

BAH-00381399 IPS-00176650
Master VIHAS DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR



Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

81135
frtfrt
SURGERY DETAILS

Date: *20/7/26*
Patient Name: *Mr. V. V. Domala* Date of Birth: *3/9/2018* Age: *7 yrs*
Gender: *Male* Ward: *POT* UHID No.: *BAH-00381399*

Date of Surgery: *20/7/26* ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: *Incisional Biopsies of intrabony lesions from bilateral mandibular Body regions.*

Time in: *4:30pm*

*Care
rut*

Time Out: *5:30pm*

NAME

AMOUNT

1. Surgeon : *V. GIRIDHAR KUMAR.*
2. Anaesthetist : *Dr. Akhila*
3. Assistant Surgeon :
4. OT Technician : *Vijay*
5. Circulating Nurse :
6. Assistant Nurse : *Alam*

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

V. Giridhar Kumar
Signature of the Surgeon

Alam
Signature of Circulating Nurse

Order No: *9713381*

Order by: *[Signature]*

BAH-00381399 IP5-00176650
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Biopsy of Cervix Multiparity
CONSUMABLES OF OT

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Technician : Date : 20/7 Time :

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used	Qty	Issued	Used	Qty	Issued	Used	Qty
ET tube (4.0, 4.5, 5.0)	1/14	01	Major Pack Drape	1	1	Inj Vit.K		
LMA 2, 2 1/2	1/1	—	Sutures			Cord Clamp		
ECG leads : A/P/N	5	03	viagra 40.50 (3-0)	2/2	1	Suction Catheter		
HME filter : A/P/N	07	01				Feeding Tube		
Syringes : 10 cc	10	02				Vacuum Suction Set		
05 cc	10	02	Gloves 6.6.5 7.7.5	2/2	—	Surgical Gloves		
02 cc	10	02	6.6.5 7.7.5	2/2	(12/1)	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A/P/N	01	—	Surgical blade 11.15	1/1	1	Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil			Nb 500 ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	01	01	Koochies			Transcutx	1	1
air spike	01	01	Ointments			Lexi Adrenaline	1	1
vacuum st	01	01	Suction Catheter			0.25 Analgin	1	—
Fentanyl	01	01	Cap, Mask	5/5	5/5	(10cc) (5cc)	2/2	2/1
Morphine			Gauze Pack nt	2/2	3	Ribbon Gauze	1	2
Ketamine			Mop Pack	1	1	26 Needle Long	1	1
Propofol	03	02	Steristrip					
Rocuronium	01	01	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	1			
Myopyrolate	01	01	Abgel					
Ondansetron	01	01	Foleys catheter			0.7 5.7	1/1	01
Pencan 25g/ Spinal Needle 22	01	—	Urobag			0.7 20/22	1/1	—
Bupivacaine 0.25%	0	—	Chest Drainage Catheter			0.2 male (P)	01	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			5cc per Pys (A)	01	—
Antibiotics			Bandage			5cc 4/6	1/1	—
Supcom	01	01	Tegaderm			Deamed (100)	01	—
Suppositories			Ioban			50cc 1 moype	1/1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Nasal drops	01	01
Supridol : 100mg			Vacuum Suction set	1	1			
Justin 12.5 mg / 25mg / 100mg	01/1	01	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
3cc 100cm 100cm	1/1	01	Microshield	1	1			
Gauze 4x4x2x2	3/3	01	Cotton Balls	1	—			
IV Cate 20/24	1/1	—	Latex Gloves	10P	10P			
Q-spike 1/1	1/1	—	Ramdone Scrub					
DeKort 1/1	1/1	—	Saral					

Surgeon 9713129 Anaesthesiologist Alam Nurse Y. Suresh OT Technician
Order No. : Ordered by :
Doc. No. : RCH / FRM / GENERAL / 125

ESTIMATION SLIP

Date: 18/07/2026 UHID / IP No.: 0055BAH-00383399 **81135** (planned on 20th July)

Name of Patient: BAH Master. Vihai Domalei Age: 74 Gender: M

Father's / Husband's Name: Mr. Diomeli. Wshme Corporate / Occupation: Greene Robotics

Address: _____ Phone: 9642408446 Email: (India)

Procedure / Plan: Cholecystectomy / Mammoplasty & fissure for Biopsy from both the lesions Bilaterally

MODE OF PAYMENT: ☐ SELF ☐ TPA: Care Health Insurance ☐ GIPSA: _____ OTHERS: _____

TARIFF INFORMATION: Dr. Giridhar / Dr. W. R. - Page 55k / 1 day with eqt 2 hiot

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee				13240						
L. Tax										

PARTICULARS	AMOUNT (₹)
Surgeon's / Anesthetists's Fee / O.T. Charges	Dr. 33600
O.T. Consumables	2500
Instrument Charges	Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations	As per actual - Not Included in Estimation
Equipment Charges	
Monitor :	Oxygen :
Ventilator :	HFO-SLE 5000 :
Phototherapy :	Double Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.	As per actual - Not Included in Estimation
Package	
Others	
Minimum Deposit	15,000 & Final sum - 15,000

REMARKS: 12:11 AM on 18/07/2026 Room Aged 5x STA.

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

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

Signature of the Client: M. Bhanu
Signatory Relationship: Mother
Signature of the Financial Counselor: Dr. H. S.

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CROSS CONSULTATION FORM

Doctor Name : Dr. Annapoorna Date : 20/7 21/7 Time : 10 AM

Diagnosis : POD - 1 mandibular biopsy

Hospital : RCH - B

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

→ doing well

→ O/E : stable vitals

chest clear.

oral cavity healthy

Adv.

Ⓚ today

Consultant :

Name : Dr. Annapoorna Signature : _____ Date & Time : 21/7

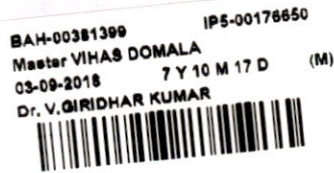
ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	9:25pm	ER	OT	
20/7	7:50pm	OT	304	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Annapoorna	20/7/26		Jessie
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]**ANY OTHER INFORMATION**

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176650 Admit Date : 20-Jul-2026 Admit Time : 01:57 PM UHID : BAH-00381399

Patient Details :

Patient Name : Master VIHAS DOMALA Age : 7 Y 10 M 17 D
Guardian : Mr DOMALA VISHNU DOB : 03-09-2018
Gender : Male Religion : Hindu
Occupation : Martial Status : Single
Address (H) : H NO. 8-3-228/D/53/A,MANILINGA SIRI
SAMPADA APARTMENTS, ICRISAT COLONY ,
VENKATAGIRI Jubilee Hills Hyderabad Phone No : 9642408446/ 7416570709
Telangana INDIA 500033 E-mail : vishnu.d@tarantula.net

Admission Details :

Bed Type : DAY CARE Bed No : POST OP 413 Ward Name : 4F-OT COMPLEX
Room No : POST OP 413 Admission Type : First Visit

Contact Details :

Name : Mr DOMALA VISHNU Relationship : Father
Contact Address : H NO. 8-3-228/D/53/A,MANILINGA SIRI Phone No : 9642408446
SAMPADA APARTMENTS, ICRISAT COLONY ,
VENKATAGIRI Jubilee Hills Hyderabad
Telangana INDIA 500033

P. B. Singh
Signature

Doctor Details :

Doctor Name : Dr. V.GIRIDHAR KUMAR Specialisation : DENTAL
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

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





PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

BAH-00381399 IP5-00178650
Master VIHAR DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR

UHID ID:



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Kidney mucopolysacchar Type III

Swelling in lower part on both sides
pain in both sides

History of present illness :

Kidney mucopolysacchar Type III

child presented with pain & swelling in lower part on both sides

no fever, no cough, no cold

4/4 Enucleated / macropalatal & have begun

Pediatric Multiorgan History & Physical Examination

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

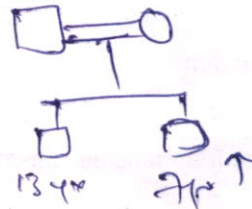
lelele muddipoddu Type 2

mild speech delay
Difficult to understand

Birth & Neonatal History:

FT/150x/1000

no h/o neonatal



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

mild speech delay
diff

Immunization History :

Vaccinated - all now



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 22.25 kg (Centile _____)

On Examination :

Temperature : 98.4 F Pulse Rate : 84 bpm B.P. 91/54 (62) SPO2 98%

Resp. rate and type of breathing : 20

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : RASCO

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : 2h+

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection Su

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regulr

Clinical Summary & Diagnostic:

Also mentioned - III
Relaxed eye lens



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: ceph

Desired goals of the treatment : stability

Planned Labs:

CBP - done on OPD basis

Planned Management

NPO in admi

Surgery - Small intestine resection
& Tube ligation

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Balaji

Date & Time: 20/2/26, 12.58 pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. S. S.

Date & Time: 21/2/26 10.2

Dr. Tadavarthi Annapoorna
Reg. No. 53354



DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date:

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



Patient St

OPERATION THEATER NOTES

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

UHID No.: Weight : Height :

Surgeon : V. GIRIDHAR KUMAR. Asst. Surgeon :

Anesthetist :

OT Nurse:

OT Technician:

Pre-Operative Diagnosis:

Surgical Procedure : Incisional Biopsies from bilateral mandibular body region (Intra bony)

Indications for Surgery : Radioluscent lesions causing osteolysis.

Date : 20/7/26

Start Time : 4.30 PM

End Time : 3.30 PM

Pre Operative Preparations:

Post Operative Diagnosis: FIBRO OSSEOUS LESIONS MANDIBLE BODY?

Peri-Operative Complications:

Operation Notes: G.A. nasotracheal intubation, throat pack in place, surgical site prepared and draped. 2% lignocaine with 1:200,000 adrenalin infiltrated into the surgical sites (bilaterally buccal vestibule and lingual vestibule). Mucoperiosteal flaps raised and incisional ~~to~~ Biopsy of the intra bony lesions done and marked No. 1 as left side lesion and No. 2 as right side lesion and stored in 10% formalin and dispatched for histopathological examination. Primary closure done using 3-0 vicryl on both sides and hemostasis

achieved. Throat pack removed
G.A reversed. Shifted to post-op.

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Two specimens obtained from Mandibular body intraony lesion

Peri-Operative Complications:

IV ~~A~~ AUGMENTIN 600mg

B.D.

IV $\rightarrow$ PARACIP ~~to~~ slow infusion.

Name of the Surgeon: V. GIRIDHAR DUNNA

Signature of the Surgeon: V. Giridhar Dunna

Date & Time: 20/7/26 5:00 PM.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7 10:30pm	S/B Resident POD-0 mandibular biopsy	
	no pain orally accepting O/E: alert stable vitals chest clear.	Adv: 1) doing well Allow orally 2) Meds as charted
		Attile
21/7/26 8am	Seen by Resident POD-1 mandibular biopsy	
	no issues doing well.	Adv
	O/E: alert vitals stable chest clear. oral cavity (N)	(D) today
		Attile
		noted by Sush 21/7/26 @ 8am

[illegible]

Patient Sticker

Vihav

BAH-00381300 IPS-00176650
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03-09-2018 7 Y 10 M 17 D (M)
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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:

Shifted to:

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Balaji

Date & Time : 20/7/20 1:45 pm

Nurse Name & Signature : Liji K

Date & Time : 20/7/20 2:10 pm

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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

DRUG CHART

Date of Admission: 20/12/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

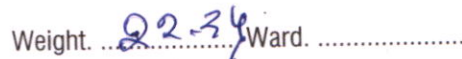
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

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

Signature
VERIFIED BY : Name

Weight. 22.2 kg. Ward.

Page: 2/4



VARIABLE DOSE		Date Time		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[illegible]



I.V. FLUIDS CHART

Weight. 22.2 kg. Ward.

[illegible]



SCHOOL AGE (5-12 years)

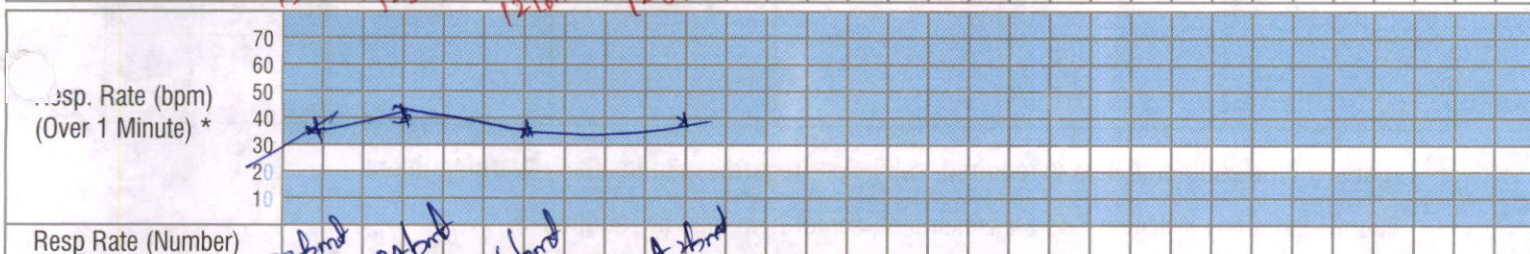
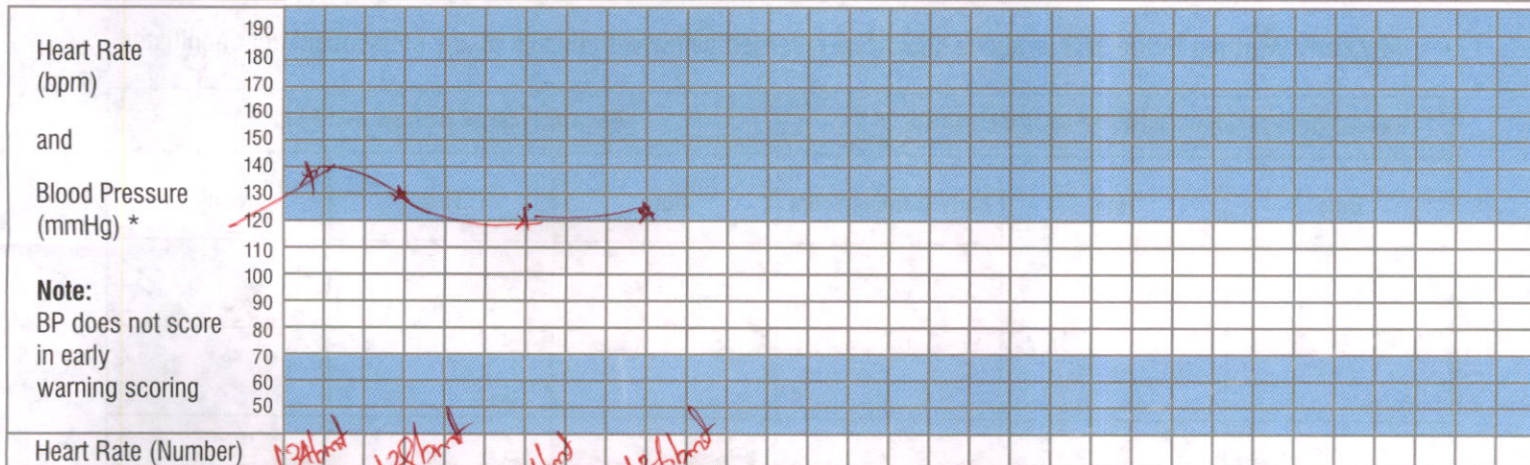
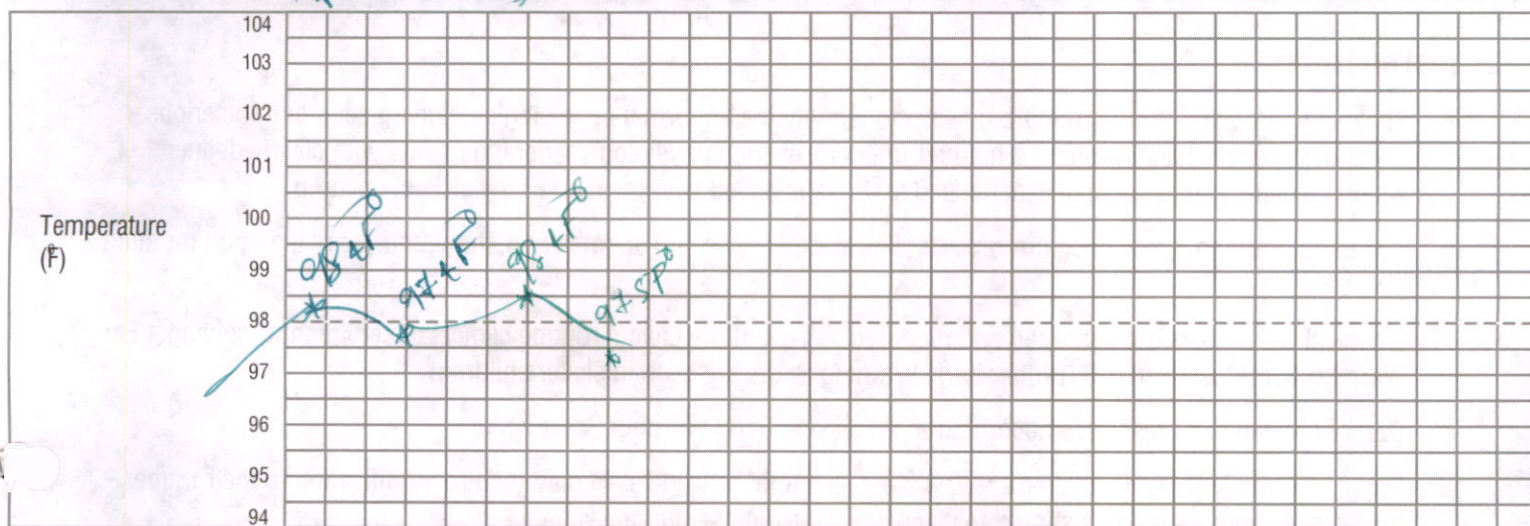
Children's Observation & Early Warning Scoring Chart

20/8/28

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern?



Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered (15/15) (15/15) (15/15) (15/15)

GCS *

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	gml	gml	R	L

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Patient Stic

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	H ₂ O										
	07:00 pm					NP			NP			
Total Intake :						Total Output : M-0 U-0						
	08:00 pm									0		Suck
	09:00 pm	H ₂ O							+	0		Suck
	10:00 pm									0		Suck
	11:00 pm	H ₂ O							NP	0		Suck
	12:00 am								1	0		Suck
	01:00 am	H ₂ O							1	0		Suck
Total Intake :						Total Output : M-0 U-0						
	02:00 am									0		Suck
	03:00 am	H ₂ O							+	0		Suck
	04:00 am									0		Suck
	05:00 am	H ₂ O							NP	0		Suck
	06:00 am								+	0		Suck
	07:00 am	H ₂ O							+	0		Suck
Total Intake :						Total Output : M-0 U-0						
Total 24 hrs. Intake												
Total 24 hrs. Output			M-0 U-0									

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20

21/7/26

FLUID CHART

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Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 27/10

Assessment: Acute pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
6 pm	Assess the pt General Condition. Relieve pain & Discomfort monitor vital signs monitor for bleeding maintain npo status pt shift to the ward	6 pm	Assessed the pt General Condition. Relieved pain & Discomfort monitored vital signs monitored for bleeding npo broken, water given maintained I/O chart pt shifted to the ward	pt is Conscious & oriented vital stable no bleeding no vomiting shifted
8:30a		8:30a		

Re-Assessment: No bleeding @ the Surgical Site

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Anil

Date & Time: 27/10 8:30



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: patient is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the patient condition and vitals check	8:30 pm	* Assessed the patient condition and vitals check	* now Patient condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12pm	* check the Fever spikes	12:30 AM	* checked the Fever spikes	
3pm	* Assess the pain and discomfort	3:30 AM	* Assessed the pain and discomfort	
6pm	* Administer medicine as per chart	6:30 AM	* Administered medicine as per chart	
7pm	* Ensure Safety	7:30 AM	* Ensured Safety	

Re-Assessment: Assess the patient condition now it is stable

Special Notes:

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

Date & Time: 20/7/26 @ 8pm

Patient



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. GIRIDHAR Department: Pediatric Date of Admission: 20/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known			
	<u>Cyst echin</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>2:25 PM</u>	<u>2:25 PM</u>	<u>2:25 PM</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.0 F</u>	<u>98.6 F</u>	<u>97.6 F</u>		
	Res:	<u>24 bpm</u>	<u>25 bpm</u>	<u>28 bpm</u>		
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>		
	Pulse:	<u>128 bpm</u>	<u>116 bpm</u>	<u>108 bpm</u>		
	BP:	<u>101/80</u>	<u>100/62</u>	<u>101/72</u>		
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>		
Recommendations	Pain Score:	<u>0/10</u>	<u>1/10</u>	<u>0/10</u>		
	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Auth.</u>	<u>Auth.</u>	<u>Sueho</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7</u>	<u>20/7</u>	<u>20/7/20</u>		
Time:		<u>2:25 PM</u>	<u>3 PM</u>	<u>8 AM</u>		
Taken Over By Name :		<u>Reena</u>	<u>Sueho</u>	<u>Syathi</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7</u>	<u>20/7/20</u>	<u>21/7</u>		
Time:		<u>2:30 PM</u>	<u>8 PM</u>	<u>8 AM</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	2pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Deet
20/7	5:30pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Deet
20/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Deet
21/7/26	12Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Deet
21/7/26	3Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Deet
21/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Deet
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

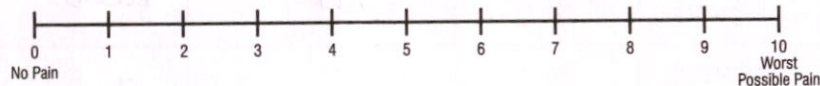
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

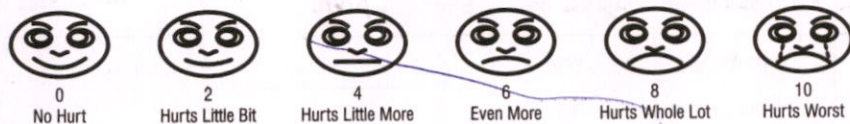
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



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BRADEN 'Q' SCALE

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					Date : 20/7	21/7		
					Time : 1 PM	8 AM		
Mobi.	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13- Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
					TOTAL SCORE			
					25 28			
					Evaluator's Name			
					Raj			

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	1st	1			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	1	1			
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2		1			
	Other Medications / None	1	1	1			
TOTAL			9	9			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate Lighting		✓	✓			
Wheel Chair Support		✓	✓			
Other Intervention(s) Specify		✓	✓			
Nurse's Name :		Reetika	Sush			
Signature :		12	Sush			
Date :		20/7	21/7/16			
Time :		2 PM	8 AM			



CHECKLIST FOR THROMBOPHLEBITIS

20/7/2018 2/1/17

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/7/2018	2 PM	8	Diagnostic / procedure	F	1	1	1	0	-	kei
21/7/2018	9:10 am	9	Normal diet	F, M	1	0	1	1	-	Saine

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 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7/26 1 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	chest evaluation	H. stability	procedure	[Signature]	☐ Nursing ☒ Others:
20/7/26 1 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	chest evaluation	H. stability	procedure	[Signature]	☒ Medical ☐ Others:
21/7/26 9:15 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 mandibular biopsy (biopsy)	Normal diet	<u>RDA</u> E: 1500kcal/d P: 26gm/d	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00381399 IP5-00176650
Master VIHAS DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 20/7

Department : P.O.T. Duration of Procedure :

Name of Surgeon : Dr. Giridhar Date of Admission : 20/7

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 :	<i>Paul</i>
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	<i>Paul</i>
3.	Patient's body temperature immediately post operation (Recovery Room) 37 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<i>Paul</i>
4.	Name of doctor or staff administering the antibiotic : 20/7 Date & Time of antibiotic administration : Date & Time procedure started : 20/7/26 @ 4.50 PM	<i>Paul</i>

- 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 :

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Incisional Biopsies of intra bony lesions from
Bilateral mandibular Body regions.
Post-Surgical Diagnosis: FIBROUS LESION.

Post-Operative Monitoring Parameters /Frequency:

Wound Care: Regular oral suctioning.
Extra oral ice pack applications.

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements: Recovery position semi reclined.

Nutritional Instructions: Cold and soft diet.

When to Start Mobilization: Once completely awake.

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

To report at Dental OPD with histopathology reports after 1 week.

N. Giridhar Kumar
Treating Surgeon
(Signature & Stamp)

Date: 20/7/26 Time: 5:15 PM.

Note: Plan of care will be readjusted if necessary.



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. Cystic lesion removed from lower jaw (bilaterally) present on
2. both sides right and left for biopsy purpose.

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Osteolytic lesions removed.</u>	

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

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

- a. Pain and swelling.
- D.

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

Patient / Patient Attendant:

Signature: P. Bhanu Priya
Name: Paladi Bhanu Priya
Relationship with patient: Mother
Date & Time: 20/7/26 3:58 PM

Witness:

Signature: D. Vishnu
Name: D. Vishnu
Date & Time: 20/7 3:58 PM

Doctor (who is taking consent):

Signature: V. Giridhar Name: V. GIRIDHAR KUMAR. Date: 20/7/26 Time: 3:30 PM.

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1
2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ ను నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

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

a.	
b.	

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Master C. Giridhar
Asst. Surgeon :
Anaesthetist :
Scrub Nurse : Rahul

Patient Name : Gender : M
UHID No. : Surgery Name : Biopsy lesion
Date : 20/7/16 In-time : 4:30 pm Out-time : 5:30 PM

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Master VIHAS DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR



Before Induction of Anaesthesia >>

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

Before Skin Incision >>

TIME OUT	Time: <u>4:50 pm</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>1 hr 15 min</u>	
☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <u>Bleeding, Difficult airway</u>	
☐ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No	
Signature : <u>Dr. Giridhar</u>	
Name : <u>Dr. Giridhar</u>	

Before Patient Leaves Operating Room

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

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
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 :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
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, Anticipated Blood Loss?		☐ Yes ☐ No ☐ NA
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?		☐ Yes ☐ No ☐ NA
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?		☐ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?		☐ Yes ☐ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.		☐ Yes ☐ No
Signature :		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
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 :		
Name :		



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2 pm Mode of Arrival: walking Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 22 Kg

..... NA Height: — cm

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Mucopolysaccharidosis III</u>	<u>NA</u>	<u>NA</u>

Family History: Nothing Significant

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If Yes, please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☒ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 22 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4 F HR: 88 bpm RR: 28 bpm BP: 90/50 mmHg

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

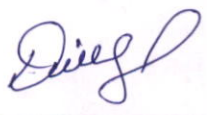
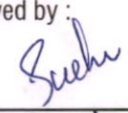
Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *Grand Mum*Siblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☐ Yes ☒ NoWaste Disposal Explained: ☐ Yes ☒ NoInfusion Pump : ☐ Yes ☒ NoHand hygiene Explained: ☐ Yes ☒ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *Mother*Nurse Signature: *[Signature]*Nurse Name: *Tamara*Date: *20/7/20*Time: *2:25 pm*

PATIENT TRANSFER FORM

Patient Name & ID BAH-00381399 Master VIHAS DOMALA 03-09-2018 7 Y 10 M 17 D (M) Dr. V. GIRIDHAR KUMAR 		Date & Time of Admission 20/7/26 @ 11:57	Date & Time of Transfer Order 20/7/26 @ 8 pm
		Transfer Ordered by Dr. Shilpa	Reason for Transfer Post-OP
From Unit OT	To Unit 304	Information to Attendant Yes ☐ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Shilpa	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 20/7/26 @ 8:15 pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

BAH-00381399
Master VIHAS DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctor order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

yes

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 10/7/20 @ 7pm

Docu. No. : RCHBH / FRM / CLINICAL / 191

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Vikas Domala Age: 7 Sex: male UHID.No: BATH 003F1349

Date: 15/7/2020 Time: 4:30 PM Proposed Operation: Cyst enucleation

Diagnosis: Cystic lesion as c ① and ② unerupted first molar

B.P / CRT: H.R: Weight: 22 Kg ASA Physical Status: ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: Glucose: Protein:
PCV: Urea: Alb:
WBC: Creat: Total Bill:
Plate: Na: Dir. Bill:
PT: K: LDH:
PTT: Ca++: Alk phos:
INR: Mg++: Amylase:
Cl -: SGOT/SGPT:

HIV: X-Ray: pan - 2 fish mouth vertebra
HBS Ag: ECG: 20/5/20
HCV: 2D Echo: Normal heart
Blood group: Stress/Angio: No skull lesion
T3: Other: No LWH
T4: NO PAH
TSH:

Allergies:

Medical History: CVS: K/O mucopolysaccharidosis III Term/Locs/3 Btgy/CIAB/Normal actin

RESP: - child was apparently normal Diabetes: - appeared normal with test

CNS: full 3 yrs of age

Renal: difficult in walking

Hepatic / GE: Physical Activity: active

Others: C/O spondyloepiphyseal dysplasia

Past Anaesthetic History: nil

Physical Exam: Pain on palpation of lower jaw, mouth opening w/o pain

Airway: MP 1 2 3 4 Mouth Opening: 2 F Mentohyoid Distance: Neck: short Teeth: w/ loose

Lungs: clear - limited lateral neck movement

Heart: S, S, D - large head

CNS: Gcs - full

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional: not done

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

(6) kindly bring recent echo.
(7) CBPA
(8) Anticipate difficult airway

Signature: [Signature] Name: Dr. SHARMA



ANAESTHESIA CHART



Difficult Airway

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status:

Adequate

Physical Status:

☒ Patient Identified

☐ Consent Present

☐ Chart Reviewed

H.R:

89 bpm

B.P / CRT:

120/80/75

SpO₂:

99%

R.R:

20

Last Feed:

6hr

Pre-OP Diagnosis:

Operation:

Urgent Blk amputation

Date:

25/8/2018

Surgeon:

Dr. Giridhar Kumar

Anaesthesiologist:

Dr. Srinivas

Technician:

TIME

N₂O / AIR / O₂ / FPM

HALO / SO / SEVO

Drugs:

Propofol 50mg
Morphine 2mg
Fentanyl 50ug
Rocuronium 10mg

FiO₂ / SaO₂

100% 100%

100% 100%

100% 100%

100% 100%

100% 100%

100% 100%

ETCO₂

35

38

35

34

34

34

ECG

82

82

82

82

82

82

Temperature

Urine Output

Fluids

Blood

Pre induction

B.P

240

V Systolic

220

A Diastolic

200

X Mean

180

Heart Rate

160

Tourniquet on Time

140

Tourniquet off Time

120

Throat Pack In

100

Throat Pack Out

80

60

40

20

10

0

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site:

☒ Art Site:

☒ EKG Lead

☒ Temp Site

☒ FiO₂ Monitor

☒ Agent Monitor

☒ Pulse Oximeter

☒ Capnograph

☒ Ventilator

☒ Nerve Stimulator

☒ Position: Supine

☒ Pressure Points Checked

☒ Eye Care:

☒ Oint

☒ Tape

☒ Padding

☒ Awake

Temp:

☒ HME

☒ Cling Film

☒ Hugger's

☒ Other

Times:

Anaes Start: 11:30am

OP Start: 11:30am

OP End: 5:30pm

Leave OR: 5:30pm

Anaesthesia:

☒ GA

☒ Monitored Anaesthesia Care

☒ Regional

Line (Size & Location)

☒ CVP: 22s

☒ ART: 22s

☒ IV: 22s

☒ IV: 22s

☒ IV: 22s

Induction

☒ IV

☒ Pre O₂

☒ Others

Mask

Airway

ETT#

Oral

Tracheostomy

Drug:

Awake

Video Laryngoscopy

Fiberoptic

Blade#

Difficulty Why?

Blat = BS

Semi Closed Circle

Closed Circle

Other

Regional:

Extremity

Spinal

Others:

Position:

Site:

Needle Size:

Depth:

Paresthesia

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

PACU

ICU

Other

Relaxant Reversed

Yes

No

NA

Name of the Doctor:

Signature of the Doctor:



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Cpt enucleation & GFA

Anaesthesiologist: Dr. SHARMA Surgeon: Dr. Srinivas

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, Bronchospasm, Laryngospasm, Difficult airway

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: P. Bani
Name: P. Shalpiya
Relationship with patient: Mother
Date & Time: 15/7/2016, 4:32

Witness:

Signature: [Signature]
Name: Bani
Date & Time: 15/7/2016 4:30pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Shalpiya Date 15/7/2016 Time: 4:30pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోదు, నొప్పి అనుభవించదు. 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 దీని 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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ 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 స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00381399 IP5-00176650
Master VIHAS DOMALA
03-09-2018 7 Y 10 M 17 D (M)
Dr. V. GIRIDHAR KUMAR

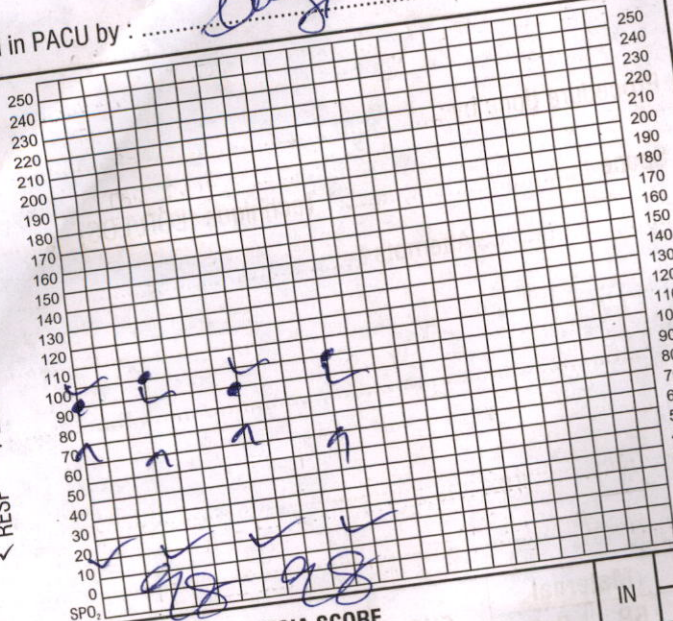
POST-ANAESTHESIA CARE UNIT RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Received in PACU by: Devgi Time Received: 5:35 PM Time Discharged: 2:28

< RESP • PULSE > < BLOOD PRESSURE >



IV Cannula Site: 228
☐ O₂ Mask ☒ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway
Vomiting: ☐ Yes ☒ No
NG Tube: ☐ Yes ☒ No
Drain: ☐ Yes ☒ No
Urinary Catheter: ☐ Yes ☒ No
Chest Tube: ☐ Yes ☒ No
Nil Oral ☐ Yes ☒ No
IV Fluids: 600 800 1000
Oral Feeds: 600 800 1000

POST ANAESTHESIA SCORE (Modified Aldrete Score)

	IN	30	60	90	OUT
Ability to move 4 extremities voluntary or on command = 2 = 1 = 0	1	1	1	2	
Ability to move 2 extremities voluntary or on command = 2 = 1 = 0	2	2	2	2	
Ability to move 0 extremities voluntary or on command = 2 = 1 = 0	2	2	2	2	
Ability to deep breathe & cough freely = 2 = 1 = 0	1	1	2	2	
BP $\pm$ 20 of Pre Anaesthetic level = 2 = 1 = 0	2	2	2	2	
BP $\pm$ 20-50 of Pre Anaesthetic level = 2 = 1 = 0	2	2	2	2	
Fully awake = 2 = 1 = 0	2	2	2	2	
Arousable on calling = 2 = 1 = 0	2	2	2	2	
Not responding = 2 = 1 = 0	2	2	2	2	
Pink = 2 = 1 = 0	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other = 2 = 1 = 0	2	2	2	2	
Cyanotic	2	2	2	2	
TOTAL	8	8	9	10	

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2017	5:35 PM	1/10		Devgi

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

Anaesthesiologist Name: Dr. Achinik

Anaesthesiologist Signature: [Signature]

Date & Time: 2017/26/08

PACU Nurse Name: [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 2017/26/08

Assessment Frequency:

Every eight hours for all hospitalized patients.

For post-operative patient, patient with chronic pain, patient with severe pain

a. Every 2 hours for first 24 hours

b. After 24 hours every 4 hours

c. Prior to pain relieving intervention

d. Within 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 304

Date & Time: 2017/26/08

Patient Sticker

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD



BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

CSE /Spinal /Epidural

Depth:

Solution Composition :

a)

Time	Infusion Rate

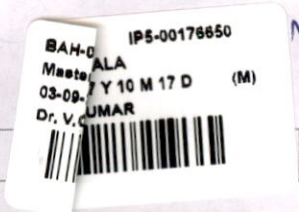
[illegible]

Delivery Details: Time: AfGA?: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Charge / Shifting ordered by
Signature.



VPO: 8.45 am (solid)



EMERGENCY ROOM TRIAGE FORM

Patient's Name : D. V. HAS Age : 7y ☒ Male ☐ Female
Date : 20/07/16 Time of Arrival : 1:25 pm Triage Completion Time : 2:00 pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): _____ ☐ Not known any drug Allergies
Source of Information : ☐ Parents ☐ Others (Specify) _____
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

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

Initial Vital Signs: Temp: 98.4 F PR: 84 bpm BP: 95/54 (64) RR: 20 bpm SpO₂: 100%
Chief Complaints: Came for procedure - Biopsy of Lesion / Massupali

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

P. Banerjee
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 : Banerjee

Signature of Triage Nurse : Banerjee

Date & Time : 20/07/16 - 1:25 pm

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



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/7/2018 Time of arrival : 1:29 pm
Chief Complaints : Came for procedure. Stopsy of leg
Height : Weight : 22.2019 BMI : Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify Nil
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☒ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☒ No
• Weak ☐ Yes ☒ No
• Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

F YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

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

Time of Initial assessment completed by ER Nurse : 20/7/2018 @ 2 pm

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

Time	Nursing Notes
<u>2pm</u>	→ Assess the pt & conscious.
	→ Seeh Dr. Ramya
	→ Vitals checked & Record
	→ Pt shifted to OT

Samples collected by: / ROFIKUL
 Samples sent by: / ROFIKUL

Time: / 1:50 pm
 Time: / 2:05 pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>103 bpm</u> BP: <u>95/61</u> CFT: <u>22 sec</u> RR: <u>24 bpm</u> SPO ₂ : <u>100%</u> GCS: <u>15/15</u> Temperature: <u>98°F</u> Pain Score: <u>0</u> Repeat RBS (if applicable): <u>Nil</u>	Shift - out from ER to: <u>OT</u> Time of Shift - out: <u>2:20pm</u> Handover given to: <u>Deena</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse: Sagar Signature of the Nurse: [Signature]

Date & Time: 20/7/20 @ 2pm

PATIENT TRANSFER FORM

Patient Name: BAH-00381399 IP5-00176650 Master VIHAS DOMALA 03-09-2018 7 Y 10 M 17 D (M) Dr. V. GIRIDHAR KUMAR 		Date & Time of Admission 20/7/26 @ 1:57 PM	Date & Time of Transfer Order 20/7/26 @ 2:25 PM
		Transfer Ordered by Dr. Ramya	Reason for Transfer Surgeonry
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? op file	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films Nil			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Rowne	1	
2.	Kooche	1	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : Teena			
Date & Time of Patient Received : 20/7/26 @ 2:30 pm			

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

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/7/26 Time: 9:30am

Weight: 22.2kg's Centile: >10th

Height: 120cm Centile: >10th

Inference: underweight child

RDA: - Calories: 1500 Kcal/D Protein: 20gm/D

Diet Recommendations: Normal diet

Re-Assessment: avoid spicy, chilled & outside foods

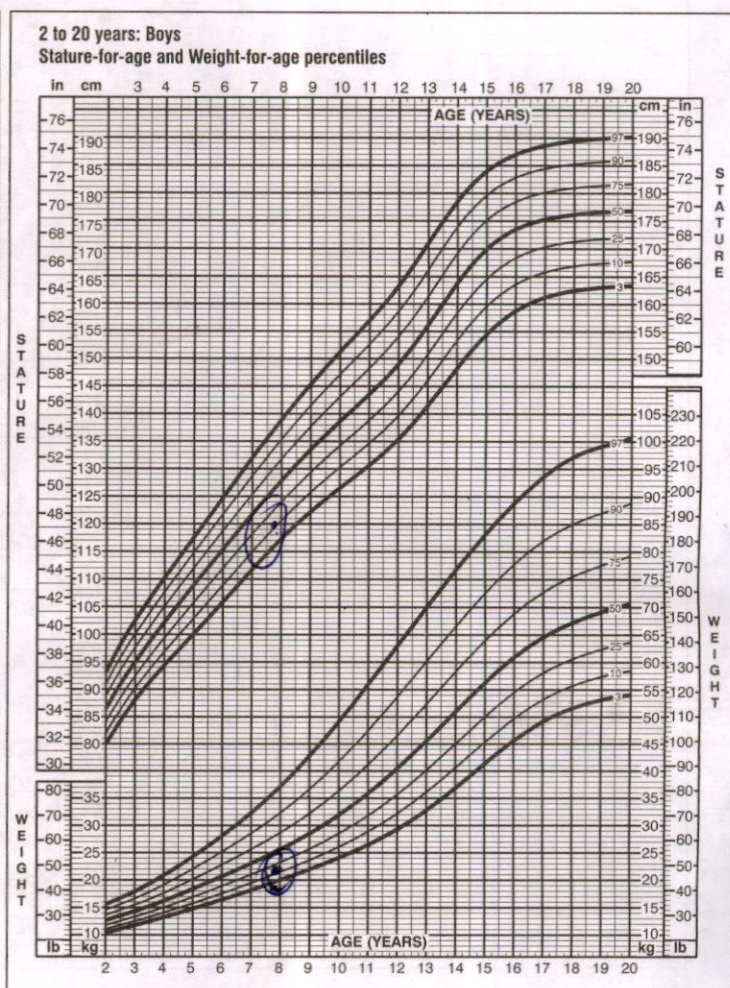
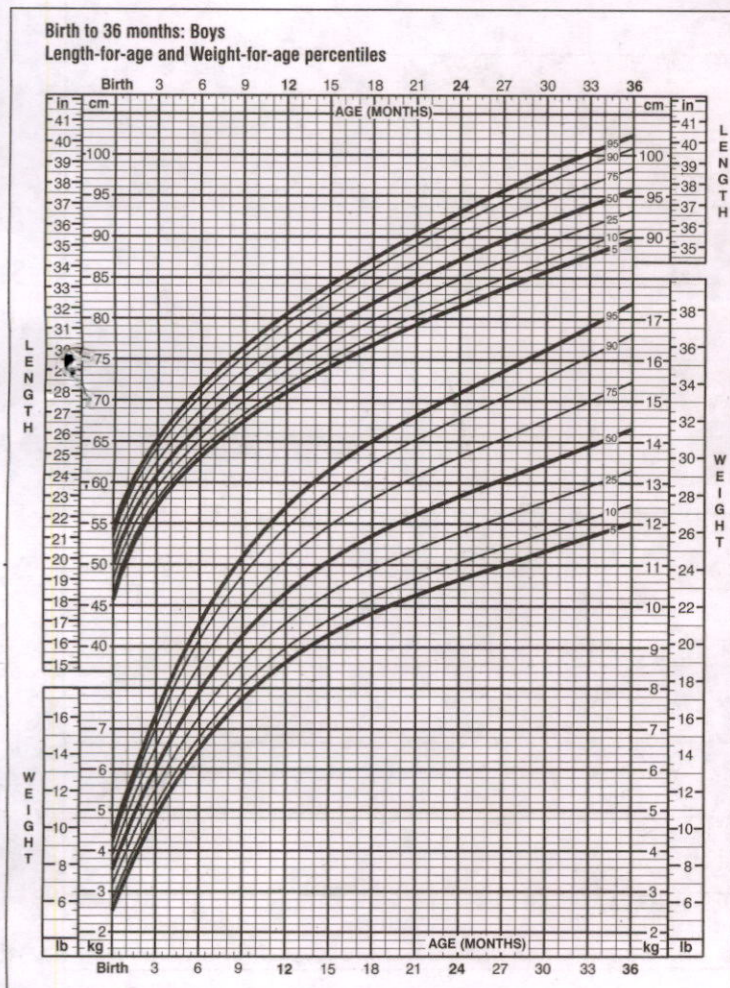
Food Allergies: NO Veg/Non-veg veg

Diagnosis: POD-1 / mandibular biopsy (biosepsis)

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Saini

Dietician's Signature: Saini

