KUH-00138404 IP5-00176005
Baby Of SANGEETHA D
17-09-2022 3 Y 9 M 19 D (M)
Dr. SRINIVAS NAMINENI

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SURGERY DETAILS

Date : 06/07/22

Patient Name: B/o Sangeetha Date of Birth: 17-09-22 Age: 34

Gender: Male Ward : P.OT UHID No.: 138404

Date of Surgery: 06/07/22 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB.

Time in : 8:40Am Time Out : 10:20am

	NAME	AMOUNT
1. Surgeon	: SRINIVAS.N	D.P.U
2. Anaesthetist	: Dr. Shilpa	
3. Assistant Surgeon	:	
4. OT Technician	: Ranthamma	
5. Circulating Nurse	: Bichadai	
6. Assistant Nurse	: Swapna	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others COLLECT 12,000/- FOR CROWNS / SPACE MAINTAINE

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9689870 Order by: Jyothi

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

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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 : IP5-00176005 **Admit Date** : 06-Jul-2026 **Admit Time** : 07:06 AM **UHID** : KUH-00138404

Patient Details :

Patient Name	: Baby Of SANGEETHA D	**Age**	: 3 Y 9 M 19 D
Guardian	: Mr NAVEEN KUMAR	**DOB**	: 17-09-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO-5115 GREATER INFRA, BULE BELLS, HMT SWARNAPURI COLONY MIYAPUR Hyderabad Telangana INDIA 500049	**Phone No**	: 9642175968/ 9866375939
		E-mail	: na123@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 403 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 403 **Admission Type** : First Visit

Contact Details :

Name : Mr NAVEEN KUMAR **Relationship** : Father

Contact Address : FLAT NO-5115 GREATER INFRA, BULE BELLS, HMT SWARNAPURI COLONY MIYAPUR Hyderabad Telangana INDIA 500049 **Phone No** : 9642175968 / 9866375939

Signature

Doctor Details :

Doctor Name : Dr. SRINIVAS NAMINENI **Specialisation** : DENTAL

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

KUH-00138404 IP5-00176005
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UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	7:40Am	CP	OT	Rachel
6/7/26	11:15 A	OT	Billing	Thyas.

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
06/07	CBP	67437	Samathy

KUH-00138404 IP5-00176005
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Dental

13.5kg

CONSUMABLES OF OT

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Circulating Staff ..... Technician : ..... Date : ..... Time : 8.30AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5 4.0 4.5	1+1	3.5 4.0	Major Pack Drape	1	1	Inj Vit.K		
LMA 2	1	—	Sutures			Cord Clamp		
ECG leads : A / P / N	3	3				Suction Catheter		
HME filter : A / P / N	1	1				Feeding Tube		
Syringes : 10 cc	10	8				Vaccum Suction Set		
05 cc	10	8	Gloves			Surgical Gloves		
02 cc	10	3	6, 6½, 7, 7½	8½	—	Gauze Pack		
01 cc	2	—	P= 6, 6½, 7, 7½	2+	1+1	Syringe 1ml / 2ml		
Cautery plate : A / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	0	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	2+1	1	Koochies			Tranexamic	1	1
O2 mask (P)	1	—	Ointments			10CC, 5CC, 2CC	2+2	1+1
Atracurium 0.1	1+1	—	Suction Catheter			Inj. Dexamethasone	1	1
Fentanyl	1	1	Cap, Mask	5	5/5	Throat pack	1	1
Morphine			Gauze Pack (N)	5+5	3	26 g needle	1	1
Ketamine			Mop Pack	1	1			
Propofol	3	1	Steristrip					
Rocuronium	1	1	Underpad	1	1	I.V cannula 22, 24	1+1	—
Glycopyrolate	1	1	Draw sheet	1	1	Dexa	1	1
Myopyrolate + Neostigmine	1+2	2	Abgel			Tranexa	1	—
Ondansetron	1	1	Foleys catheter			Minispike	1	1
Pencan 25g/ Spinal Needle 22			Urobag			midaz + Lasix and	1+1	1+1
Bupivacaine 0.25%			Chest Drainage Catheter			2+ Jelly	1	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			Atropine	1	1
Antibiotics			Bandage			Adrenaline	1	1
			Tegaderm			Dexamide 50	1	—
Suppositories			Ioban			Clonidine	1	—
Anamol : 80mg / 250mg / 170 mg	1+1	—	Double J Stent			Nasal Atony 16.18.		—
Supridol : 100mg			Vaccum Suction set	1	1	Splint B+L NO	1+1	—
Justin : 12.5 mg / 25mg / 100mg	1+1	1	Plastic Bed Sheet	1	—	q site	1	—
Tab. Misoprost : 200mg			Betadine Solution	1	—	NG. 5.6 7 8 9 10		—
Vaccum set	1	1	Microshield	1	—	Suction cath 6.8.10		—
Gauze	3	2	Cotton Balls	1	1			
Gloves sent	4	—	Latex Gloves	1	19			
IV P.cap	1	1	Ramdione Scrub					
3-way 100+10cm	1+1	1	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 7689829 Ordered by : .....

