BAH-00656741 IP5-00174482
Master REKA DHAIVIK VIHAAN
01-03-2026 0 Y 2 M 28 D (M)
Dr. HARISH JAYARAM

ENTERED

SURGERY DETAILS

Date : 29/5/26

Patient Name: Mast. Reka Dhaivik Vihaan Date of Birth: 01/03/2026 Age: male 2months

Gender: Male Ward : OT - III UHID No.: BAH - 00656741

Date of Surgery: 29/5/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Tongue Tie Release

Time in : 8.27am Time Out : 8.45am

		NAME	AMOUNT
1.	Surgeon	: Dr Harish Jayaram	
2.	Anaesthetist	: DR. Aishwarya	
3.	Assistant Surgeon	:	
4.	OT Technician	: Venkat Sai	
5.	Circulating Nurse	: Jyothi	
6.	Assistant Nurse	: Suvata	

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

Dr Harish
Signature of the Surgeon

Jyothi.
Signature of Circulating Nurse

Order No: 9632646 Order by: Benjamin

Docu. No. : RCHBH/FRM/GENERAL/114

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Tongue tie Release

CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : .... Time : 8Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5/3.0/5/4	1+1+1	—	Major Pack			Inj Vit.K		
LMA 1	1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	1	0				Suction Catheter		
HME filter : A / P / N	1	—				Feeding Tube		
Syringes : 10 cc	20	4				Vaccum Suction Set		
05 cc	20	2x2	Gloves 6 6½ 7 7½		1+1	Surgical Gloves		
02 cc	20	0				Gauze Pack		
01 cc	10	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	01	Surgical blade			Surgical Blade # 20		
IV set	1	—	NG tube			Koochies (S)		
RL	1	—	Cautery pencil	1	1	Jelly	1	—
NS : 10ml / 100ml / 500ml / 1000ml	1	01	Koochies					
miniplace	1	01	Ointments					
O2 mask (N)	1	—	Suction Catheter					
Fentanyl	1	01	Cap, Mask	5/5	5/5			
Morphine			Gauze Pack (N)	2	1			
Ketamine			Mop Pack					
Propofol	3	01	Steristrip	1	1			
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	—	Draw sheet					
Myopyrolate (Neo)	1	—	Abgel					
Ondansetron	1	—	Foleys catheter			NG tube	4	—
Pencan 25g/ Spinal Needle 22			Urobag			Suction cathetor	5	—
Bupivacaine 0.25%			Chest Drainage Catheter			O2 tray		
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dexamid	1	—
Antibiotics			Bandage			Dexat tramadol	1+1	—
Gorpem	1	—	Tegaderm			Soc tpoline	1+1	—
Suppositories			Ioban			Gauze	3	01
Anamol : 80mg / 250mg / 170 mg	1+1+1	—	Double J Stent			Glove tray	4	—
Supridol : 100mg			Vaccum Suction set			Atropine + Adrenaline	1+1	1+1
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	1	midaz + ephedrine	1+1	01
Tab. Misoprost : 200mg			Betadine Solution			[illegible]	1+1	—
vaccum set	1	—	Microshield			[illegible] + Jelly 2%	1+1	1+1
oral airway 000/00/0	1+1+1	—	Cotton Balls			Nasal prongs [illegible]	1	01
nasal airway 14/16/18	1+1+1	—	Latex Gloves	10	10+		1	
Syringe 10cm + 100cm	1+1	—	Ramdione Scrub					
IV cann nulle 22/24	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9632704 Ordered by : ....

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

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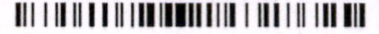
BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET



Registration Details :

Admission No : IP5-00174482 **Admit Date** : 29-May-2026 **Admit Time** : 07:08 AM **UHID** : BAH-00656741

Patient Details :

Patient Name	: Master REKA DHAIVIK VIHAAN	**Age**	: 0 Y 2 M 28 D
Guardian	: Mr REKA SAI RAHUL	**DOB**	: 01-03-2026 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO--634, KUSUMANJALI APARTMENT , Jntu Kukat pally Hyderabad Telangana INDIA 500085	**Phone No**	: 9989903002/ 9014816773
		E-mail	: NOMAIL@GMAIL.COM

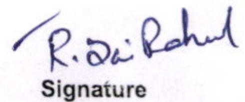
Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 404 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 404 **Admission Type** : First Visit

Contact Details :

Name	: Mr REKA SAI RAHUL	**Relationship**	: Father
Contact Address	: FLAT NO--634, KUSUMANJALI APARTMENT , Jntu Kukat pally Hyderabad Telangana INDIA 500085	**Phone No**	: 9989903002



Signature

Doctor Details :

Doctor Name	: Dr. HARISH JAYARAM	**Specialisation**	: PEDIATRIC SURGERY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

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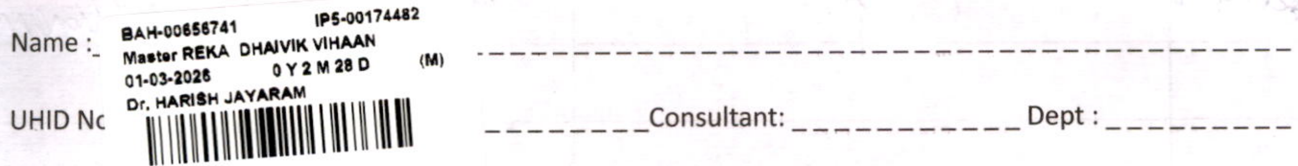
ACTIVITY RECORD FOR BILLING


BAH-00656741 IP5-00174482
Master REKA DHAIVIK VIHAAN
01-03-2026 0 Y 2 M 28 D (M)
Dr. HARISH JAYARAM

Name : ____________________

UHID No : __________ Consultant : __________ Dept : __________

Date of Admission : __________ Time : __________ Date of Discharge : __________ Time : __________

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	7:40AM	ER	OT	[illegible]
29/5/26	8:45A	OT	Postop	[illegible]
29/5/26	10:30A	Postop	Billing	[illegible]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
29/7/26	CBP	4483	[illegible signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/5/24	IV placement	(2)	2540	[signature]
	PAC done on op Basis			

ANY OTHER INFORMATION

....

....

....

....

....

....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr Harish Date : 28/5/26

Type of Admission: ☑ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: ....)

Start Time of Assessment: 7am. Weight: 4.94 kg.

Allergic History: NKA

Chief Complaints:
tongue tie.
with poor wt gain
& difficulty in feeding

Pediatric Assessment Triangle

A Appearance - TICLS (N)

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - 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 (A B C D E)

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Breathing

Rate: 36/min SpO$_2$ on FiO$_2$ 100%.

Rhythm: regular.

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BAE (+) / clear.

Palpation Findings (If necessary) ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Circulation

HR: 140/min
CFT: Central ...... / Peripheral ...... < 2 s

BP: 92/60 mmHg

Pulse Volume: Central ...... / Peripheral ...... good

If in Shock: Compensated ...... / Hypotensive ...... No

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: ...... N

ECG: ...... N

Any Signs of Heart Failure: ☐ Yes ☑ No

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ......

Disability

GCS: 15 AVPU: ......

Pupils: Responsive ☑ Non-Responsive ☐
Size: Right ...... / Left 2mm

Active Seizures: ☐ Yes ☑ No Sugars: ......

Signs of Neurological compromise ...... NFND

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ......

Exposure

Temp.: 98°F

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ......

Active bleed ...... No

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ......

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ......

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

Secondary Assessment: Head to toe examination with positive findings: ......

Labs Planned:
CBP
N.B. Bhavan 29/5/25

Treatment Planned:
1.) INF DNS
2.) Cont NPO
3.) Shift to OT.

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Tongue Tie for release

Assessment done by
Name of the Doctor: Akhila
Signature: Akhila
Date & Time: 29/5

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor: ......
Signature: ......
Date & Time: ......

