

KOH-00288424 IP5-00174443
Baby Of JYOTHI AMARABOYNA (M)
26-04-2019 7 Y 1 M 2 D
Dr. MANCHUKONDA SANTHOSH



SURGERY DETAILS

80468

Date : 28/5/20
Patient Name: Baby of Jyothi Date of Birth: 26/4/19 Age: 7y
Gender: Male Ward: P-OT UHID No.: KOH-00288424
Date of Surgery: 28/5/20 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery : Coblation Adenotomyllectomy

Time in : 1.35pm.

Time Out : 3.45pm.

	NAME	AMOUNT
1. Surgeon	:	:
2. Anaesthetist	: Dr. Tejaswini	:
3. Assistant Surgeon	:	:
4. OT Technician	: Srishta	:
5. Circulating Nurse	: Kalyan	:
6. Assistant Nurse	: Prashanth	:

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others Coblator used - 79631546

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9631545/

Order by: B doif

CONSUMABLES OF OT

Circulating staff : Technician : Date : Time : 2:30pm

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube	4.5 / 5 / 5.5	1	1	Major Pack	Drape	1	1	Inj Vit.K			
LMA	1	1	1	Sutures				Cord Clamp			
ECG leads : A / P / N		5	5					Suction Catheter			
HME filter : A / P / N		1	1					Feeding Tube			
Syringes : 10 cc		10	04					Vaccum Suction Set			
05 cc		10	04	Gloves	6.6 1/2 7-7 1/2 2x2			Surgical Gloves			
02 cc		10	00	Bf	6.6 1/2 7-7 1/2 2x2	2	2	Gauze Pack			
01 cc		5	1					Syringe 1ml / 2ml			
Cautery plate : A / P / N		1	1	Surgical blade	#			Surgical Blade # 20			
IV set		1	1	NG tube	6 NO	2	2	Koochies (S)			
RL		1	1	Cautery pencil				NS - 500ml	2	1	
NS : 10ml / 100ml / 500ml / 1000ml		1	1	Koochies				transofix	1	1	
minispike		1	1	Ointments				Savlon	1	1	
OR mask		1	1	Suction Catheter				Adriline	2	2	
Fentanyl		1	1	Cap, Mask				7 INJ. Augmentin	1	1	
Morphine				Gauze Pack	N/R	5	5	Coody			
Ketamine				Mop Pack		5	5				
Propofol		3	2	Steristrip							
Rocuronium		1	1	Underpad		1	1				
Glycopyrolate		1	1	Draw sheet		1	1				
Myopyrolate		1	1	Abgel							
Ondansetron		1	01	Foleys catheter							
Pencan 25g/ Spinal Needle		1	1	Urobag				Gauze	3	3	
Bupivacaine 0.25%				Chest Drainage Catheter		1	1	Gloves	4	1	
Bupivacaine 0.25% (Heavy)				Romodrain bag		1	1	Dexamid	1	1	
Antibiotics Aug 1.2mg		1	1	Bandage				Doxafranzaxa	1	1	
D. upem		1	01	Tegaderm				50C-tpmline	1	1	
Suppositories				Ioban				metaprolol	1	1	
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supricol : 100mg				Vaccum Suction set		2	2				
Justin 12.5 mg / 25mg / 100mg		1	01	Plastic Bed Sheet		1	1				
Tab. Misoprost : 200mg				Betadine Solution		1	1				
vaccum set		1	1	Microshield		1	1				
oral airway 1/2		1	1	Cotton Balls		1	1				
nasal airway 2/2.84		1	1	Latex Gloves		10	10				
supay 100ml/200ml		1	1	Ramdione Scrub							
Sou Camulla 2/2/24		1	1	Saral							

Surgeon : Anaesthesiologist : 9631582 Nurse : OT Technician :
 Order No. : Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125

ESTIMATION SLIP

Pre-Approval

Date: 26 May 26 UHID / IP No.: KOH-00288424 SI No. 80468
 Name of Patient: Mast. Vhaanish Gaud Age: 7y Gender: Male
 Father's / Husband's Name: Mr. Rajender Gaud Corporate / Occupation: Business
 Address: _____ Phone: 9949803040 Email: _____
 Procedure / Plan: Coblation Adenotonsillectomy

MODE OF PAYMENT: SELF TPA: Care health DGIPA: _____ OTHERS: _____

TARIFF INFORMATION:

Room Category	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee										
L. Tax										

