



Verbal

SURGERY DETAILS

Date: 2/7/26

Patient Name: AKSHITA TRIPATHI Date of Birth: 10-11-2024 Age: 1Y

Gender: Female Ward: P. OT UHID No.: BAH-00653272

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

Name of the Surgery: Left thumb ECG guided uncrew LGA

Time in: 8:30 AM

Time Out: 1:15 PM

	NAME	AMOUNT
1. Surgeon	Dr. Raghu Samala / Dr. Praneech	SF 612 1,20,240
2. Anaesthetist	Dr. SHABNA	AF - 42070
3. Assistant Surgeon		OT - 96,192
4. OT Technician	Bapu	OTC - 9500
5. Circulating Nurse	Thyja	ASF - 12,024
6. Assistant Nurse	Jyothi, Alam	AAF - 12,024
		CSSD - 3607

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others ~~Neuro~~ microscope, cusa - 9684255

neuro drill → 9684255

Signature of the Surgeon

Dr. Raghu Samala

ECOG MONITORING USED

Signature of Circulating Nurse

Order No: 9684254 / 255 / 257

Order by: Jyothi

B10

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____ IP No. : _____ Patient : _____ Dept : _____
Date of Admission : _____ (F) Discharge : _____ Time : _____
Room / Bed No : _____ Ward : _____ Bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/7/26	6:10pm	ER	Ward	Abhishek
2/7	7:30am	118	OT	Sauranth
2/7/26	1:30pm	OT	PICU	Thy
3/7/26	5:23pm	PICU	118	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Sandeep Reddy	2/7/26	9684709	Sandeep
2				
3				
4				
5				
6				
7				
8				
9				
10				

(45)

[illegible]

BAH-00653272 IP5-00175833

Baby AKSHITA TRIPATHI

10-11-2024 1 Y 7 M 22 D (F)

Dr. PRASANTHI ARIPIRALA



CONSUMABLES OF OT

Technician : J. Bapu

Date : 11/7

Time : 8AM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Anaesthesia Disposables	Issued	Used	Surgical Disposables	Issued	Used	Disposables (Baby Side)	Issued	Used
ET tube 3.5 4.0 4.5	11/1	1	Major Pack Surgical pack	1	1	Inj Vit.K Multitube holder	1	1
LMA 7.5 3.5 4.0 4.5	11/1	1	Sutures 5003	1	1	Cord Clamp (florizen red)	2	11/1
ECG leads : A/P/N	5/1	1	Propofol 6-0, 1.0, 0.50	2/2	1	Suction Catheter	1	1
HME filter : A/P/N	1	1	Vit.K 20, 30, 40	2/2	1	Feeding Tube BS drill bit	1	1
Syringes : 10 cc	20	8				Vacuum Suction Set		
05 cc	20	8	Gloves 6, 6 1/2 (7) 7 1/2	2/2	1	Surgical Gloves 9109	2	8/1
02 cc	20	6	7F 6, 6 1/2 (7) 7 1/2	2/2	1	Gauze Pack 9237	2	8/2
01 cc	5	8				Syringe 1ml / 2ml 9201	2	1
Cautery plate : A/P/N	1	1	Surgical blade (11, 15)	2/2	1	Surgical Blade # 20 9093	2	1
IV set + Blood set	2/1	1/0	NG tube Surgical fibrillar	1	1	Koochies (S) 5085	1	1
RL + Monitor	1/1	2/0	Cautery pencil	1	1	NS 500ml	2	2
NS : 10ml / 100ml / 500ml / 1000ml	5/3/3	1/2	Koochies (X1)	1	1	Tongue	1	1
O2 MASK (P)	1	1	Ointments (Neuro patches)	1	1	10" 20" 15" 21/24 21/27 21/28	2	2
Alprazolam 0.1	1/1	1	Suction Catheter 20x10 20x20	1/1	1	Bone wax	1	1
Fentanyl	1	1	Cap, Mask	5/5	2/2	Surgical 2x3	1	1
Morphine			Gauze Pack (2x4)	5/5	4/5	Amwin 0.25/1	1	1
Ketamine BP kit	1	1	Mop Pack	1	1	Lot 2 Adhesive	1	1
Propofol	5	5	Steristrip			Marker Graze	1	1
Rocuronium	1	1	Underpad	1	1	Omey Gel	1	1
Glycopyrolate	1	1	Draw sheet	1	1	C-Arm cover	1	1
Myopyrolate + Neostigmine	2	2	Abgel	1	1	Conducting drop	1	1
Ondansetron	1	1	Foleys catheter 6 (S)	1/1	1	Clips 100, 200	2/2	1
Pencan 25g/ Spinal Needle 22	1	1	Urobag (urine meter)	1	1	Pineapple gum	2	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			Sely	1	1
Bupivacaine 0.25% (Heavy)			Romodrain bag Monosyn	2/2	1	Tranexa 21/24	2/2	1/0
Antibiotics Toricim 1gm + 500mg	1/1	1	Bandage 3.0/4.0			Jelco 22/24	2/2	1/0
Amikacin 100+250	1/1	1	Tegaderm			Tegaderm 1624+252	1/1	1
Suppositories			Ioban			305 Plk + Transofix	1/1	1
Anamol : 80mg / 250mg / 170 mg	1/1	1	Double J Stent			Cameacover + Midat	1/1	1
Supridol : 100mg			Vacuum Suction set	2	2	2x1x1x1 + 2x1x1x1	1/1	1/1
Justin : 12.5 mg / 25mg / 100mg	1/1	1	Plastic Bed Sheet	1	1	Atropine + Adrenaline	1/1	1/1
Tab. Misoprost : 200mg			Betadine Solution 100ml	1	1	Boc + pmoline	5/5	2/2
Vacuum set	2	2	Microshield	1	1	Heparin + Heplock	1/5	1
Gloves all (2)	4	1	Cotton Balls	1	1	Prologroom + Transpar	2/1	1/1
IV p.c.m	1	1	Latex Gloves	10/10	15/15	Microscope cover	1	1
3-way 100+10cm	5/5	2/0	Ramdone Scrub	1	1	Dexta + Tramexa	1/1	1/1
Gauze	5	1	Saral			Minisipine	3	0