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OPERATION THEATER NOTES

Patient's Name : Mast. Reka Dhaivik Vihaan Age : 2months Gender : ☑ Male ☐ Female

UHID No.: BAH-00656741 / 00174482 Weight : 5kg Height : ....

Surgeon : Dr Malika		Asst. Surgeon : Dr Harish
Anesthetist : DR. Aishwarya	OT Nurse: Sooi / Jyothi	OT Technician: Venkat Sai
Pre-Operative Diagnosis: Tongue Tie.		
Surgical Procedure : Tongue Tie Release.		
Indications for Surgery : Tongue Tie.		
Date : 29/5/26	Start Time : 8.32am	End Time : 8.35am

Pre Operative Preparations:

5% betadine.

Post Operative Diagnosis:

Tongue Tie.

Peri-Operative Complications:

Operation Notes:

Procedure:-

– Tongue Tie release done,

Doc. No. : RCHBH/FRM / CLINICAL / 099 (P.T.O.)

Amount of Blood Loss: ≃ 0.5ml.	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

-Nil-

Peri-Operative Complications:

-Nil-

DAY CARE

(1) CROCIN -DS drops (1ml = 100mg) 0.6ml ~~PO~~ P/O Thrice daily for 3 days then SOS for pain

Review c̄ Dr. Harish Jayaram in OPD after 3 days 1/6/2026

Name of the Surgeon: Dr. Harish

Signature of the Surgeon: [signature] Dr

Date & Time: 29/5/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 7:30am	C/S/B ER Resident	
	Δ: Tongue tie for tongue tie release	
	no active symptoms	Adv.
		1.) Shift to OT
	O/E: alert	2.) IV canula
	vitals stable	send CBP
	Chest clear.	
	no dehydration	3.) Start IVF DNS
		4.) Cont. NPO
	Dr Harish 29/5/26 8AM	Akhila

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 29/5 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 / 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 ....

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REGULAR PRESCRIPTIONS

Weight. 4.9kg. Ward. OT

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																		

0 Y 2 M 28 D (M)

Dr. HARISH JAYARAM

Weight. 4.9kgs. Ward. O.T

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

01-03-2026 0 Y 2 M 28 D (M)
Dr. HARISH JAYARAM

I.V. FLUIDS CHART

Weight. 4.9kg Ward. OT

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5		IVF DNS	IV	18	[signature]				

VERIFIED BY : Name .... Signature ....

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 29/5/26

To Be Filled In By Assigned Nurse :

Department : OT- III Duration of Procedure : 15 min

Name of Surgeon : DR. Harish Jayaram Date of Admission : 29/5/26

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 : NA	[signature]
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : NA Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	[signature]
3.	Patient's body temperature immediately post operation (Recovery Room) 37.2 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	[signature]
4.	Name of doctor or staff administering the antibiotic : NA Date & Time of antibiotic administration : NA Date & Time procedure started : 29/5/26 at 8.32am	[signature]

- 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

POST-SURGICAL CARE PLAN FORM

Procedure Done: Tongue Tie Release

Post-Surgical Diagnosis: Tongue Tie.

Post-Operative Monitoring Parameters /Frequency:

TPR monitoring every 15 min for 1st 1hr

Wound Care:

—Nil—

Drain /Special Lines/Catheters:

—Nil

Special Patient Positioning and Requirements:

Nil

Nutritional Instructions:

Full feeds as soon as child is fully awake

When to Start Mobilization:

—Nil

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) [signature] for Dr Harish

Date: 29/5/26 Time: 8.45 am

Note: Plan of care will be readjusted if necessary.

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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: Ward ....

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 : Akhila Dr. Akhila

Date & Time : 28/5/26 7AM

Nurse Name & Signature: Bhavani

Date & Time : 28/5/26 @ 7:40Am

Docu. No. : RCHBH /FRM / GENERAL / 090

BAH-00556741 IP5-00174482
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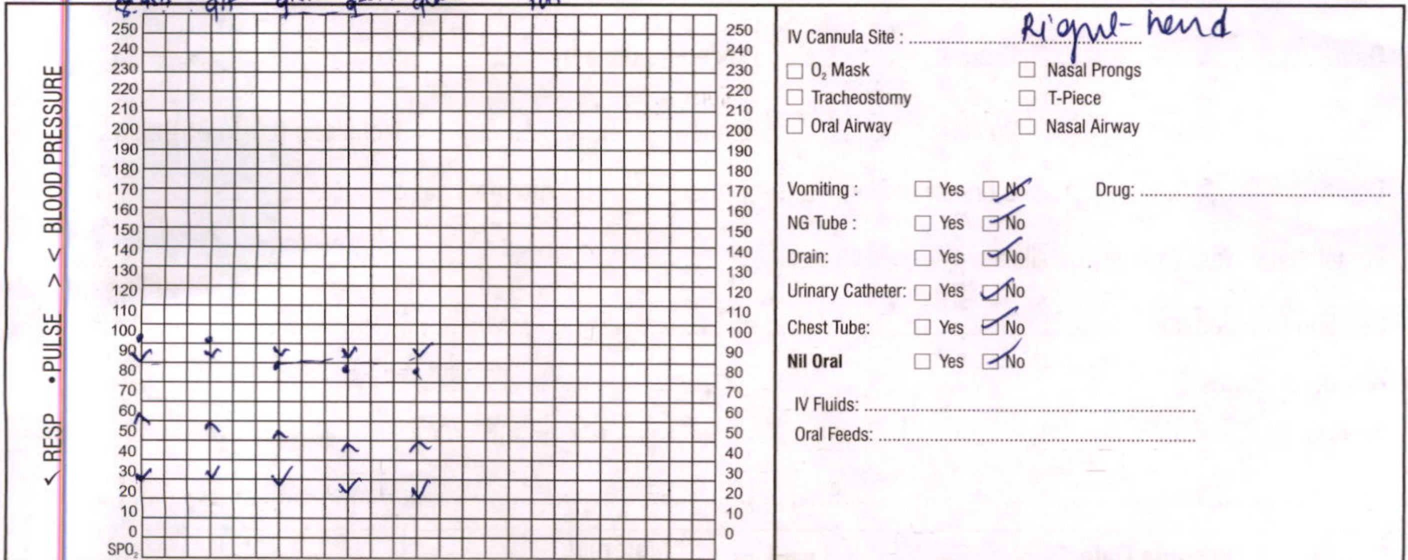
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sr. Neyrini Time Received : 8:45Am Time Discharged : 10:30Am



IV Cannula Site : Right hand

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

	Yes	No
Vomiting :	☐	☑
NG Tube :	☐	☑
Drain:	☐	☑
Urinary Catheter:	☐	☑
Chest Tube:	☐	☑
Nil Oral	☐	☑

Drug: ....

IV Fluids: ....

Oral Feeds: ....

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

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29/5	8:45A	0/10	on sedation	Ney
29/5	10:45A	0/10	No intervention.	Ney

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

Anaesthesiologist Name : Dr. Durga Bhavani

Anaesthesiologist Signature: [signature]

Date & Time: 29/5/26 at 10:30A

PACU Nurse Name : Neyrini

PACU Nurse Signature: [signature]

Date & Time: 29/5/26 at 8:45Am

Reassessment Frequency:

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

Transferred to Unit by (PACU): Billing

Date & Time: 29/5/26 at

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: .... Time: .... Procedure done by ....

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

Depth: .... Catheter at Skin: .... Attempts : ....

Parasthesia : Yes/No if yes details : ....

Solution Composition : ....

Any other issues :

a) ....

b) ....

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

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

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

BAH-00656741
Master REKA DHAIVIK VIHAAN (M)
01-03-2026 0 Y 2 M 28 D
Dr. HARISH JAYARAM

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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 Tongue tie release

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.
2. 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)
- Resolution of symptoms of feeding issues & poor weight gain	- None -

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

b.

1. I authorize Dr. Dr. Harish Jayaram 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: R. Sai Rahul

Name: R. Sai Rahul

Relationship with patient: Father

Date & Time: 29/05/2026 @ 8 Am

Witness:

Signature: Chandana

Name: Chandana

Date & Time: 29/5/26 @ 8 A

Doctor (who is taking consent):

Signature: [signature] Name: Dr. Harish Jayaram Date 29/5/26 Time: 8 AM.

Patient Sticker

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శస్త్రచికిత్స / ప్రొసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 ....

2 ....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రొసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రొసీజర్ ప్రత్యామ్నాయాలు

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

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

a.
b.

1. 4. డాక్టర్ ____________________ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రొసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.

5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రొసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.

6. 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: ....

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Master REKA DHAIVIK VIHAAN
01-03-2026 0 Y 2 M 28 D (M)
Dr. HARISH JAYARAM

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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Dr. HARISH JAYARAM

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

Patient Sticker

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

		Intake				**Output**						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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	

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mast. Dhaivik Vihaan Age : 2yr 18 months Gender : Male ☑ Female ☐

UHID NO: .... Surgeon Name: ....

Anaesthesiologist : Dr. A. Naresh Babu

Operative procedure planned : Tongue tie release

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : ....

Comments : ....

- 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 Mast. Dhaivik Vihaan the above mentioned operation / Diagnostic / Therapeutic procedures Tongue tie release

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 : R. Sai Rahul

Name : R. Sai Rahul

Relationship with Patient: Father

Date & Time : 27/5/26, 5:15 pm

Witness :

Signature : [signature]

Name : Bhavan

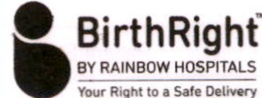
Date & Time : 27/5/26 05:15pm

Doctor (who is taking the consent) :

Signature : A. Daneshbabu

Name : Dr. A Danesh Babu

Date & Time : 27/05/26, 5:15 PM.



Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Mast. Dhaivik Vihaan Age: 2months 18 days Sex: male UHID.No :

Date: 27/05/26 Time: 5:15PM Proposed Operation: Tongue tie releas

Diagnosis:

B.P / CRT: H.R: Weight: 4.7kgs 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:** NKDA.	

Medical History: CVS : -

RESP : - Diabetes : -

CNS : Term / LSCS / 3.28 kgs / CIAB / No NICU admissi

Renal : -

Hepatic / GE : - Physical Activity: -

Others : No health issues till date

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : BAE+, clear

Heart: $S_1 + S_2 +$

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:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

CBP.

Signature: [signature] Name: Dr. A. Naresh

Docu. No. : RCH /FRM / CLINICAL / 044

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Dr. HARISH JAYARAM

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ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: confirmed

Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 136/min	B.P / CRT:	SpO_2: 100%	R.R:	Last Feed: >6 hrs

Pre-OP Diagnosis: Tongue Tie   Operation: Tongue Tie Release   Date: 29/5/26

Surgeon: Dr. Harish ; Dr. Malika   Anaesthesiologist: Dr. AISHWARYA   Technician: VENKAT

TIME		
N_2O /AIR /O_2 LPM	3 Lpm	
HALO /SO /SEVO		
Drugs:		
IV FENTANYL	6 mcg	
IV PROPOFOL	10 + 20	
FIO_2 / SaO_2	100%	100%
$ETCO_2$	30	34
ECG	SR	SR
Temperature		
Urine Output		
Fluids / Blood		

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: ....
☐ Art Site: ....
☑ EKG Lead 3
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☑ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 8:28 AM
OP Start: 8:30 AM
OP End: ↓
Leave OR: 8:45 AM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☐ IV: 24 G (R) UL
☐ IV: ....
☐ IV: ....

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA Nasal prongs
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .... Attempts: ....
Difficulty Why? ....

☑ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: ....
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: ....
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dr. AISHWARYA
Signature of the Doctor: [signature]