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

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/04	IV Placement	(1)	89630	Sammy
	PAC	(1)	89631	

ANY OTHER INFORMATION

.....

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.....

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Resident	
6/3/26		plan.
2PM	A: Dental caries now for oral Rehabilitation ↓ G.A.	① continue NPO
	no fever	② IV Fluids
	no cold/cough	③ monitor vitals
		④ Shift to OT on call
		⑤ CBP with IV cannula
	O/E: CNS alert vitals stable	
	RS- Bilateral air entry, Clear.	Noted by Rachel,
	CVS- S_1S_2 Normal	
	P/A- Normal	Madhusri

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: 6/2/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Sig...ure .....

VERIFIED BY : Name .....

Baby Of SANGEETHA D
17-09-2022 3 Y 9 M 19 D (M)
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REGULAR PRESCRIPTIONS

Weight. 15kg Ward. 07

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

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

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

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

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Weight. 15kg Ward. OT

	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
6/7	8:40AM	Inj. DEXAMETHASONE	1.5mg	IV	[signature]	Bikhale / Swapna
6/7	8:41AM	Inj. TRANEXAMIC ACID	225mg	IV	[signature]	Gowthami / Bikhale
6/7	8:45AM	Inj. PARACETAMOL	225mg	IV	[signature]	Swapna / Bikhale
6/7	8:45AM	Supp. DICLOFENAC	12.5mg	P/R	[signature]	Gowthami / Bikhale

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

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I.V. FLUIDS CHART

Weight. 15kgs 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
6/7/26		DNS	I/V	50ml/hr		Not	Connected.		

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

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RESULT SHEET

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

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

Culture and Sensitivities : .....

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.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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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						
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											
6/7	11:00 am	Water	50ml	-	-	-	-	-	-	✓	0	Thuja
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	-										
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

FLUID CHART

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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**	

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Srinivas Department: Dental Date of Admission: 6/7/26

SITUATION

Diagnosis: caries

Any Infection: ☐ Yes ☑ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	GR 8:40am	GT 11:15am				
Medical Condition (Any special condition to be noted):	NA	NA				

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.5°F	98.6°F				
Res:	24b/m	26b/m				
SpO_2:	99%	99%				
Pulse:	108bpm	110bpm				
BP:	92/51(68)	95/55				
Fall Risk Score:	13	13				
Pain Score:	0	1/10				

Recommendations

Safety Needs:	Side rails	Side rail				
Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	NA	NA				
Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	NA				
Post Operative Procedure Special Orders:	NA	NA				
Handed Over By Name :	Rachel	Thyagu.				
Signature :						
Date:	6/7/26	6/7/26				
Time:	8:40am	11.15a				
Taken Over By Name :	Richa					
Signature :	Richa					
Date:	06/7/26					
Time:	07:40					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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THE HUMPTY DUMPTY SCALE 6/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	TOTAL		13				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes				
	Call device within reach		Yes				
	Wheels Locked		Yes				
	Room free of clutter		Yes				
	Adequate Lighting		Yes				
	Wheel Chair Support		NO				
	Other Intervention(s) Specify		NO				
	Nurse's Name :		Rachel				
	Signature :						
	Date :		6/7				
	Time :		7:10Am				

KUH-00138404 IP5-00176005
Baby Of SANGEETHA D
17-09-2022 3 Y 9 M 19 D (M)
Dr. SRINIVAS NAMINENI

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others .....

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/2/26	7Am	7	Infection control measures	M	1	D	1	1	WA	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/2/26	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	oral Rehabilitation	Hemodynamic stability	NPO IVF		☐ Nursing ☐ Others:
6/2/26	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Oral Rehabilitation	Hemodynamic stability	NPO IVF		☑ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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BRADEN 'Q' SCALE

				Date :	8/7/26			
				Time :	7 AM			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			/
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	24			
				Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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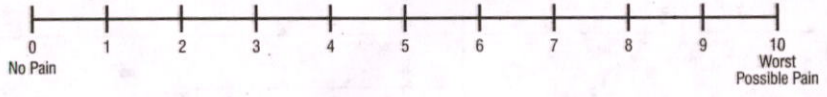
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/2	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rachel
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
a) At least every 2 hours for the first 24 hours b) Then every 4 hours.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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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 COMPREHENSIVE ORAL REHAB

2

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.

   The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
~~TEETH~~ INFECTION CONTROL	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.

b.

1. I authorize Dr. SRINIVAS.N 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: D.S.
Name: D. Sangeetha
Relationship with patient: Mother
Date & Time: 6/07/26 @ 8 am

Witness:
Signature: Freddy
Name: M. Naveen
Date & Time: 6/07/2026 @ 8.20 am

Doctor (who is taking consent):
Signature: Name: SRINIVAS Date 6/7 Time: 8.20 a.m

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనో్ చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(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 / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, 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 / ప్రాసీజర్కు 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 / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికి / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ 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: .....

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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KUH-00138404 IP5-00176005
Baby Of SANGEETHA D
17-09-2022 3 Y 9 M 19 D (M)
Dr. SRINIVAS NAMINENI

Name: Mast. Abhiram Age: 3y 9m Sex: Male UHID.No :

Date: 5/7/26 Time: 8:21pm Proposed Operation: ORAL Rehab under G.A

Diagnosis:

B.P / CRT: H.R: 106 cm Weight: 15 kg 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 : No H/o fever, Cough, Cold.

RESP : — Diabetes :

CNS : — H/o Seizure @ 1½ yr age — 6 days Admitted in Hospital. No further episode.

Renal : —

Hepatic / GE : — Physical Activity: (N) milestones.

Others : B/H: NVD/Full term/B.wt: 3kg/ uneventful/ vaccinations done till date.

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE (+)

Heart: S1S2 (+)

CNS: NAD

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 : s/c/o
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — last meal: 9:30pm, liquid: 9:30pm
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   - CBP during Counselling
   - Consent pending

Signature: Name: Dr. SHIVA

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

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ ~~No~~		Fasting Status: Confirmed	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 98 bpm	B.P / CRT: 90/60	SpO_2: 98%, on R.A	R.R: 20/min	Last Feed: >6hrs

Pre-OP Diagnosis: Dental Caries — Operation: Comprehensive Oral Rehabilitation — Date: 6/7/26

Surgeon: Dr. Srinivas — Anaesthesiologist: Dr K. Sri Surya / Dr Shilpa — Technician: Gautham

TIME	8:40	8:50	9:00	9:15	9:30	9:45	10:00 AM
N_2O / AIR / O_2 LPM							
HALO / SOT / SEVO	MAC 1						
Drugs:							
Inj MIDAZOLAM	0.4mg						
Inj FENTANYL	30mcg						
Inj PROPOFOL	30mg						
Inj ROCURONIUM	7mg + 1mg						
Inj NEOSTIGMINE							
Inj GLYCOPYROLATE							
FiO_2 / SaO_2	100	100	100	100	100	100	100
$ETCO_2$	47	44	46	48	47	48	48
ECG	NSR	NSR	NSR	NSR	NSR	NSR	NSR
Temperature							
Urine Output							
Fluids / Blood							

Antibiotic

Suppository: Inj DICLOFENAC 125mg

Blood Loss

NOTES: Throat pack IN @ 8:58 AM

Throat pack out @ 10:01 AM

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: (RT) UL
- ☐ Art Site: .....
- ☑ EKG Lead
- ☑ Temp Site Axilla
- ☑ 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: 8:40 AM
- OP Start: .....
- OP End: .....
- Leave OR: 10:10 AM

Anaesthesia:
- ☑ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP: .....
- ☐ ART: .....
- ☑ IV: 22G (LT) hand
- ☐ IV: .....
- ☐ IV: .....

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

- ☑ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# 4mm at 17 cm
- ☑ Oral ☐ Nasal ☑ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug: ROCURONIUM

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

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

Regional:
- Extremity 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 K. Sri Surya

Signature of the Doctor: [signature]

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Patient Sticker

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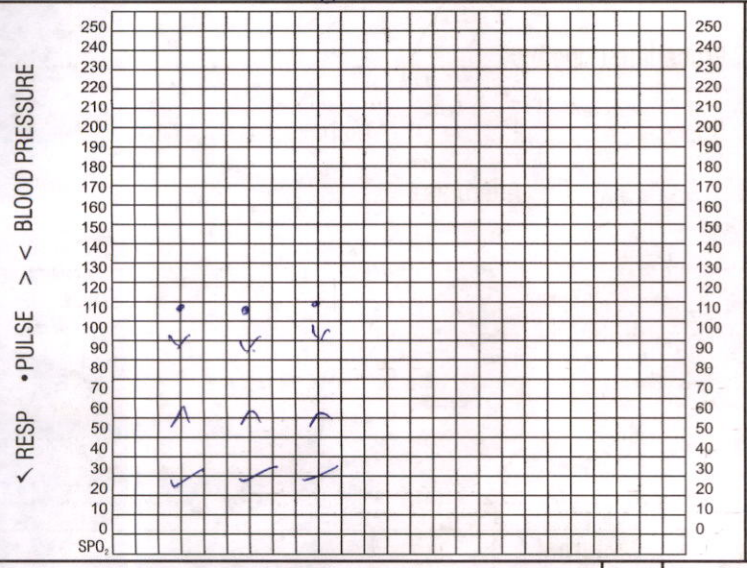
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Divya Time Received : 10:15 Am Time Discharged : 11:15



IV Cannula Site : .....

- ☐ O_2 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: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	0	1				A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2				
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION	2	2				
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	0	1				
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2				
	TOTAL	6	8				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
6/7/26	11.05	1/10	nil	Thejas.

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

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

Anaesthesiologist Name : Dr K Sri Surya
Anaesthesiologist Signature: .....
Date & Time: 6/7/26

PACU Nurse Name : Thejas
PACU Nurse Signature: .....
Date & Time: 6/7/26 @

Transferred to Unit by (PACU): Bikhlai
Date & Time: 6/7/26 @10:15 Am.

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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 BP	Maternal Pulse	FHR	Comments

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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Baby of Sangeetha D Age : 3y 9m Gender : Male ☑ Female ☐

UHID NO: ..... Surgeon Name: Dr Srinivas Naminemi

Anaesthesiologist : Dr Subhramanyan

Operative procedure planned : Comprehensive Oral Rehabilitation.

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 : Bronchospasm. laryngospasm . post procedure O2 support .

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Baby of Sangeetha D ..... the above mentioned operation / Diagnostic / Therapeutic procedures Comprehensive Oral Rehabilitation .....

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 : .....

Name : M-Naveen

Relationship with Patient: Father

Date & Time : 6/7/26 8:35 AM

Witness :

Signature : .....

Name : .....

Date & Time : 6/7/26 8:35 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. K. Sri Surya

Date & Time : 6/7/26 8:35 AM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sri ....
Asst. Surgeon : ....
Anaesthetist : Dr. Shilpa ....
Scrub Nurse : Swapna ....

Patient Name : B/o Sangeetha .. Age : 34 .. Gender : M ..
UHID No. : 00138404 .. Surgery Name : Dental ..
Date : 06/09/22 In-time : 9:40Am Out-time : 10:20am

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Dr. SRINIVAS NAMINENI

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 8:35Am

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 : D. K. Sri Surya

Before Skin Incision ➤ ➤

TIME OUT Time: 8:57Am

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 Dental ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, 1hr Anticipated Blood Loss? less than 10ml Nothing ☐Yes ☑No ☐NA

Anaesthesia Team Reviews: Nothing
- 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 : Bikila
Name : Bikila

Before Patient Leaves Operating Room

SIGN OUT Time: 10 am

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 : SRINIVAS .N

KUH-00138404 IP5-00176005
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Patien

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 06/07/26

Department : P. OT Duration of Procedure : 1hrs

Name of Surgeon : Dr. Srinivas Date of Admission : 06/07/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☑ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☑ No Name of the Antibiotic :	Bindu
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	Bindu
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Bindu
4.	Name of doctor or staff administering the antibiotic : Dr. Srinivas Date & Time of antibiotic administration : 06/07/26 at N/D Date & Time procedure started : 06/07/26 at	Bindu

- 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

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OPERATION THEATER NOTES

Patient's Name : B/o. Sangeetha Age : 3y Gender : ☑ Male ☐ Female

UHID No.: BRHT-00138404 Weight : Height :

Surgeon : Dr. Srinivas	Asst. Surgeon :	
Anesthetist : Dr. Shilpa	OT Nurse: Swapna	OT Technician: Vasuthami

Pre-Operative Diagnosis:

Surgical Procedure :
COMPREHENSIVE ORAL REHAB.

Indications for Surgery :
EARLY CHILDHOOD CARIES.

Date : 06/08/26	Start Time : 8:40Am	End Time : 10am

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

↓↓ G.A WITH NTI
RADIOGRAPHS EXPOSED.
- SS CROWN INSERTIONS ON 64, 74, 84 DONE
- RESTORATIONS ON 53 52 51 61 62 63 65 75, 85 55
- EXTRACTIONS OF 54 FOLLOWED BY INSATION OF SPACE MAINTAINER.

ANAESTHESIA UNEVENTFUL-

- SOFT DIET & GENTLE BRUSHING FOR 3DAYS.

- REVIEW IN 3DAYS.

℞ SYRUP IBUGESIC-PLUS 5ml 1-1-1 x 2DAYS.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: SRINIVAS. D

Signature of the Surgeon:

Date & Time: 6/7/26

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POST-SURGICAL CARE PLAN FORM

Procedure Done: COMPREHENSIVE OT AR REHAB

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:
CHECK BEDDING BUBBY 15 MIN

Wound Care:
—

...in /Special Lines/Catheters:
—

Special Patient Positioning and Requirements:
—

Nutritional Instructions:
—

When to Start Mobilization:
—

Special Referrals:
—

The new order for all required medications documented in the doctor order/medication sheet:
☐ Yes ☐ No —

Any Other Post-Operative Care Needed including Required Follow Up
—

Treating Surgeon
(Signature & Stamp)

Date: 6/7/26 Time: .....

Note: Plan of care will be readjusted if necessary.