Surgeon

Anaesthesiologist

Nurse

Order No. : 301 Paul 4/61 3/3 1-2/2

Ordered by :

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

Betadine

Splint 3/1 (NO) 1/1 = 1

Nasal Army 16.16.20 (1/1) 1/0

NCh. 5-6 7-8 9-10 10-11 11-12

Dextromide 50-1 1/0

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
01/07	Tv placement	1	2837	Isneep
	PAC	1	2838	Isneep
2/7	Catheterization	1	9684082	Thijs
2/7	Arterial h	1	u	
2/7	NHA	①	9608253	Prof

ANY OTHER INFORMATION

cf. brain - report ①

Date : 5/6/26

Time : @ 9.45 Am

Prepared By : Meelin

Staff Nurse

Meelin

Shift / Ward

YN - J

Billing Assistant

Billing Supervisor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175833 **Admit Date** : 01-Jul-2026 **Admit Time** : 04:34 PM **UHID** : BAH-00653272

Patient Details :

Patient Name	: Baby AKSHITA TRIPATHI	Age	: 1 Y 7 M 21 D
Guardian	: Mr DHARMENDRA TRIPATHI	DOB	: 10-11-2024 03:55 PM
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: ROAD NO 02, NEAR SAI KRISHNA SEVA SAMITHI Kothapet Hyderabad Telangana INDIA 500035	Phone No	: 6267973332/ 6261989628
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD **Bed No** : GW 118 **Ward Name** : 1F-GENERAL WARD I
Room No : GW 118 **Admission Type** : First Visit

Contact Details :

Name : Mr DHARMENDRA TRIPATHI **Relationship** : Father
Contact Address : ROAD NO 02, NEAR SAI KRISHNA SEVA
SAMITHI Kothapet Hyderabad Telangana INDIA
500035 **Phone No** : 6267973332 / 6261989628

Dharmendra
Signature

Doctor Details :

Doctor Name : Dr. PRASANTHI ARIPIRALA **Specialisation** : PEDIATRIC NEURO SURGERY
Referral Doctor : Self **Phone No** :
Co-Consultant : Dr. RAMESH KONANKI/ Dr. RAGHU SAMALA

Payment Details :

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

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	6			
7	Nursing plan of care and handover sheets	8			
8	Consultation sheet				
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)	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			
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
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)	2			
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				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
45	Extra	4			
Total No. of Pages		57			

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



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 21 D (F)
Dr. PRASANTHI ARIPIRALA



Patient Name: AKSHITA TRIPATHI.

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: infection

Desired goals of the treatment: surgical resolution of symptoms

Planned Labs:

CBP
PT
aPTT
- BT & CT
Blood group

Planned Management

- ward admission
- SA - TLM - Left FCD resection
under ECG guidance by Dr. Rajan
- Ivg levetiracetam
- Ivg valproate
- Vbg secret
- Reserve PRBC/FFP.
→ 30ml/kg

Signature of the Doctor: D. PM

Signature of the Consultant:

Name of the Doctor: Prasanthi

Name of the Consultant:

Date & Time: 01/02/2026, 4:30pm

Date & Time:



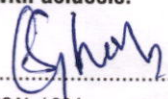
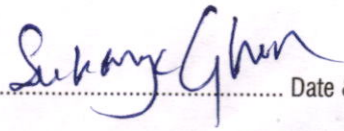
ADMISSION CRITERIA – PICU

Admission / Transfer from:

☐ Emergency ☐ Outpatient (OPD) ☒ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to PICU

- ☐ All patients requiring mechanical ventilation;
 - ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
 - ☐ All Paediatric patients after successful resuscitation;
 - ☐ **Comatose Patients;**
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
 - ☐ **All types of shock/hemodynamic instability:**
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
 - ☐ Cardiac arrhythmias after consulting with the treating consultant
 - ☐ Hypertensive Emergencies;
 - ☐ Severe acid base disorders;
 - ☐ Severe electrolyte abnormalities;
 - ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
 - ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
 - ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☒ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
 - ☐ Patients requiring nitric oxide therapy;
 - ☐ Malignant hyperpyrexia;
 - ☐ Acute hepatic failure
 - ☐ Severe dehydration with mental status change;
 - ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
- ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic and/or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4 seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
- ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O₂ Saturation < 90 % or need for O₂ > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO₂ < 60 torr, PaCO₂ > 50 torr.
 - ☐ Distress and risk of exhaustion
 - ☐ **Change of level of consciousness: GCS < 13.**
 - ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor:  Name of the Doctor:  Date & Time: 10/11/2024 3pm

DISCHARGE CRITERIA – PICU

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 21 D (F)
Dr. PRASANTHI ARIPIRALA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 1:40pm	case received	from OT.
	Diagnosis:- Drug refractory epilepsy	
	procedure:- ECOG guided resection of lesion	plan.
	in left frontal lobe.	1. keep NPO
	(? DNET / FCD).	
	sedation:- 7ug dexmedetomidine	2. send BP, S/E, ABG - now.
	7ug propofol	3. continue IV fluids 40ml/hr.
	7ug Fentanyl	
	7ug Rocuronium.	4. Monitor GCS - end hourly. pupils monitoring.
	Input:- 650ml RL	
	output:- 550ml	5. head end elevated to 30°
	Blood loss:- 30ml	6. Monitor vitals, urine output.
	Intra op:- uneventful	
	Vitals.	
	HR - 110	Dr. Mathan
	BP - 96/50 (60) mmHg.	
	RR - 22	
	SpO ₂ - 98% 2L NP	
	pupil - B/L 2mm 2mm reacting to light.	

Date & Time	Progress Notes	Doctor's Order
	ck/b <u>Neuroteam</u> 2/7/26 DRE - ② Aortal FCD ④ Epileptic Surgery → ② seizures ⑤ some of lesion. - No issues post op. ② vitale - stable. - Recognising mother - Full ② profile EEG - Symmetrical antigravity movements. ② reflexes.	
		<u>adv:</u> <u>Chw Depeharthi</u> Stop Hy: team add ② only continue para continue same ASMs. ② Bear's (plans) tomorrow <u>not by rule</u>
	Not Dr. [unclear] 12/02/26.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/11/26	Infantile onset drug refractory epilepsy - focal onset of motor seizures - 20 to left frontal FCD. Developmental delay (passive). - No new seizures. - Taking well orally - No fever spikes. Vitals stable - HMF → (N); Speech → to Reassess - EN → EOM full, RL pupils equal & reactive. - (N) tone. - Symmetrical antigravity movements - (N) reflexes - NO meningeal or cerebellar signs.	Adv: - CT Brain (plain) today - Oral intake - Shift to ward later - Remove PICC, catheter

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 22 D
Dr. PRASANTHI ARIPIRALA



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BirthRight™
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Your Right to a Safe Delivery

DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 01/07/26 Day of Admission : (3) Today's Date & Time : 01/07/26 @ 4:00am
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Δ: (L) frontal lesion (PNET) & DRS plenty	Current Issues : → Post-op monitoring
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : Atelectasis (L) chest clear,	
	CXR : 98% LRA	
	SPO ₂ : O ₂ by NC / FM / NRB mask / Oxyhood, at L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : Nitric Oxide : ☐ Yes ☒ No - If Yes, details :	
	Ventilatory Settings : Leak around ETT : Delivered Vt :	
	ABG : EtCO ₂ : P/F ratio : O.I. :	
	Chest Physiotherapy Plan : Suctioning Needs :	
	Any Nebs : ICD ? ☐ Yes ☒ No, if Yes, details :	
	Plan of care : no intervention needed	
	CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : No murmur
Quality of Pulses : well felt cap refill Time : < 2 sec Liver Edge : NP. cm below Rt costal margin		
Blood Pressures : NIBP : 114/66 mmHg IBP : CVP :		
Infusion of : ☐ Dopamine mcg / kg / min - ☐ Dobutamine mcg / kg / min		
☐ Epinephrine mcg / kg / min - ☐ Nor Epinephrine mcg / kg / min		
☐ Milrinone mcg / kg / min		
Any Other Infusions :		
Last 2D Echo Findings :		
Size of the heart and lung fields in latest CXR :		
Arterial line in situ : ☐ Yes ☒ No Place of art, line & its condition :		
CNS	Central line in situ : ☐ Yes ☒ No Place of central line & its condition :	
	Day of arterial line : Day of Central line :	
	Plan of Care : change	
	Neuro Exam : GCS = 15/15 normal interaction with mother	
	Pupils : 6/4 pupil R (L) Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : Types of Paralysis :	
Relevant CT Scan, MRI EEG, Neurosonogram etc. :		
Plan of Care : ct neurologist monitor & w/c residue Ramsay Sedation Score :		

+ 33mm balance

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : / (+/-) Input : ml/k/d UO : 2.8 ml/kg/hr Stools :	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
INFECTION	IV Fluids - Type of IVF : DNS @ 20 ml / hr (50% times maintenance)	
	TPN : ☐ Yes ☒ No - If yes, details :	
	% of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)	
	Cal/kg/d Nitrogen Trace elements & MVI	
NEPHROLOGY ISSUES	Labs : Na 141 K 4.1 Cl 114 Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT : 7 (N)	
	Abd Exam :	
	Any organomegaly ? ☐ Yes ☒ No - If yes, describe :	
HEMATOLOGY	Plan (G.I. & Liver) :	
	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☐ Yes ☐ No - If yes, details :	
	Describe c/s Reports :	
CARE PROTOCOLS	Other Labs (Latex, Serology, etc) : (N) → Cefotaxime Day (2).	
	Ongoing Antibiotics :	
	Sr. Creat : 0.7 Bld. Urea : Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
FINAL COMMENTS	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☐ Yes ☐ No - If yes, then day of Catheter :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
	Plan of Care :	
CARE PROTOCOLS	Relevant Labs (CBP etc) :	
	Any Coagulopathy :	
	Relevant Transfusion History :	
	Plan of Care :	
CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☐ No ☐ NA	
	CRBSI Bundle Used ? : ☐ Yes ☐ No ☐ NA	
	CA - UTI Bundle Used ? : ☐ Yes ☐ No ☐ NA	
	Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA	
FINAL COMMENTS	If yes, then details :	
	Pending Lab Results : ☐ Yes ☐ No	
	If yes, then details :	
	Pending Consultations : ☐ Yes ☐ No	
FINAL COMMENTS	If yes, then details :	
	1) Neurological Monitoring	
	4) Wk Feiten	

Doctor's Name (Handover given) :

Signature :

Date & Time :

[Handwritten Signature]
28/08/2020 18:00

Doctor's Name (Handover taken) :

Signature :

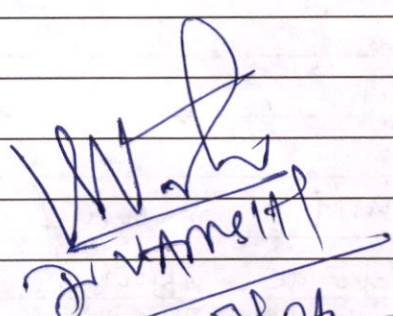
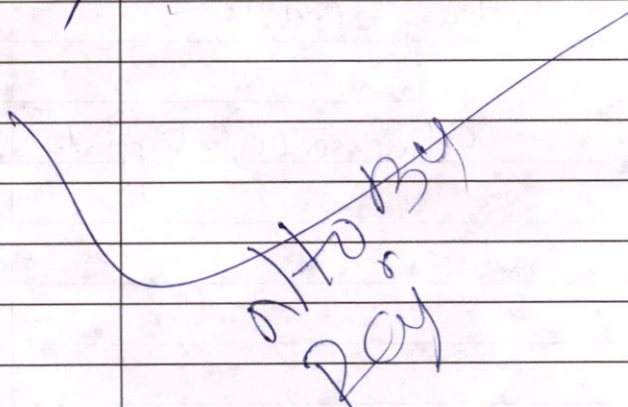
Date & Time :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/2026	cls/B Dr. Pranshu	
		Adv
		① CT head plain white
		Shifting
		② Remove Foley
		③ No IV fluids
		④ Fully oral
		⑤ shift toward
		N.B.
		Ray
		Dr. Pranshu
3/2/26	S/B Dr. Pranshu	
11am	left frontal FED	
	post resection	
	no tears	play -
	taking orally	- shift to ward
	active	- change ABM to oral
	sitting on support.	- CT scan plain.
		- change paracetamol
		to oral 5m.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>SHIFTING NOTES-</u>	
03/07/26 11:30am	Δ: (G) frontal FCD 2 DNET slp EEG guided exc i DRE	
	child was shifted to PICU for monitoring ventilator course in PICU	
	T - 98.6 F P - 126/80 mm R - 29/min RR - 100/60/min SpO ₂ - 98% on RA	
		<u>PLAN</u>
		1) CT brain prior to shift
		2) w/f seizures
		3) Inform PICU team if any issue
		4) oral intake
	 Dr. Pranshi Aripirala 03/07/26 11:40am	 Dr. Pranshi Aripirala



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[illegible]

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 22 D (F)
Dr. PRASANTHI ARIPIRALA



B positive.

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Children's
Hospital**
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RESULT SHEET

Date	1/7/26	2/7/26			
Time	6pm	2pm			
Hb	11.7	9.5 ↓			
PCV	36.7	30.5			
RBC	4.43	3.59			
WBC	9730	3270			
N/L	31/64	57/39			
Platelets	165000	108000 ↓			
CRP					
ESR					
PCT					
RBS					
Na		141			
K		4.1			
Cl		114			
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	14/1.0				
APTT	36				
CSF Protein / Sugar					
Cells					
N/L					

BAH-00853272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 21 D (F)
Dr. PRASANTHI ARIPIRALA



MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syr. Levetiracetam	4ml	PO	12h		☐ C ☐ DC
2	VIBY SATUR	2-1/2	PO	12h		☐ C ☐ DC
3	T. Clobazam	1/2-2mg	PO	12h		☐ C ☐ DC
4	Syr. valproic	2.5ml	PO	12h		☐ 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: N. Senthil Kumar - N.S.

Date & Time: 01/07/26, 5pm

Nurse Name & Signature: Abhishek

Date & Time: 01/7/26 5pm

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 24 D (F)
Dr. PRASANTHI APIPIRALA

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: PIU

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
	INJ CEFOTAXIM	550m	IV	TID		☐ C ☐ DC
2	INJ PARACETAMOL	110m	IV	TID		☐ C ☐ DC
3	Syr LEVERA (1ml = 100mg)	4ml	PO	BD		☐ C ☐ DC
4	VIRYCAUTET (500mg)	1 sachet - 1/2 sachet	PO	BD		☐ C ☐ DC
5	TAB CLOBAZAM	1/2 tab 2 tab	PO	BD		☐ C ☐ DC
6	Syr VALPROATE	2.5ml	PO	BD		☐ C ☐ DC
	TAB CLOBAZAM	1/2 tab - 2 tab	PO	BD		☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Vameith

Date & Time : 02/02/26 11:40am

Nurse Name & Signature: Pay

Date & Time : 3/6/26



DRUG CHART

Date of Admission: Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 11.4kg Ward. 81

DRUG : <u>ly. LEVETIRACETAM</u>				Date Time	1/7	2/7	3/7													
Dose	Route	Frequency	Start Date																	
400mg	IV	12H	01/7	6AM	X	pram Savath	Sim													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				change to 6pm Savath Piv																
Daily Doctor's Endorsement by a Sign				7 7 7																
DRUG : <u>ly. VALPROX AUD</u>				Date Time	1/7	2/7	3/7													
Dose	Route	Frequency	Start Date																	
100mg	IV	12H	01/7	10AM	X	pram Savath														
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				change to 10pm pram Savath Savath																
Daily Doctor's Endorsement by a Sign				7 7 7																
DRUG : <u>VIBY SACHET (500mg)</u>				Date Time	1/7	2/7	3/7	4/7	5/7											
Dose	Route	Frequency	Start Date																	
	PO	12H	01/7	6AM	X	pram Savath	pram Savath	pram Savath	pram Savath											
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				change to 6pm Savath NPO pram Savath pram Savath pram Savath																
Daily Doctor's Endorsement by a Sign				7 7 7																
DRUG : <u>TAB. CLONAZAM</u>				Date Time	1/7	2/7	3/7	4/7	5/7											
Dose	Route	Frequency	Start Date																	
	PO	12H	01/7	6AM	X	pram Savath	pram Savath	pram Savath	pram Savath											
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				change to 6pm Savath pram Savath pram Savath pram Savath																
Daily Doctor's Endorsement by a Sign				7 7 7																

Sheet No:

REGULAR PRESCRIPTIONS

Weight 11.4kg Ward DT

DRUG : INJ CETOTAXIME				Date Time																
Dose	Route	Frequency	Start Dt.																	
550mg	IV	TID	2/7/26	8am	X	8pm	X	8am	X											
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Nuthreen																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : INJ PARACETANOL				Date Time																
Dose	Route	Frequency	Start Dt.																	
110mg	IV	TID	2/7/26	6am	X	8pm	X	8am	X											
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Nuthreen																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : INJ TRAMADOL				Date Time																
Dose	Route	Frequency	Start Dt.																	
11mg	IV	TID	2/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Nuthreen																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : SUP. BEVETKACETAM				Date Time																
Dose	Route	Frequency	Start Dt.																	
6ml	PO	BD	3/7	6am																
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>SYP. VALPROATE</u>				Date Time	<u>3/7</u>	<u>4/7</u>													
Dose	Route	Frequency	Start Dt.																
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>Syp. CROCIN DS</u>				Date Time	<u>4/7</u>	<u>5/7</u>													
Dose	Route	Frequency	Start Dt.																
<u>2.5ml</u>	<u>PO</u>	<u>Q8H</u>	<u>04/07</u>																
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																			



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
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		Dose		Dose		Dose		Dose		
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		
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
2/7	8 ⁵⁰ am	Inj. LEFOTAXIM	550mg	IV	EL	Thirun. Bapu
2/7	12:30pm	Inj. PARACETAMOL	150mg	IV	EL	Ruh
3/7	12:15pm	Inj. AVIL	6mg	IV	EL	Pat
3/7	12:15pm	Syr. PEDICLOXYL	6ml	PO	EL	Pat

Weight. 11.4 kg Ward.



Nurse
Sign

[illegible]

VERIFIED BY : Name :

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 22 D (F)
Dr. PRASANTHI ARIPIRALA



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RSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 21-11-2024 @ 2pm
Source of Admission: ☐ OPD ☐ Ward ☒ Other: OT
Reason for Admission: Observation
Admission Diagnosis: Drug refractory Epilepsy
Accompanied By: ☐ Parent ☒ Guardian ☐ Other Name: _____
Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Other Specify _____
Do you require an interpreter? ☐ Yes ☒ No
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
If yes, identify _____

Source of Information: ☒ Family ☐ Patient ☐ Others, Specify _____

	Past Medical History	Past Surgical History	Last Hospital Admission
SIGNIFICANT HISTORY	<u>No past medical history</u>	<u>No past surgical history</u>	<u>Rainbow Hospital</u>
	Family History: <u>OT</u>		
	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 MEDICATIONS	Taking Medications? ☐ Yes ☒ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☒ No		
Observations: Weight: <u>11.4 kg</u> Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>98.6</u> HR: <u>96</u> RR: <u>20</u> BP: <u>99/49</u> Pain Score: <u>1/10</u> Specify Site: <u>Surgical site</u> (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: <u>21</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>20</u>) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

☐ Sleeping ☐ Crying ☐ Calm ☐ Distressed/Console ☒ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ 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):

Social History: Lives With FamilySiblings in household ☐ Yes ☒ No (if yes How Many?)

Orientation has been given regarding the following aspects:

- ☒ ID Band in situ
☒ Bedside safety explained
☐ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specifyName of Person Orientation was given to: Dr. Nathan

Orientation not given Reason:

Nurse Name: RahyNurse Signature: RahyDate & Time: 26/12 @ 2:20pm**DISCHARGE PLAN**Source of Information: ☒ Family ☐ FriendWill patient require transportation arrangements to go home: ☐ Yes ☒ NoWill Physiotherapy require at home: ☐ Yes ☒ NoIs home medical equipment anticipated: ☐ Yes ☒ NoIs home oxygen therapy anticipated: ☐ Yes ☒ NoAre dressing needs at home anticipated: ☐ Yes ☒ NoAny other needs anticipated: ☐ Yes ☒ No If Yes SpecifyDischarge Medications: ☐ Yes ☒ No

Details:

Final Diagnosis: EPI 1 dayNurse Name: RahyNurse Signature: (Signature)Date & Time: 26/12 @ 2:30pm

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 24 D (F)
Dr. PRASANTHI ARIPIRALA



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

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

Pratiksha
**Rainbow
Children's
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/11/24	Time: 2am	6am		
Doctor / Nurse / Family Concern?				
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	97.5 F	97.1 F	
	97			
	96			
	95			
	94			
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
	90			
Blood Pressure (mmHg) *	80	103 (81)	108 (84)	
	70			
	60			
	50			
	Note: BP does not score in early warning scoring			
	Heart Rate (Number)			
	102 bpm 104 bpm			
	Resp. Rate (bpm) (Over 1 Minute) *	70		
		60		
		50		
		40		
30				
20				
10				
Resp Rate (Number)				
26 bpm 28 bpm				
Resp Distress		Mod/ Severe		
None / Mild				
Receiving O ₂ (l/min)				
O ₂ Saturations (%)				
100% 100%				
Conscious Level	Normal			
Altered				
GCS *				
15/15 15/15				
TOTAL SCORE				
Number of shaded boxes	1	1		
Pain Score	0	0		
Observer's Initials				
6 8				

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : <u>31/12/26</u> ... Time: <u>4:17/126</u>													
Doctor / Nurse / Family Concern?		<u>11pm</u> <u>2am</u> <u>6am</u> <u>10am</u> <u>1pm</u> <u>6pm</u> <u>10pm</u>											
Temperature (F)	104												
	103												
	102												
	101												
	100												
	99												
	98												
	97												
	96												
	95												
94													
Heart Rate (bpm)	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
Blood Pressure (mmHg) *	90												
	80												
	70												
	60												
	50												
	40												
	30												
	20												
	10												
	0												
Note: BP does not score in early warning scoring													
Heart Rate (Number)		<u>110b/m</u> <u>118b/m</u> <u>110b/m</u> <u>116b/m</u> <u>118b/m</u>											
Resp. Rate (bpm) (Over 1 Minute) *		<u>24b/m</u> <u>28b</u> <u>26b</u> <u>26b/m</u> <u>28b/m</u>											
Resp Rate (Number)													
Resp Mod/ Severe Distress None / Mild													
Receiving O ₂ (l/min)													
O ₂ Saturations (%)		<u>100%</u> <u>99%</u> <u>99%</u> <u>100%</u> <u>100%</u>											
Conscious Level Normal / Altered													
GCS *		<u>15/15</u> <u>15/15</u> <u>15/15</u> <u>15/15</u> <u>15/15</u>											
TOTAL SCORE													
Number of shaded boxes		<u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u>											
Pain Score		<u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u>											
Observer's Initials		<u>c</u> <u>o</u> <u>o</u> <u>o</u> <u>o</u>											

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

BAH-00653272
Baby AKSHITA TRIPATHI
10-11-2024
Dr. PRASANTHI ARIPIRALA
IP5-00175833
1 Y 7 M 21 D
(F)

RCH/ FRM / CLINICAL / 125

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/11/24	Time: 6pm	10pm	2pm	8pm	6pm	10pm
Doctor / Nurse / Family Concern?						
Temperature (F)	97.5	97.5	98.5	99.0	98.5	100.3
Heart Rate (bpm)	114	102	100	128	110	110
Blood Pressure (mmHg) *	87/50	98/59	95/57	125/60	100/53	100/55
Resp. Rate (bpm) (Over 1 Minute) *	22	28	28	29	24	24
Receiving O ₂ (l/min)	0	0	0	0	0	0
O ₂ Saturations (%)	98%	100%	100%	96%	100%	100%
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1	1	1
Number of shaded boxes	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	P	P	P	P	P	P

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)

FLUID CHART

Sheet No. : ①

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

		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	1									0	Sourav Sourav Sourav Sourav
	09:00 pm	1									0	
	10:00 pm	100									0	
	11:00 pm	100									0	
	12:00 am	100									0	
	01:00 am	1									0	
Total Intake :						Total Output :						
	02:00 am	1			100ml						0	Sourav Sourav Sourav Sourav
	03:00 am	1			100ml						0	
	04:00 am	100			100ml						0	
	05:00 am	1			100ml						0	
	06:00 am	1			100ml						0	
	07:00 am	1			100ml						0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. : 2

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							
3/12	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
3/12	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :						Total Output :					
8/12	08:00 pm										0	
	09:00 pm										0	
	10:00 pm	NO SVP									0	Sur i
	11:00 pm										0	Sur
	12:00 am										0	
	01:00 am										0	
	Total Intake :						Total Output :					
4/12	02:00 am										6	
	03:00 am										0	Sur i
	04:00 am	NO SVP									0	Sur
	05:00 am										0	Sur
	06:00 am										0	
	07:00 am										0	Sur
	Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output						

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site	Sign. Nurse											
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score													
4/7			Mouth	I.V	N.G																		
	08:00 am					/					0	[Signature]											
	09:00 am					/				0													
	10:00 am	no IUF								0													
	11:00 am	Jelly water								0													
	12:00 pm					/				0													
01:00 pm					/				0														
Total Intake :						Total Output :																	
4/7	02:00 pm					/					0	[Signature]											
	03:00 pm	no IUF				/				0													
	04:00 pm	Dead Urine milk				/				0													
	05:00 pm					/				0													
	06:00 pm					/				0													
	07:00 pm					/				0													
Total Intake :						Total Output :																	
04/07	08:00 pm		Oral			/					0	[Signature]											
	09:00 pm		recl			/				0													
	10:00 pm	no IUF				/				0													
	11:00 pm		H2O			/				0													
	12:00 am					/				0													
	01:00 am					/				0													
Total Intake :						Total Output :																	
05/07	02:00 am					/					0	[Signature]											
	03:00 am					/				0													
	04:00 am	no IUF				/				0													
	05:00 am					/				0													
	06:00 am					/				0													
	07:00 am					/				0													
Total Intake :						Total Output :																	
Total 24 hrs. Intake												Total 24 hrs. Output											

Patient Sticker

FLUID CHART

Sheet No. :

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

		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

INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY

Name: Age: Gender: ☐ Male ☐ Female

UHID.No : Date:

I / We have been explained by Dr.
about the medical condition and the proposed procedure.

I / We have been told that our patient has
the following Medical Conditions / Diagnosis:

Left Frontal lesion C.DRB

Proposed Treatment / Procedure / Operation:

ECOG guided resection of Left frontal lesion & GA

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned
above and that our patient has following risks involved during the hospital stay

Weakness of limbs, CSF leak, meningitis, Pseudomeningocele, seizure disorder
60-70%, Risk of general Anesthesia

I / We have been explained risk, benefits and alternatives of the procedure.

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results,
complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no
guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

We have understood the consequences of not undergoing the proposed treatment.

I / We hereby give (my / our) full consent for the above – mentioned treatment.

I / We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences
arising from the treatment.

Patient (Or Patient Relative / Guardian):

Signature: x Kalpana

Name: Kalpana

Date & Time 2/7/26 @ 8²⁰ am

Doctor (Who is talking the consent)

Signature: Dr. Raylu

Name: Dr. Raylu

Date & Time 02.07.2026

Witness x JST

Signature: JST

Name: धनंजय प्रसाद तिवारी (मिमा)

Relative / Legal Guardian: (Relationship with Patient) Uncle

Address:

Date & Time 2/7/26 @ 8²⁰ am

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Praneeth
Asst. Surgeon :
Anaesthetist : Dr. Shabna
Scrub Nurse : Jyothi, Alam

Patient Name : Akshita Tripathi Age : 14.7m Gender : F
UHID No. : Bah00653272 Surgery Name : ECOG guided left frontal resection
Date : 2/7/26 In-time : 8:30 AM Out-time : 1:15 PM

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 22 D (F)
Dr. PRASANTHI ARIPIRALA



Before Induction of Anaesthesia ➤ ➤

Before Skin Incision ➤ ➤

Before Patient Leaves Operating Room

SIGN IN		Time: <u>8:25 AM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☒ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☐ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. SHABNA</u>		

TIME OUT		Time: <u>9:27 AM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>3 hrs</u> <u>identification of lesion</u> Anticipated Blood Loss? <u>20 ml</u> <u>intraop error</u> ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>Thejas</u>		

SIGN OUT		Time: <u>1:00 PM</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>R. Raghav</u>		



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 2/7/20

Department : P.O.T. Duration of Procedure : 3 hours

Name of Surgeon : Dr. Raghu, Dr. Praneeth Date of Admission : 1/7/20

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. ceftriaxone 550 mg	Thiya
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	Thiya
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Teena Date & Time of antibiotic administration : 2/7/20 @ 8:30 AM Date & Time procedure started : 2/7/20 @ 9:30 AM	Thiya

- 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



OPERATION THEATER NOTES

Patient's Name : AKSHITA TRIPATHI Age : 1 Y 7 M Gender : ☐ Male ☒ Female

UHID No.: BAH-00653272 Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist : <u>DR. SHBNA</u>	OT Nurse: <u>THOTHI, ALAM</u>	OT Technician: <u>BAPU</u>	
Pre-Operative Diagnosis: <u>Left frontal Lesion (DNBT/FCD) c DRE</u>			
Surgical Procedure : <u>ECOG guided resection of the lesion</u>			
Indications for Surgery : <u>Drug refractory focal epilepsy (Lesional)</u>			
Date : <u>02.07.2026</u>	Start Time : <u>9.30 AM</u>	End Time : <u>01.00 pm.</u>	
Pre Operative Preparations: <u>GA</u>			
<u>Asepsis</u>			
Post Operative Diagnosis: <u>Re Left frontal Lesion (?DNBT/FCD) c DRE</u>			
Peri-Operative Complications: <u>None</u>			
Operation Notes: <u>Under GA and asepsis,</u>			
<u>Craniotomy site was marked c neuronavigation.</u>			
<u>Left frontal craniotomy was done centered over the lesion.</u>			
<u>ECOG and depth electrode recordings were done.</u>			
<u>ECOG guided resection was done. Lesion was firm, evoked suckable and in the depth of sulcus (SFS)</u>			
<u>Post-resection ECOG was satisfactory. Hemostasis was achieved.</u>			
<u>Primary dural closure was done. Bone flap was replaced.</u>			
<u>Muscle was closed in layers and ASD was done.</u>			

BAH-00653272 IP5-00175833
Baby AKSHITA TRIPATHI
10-11-2024 1 Y 7 M 22 D (F)
Dr. PRASANTHI ARIPIRALA

Patient




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POST-SURGICAL CARE PLAN FORM

Procedure Done: Left femoral craniotomy + ECD guided resection of CA

Post-Surgical Diagnosis: Left femoral (ONETEC) T.DRE

Post-Operative Monitoring Parameters /Frequency:

. GCS - 2hrly
. Vitals - 1hrly

Wound Care:

Alternate day dressing

Drain /Special Lines/Catheters:

Foley catheter

Special Patient Positioning and Requirements:

Supine & head end elevated to 30°

Nutritional Instructions:

NPO till fully awake

When to Start Mobilization:

POD-1

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)


Dr. Prashanthi Aripirala

Date: 02-07-2024 Time:

Note: Plan of care will be readjusted if necessary.