



SURGERY DETAILS

Date : 04-07-26

Patient Name: Baby Ekaali Rajvanshi Date of Birth: 09-01-2023 Age: 3y

Gender: Female Ward: OT

UHID No.: MAH-00390620

Date of Surgery: 04-07-26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: COMPREHENSIVE ORAL REHAB (I) GIA

Time in : 9:10 AM

Time Out : 10:40 AM

	NAME	AMOUNT
1. Surgeon	DR NAMRATA	DR-II
2. Anaesthetist	Dr. Ayesha	
3. Assistant Surgeon		
4. OT Technician	Shreya	
5. Circulating Nurse	Shruti Majhi	
6. Assistant Nurse	Thejas	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others COLLECT 8000/- TOWARDS CROWNS

Namrata
Signature of the Surgeon

Shruti
Signature of Circulating Nurse

Order No: 9687169

Order by: Dr. P

MAH-00390620

IP5-00175954

Baby EKAVALI RAJVANSHI

09-01-2023

3 Y 5 M 25 D

(F)

Dr. NAMRATA KAMALAKAR RAO



Dental

CONSUMABLES OF OT

Rainbow®
Children's
Hospital

It takes a lot to treat the little.



BirthRight™

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Your Right to a Safe Delivery

Circ

Technician :

Date :

Time :

Anesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube (3.5)	1	1	1	Major Pack (Drape)	1	1		Inj Vit.K			
LMA 1 1/2	1	1	1	Sutures				Cord Clamp			
ECG leads : A (P) N	3	2	3					Suction Catheter			
HME filter : A (P) N	0	1	0					Feeding Tube			
Syringes : 10 cc	20	0	8					Vaccum Suction Set			
05 cc	20	0	8	Gloves 6.6.5	2	1		Surgical Gloves			
02 cc	20	0	8	6.6.5 (7)	2	1		Gauze Pack			
01 cc	5	1	1					Syringe 1ml / 2ml			
Cautery plate : A (P) N	0	1	1	Surgical blade				Surgical Blade # 20			
IV set	0	1	0	NG tube				Koochies (S)			
RL	0	1	0	Cautery pencil				NS 500ml	1	1	
NS : 10ml (100ml) 600ml 1000ml	2	1	1	Koochies				Transfix	1	1	
nick spile	0	1	0	Ointments				lace 5cc	2	1	
vacuum set	0	1	0	Suction Catheter				26 Needle	1	1	
Fentanyl	0	1	0	Cap, Mask	5	5		Loxi Adrenaline	1	1	
Morphine				Gauze Pack (N)	2	2		Ribbon Gauze	1	1	
Ketamine				Mop Pack	1	1					
Propofol	0	3	0	Steristrip							
Rocuronium	0	1	0	Underpad	1	1					
Glycopyrolate	0	1	0	Draw sheet	1	1					
Myopyrolate 1200	0	2	0	Abgel							
Ondansetron	0	1	0	Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag				04 suction	0	1	
Bupivacaine 0.25%	0	1	1	Chest Drainage Catheter				0.2 0.1	1	1	
Bupivacaine 0.25%(Heavy)				Romodrain bag				0.2 12.20	1	1	
Antibiotics				Bandage				0.2 max (0)	0	1	
Su Pen	0	1	0	Tegaderm				Atropine 1mg	1	1	
Suppositories				Ioban				in dox + teplidie	1	1	
Anamol : 80mg / 250mg / 170 mg				Double J Stent				Coyle + conic an	1	1	
Supridol : 100mg				Vaccum Suction set	1	1		Transpore	0	1	
Justin : 12.5 mg / 25mg / 100mg	0	1	0	Plastic Bed Sheet	1	1		20/100 4/6	1	1	
Tab. Misoprost : 200mg				Betadine Solution							
3 way 10cm + 10cm	1	1	1	Microshield	1	1					
Gauze + towel	2	1	1	Cotton Balls	1	1					
Dea + Tante	1	1	1	Latex Gloves	100	100					
TV cable 24/4	1	1	1	Ramdone Scrub							
Q. 24, split 1, 3	1	1	1	Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. 9687179

Ordered by :

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

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175954 Admit Date : 04-Jul-2026 Admit Time : 07:19 AM UHID : MAH-00390620

Patient Details :

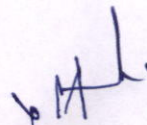
Patient Name	: Baby EKAVALI RAJVANSHI	Age	: 3 Y 5 M 25 D
Guardian	: Mr TANUSHREE BARAL	DOB	: 09-01-2023
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: 1803, Tower F, Rainbow Vistas Rock Garden, Green Hills Road Kondapur Hyderabad Telangana INDIA 500084	Phone No	: 9035967730/
		E-mail	: kaushikb112@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 402 Ward Name : 4F-OT COMPLEX
 Room No : PRE OP 402 Admission Type : First Visit

Contact Details :

Name	: Mr TANUSHREE BARAL	Relationship	: MOTHER
Contact Address	: 1803, Tower F, Rainbow Vistas Rock Garden,Green Hills Road Kondapur Hyderabad Telangana INDIA 500084	Phone No	: 9035967730


 Signature

Doctor Details :

Doctor Name	: Dr. NAMRATA KAMALAKAR RAO KOTHAPALLI	Specialisation	: DENTAL
Referral Doctor	: SELF	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
09/01/26	7:40am	ER	OT	Mugund
09/01/26	11:30am	OT	billing	Deep

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7	IV placement PAC (on op Basis)	1	0809	Dr. Khan

ANY OTHER INFORMATION

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.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[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. COMPREHENSIVE ORAL REHAB (I) GIA

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>RELIEF OF PAIN AND INFECTION</u>	<u>—</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. NO COMPLICATIONS

b. _____

- I authorize Dr. _____ 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: _____

Name: ABHINAV RAJVANSHI

Relationship with patient: FATHER

Date & Time: 04/07/2026 @ 09:05 AM

Witness:

Signature: [Signature]

Name: CHANDRASEKHAR

Date & Time: 4/07/26 @ 9:07 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. NAMRATA R

Date: 4/07/26 Time: 9:03 AM

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, అనస్థీషియా 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:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon: Dr. Namrata
Asst. Surgeon: Dr. Ayesha
Anaesthetist: Dr. Ayesha
Scrub Nurse: Thejas

MAH-00390620 IP5-00175954
Baby EKAVALI RAJIVANSHI
09-01-2023 3 Y 5 M 28 D (F)
Dr. NAMRATA KAMALAKAR RAO

Date: 9/1/26 In-time: 09:11AM Out-time: 10:40AM

Age: 34 Gender: F
Primary Name: Comprehensive Care
Rehab & Care

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Children's
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>9:05AM</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. Ayesha</u>		

TIME OUT		Time: <u>09:28AM</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, <u>1hr 15min</u>		
Anticipated Blood Loss? <u>< 20ml</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>Sujata</u>		

SIGN OUT		Time: <u>10:40AM</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 NAMRATA K</u>		

Patient Sticker

MAH-00390620 IPS-00175954
 Baby EKAVALI RAJVANSHI
 09-01-2023 3 Y 6 M 26 D (F)
 Dr. NAMRATA KAMALAKAR RAO



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Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 04/07/26

Department : OT Duration of Procedure : 1hr 15min

Name of Surgeon : Dr. Namrata Kamalakar Rao Date of Admission : 04/07/26

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 : _____	Sufata
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	Sufata
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 : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 04-07-26 @	Sufata

- 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

MAH-00390620 IP5-00175954
Baby EKAVALI RAJVANSHI
09-01-2023 3 Y 5 M 25 D (F)
Dr. NAMRATA KAMALAKAR RAO



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OPERATION THEATER NOTES

Patient's Name : Baby EkaVali Rajvanshi Age : 3y Gender : ☒ Male ☒ Female
UHID No.: MAH-00390620 Weight : 17 kgs Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:		OT Technician:
Pre-Operative Diagnosis:			
Surgical Procedure :			
Indications for Surgery :			
Date : 04-07-26	Start Time : 09:29 AM		End Time : 10:40 AM
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: GIA ⊕ NASAL INTUBATION			
1. PULPECTOMY DONE ON 52, 62			
2. ZIRCONIA CROWNS ON 52, 51, 61, 62			
3. GIC RESTORATION ON 54, 64, 74, 84			
SOFT FOOD FOR 3 DAYS			
GENTLE BRUSHING FOR 3 DAYS			
REVIEW AFTER 3 DAYS.			

R
Symp. IBUGESIC (3.5ml) * 3 DAYS
(1 — 1 — 1)

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: DR NAMRATA K

Signature of the Surgeon: Namrata

Date & Time: 04/07/26 10:35AM

Patient Sticker

MAH-00390620 IP5-00175954
Baby EKAVALI RAJVANSHI
09-01-2023 3 Y 5 M 25 D (F)
Dr. NAMRATA KAMALAKAR RAO



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: PULP THERAPY + CROWNS + FILLINGS

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

Namrata
Treating Surgeon
(Signature & Stamp)

Date: 04/07/26 Time: 10:35 AM

Note: Plan of care will be readjusted if necessary.



DRUG CHART

Date of Admission: 4/17/2 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
Additional Instructions:				

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

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



REGULAR PRESCRIPTIONS

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7/26	9:15 AM	Inj. PARACETAMOL	225 mg	PV	✗	Cguy Ceylan
4/7/26	9:18 AM	Inj. DEXAMETHASONE	1.5 mg	PV	✗	Cguy Ceylan Shirley
4/7/26	9:20 AM	Supp. DICLOFENAC	12.5 mg	PIR	✗	Cguy Ceylan Shirley
4/7/26	9:25 AM	Inj. TRANEXAMIC ACID	225 mg	PV	✗	Cguy Ceylan Shirley

IP5-00175954

Baby EKAVALI RAJVANSHI

09-01-2023

3 Y 5 M 26 D

(F)

Dr. NAMRATA KAMALAKAR RAO



Weight. Ward.

tion of I.V. Fluid
n ml./hr = Mcg/kg/min. etc)

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of Stopping

Doctor
Sign

Nurse
Sign

4/7

Dr. S.

Dr 40

2

Flourish

417

9:15AM 10 RINGER'S LALATE

IN	150
----	-----



Q

Q

2

2

Signature

VERIFIED BY: Name:



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: GR

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: *Ravi*

Date & Time: 04/07/26 7:20 am

Nurse Name & Signature: *Nandini*

Date & Time: 04/07/26 @ 7:30 am

MAH-00390620 IP5-00175954
 Baby EKAVALI RAJIVANSHI
 08-01-2023 3 Y 5 M 25 D (F)
 Dr. NAMRATA KAMALAKAR RAO



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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 :

.....

.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :

MAH-00390820 IP5-00175954
 Baby EKAVALI RAJVANSHI
 09-01-2023 3 Y 5 M 25 D (F)
 Dr. NAMRATA KAMALAKAR RAO

Patient Still

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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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	h2o										
	12:00 pm	h2o										
	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

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.
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								

Patient Still



THE HUMPTY DUMPTY SCALE

04/07/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	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				
Cognitive impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	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				
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				
TOTAL			13				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes				
Call device within reach	yes				
Wheels Locked	yes				
Room free of clutter	yes				
Adequate Lighting	yes				
Wheel Chair Support	no				
Other Intervention(s) Specify	no				
Nurse's Name :		reusali			
Signature :		[Signature]			
Date :		04/07/26			
Time :		7:30 AM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Namrata Department: OT Date of Admission: 09/01/2023

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Dental Carrier</u>							
BACKGROUND	Area	Shift Time	<u>ER</u> <u>7:40</u> <u>AM</u>					
	Medical Condition (Any special condition to be noted):		<u>NIL</u>					
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:	<u>98.5</u>					
		Res:	<u>26 bpm</u>					
		SpO ₂ :	<u>97%</u>					
		Pulse:	<u>110 bpm</u>					
		BP:	<u>98/62</u>					
	Fall Risk Score:		<u>13</u>					
Pain Score:		<u>0/10</u>						
Recommendations	Safety Needs:		<u>yes</u>					
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NIL</u>					
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NIL</u>					
Post Operative Procedure Special Orders:		<u>NIL</u>						
Handed Over By Name :		<u>[Signature]</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>11/1/2023</u>						
Time:		<u>7:45 AM</u>						
Taken Over By Name :		<u>[Signature]</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>11/1/2023</u>						
Time:		<u>7:45 AM</u>						

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 Tubes/Drains/Catheter: ☐ Yes ☐ No Vital Signs: Temp: _____ Res: _____ SpO ₂ : _____ Pulse: _____ BP: _____ Fall Risk Score: _____ Pain Score: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Safety Needs: _____ Physiotherapy ☐ Yes ☐ No Others Specify: _____ Special Diet: ☐ Yes ☐ No Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



BRADEN 'Q' SCALE

					Date : 04/7			
					Time : 7:30a			
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			
"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			
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			
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			
FRICTION-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			
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			
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			
					TOTAL SCORE	28		
					Evaluator's Name	Amritha		

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

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis

Decayed Teeth.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<i>11/1/26</i>	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>Decayed Teeth</i>	<i>Surg. mgt</i>	<i>Comp. Oral Rehab.</i>	<i>[Signature]</i>	☒ Nursing ☐ Others:
<i>11/1/26</i>	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	<i>Dental Caries</i>	<i>Surg. correction</i>	<i>Comprehensive oral Rehab.</i>	<i>[Signature]</i>	☒ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 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		
04/07	4:30 a	B	procedures	F	1	0	1	1	NR	Dr. Namrata

Part - III: CODES

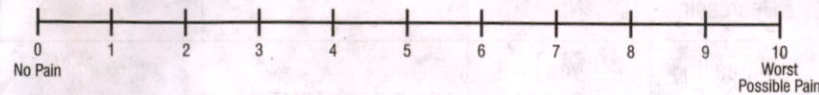
Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
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									

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

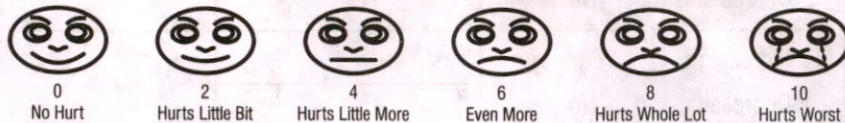
Numerical Pain Scale (Obstetric and Gynecology)



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 - 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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
09/01/2023	9:30 AM	0	Left	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil med.	Observed.
				☐ 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		
				☐ 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:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

- a) At least every 2 hours for the first 24 hours
- b) Then every 4 hours.
- c) Prior to pain pain-relieving intervention.
- d) Within 30 – 60 minutes after pain relief intervention.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Ekavali Rajwanshi Age: 3yr Sex: F UHID.No: 390620
Date: 28/6/20 Time: 5pm Proposed Operation: Comprehensive Oral Rehab
Diagnosis: Delayed teeth
B.P / CRT: H.R: Weight: 14.5kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>11.5</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>37.0</u>	Urea:	Alb:	HBS Ag:	ECG:
WBC: <u>6,900</u>	Creat:	Total Bill:	HCV:	2D Echo:
Plate: <u>298000</u>	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: Nil

Medical History: CVS:

RESP:

Diabetes:

CNS:

Renal:

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History: nil

Physical Exam:

Airway:

MP 1 2 3 4

Mouth Opening:

Mentohyoid Distance:

Neck:

Teeth:

Lungs:

Heart:

CNS:

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site +

Spine Exam for regional: +

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature]

Name: Dr. Sheela

7:00am: Coconut water
9:00pm: Solid.

* To do CBP.

MAH-00390620 IP5-00175954
Baby EKAVALI RAJVANSHI
09-01-2023 3 Y 5 M 25 D (F)
Dr. NAMRATA KAMALAKAR RAO



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 ☒ No

Fasting Status:

Confirmed

Physical Status:

☒ Patient Identified

☒ Consent Present

☐ Chart Reviewed

H.R: 100 bpm

B.P / CRT: 100/60

SpO₂: 98% on R.A

R.R: 18 /min

Last Feed: >6hrs

Pre-OP Diagnosis:

Operation: Comprehensive Oral Rehabilitation Date: 4/8/26

Surgeon: Dr. Namrata

Anaesthesiologist: Dr. K. Sri Surya

Technician: Sireesh

TIME 9:10 9:20 9:30 9:40 10:00 10:30 10:40

N₂O / AIR / O₂ LPM 100 / 0 / 100

HALO / SQ / SEVO MAC 1

Drugs: MIDAZOLAM 0.5mg

FENTANYL 30mcg

PROPOFOL 30mg + 20mg + 10mg

ROCURONIUM 4mg

Antibiotic

Suppository

SUPP D/KLOFEN 12.5mg

Blood Loss

NOTES

Throat pack in @ 9:28 AM

Throat pack out @ 10:30 AM

FiO₂ / SaO₂ 100 100 100 100 100 100 100
ETCO₂ 58 55 40 35 32 38 45
ECG NSR NSR NSR NSR NSR NSR NSR
Temperature
Urine Output

Fluids
Blood

B.P 240
V Systolic
A Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

LAB Values

ABG

GRBS

Others

- ☒ Equipment Checked and Functional
- ☒ BP
- ☒ Cuff Site: (RUE)
- ☐ 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
- ☐ Clip Film
- ☒ Hugger's
- ☐ Other
- ☐ Fluid Warmer
- ☐ OH Warmer
- ☐ Cotton Wool

Times:

Anaes Start: 9:10 AM

OP Start:

OP End:

Leave OR: 10:40 AM

Anaesthesia:

- ☒ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)

- ☐ CVP:
- ☐ ART:
- ☒ IV: 22G (R hand)
- ☐ IV:
- ☐ IV:

Induction

- ☒ IV
- ☒ Pre O₂
- ☐ Others
- ☒ Inhal
- ☐ RSI

Mask

- ☐ Airway
- ☐ ETT # 4mm at 18.5 cm
- ☐ Oral
- ☒ Nasal
- ☒ Cuff
- ☐ Tracheostomy
- ☐ Topical
- ☐ Drug: Rocuronium

Awake

- ☒ Direct Vision
- ☐ Video Laryngoscopy
- ☐ Stylette / Bougie
- ☐ Fiberoptic
- Blade # 2 Attempts: 1
- Difficulty Why?

Bilat = BS

- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional:

- Extremity
- ☐ 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: Dr. K. Sri Surya

Signature of the Doctor: (Signature)

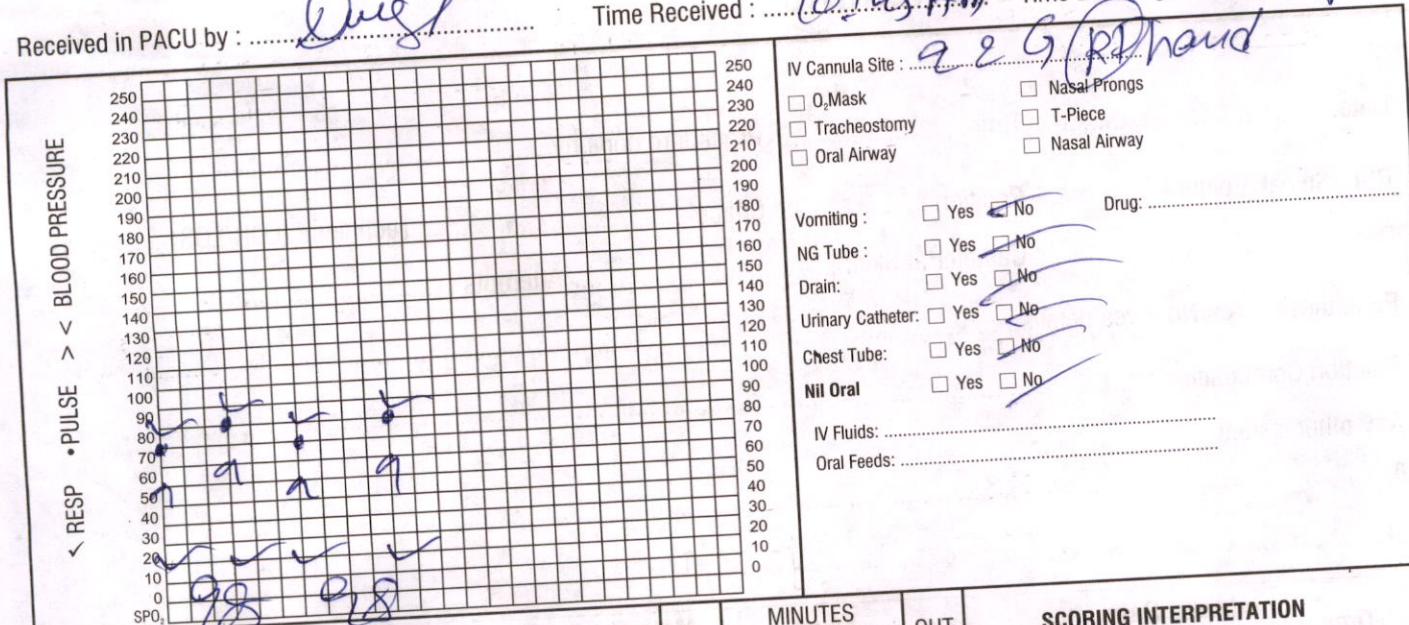
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Rainbow Children's Hospital
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. J Time Received : 10:14 AM Time Discharged : 11:30 AM



POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	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	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP ± 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2		
BP ± 20-50 of Pre Anaesthetic level	= 1							
BP ± 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	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
4/7/2023	10:14 AM	1/10		Dr. J

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature : [Signature]

Date & Time : 4/7/2023 @ 11:30 AM

PACU Nurse Name : [Signature]

PACU Nurse Signature : [Signature]

Date & Time : 4/7/2023 @ 11:30 AM

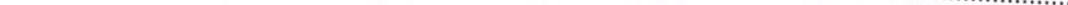
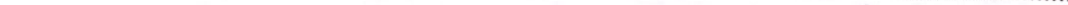
Reassessment Frequency:

- 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): bill / aug

Date & Time : 4/7/2023 @ 11:30 AM

EPIDURAL ANALGESIA RECORD

a)  b) 

[illegible]

Date and Time :

CONSENT FOR ANAESTHESIA

 Authorization By: ☐ Patient ☒ Patient Attendant

 Operative Procedure: Ekavali Rajvanshi

 Anaesthesiologist: Dr Subramanyam Surgeon: Dr Nannale

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

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: Akhil Rajvanshi

 Name: Akhil Rajvanshi

 Relationship with patient: Father

 Date & Time: 29/06/2026 5:05pm
Witness:

Signature:

Name:

Date & Time:

Doctor (who is taking consent):

 Signature: Dr Shiepa Name: Dr Shiepa

 Date 29/6/26 Time: 5pm

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 అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రీజనల్ 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 నివృత్తి 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.
☐ రీజనల్ 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 అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ 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: