

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI (F)
 21-07-2022 3 Y 9 M 17 D
 Dr. MAINAK DEB

SURGERY DETAILS

80055

Date : 08-05-26

Patient Name: BABY AVIKA ROOPWANI Date of Birth: 21-07-2022 Age: 34

Gender: FEMALE Ward: OT UHID No.: BAH-00653423

Date of Surgery: 08-05-26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Left Radical Nephrectomy

Time in : 11:30 AM

Time Out : 3:15 PM

	NAME	AMOUNT
1. Surgeon	Dr. Nabeel	
2. Anaesthetist	Dr. Subrahmanya	
3. Assistant Surgeon	Dr. Mainak Deb	
4. OT Technician	venkat	
5. Circulating Nurse	Sujata	
6. Assistant Nurse	Bokkai, Thejas	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9598283/83

Order by: [Signature]

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nephrectomy

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

CONSUMABLES OF OT

opwani

Technician : Date : *8/5/2024* Time : *10:30*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube (4.0) (W.S) (5.0)	1+1	01	Major Pack	1	1	Inj Vit.K	213	212
LMA 2, 2 1/2	1+1	—	Sutures 5/8/5, 5003	2+2	2	Cord Clamp	1	2
ECG leads : A/P/N	5	03	VP 1.0, 2.0, 3.0, 4.0, 5.0	1+1+1+1	—	Suction Catheter	1	2
HME filter : A/P/N	1	01	Moire 60	2	—	Feeding Tube	2347	2 2
Syringes : 10 cc	10	10	Heq 21, 21, 21, 21, 21	1+1+1+1+1	—	Vacuum Suction Set	872	1
05 cc	10	10	Gloves	2+2+2+2+2	—	Surgical Gloves	—	—
02 cc	10	10	6/6/2/2/2/2/2/2/2/2	—	—	Gauze Pack	1	—
01 cc	5	1	Surgical blade 15	1	1	Syringe 1ml / 2ml	—	—
Cautery plate : A/P/N	1	01	NG tube all sizes	1	—	Surgical Blade # 20	—	—
IV set + blood set	1+1	1+1	Cautery pencil	1	1	Koochies (S)	—	—
RL	1	01	Koochies XL	1	1	500ml NS	2	2
NS 10ml / 100ml / 500ml / 1000ml	5+1	3+1	Ointments	—	—	Transosin	1	2
minis pike	1	01	Suction Catheter	—	—	Jelly	1	1
vacuum set	1	01	Cap, Mask	5/5	10/10	Pocsee 2cc 2cc	1	—
Fentanyl	1	01	Gauze Pack	5/5	3+4	Multi tube holder	1	1
Morphine	—	—	Mop Pack	2P	1P	10ml Drawer	1	1
Ketamine	—	—	Steristrip	—	—	Homizone Red	2	1
Propofol	3	01	Underpad	1	1	Blue	2	1
Rocuronium	1	01	Draw sheet	4	2	Harrison pad, Blue	2+2	—
Glycopyrolate	1	01	Abgel	—	—	Desmofond	1	1
Myopyrolate + Neo	1	02	Foleys catheter 2.8	1+1	1	Nasal Air way	—	—
Ondansetron	1	—	Urobag	1+1	1	16, 18, 20	1+1+1	—
Pencan 25g/ Spinal Needle 22	1	—	Chest Drainage Catheter	—	—	Oral Air way	—	—
Bupivacaine 0.25%	1+1	06	Romodrain bag	—	—	0.1, 2, 2 1/2	1+1+1	—
Bupivacaine 0.25%(Heavy)	—	—	Bandage	—	—	epidural Ket 20ml	1	01
Antibiotics	—	—	Tegaderm	—	—	epidural Bag (new)	01	01
v pcm	1	01	loban	1	1	egg peddle	02	02
Suppositories	—	—	Double J Stent	—	—	NS 500ml	01	01
Anamol : 80mg / 250mg / 170 mg	—	—	Vacuum Suction set	2	01	—	—	—
Supridol : 100mg	—	—	Plastic Bed Sheet	1+1	01	—	—	—
Justin : 12.5 mg / 25mg / 100mg	1+1	01	Betadine Solution	1	1	—	—	—
Tab. Misoprost : 200mg	—	—	Microshield	1	1	—	—	—
day 10cm + 100cm	1+1	01	Cotton Balls	1	1	—	—	—
axa + Daxa	1+1	1+1	Latex Gloves	10P	20P	—	—	—
ax (fp)	1	—	Ramdione Scrub	—	—	—	—	—
all + Gauze	1+1	01	Saral	—	—	—	—	—
uv annula (22, 24)	1+1	—	—	—	—	—	—	—

Surge : Anaesthesiologist : Nurse : *Thejas* OT Technician : *De*
 Order No. : *9598426* Ordered by :
 Doc. No. : RCHBH/FRM/GENERAL/125

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Discharge : _____ Time: _____

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

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/5/26	5:05pm	ER	145	Abhishek
8/5/26	10:20am	145	OT	Aparajita
8/5	4:29pm	OT	145	Dilip

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/05	IV placement	①	6548	[Signature]
8/5/26	PAC	①	597572	Appu
8/5/26	NHA	①	597639	Appu
8/5	Catulosol	①	9598285	[Signature]
8/5	Blood transfusion	①	9598285	

8/5/26
 8/5/26

ANY OTHER INFORMATION

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Date : _____ Time : _____ Prepared By : _____

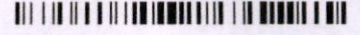
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173512 Admit Date : 07-May-2026 Admit Time : 04:19 PM UHID : BAH-00653423

Patient Details :

Patient Name : Baby AVIKA ROOPWANI Age : 3 Y 9 M 16 D
Guardian : Mr RAHUL DEV ROOPWANI DOB : 21-07-2022
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : SHIVAJI WARD, MUNGELI, Mungeli Bazar Phone No : 9993250677/ 8770026605
Guna Madhya Pradesh INDIA 495334 E-mail : AARAVTRAVLES123@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 145 Ward Name : 1F-VIBGYOR
Room No : SW 145 Admission Type : First Visit

Contact Details :

Name : Mr RAHUL DEV ROOPWANI Relationship : Father
Contact Address : SHIVAJI WARD, MUNGELI, Mungeli Bazar Phone No : 9993250677
Guna Madhya Pradesh INDIA 495334

Signature

Doctor Details :

Doctor Name : Dr. MAINAK DEB Specialisation : PEDIATRIC SURGERY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00653423 IP5-00173512
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Dr. MAINAK DES



Patient Name:

Avika.

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Anika Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K/L/O ^① Wilms tumor
planned for ^① Radical nephrectomy.

History of present illness :

^② Lumbos swelling noticed by mother 1 month ago,
got evaluated.

Ased as Wilms tumor on biopsy
- took Neo adjuvant chemotherapy for 4w.

Now posted for Radical nephrectomy - ^② side.

No fever/cough/vomitings/ loose stools.
oral intake fair



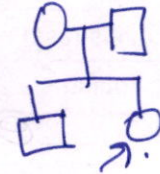
Pediatric Multiorgan History & Physical Examination

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

⊖

Birth & Neonatal History:

FT / LSCB / 4 kg / CIAB / NO NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :

Immunised as per age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13kg (Centile _____)

On Examination :

Temperature : 98.2°f Pulse Rate : 130/min B.P. 101/67 mm(Hg) SPO2 97% JRA

Resp. rate and type of breathing : 28/min

Rash _____
Lymphadenopathy ⊕
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : BAE ⊕, clear
Any added sounds : ⊕
Relevant data from outside (Chest X-Ray, ABG, etc.,) /

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : S1S2 ⊕
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____
Palpation : hard lumbar swelling noted, not tender.
Auscultation : Bowel sounds ⊕
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) / ⊕

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : (N)

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

NAD

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Kidney @ Wilms tumor
posted for Radical nephrectomy.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Resolution

Desired goals of the treatment: Hemodynamic stability

Planned Labs:

CBP

Planned Management

PAC to be done
NPO as per PAC.
Unit PRBC reserve.
N/B
Abx
step

DR. MAINAK DEB
Registration No: TSMC/FMR/02413-13

Signature of the Doctor: [Signature]

Name of the Doctor: Sanjiv

Date & Time: 7/5 4 PM

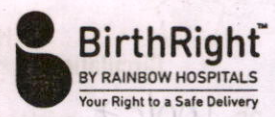
Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Anil

Date & Time: 8/5/20 7 PM

Faint handwritten notes at the bottom of the page.