PARTICULARS		AMOUNT (₹)
Surgeon's / Anesthetists's Fee / O.T. Charges		<u>(57188) + (21111) + (101)</u>
O.T. Consumables		<u>5500</u> Subject to approval by TPA / Insurance Company
Instrument Charges		<u>1500</u> Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations		<u>1500</u> As per actual - Not Included in Estimation
Equipment Charges	Monitor :	
	Ventilator :	Conventional : _____ HFO-SLE 5000 : _____ HFO Sensormedix :
	Phototherapy :	Single Surface : _____ Double Surface : _____ Triple Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.		<u>Extra</u> As per actual - Not Included in Estimation
Package		
Others		
Initial Minimum Deposit		<u>27,000</u> Subject to Coverage. <u>15000/-</u> Final bill cleared or Deposit <u>5000</u>

- MARKS:**
- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
 - The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
 - In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
 - Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
 - Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
 - For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HBs Ag, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
 - During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm.
 - Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
 - Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION
 I Rajender Gaud have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client: _____ Signature Relationship: _____ Signature of the Financial Counselor: _____

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time : _____ Time: _____

Room / Bed No : _____ Ward : _____ a bed type : _____

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	9:30 am	ED	OT	Archi
28/5/26	6:20 pm	OT	238	Suman

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Vswala Daxai	29/5/26	9632706	Barnali
2				
3				
4				
5				
6				
7				
8				
9				
10				

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174443 Admit Date : 28-May-2026 Admit Time : 11:55 AM UHID : KOH-00288424

Patient Details :

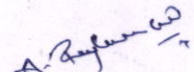
Patient Name : Baby Of JYOTHI AMARABOYNA (AMARA BOINA VIHANSH GOUD) Age : 7 Y 1 M 2 D
Guardian : Mr AMARABOYNA RAJENDER GOUD DOB : 26-04-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 11-124, DASNAPOOR, Adilabad Phone No : 9949803040/ 9573829318
Adilabad Telangana INDIA 504001 E-mail : goud.rajender872@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 401 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 401 Admission Type : First Visit

Contact Details :

Name : Mr AMARABOYNA RAJENDER GOUD Relationship : Father
Contact Address : H NO 11-124, DASNAPOOR, Adilabad Phone No : 9949803040 / 9573829318
Adilabad Telangana INDIA 504001


Signature

Doctor Details :

Doctor Name : Dr. MANCHUKONDA SANTHOSH KUMAR Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : CARE HEALTH INSURANCE LIMITED



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Baby of Jyothi (Baby)

UHID ID:

Department:

Consultant:

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Pediatric Multiorgan History & Physical Examination

Name : Baby of Jyothi Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o recurrent episodes of cold, cough
nose block ⊕

open mouth Breathing
Snoring Issues ⊕
Tonsillitis

History of present illness :

As per informant, child apparently well
then had - recurrent episodes of
cold, cough
nose block ⊕

open mouth Breathing
Snoring Issues ⊕.

o/r: had Adenoid Hypertrophy.

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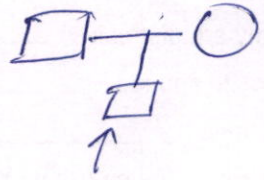


ry & Physical Examination

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

Birth & Neonatal History:

Normal perinatal transition



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : } middle

Developmental History :

Attained appropriate for age

Immunization History :

Immunized till date

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ry & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 20 kg (Centile _____)

On Examination :

Temperature : 98.0°F Pulse Rate : 70z/min B.P. 111/64 SPO2 98%-@RA

Resp. rate and type of breathing : 22/min -
regular

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : BAEFT, clear

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S₁ S₂ Heard

Any murmur : no murmur

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

Per Abdomen :

Inspection (N)

Palpation : Soft, non tender

Ausculation : BSFT

Spine : (N) External Genitelia : (N)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert Active

Cranial Nerves : Intact

Motor System:

Nutriton : Good

Tone: (R) Power OK

Co-ordinator : _____

Posture : _____

Involuntary Movements : nil

Reflexes :

DTR

(R)

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Chronic Adenotonsillitis

Now for Coblation Adenotomillectomy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent Complications

Desired goals of the treatment : For Hemodynamic stability

Planned Labs:

IV Cannula - CBP

Planned Management

- 1) Continue NPO
- 2) IV fluids
- 3) Shift to OT on call

NB
Aug
28/05/26 @ 11:50 AM

Signature of the Doctor: JV

Name of the Doctor: Jayabhi

Date & Time: 28/05/26 @ 11:40 AM

Signature of the Consultant:

Name of the Consultant: Dr. M. Santosh Kumar

Date & Time:

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28-04-2019 7 Y 1 M 2 D (M)
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Patient



OPERATION THEATER NOTES

Patient's Name : Baby of jyothi Age : 7y Gender : Male Female

UHID No. : KOH-0028824 Weight : Height :

