

3AH-00654860
 Baby YASVITHA D
 20-05-2019 7 Y 0 M 9 D (F)
 Jr. VENKAT RAM THYALAPALLI



SURGERY DETAILS

Date : 29/05/20

Patient Name: YASVITHA Date of Birth: 20-05-2019 Age: 7r

Gender: Female Ward: P.OT UHID No.: BAH-00654860

Date of Surgery: 29/05/20 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2

Name of the Surgery : lower limb pro 1+1 = 2

*Shree Anshu Singh
 + patient chart*

Time in : 11:32 AM Time Out : 12 pm

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr Venk Ram Thyalappalli</u>
2. Anaesthetist	<u>Dr. Subrahmanyan</u>
3. Assistant Surgeon
4. OT Technician	<u>Venkat</u>
5. Circulating Nurse	<u>Bikhalai</u>
6. Assistant Nurse	<u>Akhil</u>

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

[Signature]
 Signature of the Surgeon

Bikhalai
 Signature of Circulating Nurse

Order No: 9632965 Order by: Bikhalai

Lower Limb Steroid Myeloma
CONSUMABLES OF OT



Circulating staff : Technician : Date : Time : 11:00

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 4040515	111	1	Major Pack	1	1	Inj Vit.K <i>Sui. Biomedical</i>		2
LMA 1/212	11	1	Sutures			Cord Clamp <i>40mg</i>		
ECG leads : A/P/N	5	5	Monocryl 3.4	242	242	Suction Catheter		
HME filter : A/P/N	1	1				Feeding Tube		
Syringes : 10 cc	10	4				Vaccum Suction Set		
05 cc	10	4	Gloves <i>G. 61/2/2/1/2/42</i>	42	42	Surgical Gloves		
02 cc	10	0				Gauze Pack		
01 cc	5	0				Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	1	Surgical blade 11	2	2	Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	1	Cautery pencil	1	1	<i>NS 30ml</i>	1	1
NS : 10ml / 100ml / 500ml / 1000ml	511	0	Koochies			<i>meotix</i>	1	1
<i>minis pile</i>	1	0	Ointments			<i>gelly</i>	1	1
<i>oamale</i>	1	1	Suction Catheter			<i>Soft Roll</i>		
Fentanyl	1	0	Cap, Mask	515	515	<i>4 line</i>	2	2
Morphine			Gauze Pack	5	5	<i>6 line</i>	2	2
Ketamine			Mop Pack	1	0	<i>Artist zinc</i>	2	2
Propofol	3	0	Steristrip			<i>zinc</i>	2	2
Rocuronium	1	1	Underpad	1	1	<i>3 in</i>	2	2
Glycopyrolate	1	1	Draw sheet	1	0	<i>Sui. kenocast</i>	2	2
Myopyrolate <i>Neo</i>	2	2	Abgel			<i>Sui. enoxaparin</i>	1	1
Ondansetron	1	1	Foleys catheter			<i>18G needle</i>	5	2
Pencan 25g/ Spinal Needle 22	1	1	Urobag			<i>22G long spinal</i>	1	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			<i>Gauze</i>	3	0
Bupivacaine 0.25% (Heavy)			Romodrain bag			<i>Glassau</i>	4	1
Antibiotics			Bandage			<i>Dressed</i>	1	1
<i>Bupren</i>	1	1	Tegaderm			<i>dixatranexa</i>	11	1
Suppositories			loban			<i>socipromine</i>	11	1
Anamol : 80mg / 250mg / 170 mg	111	1	Double J Stent			<i>royal prasefion</i>	1	0
Supridol : 100mg			Vaccum Suction set	1	1	<i>royal prasefion</i>	1	0
Justin (2.5 mg / 25mg) 100mg	11	1	Plastic Bed Sheet	1	1	<i>royal prasefion</i>	1	0
Tab. Misoprostol : 200mg			Betadine Solution	1	1	<i>royal prasefion</i>	1	0
<i>Vaccum set</i>	1	1	Microshield	1	0	<i>royal prasefion</i>	1	0
<i>oral airway 0.1</i>	11	1	Cotton Balls	1	1	<i>royal prasefion</i>	1	0
<i>Nasal airway 16/14</i>	11	1	Latex Gloves	1	101	<i>royal prasefion</i>	1	0
<i>Subway 10cm fibero</i>	11	1	Ramdione Scrub	1	0	<i>royal prasefion</i>	1	0
<i>Subcannula 24x</i>	11	1	Saral	1	1	<i>royal prasefion</i>	1	0

Surgeon : Anaesthesiologist : *9632960* Nurse : *Saleh* OT Technician : *VS*
 Order No. : Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125


ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Tir _____ arge : _____ Time: _____

Room / Bed No : _____ Wa _____ illable bed type : _____

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	9:15 AM	ER	OT	Abhishek
29/5/26	1:40 PM	OT	Billing	h

Cross Consultation Visit

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



OPERATION THEATER NOTES

Patient's Name : Age : Gender : Male Female

UHID No.: Weight : Height :

Surgeon : <i>Dr Venkat Rama Thyalappalli</i>		Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:	
Pre-Operative Diagnosis: <i>Left 4th joint (idiopathic chondrolysis)</i>			
Surgical Procedure : <i>Intra-articular steroid injection + percutaneous adductor release</i>			
Indications for Surgery : <i>Left H/O.</i>			
Date : <i>29/05/20</i>	Start Time : <i>11:37 AM</i>	End Time : <i>11:55 AM</i>	
Pre Operative Preparations:			
Post Operative Diagnosis: <i>Same</i>			
Peri-Operative Complications:			
Operation Notes:			
<ul style="list-style-type: none"> - L sedation. - After thorough scrub. - Intra-articular steroid injection given. - percutaneous adductor release done. - Dressing done. - kept to room in stable condition. 			

OPERATION NOTES

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

Name and Number of Surgical Specimen sent for examination: _____

Peri-Operative Complications: Distal injury

Can be distal

- ① 1/2 bag of Erythro plus 1ml/50 / ② 1/2 bag
- ② 1-2 mce / 100 / ③ 1/2 bag
- ③ 1/2 bag in 0.5% of ④ 1/2 bag

Name of the Surgeon: Dr. K. S. S. S. S.

Signature of the Surgeon: [Signature]

Date & Time: 12:15 am 29/5/2022

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Pat



POST-SURGICAL CARE PLAN FORM

Procedure Done: *percutaneous aortic release + Thoracic aortic repair - (L) u*

Post-Surgical Diagnosis: *My. @ 2x. (idiopathic - Chondrolysis)*

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

[Signature]
Treating Surgeon
(Signature & Stamp)

Date: *29/5/2024* Time: *12:15pm*

Note: Plan of care will be readjusted if necessary.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Day case notes</u>	
29/05/26		
9:00 AM	Δ: Kfco Idiopathic chondrolysis of (L) Hip Joint	
	Now for POP lower limb	
		<u>Plan</u>
	O/E ± child alert	1) Continue NPO
	Resp]	2) IV cannula - CBP
	PIA] (2)	3) IV fluids
	CVS]	4) Shift to OT on call.
	Vitals - stable	
	N/S Bhavan 29/5/26	
		<u>Dr. Jayashree</u>

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Venkat Ram

Date : 29/05/26

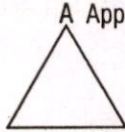
Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: Weight: 15.5 kg

Allergic History:

Chief Complaints: R/O/I Idiopathic chondrolysis of @ Hip Joint
Came for POP Lower limb (steroid Injection into Joint)

Pediatric Assessment Triangle

A Appearance - TICLS
 B  C Circulation Normal Abnormal
 Breathing ↑ WOB ↓ WOB Normal Gasping / Apnea
 Pallor
 Cyanosis
 Mottling
 Bleeding

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

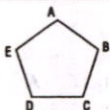
Any urgent interventions needed: Yes No
 If Yes

Significant Past History:

Medication History:


Relevant Investigations:

Primary Assessment




Airway Open Maintainable Not Maintainable

Any urgent interventions needed: Yes No
 If Yes



Breathing Rate: 24/min SpO₂ on FiO₂ 100% @ RA
 Rhythm: regular
 Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
 Respiratory Noises: Stridor Wheezing Grunting
 Air Entry: BAEA
 Palpation Findings (if necessary).....

Any urgent interventions needed: Yes No
 If Yes

Circulation  HR: 96/min

BP: 93/63 mmHg

Pulse Volume: Central Peripheral

If in Shock: Compensated Hypotensive

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

CFT Central Peripheral

Murmurs: Yes No


Liver Span:

ECG:

Any Signs of Heart Failure: Yes No

Any urgent interventions needed: Yes No

If Yes

Disability  GCS: AVPU: Alert

Pupils: Responsive Non-Responsive

Size: Right Left


Active Seizures: Yes No

Sugars:

Signs of Neurological compromise

Any urgent interventions needed: Yes No

If Yes

Exposure  Temp.: 98.5°F

Any Rash: Yes No

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes

- Final Physiological Status:**
- Respiratory Distress
 - Shock - Compensated
 - Cardiopulmonary Arrest
 - Respiratory Failure
 - Hypotensive
 - Hemodynamically Stable
 - Respiratory Arrest

Secondary Assessment: Head to toe examination with positive findings:

.....

.....

Labs Planned:

IV Cannula - CBP

N/S

Bhavani

29/5/26

Treatment Planned:

1) Continue NPO

2) IV fluids

3) Shift to OT on call.

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

Final Diagnosis with possible Differential Diagnosis (If necessary): POP Lower limb (steroid injection into joint).

Assessment done by Sr. Doctor on Duty (If necessary)

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

Signature: JSJ Signature:

Date & Time: 29/5/26 Date & Time:

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DRUG CHART

Date of Admission: 29/05/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY: Name Signature



REGULAR PRESCRIPTIONS

Weight. ...15.5kg... Ward.

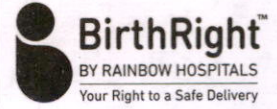
DRUG :				Date															
				Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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																			

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MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	MDI BUDESONIDE	100mcg	with Transpaer	BD	Jayanti	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Jayanti (Dr)

Date & Time: 29/05/26 @ 8:40 AM

Nurse Name & Signature: Abhishele

Date & Time: 29/5/26 @ 8:40 AM

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RESULT SHEET

Date	29/05				
Time	8:54				
Hb	10.9				
PCV	34.4				
RBC	4.60				
WBC	7.51				
N/L	30.8 489				
Platelets	313				
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					

Patient Stic

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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 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 Sticker

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 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												
	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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



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Patient Name : Baby Yashvitha D Age : 6y Gender : Male Female

UHID NO: BAH-00654860 Surgeon Name: Dr Venkat Ram Thyalapalli

Anaesthesiologist : Dr. K. Sri Surya

Operative procedure planned : TENOTOMY OF RIGHT HIP

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

Comments : post op O₂ support

- 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 Baby Yashvitha D the above mentioned operation / Diagnostic / Therapeutic procedures

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

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

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

I authorize the anaesthetic 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.

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : *D. K. Kishore*

Name : *D. K. Kishore*

Relationship with Patient: *FATHER*

Date & Time : *27/5/26 5:00 PM*

Witness :

Signature : *B. Sharan*

Name : *B. Sharan*

Date & Time : *27/5/26 5:00 PM*

Doctor (who is taking the consent) :

Signature : *Dr. K. Sri Surya*

Name : *Dr. K. Sri Surya*

Date & Time : *27/5/26 5:00 PM*

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Baby Yashvitha D Age: 6y Sex: F UHID.No: BAH-00654 & 60

Date: 29/5/26 Time: 4:50 pm Proposed Operation:

Diagnosis: Ideopathic chondrolysis of (L) hip joint.

B.P / CRT: H.R: Weight: 14.32 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/Anglo:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: None

Medical History: CVS: NVD / term / 3kg / No NICU
 RESP: ? Bronchial Asthama Diabetes:
 CNS: last episode 3 months back & Vaccinated upto date
 Renal: Inhaler * Milestones achieved as per age
 Hepatic / GE: Physical Activity: Active
 Others:

Past Anaesthetic History:

Physical Exam:

Airway: MP (1) 2 3 4 Mouth Opening: adequate Mentohyoid Distance: Neck: Teeth: All teeth intact.
 Lungs: BARE ⊕, clear
 Heart: S3 ⊕
 CNS: Grossly intact.

Pregnant: Yes No NA Venous Access Site: Accession Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

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

CURRENT MEDICATIONS	DOSAGE
/	

Pre-Operative Instructions:

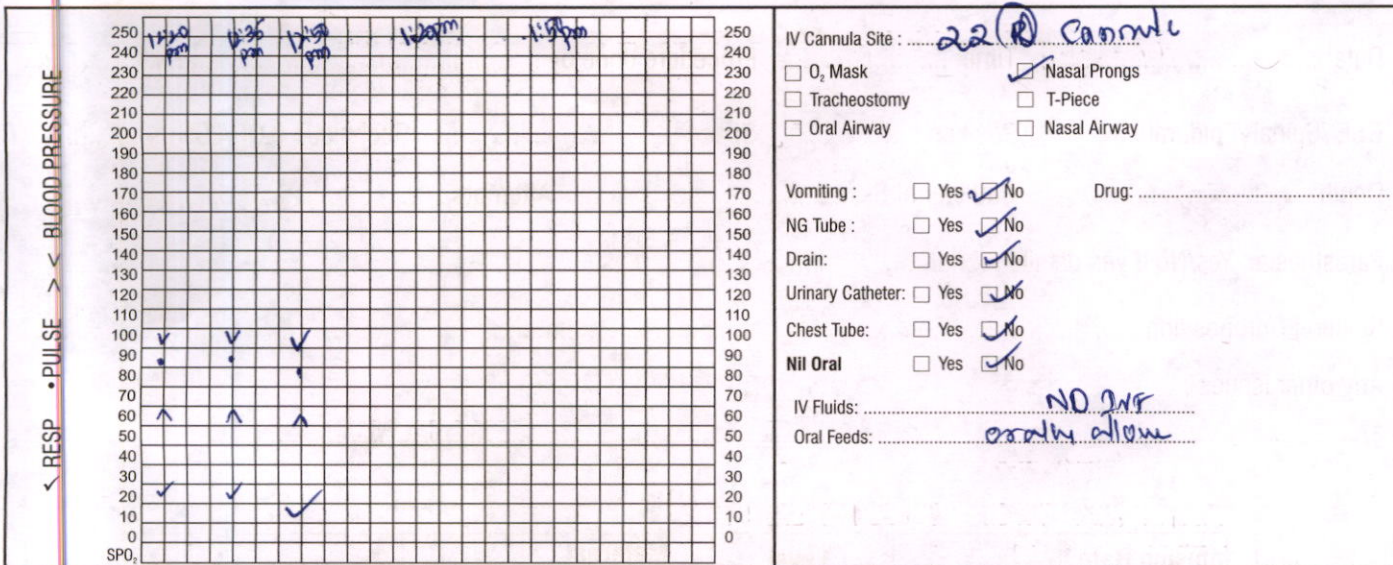
- DVT Prophylaxis:
- NIL ORAL:
 → Water / ORS 2 Hours
 → Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:
 * BP on IV cannulation
 * Bring Inhaler to OT on day of surgery.

Signature: [Signature] Name: Dr. K. Sri Sampa.



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Birkhla Time Received : 12:05pm Time Discharged : 1:16pm



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	2	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	1	2	2		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	1	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29/5	12pm	0/10	NO intervention	<u>Dr. Ashwarya</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name : Dr. ASHWARYA

Anaesthesiologist Signature: Ashwarya

Date & Time: 29/5/26 ; 1:20 pm

PACU Nurse Name : Birkhla

PACU Nurse Signature: Birkhla

Date & Time: 29/05/26 W

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): Billing

Date & Time: 29/05/26 W

