

BAH-00521519 IP5-00176269
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. P V L N MURTHY



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

BirthRight™
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Your Right to a Safe Delivery

SURGERY DETAILS

Date : 11/07/26

Patient Name: Mark Aditya Date of Birth: 17-09-2022 Age: 3y

Gender: male Ward: Ped OT UHID No.: BAH-00521519

Date of Surgery: ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Tongue tie release

Time in : 4:30 PM

Time Out : 5:30 PM

	NAME	AMOUNT
1. Surgeon	Dr. P V L N MURTHY	
2. Anaesthetist	Dr. Ravi	
3. Assistant Surgeon		
4. OT Technician	Gowthami	
5. Circulating Nurse	Alan	
6. Assistant Nurse	Thijas	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698338

Order by: Y. Ramesh



Tongue tie Release

CONSUMABLES OF OT

Circulating Staff : Technician : Date : 11/9 Time :

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used		
ET tube 4.4.5, 5	11/1	—	Major Pack			Inj Vit.K					
LMA 2	01	—	Sutures			Cord Clamp					
ECG leads : A (P) N	05	03	NS 9915	1	1	Suction Catheter					
HME filter : A (P) N	01	—				Feeding Tube					
Syringes : 10 cc	10	02				Vacuum Suction Set					
05 cc	10	02	Gloves 6.6/2.7/1.2 2+2/2	—	—	Surgical Gloves					
02 cc	10	02	PF 6.6/1.2/1.7/1.2 2+2/2	2	2	Gauze Pack					
01 cc	05	—				Syringe 1ml / 2ml					
Cautery plate : A (P) N	01	01	Surgical blade			Surgical Blade # 20					
IV set	01	—	NG tube			Koochies (S)					
RL	01	—	Cautery pencil	1	1	NS 500ml	1	1			
NS : 10ml / 100ml / 500ml / 1000ml	01	01	Koochies			10/11, 50	2/2	—			
Mask Mini & Pice	01	01	Ointments			Jelly	1	—			
Pharynx P + 02 Mask	11/1	01	Suction Catheter			Transdermal	1	1			
Fentanyl	01	01	Cap, Mask	3/5	3/3						
Morphine			Gauze Pack	2	2						
Ketamine			Mop Pack								
Propofol	03	02	Steristrip								
Rocuronium	01	0	Underpad	1	1						
Glycopyrolate	01	—	Draw sheet	1	1						
Myopyrolate / Neo	01	—	Abgel								
Ondansetron	01	—	Foleys catheter			ganger gloves 4/4	—	—			
Pencan 25g/ Spinal Needle 22	01	—	Urobag			Dexat Dexmed 1/1	—	—			
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			Tramexa 01	—	—			
Bupivacaine 0.25% (Heavy)			Romodrain bag			50 cc + pnuole 11/1	—	—			
Antibiotics IV par	01	01	Bandage								
			Tegaderm								
Suppositories			Ioban								
Anamol : 80mg / 250mg / 170 mg			Double J Stent								
Supridol : 100mg			Vacuum Suction set	1	1						
Justin : 12.5 mg / 25mg / 100mg	11/1	01	Plastic Bed Sheet	1	1						
Tab. Misoprost : 200mg			Betadine Solution								
Vacuum set	01	—	Microshield	1	—						
3ways 10 + 100 cm	11/1	—	Cotton Balls								
O.A (0.11)	11/1	—	Latex Gloves	01	01						
N.A (18, 20)	11/1	—	Ramdone Scrub								
IV Cante (22 + 24)	11/1	—	Saral								

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9698352

Ordered by :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Patient: _____ Dept : _____

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

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

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Dr. P V L N MURTHY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	4:15pm	ER	OT	
11/7/26	5:30pm	OT	146	

Cross Consultation Visit

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

(M)



Date _____

Investigations

Order No.

Signature

11/7/26

CBP

695, 6

Dust

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/12/26	Tv Placement	1	9802	[Signature]
	PAC on Of nurse			

ANY OTHER INFORMATION

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.....

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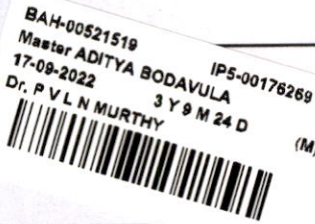
Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rain
Chil
Hos



Rainbow Children's Hospital - Banjara Hills

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 : IP5-00176269 Admit Date : 11-Jul-2026 Admit Time : 03:27 PM UHID : BAH-00521519

Patient Details :

Patient Name	: Master ADITYA BODAVULA	Age	: 3 Y 9 M 24 D
Guardian	: Mr SRIDHARA KRISHNA	DOB	: 17-09-2022
Gender	: Male	Religion	: Hindu
Occupation	:	Martial Status	: Single
Address (H)	: BLOCK - MOUREYA, FLAT NO - 102, R. B. AVANEENDRA APT MIYAPUR Hyderabad Telangana INDIA 500049	Phone No	: 8008942121 / 8897914378
		E-mail	: SRIDHAR.CSIT@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 SRIDHARA KRISHNA Relationship : Father
Contact Address : BLOCK - MOUREYA, FLAT NO - 102, R. B. AVANEENDRA APT MIYAPUR Hyderabad
Telangana INDIA 500049 Phone No : 8008942121 / 8897914378

B. Sridhar Krishna
Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : VIDAL HEALTH INSURANCE TPAPVT LTD

Aditya . B

BAH-00521514

Patient Sticker

Dr. G.V.L.N. Murthy

126


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DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00521519 IP5-00175269
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Dr. P V L N MURTHY



Patient Name: Aditya

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex 3y/m
Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

tongue fir.

NHto fever, cough, cold, loose stools

NPO - from Solids - 10:30 am
liquids - 2:20 pm.

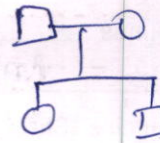


Pediatric Multiorgan History & Physical Examination

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

ASD on Speech therapy

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Speech delay on therapy

Immunization History :

on date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 112/min B.P. 95/58/67 SP02 96% on RA

Resp.rate and type of breathing : 26/min

Rash _____ ✓

Lymphadenopathy _____ -

Oedema : _____ -

Allergies (if any): _____ -

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : RRB & clear

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : SS & 1

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : 12

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Active, alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : (N)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Tongue tie



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

complicated

Desired goals of the treatment : _____

Hemodynamic stability

Planned Labs:

CBS

NIB

Sagar

11/7/26

3:40 pm

Planned Management

NPO

Continue to receive

ONS @ 47 ml/hr

NIB

Sagar

11/7/26

3:40 pm

Signature of the Doctor: _____

Name of the Doctor: Dr. Komelurthy

Date & Time: 11/7/26

Signature of the Consultant: _____

Name of the Consultant: Dr. PVL N Murthy

Date & Time: 11/7/26

DR. PVL N MURTHY
Registration No: 47267

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/17/16 9 AM	Seen by Resident ACis - tongue tie post release. child alert, afebrile hemodynamically stable.	Plan D/C today. \$ Sahithi



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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CROSS CONSULTATION FORM

Doctor Name : Dr. Vijwala D. Date : 12/7/26 Time :

Diagnosis : tongue tie

Hospital : RCH - BH

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 :

Dis. Tongue tie
s/p release.

child afebrile
accepting orally
hemodynamically stable

Plan
Can be discharged

Consultant :

Name : Dr. Vijwala D. Signature : [Signature] Date & Time : 12/7/26.

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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.,) :



DRUG CHART

Date of Admission: 11/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. 13 kg Ward.



----- <u>Curap. AUGMENTINDVO</u>				Date Time <u>11/8</u>
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>BID</u>	Start Date <u>11/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Curap. CLOXINDS</u>				Date Time <u>11/8</u>
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>11/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Tab. CANZOL 1mg</u>				Date Time <u>11/8</u>
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>11/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				
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				



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
17/7/26	4.30 pm	PARACETAMOL	145mg	IV	RC	

I.V. FLUIDS CHART

Weight. 134 Ward.

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: OT

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. P. V. L. N. Murthy

Date & Time : 11/7/26

Nurse Name & Signature: Sagan [Signature]

Date & Time : 11/7/26 @ 3:40 pm

* 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)

FLUID CHART

Sheet No. :

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

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

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/7/2020

Assessment:

Pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient general condition	2pm	* Assessed the patient general condition	
3pm	* Maintain I/O chart	3pm	* maintain I/O chart	
4pm	* Monitoring the vital signs.	4pm	* Monitoring the vital signs	
5pm		5pm		
6pm		6pm		
7pm	* Administering the medications As per orders	7pm	* Administering the medications As per orders	
8pm		8pm		

Re-Assessment:

Re - Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 11/7/2020



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 12/7/2026

Assessment: Baby is having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the general condition of the baby	8:10pm	⇒ Assessed the general condition of the baby	The baby condition is Improving slowly
10pm	⇒ monitor vital signs	10:10 pm	⇒ monitored vital signs	
12 AM	⇒ provide comfortable bed position	12:10 AM	⇒ provided comfortable bed and position	
4 AM	⇒ continue IV fluids	4:10 AM	⇒ administered medication as per doctor order	
6 AM	⇒ administer medication as per doctor order	6 AM	⇒ educated personal hygiene	
8 AM	⇒ educate personal hygiene			

Re-Assessment:

The baby is feeling uncomfortable

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 12/7/2026 8 AM



THE HUMPTY DUMPTY SCALE

11/7 12/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			11	11			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	YES	YES			
Call device within reach	YES	YES			
Wheels Locked	YES	YES			
Room free of clutter	YES	YES			
Adequate Lighting	YES	YES			
Wheel Chair Support	NO	NO			
Other Intervention(s) Specify	NO	NO			
Nurse's Name :	Sagar	Pranav			
Signature :	[Signature]	[Signature]			
Date :	11/7	12/7			
Time :	3 pm	6 AM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. PVLN MURTHY Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	ER 4:15 PM	OT 2M-8M	IST 5:00 PM		
	Medical Condition (Any special condition to be noted):		Nil	Nil	NA		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	98°F	98.8°F	98.2°F		
		Res:	24 bpm	24 bpm	26 bpm		
		SpO ₂ :	100%	100%	100%		
		Pulse:	82 bpm	82 bpm	80 bpm		
		BP:	92/51	92/61	90/70		
	Fall Risk Score:		11	11	11		
Pain Score:		0	0	0			
Recommendations	Safety Needs:		Yes	Yes	Yes		
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		Nil	Nil	NA		
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		Nil	Nil	NA		
Post Operative Procedure Special Orders:		Nil	NO	NO			
Handed Over By Name :		Sagan	Swini	Rama			
Signature :							
Date:		11/7/26	11/7/26	12/7/26			
Time:		4:15 PM	6:50 PM	8 AM			
Taken Over By Name :		Swini	Rama	Swarna			
Signature :							
Date:		11/7/26	12/7/26	12/7			
Time:		6:50 PM	8 PM	8 PM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	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:					
Recommendations	Safety Needs:							
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:		☐ 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:								

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/26	3 pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
11/7/26	11 pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
12/7/26	7 AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ 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:

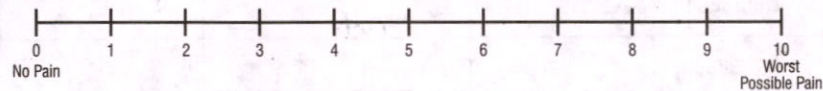
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or, fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	11/7/24	12/7/24		
					Time :	3 pm	6 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	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	6		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
TOTAL SCORE					28	28			
Evaluator's Name					g	am			

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	11/7 DAY-1			12/7 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		NA	NO	G						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		✓	✓	✓						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		✓	✓	✓						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		✓	✓	✓						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		✓	✓	✓						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		✓	✓	✓						
Signature of the Nurse				[Signature]									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 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		
11/7/26	3 pm	8.	Procedures	M	4	0	1	1	-	
12/11/26	8 am	9	soft diet	F	1	0	1	1	-	Nikitha

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice																			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)																			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio D: Demonstration V: Video O: Oral P: Printed																						
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify																				
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference																					
Understanding:	1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review																						



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 3pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Tongue tie	tongue tie releas (H. stability)	Tongue tie releas		☐ Nursing ☐ Others:
11/7/26 3pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Tongue tie	H - stability	vitals monitoring		☒ Medical ☐ Others:
12/1/26 8am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Tongue tie	soft diet	<u>RDAL</u> G: 1300 kcal/d P: 22g/d		☐ 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:

BAH-00521519
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D
Dr. P V L N MURTHY (M)

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: India

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 11/7/20

2. Destination Post Discharge: ☐ Home

☒ Family Members Notified (Person Contacted)

☒ Transfer

☐ Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 11/7/20 05:20

INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. Tongue tie release
2. _____

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Good range of tongue movements</u>	

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- a. Bleeding, injury to sub-mandibular papillae
- b. _____

1. I authorize Dr. P V L N MURTHY and his / her team to perform the procedural sedation upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: B. Sridhar Krishnan
Name: Srihar Krishnan, B
Relationship with patient: Father
Date & Time: 11/07 4.20pm

Witness:

Signature: K. Anuradha
Name: K. Anuradha
Date & Time: 11/07/26 4.20pm

Doctor (who is taking consent):

Signature: P V L N MURTHY Name: P V L N MURTHY Date: 11/7/26 Time: 4:15pm

శస్త్రచికిత్స / ప్రాసీజర్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోగానానో, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, 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 ఏర్పడినప్పుడు, 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.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- 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:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. PVLN Murthy
Asst. Surgeon : —
Anaesthetist : Dr. Ravi
Scrub Nurse : Thijas

Patient Name : Master Aditya Age : 3 Y Gender : M
UHID No. : 521519 Surgery Name : Tongue Tie Release
Date : 11/09/2026 In-time : — Out-time : —

BAH-00521519 IP5-00176269
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. P V L N MURTHY


Before Induction of Anaesthesia >>

SIGN IN		Time: <u>4:20pm</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Ravi Srinivas</u>		

Before Skin Incision >>

TIME OUT		Time: <u>—</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>10 min</u>		
Anticipated Blood Loss?	<u>1ml</u> ☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>Alam</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>—</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☒ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>PVLN Murthy</u>		

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Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. P V L N MURTHY

Patient :




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Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

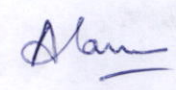
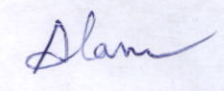
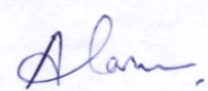
To Be Filled In By Assigned Nurse :

Date : 11/07/26.....

Department : P. OT Duration of Procedure : 10 min

Name of Surgeon : Dr. P V L N Murthy Date of Admission : 11/07/26

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 :	
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Date & Time of antibiotic administration : Date & Time procedure started : 11/07/26 @	

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

Docu. No. : RCHBH/ FRM / CLINICAL / 038

BAH-00521519 IPS-00176269
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. P V L N MURTHY

Patient S




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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

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: Time:

Note: Plan of care will be readjusted if necessary.

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Master ADITYA BODAVULA
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Dr. P V L N MURTHY



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OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female
UHID No.: Weight : Height :

Surgeon :

PVLN MURTHY

OT Nurse:

Asst. Surgeon :

OT Technician:

Anesthetist :

Pre-Operative Diagnosis:

the tongue tie

Surgical Procedure :

tongue tie release

Indications for Surgery :

Date :

Start Time :

End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

tongue tie release

BAH-00521519 IP5-00176269
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. PVLN MURTHY



Amount of Blood Loss:

Name and Number of Surgical Specimen sent for examination:

Blood Transfused (in ML)

Peri-Operative Complications:

1 Symp. AUGMENTIN Duo 5ml BID - 1wk
2 Symp. CLOXIDS 5ml TID 1wk

Name of the Surgeon: PVLN MURTHY

Signature of the Surgeon: [Signature]

Date & Time: 11/7/20



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mast Aditya Age: 3y 9 months Sex: male UHID No:
Date: 10/07/26 Time: 7:30 PM Proposed Operation: Tongue tie release

Diagnosis:
B.P / CRT: H.R: Weight: 13 Kgs 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/Angio:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS:

RESP: W/O CRT 3 days back, Snoring (+) Diabetes:

CNS:

Renal: ? ASD on speech therapy.

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History:

Physical Exam:

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

Lungs: BAGT, clear

Heart: S1 + S2 +

CNS:

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site:

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

CBP

Signature: [Signature] Name: Dr. A. Dhanesh



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status:	CONFIRMED
Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed

H.R.: B.P / CRT: CRT 202 SpO₂: R.R: Last Feed:
Pre-OP Diagnosis: TONGUE TIE Operation: TONGUE TIE Release Date 11/7/28
Surgeon: MURTHY Anaesthesiologist: RC Technician: VENKAT

TIME
N₂O / AIR / O₂ LPM
HALO / ISO / SEVO
Drugs:

ROFENANOL 20
Fentanyl 0.2mg
PARACETAMOL 165

FiO₂ / SaO₂ 99 96 99
ETCO₂
ECG 88 88 80
Temperature
Urine Output

Fluids
Blood

B.P 240
V Systolic 220
A Diastolic 200
X Mean 180
• Heart Rate 160
Tourniquet on Time 140
Tourniquet off Time 120
Throat Pack In 100
Throat Pack Out 80

LAB Values

ABG
GRBS
Others

- ☒ Equipment Checked and Functional
☒ BP
☐ Cuff Site:
☐ Art Site:
☒ EKG Lead
☐ Temp Site
☐ FIO₂ Monitor
☐ Agent Monitor
☒ Pulse Oximeter
☒ Capnograph
☐ Ventilator
☐ Nerve Stimulator
Position: DURING
☐ Pressure Points Checked

Eye Care:
☐ Oint
☒ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hoyer's ☐ Cotton Wool
☒ Other
Times:
Anaes Start: 2.30pm
OP Start: 2.42pm
OP End: 2.48pm
Leave OR:
Anaesthesia:
☐ GA
☒ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART: 22G 50L
☐ IV:
☐ IV:

Induction
☒ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others
☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# at cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# Attempts:
Difficulty Why?
☒ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:
Transportation to ☒ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☒ NA
Name of the Doctor: RAVI
Signature of the Doctor: Ravi



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sru

Time Received :

Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>ln</u>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway
< RESP • PULSE • > BLOOD PRESSURE	100% 100%	Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : Oral Feeds :
		Drug :

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7	@SPR	0/10	Nil	<u>[Signature]</u>

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature: [Signature]

Date & Time: 11/7/20 @ 8:00

PACU Nurse Name : Sru

PACU Nurse Signature: [Signature]

Date & Time: 11/7/20 @ 8:00

Reassessment Frequency:

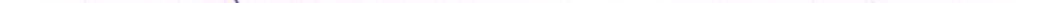
- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 146

Date & Time: 11/7



EPIDURAL ANALGESIA RECORD

b) 

Date and Time :

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



BAH-00521519 IP5-00176269
Master ADITYA BODAVULA
17-09-2022 3 Y 9 M 24 D (M)
Dr. P V L N MURTHY

Patient Name : Master Aditya Age : 3y 9 months Gender : Male ☒ Female ☐

UHID NO: Surgeon Name:

Anaesthesiologist : Dr. A. Dhanesh Babu

Operative procedure planned : Tongue tie release

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

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

☐ Others : Laryngospasm, Bronchospasm

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master Aditya the above mentioned operation / Diagnostic / Therapeutic procedures Tongue tie release

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☒ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : B. Sudhakar Krishn

Name : SRI DHARA KRISHNA

Relationship with Patient : Father

Date & Time : 11/07/2016

Witness :

Signature : K. Anuradha

Name : K. Anuradha

Date & Time : 11/07/2016

Doctor (who is taking the consent) :

Signature : A. Jareesh Babu

Name : Dr. A. Jareesh Babu

Date & Time : 10/07/2016, 7:30 AM

PATIE



Patient Name & UHID No.		Date & Time of Admission 11/7/26 @ 3:24 PM	Date & Time of Transfer Order 11/7/26 @ 5 PM
Treating Consultant Name		Transfer Ordered by Dr. Murthy	Reason for Transfer Post op
From Unit OT	To Unit 146	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films Nil			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nil		
2.			
3.			
4.			
5.			
Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Sruvi		Name of Person Ordered Transfer Dr. Murthy	
Patient & Clinical Records Received by : Nikhitha			
Date & Time of Patient Received : 5 PM 11/7/26			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00521519 IP5-00176269 Master ADITYA BODAVULA 17-09-2022 3 Y 9 M 24 D (M) Dr. P V L N MURTHY 		Date & Time of Admission 11/7/26 @ 3:27 pm	Date & Time of Transfer Order 11/7/26 @ 4:15 pm
		Transfer Ordered by Dr. Ramakrishna	Reason for Transfer Surgery.
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? <i>op file</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Gown	①	
2.	Booche	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Ramakrishna	
Patient & Clinical Records Received by : Teena 11/7/26 @ 6M			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



10:30am - Solid } NPO.
2pm - liquid }

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Aditya Bodavula Age : 3 years Gender: ☒ Male ☐ Female
Date : 11/07/26 Time of Arrival : 2:55pm Triage Completion Time : 2:57pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify):
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life -Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.0°F PR: 112b/m BP: 95/58 RR: 26b/m SpO₂: 96%NA

Chief Complaints: Cantor procedure - Tongue Tie release.

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

B. Sridharan
Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Neeraj

Date & Time : 11/07/26 @ 2:57pm

Docu. No. : RCHBH /FRM / CLINICAL / 085

Signature of Triage Nurse : [Signature]



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/7/26 Time of arrival : 2:57 pm
Chief Complaints : Procedural Tongue Tie release RBS : /
Height : - Weight : 13kg BMI : - Head Circumference (<2 years) : -
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: /
If yes, identify : Nil
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: - Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

RISK FOR FALL:

- ☒ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☐ Yes ☐ No
Ambulatory Aids:
• Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No
Gait/Transferring:
• Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No
Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
☒ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: - (Date/Time): -

Social History: Lives With Family

Siblings in household ☐ Yes ☐ No (if yes How Many?) 1 sister

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 11/7/26

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
3:15pm	→ Assess the pt & conscious
	→ Seen Dr. Ramakrishna
	→ Vitals checked & recorded

Samples collected by: _____

Time: _____

Samples sent by: _____

Time: _____

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 82 bpm BP: 95/52 CFT: 12 sec RR: 24 bpm SPO ₂ : 100% GCS: 15/15 Temperature: 98°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: OT Time of Shift - out: 4:15 pm Handover given to: _____ (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): _____

IV placement done

Name of the Nurse: Sagan Signature of the Nurse: _____

Date & Time: 11/7/26 @ 4:15 pm



146

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/12/26 Time: 8am

Weight: 13 kgs Centile: 75th

Height: 94 cms Centile: 25th

Inference: under weight child

RDA: - Calories: 1300 kcal/d Protein: 22 g/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled & outside foods.

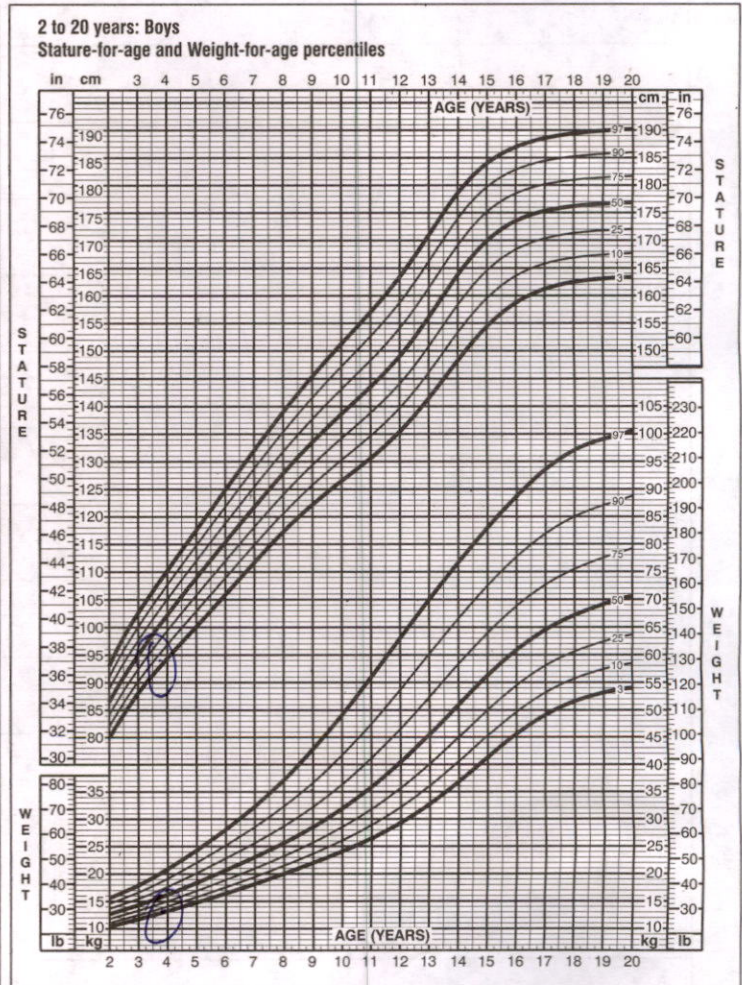
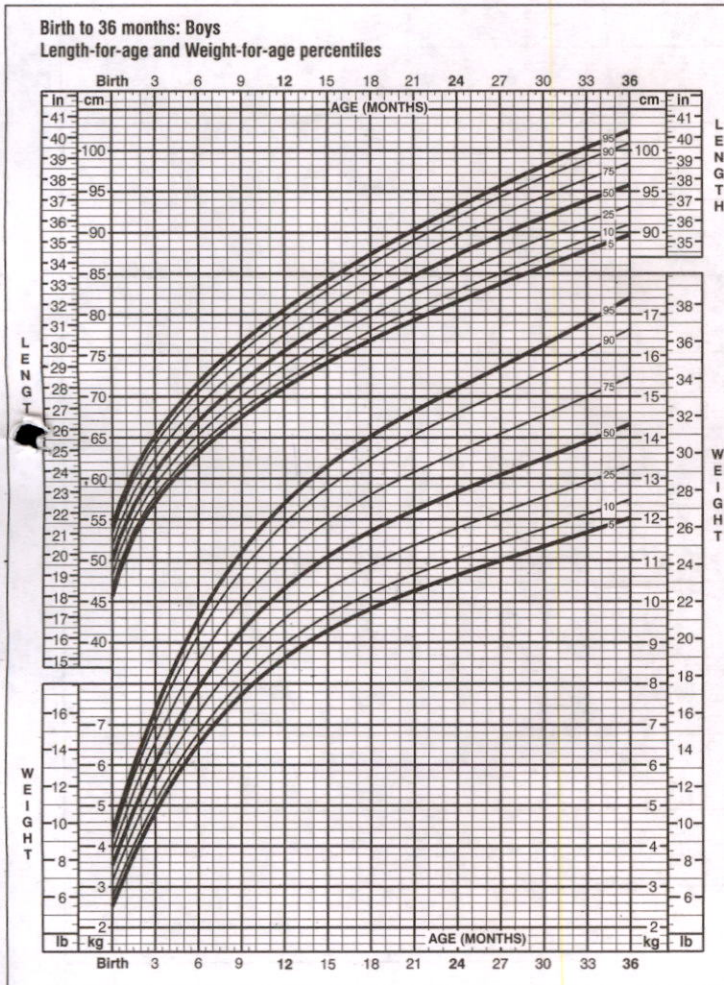
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: Tongue tie

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: B. Sridhara

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Blank lined paper with horizontal ruling lines.