Surgeon : Dr. santhosh Asst. Surgeon :

Anesthetist : Dr. Tejaswini OT Nurse : Prabhavathi OT Technician :

Pre-Operative Diagnosis:

Surgical Procedure : coblation Adenotonsillectomy

Indications for Surgery :

Date : 28/5/26 Start Time : 1:48 pm End Time : 3:14 pr

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Grade IV Adenoid hypertrophy
Grade III tonsillar
coblation Adenoidectomy
& intracapsular tonsillectomy
done

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

1. Inj. Augmentin
1000mg IV BD


2. Inj. PCM 300mg IV TID

3. Nasoclear n/d
3 (2° / 2° / 2° / 2°)

4. Refacine mouth garg
8 times daily

5. Inj. Tranexa
250mg IV BD

Name of the Surgeon: Dr. Parthash

Signature of the Surgeon: 

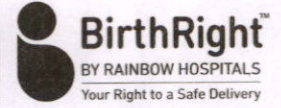
Date & Time: 28/8/26 11

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 26-04-2019 7Y 1M 2D
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5	<u>C/S/B Resident</u>	
8:30pm	No fever	
	No pain	<u>Plan</u>
	No bleeding	• D/C 7/25
	Hemodynamically stable	• Cont - med ⁿ on perche
		• Inform SOS
		<u>Ayushman</u>
29/5	<u>C/S/B Resident</u>	
8:30am	Sp adenotonsillectomy POD-1	Adv.
	→ no fever / vomiting / bleeding	17 (D) today
	→ accepting orally	
	O/E: alert	
	vitals stable	<u>Akhil</u>
	chest clear	Dr. Akhile
	abdomen soft	
	throat healthy.	

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CROSS CONSULTATION FORM

Doctor Name : Date : 29/5/20 Time :

Diagnosis : Chr: Adenotonsillitis -> sp Collatⁿ Adenotonsillectomy

Hospital : RCH, Banjara hills

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

No fever
 mild pain
 No bleeding
 Oral intake - fair
 ENT - (N)
 Hemodynamically stable

Plan
 -> (B) today
 -> Flup - ENT

Consultant : Dr. Ujjwala

Name : Signature : DR. UJJWALA DESAI Registration No: 90550 Date & Time : 29/5/20

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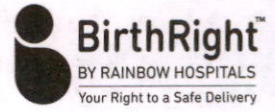


RESULT SHEET

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					

N/C

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MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Jaya Sri (Dr)

Date & Time: 28/05/2026 @ 11:50 pm

Nurse Name & Signature: Anji

Date & Time: 28/5/26 @ 11:50 pm



DRUG CHART

Date of Admission: 28/5/20 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:																			

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 20kg Ward.

VERIFIED

DRUG : <u>NASUCLEAR Drip</u>					Date Time	<u>28/5</u>	<u>2015</u>													
Dose	Route	Frequency	Start Date																	
<u>20ml</u>	<u>Drop</u>	<u>TID</u>	<u>28/5</u>		<u>6am</u>	<u>X</u>	<u>11am</u>	<u>10am</u>												
Name & Signature of the Doctor Starting the Drugs: <u>Ayushma</u>					<u>[Signature]</u>															
Additional Instructions:					<u>[Signature]</u>															
Daily Doctor's Endorsement by a Sign					<u>AA</u>															

DRUG : <u>Inj AUGMENTIN Dose</u>					Date Time															
Dose	Route	Frequency	Start Date																	
<u>600mg</u>	<u>IV</u>	<u>BD</u>	<u>28/5</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Ayushma</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>Inj PARACETAMOL</u>					Date Time	<u>28/5</u>	<u>2015</u>													
Dose	Route	Frequency	Start Date																	
<u>300mg</u>	<u>IV</u>	<u>TID</u>	<u>28/5</u>		<u>6am</u>	<u>X</u>	<u>11am</u>	<u>10am</u>												
Name & Signature of the Doctor Starting the Drugs: <u>Ayushma</u>					<u>[Signature]</u>															
Additional Instructions:					<u>[Signature]</u>															
Daily Doctor's Endorsement by a Sign					<u>AA</u>															

DRUG : <u>Inj TRANSXA</u>					Date Time	<u>28/5</u>	<u>2015</u>													
Dose	Route	Frequency	Start Date																	
<u>200mg</u>	<u>IV</u>	<u>BD</u>	<u>28/5</u>		<u>10am</u>	<u>300am</u>	<u>01</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Ayushma</u>					<u>[Signature]</u>															
Additional Instructions:					<u>[Signature]</u>															
Daily Doctor's Endorsement by a Sign					<u>AA</u>															

VERIFIED

VERIFIED

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Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : <i>inj AUGMENTIN</i>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<i>6mg/kg</i>	<i>IV</i>	<i>STAT</i>	<i>28/5</i>	<i>08:00</i>	<i>01</i>															
Name & Signature of the Doctor Starting the Drugs:																				
<i>Srinivasan</i>				<i>topo scaria nitat</i>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<i>A A</i>																
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																				

VERIFIED

Signature

Date

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



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

VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose		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
28/5	30 pm	Inj Augmentin	500mg	PO	[Signature]	Teena Kalyan
28/5/26	1:45pm	Inj PARACETAMOL	300mg	IV	[Signature]	Shwishi Kalyan
28/5/26	1:35pm	Inj DEXAMETHASONE	2mg	IV	[Signature]	Shwishi Kalyan
28/5/26	1:35 pm	Inj TRANEXAMIC ACID	300mg	IV	[Signature]	Shwishi Kalyan
28/5/26	1:45pm	Sup. DICLOFENAC	12.5mg	PR	[Signature]	Shwishi Kalyan
2/8						

VERIFIED BY : Name Signature

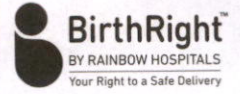
KOH-00288424 IP5-00174443
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 Dr. MANCHUKONDA SANTHOSH



CHBH/ FRM / CLINICAL / 126

28/5/25

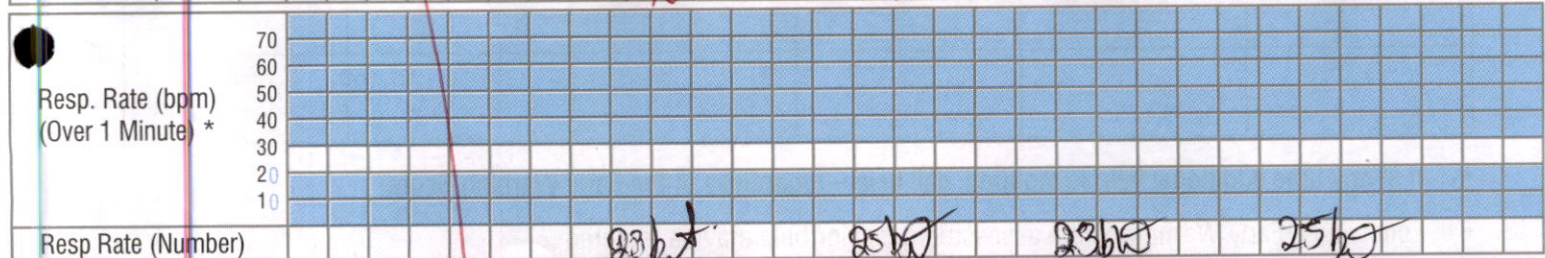
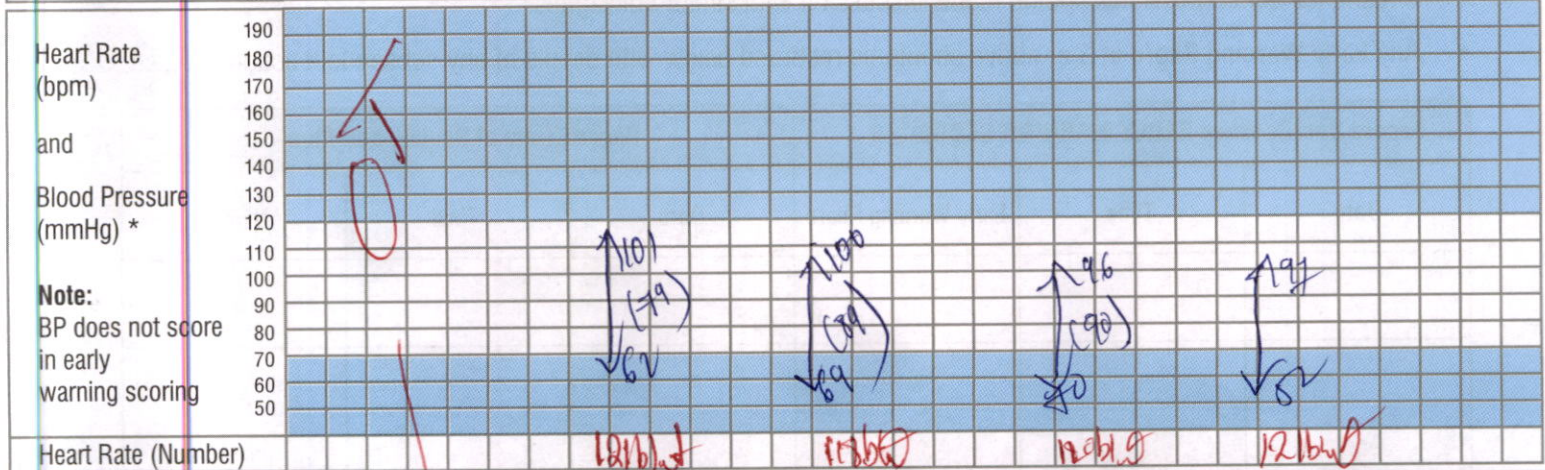
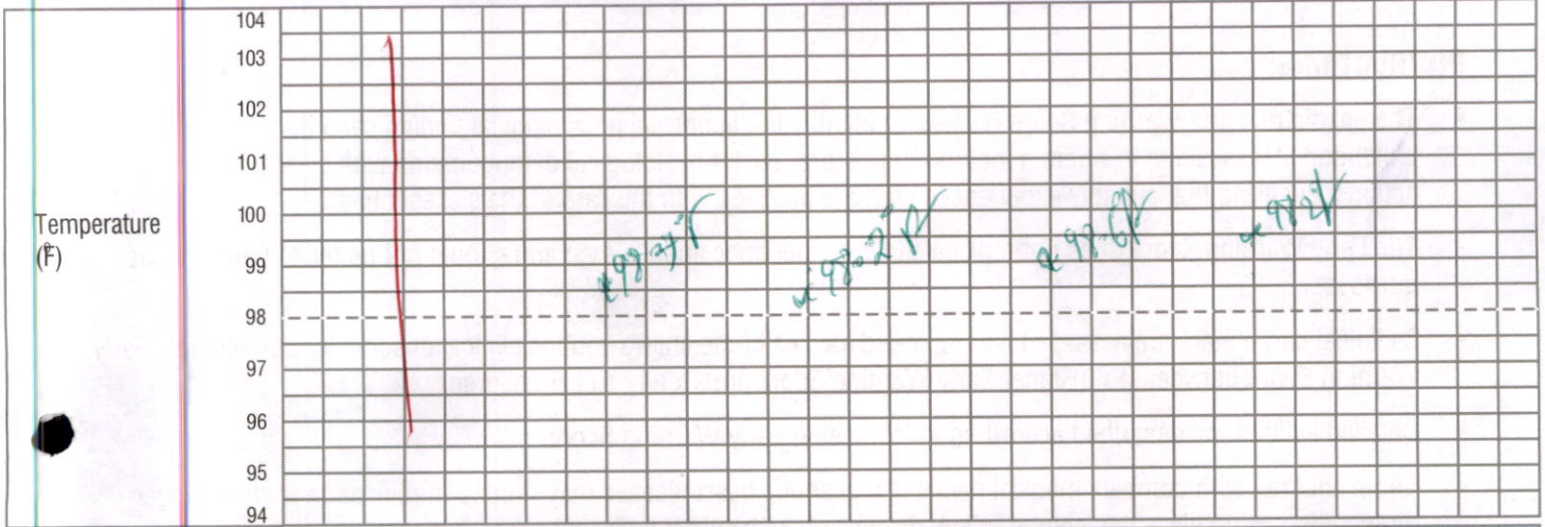
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 7pm 10pm 2AM 6AM

Doctor / Nurse / Family Concern?



Resp Distress	None / Mild	None / Mild	None / Mild	None / Mild
Receiving O ₂ (l/min)	0	0	0	0
O ₂ Saturations (%)	98	98	98	98
Conscious Level	Normal	Normal	Normal	Normal
GCS *	15/16	15/16	15/16	15/16

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

ACTIONS

- 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)

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FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	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		good				Total 24 hrs. Output		M-0 O-3					

Patient Sticker

FLUID CHART



27/5/26

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake						Total 24 hrs. Output								

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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. coblation Adenoidectomy
 2. Tonsillectomy

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
 The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>More block mouth breathing</u>	<u>—</u>

- 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:

b. Bleeding

- I authorize Dr. _____ and his / her team to perform the procedural sedation upon the patient / myself.
- 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.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient/ Patient Attendant:
 Signature: A. Rajendar Goud
 Name: A. RAJENDAR GOUD
 Relationship with patient: Father
 Date & Time: 28/5/26 @ 1pm

Witness:
 Signature: Jyothi
 Name: JYOTHI
 Date & Time: 28/5/26 @ 1pm

Doctor (who is taking consent):
 Signature: [Signature] Name: Dr. M. Santosh Date: 28/5/26 Time: 1pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

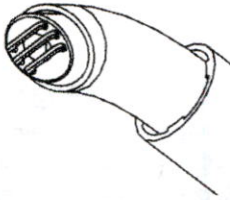
నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్ఫో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

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 / ప్రాసీజర్ ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి. ఈ శస్త్రచికిత్స / ప్రాసీజర్ గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

REF EIC5874-01
LOT 2201068
EVAC[®] 70 XTRA HP
WITH INTEGRATED CABLE



3. ఏ, థ్రా, అం, రోగి,

అదనంగా, 1

- a.
- b.

1. 4. డాక్టర్ / ప్రాసీజర్ ను
5. వైద్యం ఒక శాస్త్ర గానీ ఏ గ్యారంటీ
6. పై వివరాలన్నీ నాకు సమాధానం ఇచ్చారు. ఈ అనుమతిని నేను ఇచ్చి

SmithNephew QTY: (1)

STERILE R

Rx only

2025-10-21

2028-10-21

ArthroCare Corporation
7000 West William Cannon Drive
Austin, TX 78735 USA

Smith & Nephew Operations B.V.,
Bloemlaan 2, 2132 NP Hoofddorp,
Netherlands

UDI (01) 0 0817470 00459 5 (17) 281021 (10) 2201068

(11) 251021

CE 0123 MD

EC REP

NI18H0000MD_2

శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు	

నుండి ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జి, పక్షవాతం, డీప్ వెయిన్ థ్రంబోసిస్ ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. నాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

బు కూడా నాకు వివరించబడ్డాయి:

_____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స వల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం _____ సహా ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాషలో వివరించబడ్డాయి.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:


సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sant' L
 Asst. Surgeon :
 Anaesthetist : Dr. Subramanyam
 Scrub Nurse : Prabhavathi

Patient Name : Baby of Jyothi Age : 7y Gender : M
 UHID No. : KOH-008844 Surgery Name : Hematomyelia
 Date : 28/5 In-time : 1:35 PM Out-time : 3:45 PM

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 Baby Of JYOTHI AMARABOYNA (M)
 28-04-2019 7 Y 1 M 2 D
 DR. MANCHUKONDA SANTHOSH



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: <u>12:30 PM</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. M. Subramanyam</u>	

TIME OUT	Time: <u>1:45 PM</u>
Confirm all team members have introduced themselves by Name and Role	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>bleeding</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Kalyan</u>	

SIGN OUT	Time: <u>3:45 PM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Santosh</u>	

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



KOH-00288424 IP5-00174443
 Baby Of JYOTHI AMARABOYNA (M)
 26-04-2019 7 Y 1 M 2 D
 Dr. MANCHUKONDA SANTHOSH

MATER VISHANLU GOUD

Name: Age: 7y Sex: male UHID.No:

Date: 28/5/20 Time: 11.20 AM Proposed Operation: ADENOTONSILLECTOMY

Diagnosis: CHRONIC ADENOTONSILLAR HYPERTROPHY.

B.P / CRT: ~ 30c H.R: 108 Weight: 20 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

<input checked="" type="checkbox"/> Hgb:	Glucose:	Protein:	HIV:	X-Ray:
<input type="checkbox"/> PCV:	Urea:	Alb:	HBS Ag:	ECG:
<input checked="" type="checkbox"/> WBC:	Creat:	Total Bill:	HCV:	2D Echo:
<input checked="" type="checkbox"/> Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
<input type="checkbox"/> PT:	K:	LDH:	T3	Other:
<input type="checkbox"/> PTT:	Ca++:	Alk phos:	T4	
<input type="checkbox"/> INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: XXX

Medical History: CVS: - ATNO. VACCINATED to date

RESP: wake breathing / snoring Diabetes: XXX

CNS: - Bronchial asthma

Renal: -

Hepatic / GE: - Physical Activity: ACTIVE

Others: -

Past Anaesthetic History: two years ago - finger injury repair - uneventful.

Physical Exam: ACTIVE / AFBRIK.

Airway: MP 1 2 3 4 Mouth Opening: adequate Mentohyoid Distance: = 2 finger breadth Neck: NAD Teeth: Not loose

Lungs: J

Heart: clinically NAD

CNS: J

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

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: NPO from 7.30 AM 28.5.20

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - NIL ORAL Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

✓ CBL after SV cannulation

Signature: Gow Name: Ravi



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No **Fasting Status:** 6 hrs

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 102 B.P / CRT: 93/55 SpO₂: 100% R.R: 18 Last Feed: 7:30 AM

Pre-OP Diagnosis: Tonsillitis Operation: Adenotonsillectomy Date: 28/5/26

Surgeon: Dr. Santosh Anaesthesiologist: Dr. N. Subrahmanyam Technician: Siresha

TIME	N.O (AIR) / LPM	HALO / SO / SEVO	Drugs	Antibiotic
1:30			Fentanyl 60mcg	
2:00			Droperidol 60/30mg	
2:15			Rocuronium 10mg/5mg	
2:30			PARACETAMOL 300mg	
			TRANEXAMIC ACID 300mg	
			DEXAMETHASONE 2mg	
			HYDROXYLATE 2ml	
				2nd ACUBENTIN 600mg Suppository
				DICLOFENAC 12.5mg PR
				Blood Loss

LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP **RU**

Cuff Site:

Art Site:

EKG Lead **3**

Temp Site **skin**

FIO₂ 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: 1:35 PM

OP Start: 1:45 PM

OP End: 3:35 PM

Leave OR: 3:45 PM

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP:

ABT:

IV: 22 G ROL

IV:

IV:

IV:

Induction:

IV Inhal

Pre O₂ RSI

Others

Mask SGA

Airway Oral Nasal

ETT# 5.0 at 15 cm

Oral Nasal Cuff

Tracheostomy Topical

Drug:

Awake Direct Vision

Video Laryngoscopy Stylette / Bougie

Fiberoptic

Blade# 3 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. N. Subrahmanyam**

Signature of the Doctor: **Dr. N. Subrahmanyam**



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Suman Time Received : 2:50 pm Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂		250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site :
			<input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Prongs <input type="checkbox"/> T-Piece <input type="checkbox"/> Nasal Airway
Vomiting : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No NG Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drain : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Urinary Catheter : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Chest Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Nil Oral : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Drug :
IV Fluids : <u>Orally H₂O Str</u> Oral Feeds :			

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 1 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	2			A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0 RESPIRATION	2	2	2			
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0 CIRCULATION	2	2	2			
Fully awake = 2 Arousable on calling = 1 Not responding = 0 CONSCIOUSNESS	1	1	2			
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0 COLOR	2	2	2			
TOTAL	7	8	10			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
28/5	4:5 pm	2/10	m)	Suman

Pain Tool Used: N PASS FLACC Wong Baker NPS
 Anaesthesiologist Name : Dr. Thejas
 Anaesthesiologist Signature: [Signature]
 Date & Time: 28/5/26 5A
 PACU Nurse Name : Suman
 PACU Nurse Signature: [Signature]
 Date & Time: 28/5/26

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 relieving intervention
 d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): Thejas 235
 Date & Time: 28/5/26 6:20 pm



CONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: ADENOTONSILLECTOMY.

Anaesthesiologist: Dr. JOGBRAHMANIYAN Surgeon: Dr. SANTOSH

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 can be achieved by infusing weak solutions of local anaesthetics 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 Renal Failure Multi Organ Failure Hepatic Disorders
 Shock Obesity Chronic Obstructive Pulmonary Disease
 Others

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
 Regional Anaesthesia General Anaesthesia Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- 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: Jyothi

Name: A. Jyothi

Relationship with patient: Mother

Date & Time: 28/5/26 @ 11:30 am

Witness:

Signature: A. Rajender Reddy

Name: A. RAJENDER REDDY

Date & Time: 28/5/26 11 am

Doctor (who is taking consent):

Signature: Ravi Name: Ravi

Date: 28/5/26 Time: 11:35 AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి పీక్ లోకల్ అనస్థీషియా లేదా సార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

హృదయ వ్యాధి రక్తపోటు మధుమేహం మూత్రపిండాల వైఫల్యం బహుశ అవయవ వైఫల్యం

కాలేయ సమస్యలు షాక్ ఊబకాయం దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
 లీజనల్ అనస్థీషియా జనరల్ అనస్థీషియా మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిలయల్ లైన్, సపోజిటలీలు, నొప్పి నివారణ కోసం నర్స్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



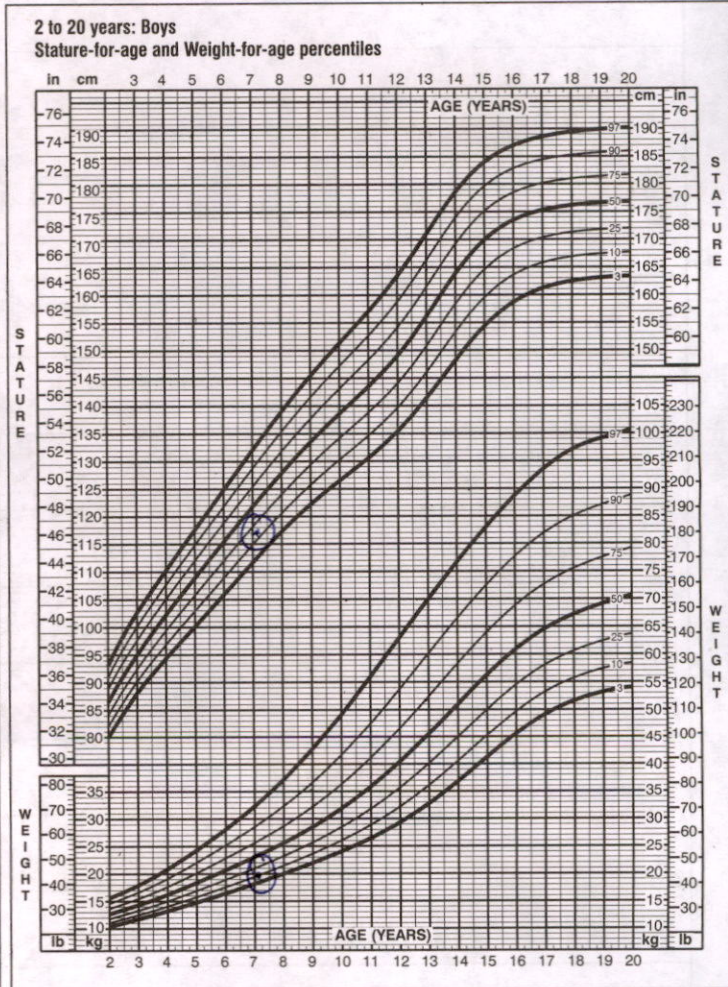
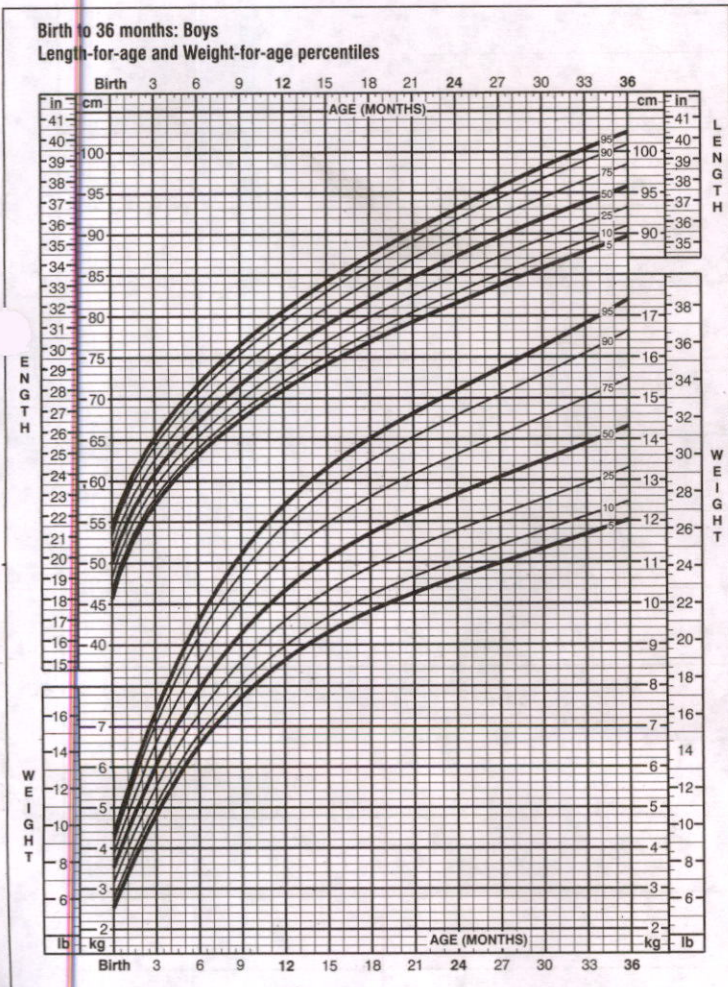
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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 29/5/26 Time: 9am

Weight: 20kgs Centile: >10th
 Height: 117cm Centile: >10th
 Inference: Underweight child
 RDA: - Calories: 1500 kcal/d Protein: 26g/d
 Diet Recommendations: soft diet
 Re-Assesment: Avoid spicy, Outside foods
 Food Allergies: No Veg/Non-veg: Non-veg
 Diagnosis: Adenotonsillectomy
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: Jyoti

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

