M2641042	01/30	4	100.00	400.00
4	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	020260324	03/29	1	850.00	850.00
5	NEURO SURGICAL PATTIES (M)	Surgiwere		2511CA0	10/30	1	67.00	67.00
6	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS		ENPF030020	11/28	20	25.00	500.00
7	NS 1000 ML ACCULIFE-EH	Aculife Health Care Pvt.Ltd(Nirif)	H	2B260500	01/29	2	62.24	124.48
8	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1B260969	01/29	1	39.72	39.72
9	PROTECTIVE SHEET 20X20	Local		PSRCH1010526	04/29	1	250.00	250.00
10	PROTO GOWN (ADULT)	Diamond Medicare	H	PGRCH1010526	04/29	2	250.00	500.00
11	SGLOVE # 6.5 (POWDER FREE)	ANSEL		0260300811T	03/29	2	128.00	256.00
12	SGLOVE # 6.5 (POWDER FREE)	ANSEL		260300871T	03/29	2	128.00	256.00
13	SGLOVE # 6 (POWDER FREE)	ANSEL		260300701T	03/29	1	128.00	128.00
14	SGLOVE # 7.5 (SURGICARE)	ICARE (KANAM LATEX)		24IO233KK	08/29	2	90.94	181.875
15	UNDERPADS CARE 60 X 90 (FRIENDS)			000100500720	12/30	1	205.00	205.00
16	VACCUME SUCTION SET	ROMSONS		0K26C010031	02/31	4	679.50	2,718.00
Total :							3,125.90	6,598.57

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : RISHI S

Receiver Name



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Anna Nagar

Old Survey No.230/7A part, Town Survey No.8, Pillaiyar Koil Street,
Thirmangalam Anna Nagar West Chennai Tamil Nadu INDIA 600040
Tel No : 044-69289928

CIN :

VAT TIN :

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	IP28-00004476	Ward	5F-PRE/POST
Patient Name	Master S.N.THARUN CHAKRAVARTHI	Bed Name	PRE & POST OP 503
Age/Sex	5 Y 7 M 0 D / Male	Order No	28-0000147276
Date	28/05/2026 10:29	Prescription No	PRIP28-0069234
Payor	SELFPAAY	Dispensed Date	28/05/2026 10:29
UHID	ANC-00006446		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
						2	108.23	216.46
1	AEQUIMENTIN INJ 600MG	AEQUITAS HEALTHCARE PVT LTD		0G352514A	08/27	1	840.00	840.00
2	AMNEPARA 100ML GLASS BOTTLE		H	0EL00125032	08/27	1	45.30	45.30
3	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303351	06/27	1	10.88	10.88
4	DEXARIL 4MG INJ		H	0DEX25008SR	06/27	1	644.06	644.06
5	DEXTOMID INJ AMP 100 MCG 1 ML	NEON LABORATORIES LTD	H	01258025	01/27	1	22.03	22.03
6	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirliif	H	01B260748	01/27	4	25.78	103.12
7	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26B16K49	01/31	1	24.00	24.00
8	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)		5344207	11/30	4	21.56	86.24
9	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26B16K55	01/31	2	50.63	101.26
10	DSYRINGE DISCARDIT 20ML (BD)	BECTON DICKINSON (BD)	GENERAL	2403504	02/29	1	10.31	10.31
11	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	026A21K64	12/30	1	10.32	10.32
12	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirliif	H	2254093	09/28	4	2.58	10.32
13	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0060425	03/27	5	34.65	173.25
14	ET TUBE -5.0 CUFFED (WELCO LIFE)			250650	06/30	1	891.00	891.00
15	FLEXOMETALIC TUBE 5.0 CUFFED	Intrasurgical		23EE11	04/28	1	1,691.25	1,691.25
16	INFANT FEEDING TUBE-5	ROMSONS	GENERAL	G25L010577	11/30	1	63.00	63.00
17	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353003	09/27	1	69.10	69.10
18	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350474	09/27	1	127.48	127.48
19	NEEDLE 16 G 1.5INC	Dispovan	GENERAL	15544D	03/30	1	4.88	4.875
20	NEEDLE 24 G	Dispovan		39462R	08/29	1	2.44	2.438
21	NEOMOL SUPPOSITORIES 250 MG 5 S	Neon Laboratories Ltd	H	BLNP291046	11/28	1	22.31	22.31
22	Oxygen Mask With Tubing - PeadROMSONS-FC		GENERAL	G25L040045	11/30	1	336.00	336.00
23	PEDIADRISET PLUS	ROMSONS		G26A020313	02/31	1	311.00	311.00
24	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1C261674	02/29	1	69.39	69.39
25	SUCOL INJ 50 MG 10 ML	Neon Laboratories Ltd	H	248221	01/27	1	55.64	55.64
26	VEIN-O-LINE 100CM ROMSONS	ROMSONS		0G24J011013	09/29	1	433.00	433.00



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INPATIENT ISSUES AGAINST ORDERS

IP No	IP28-00004476	Ward	5F-PRE/POST
Patient Name	Master S.N.THARUN CHAKRAVARTHI	Bed Name	PRE & POST OP 503
Age/Sex	5 Y 7 M 0 D / Male	Order No	28-0000147276
Date	28/05/2026 10:29	Prescription No	PRIP28-0069234
Payor	SELPAY	Dispensed Date	28/05/2026 10:29
UHID	ANC-00006446		
			Total : 5,916.49 6,363.71

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : RISHI S

Receiver Name

ANC-00008446 IP28-00004476
Master S.N.THARUN CHAKRAVARTHI
28-10-2020 5 Y 7 M 0 D (M)
Dr. NITHYA R



POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

Vital signs 1 hr 4 times

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Prone position

Nutritional Instructions:

nil by mouth - water - ice cream -
normal diet

When to Start Mobilization:

one full walk

Special Referrals:

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

Yes No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: NITHYA R

Signature of the Surgeon: NM

Date & Time: 28/1/20 9:00 am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>21/12/20 Post OP discharge</p> <p>21/12/20</p> <p>(1) Sy Asymetric 570g in 08y</p> <p>(2) Sy Paracelent 200 in 06y</p> <p>(3) Sy Invariant of anal - anal - 4ul</p> <p>(4) Sy Invariant anal - 5ul - 5ul</p> <p>(5) Sy STAININ P Nad my 30 30-10</p> <p>(6) Sy 20ul of water + 5ul of Nychapero 10ul of water after every feeds</p> <p>ON DISCH</p> <p>Sy Asymetric EC anal - 0 - 4ul</p> <p>Sy Paracelent (200) 5ul / per</p> <p>(3) + (4) + (5) + 6</p> <p>26 after 7 weeks in OPD</p> <p>M (6/20)</p>	

Patient Name : _____ I.P. No. _____ Sheet No. _____ Wards _____ Weight (kg) _____

DAILY PRESCRIPTIONS

DRUG : Inj. AUGMENTIN Date: 28/10/20
 Time: 4 PM

Dose	Route	Frequency	Start Dt.
50mg	IV	Q8H	28/10

Name & Signature of the Doctor starting the Drugs:
Aneshu 163765

Additional Instructions:
 @ 30mg/kg/dose

Daily Doctor's Endorsement by a Sign. _____

DRUG : Syp. SINAREST AF Date: 28/10/20
 Time: 10 PM

Dose	Route	Frequency	Start Dt.
4ml	P/O	Q8H	28/10

Name & Signature of the Doctor starting the Drugs:
Aneshu 163765

Additional Instructions:

Daily Doctor's Endorsement by a Sign. _____

DRUG : Syp. IBUGESIC Date: 28/10/20
 Time: 10 PM

Dose	Route	Frequency	Start Dt.
5ml	P/O	Q8H	28/10

Name & Signature of the Doctor starting the Drugs:
Aneshu 163765

Additional Instructions:

Daily Doctor's Endorsement by a Sign. _____

DRUG : OTRIVIN-P nasal Date: 28/10/20
 Time: 10 PM

Dose	Route	Frequency	Start Dt.
3 ^o	Nasal drops	Q8H	28/10

Name & Signature of the Doctor starting the Drugs:
Aneshu 163765

Additional Instructions:

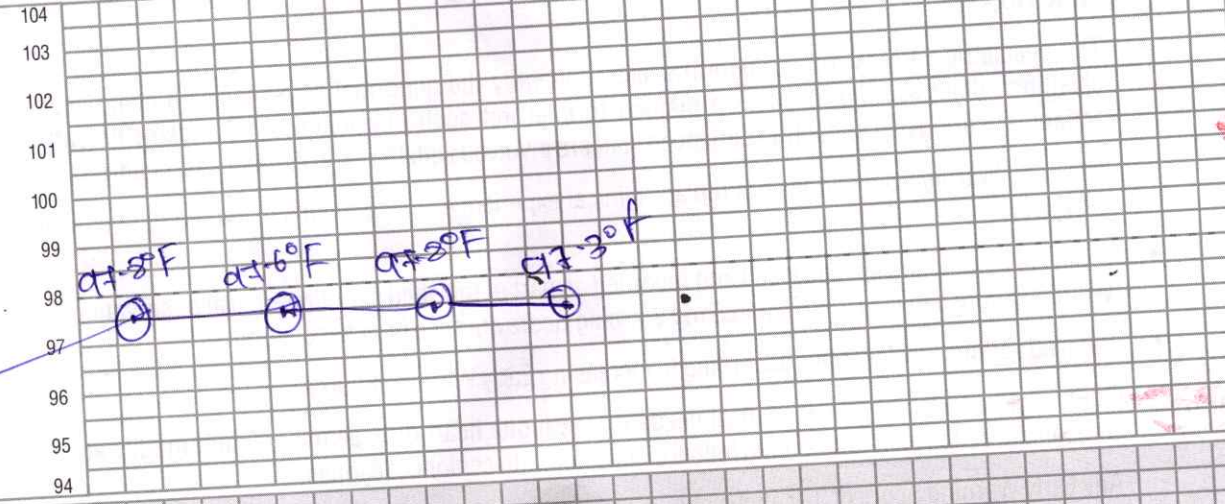
Daily Doctor's Endorsement by a Sign. _____



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5/26 Time: 9am 11am 12pm
 Doctor / Nurse / Family Concern?

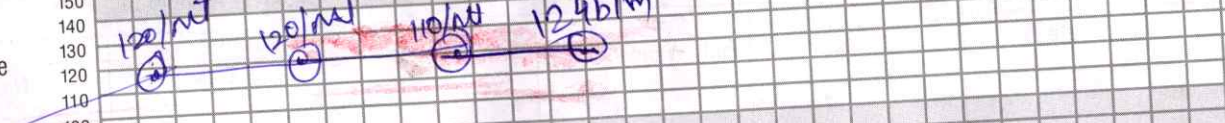
Temperature (°F)



Heart Rate (bpm)



Blood Pressure (mmHg) *

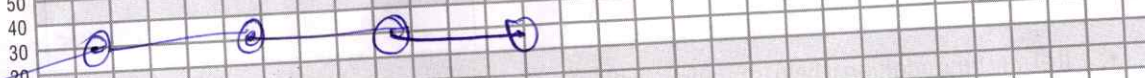


Note:
 BP does not score in early warning scoring

Heart Rate (Number)



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



Resp Rate (Number)



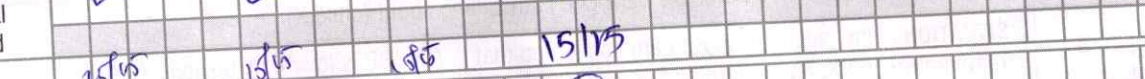
Resp Distress Mod/ Severe None / Mild



Receiving O₂ (l/min) O₂ Saturations (%)



Conscious Level Normal Altered



GCS *

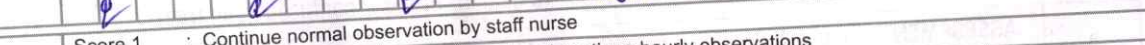


TOTAL SCORE

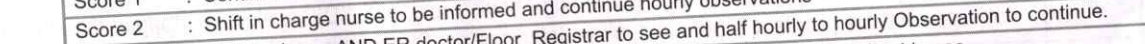
Number of shaded boxes



Pain Score



Observer's Initials



- ACTIONS**
- 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.

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)



Dr. NITHYA R

NURSING CARE RECORD

Date: 22/5/26

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
From Morning	→ Assess the RT → vitals are checked → comfortable position	am	→ assessed the RT → vitals are checked → comfortable position given	Vitals are stable	Re-assessment done	S. Subit 620715
Afternoon						
Night						

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



FLUID CHART

Sheet No. : 22/5/20

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	N P RL		100ml							0	2	
	09:00 am	O RL		50ml							0	2	
	10:00 am	RL		50ml							0	2	
	11:00 am	H ₂ O	20ml								0	2	
	12:00 pm										0	2	
	01:00 pm	H ₂ O	20ml								0	2	
Total Intake :			40 + 200 = 240ml. M - O			Total Output : U - 1 TIME							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



CHECKLIST FOR THROMBOPHLEBITIS

28/5/20

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-									
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Pearl
607227

Signature : *Pearl* Name : *Silva Kumari*

Signature of Ward In Charge :

Signature : *Pearl*



NURSES NOTES

No Known Drug Allergies

Drug Allergies NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>OT Notes</u>	
28/10/20	7:30 AM	<p>⇒ patient received from ER to OT patient general condition are stable and vitals are checked and recorded</p> <p>⇒ IVE RL on flow line is good no sad ness and NO swelling</p> <p>⇒ patient sign in done name & UHD Number.</p> <p>⇒ patient general Anesthesia given by DR. Mahalakshmi</p> <p>⇒ patient time out done Name & UHD Number.</p>	 28/10/15
	7:45 AM	<p>⇒ Inj. Augmentin IV given no Allergies and no Any complans</p>	
	8:00 AM	<p>⇒ Inj. Augmentin full dose IV given 600mg No Allergies</p> <p>⇒ tablation Assesed</p> <p>Adenoidectomy ↓ OIA case done by DR. Nithya R nam.</p>	
	8:15 AM	<p>⇒ Instrument count checked and informed.</p> <p>⇒ patient vitals are stable</p>	 28/10/15

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



No known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
28/5/26	9.20 AM	→ patient shifted to post up ward	J. Doss 020715
	10.00 AM	→ patient sleeping well. → patient vitals are stable and record.	
	10.45 AM	No Any Complaint → patient all stable and patient sleeping well patient shifted to N-FLOOR.	
<u>Receiving NOTES (28/5/26)</u>			
28/5/26	11 AM	Baby Recvd from OT Baby is stable and well oriented & NPO Breasted and IV line present and pattern → PP 05.	
28/5/26	12 PM	patient vital signs checked and documented in file → PP	
28/5/26	2 PM	patient handed over with to evening duty staff → PP	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>diagnostic hysterectomy</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>NIL</i>						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>28/5</i>	<i>28/5/26</i>	<i>28/5/26</i>				
	Shift	<i>M</i>	<i>OT</i>	<i>M</i>				
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Diet:	<i>NPO</i>	<i>NPO</i>	<i>NPO</i>				
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	<i>- RA -</i>				
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>97.9°F</i>	<i>97.8°F</i>	<i>97.30°F</i>			
		Res:	<i>28b/m</i>	<i>30/m</i>	<i>27b/m</i>			
		SpO ₂ :	<i>100%</i>	<i>100%</i>	<i>97%</i>			
		Pulse:	<i>110b/m</i>	<i>120/m</i>	<i>124</i>			
		BP:	<i>97/74(120)</i>	<i>100/60</i>				
		LOC:	<i>Alert</i>	<i>Alert</i>	<i>Alert</i>			
Fall Risk Score:	<i>14</i>	<i>14</i>	<i>14</i>					
Pain Score:	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>					
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>					
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>NPO</i>	<i>NPO</i>	<i>NPO</i>				
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>Dependent</i>	<i>Dependent</i>	<i>Dependent</i>					
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	/	/	/	/	/	/	
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
	Pain Score:							
	Skin Integrity							
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								