BAH-00853423
Baby AVIKA ROOPWANI
21-07-2022
Dr. MAINAK DEB
3 Y 9 M 18 D (F)



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr Mainak Deb Date : 7/5/26

Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: 4 PM Weight: 13kg

Allergic History:

Chief Complaints:
Kidney (L) Wilms's tumour.
underwent Neoadjuvant
chemotherapy
planned for Radical Nephrectomy
(L) only

Pediatric Assessment Triangle

A Appearance - TICLS (N)

B Breathing

C Circulation

Normal
 Abnormal

Pallor
 Cyanosis
 Mottling
 Bleeding

Breathing

↑ WOB
 ↓ WOB
 Normal
 Gaspings / Apnea

Initial Physiological Status: Stable Unstable

Life Threatening
Non Life Threatening

Any urgent interventions needed: Yes No
If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment

Airway Open
 Maintainable
 Not Maintainable

Any urgent interventions needed: Yes No
If Yes

Breathing

Rate: 28/min SpO₂ on FiO₂ 97% RA
Rhythm: Reg
Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
Respiratory Noises: Stridor Wheezing Grunting
Air Entry: BAE (+), clear.
Palpation Findings (If necessary)

Any urgent interventions needed: Yes No
If Yes



Circulation

HR: 130/min

CFT [Central ~~Low~~
Peripheral

Any urgent interventions needed: Yes No

BP: 100/67 mmHg

Pulse Volume: [Central good
Peripheral

Murmurs: Yes No

Liver Span: Yes No

If in Shock: [Compensated
Hypotensive

ECG: Yes No

Any Signs of Heart Failure: Yes No

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No



Disability

GCS: 15/15 AVPU: A V P U

Any urgent interventions needed: Yes No

Pupils: [Responsive Non-Responsive
Size [Right Equal
Left

If Yes Yes No

Active Seizures: Yes No Sugars: Yes No

Signs of Neurological compromise Yes No

Exposure



Temp.: 98.2°F

Any urgent interventions needed: Yes No

Any Rash: Yes No

If Yes Yes No

If yes describe the rash Yes No

Active bleed Yes No

Lacerations Abrasions bruises

Describe: Yes No

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

Secondary Assessment: Head to toe examination with positive findings: ① lumbar swelling

Labs Planned: PAC
CBP

Treatment Planned: PAC to be done
NPA acc-to PAC
1 unit PRBC reserve

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Yes No

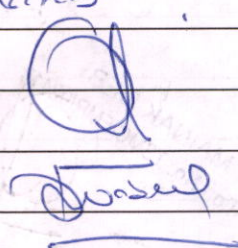
Assessment done by
Name of the Doctor: Sainthi
Signature: [Signature]
Date & Time: 7/5/26 4 pm

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor: Yes No
Signature: Yes No
Date & Time: Yes No

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/5/26 <u>7pm</u>	C/S/B Dr. Nasheel POD - 0 afebrile vitals stable UOP - Adequate	Adv NPO - Allow sips of clear liquids NG - 2 nd hourly check - continuous - UOP - 4 th monitor - Monitor vitals
		 DR. MAINAK DEB Registration No: TSMC/FMR/02413
9/5/28 <u>9:30 AM</u>	C/S/B Dr. Malika POD (1) afebrile vitals stable P/A - soft U.O. - 1-33 cc/kg/hr NG - 52ml bilious	Adv 1) Sips of clear liquids 2) NG aspiration 2 nd hourly + continuous drainage

Malika
9/5/28
9:30 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26. 5:30pm	<p>CS/B Dr. Mainak Deb</p> <p>POD - ①</p> <p>afebrile vitals stable</p> <p>P/A - soft</p>	<p><u>Adv</u></p> <p>1) Sips of water/ORS.</p> <p>2) Continue IV fluids</p>
	<p>DR. MAINAK DEB Registration No: TSMC/FMR/02418</p> <p><i>[Signature]</i> 9/5 IR</p>	<p>Malika Dr. Malika 9/5/26 5:30pm</p>
10/5/26 10:30am	<p>CS/B Dr. Malika</p> <p>POD - 2</p> <p>afebrile vitals stable</p> <p>P/A - soft</p> <p>NG - 118ml (bilious) - NS bolus 100ml - shd</p> <p>UCP - 175ml (24hr)</p> <p>↳ 0.6u/kg/hr - sips of clear liquid allowed</p>	<p><u>Adv</u></p> <p>come outpatient Monday hrg for next 4hrs.</p> <p><i>[Signature]</i> 10/5/26 (P.T.O)</p>

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 Dr. MAINAK DES



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26 9 AM	<p>CLIP Dr. Malika</p> <p>POD - (3)</p> <p>Afebrile</p> <p>Vitals stable</p> <p>P/A - soft.</p> <p>did not pass stool</p> <p>I.O - 1-9cc/kg/hr.</p> <p>NG - 164 ml. (bilious)</p>	<p>Achr</p> <p>1) Full feeds.</p> <p>1) Clear liquids - (Sips)</p> <p>2) NG aspiration 2nd hourly (Clamp NG 4th hourly)</p> <p>3) Remove epidural.</p>
	<p>Clamp NG and aspirate 4th hourly</p> <p><u>Malika</u></p>	<p>Malika</p> <p>11/5/26</p> <p>9 AM</p>



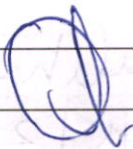
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 9 AM	<p style="text-align: center;"><u>C/S/B Dr. Hanish</u></p> <p>POD - (4)</p> <p>Afebrile Vitals stable</p> <p>P/A - soft passed stool</p> <p>U.O - po adequate.</p>	<p style="text-align: right;">25/2/26</p> <p style="text-align: right;">12/5/26</p> <p style="text-align: right;">9 AM</p> <p style="text-align: center;"><u>Adv</u></p> <p>1) Soft diet.</p> <p>2)</p>
<p style="text-align: center;">(Signature)</p> <p style="text-align: center;">Dr. Hanish</p> <p style="text-align: center;">12/5/26</p> <p style="text-align: center;">9 AM</p>		<p style="text-align: right;">Malika</p> <p style="text-align: right;">12/5/26</p> <p style="text-align: right;">9 AM</p>
	<p style="text-align: center;"><u>C/S/B Dr. Malika</u></p>	
12/5/26 15:30 pm	<p>POD - (4)</p> <p>Afebrile Vitals stable</p> <p>P/A - soft.</p> <p>U.O - adequate</p>	<p style="text-align: center;"><u>Adv</u></p> <p style="text-align: center;"><u>Adv</u></p> <p>1) Soft diet → full feeds.</p> <p>2) Plan discharge tomorrow.</p>
		<p style="text-align: right;">Malika</p> <p style="text-align: right;">12/5/26</p> <p style="text-align: right;">5:30 pm (P.T.O)</p>

BAH-00653423 IP5-00173512
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 Dr. MAINAK DEB



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26	c/s/b Dr. Malika.	
8:05 AM	POD - (5)	
	Afebrile	Adv
	Vitals stable	1) Full feeds
	P/A - soft	2) Plan discharge today.
	U-O - adequate.	
	 Dr. Malika 13/5/26 8:05 AM	

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RESULT SHEET

Date		8/5/26			
Time					
Hb	7.5				
PCV	24.6				
RBC	3.56				
WBC	4730				
N/L	24165				
Platelets	4.87				
CRP					
ESR					
PCT					
RBS					
Na	137				
K	4.6				
Cl	108				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.3				
ALP		139			
SGPT		18			
SGOT		51			
T.Bill/Conj		0.4 - 0.1			
T.Protein		6.8			
S.Albumin		4			
S.Globulin		2.8			
A/G Ratio		1.4			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14/1.0				
APTT	39				
CSF Protein / Sugar					
Cells					
N/L					

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MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: ER Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp MOKTEL	2.5 ml	PO	OD	6/5	<input type="checkbox"/> C <input type="checkbox"/> DC
2	Syp CALCIMAX	2 ml	PO	OD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	Syp TONOFERON	3 ml	PO	OD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4	Syp BACTRIM	4 ml	PO	alt. day		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<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: Salilini

Date & Time: 4 pm. 7/15/26

Nurse Name & Signature: Abhishele

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

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DRUG CHART

Date of Admission: 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



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/5/2026	11:30AM	INJ PIPERACILLIN TAZOBACTAM	0.3g	IV	<i>[Signature]</i>	Venkat Thyas
8/5/26	2:30PM	INJ ONDANSETRON	1.3mg	IV	<i>[Signature]</i>	Venkat Thyas
8/5/26	3pm	INJ PARACETAMOL	180mg	IV	<i>[Signature]</i>	Venkat Thyas
10/5/26	10:30am	NS	100ml	IV	<i>[Signature]</i>	10:50AM <i>[Signature]</i>

VERIFIED BY : *[Signature]*

I.V. FLUIDS CHART

Weight. 13 kg Ward.



Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
7/5	5:30 AM	DNS (100% maint)	IV	45 ml/hr	[Signature]	Malha me			[Signature]
8/5/2024	11:30 AM	RINGER LACTATE	IV	130 ml/hr	[Signature]	[Signature] Bikali	S/S	[Signature]	[Signature] Bikali
8/5/2024	1:10 PM	PRBC	IV	150 ml/hr	[Signature]	[Signature]	S/S	[Signature]	[Signature]
11/5/26	9:10 AM	DNS (full maintenance) + 5CC KCE	IV	46 ml/hr	Malha	[Signature] Bikali	3:55 PM	Malha	[Signature]
11/5/26	3:55 PM	DNS + 5CC KCE	IV	46 ml/hr	Malha	[Signature] Bikali	9 AM	Malha	[Signature]
12/5/26	9 AM	DNS (1/2 maintenance)	IV	23 ml/hr	Malha	[Signature] Bikali	not	Completed	

Signature

VERIFIED BY : Name

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 21 D (F)
 Dr. MAINAK DEB

Doc. No. : RCHBH/ FRM / CLINICAL / 125

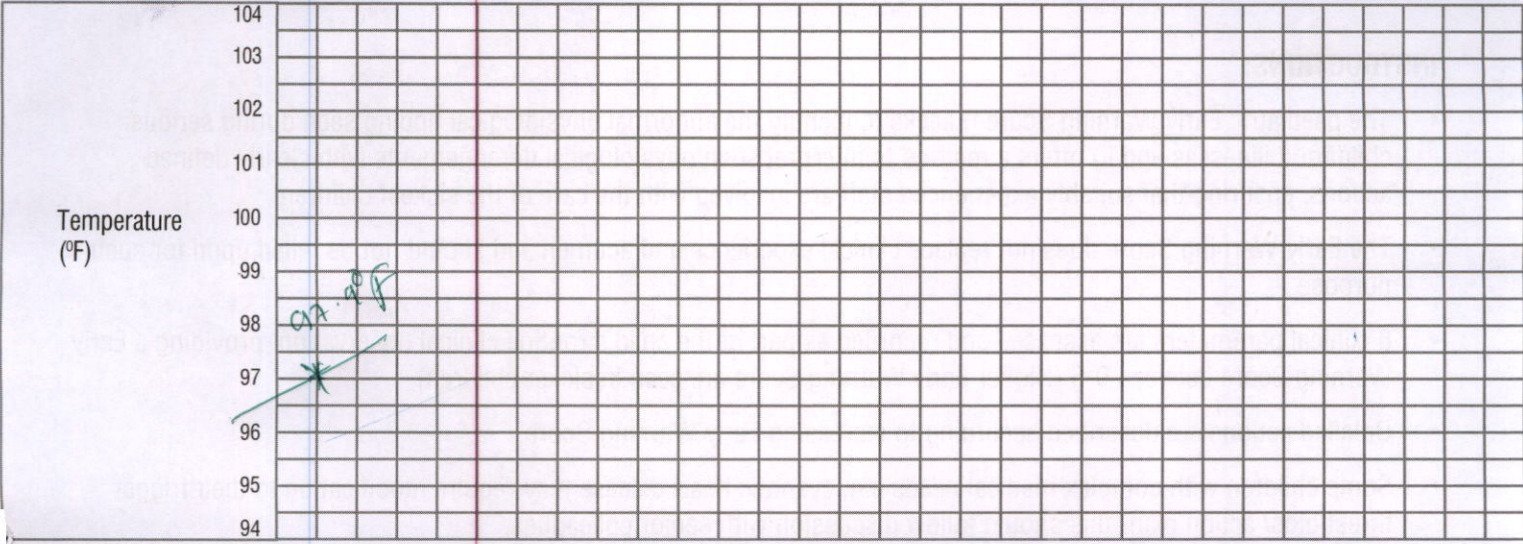
PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/7

Doctor / Nurse / Family Concern? 69M



Heart Rate (bpm)	
and	
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	

Heart Rate (Number) 97b L

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	26 L

Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		100.1

Conscious Level	Normal	
	Altered	
GCS *		15/15

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 20 D (F)
 Dr. MAINAK DEB

Doc. No. : RCHBH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12.15	Time:					
Doctor / Nurse / Family Concern?	6am	10am	2pm	6pm	10pm	12.15 am
Temperature (°F)	96.5F	98.5F	98.1F	98.2F	97.5F	98.2F
Heart Rate (bpm) and Blood Pressure (mmHg) *	110/88	110/60	110/62	113/59	113/81	110/60
Heart Rate (Number)	102b/m	119b/m	113b/m	112b/m	102b/m	112b/m
Resp. Rate (bpm) (Over 1 Minute) *	26b/m	27b/m	28b/m	28b/m	26b/m	27b/m
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	98%	99%	100%	100%	100%	99%
Conscious Level Normal / Altered	15/15	15/15	15/15	15/15	15/15	15/15
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	0	0	1	1	1
Number of shaded boxes	1	0	0	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	DB	DB	DB	DB	DB	DB

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
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	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.

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Date	Time	Early Warning Score	Date	Time	Name

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B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 20 D (F)



Doc. No. : RCHBH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/5	Time: 6am				
Doctor / Nurse / Family Concern?		10am	1pm	6pm	10pm
Temperature (°F)	98.4	97.8	98.3	98.4	98.2
Heart Rate (bpm)	113	100	115	112	100
Blood Pressure (mmHg) *	112/83	101/84	118/88	101/82	104/85
Resp Rate (bpm)	28	28	28	29	28
O ₂ Saturations (%)	99%	100%	100%	99%	98%
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1	1
Observer's Initials	S	D	S	S	S

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	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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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- 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!
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 19 D (F)
 Dr. MAINAK DEB

Doc. No. : RCHBH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 AM 5:40 PM 6 PM 10:30 PM 2 AM

Doctor / Nurse / Family Concern?

Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99	98.8	99.1	98.7	98.7
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90				
80					
70					
60					
50					
Heart Rate (Number)	118 bpm	108 bpm	103 bpm	101 bpm	100 bpm

Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	Resp Rate (Number)	26 bpm	26 bpm	26 bpm	23 bpm	23 bpm

Resp Distress	Mod/ Severe None / Mild				
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98%	99%	97%	98%

Conscious Level	Normal / Altered				
GCS *		15/15	15/15	15/15	15/15

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

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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* 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.



RVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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
		(25)		(10)	

- 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. BR 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/5 Time: 11 PM 12 AM 2 AM 6 AM
 Doctor / Nurse / Family Concern?

Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99				
	98				
	97				
	96				
	94				

Handwritten notes: 100.5°F, Ant: PCM, 96°F, 97°F, 96°F

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	90			
80				
70				
60				
50				
Heart Rate (Number)				

Handwritten notes: 100 (72), 101 (83), 105b/m, 113b/m

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)				

Handwritten notes: 23b/m, 29b/m

Resp Distress	Mod/ Severe			
	None / Mild			
Receiving O ₂ (l/min)				
O ₂ Saturations (%)				

Handwritten notes: 100%, 100%

Conscious Level	Normal			
	Altered			
GCS *				

Handwritten notes: 15/15, 15/15

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

Handwritten notes: 1, 0, 1, 0

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 19 D (F)
 Dr. MAINAK DEB

C ATION

and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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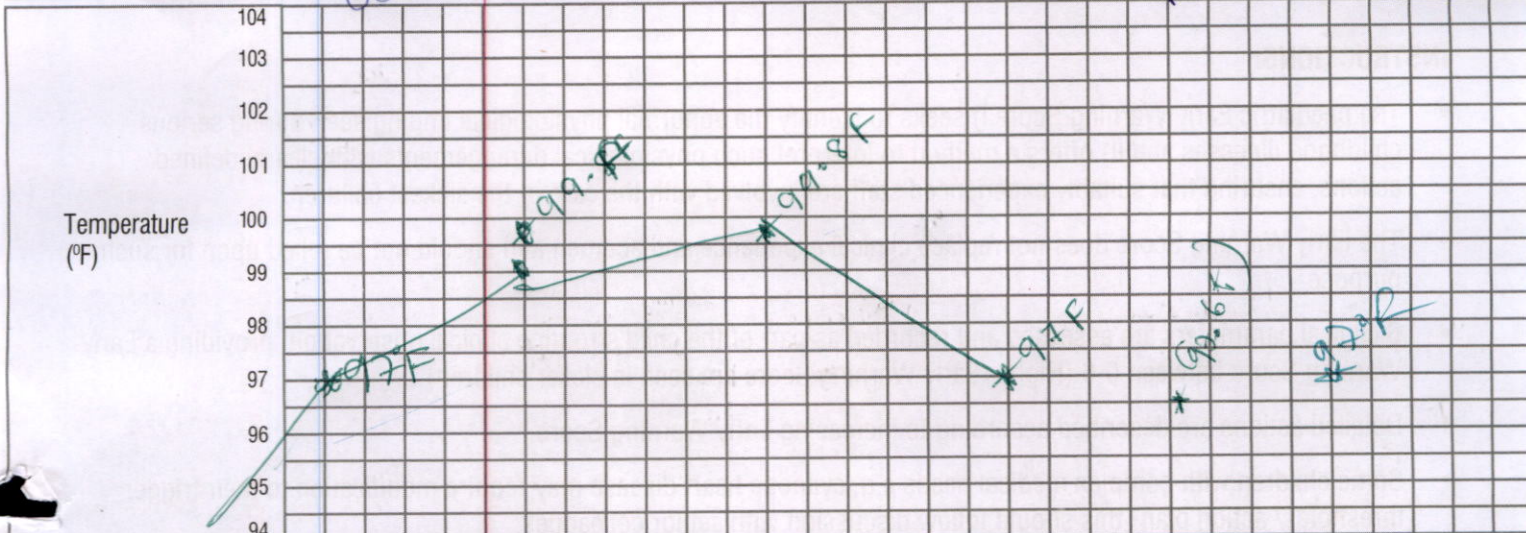
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/8/20 Time: 9:15 10am 11:30am 1pm 6pm 10PM

Doctor / Nurse / Family Concern? 6am 6pm



Heart Rate (bpm)	Blood Pressure (mmHg) *
112b/m	110/45
100bpm	94/63
101bpm	94/60
100bpm	99/67
102bpm	98/60
120b/m	99/68

Note: BP does not score in early warning scoring

Resp Rate (Number)
26b/m
28bpm
28bpm
28bpm
26b/m
29b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 97% 98% 99% 98%

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15 15/15 15/15 15/15

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

- 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.
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BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 19 D (F)
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SITUATION AND EARLY WARNING SCORING TOOL

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- 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)

BAH-00653423
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 17 D (F)
 Dr. MAINAK DEB

Io. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 08/05 Time: 6pm 10pm 2am

Doctor / Nurse / Family Concern?

Temperature (F)	104		
	103		
	102		
	101		
	100		
	99	99.1F	
	98	97.8F	98.2F
	97		
	96		
	95		
	94		

Heart Rate (bpm)	190		
and	180		
Blood Pressure (mmHg) *	170		
	160		
	150		
	140		
	130		
	120		
	110	111	110
	100		
	90		
	80		
	70		
	60		
	50		

Note:
 BP does not score in early warning scoring

Heart Rate (Number) 116 bpm 102 bpm 122 bpm

Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		

Resp Rate (Number) 25 bpm 26 bpm 26 bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 100% 98% 99%

Conscious Level Normal / Altered

GCS * 15/15 15/15 15/15

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

ACTIONS
 NB: Scores 3 should be recorded overleaf

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

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



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

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

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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 17 D (F)
 Dr. MAINAK DEB

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

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

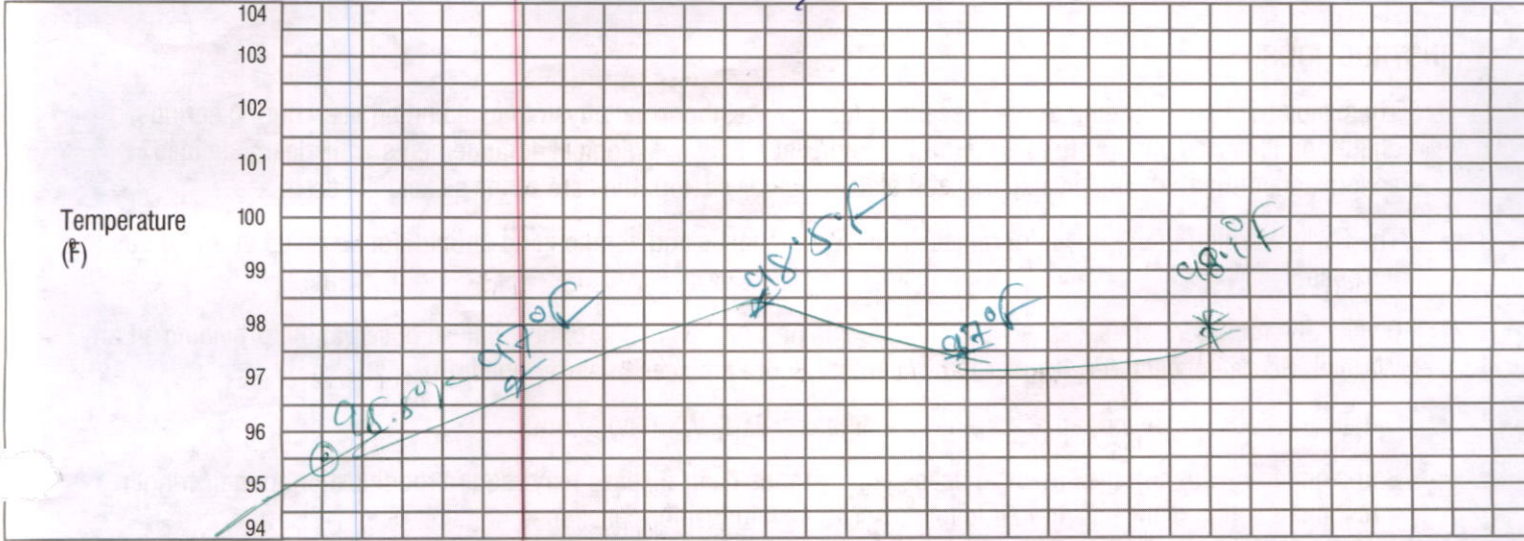
Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time : 6pm 10:30am 8:15am 6am 10am

Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	112	101	104	115	118	110	100	90	80	70	60	50			
Note: BP does not score in early warning scoring															
Heart Rate (Number)	102	110	101	102	112										

Sp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10								
Resp Rate (Number)	22	20	21	25	26										

Resp Mod/ Severe Distress	None	Mild													
Receiving O ₂ (l/min)	100%	90%	100%	100%	100%										
O ₂ Saturations (%)	100%	90%	100%	100%	100%										
Conscious Level	Normal	Altered													
GCS *	15/15	15/15	15/15	15/15	15/15										

TOTAL SCORE															
Number of shaded boxes	1	1	1	1	1										
Pain Score	0	0	0	0	0										
Initials															

- 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.
- When requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 19 D (F)
 Dr. MAINAK DEB



CLINICAL 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.
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- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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Date	Time	Early Warning Score	Date	Time	Name

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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 16 D (F)
 Dr. MAINAK DEB



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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			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											
	08:00 pm			45ml								
	09:00 pm			45ml								
	10:00 pm			45ml								
	11:00 pm			45ml								
	12:00 am			45ml								
	01:00 am			45ml								
	02:00 am			45ml								
	03:00 am			45ml								
	04:00 am			45ml								
	05:00 am			45ml								
	06:00 am			45ml								
	07:00 am			45ml								
	08:00 am			45ml								
Total Intake :			540ml			Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 17 D (F)
 Dr. MAINAK DEB

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	NG	Diarrhoea	Vomit	Drainage	Urine			
8/5	08:00 am		NPO	45ml	/						0	PN
	09:00 am			45ml							0	PN
	10:00 am	DNS		45ml	/						0	PN
	11:00 am	RL		130	/						0	PN
	12:00 pm	RL		50	/						0	PN
	01:00 pm	R		130	/						0	PN
Total Intake :						Total Output :						
8/5	02:00 pm	blood		50							0	PN
	03:00 pm	blood		100							0	PN
	04:00 pm	blood		100							0	PN
	05:00 pm		NPO	45ml							0	PN
	06:00 pm	DNS		40ml	4ml	/			150ml		0	PN
	07:00 pm			45ml		/					0	PN
Total Intake :						Total Output :						
8/5	08:00 pm			45ml							0	PN
	09:00 pm			45ml	4ml						0	PN
	10:00 pm	DNS	water	45ml		NP			200ml		0	PN
	11:00 pm				15ml						0	PN
	12:00 am										0	PN
	01:00 am				45ml	14ml				300ml		0
Total Intake :						Total Output :						
9/5	02:00 am			45ml					35ml		0	PN
	03:00 am			45ml	15ml						0	PN
	04:00 am	DNS	water	45ml	15ml	NP			250ml		0	PN
	05:00 am			45ml					30ml		0	PN
	06:00 am			45ml	10ml						0	PN
	07:00 am										0	PN
Total Intake :			52ml			Total Output :					415ml	
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. :

- 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			aspiration		Output			IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			45ml							0	Rajshree
	09:00 am	water		45ml		10ml				10ml	0	Rajshree
	10:00 am	DNS		45ml							0	Rajshree
	11:00 am	water		45ml		15ml					0	Rajshree
	12:00 pm			45ml							0	Rajshree
	01:00 pm	coconut water		45ml		5ml				25ml	0	Rajshree

Total Intake :

Total Output :

	02:00 pm			45ml							0	Shree
	03:00 pm	water		45ml		2ml					0	Shree
	04:00 pm	DNS		45ml						30ml	0	Shree
	05:00 pm			45ml		32ml					0	Shree
	06:00 pm			45ml							0	Shree
	07:00 pm			45ml		9ml				15ml	0	Shree

Total Intake :

Total Output :

	08:00 pm			45ml							0	Shree
	09:00 pm	water		45ml		14ml					0	Shree
	10:00 pm	DNS		45ml							0	Shree
	11:00 pm	water		45ml		5ml				30ml	0	Shree
	12:00 am			45ml							0	Shree
	01:00 am			45ml		6ml					0	Shree

Total Intake :

Total Output :

	02:00 am			45ml							0	Shree
	03:00 am			45ml		16ml				50ml	0	Shree
	04:00 am	DNS		45ml							0	Shree
	05:00 am			45ml		5ml					0	Shree
	06:00 am			45ml							0	Shree
	07:00 am			45ml		5ml				15ml	0	Shree

Total Intake :

Total Output :

178ml/24h

Total 24 hrs. Intake

Total 24 hrs. Output

NG- 118ml

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.

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output		IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine		
10/5	08:00 am		-	180ML						0	Aranya	
	09:00 am		-	18ML				5ML		0	Aranya	
	10:00 am			45ML						0	Aranya	
	11:00 am	DNS		45ML 18ML					25ML	0	Aranya	
	12:00 pm			45ML					35ML	0	Aranya	
	01:00 pm			-	17ML				15ML	0	Aranya	
Total Intake :					Total Output : 115ML							
10/5	02:00 pm			45ML					35ML	0	Aranya	
	03:00 pm			45ML 11ML					25ML	0	Aranya	
	04:00 pm			45ML					20ML	0	Aranya	
	05:00 pm	DNS		45ML 23ML					25ML	0	Aranya	
	06:00 pm			45ML					20ML	0	Aranya	
	07:00 pm			45ML 12ML					25ML	0	Aranya	
Total Intake :					Total Output :							
10/5	08:00 pm			45ML					15ML	0	Aranya	
	09:00 pm			45ML 10ML					15ML	0	Aranya	
	10:00 pm			45ML					75ML	0	Aranya	
	11:00 pm	DNS		45ML 12ML					25ML	0	Aranya	
	12:00 am			45ML					20ML	0	Aranya	
	01:00 am			45ML 10ML					15ML	0	Aranya	
Total Intake :					Total Output :							
10/5	02:00 am			45ML					25ML	0	Aranya	
	03:00 am			45ML 2ML					25ML	0	Aranya	
	04:00 am			45ML					12ML	0	Aranya	
	05:00 am	DNS		45ML 15ML					18ML	0	Aranya	
	06:00 am			45ML					10ML	0	Aranya	
	07:00 am			45ML 10ML					15ML	0	Aranya	
Total Intake :					Total Output : 164ML 585ML							
Total 24 hrs. Intake												
Total 24 hrs. Output												

Patient Sticker

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 19 D (F)
 Dr. MAINAK DEB



FLUID CHART

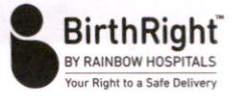
Sheet No. :

- 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				Green						0	
	09:00 am			460	74 (Green)				5ml.		0	Swan
	10:00 am		460	46w							0	
	11:00 am	ONS		46w							0	Sueb
	12:00 pm	Suit		46	22ml (yellow)				2ml.		0	
	01:00 pm	KCL		w							0	Sueb
Total Intake :						Total Output :						
	02:00 pm								5ml		0	At
	03:00 pm								57ml		0	At
	04:00 pm	ONS									0	At
	05:00 pm	+ Bact									0	At
	06:00 pm	sucker									0	At
	07:00 pm										0	At
Total Intake :						Total Output :						
	08:00 pm			46ml							0	At
	09:00 pm			46ml							0	At
	10:00 pm			46ml							0	At
	11:00 pm	ONS + Sucker		46ml							0	At
	12:00 am										0	At
	01:00 am			46ml							0	At
Total Intake :						Total Output :						
	02:00 am			46ml							0	At
	03:00 am			46ml							0	At
	04:00 am	ONS + Sucker		46ml							0	At
	05:00 am			46ml							0	At
	06:00 am										0	At
	07:00 am			46ml							0	At
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI (F)
 21-07-2022 3 Y 9 M 18 D
 Dr. MAINAK DEB

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.

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
12/5	08:00 am	NO IVF	Jelly	NA	NA	/	/	/	/	/	0	Soni
	09:00 am										0	
	10:00 am										0	
	11:00 am										0	
	12:00 pm										0	
	01:00 pm										0	
Total Intake :					Total Output :							
12/5	02:00 pm	NO IVF	/	NA	NA	/	/	/	/	/	0	Soni
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm										0	
	06:00 pm										0	
	07:00 pm										0	
Total Intake :					Total Output :							
12/6	08:00 pm	NO IVF	Jelly	NA	NA	/	/	/	/	/	0	Appu
	09:00 pm										0	
	10:00 pm										0	
	11:00 pm										0	
	12:00 am										0	
	01:00 am										0	
Total Intake :					Total Output :							
13/7	02:00 am	NO IVF	/	NA	NA	/	/	/	/	/	0	Appu
	03:00 am										0	
	04:00 am										0	
	05:00 am										0	
	06:00 am										0	
	07:00 am										0	
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 18 D (F)
 Dr. MAINAK DEB



Name: Age: 3Y 9M Sex: F UHID.No:

Date: 07/05/26 Time: 7:20 pm Proposed Operation: Radical Nephrectomy

Diagnosis: K/C/O ⊕ Wilms tumor

B.P / CRT: 101/67 H.R: 132 bpm Weight: 13kg ASA Physical Status: 1 2 3 4 5

SPO₂ = 97% @ RA
 (07/05/26) 7.5-7.5

RR = 28 cpm
 Laboratory Data:
 Hgb: Protein: 6.8
 Glucose: Alb: 4.0
 Urea: Creat: 0.3
 Total Bill: 0.1
 Na: 137
 Dir. Bill: 0.1
 K: 4.6
 LDH:
 Ca⁺⁺: Alk phos: 139
 Mg⁺⁺: Amylase:
 Cl⁻: 108 SGOT/SGPT: 5/178

HIV: X-Ray:
 HBS Ag: ECG:
 HCV: 2D Echo: Structurally ⊕ heart
 Blood group: O+ve Stress/Angio: Good Biventric
 T3 Other: Trileaflet fu
 T4
 TSH:
 (08/04/26) PET-CT Aortic valve
 large exophytic tumor

Allergies:
 16.1 X 8.2 X 8.5 cm.
 upper pole of ⊕ kid
 FT / LSCS / 2.4 kg / CIAB / No NICU stay

Medical History: CVS: -
 RESP: - ⊕ lumbar swelling → 1 month ago Diabetes:
 CNS: - ⊕ Wilms tumor → Biopsy. Development as per age
 Renal: - Neo Adjuvant chemo ⊕ Immuned as per age
 Hepatic / GE: -
 Others: H/O Allergy over the skin of R/L lower limb Not on medication
 Past Anaesthetic History: -
 Physical Exam: Physical Activity: Active

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: ⊕ Neck: ⊕ Teeth: No loose teeth
 Lungs: B/L A/E ⊕, Clear, Abdominal distension ⊕
 Heart: S1, S2 ⊕
 CNS: HMF ⊕

Pregnant: Yes No NA Venous Access Site: ⊕ UL Spine Exam for regional: ⊕
 Anaesthetic Plan: MAC REGIONAL GA-ETT LMA 229

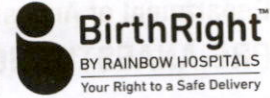
Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:
 1. DVT Prophylaxis :
 2. NIL ORAL → Water / ORS 2 Hours } explained
 → Others 6 Hours
 3. Informed Consent: Standard High Risk
 4. Post Operative Pain Management: Discussed with Patient
 5. Other Instructions:
 • P.T INR, A.P.T.T, S: creat, S: electrolyte
 • L.F.T, Blood grouping, typing
 • Reserve 10 PRBC

Signature: DR SHINNY Name: DR SHINNY

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: confirmed

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 114/min B.P / CRT: 80/58mmHg SpO₂: 100% R.R: 24/min Last Feed: >6hrs

Pre-OP Diagnosis: Wilms's Tumour Operation: Tumour excision left side Date: 8/05/2026

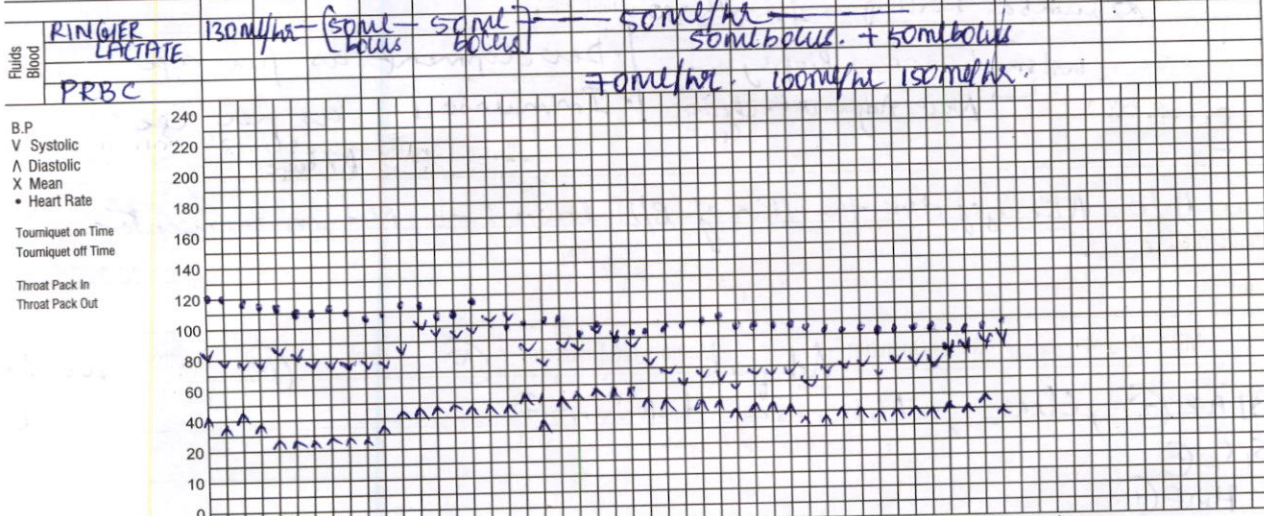
Surgeon: Dr. Nabeel / Dr. Mainak Deb Anaesthesiologist: Dr. Nikitha / Dr. Tejasvini Technician: Venkat

TIME	11:30am	12pm	12:30	1:30	2:30pm	3:30pm	4pm
N ₂ O / AIR / O ₂ LPM	0.6 / 1 / 10	0.6 / 1 / 10	0.6 / 1 / 10	0.6 / 1 / 10	0.6 / 1 / 10	0.6 / 1 / 10	0.6 / 1 / 10
HALO / SO / SEVO	MAC 1.2	1.1	1.1	1.0	1.0	1.0	1.0
Drugs:	MIDAZOLAM 0.6mg FENTANYL 25mcg PROPOFOL 30mg + 20mg ROCCURONIUM 8mg ONDANSETRON PHENYLEPHERINE Epidural 0.1% LEVOBUPRIVACINE + 1mcg/ml FENTANYL NEOSTIGMINE + DILYCOPYRROLATE 1mg/hr infusion 1mg + 3mg 30mcg						
FiO ₂ / SaO ₂	100	99	98	98	100	100	100
ETCO ₂	32	35	36	35	41	43	40
ECG	SR	SR	SR	SR	SR	SR	SR
Temperature	34.5	35.1	35.1	34.6	34.8	35.1	35.2
Urine Output							

Antibiotic: PIPERACILLIN TAZOBACTAM 13g Suppository

Blood Loss: ~ 50ml

NOTES: Total output = 240ml



LAB Values

ABG	
GRBS	
Others	

Equipment Checked and Functional
 BP
 Cuff Site: RLL
 Art Site:
 EKG Lead 3 leads
 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: 11:30 AM
 OP Start: 12:25 AM
 OP End: 3 PM
 Leave OR: 3:15 pm

Anaesthesia:
 GA
 Monitored Anaesthesia Care
 Regional

Line (Size & Location)
 CVP:
 ART:
 IV: 22G @ UL
 IV: 22G @ RL
 IV:

Induction:
 IV Inhal
 Pre O₂ RSI
 Others

Mask SGA
 Airway Oral Nasal
 ETT# 4.5 at 13 cm
 Oral Nasal Cuff
 Tracheostomy Topical
 Drug: ROCCURONIUM
 Awake Direct Vision
 Video Laryngoscopy Stylette / Bougie
 Fiberoptic
 Blade# 2 Attempts: 1
 Difficulty Why?

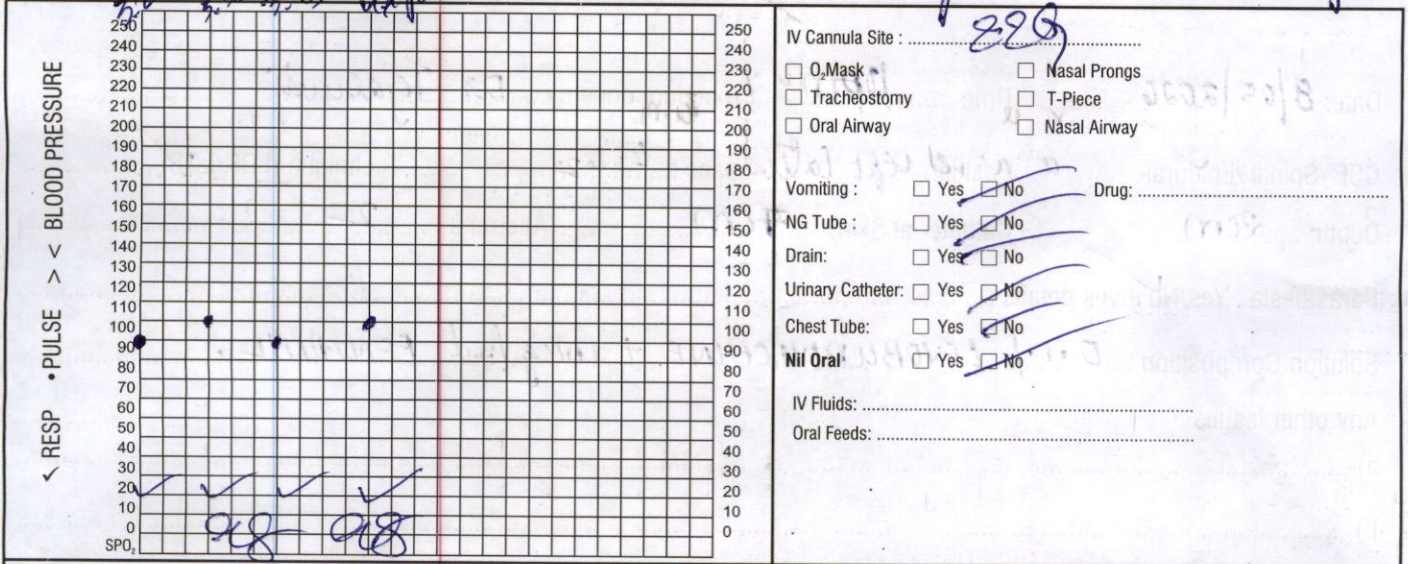
Regional:
 Extremity Specify:
 Spinal Epidural Caudal
 Others:
 Position: left lateral
 Site: L1-L2
 Needle Size: 20G (T) Depth: 2cm
 Parasthesia Yes No
 Catheter at skin 7cm Tunnelled at 13cm
 Drug Name & Conc:
 Bolus: 0.25% BUPIVACINE 3ml
 Infusion: 0.1% BUPIVACINE + 1mcg/ml FENTANYL
 Block Level:
 Comments: 2.5ml to B and 4ml

Transportation to
 PACU ICU Other
 Relaxant Reversed Yes No NA
 Name of the Doctor: Dr. Tejasvini
 Signature of the Doctor:



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Bilkyo Time Received: 3:120pm Time Discharged: 5:10pm



IV Cannula Site: 22G

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting: Yes No Drug: _____
 NG Tube: Yes No
 Drain: Yes No
 Urinary Catheter: Yes No
 Chest Tube: Yes No
 Nil Oral: Yes No
 IV Fluids: _____
 Oral Feeds: _____

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/5	3:120pm	1	—	<u>Dr. Tejasini</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Tejasini
 Anaesthesiologist Signature: [Signature]
 Date & Time: 8/5/2022 5:10pm
 PACU Nurse Name: [Signature]
 PACU Nurse Signature: [Signature]
 Date & Time: 8/5/2022 @ upr

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): [Signature]

Date & Time: 8/5/2022 @ 3:15pm

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 18 D (F)
 Dr. MAINAK DEB



Epidural Analgesia Record

Date: 8/05/2026 Time: 12pm Procedure done by Dr. Tejaswini

CSE / Spinal / Epidural Position: left lateral Space: L1-L2 Technique (LOR/LQS)

Depth: 2cm Catheter at Skin: 7cm Attempts: 2

Parasthesia: Yes/No if yes details:

Solution Composition: 0.1% LEVOBUPIVACAINE + 1mcg/ml FENTANYL

Any other issues:

- a)
- b)

3/5/26
 0/5/26
 n15/26

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
11AM	3ml/hr				110/45	112/min		clonidine
11:40AM	3ml/hr	4ml 0.75% CONT ADR			109/50	101/min		mild pain
5:00PM	3ml/hr				108/63			
8:00PM	3ml/hr	70						

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

Catheter Removed by and Tip Inspected: yes

Patient Satisfaction: yes

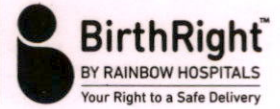
Discharge / Shifting ordered by

Doctor Signature: [Signature]

Doctor Name: Dr. Anura

Date and Time: 8/5/26 @ 12:30pm

BAH-00653423 IP5-00173512
 Baby AVIKA ROOPWANI
 21-07-2022 3 Y 9 M 17 D (F)
 Dr. MAINAK DEB



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 08-05-26 Time: 01:10pm

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve

Blood Bank Issue No: BAH 26-00911 Date of Collection: 14/04/26 Date of Expiry: 26/05/26

Date & Time of Starting Transfusion: 08/5/26 @ 1:10pm Planned duration of Transfusion: 2 1/2 hrs

Check for Correct Unit: Correct Patient:

Blood products cross checked by: Nurse 1: Sufata Nurse 2: Babi

Before starting transfusion vitals: Temp: 35.1°C HR 92b/m RR: 20b/m BP: 66/58 SpO₂ 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
8/5/26	15 Min 1:25pm	107b/m	35.0°C	62/58	100%	-	-	-	-
8/5/26	15 Min 1:40pm	101b/m	35.0°C	61/43	100%	-	-	-	-
8/5/26	30 Min 2:10pm	100b/m	34.7°C	63/56	100%	-	-	-	-
8/5/26	30 Min 2:40pm	92b/m	35.0	70/37	100%	-	-	-	-
8/5/26	30 Min	84	36.0	90/42	100	-	-	-	-
	1 Hr								
	1 Hr								

Comments:

Nil

Name of the Incharge-Nurse: Kumari

Name of the Nurse: Sufata

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 8/5/26 @

Date & Time: 8/5/26 @

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

LEUCO REDUCED BLOOD CELLS I.P

Qty. 245 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D.A. Solution.



Rh Positive

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

Unit No.: BAH26-00911
Blood Group: O Rh Positive
Collection Date: 14/Apr/2026
Expiry Date: 26/May/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not

Add A Group With F There Appro Antib

Issue Label / CrossMatching Report

Patient : **BABY.AVIKA ROOPWANI -**
 Patient's Blood Group : **O Rh Positive**
 Hosp/Dr : **Rainbow Childrens Hospital, MANIK DEB**
 UHID No.: **BAH-00653423** Wd-Bed No.:
 Product : **LR-PRBC**
 Blood Group : **O Rh Positive** Issue Dt : **08/May/2026**
 Unit No.: **BAH26-00911** Colln. Dt : **14/Apr/2026**
 XMatching Report: **Compatible** Exp. Dt : **26/May/2026**
 X-matched by: **PILLEM** Issued By : **Premalatha**

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital

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

(Faint background text and handwritten notes, including 'BLOOD PRODUCTS TRANS...', 'BAH 26-00911', and 'PLEASE MONITOR THE FOLLOWING:')

Temp	HR	BP	SpO2	RR	Time
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026
100.0	100	100/60	100	20	10/10/2026

Signature of the Nurse: _____
 Name of the Incharge Nurse: _____
 Date & Time: _____

BAH-00653423 IP5-00173512
Baby AVIKA ROOPWANI
21-07-2022 3 Y 9 M 17 D (F)
Dr. MAINAK DEB



CONSENT FOR BLOOD TRANSFUSION

Name: BABY AVIKA ROOPWANI Age: 3Y Gender: Male Female
UHID.No: BAH-00653423 Date: 08-05-26

- Type of Blood Product:**
- | | | |
|--|--|---|
| <input type="checkbox"/> Fresh Frozen Plasma | <input checked="" type="checkbox"/> Packed Red Blood Cells | <input type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> Cryoprecipitate | <input type="checkbox"/> Single Donor Platelet | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> Albumin | <input type="checkbox"/> Red Blood Cell | <input type="checkbox"/> Others |

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

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

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

Patient (Or Patient Relative / Guardian):
Signature: [Signature]
Name: Rahul Roopwani
Date & Time: 8/5/26 @ 01:05pm

Doctor (Who is talking the consent)
Signature: [Signature]
Name: Dr. Tejaswini
Date & Time: 8/5/2026 @ 01:00pm

Witness
Signature:
Name:
Date & Time

CONSENT FORM FOR GENERAL REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

BAH-00653423 IP5-00173512
Baby AVIKA ROOPWANI
21-07-2022 3 Y 9 M 16 D (F)
Dr. MAINAK DEB



Patient Name : Baby Avika Roopwani Age : 3Y 9M Gender : Male Female
 UHID NO: BAH-00653423 Surgeon Name: Dr. MAINAK DEB
 Anaesthesiologist : DR. SHINNY
 Operative procedure planned : RADICAL NEPHRECTOMY

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 : HYPERTENSION, BRADYCARDIA, BRONCHOSPASM, LARYNGOSPASM

Comments : REQUIREMENT OF BLOOD TRANSFUSION

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Baby Avika Roopwani the above mentioned operation / Diagnostic / Therapeutic procedures RADICAL NEPHRECTOMY

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 : Neeraja

Name : Neeraja Roorwani

Relationship with Patient : Mother

Date & Time : 07/05/26, 7:25 pm

Witness :

Signature : Bahul

Name : Bahul Roorwani

Date & Time : 7/5/26 @ 7²⁵ pm

Doctor (who is taking the consent) :

Signature : DR SHINU

Name : DR SHINU

Date & Time : 07/05/26, 7:20 pm



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 8/5/26 Time: 9 am

Weight: 13kg Centile: 5th

Height: 90cms Centile: 5th

Inference: underweight child

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

Diet Recommendations: child is on Npo

Re-Assessment:

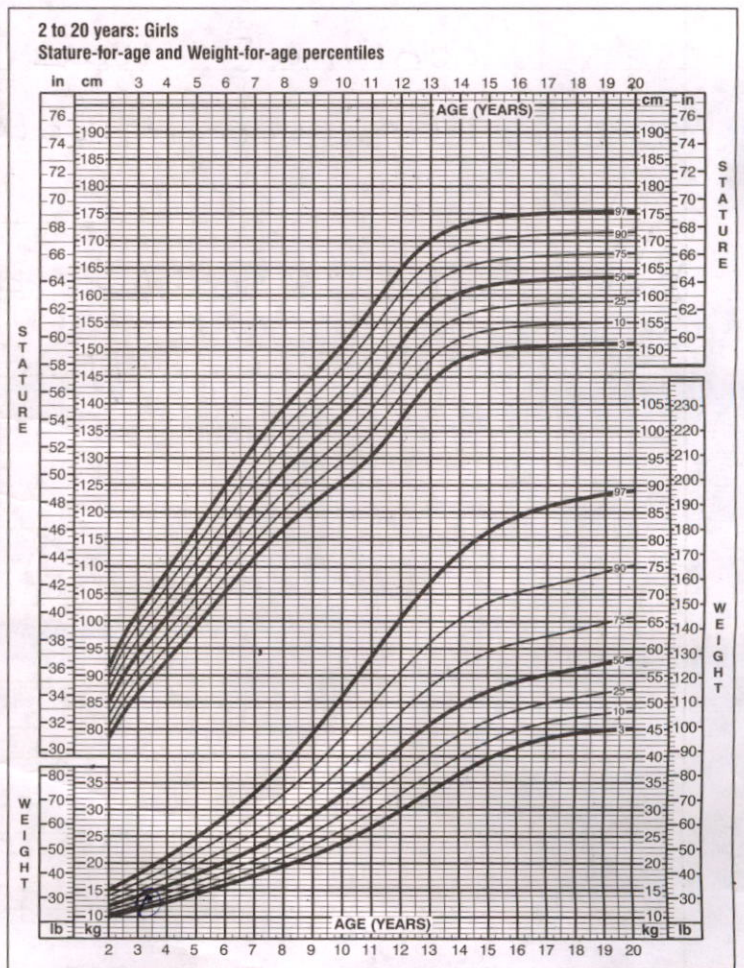
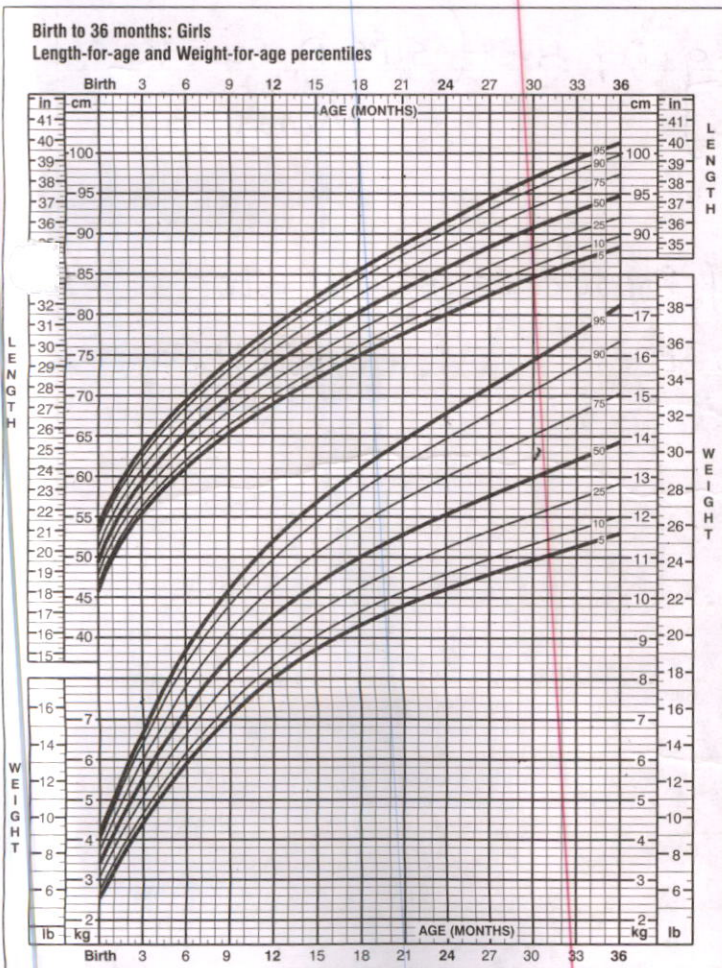
Food Allergies: Veg/Non-veg

Diagnosis: K/K/O (O) kid's Tumour posted for Radical

Nutritional Intervention - Oral Enteral Parenteral nephrectomy

Patient's Signature:

GROWTH CHART (GIRLS)



Dietician's Name saima

Dietician's Signature saimg

Daily Notes:

08/10/26 AM Child as on NPO

09/10/26 Child's ^(stable) can start with sips of clear liquids
[water, ORS, coconut water] poorly

10/10/26 Child is stable. oral intake is moderate.
~~11/10/26~~ continue to clear liquid diet (sips
of water, ORS, coconut water) Nikhita

11/10/26 Child is stable. oral intake is better.
continue clear liquid diet (sips of water
ORS, coconut water) Mounica

12/10/26 Child is stable. oral intake is moderate.
continue to soft diet Nikhita