UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
r. MANCHUKONDA SANTHOSH

Master K. KRISHNA SRIHAN (8 Y 1 M 28 D/ M)
SWAB
NINV00840
BA26050967017
CUV-00171083

SURGERY DETAILS

Date : 19/05/26

Patient Name: MASTER. K. KRISHNA SRIHAN Date of Birth: 21/03/2018 Age: 8 yrs

Gender: MALE Ward :

UHID No.: CUV — 00171083

Date of Surgery: 19/05/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☑ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : coblation Adenotonsillectomy Intracapsular

Time in : 3:05 pm Time Out : 4:00 pm.

	NAME	AMOUNT
1. Surgeon	: DR. M. SANTHOSH	
2. Anaesthetist	: DR. Saritha	
3. Assistant Surgeon	:	
4. OT Technician	: NISHAND	
5. Circulating Nurse	: AMOS	
6. Assistant Nurse	: Thejas	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator ☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa ☐ Neuro Cusa ☐ Others coblator → 9616060

Signature of the Surgeon

Jyothi
Signature of Circulating Nurse

Order No: 9616059 Order by: Jyothi.

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

Mst. KRISHNA SRIHAN
Adeno
0017083
8Y/M 21.5kg
5091

Patient Sticker

CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : 19/5/26 Time : 12:30pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube Oral 4.0/4.5/5.0	|||||	01	Major Pack Drape	1	1	Inj Vit.K		
LMA		—	Sutures			Cord Clamp		
ECG leads : A / (P) / N	5	03				Suction Catheter		
HME filter : A / (P) / N	1	01				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	3	Gloves 6, 6.5, 7, 7.5 2+2+2+2		|||	Surgical Gloves		
02 cc	10	2	16, 16.5, 7, 7.5 2+2+2+2			Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / (P) / N	1	—	Surgical blade			Surgical Blade # 20		
IV set	1	01	NG tube 6	2	2	Koochies (S)		
RL	1	01	Cautery pencil			NS 500ml	2	1
NS : 10ml / (100ml) / 500ml / (1000ml)	|+|	1+1	Koochies			Adrenalin	3	3
minispike	1	01	Ointments			(OC) Sa	2+2	1
Damaile (P)	1	—	Suction Catheter			Savlon	1	1
Fentanyl	1	01	Cap, Mask	8/8	8/8			
Morphine			Gauze Pack (N) FR	4+4	2			
Ketamine			Mop Pack	1				
Propofol	3	01	Sterestrip					
Rocuronium	1	01	Underpad	1	1			
Glycopyrolate	1	01	Draw sheet	1	1			
Myopyrolate	1	—	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			Gauze	3	01
Bupivacaine 0.25%			Chest Drainage Catheter			Glassum	4	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			Dexamed	1	—
Antibiotics Aug 1.02mg	1	01	Bandage			Dexa-Tranexa	1+1	1+1
I.V. pcm	1	01	Tegaderm			50C pm line	1+1	—
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	—	—			
Vacum set	1	01	Microshield	1	0			
Oral airway 1/2	1+1	—	Cotton Balls	1	0			
Nasal airway 18/20	1+1	—	Latex Gloves	10p	10p			
3way Extension	1+1	01	Ramdione Scrub					
IV cannula 22/24	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse Anus OT Technician

Order No. : 9615904 Ordered by : ....

Doc. No : RCH / FRM / GENERAL / 125

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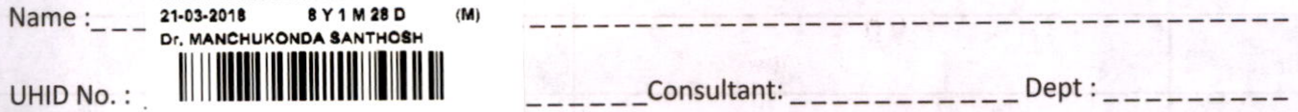
ACTIVITY RECORD FOR BILLING

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Name : ___



UHID No. : ______ Consultant: ____________ Dept : __________

Date of Admission: _________ Time : _________ Date of Discharge : _________ Time: _________

Room / Bed No : __________ Ward : __________ Suggested Billable bed type : _______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/5/26	12:10pm	ER	OT	Abhishek
19/05/26	5:30 pm	~~[illegible]~~ OT	239	[signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. faisal B nandi	20/5/26	056/7043	Barnali
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/5	replacement	①	15425	[illegible]
	PAC OPD			
20/5/26	NHA	①	96170444	Bosil

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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 : IP5-00174013 **Admit Date** : 19-May-2026 **Admit Time** : 10:59 AM **UHID** : CUV-00171083

Patient Details :

Patient Name	: Master K. KRISHNA SRIHAN	**Age**	: 8 Y 1 M 28 D
Guardian	: Mr RAGHAVENDER	**DOB**	: 21-03-2018
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: CARE OF POWER GRID COPRATION QUATER NOC-1 Nunna Krishna Andhra Pradesh INDIA 521212	**Phone No**	: 8527391638/ 9182941655
		E-mail	: SAHITYAANANTHULA@gmail.com

Admission Details :

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

Contact Details :

Name	: Mr RAGHAVENDER	**Relationship**	: Father
Contact Address	: CARE OF POWER GRID COPRATION QUATER NOC-1 Nunna Krishna Andhra Pradesh INDIA 521212	**Phone No**	: 8527391638 / 9182941655

K. Sahitya

Signature

Doctor Details :

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

Payment Details :

		Deposit Amount	: 0.00
Payment Mode	: Cash	**Payor Name**	: POWER GRID CORPORATION OF INDIA

239.

CUV-00171?83 IP5-00174013
Master K. K?ISHNA SRIHAN
21-03-2018 8 Y 1 M 29 D (M)
Dr. MANCH?UKONDA SANTHOSH

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DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : [signature] 20/05

(P.T.O)

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Patient Name: ______________________

UHID ID: ______________________

Department: ______________________

Consultant: ______________________

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Information given by: ______ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

c/o recurrent episodes of
cold, cough, noseblock(+)
Tonsillitis
Open mouth Breathing
Snoring Issues(+)

History of present illness :

As per informant, child apparently well
then had recurrent episodes of cold, cough,
Tonsillitis
Open mouth Breathing
Snoring Issues
Had Adenoid Hypertrophy(+)

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

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

Similar illness since 1 year

Birth & Neonatal History:

(N) perinatal transition

Birth & Socio Economic History:

About Father :
About Mother :
Any additional Information :

middle

Developmental History :

Attained appropriate for age.

Immunization History :

Immunised till date

(P.T.O.)

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 20.7Kg (Centile ______)

On Examination :

Temperature : 98.2°f Pulse Rate : 103/min B.P. 95/52(59)mmHg SPO2 99.1 RA

Resp.rate and type of breathing : 24/min

Regular

Rash______

Lymphadenopathy______

Oedema :______

Allergies (if any): ______

Respiratory System :

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

Air entry & breath sounds : BAE(+), clear

Any addes sounds : ______

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S_1S_2(+) Heard

Any murmur :______

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

Per Abdomen :

Inspection (N)

Palpation : soft, non tender

Ausculation : BS(+)

Spine : (N) External Genitelia : (N)

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

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert/Active

Cranial Nerves : Intact

Motor System:

Nutriton : Good

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements : Nil

Reflexes :

DTR (N) **Superficials:**

Plantars

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Coblation Adenotonsillectomy

(P.T.O.)

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent Complications

Desired goals of the treatment : For Hemodynamic stability

Planned Labs:

IV Cannula

Planned Management

1) Continue NPO
2) IV fluids DNS @ 50ml/hr
3) Shift to OT on call

Signature of the Doctor: JA

Name of the Doctor: Jaya Sri

Date & Time: 19/5/26

Signature of the Consultant:

Name of the Consultant: Dr. M. Santosh Kumar

Date & Time:

UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
r. MANCHUKONDA SANTHOSH

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OPERATION THEATER NOTES

Patient's Name : .... Age : .... Gender : ☐ Male ☐ Female

UHID No.: .... Weight : .... Height : ....

Surgeon :		Asst. Surgeon :
Anesthetist : DR. SHINY	OT Nurse: Thejas	OT Technician: Nishad
Pre-Operative Diagnosis:		
Surgical Procedure : coblation Adenotonsillectomy		
Indications for Surgery :		
Date :	Start Time : 1:25pm	End Time : 2:25 pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

- Grade III adenoid & tonsillar hypertrophy
coblation Adenoidectomy & intracapsular Tonsillectomy
- Pus & polypoidal mucosa in b/l OME
- swab sent for C&S

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

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

1. Inj. Augmentin 500mg IV BD

2. Inj. PCM 300mg IV TID

3. Inj. Tranexa 500mg IV BD

4. Nasoclear n/d 3-3-3

5. Betadine mouth gargle 2 times daily

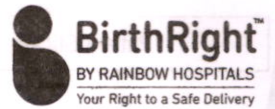
Name of the Surgeon: Dr. Santhosh

Signature of the Surgeon: [signature]

Date & Time: 19/5/26 @ 3:30 pm

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

8yr.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5 6:00pm	C/S/B Resident	
	child doing well	Plan
	no fresh complaint	① Inj Augmentin
	Started oral soft food.	② Inj Pcm.
	NO nasal bleed / NO vomits	③ Inj Tranexa 200mg.
	Vitals : Stable	④ Nasoclear Nd.
		⑤ Betadine gargle
		sohel (Dr. Sohel)
20/5/26 8 AM	Seen by Resident : Dr Saiuthi	
	S/P coblation adenotonsillectomy	
	No fresh issues	Plan
	accepting orally	1. Plan D/C today
	O/E	
	child afebrile, active	Sahithi
	hemodynamically stable.	

CUV-00171083 IP5-00174013
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21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 29 D (M)
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CROSS CONSULTATION FORM

Doctor Name: Dr. Faisal Date: 20/5/26 Time:

Diagnosis:

Hospital: Ref - Ped

Referred for: ☑ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral:
☐ Emergency
☐ Urgent
☑ Non Urgent

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

Signature:

Findings and Recommendations:

Chronic adenotonsillitis
S/P adenotonsillectomy POD-1.

N/o fever / vomitings / bleeding

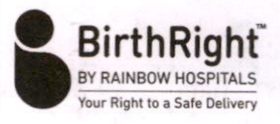
Accepting orally

O/E
child alert, afebrile
hemodynamically stable.
chest clear
abdomen soft

Plan
1. can be discharged today
2. f/u c̄ ENT surgeon.

Consultant:

Name: Dr. Faisal Signature: DR. FAISAL B NAI[illegible] Registration No: 66249 Date & Time: 20/5/26.



RESULT SHEET

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

D/C

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.,) : ....

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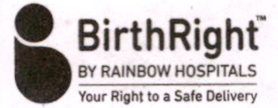

MEDICATION RECONCILIATION FORM

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: 07

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 : Sai

Date & Time : 19/5/26

Nurse Name & Signature: Abhishek

Date & Time : 19/5/26

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DRUG CHART

Date of Admission: 19/05/16 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

COV-00171083 IPS-00174013
Master K. KRISHNA SRIHAN
21-03-2016 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

REGULAR PRESCRIPTIONS

Weight. 20kg Ward. ....

DRUG: Inj AUGMENTIN				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date		1230PM	Nilai
500mg	I.V	BID	19/5	6am	O/	Kala
Name & Signature of the Doctor Starting the Drugs: Sohel						
					10pm	
Additional Instructions:				6pm	Kala Nilai	
Daily Doctor's Endorsement by a Sign						

DRUG: Inj TRANEXA				Date / Time	19/5	
Dose	Route	Frequency	Start Date			
200mg	I.V	BID	19/5	10am	O/	
Name & Signature of the Doctor Starting the Drugs: Sohel				10pm	Kala Nilai	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG: INJ PARACETAMOL				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date			
300mg	I.V	TID	19/5	6am	X	Kala Nilai
Name & Signature of the Doctor Starting the Drugs: Sohel				2pm	Kala Nilai	
Additional Instructions:				10pm	Kala Nilai	
Daily Doctor's Endorsement by a Sign						

DRUG: NASOCLEAR DROPS				Date / Time	19/5	20/5
Dose	Route	Frequency	Start Date			
3°	N/D	TID	19/5	6am	X	Kala Nilai
Name & Signature of the Doctor Starting the Drugs: Sohel				2pm	X	
Additional Instructions:				10pm	Kala Nilai	
Daily Doctor's Endorsement by a Sign						

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Dr. MANCHUKONDA SANTHOSH

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Sheet No: ....

REGULAR PRESCRIPTIONS

Dept. .... Ward. ....

DRUG : BETADINE MOUTH GARGLE

Dose	Route	Frequency	Start Dt.
	P/O	TID	19/5

Name & Signature of the Doctor Starting the Drugs: Soheb

Additional Instructions: 5ml BETADINE IN 1Glass water

Daily Doctor's Endorsement by a Sign

Date / Time	19/5	20/5
6am	X	Kalle Vikas
2pm	X	
10pm	X	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

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 ....

Patient Sticker

Sheet No: ....

REGULAR PRESCRIPTIONS

Dept. .... Ward. ....

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

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				

Weight. .... Ward. ....

DRUG :		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
19/5	1:30pm	Inj PARACETAMOL	315mg	iv	[illegible]	Pavitra (1:30pm)
19/5	1:40pm	Inj-TRANEXAMIC ACID	300mg	iv	[illegible]	Pavitra (1:45pm)
19/5	1:45pm	Inj DEXAMETHASONE	2mg	iv	[illegible]	Pavitra (1:50pm)
19/5	1:20pm	Inj. AUGMENTIN	630mg	IV	[illegible]	Pavitra (1:20pm)

21-03-2016
Dr. MANCHUKONDA SANTHOSH

I.V. FLUIDS CHART

Weight. 20.7 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
19/5	8am	Ivf. DNS	IV	50ml/hr	Sai	Baonali / Nitai	not connected		
19/5	1:15pm	RINGER LACTATE	iv	210ml/hr	S				

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

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Dr. MANCHUKONDA SANTHOSH

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
19/5	11:30 am	8	procedures	M	1	O	1	1	-NA-	Abhishek
20/1/24	9 am	9	soft diet	F	1	O	1	1	-	Monica

Part - III: CODES

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

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

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

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

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

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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
19/5 11:30AM	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Chronic Adenotonsillitis	For Hemodynamic stability	Adenotonsillectomy with coblation	Jayasri	☑ Nursing ☐ Others:
19/5 11:30AM	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Chronic Adenotonsillitis	Hemodynamic Stability	Adenotonsillectomy with coblation	Abhishek	☑ Medical ☐ Others:
21/5/26 9am	☐ Medical ☐ Nursing ☑ Others: Dietitian	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Adenotonsillitis	Soft diet	RDA E - 1550 kcal/d P - 27 g/d	Mounica	☐ Medical ☐ Nursing ☑ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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ipo – 8:30pm (Solid)
8:30 AM (Coconut water)

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Krishna. Srihan. Age : 8y 1M Gender: ☑ Male ☐ Female

Date : 19/05/26 Time of Arrival : 10:32 AM Triage Completion Time : 10:34AM

Allergies: ☐ No ☑ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies

Source of Information : ☑ Parents ☐ Others (Specify) Nil

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

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

Initial Vital Signs: Temp: 98.2°F PR: 103b/m BP: 95/50(58) RR: 22b/m SpO2: 98% RA

Chief Complaints: Came for. Coblation Adeno Tonsilectomy

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

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

* CTAS - Canadian Triage and Acuity Scale

K. [signature]
Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No

   If yes, State Location: ....

2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : NR Subnu Signature of Triage Nurse : [signature]

Date & Time : 19/05/26 at 10:34 AM

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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Master K. KRISHNA SRIHAN (M)
21-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

19/5/26

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	6pm	10pm	2Am	6am
Date : .... Time:	6pm	10pm	2Am	6am
Doctor / Nurse / Family Concern?				
Temperature (F) (94–104)	98.2°F	96.3°F	96.2°F	94.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190)	106/58 (67)	103/60 (76)	101/56 (65)	96/63 (59)
Heart Rate (Number)	118 b/m	102 B/m	112 B/m	106 B/m
Resp. Rate (bpm) (Over 1 Minute) * (10–70)				
Resp Rate (Number)	26 b/m	24 B/m	22 B/m	24 B/m
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min)	1L		RA	RA
O_2 Saturations (%)	100%	100%	99%	
Conscious Level: Normal / Altered				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]		[illegible]

Note: BP does not score in early warning scoring

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

19/5/26

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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	↑		–							0	Dipanwita
19/5	06:00 pm	No	Idly	–			Np			✓	0	Dipanwita
	07:00 pm	IVF ↓	Dates	–							0	Dipanwita
Total Intake :						Total Output : M – 0 U – 1						
	08:00 pm		Ice	–							0	Swati
	09:00 pm		cream	–						✓	0	Swati
	10:00 pm	No		–			Np				0	Swati
	11:00 pm	IVF		–						✓	0	Swati
	12:00 am			–							0	Swati
	01:00 am	↓		–							0	Swati
Total Intake :						Total Output : M – U – 2						
	02:00 am			–							0	Swati
	03:00 am	No		–						✓	0	Swati
	04:00 am	IVF		–			Np				0	Swati
	05:00 am			–						✓	0	Swati
	06:00 am			–							0	Swati
	07:00 am	↓	Milk	–						✓	0	Swati
Total Intake :			Good			Total Output : M – U – 3						

OT (written across the 08:00 am – 05:00 pm rows with arrows)

Total 24 hrs. Intake	

Total 24 hrs. Output	M – 0 U – 5

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FLUID CHART

Sheet No. : 20/5/26

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

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

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

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: ADENO-TONSILLECTOMY c̄ COBLATION

Anaesthesiologist: Dr. Ayesha Surgeon: Dr. SANTHOSH KUMAR

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 Laryngospasm, Bronchospasm

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: K. Sahitya

Relationship with patient: Mother

Date & Time: 18/5/26, 12:55pm

Witness:

Signature: [signature]

Name: Deena

Date & Time: 18/5/26 @ 12:55pm

Doctor (who is taking consent):

Signature: [signature] Name: Dr. Sk. Ayesha Date 18/5/26 Time: 12:55pm

Patient Sticker

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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 రిస్క్:

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

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ 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: ....

CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 28 D (M)
Dr. MANCHUKONDA SANTHOSH

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

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

1. coblation Adenoidectomy
2. & Tonsillectomy (Intracapsular)

I acknowledge the following:

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

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Nose block M-breathing	

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

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

a.

b.

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

Patient / Patient Attendant:

Signature: [signature]

Name: K. Sahithya

Relationship with patient: Mother

Date & Time: 19/5/26, 12:54pm

Witness:

Signature: [signature]

Name: A. Sangeetha

Date & Time: 19/5/26, 12:54pm

Doctor (who is taking consent):

Signature: [signature] Name: Dr M. Santhosh Date 19/5/26 Time: 12:50 pm

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

శస్త్రచికిత్స / ప్రొసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 ....

2 ....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రొసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రొసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రొసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రొసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b.

1. 4. డాక్టర్ ______________________ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రొసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రొసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
   ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: ....

పేర్లు: ....

రోగితో సంబంధం: ....

తేదీ & సమయం: ....

సాక్షి:

సంతకం: ....

పేరు: ....

తేదీ & సమయం: ....

డాక్టర్ :

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

UV-00171083 IP5-00174013
aster K. KRISHNA SRIHAN
-03-2018 8 Y 1 M 28 D (M)
. MANCHUKONDA SANTHOSH

SURGICAL SAFETY C[illegible]

Patient Name : Mt. K.Krishna Srihan Age : 8y Gender : M

UHID No. : .... Surgery Name : ....

Date : .... In-time : .... Out-time : ....

Before Induction of Anaesthesia ➢➢

SIGN IN Time: 12:40AM

Patient Has Confirmed

- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☑ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:

- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☑ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : [signature]

Name : Dr. Nikita

Before Skin Incision ➢➢

TIME OUT Time: 1:23pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, 1hr Anticipated Blood Loss? ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews: Laryngospasm, Bronchospasm

Are There Any Patient-specific Concerns? ☑ Yes ☐ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☑ Yes ☐ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [signature]

Name : Teena

Before Patient Leaves Operating Room

SIGN OUT Time: 2:25 pm

Nurse Verbally Confirms with the Team:

- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☐ Yes ☐ No ☑ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : [signature]

Name : DR. M. Santhosh

Patient Sticker: UV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
1-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 19/5/26

To Be Filled In By Assigned Nurse :

Department : P. OT   Duration of Procedure : 1 hr

Name of Surgeon : DR. M. Santhosh   Date of Admission : 19/5/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : Inj. Augmentin	[signature]
2.	Hair Removal ☐ Yes ☑ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : .... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	[signature]
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	[signature]
4.	Name of doctor or staff administering the antibiotic : Amaan Date & Time of antibiotic administration : 19/5/26 @ 1:20 pm Date & Time procedure started : 19/5/26 @ 1:20 pm	[signature]

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

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

Patient UV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN (M)
1-03-2018 8 Y 1 M 28 D
Dr. MANCHUKONDA SANTHOSH

POST-SURGICAL CARE PLAN FORM

Procedure Done: ....

Post-Surgical Diagnosis: ....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: .... Time: ....

Note: Plan of care will be readjusted if necessary.

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CUV-00171083 IP5-00174013
Master K. KRISHNA SRIHAN
21-03-2018 8 Y 1 M 29 D (M)
Dr. MANCHUKONDA SANTHOSH

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/1/26 Time: 9:00am

Weight: 20.7kg Centile: 5th

Height: 120 cm Centile: 75th

Inference: Under weight Child

RDA: – Calories: 1550 kcal/d Protein: 27g/d

Diet Recommendations: Soft diet

Re-Assesment: Avoid spicy, outside Foods

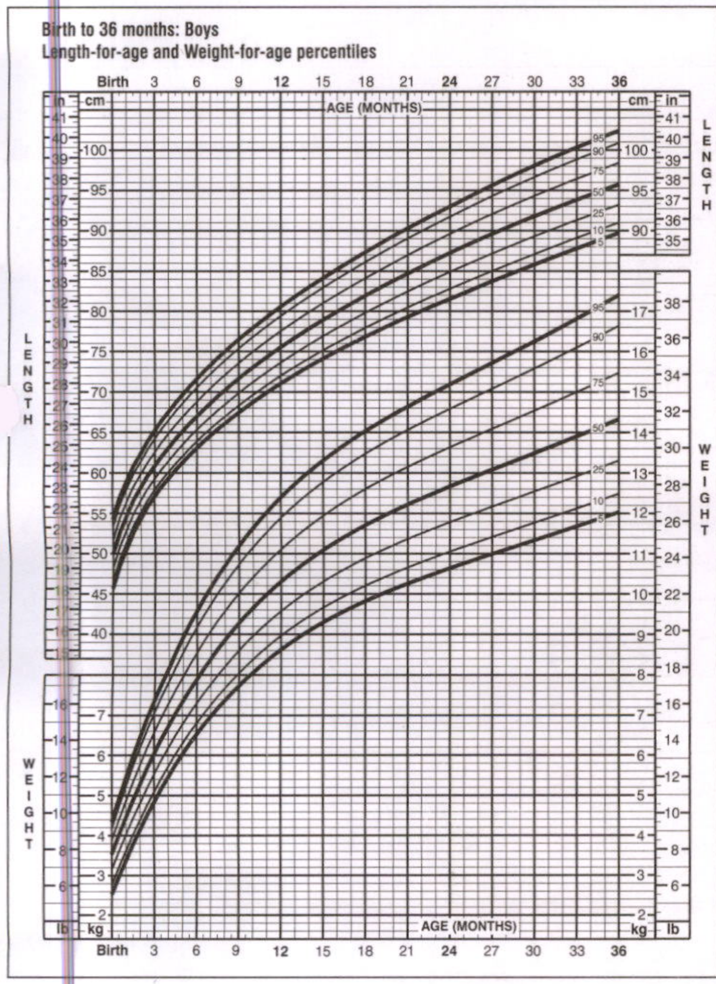
Food Allergies: NO Veg/Non-veg Non-veg.

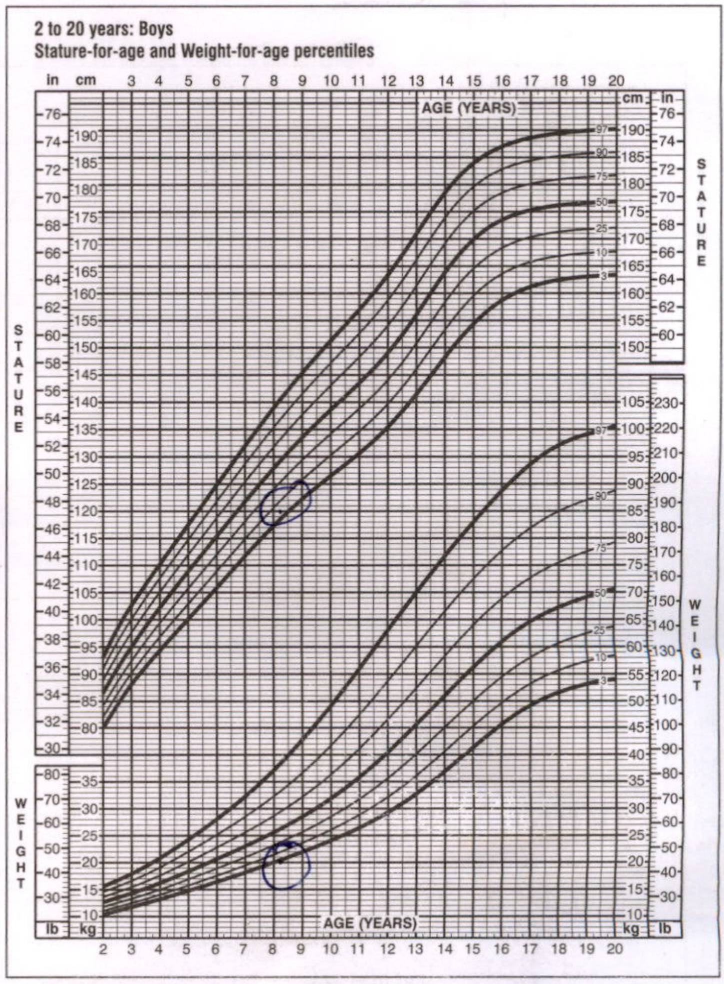
Diagnosis: Adenotonsillectomy

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (BOYS)





Dietician's Name Mounica Dietician's Signature Mounica

Daily Notes: