

KUH-00160020 IP5-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 5 D (F)
Dr. P V L N MURTHY



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

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Your Right to a Safe Delivery

SURGERY DETAILS

80411
Date : 20/7/2020
Patient Name: Baby - Annapureddy Yashu Date of Birth: 15/11/2016 Age: 24
Gender: 24 female Ward: POF UHID No: KUH-00160020
Date of Surgery: 20/7/2020 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Abdominal hysterectomy & oophorectomy

Time in : 6.45 PM

Time Out : 7.45 PM

	NAME	AMOUNT
1. Surgeon	P V L N MURTHY	
2. Anaesthetist	Dr. Akhila	
3. Assistant Surgeon		
4. OT Technician	Vijay	
5. Circulating Nurse	Devi	
6. Assistant Nurse	Teja	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others: Coagulator - 9713414

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9713413

Order by: Devi

ESTIMATION SLIP

80411

Date : 22 May 26 UHID / IP No. : KUH 00160020 SI No.
 Name of Patient : Baby Yashvika Reddy Age: 2y Gender: Female
 Father's / Husband's Name : Mr. Sudhakar Reddy Corporate / Occupation : HCL Tech
 Address : Phone : 9705652080 Email :
 Procedure / Plan : Adenoidectomy + Tonsillectomy + coblation.

MODE OF PAYMENT : ☐ SELF ☐ TPA : ☒ GIPSA: MA New India OTHERS

TARIFF INFORMATION :

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges			X							
Doctor's Fee		In Pkg per day			NA					
L. Tax										
PARTICULARS					AMOUNT (₹)					
Surgeon's / Anesthetist's Fee / O.T. Charges					In Pkg					
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 :				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					Pvt. Coe → 46,400					
Others					Circ. Ward → 27,000 Self purchase					
Initial Minimum Deposit					15,000/- Mnd bill clearance.					

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, H.V. etc., 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 7:00 AM), 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, Sudhakar Reddy 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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176667

Admit Date : 20-Jul-2026

Admit Time : 05:18 PM UHID : KUH-00160020

Patient Details :

Patient Name : Baby ANNAPUREDDY YASHVIKA REDDY

Age : 2 Y 8 M 5 D

Guardian : Mr SUDHAKARA REDDY ANNAPUREDDY

DOB : 15-11-2023

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 5-5-177/11/A, MALLIKARJUNA NAGAR,
ROAD NO 02, MANSOORABAD Auto Nagar
Hyderabad Telangana INDIA 500070

Phone No : 9705652080/ 7095292089

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 403

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 403

Admission Type : First Visit

Contact Details :

Name : Mr SUDHAKARA REDDY ANNAPUREDDY Relationship : Father

Contact Address : H NO 5-5-177/11/A, MALLIKARJUNA NAGAR,
ROAD NO 02, MANSOORABAD Auto Nagar
Hyderabad Telangana INDIA 500070

Phone No : 9705652080

A. Sudhakar Reddy
Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY

Specialisation : EAR NOSE AND THROAT

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



CROSS CONSULTATION FORM

Doctor Name : Dr. Annapoorna Date : 20/7/26 Time : 9am

Diagnosis : Sp adenotonsillectomy POD 1

Hospital : RCH B

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:

Signature: _____

Findings and Recommendations :

- no fever/bleed/vomiting
- orally accepting

O/E : vitals stable
alert
chest clear
throat healthy

Adv :

Ⓟ today

Consultant :

Name :

Dr. Annapoorna

Signature :

10A Date & Time :

21/7

LABORATORY FORM

Dr. [illegible]
1/1/74
[illegible]
[illegible]
[illegible]

100% blood / normal
- slightly acidic
O/R - vital stable
chest clear
throat - healthy

1/1/74

Reg. No. 23024
Dr. [illegible]

Dr. [illegible]

ACTIVITY RECORD FOR BILLING

Name : _____

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

KUH-00160020 IP5-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 6 D (F)
Dr. P V L N MURTHY

Date of Admission: _____ Ti _____ Charge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	6:15P	ER	OT	<i>[Signature]</i>
20/7/26	9:30P	OT	301	Benjamin

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Annapurna	20/7/26	9713860	Sheha
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement pac (op Burs)	1	12966	Israf

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Patient



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OPERATION THEATER NOTES

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


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PEDIATRIC IN-PATIENT MEDICAL RECORD

KUH-00160020 IP5-00176667
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Patient Name:

Yashvika Reddy

UHID ID:

Department:

Consultant:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/11 10:30am	C/S/B Resident sp adenotonsillectomy no fever/vomiting O/E: alert vitals stable chest clear	Adv. - (D) 4m - Encourage orally. - cont all medications Akhile
20/11 8am	C/S/B Resident no fever/big bleeds orally accepting O/E: alert vitals stable chest clear throat (D)	Adv (D) today Akhile noted by Sushu 21/11/23 @ 8am

7. PVLK MORTAL



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

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

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Balaji

Date & Time: 20/2/24, 4:30 PM

Nurse Name & Signature: Nr. Seemita

Date & Time: 20/7/26 @ 5 PM



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Tab LANZOL				Date Time	2/17														
Dose 15mg	Route PO	Frequency OD	Start Dt. 20/7																
Name & Signature of the Doctor Starting the Drugs: Akhile																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : Tab TRANEXA				Date Time	2/17														
Dose 1/4 tab	Route PO	Frequency BID	Start Dt. 20/7																
Name & Signature of the Doctor Starting the Drugs: Akhile																			
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																			

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature
VERIFIED BY : Name

KUH-00160020 IP5-00176667
 Patient Baby ANNAPUREDDY YASHVIKA
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DRUG CHART

Date of Admission: 20/12/26 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:				



REGULAR PRESCRIPTIONS

Weight. 11kg Ward.

DRUG: <u>SYP AUGMENTIN DUO</u>				Date Time
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>BID</u>	Start Date <u>20/7</u>	<u>10am</u> <u>5pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Akhile</u>				
Additional Instructions: <u>5/200</u>				<u>10pm</u>
Daily Doctor's Endorsement by a Sign				

DRUG: <u>SYP OMNACORTIN</u>				Date Time
Dose <u>4ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>20/7</u>	<u>11am</u> <u>5pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Akhile</u>				
Additional Instructions: <u>5ml/5ml</u>				<u>11pm</u>
Daily Doctor's Endorsement by a Sign				

DRUG: <u>SYP XYZAL M</u>				Date Time
Dose <u>4ml</u>	Route <u>PO</u>	Frequency <u>BID</u>	Start Date <u>20/7</u>	<u>9am</u> <u>5pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Akhile</u>				
Additional Instructions:				<u>9pm</u> <u>11pm</u>
Daily Doctor's Endorsement by a Sign				

DRUG: <u>SYP CROCIN DS</u>				Date Time
Dose <u>4ml</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>5/7</u>	<u>6am</u> <u>11am</u> <u>5pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Akhile</u>				
Additional Instructions:				<u>10pm</u>
Daily Doctor's Endorsement by a Sign				



Weight. 11 kg Ward. 05

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/7/26	6:22am	NEB E LEVOLIN	0.31mg	neb		Renula Dingo.
20/7/26	6:45pm	2mg AMOXICILLIN CLAVULANIC ACID	300mg	iv		Sham The
20/7/26	6:00pm	2mg TRANEXAMUL ACID	150mg	iv		Sham The
20/7/26	6:50pm	2mg DEXAMETHASO NE	1mg	iv		Sham The
20/7/26	7:00pm	5mg PARACETAMOL	150mg	iv		Sham The
20/7/26	6:50pm	SUP-DICLOFENAC	12.5mg	PR		Sham The



Weight. Ward.

[illegible]

Signature

VERIFIED BY : Name

KUH-00160020 IP5-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 5 D (F)
Dr. P V L N MURTHY



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

PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

Pratiksha
**Rainbow
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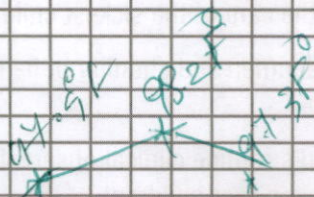
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10/11/26 11pm 3:45pm 6pm

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

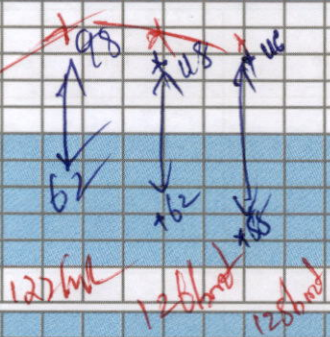
and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

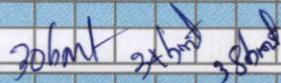
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50



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

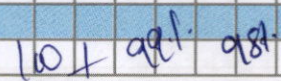
Resp Rate (Number)

70
60
50
40
30
20
10



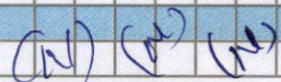
Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)



Conscious Level Normal
Altered

GCS *

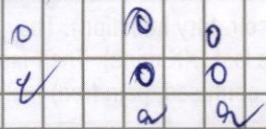


TOTAL SCORE

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.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient

KUH-00160020
IP5-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 5 D (F)
Dr. P V L N MURTHY

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

BirthRight™
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FLUID CHART

Sheet No. : 12

20/11/23

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 :						
20/11	08:00 pm											
	09:00 pm	water	200	-	-	-	-	-	-	-	0	12
	10:00 pm									✓	0	Smk
	11:00 pm	HO	100								0	Smk
	12:00 am	inf	100							✓	0	Smk
	01:00 am		100								0	Smk
Total Intake :						Total Output : 6-2 m-0						
	02:00 am										0	Smk
	03:00 am		100								0	Smk
	04:00 am										0	Smk
	05:00 am	HO	100								0	Smk
	06:00 am									✓	0	Smk
	07:00 am		100								0	Smk
Total Intake :						Total Output : 6-1 m-0						
Total 24 hrs. Intake												
Total 24 hrs. Output			V-3 M-0									

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.

		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											
	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: 27/12/26

Assessment:

Acute pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8. Am	* Assess the pt General condition. * Relieve pain & discomfort. * Monitor vitals signs * Maintain I/O chart * Monitor for bleeding * Maintain NPO status * Pt shift to ward.	8. Am	* Assessed the pt General Condition * Relieved pain & discomfort * Monitored vital signs * Monitored for bleeding * Maintained I/O chart * NPO Broben ^{pi} water given * Pt shifted to ward	Pt is conscious and oriented. * vitals stable * No bleeding * Maintained * NO vomiting * shifted.
9.30		9.30		

Re-Assessment:

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 27/12/26 @ 9.30pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/11/26

Assessment: patient is having 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
10pm	Assess the patient's current condition	10:30pm	Assessed the patient's current condition	As per patient is stable
12am	Administer medication as per chart	12:30am	Administered medication as per chart	
3am	Maintain fluid balance	3:30am	Maintained fluid balance	
6am	Maintain vital signs	6:30am	Maintained vital signs	
7am	Ensure safety	7:30am	Ensured safety	

Re-Assessment: Re-assessment done every 3rd hourly

Special Notes: All

Nurse Signature: [Signature]

Nurse Name: Suela

Date & Time: 21/11/26 @ 5am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Murthy Department: ER Date of Admission: 20/7/26

SITUATION	Diagnosis: <u>Adenotonsil.</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	<u>ER</u>	<u>OT</u>	<u>3rd floor</u>		
	Shift Time	<u>6:15 AM</u>	<u>9 AM</u>	<u>1 PM to 5 PM</u>		
	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>nil</u>	<u>nil</u>		
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: <u>98.6 F</u>	<u>98.6 F</u>	<u>98.9 F</u>		
	Res:	<u>20 bpm</u>	<u>22 bpm</u>	<u>28 bpm</u>		
	SpO ₂ :	<u>97%</u>	<u>98 bpm</u>	<u>100%</u>		
	Pulse:	<u>113 bpm</u>	<u>115 bpm</u>	<u>114 bpm</u>		
	BP:	<u>112/52 (13)</u>	<u>115/60</u>	<u>100/62</u>		
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>nil</u>	<u>nil</u>	<u>nil</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>nil</u>	<u>nil</u>	<u>nil</u>		
Post Operative Procedure Special Orders:		<u>nil</u>	<u>nil</u>	<u>nil</u>		
Handed Over By Name :		<u>Sushmita</u>	<u>Beena</u>	<u>Beena</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7/26</u>	<u>20/7/26</u>	<u>21/7</u>		
Time:		<u>8:15 PM</u>	<u>9:30 PM</u>	<u>8 AM</u>		
Taken Over By Name :		<u>[Signature]</u>	<u>Sushmita</u>	<u>Syothi</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7</u>	<u>20/7/26</u>	<u>21/7</u>		
Time:		<u>6:30 PM</u>	<u>9:55 PM</u>	<u>8 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:						

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BRADEN 'Q' SCALE

				Date : 20/11/23	21/7		
				Time : 5 PM	8 AM		
Mobility	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	
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	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	Dr. PVLN	Dr. PVLN	

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

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PAIN ASSESSMENT FORM

Score (10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign		
20/12/23	Spine	20	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	ns
20/12	10 pm	2/10	st/s pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Phen sup/croon	Snub
21/12	12 am	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ns ns	Snub
21/12	6 am	2/10	st/s pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Phen/croon sup	Snub
21/12	7 am	0/10	ns	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ns ns	Snub
				☐ 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:

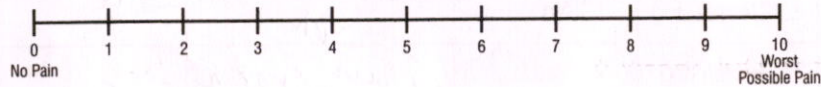
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 - 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



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THE HUMPTY DUMPTY SCALE 20/11/2023

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	17			
	3 to less than 7 years old	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			11	11			

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 :		Susmitha	20/11/2023			
Signature :		[Signature]	20/11/2023			
Date :		20/11/2023	4:47 PM			
Time :		4:47 PM	5 PM			



CHECKLIST FOR THROMBOPHLEBITIS

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

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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KUH-00160020 IP5-00176667
Baby ANNAPUREDDY YASHVIKA (F)
16-11-2023 2 Y 8 M 6 D
Dr. P V L N MURTHY

Telegu

Patient / Learner Literacy:

☐ Read☒ Write☐ SpeakWillingness to Learn: ☐ Yes ☒ NoHealthcare Literacy: ☐ Yes ☒ No

Treatment and Care Plan

3. Pain Management

4. Informed Consent

5. Medication / Therapy (safety, effects/ side effect, interactions)

6. Discharge Medication

7. Infection Control Measures

8. Diagnostic Test / Procedures

9. Nutrition / Diet

10. Fall Risk Education

11. Safe use of Medical Equipment / Implantable Devices Safety

12. Patient's / Family Rights

13. Risk / Safety

14. Activity / Exercise

15. Social & Rehabilitation Needs

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		
20/7/26	5 PM	7	Infection control measures		4	0	1	1	-	
21/7/26	9:40 am	9	soft diet	M	1	0	1	1	-	Saima

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 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7/26 5:30pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillectomy	H-Stability	→ procedure → IV fluid	Baigalio	☒ Nursing ☐ Others:
20/7/26 5:40pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillectomy	H-Stability	→ NPO → IV fluids	Renuke	☒ Medical ☐ Others:
21/7/26 9:40 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Adenotonsillectomy	soft diet	<u>RDA</u> E: 1250Kcal/D P: 21gm/D	Saima	☐ 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:

SURGICAL SAFETY CHECKLIST

Surgeon : D. Murthy
Asst. Surgeon : Dr. Subrah
Anaesthetist : Thapa
Scrub Nurse : Thapa

Baby ANNAPUREDDY TASHVINA
15-11-2023 2 Y 6 M 6 D (F)
Dr. P V L N MURTHY



Age : Gender :
Baby Name : Adi

Date : In-time : 6:45 PM Out-time : 7:45 PM

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Before Induction of Anaesthesia >>

SIGN IN	Time: <u>6:23pm</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. Subrah</u>	

Before Skin Incision >>

TIME OUT	Time: <u>6:50 PM</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>7:40</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. P V L N 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 :	



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. Adenotonsillectomy & Tonsillectomy
2. _____

I acknowledge the following:

1. 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 Gland</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 regurgitation.
- 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: A. Sathya Reddy
 Name: A. Sathya Reddy
 Relationship with patient: FATHER
 Date & Time: 20/11/26

Witness:

Signature: _____
 Name: _____
 Date & Time: _____

Doctor (who is taking consent):

Signature: [Signature] Name: P V L N MURTHY Registration No: 47207 Date: 20/11/26 Time: _____

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

 అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

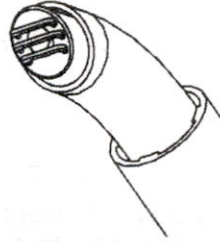
నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ ఈ శస్త్రచికిత్స / ప్రాసీజర్ నాకు స్పష్టంగా వివరించబడ్డాయి. లు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

REF EIC5874-01
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శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ డ్రాంబోసిస్ (DVT), అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ రోగి/నా కోసం అవసరం.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్

a.

b.

- డాక్టర్ / ప్రాసీజర్ను చేయడం

- వైద్యం ఒక శాస్త్రం మరియు ఏ గ్యారంటీ ఇవ్వడం

- పై వివరాలన్నీ నాకు సమాధానం ఇచ్చారు. ఈ అనుమతిని నేను

ం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ సంభవించే అవకాశం ఉందని నాకు తెలుసు. న్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, కూడా నేను అనుమతిస్తున్నాను.

నాకు వివరించబడ్డాయి:

గాలిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స

పవల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం

వకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష న్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

తేదీ & సమయం:

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 20/7/26

Department : P.O.T. Duration of Procedure : 20/7/26

Name of Surgeon : Dr. Murthy Date of Admission : 1hr

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 :	
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleansing surgical area with antiseptic agent)? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 37 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Vijen Date & Time of antibiotic administration : 20/7/26 6.50 PM Date & Time procedure started : 20/7/26 6.50 PM	

- 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

KUH-00160020
Baby ANNAPUREDDY YASHVIKA (F)
15-11-2023 2 Y 8 M 5 D
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

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

CONSENT FORM FOR ANAESTHESIA

Patient Name : Yashvika Reddy Age : 2y 8m Gender : Male ☐ Female ☒
UHID NO: BAY Surgeon Name: Dr. Murthy
Anaesthesiologist : Dr. Subramanyam Operative procedure planned : Adenotonsillectomy

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 : Laryngospasm, bronchospasm

- 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 Anesthesia / ☐ 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 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 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 :

Relationship with Patient:

Date & Time :

Witness :

Signature : [Signature]

Name : [Signature]

Date & Time : 20/01/26 4:15 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Ashwika K.

Date & Time : 20/01/26 4:15 PM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

KUH-00160020 IPS-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 5 D (F)
Dr. P V L N MURTHY



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Name: Yashvika Reddy Age: 2y 8m Sex: F UHID.No: KUH-00160020

Date: 20/11/23 Time: 4:15pm Proposed Operation: Adenotonsillectomy

Diagnosis: Adenotonsillar hypertrophy

B.P / CRT: 13sec H.R: 122 Weight: 11kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG: <u>Small Q</u>
WBC:	Creat:	Total Bill:	HCV:	2D Echo: <u>ASD 3.4mm</u>
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio: <u>lt -> Rt shunt</u>
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS: ASD -> on regular followup RT/NVD/3kgs/NICU for 1 day

RESP: 110 cold & cough - 1 wk Diabetes: motor & speech delay

CNS: Adenoid facies

Renal: mouth breathing BIL hearing loss (+)

Hepatic / GE: / Physical Activity: on speech therapy

Others: Gene 4g deletion

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: (N) Teeth: (N)

Lungs: BAE (+) chr conducted sounds (+)

Heart: S1hr (+) no murmur

CNS: active

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

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 ☒ Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

-> CBC on cancellation
-> Nebulisation Levulin 0.3mg b4 surgery

Signature: (Signature) Name: Dr. Akhila K



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Benjamin Time Received : 8:00 PM 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>Right</u>	
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway	☐ Nasal Prongs ☐ T-Piece ☐ 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 : <u>Oral</u>			
Oral Feeds : <u>Alb</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	0	1	2		2	A Minimum Total Score of 8 is Required for Discharge
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	Exceptions to this, are to be explained in the space below by the Discharging Physician:
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2		2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	0	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		6	8	10		12	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/11/23	9:00 PM	1/10	m	TS

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

Anaesthesiologist Name : Benjamin

Anaesthesiologist Signature: [Signature]

Date & Time: 20/11/23 9:10 PM

PACU Nurse Name : Benjamin

PACU Nurse Signature: [Signature]

Date & Time: 20/11/23 8:40 PM

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): Divy

Date & Time: 20/11/23

KUH-00160020 IP5-00176667
Baby ANNAPUREDDY YASHVIKA
15-11-2023 2 Y 8 M 5 D (F)
Dr. P V L N MURTHY



D ... physiology

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 : *no other*

a)

b)

[illegible]

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 21/7/26

9:46am

Weight: 11kg's Centile: <5th

Height: 86cm Centile: <5th

Inference: underweight child

RDA: — Calories: 1250kcal/d Protein: 21g

Diet Recommendations: soft diet

Re-Assessment: avoid spicy & outside foods

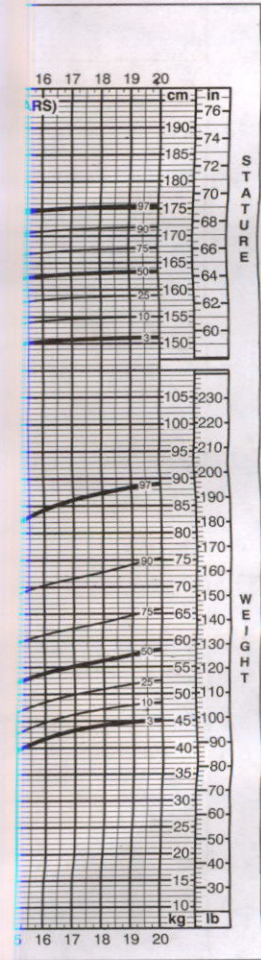
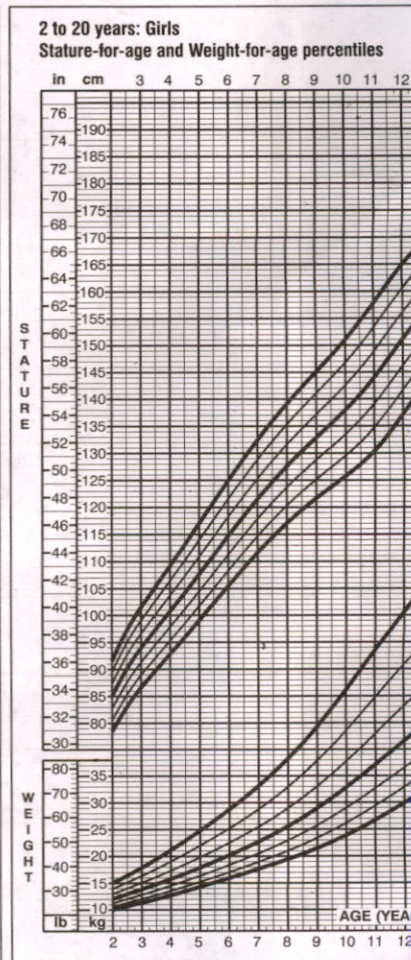
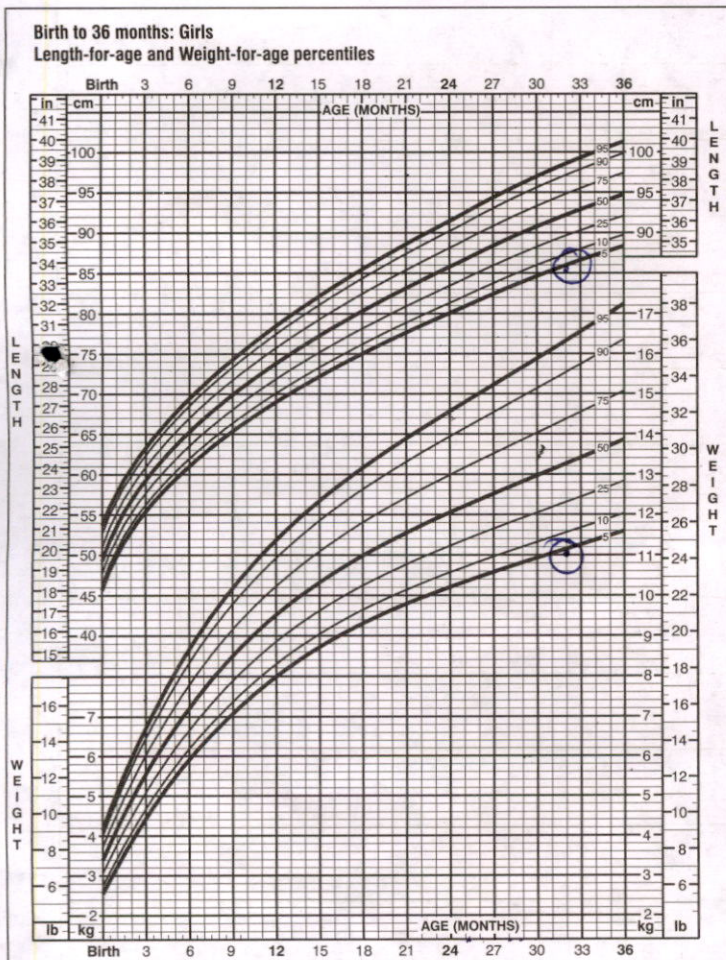
Food Allergies: NO Veg/Non-veg NON-veg

Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Lalith

GROWTH CHART (GIRLS)



Dietician's Name Saini

Dietician's Signature Sa

Daily Notes: