

Patient



SURGERY DETAILS

RC 00A Done

Date : 18/07/26

Patient Name: Baby .v. Jayasri Date of Birth: 08 - 04 - 2011 Age: 15 yrs

Gender: Female Ward : P.O.T - I UHID No.: BAH - 00266870

of Surgery: 18/07/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Craniotomy and tumour excision

Time in : 9:10 am

Time Out : upm

NAME

AMOUNT

- | | | |
|----------------------|----------------------------------|-------|
| 1. Surgeon | : Dr. Praneeth / Dr. Sri Pranthi | _____ |
| 2. Anaesthetist | : Dr. Shilpa | _____ |
| 3. Assistant Surgeon | : | _____ |
| 4. OT Technician | : Ravi | _____ |
| 5. Circulating Nurse | : Swapna | _____ |
| 6. Assistant Nurse | : Jayathi / Sajitha | _____ |

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : Neurodrill, Microscope - 9709735

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9709734

Order by: Jayathi

15yrs/42kg DARY V. AYAS ^{Craniotomy Tumor.}
 5412 VDH-00266870 ^{Excision}

CONSUMABLES OF OT

Circulating staff :

Technician : J. BRPU

Date : 18-07-26

Time : 9 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 5.5-5.6	1+1	1	Major Pack <u>Drape</u>	1	1	Inf Vit-K Rapid vial 50	2	
LMA 3	01	—	Sutures mono syn 4-0			Cord Clamp <u>Bonheur</u>	2	1
ECG leads : A/P/N	5	5	<u>Vinyl 2-0, 3-0, 4-0</u>			Suction Catheter B ₁	1	1
HME filter : A/P/N	01	1	<u>proline 4-0, 5-0, 6-0, 8-0, 9-0</u>			Feeding Tube PDS 3.0	02	1
Syringes : 10 cc	20	60	<u>PDS 5-0, 5003, 5037, 5050</u>			Vaccum Suction Set 4.0	02	1
05 cc	20	60	Gloves <u>guthen 2-0, 3-0</u>	1	1	Surgical Gloves PDS 6.0	02	1
02 cc	20	6	<u>6 1/2, 7 1/2, 8 1/2</u>	1	1	Gauze Pack <u>craniotomy</u>		
01 cc	—	—	<u>pac 6, 8, 10, 12, 15</u>	2+2+2		Syringe 1ml / 2ml <u>drape</u>	01	1
Cautery plate : A/P/N	01	1	Surgical blade <u>(11, 12, 15)</u>	1+1	2+1+1	Surgical Blade # 20 PDS 3.0	02	
IV set + blood set	1+1	1+1	NG tube 5, 6	1+1	—	Koochies (S) <u>G-arm cover</u>	01	1
RL + Dextrose	1+1	3+0	Cautery pencil	1	1	NS 500ml	1	1+2
NS : 10ml / 100ml / 500ml / 1000ml	2+2	2+2	Koochies <u>Adult</u>	1	1	<u>10cc syringe (20cc)</u>	2+2	2+2
<u>Mini Spike</u>	02	0	Ointments <u>mono syn 3-0, 4-0</u>	2+2		<u>Morphine</u>	1	1
<u>Gauze</u>	03	6	Suction Catheter			<u>Erythraeus airt</u>	1	
Fentanyl	01	1	Cap, Mask	5/5	5/5	Trimmer blade	02	2
Morphine	01	1	Gauze Pack	5/5	3/3	skin stapler	01	—
Ketamine <u>campana cover</u>	0	—	Mop Pack	1	1	Focus of fix	01	—
Propofol	0+7	3	Steristrip <u>Lox Adrenaline</u>	01	1	Atropine +ADR	1+1	1+1
Rocuronium	01	2	Underpad	1	1	<u>Nidex + Epidrine</u>	1+1	1+1
Glycopyrolate	01	1	Draw sheet	1	1	<u>Fluorant (2 mask)</u>	01	0+1
Myopyrolate	01	1	Abgel	2	2	<u>Lox cord + Jelly</u>	1+1	1+1
Ondansetron	01	1	Foleys catheter <u>(6, 9, 10, 14)</u>	1+1	1	NG Tube + Suction	10+0	—
Pencan 25g/ Spinal Needle 22			Urobag <u>(monomer)</u>	1+1	1	Nasal Airway		
Bupivacaine 0.25% <u>tegaderm</u>	1+1	—	Chest Drainage Catheter			22124	1+1	—
Bupivacaine 0.25% (Heavy) <u>Gelp</u>	01	—	Romodrain bag <u>Trij. Hepatic</u>	1	1	oral Airway		
Antibiotics <u>Taxine .1 gm</u>	01	1	Bandage <u>protogaur</u>	3+2	3	.1, 2, 3	1+1	—
<u>Amikoeine .250+500mg</u>	1+1	—	Tegaderm <u>Demi marker</u>	1	1	<u>Gelcan caudal 224</u>	2+2	—
Suppositories			Ioban	1	—	<u>in caudal (20, 18)</u>	2+2	1+1
iamol : 80mg / 250mg / 170 mg			Double J Stent <u>5087</u>	1	1	<u>AKP Kft + Hot line</u>	1+1	1+0
Supridol : 100mg			Vaccum Suction set	2	2	<u>Hepaflow + Heplock</u>	1+5	0+1
Justin : 12.5 mg / 25mg / 100mg	1+2	—	Plastic Bed Sheet	1	0	<u>50 cc + proline</u>	5+5	—
Tab. Misoprost : 200mg			Betadine Solution <u>10%</u>	1	1	<u>Stop cock + Fraclper</u>	5+2	0+2
Vaccum Set	01	2	Microshield	1	1	<u>Soft probe 4, 6</u>	2+2	2+1
Doxa + Dexmed	1+1	1+0	Cotton Balls	1	1	<u>gik-3-0 + K nidesal</u>	1+1	—
Iranaxa + pm	1+1	2+1	Latex Gloves	20P	20P	<u>micro scope cover</u>	01	1
<u>Alouette + clouette</u>	5+1	1+1+0	Ramdone Scrub	1	1	<u>protogaur</u>	03	1
<u>100cm + 100cm Zurey</u>	3+3	2+2	Saral <u>Multi Tube holder</u>	01	01	<u>ESofegus term probe</u>	01	1
<u>Betadine Scrub 60P</u>	01	—	<u>Huizen (R) (B)</u>	1+1	1+1	<u>Warm blanket sheet</u>	01	—

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. :

Ordered by :

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

W/ADL. E. keserlyas - 2-2

Flow Normal

CVC - 7F, 15cm
 5.5F 16cm
 5.5F 15cm

CVC - 5.5F 32cm

used

B2

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D (F)
Dr. KOKKULA PRANEETH

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP 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
17/7/26	3:20pm	CR	139	[Signature]
18/7/26	8:50AM	139	ST	Sushma
19/7/26	7pm	1100	139	Wardan

Cross Consultation Visit

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

[illegible]

17/7

CBP, PT, INR

069248

By

1817

CBP, Elektrolyte.

→ 26072013

Vander

PT, ADT, T

→ 26072235

Vendor

-ABG

→ 2607224

Vendor

1917126

RBS

26072308

Lami's

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

1812	Infusion Pump	30m	stop	9708894	Cy
1817	INV monitor	stop	4pm	9710096	push
	IMK pump			9710096	
	S. pump			9710096	
	oxygen			9710096	
191126	INV. monitor	stop		9710095	slow
	INF. pump			9710096	
	INF. pump			9710095	
	Syr. pump			9710095	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7	PAC	1	9708890	Cy
18/7	TV placement	1	9708890	Shayk
18/7	Arterial line	1 (1)	9710059	Shayk
	Catheterization	1	9710058	Under
18/7	Blood Transfusion	1 (1)	9710060	Under
20/7	NHA	1 (1)	260352	R

ANY OTHER INFORMATION

ABG - (1)

Date : 20/7/26

Time : 20/7/26 @ 9am

Prepared By : Shariya

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Shariya	Am 1		

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176522

Admit Date : 17-Jul-2026

Admit Time : 02:24 PM UHID : VIH-00206870

Patient Details :

Patient Name : Baby VEMAVARAPU JAYASRI

Age : 15 Y 3 M 11 D

Guardian : Mr VEMAVARAPU VIKRAMARKUDU

DOB : 08-04-2011

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 1-24, PHANIDEM, SATTENAPALLI (M)
Sattenapalle Guntur Andhra Pradesh INDIA
522403

Phone No : 9063313120/ 9666875784

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : PICU

Bed No : PICU 215

Ward Name : 2F-PICU I

Room No : PICU 215

Admission Type : First Visit

Contact Details :

Name : Mr VEMAVARAPU VIKRAMARKUDU

Relationship : Father

Contact Address : H NO 1-24, PHANIDEM, SATTENAPALLI (M)
Sattenapalle Guntur Andhra Pradesh INDIA
522403

Phone No : 9063313120

Signature

Doctor Details :

Doctor Name : Dr. KOKKULA PRANEETH

Specialisation : PEDIATRIC NEURO SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE/ Dr.
SRIPARTHA KRISHNA YERRAMILLI

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 300000.00

Payor Name : SELF PAY

ADMISSION SHEET


Registration Details :

Admission No : IP5-00176522 Admit Date : 17-Jul-2026 Admit Time : 02:24 PM UHID : VIH-00206870

Patient Details :

Patient Name	: Baby VEMAVARAPU JAYASRI	Age	: 15 Y 3 M 9 D
Guardian	: Mr VEMAVARAPU VIKRAMARKUDU	DOB	: 08-04-2011
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 1-24, PHANIDEM, SATTENAPALLI (M) Sattenapalle Guntur Andhra Pradesh INDIA 522403	Phone No	: 9063313120/ 9666875784
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 139 Ward Name : 1F-GENERAL WARD II
 Room No : GW 139 Admission Type : First Visit

Contact Details :

Name : Mr VEMAVARAPU VIKRAMARKUDU Relationship : Father
 Contact Address : H NO 1-24, PHANIDEM, SATTENAPALLI (M)
Sattenapalle Guntur Andhra Pradesh INDIA
522403 Phone No : 9063313120

V. B. Lakshmi
 Signature

Doctor Details :

Doctor Name : Dr. KOKKULA PRANEETH Specialisation : PEDIATRIC NEURO SURGERY
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. SRIPARTHA KRISHNA YERRAMILLI

Payment Details :

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

VIH-00206870 IP5-00176522
 Baby VEMAVARAPU JAYASRI
 08-04-2011 15 Y 3 M 11 D (F)
 Dr. KOKKULA PRANEETH



EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	2			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list <i>Transmission</i>	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Extra</i>	4			
	Total No. of Pages	53			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



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PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D (F)
Dr. KOKKULA PRANEETH



Patient Name:

Jayasri

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Jayari Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Slp @ mid posited VP shunt
↓

History of present illness :

Child was apparently normal 5 days back, later she developed
severe headache & vomitings for which she was admitted
to hospital as hydrocephalus & raised ICP.

↓
Diagnosed as

Acute Onset Encephalopathy with raised ICP
with acute hydrocephalus. Shunt down.

! pilocytic astrocytoma
2 glioma

↓
for which she underwent

Right mid posited VP shunt done on 13-2-20

↓
2 found tumor in right frontal margin
(Craniotomy & Excision)

Pediatric Multiorgan History & Physical Examination

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

Not recorded

Birth & Neonatal History:

Term / NVD / C/S / BW - 2.8 kgs
Apgar 1 & 5
if/used

Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____
male 2nd

Developmental History :

Achieved all milestones as per age in all domains

Immunization History :

recorded till now as per NIS



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10.2 kgs (Centile _____)

On Examination :

Temperature : _____ Pulse Rate : 22 bpm B.P. 11/6 r (syst) SP02 96 %

Resp. rate and type of breathing : 22 / min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : RAS (+)

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : OK (+)

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection Soft, non-tender

Palpation : _____

Ausculation : _____

Spine : _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : ~~5/5~~

Cranial Nerves : _____

Motor System:

Nutriton : Good

Tone: (N)

Power 2/5 - all 4 limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars Spontaneous

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Child - Acute onset encephalopathy to raised ICP & hydrocephalus

SP (R) and parietal VP shunt

? BCSOL / ? Pilocytic astrocytoma
? glioma



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Basal 2 ch. Quadiparous

Desired goals of the treatment :

Haemodynamic stability

Planned Labs:

As per PAC
MS & LFTs
18/4/26

Planned Management

- Admit to ward

- PAC

- Catheter

Tbl. LEVETIRACETAM

Tbl. CEFIXIME

Tbl. PAN TOPIRIZOLE

Tbl. DEXAMETHASONE C

Sx-plcr - tomorrow

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Balaji

Date & Time: 12/7/2026 1:50 PM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Praneeth

Date & Time: 12/7/2026

Dr. KOKKULA PRANEETH
Reg. No: APMC/FE/102734

04-2011
KOKKULA PRANEETH



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V. Jayasri

PROGRESS NOTES AND DOCTOR'S ORDER

Doctor's Order

Progress Notes

17/7/2026

cls/B Dr. Praveen

Adm

Adm
① Arrange PRBC 20cc/kg

② PAC

② PAC

③ Financial characte

Dr. KOKKULA PRANEETH
Reg. No: APMC/FMR/92741

Doc

RCHBH / FRM / CLINICAL / 088

PROGRESS NOTES AND DOCTOR'S ORDER

Date
& Time

Progress Notes

Doctor's Order

18/07/26

4pm

C/S/B Resident

Δ: Acute Onset Encephalopathy
± Vasculitis ± Acute Hydrocephalus
± IC SOL - ? Pilocytic Astrocytoma
S/P Craniotomy + Tumor excision (POD-0).

→ Sedation:- Propofol, Fentanyl,
Morphine

Paralytic:- Rocuronium.

→ ET tube:- 6 → fixed at 18cm
no.

Extubated post operatively

CT done & shifted to PICU

→ Input:- 1700ml.

crystalloids = 980

colloid } 500

gelo

PRBC = 230ml.

P/Can

1) DO CBP, ABG,
& electrolytes
ATTN

2) Inj Paracetamol } pain
Inj Tramadol } control

3) Inj cefotaxime to
continue

4) Inj Levetiracetam

5) Monitor for Vitals,
Sensorium

4) NPO till further
advice

→ Continue IV fluids (GO.F.).

6) Inform SOS

→ R/V Dexamethasone.

Noted by
Unelana
18/7/26
@ 4pm

Dr. Jayashree

(P.T.O)

CVS:- S1S2 heard.

Resp:- BAE ⊕.

hemodynamically stable

BL reacting
equal to dish

Date & Time	Progress Notes	Doctor's Order
17/11/2024	C/S/B Dr. Praneeth A: ICSOL ? pilocytic astrocytoma & acute hydrocephalus s/p vp shunt & tumor excision. Child on room air. Spo2: 98%. RR: 70/w. RR: 20/w. BP: 120/55. CNS: GCS 15/15 Pupil: 2+ 2+ Tone: (N).	Plan: - Remove foley - Remove arterial line - Stop iv fluids - Allow orally. - Cont drugs as per chart - Shift to Ward. - Syp Smooth. add. - PC Enema (SOS). - Pranexol cross
		Dr. KOKKULA PRANEETH Reg. No: APMC/FMR/92741



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5/26 9am	C/S <u>B Neuroteam</u> - No new issues - taking well orally <u>2/E</u> - HMF - (N) - CN - EOMs fulls R/L pupils equals Reactive - ? R/L facial weakness (N) tone, range & reflexes - No surgical or cerebellar signs	<u>Ach:</u> - Steady - Review on - Encourage oral liquids - Mobilise - Plenty of oral fluids - monitor <u>1/0</u> <u>Abhishek</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 8:30AM	<u>CLS/B Neuroteam</u> Δ: Acute Onset Encephalopathy c/ vermin ICSOL S/p VP shunt with Gross total excision of tumor ? pilocytic astrocytoma <u>Issues:</u> No pain over B/L temporal region and over the back of neck (posterior cervical muscles) No fever spikes / vomiting / seizures o Accepting feeds - (N) o Swaying while walking - ↓	
	<u>O/E:</u> HMF - (N) B/L pupils - NSRL EOM - full mild B/L facial nerve weakness Tone - (N) weight bearing (+) Able to walk c/ mild truncal & gait ataxia DTR: +2 (R) frontal sinus tenderness (+)	<u>Adv</u> ① plan to shift to Oral ② plenty of Oral fluids ③ T. ULTRACET <u>Plan:</u> DISCHARGE TODAY o Tab TAXIM-O 200mg PO BID x 2 days o Tab ULTRACET 170mg SOS o Review on 01/08/27 RCH Ashishell Vikramprasad

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

VIH-00206870 IP5-00176522
 Baby VEMAVARAPU JAYASRI
 08-04-2011 15 Y 3 M 9 D (F)
 Dr. KOKKULA PRANEETH



BOS
 B + VC


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RESULT SHEET

Date	17/7/26	18/7/26			
Time		4:30pm			
Hb	13.1	10.9			
PCV	40.7	33.5			
RBC	4.81	4.02			
WBC	6240	12,410			
N/L	69.8/23.1	79/11			
Platelets	2.95	2.66 lakh			
CRP					
ESR					
PCT					
RBS					
Na		134			
K		3.9			
Cl		105			
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	14/1	16/1.2			
APTT	30	29			
CSF Protein / Sugar					
Cells					
N/L					



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: PICU 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	Inj. cefotaxime	1g	i.v.	BD	19/2/26	☒ C ☐ DC
2	Inj. PARACETAMOL	650mg	i.v.	TID	19/2/26	☒ C ☐ DC
3	Inj. LEVETIRACETAM	840mg	i.v.	BD	19/2/26	☒ C ☐ DC
4	Inj. esomeprazole	40mg	i.v.	OD	19/2/26	☒ C ☐ DC
5	Inj. DEXAMETHASONE	4mg	i.v.	TID	19/2/26	☒ C ☐ DC
6	Syp. smutti	10ml	PO	OD/HS	19/2/26	☒ 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. Hineja

Date & Time: 19/2/26 12:30pm

Nurse Name & Signature: Santhana Devi

Date & Time: 19/2/26 @12:30pm



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	Tab. LEVETIRACETAM	500 mg	PO	BD	12/12/20 9 AM	☐ C ☐ DC
2	Tab. CEFIXIME	200 mg	PO	BD	12/12/20 9 AM	☐ C ☐ DC
3	Tab. PANTOPRAZOLE	40 mg	PO	OD	12/12/20 8 AM	☐ C ☐ DC
4	Tab. DEXAMETHASONE	4mg	PO	TID for 2dy	12/12/20 11:30 AM	☐ C ☐ DC
5	Tab. DEXAMETHASONE	4mg	PO	BD for 2dy		☐ C ☐ DC
6	Tab. DEXAMETHASONE	4mg	PO	OD for 2dy		☐ C ☐ DC
7	Tab. DEXAMETHASONE	2mg	PO	OD for 2dy		☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]

Date & Time: 12/12/20 3pm

Nurse Name & Signature: Bhavani [Signature]

Date & Time: 12/12/20 2pm



DRUG CHART

Date of Admission: 12/2/20 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. 42 kg Ward. 05

DRUG : TAB. LEVETIRACETAM				Date Time	14/12/17
Dose 500mg	Route PO	Frequency BD	Start Date 12/12/16		
Name & Signature of the Doctor Starting the Drugs:				10 AM outside hospital 18.20 pm	
Additional Instructions:				10 PM AM	
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. RANTOPRAZOLE				Date Time	14/12/17
Dose 150mg	Route PO	Frequency OD	Start Date 12/12/16		
Name & Signature of the Doctor Starting the Drugs:				6 AM outside hospital 11 PM	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. CEFIXIME				Date Time	14/12/17
Dose 200mg	Route PO	Frequency BD	Start Date 12/12/16		
Name & Signature of the Doctor Starting the Drugs:				10 AM outside hospital	
Additional Instructions:				10 PM AM	
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. DEXAMETHASONE				Date Time	14/12/17
Dose 4mg	Route PO	Frequency TID	Start Date 12/12/16	GAM X 11 PM	
Name & Signature of the Doctor Starting the Drugs:				11:30 PM 2 PM outside hospital	
Additional Instructions: for 2 days (Tapering down)				10 PM AM	
Daily Doctor's Endorsement by a Sign					

DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 12/07/26 Day of Admission : 03 Today's Date & Time : 12/07/26

PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Acute Onset Encephalopathy Exsultilis E Acute Hydrocephalus ETCSOL ? pilocytic Astrocytoma s/p craniotomy + tumor excision (NOD)	Current Issues :
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : B/L AE (+) chest clear	
	CXR :	
	SPO ₂ : 98% on room air O ₂ by NC / FM / NRB mask / Oxyhood, at : L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : Nitric Oxide : ☐ Yes ☒ No - If Yes, details :	
	Ventilatory Settings : Leak around ETT : Delivered Vt : ABG : pH 7.414, PCO ₂ 34.6 PO ₂ 209 HCO ₃ 22.9 Lac 2.3 BE -2.1 EtCO ₂ : P/F ratio : OI :	
	Chest Physiotherapy Plan : -NO- Suctioning Needs : -NO-	
	Any Nebs : -NO- ICD ? ☐ Yes ☒ No, if Yes, details :	
	Plan of care :	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : S1 S2 (+) NO MURMUR	
	Quality of Pulses : good cap refill Time : <3 sec Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : IBP : 128/74 mmHg CVP :	
	Infusion of : ☐ Dopamine mcg / kg / min - ☐ Dobutamine mcg / kg / min ☐ Epinephrine mcg / kg / min - ☐ Nor Epinephrine mcg / kg / min ☐ Milrinone mcg / kg / min	
	Any Other Infusions :	
	Last 2D Echo Findings :	
	Size of the heart and lung fields in latest CXR :	
	Arterial line in situ : ☒ Yes ☐ No Place of art, line & its condition : Left Radial	
	Central line in situ : ☐ Yes ☒ No Place of central line & its condition :	
	Day of arterial line : 03 Day of Central line :	
CNS	Neuro Exam : Eu VS MG	
	Pupils : Symmetrical & Reacting to light Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : Types of Paralysis :	
	Relevant CT Scan, MRI EEG, Neurosonogram etc. :	
	Plan of Care : Monitor for signs of raised ICP.	
Ramsay Sedation Score :		

FLUIDS STATUS NUTRITION AND G.I	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : <u>-200ml</u> / (+/-) Input : ml/k/d UO : <u>1.6</u> ml/kg/hr Stools : <u>As of 10/11</u>	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
	IV Fluids - Type of IVF : <u>DMS</u> @ <u>40</u> ml / hr (..... times maintenance)	
INFECTION	TPN : ☐ Yes ☒ No - If yes, details :	
	 % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)	
	 Cal/kg/d Nitrogen Trace elements & MVI	
	Labs : Na <u>134</u> K <u>3.9</u> Cl <u>105</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT :	
NEPHROLOGY ISSUES	Abd Exam :	
	Any organomegaly ? ☐ Yes ☒ No - If yes, describe :	
	Plan (G.I. & Liver) :	
		
		
HEMATOLOGY	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☐ Yes ☐ No - If yes, details :	
	Describe c/s Reports :	
	Other Labs (Latex, Serology, etc) :	
	Ongoing Antibiotics :	
CARE PROTOCOLS	Sr. Creat : Bld. Urea : Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☐ Yes ☒ No - If yes, then day of Catheter :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
FINAL COMMENTS	Plan of Care :	
		
		
		
		
HEMATOLOGY	Relevant Labs (CBP etc) :	
	Any Coagulopathy :	
	Relevant Transfusion History :	
	Plan of Care :	
		
CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☐ No ☒ NA	
	CRBSI Bundle Used ? : ☐ Yes ☐ No ☒ NA	
	CA - UTI Bundle Used ? : ☐ Yes ☐ No ☒ NA	
	Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA	
	If yes, then details :	
FINAL COMMENTS	Pending Lab Results : ☐ Yes ☒ No	
	If yes, then details :	
		
	Pending Consultations : ☐ Yes ☒ No	
	If yes, then details :	
FINAL COMMENTS	- monitor for signs of raised ICP.	
		
		
		
		

Doctor's Name (Handover given) : Dr. [Signature]

Signature : [Signature]

Date & Time : 19/12/16 8:00 AM

Doctor's Name (Handover taken) : [Signature]

Signature : [Signature]

Date & Time : 19/12/16



Sheet No: 10

REGULAR PRESCRIPTIONS

Weight 4.8 kg Ward 05

DRUG : Iiv CEFOTAXIME				Date Time	18/7	19/7	20/7	21/7
Dose	Route	Frequency	Start Dt.					
1gm	iv	BD	18/7	10am				
Name & Signature of the Doctor Starting the Drugs:								
Additional Instructions:				10pm Stop prn Prn Prn Prn Prn Prn				
Daily Doctor's Endorsement by a Sign				4				
DRUG : INT PARACETAMOL				Date Time	18/7	19/7	20/7	21/7
Dose	Route	Frequency	Start Dt.					
650mg	iv	TID	18/7	6am				
Name & Signature of the Doctor Starting the Drugs:								
Additional Instructions:				2pm 10pm Stop prn Prn Prn Prn Prn				
Daily Doctor's Endorsement by a Sign				4				
DRUG : INT TRAMADOL				Date Time	18/7	19/7	20/7	21/7
Dose	Route	Frequency	Start Dt.					
40mg	iv	TID	18/7	10am				
Name & Signature of the Doctor Starting the Drugs:								
Additional Instructions:				10am X 10pm X Stop 19/7				
Daily Doctor's Endorsement by a Sign				4				
DRUG : INT LEVETIRACETAM				Date Time	18/7	19/7	20/7	21/7
Dose	Route	Frequency	Start Dt.					
840mg	iv	BD	18/7	10am				
Name & Signature of the Doctor Starting the Drugs:								
Additional Instructions:				10pm Stop prn Prn Prn Prn Prn Prn				
Daily Doctor's Endorsement by a Sign				4				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 12.24 Ward 01

DRUG : INT GOMEPRAZOL				Date Time	18/7	19/7	20/7	21/7												
Dose	Route	Frequency	Start Dt.																	
4mg	iv	OD	18/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : DMS DEXAMETHASONE				Date Time	18/7	19/7	20/7	21/7												
Dose	Route	Frequency	Start Dt.																	
4mg	iv	TDS	18/07																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : SYP SMUTH.				Date Time	19/7	20/7	21/7													
Dose	Route	Frequency	Start Dt.																	
10ml	PO	OD/1hr	19/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : T. LEVITIL				Date Time																
Dose	Route	Frequency	Start Dt.																	
500mg	PO	BD	22/7																	
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 : T. DOLO				Date Time															
Dose	Route	Frequency	Start Dt.																
650mg	PO	Q8H	22/7																
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																			

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



Weight. 42 kg Ward. 05

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
18/3/11	9:45 AM	INT PARACETMA	630ml	IV	A	Ang @ 9:50 AM
18/3/11	9:30 AM	INT CEFOTAXIM	1gm	IV	Ang	Ang @ 9:30 AM
18/3/11	10:35 AM	INT MORPHINE SULPHATE	3MG	IV	Ang	Ang @ 10:35 AM
18/3/11	9:20 AM	INT DEXAMETHASONE	4+1g	IV	Ang	Ang @ 9:20 AM
18/3/11	11:23 AM	INT 20% MANNITOL	4g	IV	Ang	Ang @ 11:23 AM
19/3/11	8:30 AM	PC Enema	1unit	per rectum	Ang	Ang @ 8:30 AM



I.V. FLUIDS CHART

Weight: 62 kgs Ward: 05

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
18/2	2pm	NS DNS (full me)	iv	80	Ch	Char	18/2	Ch	Ch
18/2	10:20AM	RINGER LACTATE	iv	420	Ch	Ch	18/2 11:30AM	Ch	Ch
18/2	11:32AM	RINGER LACTATE	iv	420	Ch	Ch	18/2	Ch	Ch
18/2	12:30pm	PlasmaLyte	iv	300	Ch	Ch	18/2	Ch	Ch
18/2	12:30pm	heparine	iv	500	Ch	Ch	18/2	Ch	Ch
18/2	1:50pm	PRAL	iv	60	Ch	Ch	18/2	Ch	Ch
18/2	4pm	DNS	iv	25ml/h	Ch	Ch	18/2	Ch	Ch
18/2	6:30pm	3% NS	iv	20ml/h	Ch	Ch	18/2	Ch	Ch



TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible][illegible]

Temperature (°F)

104

103

102

101

100

99

98

97

96

95

94

[illegible][illegible][illegible][illegible][illegible]

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.



TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

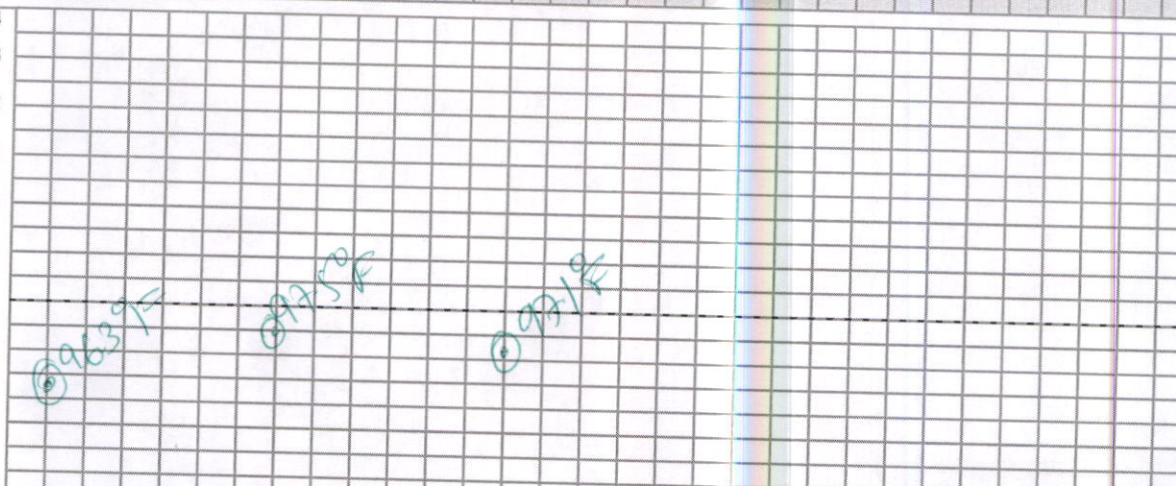
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/8 Time: 10pm 2Am 6Am

Doctor / Nurse / Family Concern?

Temperature
 (°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
 (bpm)

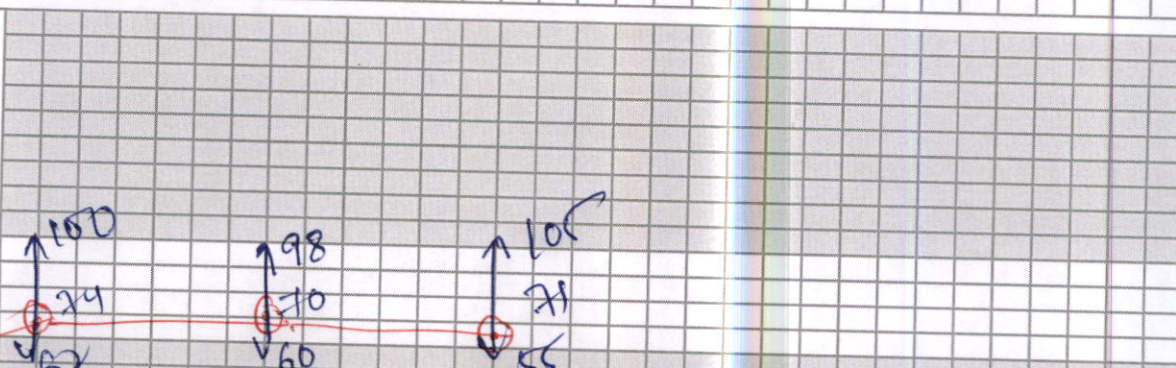
and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

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



Heart Rate (Number)

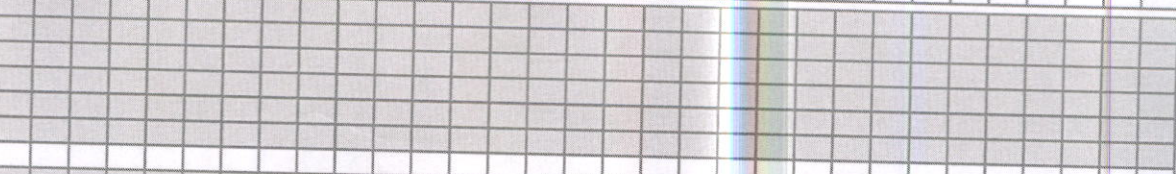
100bpm

98bpm

105bpm

Resp. Rate (bpm)
 (Over 1 Minute)

70
60
50
40
30
20
10



Resp Rate (Number)

20bpm

18bpm

19bpm

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂ (l/min)
 O₂ Saturations (%)

98%

99%

99%

Conscious Level
 Normal Altered

GCS *

15/15

15/15

15/15

TOTAL SCORE

Number of shaded boxes

0

0

0

Pain Score

0

0

0

Observer's Initials

PC

PC

PC

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.

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 12 D (F)
Dr. KOKKULA PRANEETH



loc. No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)
**Children's Observation &
Early Warning Scoring Chart**

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

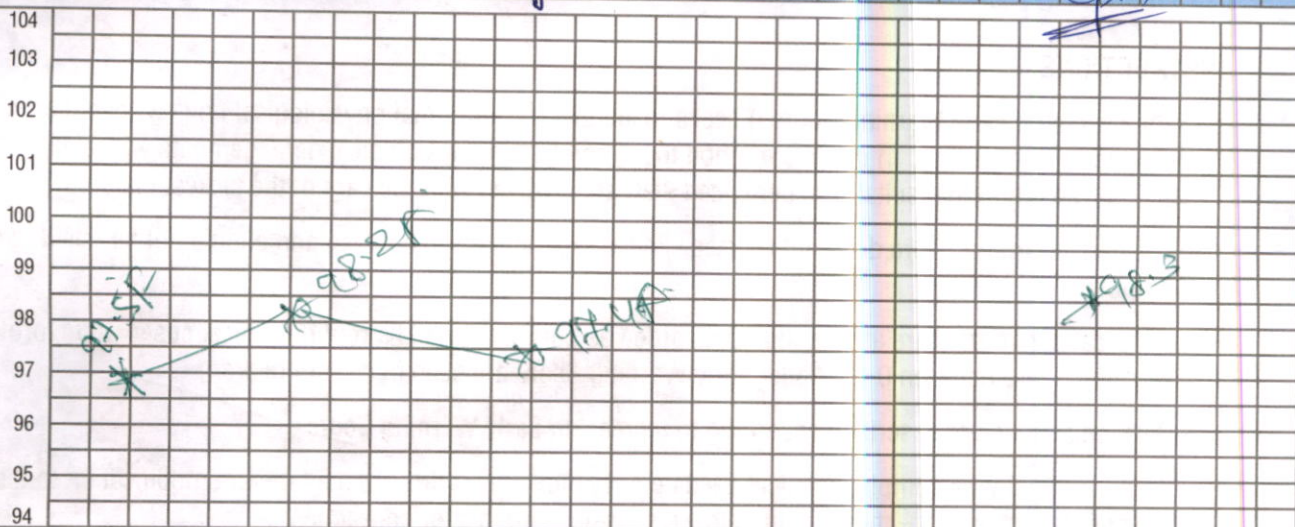
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/2/26 Time: 10:00 AM

Doctor / Nurse / Family Concern? 605 10:00 AM 2 PM 6 PM

Temperature
(°F)



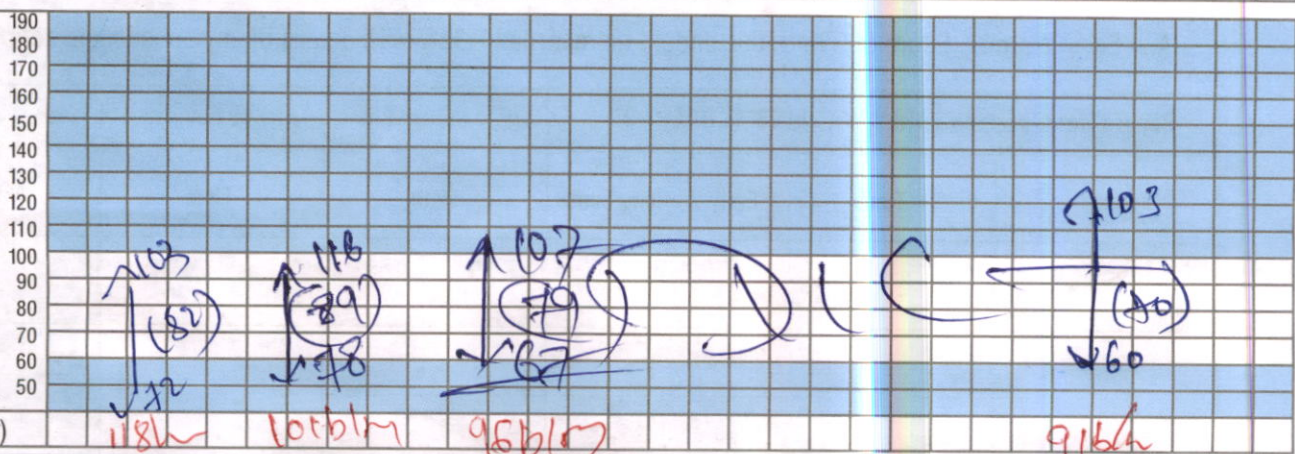
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring



Heart Rate (Number)

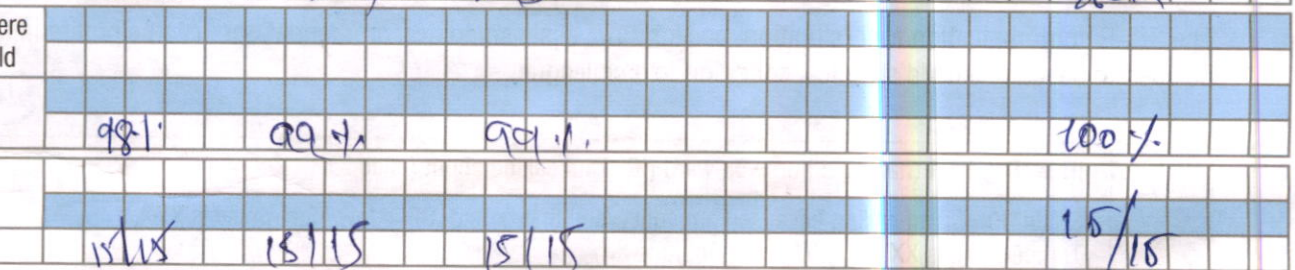
Resp. Rate (bpm)
(Over 1 Minute)



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)



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

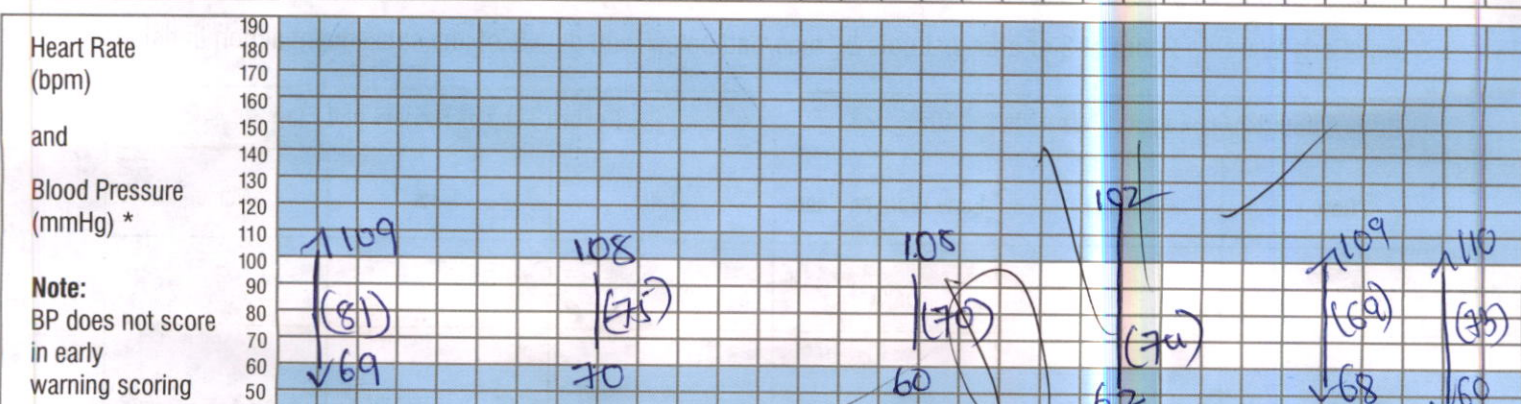
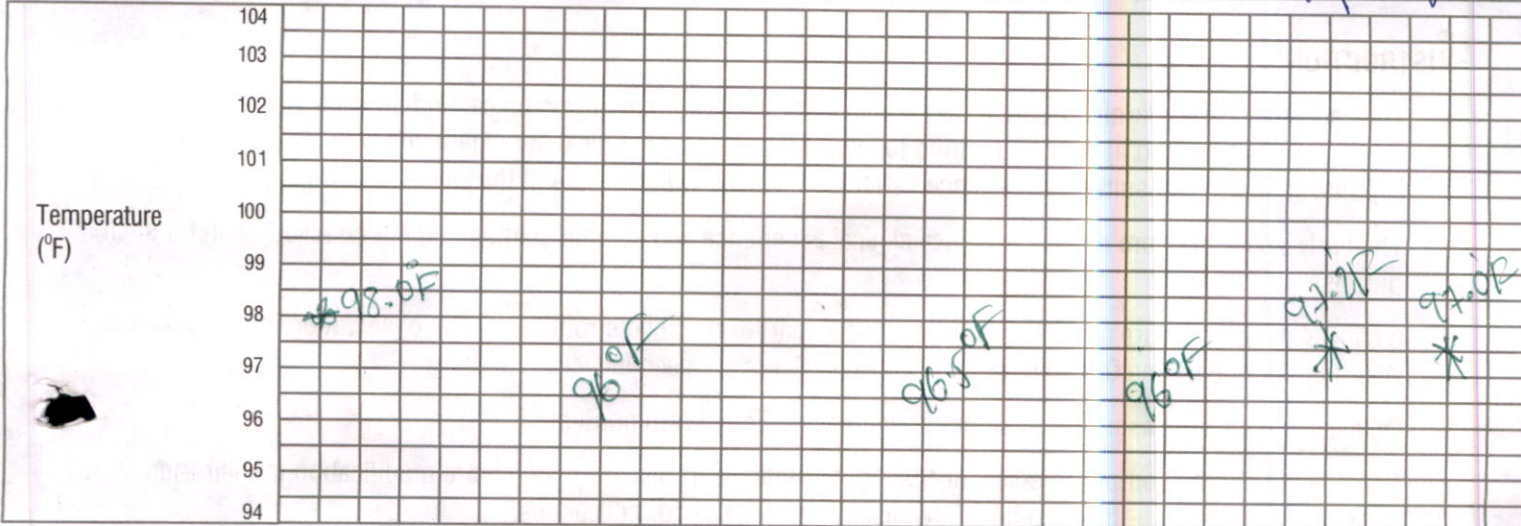
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7 Time: 6am 10am 1pm 6pm 10pm 2am
 Doctor / Nurse / Family Concern? 6am 10am 1pm 6pm 10pm 2am



Heart Rate (Number)

Resp. Rate (bpm) (Over 1 Minute)

Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

Conscious Level Normal Altered

GCS *

TOTAL SCORE
 Number of shaded boxes
 Pain Score
 Observer's Initials

ACTIONS
 NB: Scores 3 should be recorded overleaf
 Score 1 : Continue normal observation by staff nurse
 Score 2 : Shift in charge nurse to be informed and continue hourly observations
 Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

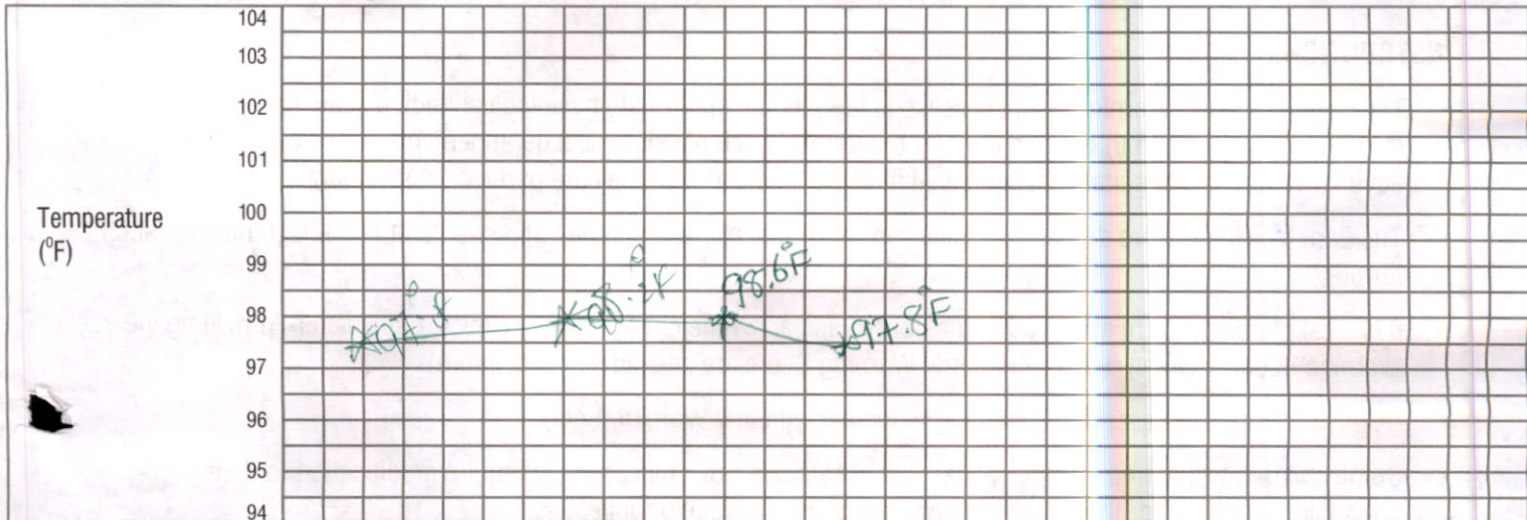
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/07/16 Time: 2 pm 6 pm 10 pm 2 am
 Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
2 pm	110	100/60
6 pm	120	110/70
10 pm	83b/m	113/77
2 am	111b/m	102/78

Resp. Rate (bpm) (Over 1 Minute)

Time	Resp. Rate (bpm)
2 pm	26b/m
6 pm	26b/m
10 pm	26b/m
2 am	26b/m

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	O ₂ Saturations (%)	
Conscious Level	Normal	Altered
GCS *		

TOTAL SCORE	
Number of shaded boxes	
Pain Score	
Observer's Initials	

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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- 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)
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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.

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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)

VH-00206870
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D (F)
Dr. KOKKULA PRANEETH



0. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

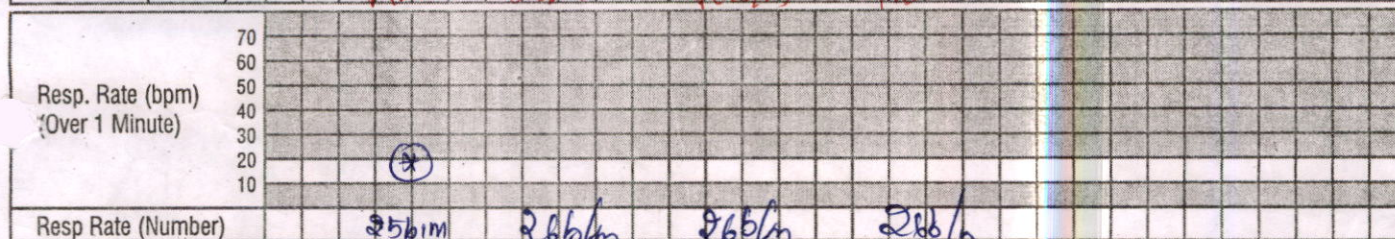
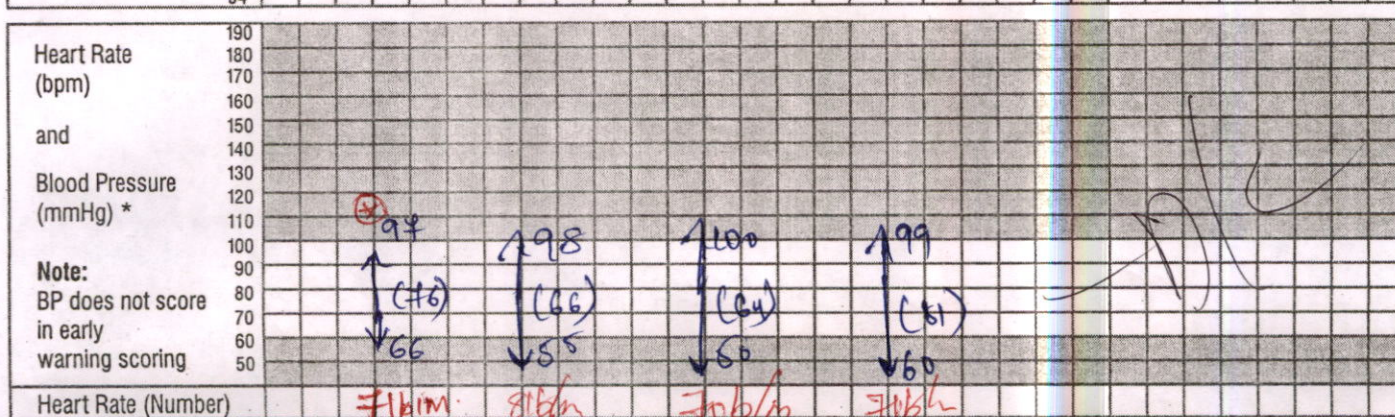
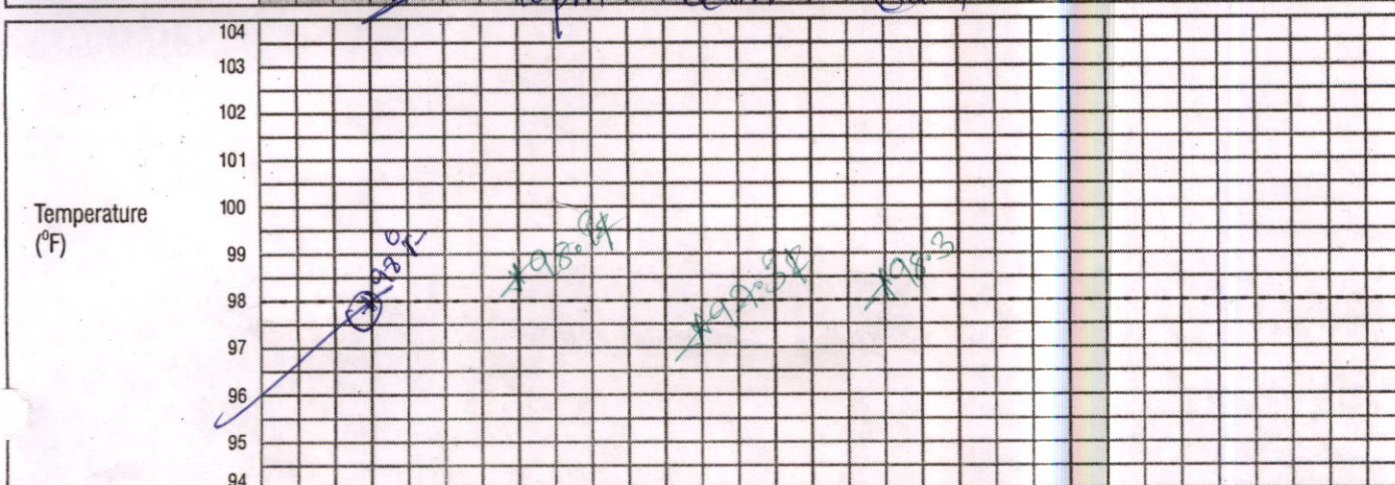
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/11/2016 Time: 10pm

Doctor / Nurse / Family Concern? 10pm 2am 6am



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	100%	99%
O ₂ Saturations (%)	100%	99%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

TOTAL SCORE	
Number of shaded boxes	1
Pain Score	0
Observer's Initials	13

ACTIONS	Score 1 : Continue normal observation by staff/nurse
NB: Scores 3 should be recorded overleaf	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.

VIH-00206870 IP5-00176522
 Baby VEMAVARAPU JAYASRI
 08-04-2011 15 Y 3 M 9 D (F)
 Dr. KOKKULA PRANEETH



Patient

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ①

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm	1	chepathu	-							0	
	05:00 pm	NO		-							0	pran
	06:00 pm	2vf		-							0	pran
	07:00 pm	1		-							0	
Total Intake :					Total Output :							
	08:00 pm	1	Rice								0	Chand
	09:00 pm	1									0	Chand
	10:00 pm	no									0	Chand
	11:00 pm	8vf									0	Chand
	12:00 am	1									0	Chand
	01:00 am	1									0	
Total Intake :					Total Output :							
	02:00 am	1	Bread								0	Chand
	03:00 am	1	Npo	80ml							0	Chand
	04:00 am			80ml							0	Chand
	05:00 am	1	ONS	80ml							0	Chand
	06:00 am	1		80ml							0	Chand
	07:00 am	1		80ml							0	Chand
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		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								
19/07/11	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
19/07/11	02:00 pm	↑											
	03:00 pm												
	04:00 pm	NO											
	05:00 pm	SUR											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
19/7	08:00 pm												
	09:00 pm												
	10:00 pm	NO											
	11:00 pm	IVF											
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
20/7	02:00 am												
	03:00 am												
	04:00 am	NO											
	05:00 am	IVF											
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
2/1/7			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	NO										
	10:00 am	IVF										
	11:00 am											
	12:00 pm											
	01:00 pm		RICE									
Total Intake :			Total Output :									
2/1/7	02:00 pm											
	03:00 pm											
	04:00 pm	NO										
	05:00 pm	IVF										
	06:00 pm											
	07:00 pm											
Total Intake :			Total Output :									
2/1/7	08:00 pm											
	09:00 pm											
	10:00 pm	NO										
	11:00 pm	IVF										
	12:00 am											
	01:00 am											
Total Intake :			Total Output :									
2/1/7	02:00 am											
	03:00 am											
	04:00 am	NO										
	05:00 am	IVF										
	06:00 am											
	07:00 am											
Total Intake :			Total Output :									
Total 24 hrs. Intake			Total 24 hrs. Output									

FLUID CHART

Sheet No. :

1. All measurements in ml.
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		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse											
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine													
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Total Intake :						Total Output :																	
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	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											



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 17/7/26 Time: 4pm

Weight: 42kgs Centile: 25th

Height: 1.53m Centile: 75th

Inference: Underweight child

RDA: — Calories: 1900kcal/d Protein: 3g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled and out side foods

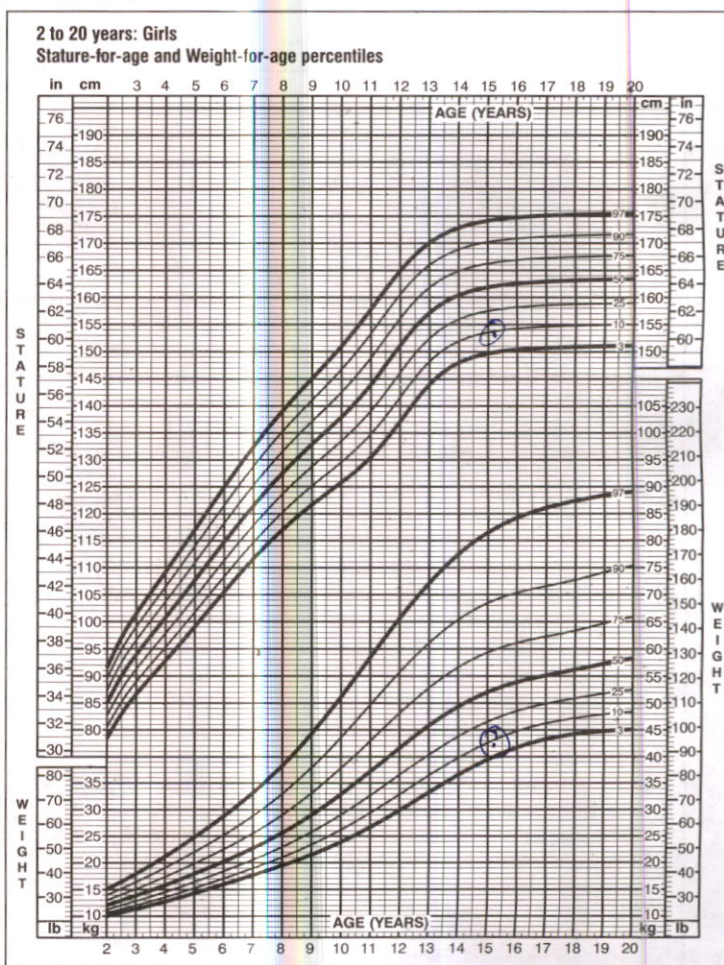
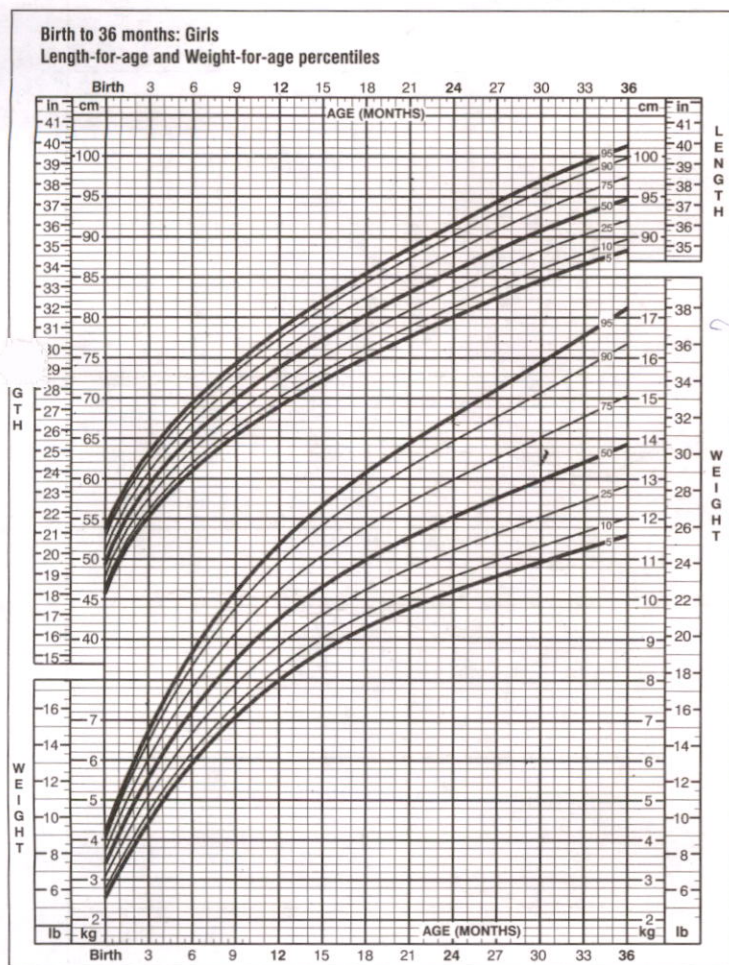
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: K/40 Acute onset Encephalopathy & A. hydrocephalus s/p shunt ? phenister.

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: V. Bhaskarshmi

GROWTH CHART (GIRLS)



Dietician's Name: Moulika

Dietician's Signature: Moulika

Docu. No. : RCHBH / FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

2/17/26
11am

child is stable oral intake is fair

continue c normal diet

—nicitig

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date:18/07/26

Time:1:50 pm

Blood Group of the Patient:B+ve

Blood Group on the Blood Bag:B+ve

Blood Bank Issue No:BAH26-01633

Date of Collection:09/Jul/26

Date of Expiry:20/Aug/26

Date & Time of Starting Transfusion:18/07/26 @

Planned duration of Transfusion:100 mins

Check for Correct Unit:☒

Correct Patient:☒

Blood products cross checked by: Nurse 1:Swapna

Nurse 2:Baru

Before starting transfusion vitals: Temp:98.6°F

HR:102/bt

RR:18

BP:95/76 mmHg

SpO2:100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min 2:05 pm	20/bt	98.6°F	100/60 mmHg	100%	—	—	—	—
	15 Min 2:15 pm	18/bt	98.6°F	98/76 mmHg	100%	—	—	—	—
	30 Min 2:45 pm	20/bt	98.6°F	100/60 mmHg	100%	—	—	—	—
	30 Min 3:15 pm	18/bt	98.6°F	100/60 mmHg	100%	—	—	—	—
	30 Min								
	1 Hr								
	1 Hr								

Comments:Nil

Name of the Incharge-Nurse:Kumari

Signature of the Incharge-Nurse:Kumari

Date & Time:18/7/26 9 am

Name of the Nurse:Swapna

Signature of the Nurse:Swapna

Date & Time:18/07/26 @ 9 am

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital,
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS LP

Qty. 260 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A. Solution.

B
Rh Positive

HIV I & II/ HBsAG/HCV - Non reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non reactive

Unit No.: **BAH26-01633**
Blood Group: **B Rh Positive**
Collection Date: **09/Jul/2026**
Expiry Date: **20/Aug/2026**

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's Group and Name Before Administration. 5) Use Sterile Transfusion With Filter. 6) Do Not Use Without Prescription. 7) Do Not Use if

Issue Label / CrossMatching Report	
Appropriate Patient:	BABY.VEMAVARAPU JAYASRI -
Antibodies Patient's Blood Group:	B Rh Positive
Hosp/Dr.:	Rainbow Childrens Hospital, DR KOKKULA
UHID No.:	VIH-00206870
Wd-Bed No.:	
Product:	LR-PRBC
Blood Group:	B Rh Positive
Unit No.:	BAH26-01633
XMatching Report:	Compatible
X-matched by:	PILLEM
Issued By:	MONOJ
Rainbow Hospital Blood Centre, Rainbow Childrens Hospital	
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad Telangana State	
Lic.No. 46/HD/TS/2018/BB/G	

INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY



VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 10 D (F)
Dr. KOKKULA PRANEETH

Name: V. JAYASRI Age: 15y 3m Gender: ☐ Male ☒ Female

UHID.No : VIH-00206870 Date: 17/7/2026

I / We have been explained by Dr. Praneeth about the medical condition and the proposed procedure.

I / We have been told that our patient V. JAYASRI has the following Medical Conditions / Diagnosis:

Middle brain SOL S/P VP shunt

Proposed Treatment / Procedure / Operation:

Craniotomy and excision of tumour

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned above and that our patient has following risks involved during the hospital stay

Bleeding, Cranial nerve deficit, eye vision disturbance, limb weakness, residual tumour, recurrence, adjuvant therapy,

I / We have been explained risk, benefits and alternatives of the procedure. life risk, ICU stay,

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results, complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

I / We have understood the consequences of not undergoing the proposed treatment. ventilator support

I / We hereby give (my / our) full consent for the above - mentioned treatment. visual deterioration

I / We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences arising from the treatment. Tracheostomy

Patient (Or Patient Relative / Guardian):

Signature: V. Veeram

Name: V. Veeramarkudu

Date & Time 17/7/2026 5pm

Doctor (Who is talking the consent)

Signature: Praneeth

Name: Dr. Praneeth

Date & Time 17/7/2026 5pm

Witness

Signature: V. Bhulakshmi Name: V. Bhulakshmi

Relative / Legal Guardian: (Relationship with Patient) Mother

Address: Moulali, Hyderabad

Date & Time 17/7/2026

CONSENT FOR BLOOD TRANSFUSION



Name: Age: Gender: Male ☐ Female ☐
UHID.No : Date:

Type of Blood Product:

☐ Fresh Frozen Plasma	☒ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: V. Vikram
Name: V. Vikramarkudee
Date & Time: 18/07/26 @ 9am

Doctor (Who is talking the consent)

Signature: [Signature]
Name: Dr. Dmg. Bhrami
Date & Time: 18/7/26 @ 9am

Witness

Signature: V. Bhulakshmi
Name: V. Bhulakshmi
Date & Time: 18/07/26 @ 9am

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets
☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే దాత ఫ్లేటిలెట్స్ ☐ Whole Blood
☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిస్టిస్ లక్షణాలు లేవని పరీక్షించి బడిసనిది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని శూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతివర్కాలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలివైనప్పు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం/ లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ఫ్లేటిలెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెన్షన్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist : Dr. Skilpa
Scrub Nurse : Prath / Jayatta

Patient Name : V. Jayasri Age : 15y Gender : F
UHID No. : 644-00206870 Surgery Name : Craniotomy + Excision of tumor
Date : 18/07/26 In-time : 9:10 am Out-time : 3:00 pm

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 10 D (F)
Dr. KOKKULA PRANEETH


Before Induction of Anaesthesia >>

SIGN IN	Time: <u>8:56 am</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>Dr. Skilpa</u>	
Name : <u>Dr. Skilpa</u>	

Before Skin Incision >>

TIME OUT	Time: <u>10:41 am</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: <u>Bleeding Tumor excision</u>	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews: <u>Bleeding of blood transfusion</u>	
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>Surgeon</u>	
Name : <u>Surgeon</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>3 pm</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) <u>Tumor</u> ☒ 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>Pranith</u>	
Name : <u>Dr. Pranith</u>	

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

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

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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 :		



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 18/04/2016

Department : P.O.T. Duration of Procedure : 6 hrs

Name of Surgeon : Dr. Praneeth Date of Admission : 17/04/2016

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 (cleanse surgical area with antiseptic agent) ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 18/04/2016 @ 10:41 am	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department



Pa

OPERATION THEATER NOTES

Patient's Name: Baby V. Jayasri Age: 15y Gender: ☐ Male ☒ Female
 UHID No.: KAH - 00206870 Weight: 42kgs Height:

Surgeon: Dr. Praneeth / Dr. Sri Parth Asst. Surgeon:

Anesthetist: Dr. Sri Pa OT Nurse: Jyoti / Sufatha OT Technician: Rapu

Pre-Operative Diagnosis: Superior Vermian SOL

Surgical Procedure: Left occipital transtentorial ~~eq~~ approach and Gross total

Indications for Surgery: Tumour Excision

Date: 18/04/26 Start Time: 10:15 am End Time: 3pm

Pre Operative Preparations:

Betacarb → Chlorhexidine → Betadine X 3

Post Operative Diagnosis: Same

Peri-Operative Complications: Blood loss

Operation Notes:

- ① Patient positioned prone
- ② ④ nitre's flap raised
- ③ ④ parasagittal p'o' craniotomy done
- ④ Draped band on superior sagittal sinus and transverse sinus
- ⑤ Interhemispheric approach taken
- ⑥ Tentorium divided
- ⑦ Tumour visualised in posterior quadrigeminal cistern
- ⑧ Tumour capsule opened, hematoma evacuated

- Tumour greyish, partially sechable
- (9) plane from the surrounding structures good
 - (9) Gross total excisions done
 - (10) Hemostasis secured
 - (11) Dura closed. Bone flap replaced
 - (12) wound closed in layers

Amount of Blood Loss: ~ 400 ml

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Tumour tissue

Peri-Operative Complications:

Nil

Name of the Surgeon: Dr. Branelti

Signature of the Surgeon: [Signature]

Date & Time: 18/7/2026



POST-SURGICAL CARE PLAN FORM

Procedure Done: *Craniotomy and biopsy*

Post-Surgical Diagnosis: *Glomangioma lesion*

Post-Operative Monitoring Parameters /Frequency:

vitals, a/c

and Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Prone

Nutritional Instructions:

NPO till fully awake

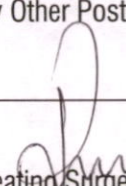
When to Start Mobilization:

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: *15/7/2020* Time:

Note: Plan of care will be readjusted if necessary.

VIH-00206870 IP5-00176522
 Baby VEMAVARAPU JAYASRI
 08-04-2011 15 Y 3 M 11 D (F)
 Dr. KOKKULA PRANEETH

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:20pm Mode of Arrival: Wheeler Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: no Allergic reaction Body Weight: Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: NA

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

If yes please list

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

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

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

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

Temp.: 98.1°F HR: 82b/m RR: 21b/m BP: 110/62

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

Fall Risk Assessment: ☐ Yes ☒ No Score: 9 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☐ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☐ No

Information given to

Nurse Signature: fNurse Name: pramillaDate: 12/2/16Time: @ 3:30pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D
Dr. KOKKULA PRANEETH (F)



Patient Name : BABY VEMAVARAPU JAYASRI Age : 15 Y 3 M Gender : Male ☐ Female ☒

UHID NO: VIH 00206870 Surgeon Name: Dr. PRANEETH

Anaesthesiologist : DR ADITI NEWASKAR

Operative procedure planned : CRANIOTOMY + TUMOUR EXCISION

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease
☐ Others :

Comments : DESATURATION, BLEEDING, BLOOD TRANSFUSION
POST OPERATIVE PAIN

- 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
CRANIOTOMY + TUMOUR EXCISION

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 anaesthesia.

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

I authorize the 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 : V. Bhulakshmi

Name : V. Bhulakshmi

Relationship with Patient : Mother

Date & Time : 12/7/26 @ 8am

Witness :

Signature : V. Vikram

Name : V. Vikram Arudra

Date & Time : 12/7/26 am

Doctor (who is taking the consent) :

Signature : Aditi

Name : DR ADITI NEWASKAR

Date & Time : 12/7/26 8am

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

VH-00206870
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D
Dr. KOKKULA PRANEETH (F)

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Name: _____ Age: 15 Sex: F UHID No: _____

Date: 17/7/21 Time: 2:10 Proposed Operation: CRANIOTOMY + TUMOUR EXC

Diagnosis: Acute onset encephalopathy with raised ICP & acute hydrocephalus. ICSOL

B.P / CRT: 97/16 H.R: 71 Weight: 42 ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13g/l	Glucose: _____	Protein: _____	HIV: _____	X-Ray: _____
PCV: _____	Urea: _____	Alb: _____	HBS Ag: _____	ECG: _____
WBC: _____	Creat: _____	Total Bill: _____	HCV: _____	2D Echo: _____
Plate: _____	Na: _____	Dir. Bill: _____	Blood group: B+V	Stress/Angio: _____
PT: 14	K: _____	LDH: _____	T3: _____	Other: _____
PTT: 31.85	Ca++: _____	Alk phos: _____	T4: _____	
INR: 1	Mg++: _____	Amylase: _____	TSH: _____	
	Cl-: _____	SGOT/SGPT: _____		

Allergies: NKA

Medical History: CVS:

RESP: HEADACHE + VOMITING 5 days Diabetes: _____

CNS: BIL & unidirectional VP shunt

Renal: _____

Hepatic / GE: _____

Physical Activity: _____

Others: _____

Past Anaesthetic History: RIGHT MID PARIENTAL VENTRICULO PERITONEAL SHUNT (31/3/2021) → EXTUBATED AFTER 2 days.

Physical Exam: Conscious, oriented

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (C) Neck: (C) Teeth: (C)

Lungs: AERAE

Heart: S1S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: RUL Spine Exam for regional: (B226)

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

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

CURRENT MEDICATIONS	DOSAGE
TAB LEVETIRACETAM	500mg PO BD
TAB DEXAMETHASONE	4mg PO
TAB CEFEMID	200mg PO
20	

Pre-Operative Instructions:

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

Signature: Aditi Name: Dr Aditi N

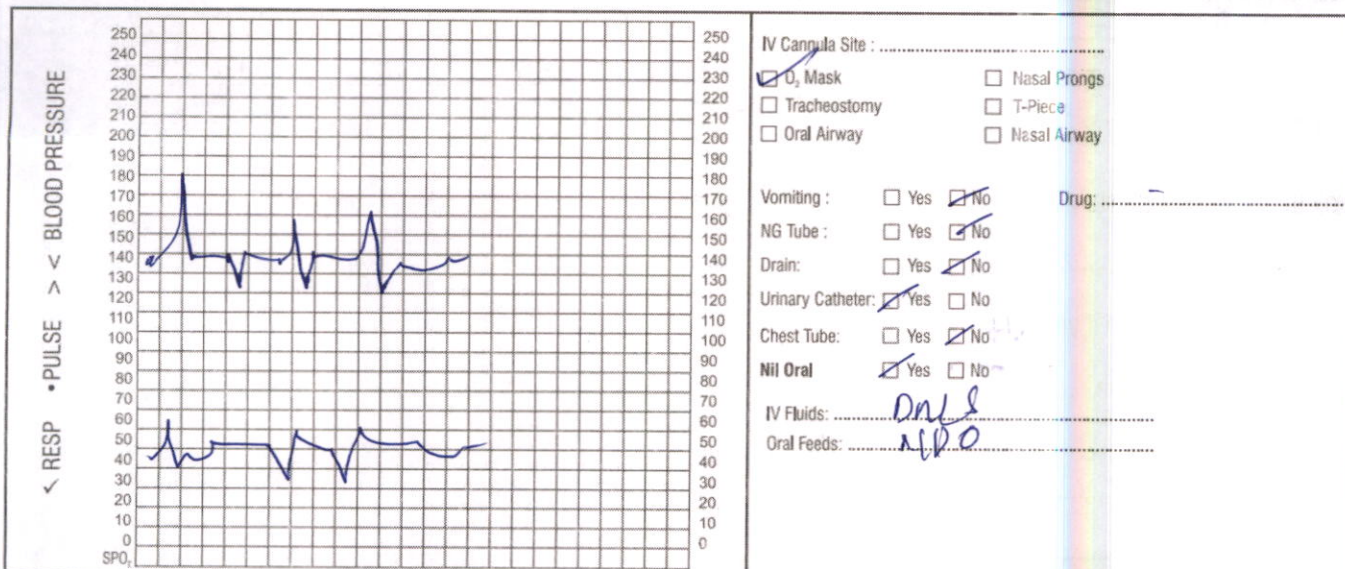
→ 20 PRBC to be reserved
→ Give morning dose of Leviteracetam before shifting to OT
→ CBC, PT INR

MRI Brain: focal encephalitis 28x25mm mass effect on lateral plate & midline shift. Shunt moderate obstruction hydrocephalus with mild transpendymal & hemorrhagic posterior fossa necrosis



POST-ANALGESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :



IV Cannula Site :
☒ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☒ No

Drug:

NG Tube : ☐ Yes ☒ No

Drain: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Chest Tube: ☐ Yes ☒ No

Nil Oral ☒ Yes ☐ No

IV Fluids: only 100

Oral Feeds: nil

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
18/7	6pm	2/10	Reg - Pain	Chuf.

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name : Vandana

PACU Nurse Signature: [Signature]

Date & Time: 18/7/20 @ 4pm

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
 - Within 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time:

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level 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 :



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LIST

Date: 19/7/2026

Patient's Name: B. Demavarapu S. Age: 15y Gender: ☐ M ☒ F

Blood Group: ————— UHID: VJH-00206870

Planned Surgery: Craniotomy-Tumour resection. DR. KOKKULA PRANEETH

Anesthetist: DR. Subhakar Date & Time of Operation: 18/7/2026

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse : @ 9 Am.

S.No	INSTRUCTIONS	ER/Ward, Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1.	Weight checked and recorded? 42	☒	☐	☐	☒	☐	☐
	Is the patient fasting for over 6 hours Pre-Operatively?	☒	☐	☐	☒	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☒	☐	☐	☒	☐	☐
4.	Enema given / Bowel Preparation	☐	☒	☐	☐	☐	☒
5.	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☒	☐	☐	☒	☐	☐
6.	Sterile Gown Given	☒	☐	☐	☒	☐	☐
7.	Is Blood arranged as required?	☒	☐	☐	☒	☐	☐
8.	If Blood has been ordered - is Blood bag ready?	☒	☐	☐	☒	☐	☐
9.	IV Cannula to be placed / IV fluids if Indicated	☒	☐	☐	☒	☐	☐
10.	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐	☒	☐	☐
11.	Pre Medications Given? (Sedatives / etc)	☒	☐	☐	☒	☐	☐
12.	Skin Preparation	☒	☐	☐	☒	☐	☐
13.	Site is marked	☐	☐	☐	☐	☐	☒
14.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☒	☐	☐	☒	☐	☐
15.	Implants are available	☒	☐	☐	☒	☐	☐
	Equipment is available	☒	☐	☐	☒	☐	☐
17.	Antibiotic Prophylaxis is given within the last 60 minutes	☒	☐	☐	☒	☐	☐
18.	Other (if any)	☐	☐	☐	☒	☐	☐

NOTE: If any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken: ☐ Yes ☐ No

Billing Executive Name: —————

Billing Executive Signature: —————

Date & Time: —————

OT Nurse Name: —————

Signature of OT Nurse: —————

Date & Time: 18/7/2026 @ 8:40 am

ER/Ward Nurse Name: —————

Signature of ER/Ward Nurse: —————

Date & Time: 19/7/2026



POST OPERATIVE - DOCTORS HANDOVER FORM

OT to ☒ PICU ☐ NICU ☐ MICU ☐ WARD

Date: 12/7/20 Time: 3:50pm

Name of the Surgery: Craniotomy + Intracranial resection

Drugs used for sedation during surgical procedure: Propofol, pentamyl, morphine
Lorazepam

IV fluids type / amount used using surgical procedure: RL, plasma-lyte, fentanyl

Crystalloids → Colloid - 500ml PRBC - 220ml
Input 1700 ml Output 600 ml Blood Loss 800-900 ml GRBS - 130g
L3: 28 PM

Blood Transfusion if any: yes - 220ml PRBC

Any intra operative event: nil urine 600ml

On arrival to PICU / NICU / MICU / WARD:

Temp: HR: RR: BP: CRT:

Peripheries: SpO₂:

Drains:

Tube: ☐ Cuffed ☐ Uncuffed Extubated

Size of ETT: Length of Fixation of ETT:

Surgeon's Notes: ☒ Yes ☐ No

Time of Arrival to Unit: 3:50pm

Handover given by: Handover taken by:

Anesthesiologist's Name Dr. Brunda Doctor's Name

Signature: B de Signature:

Date & Time: 12/9/20, 3:50pm Date & Time:

VIH-00206870 IP5-00176522
Baby VEMAVARAPU JAYASRI
08-04-2011 15 Y 3 M 9 D (F)
Dr. KOKKULA PRANEETH



V. Jayasri



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/2026	cls/B Dr. Prameeth	Adv ① Arrange PRBC 20cc/kg ② PAC ③ Financial clearance ④
		<i>[Signature]</i> Dr. KOKKULA PRAMEETH Reg. No: APMC/FMR/92741



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/26	C/S/B Resident	
4pm	Δ: Acute Onset Encephalopathy ± Vasculitis ± Acute Hydrocephalus ± ICSOL - ? Pilocytic Astrocytoma S/P Craniotomy + Tumor excision (POD-0).	
	→ Sedation:- Propofol, Fentanyl, Morphine Paralytic:- Rocuronium.	<u>Plan</u> 1) DO CBP, ABG & electrolytes ATTNR
	→ ET tube:- 6 → fixed at 18cm nb. Extubated Port operatively CT done & shifted to PICU	2) Inj Paracetamol } Pain Inj Tramadol } Control
	→ Input:- 1700ml. crystalloids = 980 colloid } 500 gels PRBC = 230ml.	3) Inj cefotaxime to continue 4) Inj Levetiracetam 5) Monitor for Vitality, sensorium
	(Urine) Output = 600ml - (1.5 cc/kg/4hrs) Balance:- +200ml. Blood loss:- 900ml. child on FM ± 5 lit O ₂ Vitality:- HR:- 82/min SpO ₂ :- 100% BP:- CVS:- S ₁ , S ₂ heard. Resp:- BAE⊕. Hemodynamically stable Pupils:- 2mm B/L reactivity equal to light	4) NPO till further advice 5) Continue IV fluids (GO-f). 6) Inform SOS 7) R/V Dexamethasone.
		Noted by Vemalana 18/7/26 @ 4pm
		Dr. Jayasri



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/3/2020 8:20 AM	<u>C/S/B Dr. Praneeth</u> Δ: ICSOL ? pilocytic astrocytoma ± acute hydrocephalus s/p VP shunt & tumor excision.	<u>Plan:</u> ① Remove foley ② Remove external line Child on room air. SPO ₂ : 98% RR: 40/min RR: 20/min BP: 120/55 CNS: GCS 15/15 Pupil: 2+ 2+ Tone: (N).
		③ Stop IV fluids ④ Allow orally. ⑤ Cont drugs as per chart. ⑥ Shift to ward. ⑦ Syp Smooth. add. ⑧ PC Enema (SOS) ⑨ Pramedol cross

Dr. Praneeth

Dr. KOKKULA PRANEETH
Reg. No: APMC/FMR/92741

Date & Time	Progress Notes	Doctor's Order
	<u>clab Neurokam</u> 19/4/06 Acute onset encephalopathy with vermian, foci - of upstroke q: usar - across total excretion - ? p/wyte Astrocytoma. po dr. - No new issues - taking well orally - ofc: - vitals - stable - Hct - 15/15 - CN - 3/4/6/7/8/9/10/11/12 - pupils equal & reactive. - tone power & reflexes - No meningeal or cerebellar signs. Divine Boost	Adv: - shift to hard - remove Foley - extubation - vitals, izform Ws. - Cerebral - Feeding



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Date & Time	Progress Notes	Doctor's Order
19/07/2026 11:30 AM	CL/16 Mr. Sandeep Δ 1CSOL 2/p. upshunt E tuning Excel O/E Vital - stable on Room air hemodynamically stable	Plan: 1) Shift to ward 2) Remove Foley & arterial line 3) Inform ROS Ward Placed by Nurse



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/25 9Am	<u>CS/B Neuroteam</u> Acute Onset Encephalopathy & Vermian 1CSOL SP VP shunt with gross total erosion. No new issues - taking well orally. of - vitals → stable. - APT → (N) - CN → AEL CN intact = ? Bk peral weakness. - (N) temperature & reflexes - mild truncal & gait ataxia.	
		Adv. - vitals. of today after discussing with Neurosurgery today.
6:30pm	No new issues - Vertigo → reduced. - Ataxia ↓	adv. - vitals - 18/100