SURGERY DETAILS

No RC

Date : 27/05/26

Patient Name: Mast. Usurupati Richard Kiran Date of Birth: 25-11-2016 Age: 9y

Gender: Male Ward : P. OT UHID No.: CUV-00047221

Date of Surgery: 27/05/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Adenotonsillectomy c̄ coblation B/L Tympanoplasty

---

Time in : 6 PM Time Out : 7 PM

		NAME	AMOUNT
1.	Surgeon	: PVLN Murthy	
2.	Anaesthetist	: Dr. Aditi	
3.	Assistant Surgeon	: —	
4.	OT Technician	: Prashanth	
5.	Circulating Nurse	: Alam	
6.	Assistant Nurse	: Bobi	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others Cobulator used ⇒ 9629947

[signature]
Signature of the Surgeon

Alam
Signature of Circulating Nurse

personal equipment used 7500/-

Order No: 9629946 Order by: Y. Ramadevi

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174392 **Admit Date** : 27-May-2026 **Admit Time** : 03:05 PM **UHID** : CUV-00047221

Patient Details :

Patient Name : Master USURUPATI RICHARD KIRAN
Guardian : Mr RAVI KIRAN U S
Gender : Male
Occupation :
Address (H) : FLAT NO : 103, PRIME RESIDECNY, KALYANIPURI, SURVEY OF INDIA , Vijayawada Railway Statio Vijayawada Andhra Pradesh INDIA 520001

Age : 9 Y 6 M 2 D
DOB : 25-11-2016
Religion :
Martial Status : Single
Phone No : 7799611107/ 7799611102
E-mail : ravi_blossom87@yahoo.co.in

Admission Details :

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

Contact Details :

Name : Mr RAVI KIRAN U S
Contact Address : FLAT NO : 103, PRIME RESIDECNY, KALYANIPURI, SURVEY OF INDIA , Vijayawada Railway Statio Vijayawada Andhra Pradesh INDIA 520001

Relationship : Father
Phone No : 7799611107 / 7799611102

Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY
Referral Doctor : SELF
Co-Consultant : Dr. FAISAL B NAHDI

Specialisation : EAR NOSE AND THROAT
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : CARE HEALTH INSURANCE LIMITED

ACTIVITY RECORD FOR BILLING

Name : ____

UHID No. : __________ IP N nt: ___________ Dept : _________

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

Date of Admission: ________ ischarge : ________ Time: ________

Room / Bed No : __________ ________ uggested Billable bed type : ______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	4:15pm	ER	OT	[illegible]
27/5	9pm	OT	305	[illegible]

Cross Consultation Visit

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

Docu. No. RCHBH/FRM/GENERAL/145

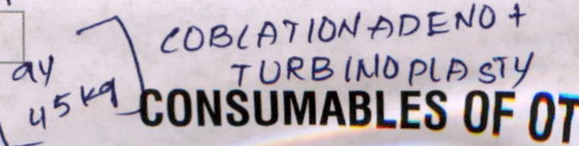
INVESTIGATIONS

Date	Investigations	Order No.	Signature

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

KIRAN

ay
45 kg


COBLATION ADENO + TURBINOPLASTY

CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : .... Time : 4:15 pm

Anaesthesia Disposables (oral)	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.5, 5, (5.5)	1+1+1	1	Major Pack Drape	1	1	Inj Vit.K		
LMA 2½, 3	1+1	—	Sutures			Cord Clamp		
ECG leads (A) / P / N	5	3				Suction Catheter		
HME filter (A) / P / N	1	1				Feeding Tube		
Syringes : 10 cc	10	5						
05 cc	10	5	Gloves			Surgical Suction Set		
02 cc	10	5	6, 6½, 7, 7½	2+3	—	Gauze Pack		
01 cc	3	—	PF 6, 6½, 7, 7½	2+2	1+1	Syringe 1ml / 2ml		
Cautery plate (A) / P / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	1	NG tube 6	2	2	Koochies (S)		
RL	1	1	Cautery pencil					
NS : 10ml / (100ml) / (500ml) / (1000ml)	1+1+1	1+1+1	Koochies			NS 500 ml	1	2
minispike	1	1	Ointments			Tranexa	1	0
O2 Mask (A)	1	1	Suction Catheter			(10cc) 5cc, 2cc	2+	1
Fentanyl	1	1	Cap, Mask	5/5	5/5	Savlon	1	1
Morphine			Gauze Pack (N)	5+5	5	Inj. Adrenalin	03	5
Ketamine			Mop Pack	1	1	[illegible]	1	1
Propofol	3	2	Steristrip					
Rocuronium	1	1	Underpad	1	1			
Glycopyrolate	1	1	Draw sheet	1	0			
Myopyrolate +	1	1	Abgel					
Ondansetron	1	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			IV Aug 1.2 mg	1	1
Bupivacaine 0.25%			Chest Drainage Catheter			50cc + Pmoline	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dextomid 50	1	—
Antibiotics			Bandage			Nasal Airway	—	—
IV PCM	1	1	Tegaderm				1+1	—
Suppositories			Ioban			Oral Airway	—	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			2, 3	1+1	—
Supridol : 100mg			Vaccum Suction set	2	2	Metapradol	1	1
Justin (12.5 mg) (25mg) / 100mg	1+1	1+1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	0			
Glove all Gauze	4+3	—	Microshield	1	0			
3way 10 + (100cm)	1+1	1	Cotton Balls	1	1			
IV cannula 20, 18	1+1	—	Latex Gloves	1	10			
Dexa + Tranexa	1+1	1+2	Ramdione Scrub					
Vaccum set	1	1	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9629935 Ordered by : ....

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

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
27/5	Iv placement ~~[illegible]~~	(1)	29535	Sachel
	PAC op			

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

SURGERY DETAILS

NOFL

Date : 27-05-26

Patient Name: Baby. Chilamkurty Niyati Date of Birth: 08-07-2018 Age: 7Y

Gender: Female Ward : OT UHID No.: BAH-00454722

Date of Surgery: 27/05/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Coblation Assisted Adenotonsillectomy

Ad - SBI - Grade - III

Time in : 2:05 PM Time Out : 3:05 PM

		NAME	AMOUNT
1.	Surgeon	Dr Manish Gupta	
2.	Anaesthetist	Dr. Ayeswarya	
3.	Assistant Surgeon		
4.	OT Technician	Nishanth	
5.	Circulating Nurse	Sujata	
6.	Assistant Nurse	Akeel	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Coblator used → 9629914

Signature of the Surgeon [signature] Signature of Circulating Nurse [signature]

Order No: 9629913 Order by: Y. Ramesh [illegible]

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

BAH-00454722 IP5-00174381
Baby CHILAMKURTY NIYATI
08-07-2018 7 Y 10 M 19 D (F)
Dr. MANISH GUPTA

Adeno

CONSUMABLES OF OT

Circulating staff : .... Technician : Nishanth .... Date : 27/5 .... Time : 12:30pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5, 4, (4.5) Oral	1+1+1	01	Major Pack Drape.		1	Inj Vit.K		
LMA 1, 1½,	1+1	—	Sutures			Cord Clamp		
ECG leads : A / (P) / N	05	03				Suction Catheter		
HME filter : A / (P) / N	01	01				Feeding Tube		
Syringes : 10 cc	10	10				Vaccum Suction Set		
05 cc	10	6	Gloves PF 6 1/6.5 (7) (7.5) 2+2+2+2	1+1		Surgical Gloves		
02 cc	10	[illegible]				Gauze Pack		
01 cc	05	—				Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube 6	2	2	Koochies (S)		
RL	01	01	Cautery pencil			NS 500ml	2	0
NS : 10ml / 100ml / 500ml / 1000ml	1+1	01	Koochies			10cc	2	1
Mini Spike	01	01	Ointments			Adrenalin	3	3
O2 mask (P)	01	—	Suction Catheter			Savlon	1	1
Fentanyl	01	01	Cap, Mask	15	5/5			
Morphine			Gauze Pack (N) R	3	2			
Ketamine			Mop Pack	1	—			
Propofol	03	02	Steristrip					
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	0			
Myopyrolate (Neo)	02	01	Abgel			Gauze + Gloves all	4+4	1+1
Ondansetron	01	01	Foleys catheter			Dexa + Tranexa	1+1	—
Pencan 25g/ Spinal Needle 22			Urobag			Dermed	01	—
Bupivacaine 0.25%			Chest Drainage Catheter			50cc + pmo line	1+1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Inj pcm	01	01	Bandage					
Aug (600mg)	01	01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	2			
Justin : 12.5 mg / 25mg / 100mg	1+1	01	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	—				
Vaccum Set	01	01	Microshield	1	0			
Oral airway 0, 1		—	Cotton Balls	1	—			
Nasal airway 16, 18		—	Latex Gloves	1p	1p			
IV cannula 22, 24		—	Ramdione Scrub					
3 way 10cm + (100cm)		01	Saral					

Surgeon .... Anaesthesiologist .... Nurse .... OT Technician

Order No. : 962958 .... Ordered by : ....

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

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

OPERATION THEATER NOTES

Patient's Name : Mast · Usurupati Richard Kiran Age : 9y Gender : ☑ Male ☐ Female

PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

Patient Name:

UHID ID:

Department:

Consultant: Dr. PVLN murthy

Docu. No. : RCHBH /FRM / GENERAL / 065

(P.T.O.)

Amount of Blood Loss: | Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

1 T. CEPODEM XP BID 2WKY

2 T: XYZAL-M BID 2WKY

3 T. DEFCORT 6MG BID - 1WKY

4 T. HIFENAC-P BID - 2WKY

5 T - PAN-D 40MG BID - 2WKY

6 T - TRANEXA 500MG BID 2WKY

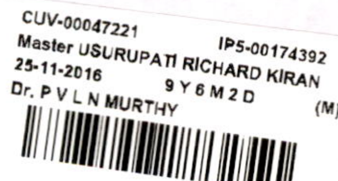
7 NASOCLEAR Saline wash TID 2WKY

8 Salt water gargle TID 2WKY

Name of the Surgeon: P V L N Murthy

Signature of the Surgeon: DR. P V L N MURTHY Registration No: 47267

Date & Time: 27/5/26



POST-SURGICAL CARE PLAN FORM

Procedure Done: Adeno tonsillectomy c cobldaion + B/L Tympano plasty

Post-Surgical Diagnosis: Chr. Ad T.S + H.L

Post-Operative Monitoring Parameters /Frequency:

Vitals, Bleeding

Wound Care:

Mouth wash, saline nasal wash

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

Lateral

Nutritional Instructions:

veg soft diet

When to Start Mobilization:

after 1hr

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

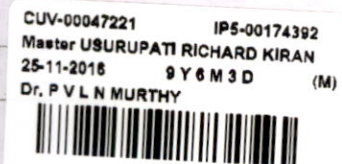
2 wks

DR. P V L N ... Registration ...

Treating Surgeon
(Signature & Stamp)

Date: 27/5/26 Time: ....

Note: Plan of care will be readjusted if necessary.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	C/S/B Resident	
10pm	Chronic Adenotonsillitis	
	with Hypertrophied	
	Inferior turbinate	
	S/p → Adenotonsillectomy with B/L	
	Turbinoplasty	
		Plan
	Child on Room air	
	No bleeding	1) continue oral medication
	no vomiting	as charted
	no fever	2) W/F signs of bleeding
	vitals: stable	3) Allow and encourage
	$S_1 S_2$ (+)	orally
	RAE (+)	4) vital monitoring 3rd hrly
	P/A: soft	
		Sai
28/5/26 8:45PM	Seen by Resident: Dr Sahithi	Noted by Durga
	Chronic adenotonsillitis c̄ HIT	
	post adenotonsillectomy c̄ B/L turbinoplasty.	
	child asleep, afebrile	
	hemodynamically stable.	Plan
	chest clear.	1. Discharge today
	throat healthy.	
		Sahithi 28/5/26 9AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

RESULT SHEET

Date	18/5/26					
Time	6:31pm					
Hb	12.1					
PCV						
RBC	4.82					
WBC						
N/L						
Platelets	2.67					
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 : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

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

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

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 : Pavani. J

Date & Time : 27/5/26 @ 3:55pm

Nurse Name & Signature: Rachel

Date & Time : 27/5/26 @ 4:30pm

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 3 D (M)
Dr. P V L N MURTHY

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight ..58.kg.. Ward ....

DRUG : T. HIFENAC-P

Dose	Route	Frequency	Start Dt.
1tab	P/O	Q12H	27/5

Name & Signature of the Doctor Starting the Drugs: Sai

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾: 27/5, 28/5
10AM: X (27/5), [signature] (28/5)
10PM: [signature] (27/5)

DRUG : T. TRANEXAMIC ACID

Dose	Route	Frequency	Start Dt.
500mg	P/O	Q12H	27/5

Name & Signature of the Doctor Starting the Drugs: Sai

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾: 27/5, 28/5
10AM: X (27/5), [signature] (28/5)
10PM: [signature] (27/5)

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

...nal Instructions:

...Endorsement by a Sign

Date ▸ Time ▾

VERIFIED

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

Patient Sticker

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

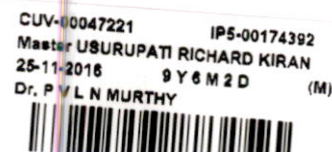
DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

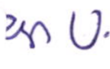
DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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


CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY



DRUG CHART

Date of Admission: 27/11/16 .... 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 / 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 .... Signature

Master USURUPATI RICHARD KIRAN IP5-00174392
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

REGULAR PRESCRIPTIONS

Weight. 50kg Ward. OT

DRUG : T. CEFPODOXIME CLAVULANIC ACID				Date / Time	27/5	28/5
Dose	Route	Frequency	Start Date			
1 tab	P/O	Q12H	27/5	10AM	X	[signature]
Name & Signature of the Doctor Starting the Drugs: Sai						
Additional Instructions: 200mg cefpodoxime 125mg clavulanic acid				10PM	Sumana	
Daily Doctor's Endorsement by a Sign						

DRUG : T. XYZAL-M				Date / Time	28/5
Dose	Route	Frequency	Start Date		
1 tab	p/o	Q12H	27/5	10AM	[signature]
Name & Signature of the Doctor Starting the Drugs: Sai					
Additional Instructions:				10PM	
Daily Doctor's Endorsement by a Sign					

DRUG : T. DEFCORT				Date / Time	27/5	28/5
Dose	Route	Frequency	Start Date			
6mg	P/O	Q12H	27/5	9AM	X	[signature]
Name & Signature of the Doctor Starting the Drugs: Sai						
Additional Instructions:				9PM	Sumana	
Daily Doctor's Endorsement by a Sign						

DRUG : T. PANTOP-D				Date / Time	28/5
Dose	Route	Frequency	Start Date		
1 tab	P/O	Q24H	27/5		
Name & Signature of the Doctor Starting the Drugs: Sai				6AM	Sumana
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VERIFIED

Master USURUPATI R... (M)
25-11-2016 9 Y 6 M 2 D
Dr. P V L N MURTHY

Weight. 80 kg Ward. OT

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
27/5/21	6.05pm	INJ AUGMENTIN	1.2gm	IV	[signature]	Bobi / Venkat
27/5/21	6.05pm	INJ PARACETAMOL	750mg	IV slow	[signature]	Bobi / Venkat
27/5/21	6.10pm	INJ TRANEXA	750mg	IV	[signature]	Bobi / Venkat
27/5/21	6.19pm	INJ DEXAMETHASONE	5mg	IV	[signature]	Bobi / Venkat
27/5/21	6.15pm	SUPPOSITORY DICLOFENAC	25mg + 25mg	PR	[signature]	Bobi / Venkat

VERIFIED
VERIFIED

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

Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

I.V. FLUIDS CHART

Weight. 50Kg Ward. OT

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
27/5		IVF · DNS	IV	70	Pavs		Not	Connected	
27/5/21	6.00	RINGER LACTATE	IV	500ml/h	[illegible]	Suman Bobi	27/5	[illegible]	Suman Bobi

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

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN (M)
25-11-2015 9 Y 6 M 3 D
Dr. P V L N MURTHY

Doc. No. : RCHBH/FRM/CLINICAL / 126

27/5/26

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	10PM	2AM	6AM
Doctor / Nurse / Family Concern?			
Temperature (F) (scale 94–104)	97.6°F	97.8°F	98.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring	100/49	102/55	98/54
Heart Rate (Number)	102 b/m	115 b/m	88 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)			
Resp Rate (Number)	28 b/m	28 b/m	28 b/m
Resp Distress — Mod/ Severe / None / Mild			
Receiving O_2 (l/min) / O_2 Saturations (%)	98%	98%	98%
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	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse ... observation to continue.

Patient Sticker

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 requir help – regardless of the Early Warning Score!
- Following a Early Warning Score ass t, senior help may be required

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

I	**IDENTITY:** I am (name), a nur X). I am calling about (child X)
S	**SITUATION :** I am calling bec cerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Wa XX)
B	**BACK GROUND :** Child (X) w (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). ition has changed in the last (XX mins). Their last set of observations were (XXX). The child's n s ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the proble s deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I r to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (peat observation)

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN (M)
25-11-2016 9 Y 6 M 3 D
Dr. P V L N MURTHY

No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	Scale	Observations
Date : .... Time:		
Doctor / Nurse / Family Concern?		
Temperature (°F)	104	
	103	
	102	
	101	
	100	
	99	
	98	
	97	
	96	
	95	
	94	
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)		
Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)		
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2 (l/min)		
O_2 Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
Observer's Initials		

ACTIONS NB: Scores 3 should be recorded overleaf	Score	Action
	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.

Patient Sticker

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)

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		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											
8/5	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm	H2O		—	—	—	—	—	—	—	0	
	09:00 pm	Icegola		—	—	—	—	—	—	—	0	Durga
	10:00 pm										0	Durga
	11:00 pm	Icecream									0	Durga
	12:00 am									✓	0	Durga
	01:00 am	H2O									0	Durga
Total Intake :						**Total Output :** U-1 M-0						
	02:00 am	H2O									0	Durga
	03:00 am										0	Durga
	04:00 am	H2O					✓			✓	0	Durga
	05:00 am										0	Durga
	06:00 am	H2O								✓	0	Durga
	07:00 am										0	Durga
Total Intake :						**Total Output :** U-2 M-1						

Total 24 hrs. Intake		**Total 24 hrs. Output**	U-3 M-1

Patient Sticker

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

Total 24 hrs. Intake	

Total 24 hrs. Output	

Docu. No. : RCHBH/FRM/CLINICAL/092

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: MASTER RICHARD KIRAN V. Age: 9Y5M Sex: M UHID.No : CUV 00047221

Date: 9/5/26 Time: 2:21 Proposed Operation: GRADE IV Adenoids

Diagnosis: Adenotonsillectomy with Coablation + Turbinoplasty

B.P / CRT: 105/75 H.R: 92 bpm Weight: 30.10kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

18/5/26

Hgb: 12.1	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC: 5990	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.67	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
CRP:- 30.5	Cl -:	SGOT/SGPT:	**Allergies:** ~~No known allergy~~ Fish allergy (itching)	

Medical History: CVS : —

RESP : —

Diabetes : —

CNS : —

Renal : —

Hepatic / GE : —

Physical Activity: playful Active

Others : —

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: No loose teeth

Lungs : AEBE

Heart: S1S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site : RUL LUL Spine Exam for regional : —

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

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

CURRENT MEDICATIONS	DOSAGE
Syp UPRISE D3 60K	OD

Pre-Operative Instructions: 10:40AM FOOD

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

CT scan. - DNS to right
Rt bilateral inferior turbinate c̄ hypertrophy

Signature: Aditi Name: Dr Aditi N

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

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M
Dr. P V L N MURTHY

ANAESTHESIA CHART

Pre Induction Assessment: 5.30 PM

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

5.00 PM

H.R.: 88/min	B.P / CRT: 122/74 mmHg	SpO_2: 100	R.R.: 24	Last Feed: 8 hr

Pre-OP Diagnosis: Adeno tonsillectomy Operation: Adenotonsillectomy Date: 27/5/26

Surgeon: Dr. P V L N Murthy Anaesthesiologist: Dr. Srujan / Dr. Aditya Technician: Prasad

TIME	6
N_2O / AIR / O_2 LPM	Air 50%, O_2
HALO / ISO / SEVO	MAC 0.9
Drugs:	
INJ MIDAZOLAM 2 MG	
INJ FENTANYL 100 MCG	
INJ PROPOFOL 100 MG	
INJ ROCURONIUM 25 mg	
INJ PARACETAMOL 350 mg	
INJ TRANEXA 750 mg	
INJ DEXA 5 MG	
FIO_2 / SaO_2	100 100 100 100
$ETCO_2$	35 36 35 35
ECG	SR SR SR SR
Temperature	
Urine Output	
Fluids / Blood	IVF RL @ 500 ml/hr

Antibiotic: Inj Augmentin

Suppository: 25 mg

25 ml

Blood Loss: Drops

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 10, 0

Tourniquet on Time
Tourniquet off Time
Throat Pack In 6.35 pm
Throat Pack Out

LAB Values

ABG

GRBS

Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: ....
☐ Art Site: ....
☑ EKG Lead 3 lead
☑ Temp Site SKIN
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: ....
☐ 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: 6.00 PM
OP Start: 6.15 PM
OP End: ....
Leave OR: 7.10 pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

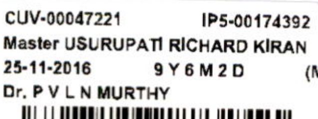
Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: ....
☐ IV: 20G RUL
☐ IV: ....

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

☑ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
☐ ETT# 5.5 at 17 cm
☑ Oral ☐ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: Rocuronium
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 3 Attempts: 1
Difficulty Why? ....

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

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



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Divya Time Received : 7:15pm Time Discharged : ....

RESP • PULSE ∨ ∧ BLOOD PRESSURE (chart 0–250, SPO₂: 98, 98)

IV Cannula Site : 22G

☐ O₂Mask ☐ 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	30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0		ACTIVITY	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 leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 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
27/5	7:15pm	0/10		Divya

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

Anaesthesiologist Name : Dr. Aruen
Anaesthesiologist Signature: Dr Arun
Date & Time: 27/5/20

PACU Nurse Name : Divya
PACU Nurse Signature: Divya
Date & Time: 27/5/20

Reassessment Frequency:

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

Transferred to Unit by (PACU): 305
Date & Time: 27/5/20

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 2 D (M)
Dr. P V L N MURTHY

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: .... Time: .... Procedure done by ....

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

Depth: .... Catheter at Skin: .... Attempts : ....

Parasthesia : Yes/No if yes details : ....

Solution Composition : ....

Any other issues :

a) ....

b) ....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

RICHARD KIRAN

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: ADENOTONSILLECTOMIC COABLATION + BIL TURBINOPLASTY

Anaesthesiologist: Dr Aditi N Surgeon: Dr P V L N MURTHY

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others DESATURATION, POST PROCEDURE O_2 requirement

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team

  ☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care

- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [signature]

Name: Ravi Kiran. US

Relationship with patient: FATHER

Date & Time: 27/5/26 2-37PM

Witness:

Signature: [signature]

Name: Nirmala kumari

Date & Time: 27/5/21 2.37PM

Doctor (who is taking consent):

Signature: Aditi Name: Dr Aditi N Date 27/5/26 Time: 2:37

Docu. No. : RCHBH / FRM / CLINICAL / 021

(P.T.O)

Patient Sticker

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: ....

అనస్థీషియా వైద్యుడు: .... శస్త్రచికిత్స నిపుణుడు: ....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

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

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: ....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: ....

పేరు: ....

రోగితో సంబంధం: ....

తేదీ & సమయం: ....

సాక్షి:

సంతకం: ....

పేరు: ....

తేదీ & సమయం: ....

డాక్టర్ :

సంతకం: .... పేరు: .... తేదీ & సమయం: ....

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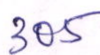
(P.T.O)

CUV-00047221 IP5-00174392
Master USURUPATI RICHARD KIRAN
25-11-2016 9 Y 6 M 3 D (M)
Dr. P V L N MURTHY



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 28/5/26 Time: 9am

Weight: 50·3kgs Centile: >97th

Height: 143cms Centile: >75th

Inference: Obese child

RDA: – Calories: 1600 kcal/d Protein: 28g/d

Diet Recommendations: Soft diet

Re-Assesment: Avoid spicy, Outside foods

Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

AGE (MONTHS): Birth, 3, 6, 9, 12, 15, 18, 21, 24, 27, 30, 33, 36

LENGTH (cm / in), WEIGHT (kg / lb); percentiles 5, 10, 25, 50, 75, 90, 95

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

AGE (YEARS): 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

STATURE (cm / in), WEIGHT (kg / lb); percentiles 3, 10, 25, 50, 75, 90, 97

Dietician's Name: Nikitha Dietician's Signature: Nikitha

Daily Notes: