

VIH-00109019 IP5-00175929
Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

80895
Date : 3/2/16
Patient Name: Mr. Sree Rehanish Date of Birth: 16-03-2017 Age: 9 Y
Gender: M Ward: D-OT UHID No.: 0185929
Date of Surgery: 3/2/16 ☒ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Adeno to orchiectomy & collection
Bic tubal ligation

Time in : 6:55 AM Time Out : 8:30 PM

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist	Dr. Shabnam	
3. Assistant Surgeon		
4. OT Technician	Shivabeela	
5. Circulating Nurse	Achil	
6. Assistant Nurse	Achil	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : coagulator → 9686355

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9686354

Order by: Sufath

9686400
Patient Sucker

Adeno + Turbinoplasty

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5214

CONSUMABLES OF OT

Circulating staff : Technician : Shaleeley Date : Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 5.5-5.6	1+1	1	Major Pack <u>Drape</u>	1	1	Inj Vit.K		
LMA 3	01	1	Sutures			Cord Clamp		
ECG leads A/P/N	5	3				Suction Catheter		
HME filter A/P/N	01	1				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	5	Gloves 7.	2	2	Surgical Gloves		
02 cc	10	5	PP 7.	2	2	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube 6.00	2	2	Koochies (S) 100	1	2
RL	01	1	Cautery pencil			NS 500ml	1	2
NS : 10ml / 100ml / 500ml / 1000ml	1+1	1+1	Koochies			Transoxia	1	1
mini spike	01	0	Ointments			Surgard	1	1
Guava	03	1	Suction Catheter			Adrenalin	3	3
Fentanyl	01	1	Cap, Mask	1	1	Savlon	1	1
Morphine			Gauze Pack NTR	2	2	Dermide 100mg	01	1
Ketamine			Mop Pack	1	1	500mg 100mg	1	1
Propofol	02	2	Steristrip			midazol	01	1
Rocuronium	01	1	Underpad	1	1	Nasal Airway		1
Glycopyrolate	01	1	Draw sheet	1	1	221 24	1	1
Myopyrolate	01	1	Abgel			oral Airway		1
Ondansetron	01	1	Foleys catheter			2,3	1	1
Pencan 25g/ Spinal Needle 22			Urobag			metaprolol	01	1
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			02 mask (N)	01	1
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Agmetofel 1.2gm	01	1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	2			
Justin : 12.5 mg / 25mg / 100mg	1+1	1+1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution					
vaccum set	01	1	Microshield	1	1			
Dexta + Dermide	1	1	Cotton Balls					
Transoxia + 100	2	1	Latex Gloves	100	100			
Glovaal + 100	5	1	Ramdone Scrub					
100m + 100m 300	1	1	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9686400

Ordered by :

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

ESTIMATION SLIP

80895

Date : 26/06/2026 UHID / IP No. : VIIH - 00109018 SI No.

Name of Patient : Mr. Sagar B. Bhanush. Age: 44 Gender: M.

Father's / Husband's Name : Mr. Rajesh. Corporate / Occupation : 2nd B's.

Address : Phone : 9878977382 Email :

Procedure / Plan : Adenotomylary Tonsillectomy + Coblation

MODE OF PAYMENT : ☐ SELF ☒ TPA : ☐ GIPSA : ☐ OTHERS

TARIFF INFORMATION : Dr. P. C. M. Murthy (C-29+C-5)

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee			10640							
L. Tax			10640							
PARTICULARS										
Surgeon's / Anesthetists's Fee / O.T. Charges										
O.T. Consumables										
Instrument Charges										
Pharmacy, Consumables & Investigations										
Equipment Charges										
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.										
Package										
Others										
Initial Minimum Deposit										

REMARKS: 1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.

2. The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.

3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.

4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.

5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.

6. For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.

7. During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm

8. Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.

9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I Mr. Rajesh have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In 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

Signature of the Client

Signature of the Financial Counselor

ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____
 Date of Admi: _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

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 Dr. P V L N MURTHY



Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	4:13 pm	ER	OT	Annel
3/7	9:10 PM	OT	114	Diya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr :- Ujjwal Desai	04/07/26	9681054	Sharef
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

3/7/20

CBP

6651

Choram

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7/26	IV placement PAC op basis	①	5891	Choren

ANY OTHER INFORMATION

Call

Date : 4/7/26

Time : 10am.

Prepared By : J. Kailaja

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
J. Kailaja	<u>118408</u>		

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175929 Admit Date : 03-Jul-2026 Admit Time : 03:32 PM UHID : VIH-00109019

Patient Details :

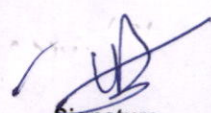
Patient Name	: Master SREE REHANSH	Age	: 9 Y 3 M 17 D
Guardian	: Mr RAJESH UPPU	DOB	: 16-03-2017
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO 23-228, NEAR SHALOM PRAYER HOUSE Trimulgherry Hyderabad Telangana INDIA 500015	Phone No	: 9972977883/ 9381909435
		E-mail	: na123@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : POST OP 409 Ward Name : 4F-OT COMPLEX
Room No : POST OP 409 Admission Type : First Visit

Contact Details :

Name : Mr RAJESH UPPU Relationship : Father
Contact Address : H.NO 23-228, NEAR SHALOM PRAYER
HOUSE Trimulgherry Hyderabad Telangana
INDIA 500015 Phone No : 9972977883 / 9381909435


Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : CARE HEALTH INSURANCE LIMITED



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY



Pediatric Multiorgan History & Physical Examination

Name : Sree Rehanish Age/Sex 9Y/M

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Breathing issues
open mouth breathing
sleep disturbance
poor quality of sleep } x 1 1/2 Yr

History of present illness :

Breathing issues
open mouth breathing
sleep disturbance
poor quality of sleep } x 1 1/2 Yr.



Adenotonsillitis
B/L ^{EA} concha impaction



Came for loblation adenotonsillectomy
with B/L turbinateoplasty



Pediatric Multiorgan History & Physical Examination

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

Not significant.

Birth & Neonatal History:

FT / LSCS / CIAB / B.wt - 3Kg

NO H/O NICU admission

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

Achieved as per age

Immunization History :

As per schedule

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Breeding, Sepsis

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

GBP

Planned Management

- NPO as advised
- IVF Dns

Signature of the Doctor: Neelika

Signature of the Consultant:

Name of the Doctor: Dr. Nandan

Name of the Consultant:

Date & Time: 03/07/2026, 3:30 PM

Date & Time:

Patic



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26	Case reviewed by Resident Asleep, doing well vitals @	Front same plan ok <u>Shawls</u>
4/7/26 8 AM	A: Chr Adenotomylitis + HIT str Adenotomylitis + Bic tracheoplasty No pain ⊕ child asleep unstable	Plan. ① cont. care ② plan w/charge today.
		Madame



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[illegible]



INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. Adenotomyllectomy + Tonsillectomy + BIC Tuberoplasty
- 2.

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Good Health	

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- a. Bleeding, Change in voice, vocal regurgitation
- b. Rec. of Adenoid

- I authorize Dr. P V L N MURTHY and his / her team to perform the procedural sedation upon the patient / myself.
- I recognize 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.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Ramesh Vppu
Relationship with patient: Father
Date & Time: 03-07-26 4:50 PM

Witness:

Signature: [Signature]
Name: Deepthi
Date & Time: 03-07-26 4:50 PM

Doctor (who is taking consent):

Signature: [Signature] Name: P V L N MURTHY Date: 3/7/26 Time:

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.	
b.	

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : DR. PVL MURTHY
Asst. Surgeon :
Anaesthetist : Dr. Shabnam
Scrub Nurse : L. Ravi

Patient Name : Muth Sree R. N Age : 9 Y Gender : M
UHID No. : 0109019 Surgery Name : Adeno tonsillectomy
Date : 8/8/16 In-time : 6:55 PM Out-time :

VIH-00109019 IP5
Master SREE REHANSH
16-03-2017 9 Y 3 M
Dr. P V L N MURTHY



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: <u>6:55 PM</u>
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 : <u>[Signature]</u>		
Name : <u>Dr. Shabnam</u>		

Before Skin Incision ➤ ➤

TIME OUT		Time:
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? <u>[Signature]</u> ☐ 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 : <u>[Signature]</u>		
Name : <u>Anil</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time:
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>PVL Murthy</u>		

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18-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY

Patient Stick



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 3/2/26

Department : P.O.S. Duration of Procedure : 1hr

Name of Surgeon : DR. P.V.L.N. MURTHY Date of Admission : 3/2/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : Sui. Agunath 1gm	
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Archi. 1gm Date & Time of antibiotic administration : Archi. Date & Time procedure started : 3/2/26 @	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038

OPERATION THEATER NOTES

Patient's Name : masht soze Rehanah Age : 77 Gender : ☒ Male ☐ Female

UHID No.: 0109019 Weight: 20 kg Height:

[illegible]

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1 SyP. AUGMENTIN - ES 75ml BID - 2wks	
2 SyP. OMNACORTIL 5ml BID - 1wk	
3 SyP. XYZALM 5ml BID - 2wks	
4 SyP. CROCI N DS 75ml TID - 2wks	
5 T. LANA ZOLE DT 30ml BID 2wks	
6. T. TRANEXA 500ml BID - 2wks	
7 Normal Saline with BID 2wks	
8 Salt water gargle TID 2wks	

Name of the Surgeon: Dr. P. P. Meekus

Signature of the Surgeon: [Signature]

Date & Time: 3/7/26

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16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY



Patient Sticker



POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

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

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.



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: ER 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: Dr. Nandan

Date & Time: 03/07/2026, 3:30 pm

Nurse Name & Signature: Pooja

Date & Time: 3/7/26 & 3:35 pm

CROSS CONSULTATION FORM

Doctor Name : Date : 4/7/26 Time :

Diagnosis : chr Adenotomitis + HT

Hospital : LCH Bangalore

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

chronic Adenotomitis +
HT

Signature: madhu

Findings and Recommendations :

A: chr. Adenotomitis + HT

plan

4-6 pm

① work - same

② plan discharge

o/c - child alert
vital stable

cr
in | (N)
Pla

Consultant :

Name : Dvijwan Signature : Don Date & Time : 4/7/26

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RESULT SHEET

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

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :

Ward

DRUG : <u>SYP-CRODIN DS</u>				Date Time	<u>3/7</u> <u>4/7</u>
Dose	Route	Frequency	Start Dt.		
<u>10ML</u>	<u>PO</u>	<u>TID</u>	<u>3/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahanika</u>				GAM	X Paw Paw
Additional Instructions:				2PM	X
				10PM	Paw Paw
Daily Doctor's Endorsement by a Sign					
DRUG : <u>T- CANZOL</u>				Date Time	<u>3/7</u> <u>4/7</u>
Dose	Route	Frequency	Start Dt.		
<u>30mg</u>	<u>PO</u>	<u>OD</u>	<u>3/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahanika</u>				GAM	Paw Paw Paw
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>T- TRAPROX</u>				Date Time	<u>3/7</u> <u>4/7</u>
Dose	Route	Frequency	Start Dt.		
<u>1 tab</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahanika</u>				GAM	X Paw Paw
Additional Instructions: <u>1 tab = 500mg</u>				GAM	OT Tues
Daily Doctor's Endorsement by a Sign					
DRUG : <u>NASOQUA WASH</u>				Date Time	<u>4/7</u>
Dose	Route	Frequency	Start Dt.		
		<u>SD</u>	<u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahanika</u>				10AM	X
Additional Instructions:				10PM	Paw Paw
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 03/07/2026 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:																			



REGULAR PRESCRIPTIONS

Weight. 38.5 Kg Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : SYP. AUGMENTIN				Date Time 3/7/17
SML	PO	BD	3/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : SYP. OMNAPORTOL				Date Time 3/7
SML	PO	BD	3/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : SYP. XYZAL-M				Date Time 3/7
SML	PO	BD	3/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



Weight. 38.5 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7/26	7:00pm	Ty AUGMENTIN	1.2g	IV	SL	Dr. P. V. L. N. Murthy Barbara
3/7/26	7:00pm	Ty DEXONA	3mg	IV	SL	Dr. P. V. L. N. Murthy Barbara
3/7/26	7:10pm	Ty TRANEXAMIC ACID	600mg	IV	SL	Dr. P. V. L. N. Murthy Barbara
3/7/26	7:10pm	Ty PARACETAMOL	600mg	IV	SL	Dr. P. V. L. N. Murthy Barbara
3/7/26	7:15pm	DICLOFENAC Suppository	2 sup	PR	SL	Dr. P. V. L. N. Murthy Barbara

Weight. 38.5 kg Ward.

[illegible]

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16-03-2017 9 Y 3 M 18 D (M)
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SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

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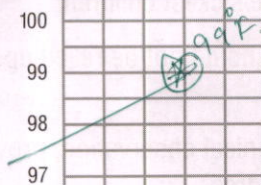
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/3/20 Time:

Doctor / Nurse / Family Concern? 6AM

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

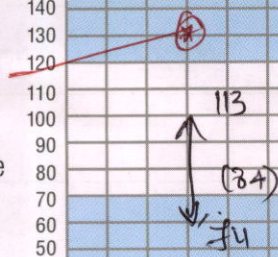
and

Blood Pressure
(mmHg) *

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Note:

BP does not score
in early
warning scoring



Heart Rate (Number)

131b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

25b/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

99%

Conscious Level
Normal Altered

GCS *

15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1

0

11/3

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.

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)

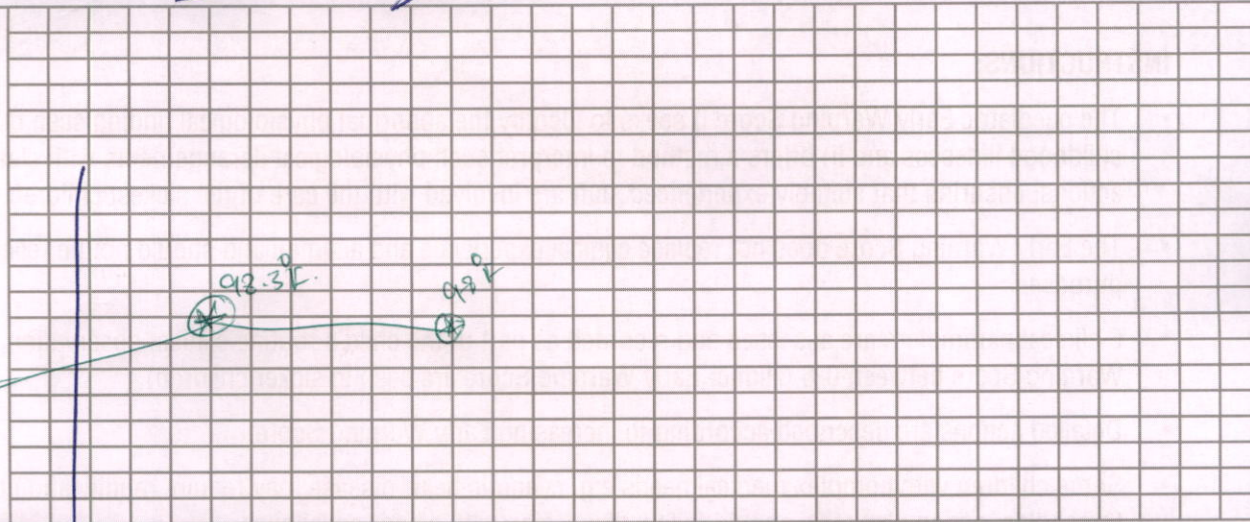


EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/3/26 Time: 10pm 2AM 4/1/26
Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



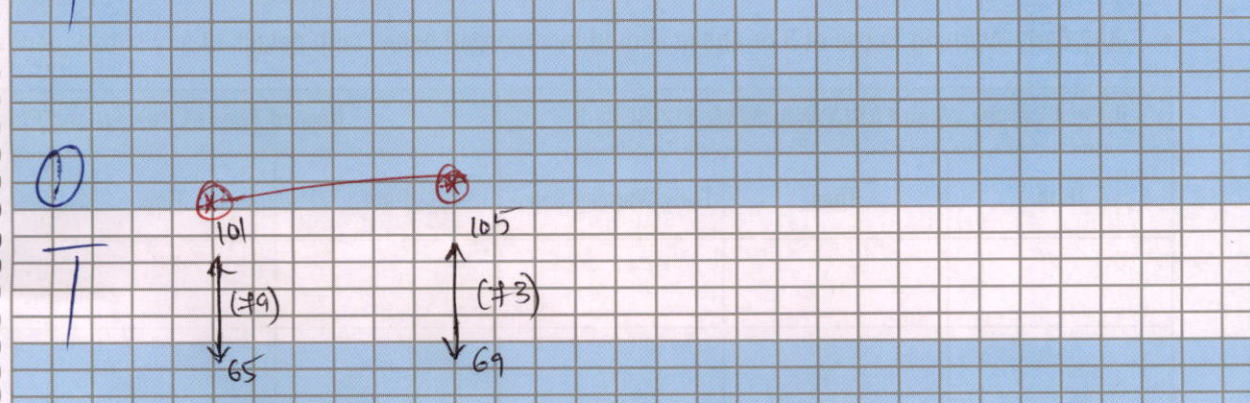
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

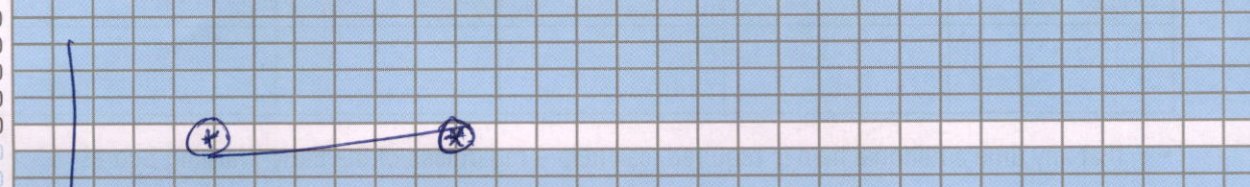


Heart Rate (Number)

117bim 125bim

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

70
60
50
40
30
20
10



Resp Rate (Number)

29bim 27bim

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100% 100%

Conscious Level
Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 1

Pain Score

0 6

Observer's Initials

[Signature] [Signature]

ACTIONS

NB: Scores 3 should be
recorded overleaf

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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)

FLUID CHART

Sheet No. :

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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
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

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16-03-2017 9 Y 3 M 18 D (M)
Dr. P V L N MURTHY



FLUID CHART

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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sgn. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
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						

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment:

Acute pain & Discomfort

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
2pm	Assess the pt General Condition	2pm	Assessed the pt General Condition.	pt is Conscious & oriented
3pm	Relieve pain & Discomfort	3pm	Relieved pain & Discomfort	vital stable
4pm	monitors vital signs	4pm	monitored vital signs	no bleeding
5pm	monitors for bleeding	5pm	monitored for bleeding	maintained
6pm	maintain i/o chart	6pm	maintained i/o chart	no vomiting
7pm	npo status maintained	7pm	npo broken, water given	shifted
8pm	pt shift to the ward	8pm	pt shifted to the ward	

Re-Assessment:

After surgery pt is Conscious & oriented

Special Notes:

pt had ice cream, no vomiting

Nurse Signature: [Signature]

Nurse Name: Divya

Date & Time: 3/7/26 @ 9pm

VH-00109019 IPS-001/5929
Master SREE REHANSH
16-03-2017 9Y3M18D (M)
Dr. P V L N MURTHY

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/2025

Assessment: Baby is having dull activity

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
8pm	⇒ Assess the general condition of the baby	8:10pm	⇒ Assessed the general condition of the baby	The baby condition is Improving slowly
11pm	⇒ provide comfortable bed and position	11:10pm	⇒ provided comfortable bed and position	
2AM	⇒ monitor vital signs	2:10pm	⇒ monitored vital signs	
4AM	⇒ Administer medication as per doctor order	4:10AM	⇒ administered medication as per doctor order	
6AM	⇒ provide personal hygiene	6:10AM	⇒ provided personal hygiene	

Re-Assessment: Baby is feeling discomfortable

Special Notes:

Nurse Signature: pramila

Nurse Name: pramila

Date & Time: 4/7/2026 8AM

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. PVLN Murthy Department: OT Date of Admission: 3/7/16

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	<u>Adenotonsillectomy</u>						
BACKGROUND	Area	Shift Time	ER 4:13 pm	OT 11:30 am	IST 8:00 am		
	Medical Condition (Any special condition to be noted):		no	NA	NA		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	98.2°F	98.6°F	98.2°F		
		Res:	22 bpm	25 bpm	28 bpm		
		SpO ₂ :	97%	98%	99%		
		Pulse:	94 bpm	84 bpm	84 bpm		
		BP:	124/55	101/64	100/70		
		Fall Risk Score:	10	10	11		
Pain Score:	0/10	0/10	0/10				
Recommendations	Safety Needs:	yes	yes	yes			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	no	NA	NA			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	no	NA	NA			
Post Operative Procedure Special Orders:		no	NA	NA			
Handed Over By Name :		poofa	Pranila	Pranila			
Signature :							
Date:		3/7/16	3/7/16	4/7/2016			
Time:		4:20 pm	8 am	8 am			
Taken Over By Name :		Pranila	Pranila	Shariya			
Signature :							
Date:		3/7	3/7/16	4/7			
Time:		4:20 pm	8 pm	8 am			



JRSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Recommendations		Pain Score:						
	Safety Needs:							
	Physiotherapy	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



THE HUMPTY DUMPTY SCALE

3/7 4/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2		1			
	Other Medications / None	1	1				
TOTAL			10	10			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes			
Call device within reach	Yes	Yes			
Wheels Locked	Yes	Yes			
Room free of clutter	Yes	Yes			
Adequate Lighting	Yes	Yes			
Wheel Chair Support	No	No			
Other Intervention(s) Specify	No	No			
Nurse's Name :	Aml	Pranvi			
Signature :	Aml	Pranvi			
Date :	3/7	4/7			
Time :	3:20	6AM			



BRADEN 'Q' SCALE

				Date : 3/7/20	4/7/20		
				Time : 3:00 PM	6:00 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	
'Activity The degree of physical activity'	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	OK
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
				TOTAL SCORE	28	28	
				Evaluator's Name	Anel	Poamila	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

VIH-00109019 IP5-00175929
Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY

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Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY



INTERDISCIPLINARY

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/17	3:29 pm	0/10	SS	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO NO	Anu
3/7	5:35 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Dr. S
4/7	4:35 AM	1/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pranika
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: Adenotonsillectomy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<u>3 PM</u> <u>3:45 pm</u>	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>Adenotonsillectomy</u>	<u>hemodynamic stability.</u>	<u>adenotonsillectomy</u>	<u>B. Achil</u>	☒ Nursing ☐ Others:
<u>3 PM</u> <u>3:45 pm</u>	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>Adenotonsillectomy</u>	<u>W. stable</u>	<u>NPO</u> <u>1W</u>	<u>As:</u>	☒ Medical ☐ Others:
<u>4 PM</u> <u>9 am</u>	☐ Medical ☐ Nursing ☐ Others: <u>dictation</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>Adenotonsillectomy</u> <u>EBL Seal</u> <u>cleared</u> <u>impaction</u>	<u>soft diet</u>	<u>RDA</u> <u>E: -1600 kcal/d</u> <u>PL- 28 g/d</u>	<u>mouning</u>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Docu. No. : RCHBH / FRM / CLINICAL / 040

stimulation - quick
recovery

equal to 75% with stimulation -
slow recovery Out of sync or
fighting ventilator



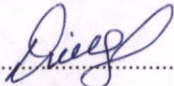
CHECKLIST FOR THROMBOPHLEBITIS

5/7/26

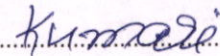
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	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	1	-	-							
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	1	-	-							
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	1	-	-							
Signature of the Nurse				Dijal pramila									

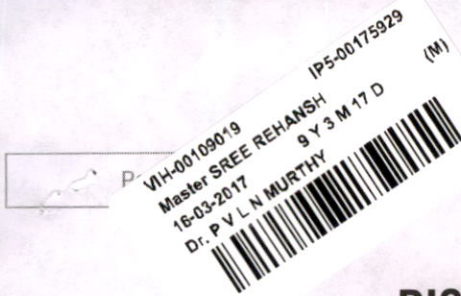
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 



DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: as per doctor order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

Yes

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: medication

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 3/7/2017 @ 9pm

VIH-00109019
Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4 PM

Mode of Arrival:

Walking

Admitting From:

☒ ER ☐ OPD ☐ Direct
Body Weight: 40 Kg
Height: cm

Allergy / Adverse Reaction

Nil

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History:

Nothing significant

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

Is 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: 40 kg

Length:

Head Circumference (< 2 years):

Temp: 98.4 F

HR:

90 bpm

RR:

22 bpm

BP:

90/50 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)

22

(Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No

If Yes, Pain Score: 0/10

Pain tool used:

☒ N Pass

☐ FLACC

☐ Wong Baker

Character of Pain

Location

Frequency

Duration

FUNCTIONAL SCREENING:

- ☐ Mobility Problem
☐ Developmental Delay

- ☒ No Abnormalities Detected
☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- ☐ Underweight
☐ Feeding Problem

- ☒ No Abnormalities Detected
☐ Overweight
☐ Special diet

- ☐ Special Feeding Method
☐ 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):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.

Social History: Lives With Patient

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse Signature: [Signature]

Nurse Name: Reena

Date: 3/4/20

Time: 4pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

VIM-00109019 IP5-00175929
Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Sree Rehanish Age: 9y Sex: M UHID.No: VIM-00109019

Date: 11/7/26 Time: 4:55 pm Proposed Operation: Adenotonsillectomy & Coblation B/L & turbinoplasty

Diagnosis:

B.P / CRT: H.R: Weight: 38.5kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies:

Medical History: CVS : Not Significant C-section / Term / 3kg / No NICU adm
RESP : Diabetes :
CNS : * Vaccinated upto date
Renal : * Milestones delayed, Speech
Hepatic / GE : Physical Activity: Active still del
Others :

Past Anaesthetic History:

Physical Exam:

Airway: MP 1/2 3 4 Mouth Opening: adequate Mentohyoid Distance: (N) Neck: (N) Teeth: All teeth intact
Lungs : RAT @, clear
Heart: S1 S2 @
CNS: Grossly Intact.
Pregnant: ☐ Yes ☒ No ☐ NA Venous Access Site : Accessible Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis : coconut water Explained
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient Attender
- Other Instructions:
• CBP on IV cannulation.

Signature: [Signature] Name: Dr K S Ranga



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status:	adequate
Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed

H.R:	111	B.P / CRT:	94/86	SpO ₂ :	100	R.R:	21	Last Feed:	> 6h	
Pre-OP Diagnosis:		Adenoid hypertrophy		Operation:		adenotomylary tubu		Date:		3/7/2020
Surgeon:		Dr. PVLN Muthy		Anaesthesiologist:		Dr. Shalini		Technician:		

TIME	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
N ₂ O (AIR/O ₂) LPM	1:1																																									
HALO/ISO/SEVO	MAC																																									
Drugs:																																										
Propofol	1.5mg																																									
Propofol	70mg																																									
Propofol	100																																									
ROCURONIUM	20mg																																									
Dexona	3mg																																									
TRANXA	800																																									
PARACETAMOL	1600mg																																									
FiO ₂ / SaO ₂	100	100	100	100	100																																					
ETCO ₂																																										
ECG	SR	SR	SR	SR	SR																																					
Temperature																																										
Urine Output																																										
Fluids	RINGER 500ml																																									
Blood	LACTATE																																									
B.P	240																																									
V Systolic	220																																									
A Diastolic	200																																									
X Mean	180																																									
Heart Rate	160																																									
Tourniquet on Time	140																																									
Tourniquet off Time	120																																									
Throat Pack In	100																																									
Throat Pack Out	80																																									
	60																																									
	40																																									
	20																																									
	10																																									
	0																																									

LAB Values	ABG	
	GRBS	
	Others	

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: <u>C arm</u> ☐ Art Site: ☒ EKG Lead ☒ Temp Site: <u>skin</u> ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: <u>Supine</u> ☒ 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: <u>6:55 am</u> OP Start: <u>7:31 pm</u> OP End: Leave OR: Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>R 22g</u> ☐ IV: ☐ IV:	Induction ☒ IV ☐ Inhal ☒ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# <u>6</u> at cm ☐ Oral ☐ Nasal ☒ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: <u>ROCURONIUM 20mg</u> ☐ Awake ☒ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# <u>2</u> Attempts: <u>1</u> Difficulty Why? ☐ Bilal = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☒ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. Shalini</u> Signature of the Doctor: <u>[Signature]</u>
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Durg Time Received : 8:35pm Time Discharged : 9:30pm

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 ← RESP • PULSE → BLOOD PRESSURE ← RES → SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>996</u> ☐ 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 : _____
	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	1	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 move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP ± 20 of Pre Anaesthetic leve	= 2	2	2	2	2		
BP ± 20-50 of Pre Anaesthetic leve	= 1						
BP ± 50 of Pre Anaesthetic leve	= 0						
Fully awake	= 2	1	1	2	2		
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/7	8:35pm	1/10	—	Durg

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

Anaesthesiologist Name : Durg

Anaesthesiologist Signature: Durg

Date & Time: 3/7/26 9:30pm

PACU Nurse Name : Durg

PACU Nurse Signature: Durg

Date & Time: 3/7/26 @ 9:30pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): 114

Date & Time: 3/7/26 @ 9:30pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Adenotonsillectomy & coblation

Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. PVLN Murthy

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 can be achieved by infusing weak solutions of local anaesthetics and 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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Laryngospasm, Bronchospasm, post Op O₂ Support, post Op Ventilator Support

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]

Name: Rajesh Uppu

Relationship with patient: Father

Date & Time: 1/7/26 5:05 PM

Witness:

Signature: [Signature]

Name: Deepthi

Date & Time: 1/7/26 5:05 PM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. K. Srinivas

Date: 1/7/26 Time: 5:05 pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నిష్పత్తి చేయబడ్డాయి.

- ☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం
- ☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)
- ☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అనాహారం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00109019 IP5-00175929 Master SREE REHANSH 16-03-2017 9 Y 3 M 17 D (M) Dr. P V L N MURTHY 		Date & Time of Admission 3/7/26 @ 3:32 pm	Date & Time of Transfer Order 3/7/26 @ 4:13 pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 2	Number of Imaging Films NA	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op files	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Protogon	(1)	
2.	Adult (m) drapper	(1)	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Anneel		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Tareu			
Date & Time of Patient Received : 3/7/26 @ 4:15 pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00109019 IP5-00175929 Master SREE REHANSH 16-03-2017 9 Y 3 M 17 D (M) Dr. P V L N MURTHY 		Date & Time of Admission 3/7/26 @ 3:30 pm	Date & Time of Transfer Order 3/7/26 @ 9 pm
Transfer Ordered by Dr. PVLN Murthy		Reason for Transfer Post-Op	
From Unit OT	To Unit 119	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	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.	Op file @		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. PVLN Murthy	
Patient & Clinical Records Received by : Divya			
Date & Time of Patient Received : 3/8/26 6 pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

Npo - 11:30 AM (saled)
3pm (Dns)

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Sree Rehansh Age : 9y3M Gender: ☐ Male ☐ Female
Date : 03/07/26 Time of Arrival : 3:15pm Triage Completion Time : 3:17pm
Allergies: ☐ No ☒ Yes ☐ Food ☐ Medications ☐ Other (Specify): Banana, Lobster, Dust ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify) _____
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS	
Appearance	Work of Breathing	☒ Stable	
☒ Normal	☒ Normal	☐ Unstable:	
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening	
☒ Normal	☐ Decreased	☐ Life - Threatening	
☐ Abnormal	☐ Gasping / Apnea		
☐ Bleeding			

Initial Vital Signs: Temp: 98.2°F PR: 94bpm BP: 124/55 (79) RR: 22bpm SpO₂: 97% RA
Chief Complaints: Came for Coblation Adenotonsilectomy + Turbinoplasty.

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: [Signature]

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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: _____
- Are your parents / close contacts at home 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 : NR Dubow

Date & Time : 3/7/26 at 3:17pm

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

Signature of Triage Nurse : [Signature]

VIH-00109019
Master SREE REHANSH
16-03-2017 9 Y 3 M 17 D (M)
Dr. P V L N MURTHY

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 31/2/22 Time of arrival : 3:18 pm
Chief Complaints: came for cleft lip - Adenotonsillectomy + Turbinoplasty RBS: NA
Height : NA Weight : 40.4kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☒ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☒ Food ☐ Other:
If yes, identify Banana, lobster, dust
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character nil ☐ Location nil ☐ Frequency nil ☐ Duration nil

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
- ☐ If Patient is > 6 years
Assess the below parameters
- History of Falling: within past 3 months ☐ Yes ☒ No
- Ambulatory Aids:**
- Wheelchair ☐ Yes ☒ No
 - Uses furniture for support ☐ Yes ☒ No
- Gait/Transferring:**
- Bedrest / immobile ☐ Yes ☒ No
 - Weak ☐ Yes ☒ No
 - Impaired ☐ Yes ☒ No
- Mental Status:** Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With parents

Siblings in household ☐ Yes ☐ No (if yes How Many?) 1 elder sister

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 3:20 pm

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

Time	Nursing Notes
3:12pm	After the child condition
	- monitored vitals & recorded
	- seen Dr. Nandan
	- shifted to

Samples collected by:
 Samples sent by: / NR. prasad

Time: / 3:45pm
Time:

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: 94b/m BP: 124/65 CFT: 2 sec RR: 22b/m SPO ₂ : 100% GCS: 4/5/6 Temperature: 97.8°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: OT Time of Shift - out: 4:13 pm Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):
20 placement done

Name of the Nurse : pooja Signature of the Nurse : P

Date & Time : 3/7/26 @ 3:45 pm



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 4/7/26 Time: 9am

Weight: 38.5 kgs Centile: >90th

Height: 144 cms Centile: >90th

Inference: overweight child

RDA: - Calories: 1600 kcal/d Protein: 28 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy & outside foods

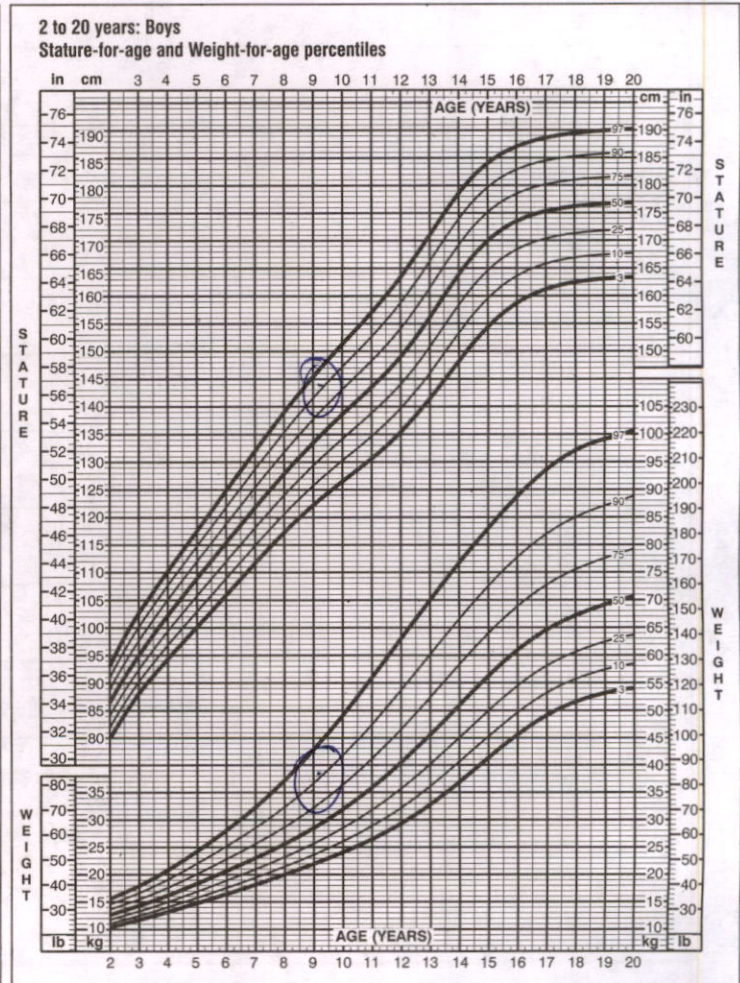
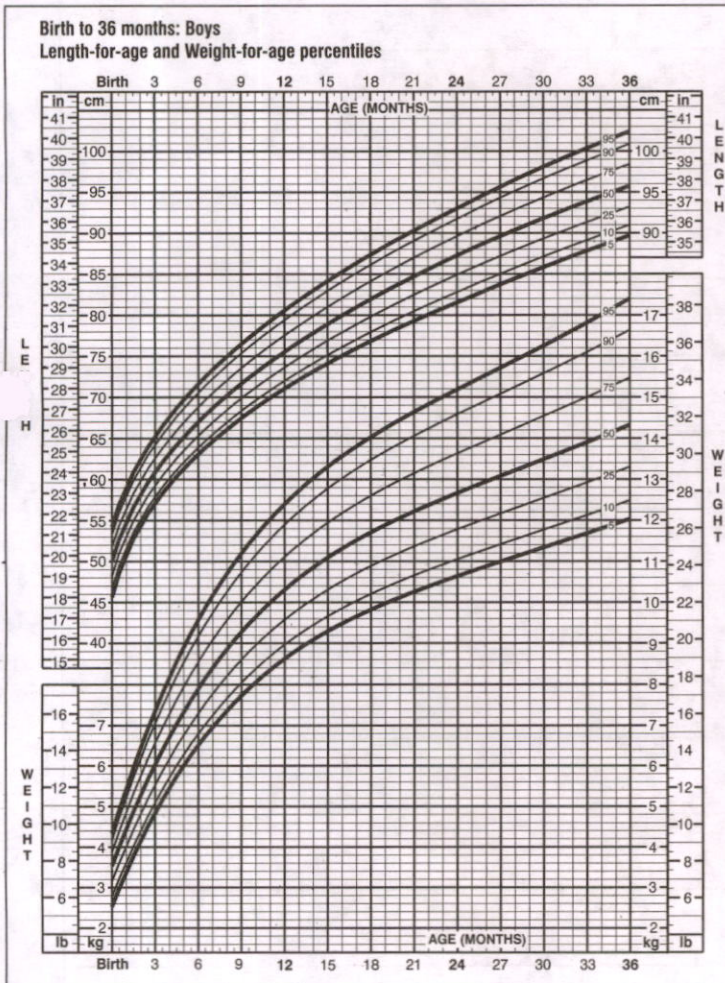
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Adenotonsillitis & Bil. faecal impaction

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)



Dietician's Name: mounica

Dietician's Signature: mounica

Daily Notes: