

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 5 Y 5 M 25 D (F)
Dr. P V L N MURTHY



SmithNephew
EVAC° 70 XTRA HP
WITH INTEGRATED CABLE
REF EIC5874-01
LOT 2203235
2028-11-06

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ENTERED
81139
SURGERY DETAILS

Date: 20/7/20
Patient Name: Baby Narayana Chathurveda Date of Birth: 25/1/21 Age: 5y
Gender: female Ward: P.O.T UHID No.: BAH-00619578
Date of Surgery: 20/7/20 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Adeno to millerotomy & collection

Time in: 6:00 PM Time Out: 7:00 PM
Cath
Gw

	NAME	AMOUNT
1. Surgeon	Dr. P V L N MURTHY	SV = 31,760
2. Anaesthetist	Dr. Akhila	AN = 9530
3. Assistant Surgeon		OT = 85,408
4. OT Technician		OTC = 85.00
5. Circulating Nurse	Ala	
6. Assistant Nurse	Thyagar	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others: Calender 9713394

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9713393

Order by: Benjamin

ESTIMATION SLIP

Through what type of insurance?

Date: 18/07/2025 UHID / IP No.: BAH-00619578 SI No. 81139
 Name of Patient: Baby Chathuranga Alaraja Age: 54 Gender: F.
 Father's / Husband's Name: Mr. Alaraja Alaraja Corporate / Occupation:
 Address: Phone: 998988007 Email:
 Procedure / Plan: A demo-lensilectomy + loblation.

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

TARIFF INFORMATION:

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(P Day)	Room Rent & Nursing Charges										
	Doctor's Fee										
	L. Tax	10650 puray									
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				SEPARATE 341936 ARIKAR TOT. 12706 25408							
O.T. Consumables				Subject to approval by TPA / Insurance Company							
Instrument Charges				Not Covered by TPA / Insurance company							
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation							
Equipment Charges	Monitor :	Oxygen :				Infusion pump / Syringe pump :					
	Ventilator :	Conventional :	HFO-SLE 5000 :				HFO Sensormedix :				
	Phototherapy :	Single Surface :	Double Surface :				Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation							
Package											
Others				As per actual - 28,000							
Initial Minimum Deposit				Approx. 1,60,000							

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- 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.
- 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.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- 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.
- 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.
- 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
- 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.
- 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. Alaraja Alaraja, 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

Signature of the Financial Counselor

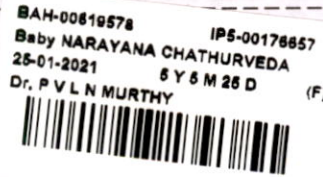
ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Dept : _____

Date of Admission: _____ Time _____ e : _____ Time: _____

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/5/20	3:40pm	CR	OT	
20/5/20	9:30pm	OT	12H	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. V. Swale	21/7/20	9713925	
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Signature

Tennant

De

BABY 1 HATURVEDA NARAYANA
 BAH-0019578 54/5m
 5456 16/08

CONSUMABLES OF OT



Circulating staff : Technician : Shirley Date : 20/7 Time :

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube	40.4550	144	Major Pack	1	1	Inj Vit.K		
LMA	2	01	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	6-6-57-75	242	Surgical Gloves		
02 cc	10	5	PF 7	2	2	Gauze Pack		
01 cc	5					Syringe 1ml / 2ml		
Cautery plate : A P N	01	20	Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube	6 NO	2	Koochies (S)		
RL	01	1	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	144	144	Koochies			Transfix	1	1
mid sp R	01	1	Ointments			Sawlon	1	1
valley set	01	1	Suction Catheter			5cc. 10cc	2	2
Fentanyl	01	4	Cap, Mask	55	55	Adrenaline	3	3
Morphine			Gauze Pack	1	242			
Ketamine			Mop Pack	1	1	Nalvion nasal	1	0
Propofol	03	1	Steristrip			drop PR		
Rocuronium	01	1	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1	1			
Myopyrolate + Neostigmine	02	2	Abgel					
Ondansetron	01		Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%	01		Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics	01	1	Bandage					
SV PCN	01	1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin 12.5 mg / 25mg / 100mg	144	4	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
3way 10cm 1100cm	144	1	Microshield	1	1			
Gave + G/odecap	544		Cotton Balls					
Dese + G/onece	144	144	Latex Gloves	10P	10P			
SV Cauter 2444	144		Ramdione Scrub					
Q. SUE, splat 113	144		Saral					

Surgeon : Anaesthesiologist : Nurse : OT Technician :
 Order No. : 9713187 Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	12669.	Tenavef
20/7	PAC	1		Devi
21/07	NRMS	1	512.8	

ANY OTHER INFORMATION

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Date : 21/7/26 Time : 10:45 Prepared By : Anupa

Staff Nurse Anupa	Shift / Ward Q20-11 144	Billing Assistant	Billing Supervisor
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ADMISSION SHEET

Registration Details :

Admission No : IP5-00176657

Admit Date : 20-Jul-2026

Admit Time : 03:05 PM **UHID :** BAH-00619578

Patient Details :
Patient Name : Baby NARAYANA CHATHURVEDA

Age : 5 Y 5 M 25 D

Guardian : Mr NARAYANA NAVEEN KUMAR

DOB : 25-01-2021

Gender : Female

Religion :
Occupation :
Martial Status : Single

Address (H) : H NO 10-83/2, KALKI NAGAR, STREET NO 01
 Kamareddy Telangana INDIA 503111

Phone No : 9989880071/ 9490513017

E-mail :
 NARAYANAARUNKUMAR@GMAIL.CO

Admission Details :
Bed Type : DAY CARE

Bed No : PRE OP 401

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 401

Admission Type : First Visit

Contact Details :
Name : Mr NARAYANA NAVEEN KUMAR

Relationship : Father

Contact Address : H NO 10-83/2, KALKI NAGAR, STREET NO 01
 Kamareddy Telangana INDIA 503111

Phone No : 9989880071 / 9490513017


Doctor Details :
Doctor Name : Dr. P V L N MURTHY

Specialisation : EAR NOSE AND THROAT

Referral Doctor : SELF

Phone No :
Co-Consultant : Dr. SANDEEP REDDY

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00619576 IP5-00178657
Baby NARAYANA CHATHURVEDA
25-01-2021 6 Y 5 M 25 D (F)
Dr. P V L N MURTHY



Patient Name:

Narayana Chathurveda

UHID ID:

Department:

Consultant:



Handwritten signature

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

*do mouth Breaths
Swallowing*

History of present illness :

*child was apparently well till 2 yrs ago
Co for developed Swallowing a week before
↓
started with mouth
↓
became again
↓
Admitted - Admitted to hospital*

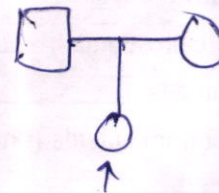


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

FT / WSC / C / Bw - 2.5 kg



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Assured as per age in all 4 domains

Immunization History :

Vaccinated till now as per IMZIS



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) _____ (Centile _____)

On Examination :

Temperature : 96.4 F Pulse Rate : 95 bpm B.P. 96/63 (21) SPO2 96%

Resp. rate and type of breathing : 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : BAE ⊕

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : Sub ⊕

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection SK

Palpation : _____

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/16

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Enlarged Adenoids & Tonsils



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Septic & Decubitus infection

Desired goals of the treatment: Resolution of symptoms

Planned Labs:

CBP N/B
1 sample
20/07/20

Planned Management

> NPO as advised
- PAC to be done
- vital monitoring

N/B
1 sample
20/7/20

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Balaji

Date & Time: 20/7/20, 2:40 pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. P.V.L. Murthy

Date & Time: 20/07/20 5pm

DR. PVLN MURTHY
Registration No: 47267

Date & Time	Progress Notes	Doctor's Order
20M/26	CS/B Resident Chronic Adenotonsillitis S/P: Adenotonsillectomy & Coablation Child doing well not started food encourage soft food. no blood from nose & site hemodynamically stable vitals - stable	Plan ① continue medication ② monitor for bleed Inform for ③ encourage soft feed. ④ monitor vitals which
21/1/26 8:30 AM	Seen by Resident chronic adenotonsillitis S/P coablation adenotonsillectomy hemodynamically stable	Plan D/C today. f santhos

7. P V L N MURTHY



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Vijwala D. Date : 21/7/26 Time :

Diagnosis : post Adenotomillectomy

Hospital : RCH-BH

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:

opinion for discharge

Signature: _____

Findings and Recommendations :

Asis - Chronic adenotomillitis
S/P coblation adenotomillectomy.
p. no fever/ bleeding
accepting orally

O/E hemodynamically stable
throat healthy

Plan
1. can be discharged
2. f/u : ENT surgeon.

Consultant :

Name : Dr. Vijwala Signature : [Signature] Date & Time : 21/7/26

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 6 Y 6 M 28 D (F)
Dr. P V L N MURTHY



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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Balaji

Date & Time: 20/12/20, 2:35 pm

Nurse Name & Signature: Penuk

Date & Time: 20/12/20 & 2:40 pm

BAH-00619578 IP5-00176657
 Baby NARAYANA CHATHURVEDA
 25-01-2021 5 Y 5 M 25 D (F)
 Dr. P V L N MURTHY



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : LANZOL DT				Date Time	20/1/17														
Dose	Route	Frequency	Start Dt.																
15mg	P/O	OD	20/1																
Name & Signature of the Doctor Starting the Drugs: <u>Sohel</u>				11:30pm 6AM - 11:30pm Drug given															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : TAB TRANEXA				Date Time	20/1														
Dose	Route	Frequency	Start Dt.																
1/4 tab	P/O	BID	20/1																
Name & Signature of the Doctor Starting the Drugs: <u>Sohel</u>				10AM X 11:30pm 14pm Drug given															
Additional Instructions: 1 tab = 500mg																			
Daily Doctor's Endorsement by a Sign																			
DRUG : SALT WATER GARGLE				Date Time	20/1														
Dose	Route	Frequency	Start Dt.																
150ml water	P/O	TID	20/1																
Name & Signature of the Doctor Starting the Drugs: <u>Sohel</u>				6AM 2pm 10pm															
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																			

Signature

VERIFIED BY: Name

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 5 Y 5 M 25 D (F)
Dr. P V L N MURTHY



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				



ade

DRUG CHART

Date of Admission: 25-01-2021 Drug Allergies: Not known any Drug Allergies ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Signature
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

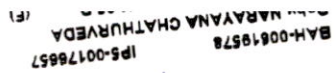
Weight 12 kg Ward

DRUG : <u>SYP AUG, ME</u>				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 : <u>SYP AUGMENTIN DA</u>				Date Time <u>20/7</u>
Dose <u>4ml</u>	Route <u>P/O</u>	Frequency <u>BID</u>	Start Date <u>20/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>				<u>10AM X</u>
Additional Instructions:				<u>11:20pm</u> <u>10pm pram</u> <u>Divya</u>
Daily Doctor's Endorsement by a Sign				

DRUG : <u>SYP XYZAL M</u>				Date Time <u>20/7</u>
Dose <u>5ml</u>	Route <u>P/O</u>	Frequency <u>OD</u>	Start Date <u>20/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>				<u>11:20pm</u> <u>10pm pram</u> <u>Divya</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>SYP CROCIN D</u>				Date Time <u>20/7</u>
Dose <u>5ml</u>	Route <u>P/O</u>	Frequency <u>TID</u>	Start Date <u>20/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>				<u>6AM X</u> <u>pram</u> <u>Divya</u>
Additional Instructions:				<u>2pm X</u> <u>11:30pm</u> <u>pram</u> <u>Divya</u>
Daily Doctor's Endorsement by a Sign				



Weight. 174 Ward.

[illegible]

BAH-00619578 IPS-00178857
 Baby NARAYANA CHATHURVEDA
 25-01-2021 6 Y 6 M 26 D (F)
 Dr. P V L N MURTHY



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					

Handwritten signature

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 5 Y 5 M 25 D (F)
Dr. P V L N MURTHY



HBH/ FRM / CLINICAL / 126

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/01/2021 Time: 10:00

Doctor / Nurse / Family Concern?

Temperature (°F)

Heart Rate (bpm)

and

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 Mod/ Severe Distress 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

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.
	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)

BAH-00619578 IP5-00176657
 Baby NARAYANA CHATHURVEDA
 25-01-2021 5 Y 5 M 25 D (F)
 Dr. P V L N MURTHY



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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 Thrombophlebitis 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	water									0	2
	09:00 pm											
20/1	10:00 pm	100 ml		1				1	1		0	1
	11:00 pm										0	1
	12:00 am										0	1
	01:00 am										0	1
Total Intake :						Total Output :						
	02:00 am	100 ml		1				1	1		0	1
	03:00 am										0	1
21/1	04:00 am	100 ml		1				1	1		0	1
	05:00 am										0	1
	06:00 am										0	1
	07:00 am										0	1
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

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FLUID CHART

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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.

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						



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 20/7/20

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
7pm	* Assess the pt General Condition. * Relieve pain & Discomfort * monitor vital signs * monitor for bleeding * maintain I/O chart * maintain NPO status	7pm	* Assessed the pt General Condition. * Relieved pain & Discomfort * monitored vital signs * monitored for bleeding * maintained I/O chart * NPO broken, water given	pt is Conscious & oriented * vital stable * no bleeding * maintained * no vomiting
9:30pm	* pt shift to the ward	9:30pm	* pt shift to the ward	* shifted

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 20/7/20 9:30pm

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NURSING CARE RECORD

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☒ Night

Date: 20/7/26

Assessment: Baby having pain.

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 patient.	8pm	* Assessed the general condition of the patient.	By doing all the procedures the patient can be stable.
10pm	* maintain personal hygiene.	10pm	* maintained personal hygiene.	
2am	* monitor vitals.	2am	* monitored vitals.	
6am	* maintain good nutrition	6am	* maintained good nutrition	

Re-Assessment: monitor vitals.

Special Notes:

Nurse Signature: @ef

Nurse Name: @inpa

Date & Time: 21/7/26 @ 2am

Pat



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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					
	Other Medications / None	1	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 :		Renul	any			
Signature :		R	any			
Date :		25/1/21	2/1/21			
Time :		3:40 PM	6:00 PM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Murthy Department: ICU Date of Admission: 20/1/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known				
	<u>Adenotonsillectomy</u>		If Yes Specify:				
BACKGROUND	Area	Shift Time	EX 3:40P	OT	1st 7:30P-8P		
	Medical Condition (Any special condition to be noted):		NA	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:	98.6°	98.2	98.2°	
	Res:		22b/min	20	28L		
	SpO ₂ :		96%	98%	98%		
	Pulse:		95b/min	101	108L		
	BP:		96/63(mm)	98/65	99/62		
	Fall Risk Score:		10	11	11		
	Pain Score:		0/10	1/10	0/10		
	Recommendations	Safety Needs:		Side rail	yes	yes	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		NA	NA	NA			
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		NA	NA	NA			
Post Operative Procedure Special Orders:		NA	G/L SD	NA			
Handed Over By Name :		Renub	Pranav	Pranav			
Signature :							
Date:		20/1/20	20/1	20/1			
Time:		3:45P	9:30P	8P			
Taken Over By Name :		Teena	Pranav	Pranav			
Signature :							
Date:		20/1	20/1	20/1			
Time:		3:40 3:40P	9:30P	8:30P			

NURSING 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					
	Medical Condition (Any special condition to be noted):						
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:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		Fall Risk Score:					
Pain Score:							
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:						
	Special Diet:	☐ 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:							

BAH-00819578 IP5-00178657
 Baby NARAYANA CHATHURVEDA
 25-01-2021 6 Y 6 M 28 D (F)
 Dr. P V L N MURTHY

BRADEN 'Q' SCALE

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					Date :	20/12/21		
					Time :	2:40		
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 e.tremity 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		
FRICITION-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		
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					Renuka			

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

P-00619578
by NARAYANA CHATHURVEDA
25-01-2021 6 Y 6 M 26 D (F)
Dr. P V L N MURTHY



PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/1/20	2:45 PM	0/10	PA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Penub
20/1/20	8 PM	1/10	Tha	☐ Continuous ☒ Intermittent	☒ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	10 cre	As
21/1/20	6 AM	0/10	WA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	8
				☐ 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:

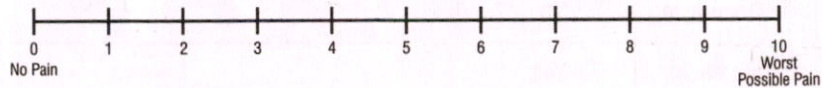
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - slow recovery - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			21/7 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		-	-							
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				[Signature]									

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 : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

Patient

BAH-00619578
Baby NARAYANA CHATHURVEDA (F)
25-01-2021 5 Y 5 M 25 D
Dr. P V L N MURTHY

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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)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 20/7/26 @ 6pm

Docu. No. : RCHBH /FRM / CLINICAL / 191



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 8:40 p.m. Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: N/A Body Weight: Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Admission to NICU	N/A	N/A

Family History: Notifying Significant

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

If yes please list,

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

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

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

Observations: Weight: Length: Head Circumference (< 2 years):

Temp: 98.4 F HR: 90 b/m RR: 28 b/m BP: 90/50 mm Hg

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 13 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 20) (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:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual 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 WithSiblings 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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☐ NoInformation given to MotherNurse Signature: [Signature]Nurse Name: [Name]Date: 20/7/20Time: 8:40 pm

BAH-00619578 IPS-00178657
 Baby NARAYANA CHATHURVEDA
 25-01-2021 6 Y 6 M 25 D (F)
 Dr. P V L N MURTHY



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

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

Relug

Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/1/20	5:00 PM	8	procedure	M	4	0	1	1	-	Relug
21/1/20	9 am	9	soft diet	F	1	0	1	7	-	Relug

Part - III: CODES

Who was taught: PT: Patient		F: Father		M: Mother		S: Spouse		Sn: Son		D: Daughter		C: Caregiver		O: Other (Specify)	
Learning Barriers:															
1. No Learning Barriers		4. Language Barrier		7. Impaired Thought Process/Cognitive limitations				10. Financial Difficulties		13. Cultural/Religion Practice					
2. Physical Impairment		5. Educational Level		8. Responsibilities at Home				11. Beliefs and Values		14. Others (Specify)					
3. Emotional Barriers		6. Desire / Motivate to Learn		9. Cultural Differences				12. Impaired Vision/ or Hearing							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed															
Mechanism/s to overcome barrier/s:															
1. None		3. Reassurance & Support		5. Respect values & beliefs				7. Other, Specify							
2. Obtain translator		4. Teach Family / Others		6. Respect Cultural / Religion Preference											
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review															

BAH-00619578 IP5-00176657
 Baby NARAYANA CHAKRVEDA (F)
 25-01-2021 6 Y 5 M 26 D
 Dr. PVLN MURTHY



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/1/16 3:00P	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotomectomy	H-stability	Fv fluid	mancha	☒ Nursing ☐ Others:
20/1/26 3:20P	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotomectomy	H-stability	Surgery	Renut	☒ Medical ☐ Others:
21/1/26 9am	☐ Medical ☐ Nursing ☒ Others: <u>Dickhan</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotomectomy	soft diet	<u>RDA</u> E:-1400 kcal/d PR 24g/d	<u>Neerita</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:



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 to children
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)
<u>Good results</u>	

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 sequestration
- b. rec. of adenoid

1. I authorize Dr. P V L N Murthy and his / her team to perform the procedural sedation upon the patient / myself.

2. 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.

3. 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: _____

Name: N. Narasim Kumar

Relationship with patient: Father

Date & Time: 20/7/2021 6pm

Witness:

Signature: N. Arun Kumar

Name: N. Arun Kumar

Date & Time: Babai 20/7/21 6pm

Doctor (who is taking consent):

Signature: P V L N Murthy Name: P V L N Murthy Date: 20/7/21 Time: 6pm

శస్త్రచికిత్స / ప్రాసీజర్కు అనుమతి పత్రం

 అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

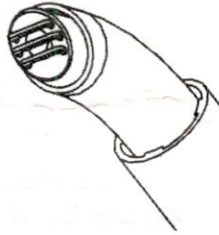
- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు వివరించబడ్డాయి. ఈ శస్త్రచికిత్స / ప్రాసీజర్కు ఉన్న ప్రమాదాలు నాకు వివరించబడ్డాయి.

REF EIC5874-01
LOT 2203235

SmithNephew
QTY: (1)
EVAC® 70 XTRA HP
 WITH INTEGRATED CABLE

శస్త్రచికిత్స / ప్రాసీజర్:

శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

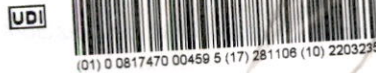


- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలా, డ్రాబోసిస్ (DVT), పల్మానరీ థ్రోంబోసిస్, పై శస్త్రచికిత్స / ప్రాసీజర్ రోగి/నా కోసం అవసరమని వైద్యుడు

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వ

a.

b.


STERILE R
Rx only

2025-11-06
2028-11-06

 ArthroCare Corporation
 7000 West William Cannon Drive
 Austin, TX 78735 USA

EC REP

 Smith & Nephew Operations B.V.,
 Bloemlaan 2, 2132 NP Houtfildorp,
 Netherlands

NL18H0000MD_v2

సూచనలు అలెల్లి, పక్షవాతం, డీప్ వెయిన్ థ్రోంబోసిస్ ఉందని నాకు తెలుసు. లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, అనుమతిస్తున్నాను.

పబ్లిషర్:

- డాక్టర్ / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.

- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళగానీ ఏ గ్యారంటీ ఇవ్వలేదు నేను అనుమతిస్తున్నాను.

- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమై సమాధానం ఇచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో ఇస్తున్నాను.

మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స

శస్త్ర / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం

ప్తరు, మరియు అవస్థ నాకు అర్థమయ్యే భాష

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

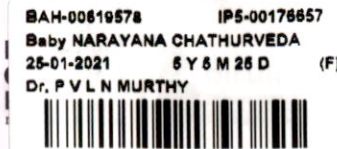
డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. PVL Murthy
Asst. Surgeon :
Anaesthetist :
Scrub Nurse : Thirug

Patient Name : Bhargava Age : 6Y Gender : F
UHID No. : Surgery Name : Append
Date : 20/7 In-time : 6 PM Out-time : 7 PM



Before Induction of Anaesthesia >>

SIGN IN		Time: <u>5:15pm</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. Shripa</u>		

Before Skin Incision >>

TIME OUT		Time: <u>6:10pm</u>
Confirm all team members have introduced themselves by Name and Role		
	☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	☐ Yes ☒ No ☐ NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☐ Yes ☒ No ☐ NA	
Is Essential Imaging Displayed?		
	☐ Yes ☒ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☒ Yes ☐ No	
Signature : <u>[Signature]</u>		
Name : <u>[Signature]</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>6:50pm</u>
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>Dr. PVL Murthy</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☐ Yes ☐ No	
Site	☐ Yes ☐ No	
Procedure	☐ Yes ☐ No	
Consent	☐ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☐ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☐ No ☐ NA	
Signature :		
Name :		

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? ☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No		
Signature :		
Name :		

Before Patient Leaves Operating Room

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

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 5 Y 5 M 25 D (F)
Dr. P V L N MURTHY

Patient Sticker



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 20/7

Department : P.O.T. Duration of Procedure :

Name of Surgeon : Dr. P V L N MURTHY Date of Admission : 20/7

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 : Zin Augmentin	
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) 37.6 ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : 20/7 Date & Time of antibiotic administration : 20/7 Date & Time procedure started : 20/7/25 6 AM	

- 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



Patient S

OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female

UHID No. : Weight : 16 Kg Height :

Surgeon : Dr. P V L N MURTHY Asst. Surgeon :

Anesthetist :

OT Nurse:

OT Technician:

Pre-Operative Diagnosis: Adenotomectomy

Surgical Procedure : Adenotomectomy & Tonsillectomy

Indications for Surgery :

Date : 22/1/21

Start Time : 6.15 AM

End Time : 6.50 PM

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Adenotomectomy & Tonsillectomy

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1 Symp. AVU MENTON DSS 5ml BID-2wky	
2 Symp. OMNACORTIL 5ml BID-2wky	
3 Symp. X7ZAL-M 5ml BID-2wky	
4 Symp. CROCLIN DS 5ml TID 2wky	
5 T. LANA ZOLEDT 100 BID-2wky	
6 T. TRANEKA 500ml 4x tab old BID-2wky	
7 Salt water gargle TID 2wky	

Name of the Surgeon: Pradeep Mehta

Signature of the Surgeon: [Signature]

Date & Time: 20/7/26

BAH-00619578 IP5-00176657
Baby NARAYANA CHATHURVEDA
25-01-2021 5 Y 5 M 25 D (F)
Dr. P V L N MURTHY

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

Date: Time:

readjusted if necessary.

CONSENT FORM FOR ANAESTHESIA

Surgeon Name: Dr. K. B. Ray Age: 6y Gender: Male ☐ Female ☒
Operative procedure planned: Adenotomylabry & Colobotomy
Anesthesiologist: Dr. K. B. Ray

PLEASE READ THIS BEFORE

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local 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 mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others: Desaturation, laryngospasm

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

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

Patient / Patient Attendant :

Signature: [Signature]
Name: Naveen Kumar
Relationship with Patient: Father
Date & Time: 20/6/26 6p

Witness :

Signature: [Signature]
Name: N. Lakshana
Date & Time: 20/6/26 6p

Doctor (who is taking the consent) :

Signature: [Signature]

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

Name: Dr. K. B. Ray



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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

Name: Noranyan dathurveda Age: 5 Y 6 M Sex: F UHID.No:
Date: 20/10/2026 Time: Proposed Operation: Aden X ectomy
Diagnosis: Adenotonsillar Hypertrophy
B.P / CRT: H.R: Weight: 18 kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies:

Medical History: CVS: No of mouth Breathing & snoring PT / LUS / NO NICE adams
RESP: Diabetes: BW 28 kg
CNS: (Gm) - Coriolatrucked and Orthodontic treatment
Renal: admitted in ICU. No rule stone delay
Hepatic / GE: Ba 7 day e Nard Physical Activity: active
Others: prolong oxygenation.

Past Anaesthetic History:

Physical Exam:

Airway: MP 2 3 4 Mouth Opening: 2 fingers Mento-hyoid Distance: 2.5 cm Neck: (2) Teeth: (2) loose
Lungs: BAC (P) clear
Heart: normal
CNS: Subcut

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: (P) Dorsum Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL Water / ORS 2 Hours & expand
Others 6 Hours
- Informed Consent: ☐ Standard ☒ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient Abudu
- Other Instructions:

Signature: [Signature] Name: Dr. Leela Ramya

Patient Sticker

ANAESTHESIA CHART

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

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

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ NoFasting Status: Adequate

Physical Status:

☐ Patient Identified☒ Consent Present☒ Chart ReviewedH.R: 112/7mmB.P / CRT: 60/60SpO₂: 100%R.R: 18/7mm

Last Feed:

Pre-OP Diagnosis:

Operation: AdenotonsillectomyDate: 20/8/20Surgeon: Dr. [Signature]Anaesthesiologist: SNTechnician: [Signature]

TIME

N₂O / AIR / O₂ LPM

HALO / SO / SEVO

Drugs:

Propofol 4mgPENTANYL 30Rompidolium 10mg

Antibiotic

Suppository

Blood Loss

NOTES

Fluids
BloodB.P
V Systolic
A Diastolic
X Mean
• Heart RateTourniquet on Time
Tourniquet off TimeThroat Pack In
Throat Pack Out

LAB Values

ABG

GRBS

Others

☐ Equipment Checked and Functional☒ BP☒ Cuff Site:☐ Art Site:☒ EKG Lead☐ Temp Site☐ FIO₂ Monitor☒ Agent Monitor☒ Pulse Oximeter☒ Capnograph☒ Ventilator☐ Nerve Stimulator☐ Position: Supine☐ Pressure Points Checked☐ Eye Care:☐ Oint☒ Tape☐ Padding☐ Awake

Temp:

☒ HME☒ Cling Film☒ Hugger's☐ Other☐ Fluid Warmer☐ OH Warmer☐ Cotton Wool☐ Other

Times:

Anaes Start: 6:00pm

OP Start:

OP End:

Leave OR: 7:00pm☐ Other

Induction

☒ IV☐ Pre O₂☐ Others☐ Inhal☐ RSI☐ Mask☐ Airway☐ ETT#☐ Oral☐ Nasal☐ Cuff☐ Tracheostomy☐ Topical☐ Drug:☐ Awake☐ Video Laryngoscopy☐ Fiberoptic☐ Blade#☐ Attempts:☐ Difficulty Why?☐ Bilal = BS☐ Semi-Closed Circle☒ Closed Circle☐ Other☐ Other☐ Other☐ Other☐ Other

Regional:

Extremity

☐ Spinal☐ Epidural☐ Caudal

Others:

Position:

Site:

Needle Size:

Depth:

Parasthesia ☐ Yes ☐ No

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU☐ ICU☐ OtherRelaxant Reversed ☒ Yes ☐ No ☐ NAName of the Doctor: Dr. ShihSignature of the Doctor: [Signature]

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : QuigTime Received : 7:15pm

Time Discharged :

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 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>225</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: <u>Soft Diet</u>

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 $\pm$ 20 of Pre Anaesthetic leve	= 2	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1						
BP $\pm$ 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
2017	7:15pm	1/10		Quig

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPSAnaesthesiologist Name : Dr. Archana KAnaesthesiologist Signature: [Signature]Date & Time: 2017/26/9 AMPACU Nurse Name : [Signature]PACU Nurse Signature: [Signature]Date & Time: 2017/26/9 9:30

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): 1HHDate & Time: 2017/26/9

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 :



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 21/7/26 Time: 9am

Weight: 17kgs Centile: 25th

Height: 107cms Centile: 25th

Inference: well child

RDA: - Calories: 1400kcal/d Protein: 24g/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy & outside foods

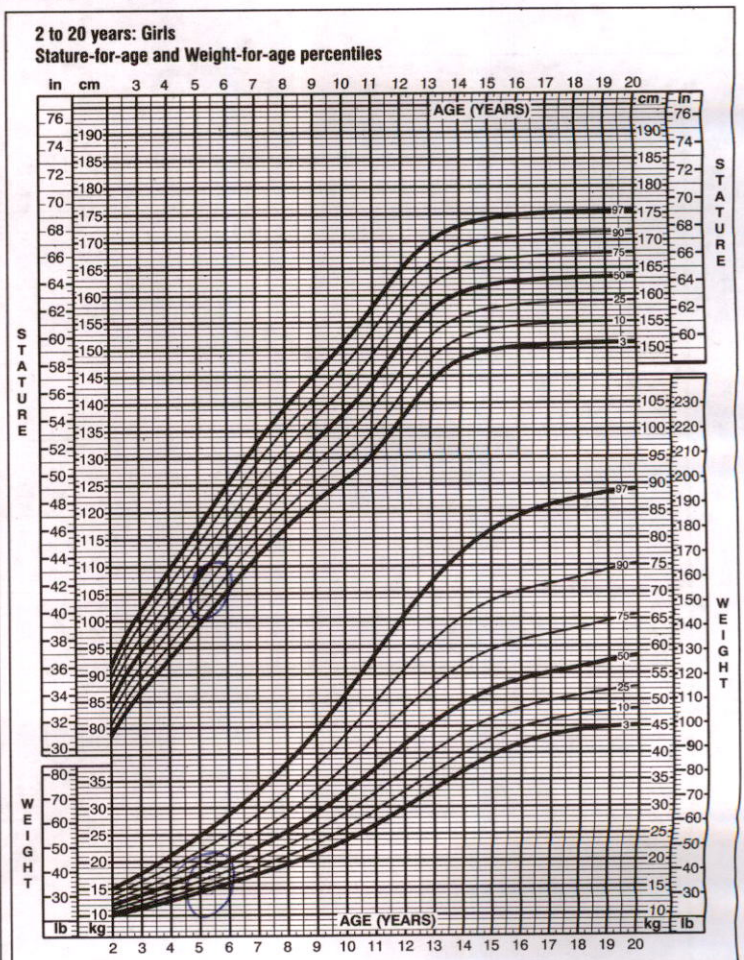
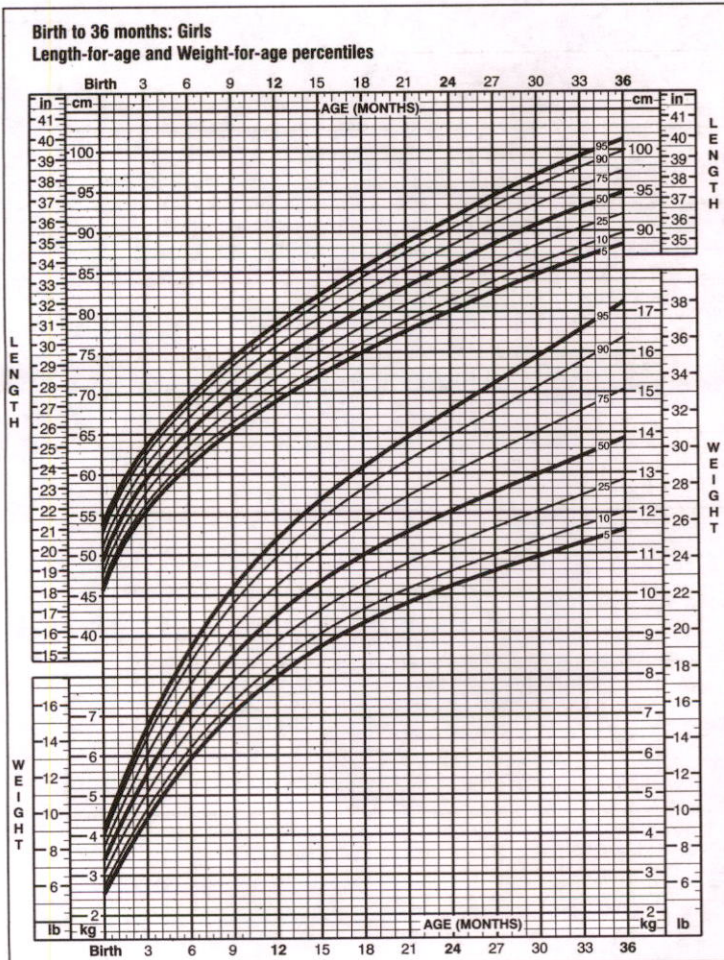
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes: