

BAH-00496779 IP5-00176004
Master MD FAWAZ
27-05-2021 5 Y 1 M 9 D (M)
Dr. VENKAT RAM THYALAPALLI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 6/7/26
Patient Name : Mast. MD Fawaz Date of Birth : 27/5/21 Age : 5 years
Gender : male Ward : OT-1 UHID No.: BAH-00496779
Date of Surgery : 6/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : ~~Rectal~~ bigger knot 1+1-(2).
Unilateral

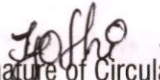
Time in : 8.30am

Time Out : 10.30am

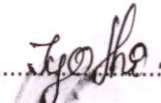
	NAME	AMOUNT
1. Surgeon	Dr. Venk. Ram Thyalapalli	
2. Anaesthetist	DR. Anaga Bhavane	
3. Assistant Surgeon		
4. OT Technician	Bapu	
5. Circulating Nurse	Jyothi	
6. Assistant Nurse	Akhil, Tejas	

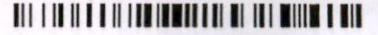
Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others


Signature of the Surgeon


Signature of Circulating Nurse

Order No: 9689873

Order by: 

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176004 Admit Date : 06-Jul-2026 Admit Time : 06:55 AM UHID : BAH-00496779

Patient Details :

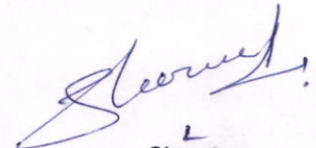
Patient Name	: Master MD FAWAZ	Age	: 5 Y 1 M 9 D
Guardian	: Mr MD SHARUKH	DOB	: 27-05-2021
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO.22-70, GIRI NAGAR, OPP IDPL COLONY Bala Nagar(ranga reddy) Hyderabad Telangana INDIA 500037	Phone No	: 8309926726/ 9182099775
		E-mail	: SHARUKHSIDD999@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 402 Ward Name : 4F-OT COMPLEX
 Room No : PRE OP 402 Admission Type : First Visit

Contact Details :

Name : Mr MD SHARUKH Relationship : Father
 Contact Address : H NO.22-70, GIRI NAGAR, OPP IDPL
 COLONY Bala Nagar(ranga reddy) Hyderabad
 Telangana INDIA 500037 Phone No : 8309926726 / 9182099775


 Signature

Doctor Details :

Doctor Name : Dr. VENKAT RAM THYALAPALLI Specialisation : ORTHOPEDICS
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP N: _____ t: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/2/26	2:40 AM	ER	OT	Rachel
6/2/26		OT	Billing	Thyja

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

BAH-00496779
Master MD FAWAZ
27-05-2021
Dr. VENKAT RAM THYALAPALLI

IP5-00176004

5 Y 1 M 9 D



(M)

TA Transfer + plgk

CONSUMABLES OF OT

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

BirthRight
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Circulating staff: Technician: Date: Time: 8:30 AM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used	Qty	Issued	Used	Qty	Issued	Used	Qty
ET tube 4.0.4.5.5.0	4	4	Major Pack Drape	1	1	Inj Vit.K		
LMA 2	1	1	Sutures			Cord Clamp		
ECG leads : A/P/N	5	3				Suction Catheter		
HME filter : A/P/N	1	1				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	4	Gloves			Surgical Gloves		
02 cc	10	3	G, 6/1/2	2	2	Gauze Pack		
01 cc	2	1	6/6/1/1	2	2	Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	1	Surgical blade	1	1	Surgical Blade # 20		
IV set	1	1	NG tube			Koochie (S)		
RL	1	1	Cautery pencil	1	1	NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	3	1	Koochie			Transfix	1	1
02 mask (P)	1	1	Ointments			10cc, 5cc, 1cc	2	2
Airway 0-1	1	1	Suction Catheter			18 g needle	5	5
Fentanyl	1	1	Cap, Mask	1	1	Get All size	2	2
Morphine			Gauze Pack N+R	3	2	Get All size	2	2
Ketamine			Mop Pack	1	1	7.5 (3 inch)	04	04
Propofol	3	1	Steristrip			5 (2 inch)	02	02
Rocuronium	1	1	Underpad	1	1	Iv camla 22, 24	1	1
Glycopyrolate	1	1	Draw sheet	1	1	Dexa	1	1
Myopyrolate	1	1	Abgel			Tromexa	1	1
Ondansetron	1	1	Foleys catheter			Mpmsplu	1	1
Pencan 25g/ Spinal Needle 22	1	1	Urobag			Dextomid 50	1	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			Clonidine	1	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			mpdel 2	1	1
Antibiotics			Bandage			Nascul Army 16/16.20		
Suppositories			Tegaderm			Etac Nascul pncp	1	1
Anamol : 80mg / 250mg / 170 mg	1	1	Ioban			50cc + pmolue	1	1
Supridol : 100mg			Double J Stent			Sobt Paul 6/4	1	1
Justin : 12.5 mg / 25mg / 100mg	1	1	Vaccum Suction set	1	1			
Tab. Misoprost : 200mg			Plastic Bed Sheet	1	1			
Vaccum set	1	1	Betadine Solution	1	1			
Gauze	3	2	Microshield	1	1			
Gloves 6.5	4	1	Cotton Balls	1	1			
Iv p.cm	1	1	Latex Gloves	1	1			
3-way 100-110cm	1	1	Ramdone Scrub	1	1			
			Saral					

Surgeon: Anaesthesiologist: Ordered by:
Order No.: 9689922 Doc. No.: RCH / FRM / GENERAL / 125

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07/19	Tr Placement	6	9624	} Samyhy
	Pac Done on	of Bass		

ANY OTHER INFORMATION

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Patient



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 6:50 AM	flv case of B/L club foot. now admitted for TA transfer + plaster no fever no vomity vitals - stable Ks-BLUE (+) clear p/a-10ft.	Plan 1. Admit ↓ daycare 2. continue upo. 3. <u>Noted by</u> / send CBP now. Lack! <u>Lana</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

DRUG CHART

Date of Admission: 6/2/21 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



REGULAR PRESCRIPTIONS

Weight. 12kg Ward. 209

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

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

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

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
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
6/7	8:35AM	IND. CE-FOXTAXIM	850MG	IV	[Signature]	Jyothi Bapu
6/7	8:40AM	DICLOFENAC suppository	12.5MG	PR	[Signature]	Bapu Jyothi
6/7	8:45AM	IND. TRANEXAMICACID	250MG	IV	[Signature]	Bapu Jyothi
6/7	8:46AM	IND. PARACETAMOL	250MG	IV	[Signature]	Bapu Jyothi

VERIFIED BY : Name Signature

27-05-2021

6Y1M9D

(M)

Dr. VENKAT RAM THYALAPALLI



Weight. 176 Ward. 07

Weight.

Ward

[illegible]



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Lachel
				☐ 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		
				☐ 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		
				☐ 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:

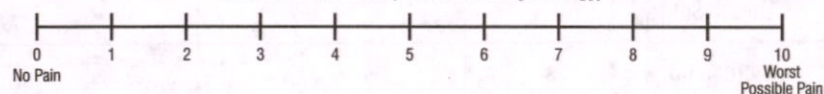
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

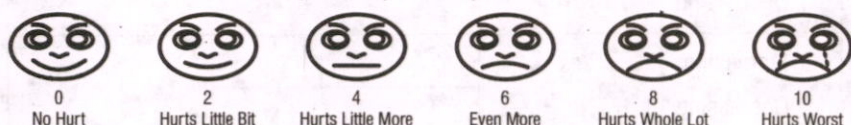
Numerical Pain Scale (Obstetric and Gynecology)



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 - 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



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Hindi 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		
6/7/26	7 AM	7	Infection control measures	M	1	0	1	1	NA	Lachar

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
6/5/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	left clubfoot. for TA transfer	hemodynamic stability successful procedure	TA transfer		☐ Nursing ☐ Others:
6/7/20 9 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	TA transfer + plaster	Hemodynamic stability	NPO IVF		☒ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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Barcode

Patient


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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						

Patient

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(M)

27-06-2021

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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.

		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												

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output						IV Site 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													
	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								

Patient

THE HUMPTY DUMPTY SCALE 6/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2				
	Oriented to own Ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
	Other Medications / None	1	1				
TOTAL			12				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	44				
Call device within reach	44				
Wheels Locked	44				
Room free of clutter	44				
Adequate Lighting	44				
Wheel Chair Support	NO				
Other Intervention(s) Specify	NO				
Nurse's Name :	Salah				
Signature :	Q				
Date :	6/2/20				
Time :	7:10am				

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Venkat Lam Department: Ortho Date of Admission: 6/7/26

SITUATION	Diagnosis: <u>R/L club foot.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	<u>ER</u> <u>7:15 AM</u>			
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>			
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.3 F</u>			
		Res:	<u>24 b/m</u>			
		SpO ₂ :	<u>98%</u>			
		Pulse:	<u>92 b/m</u>			
		BP:	<u>98/65 (mm)</u>			
		Fall Risk Score:	<u>12</u>			
Pain Score:		<u>0</u>				
Recommendations	Safety Needs:		<u>side rails</u>			
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>			
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>				
Handed Over By Name :		<u>Laksh</u>				
Signature :		<u>[Signature]</u>				
Date:		<u>6/7/26</u>				
Time:		<u>7 AM</u>				
Taken Over By Name :		<u>Aishwarya</u>				
Signature :		<u>[Signature]</u>				
Date:		<u>06/07/26</u>				
Time:		<u>7:45 AM</u>				

BAH-00496779

IP5-00176004

Master MD FAWAZ

27-05-2021

6 Y 1 M 9 D

(M)

Dr. VENKAT RAM THYALAPALLI



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date : 6/1/22			
				Time : 7:25			
Mobility	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 e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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		
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		
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		
FRICION-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		
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		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23				TOTAL SCORE	28		
Docu No : BCHRH /ERM / CLINICAL / 110				Evaluator's Name	(D)		

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



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. TA transfer, TA lensing, glenoid fossa release + glenoid
2. _____

I acknowledge the following:

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

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>supination dystonia correction</u> <u>or joint</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.

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

Infection
b. _____

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

Patient / Patient Attendant:

Signature: MD SHARUKH

Name: Sharukh

Relationship with patient: FATHER

Date & Time: 6/7/26 - 8 AM

Witness:

Signature: Mughat

Name: Mughat Jahan

Date & Time: 6/07-2026 [7:47] Am

Doctor (who is taking consent):

Signature: Venkat Ram Thyalapalli Name: Venkat Ram Thyalapalli

Date: 6/7/26 Time: 7:47 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో 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 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.	

4. 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:



OPERATION THEATER NOTES

Patient's Name : Master MD Fawaz Age : 5 years Gender : ☒ Male ☐ Female
UHID No. : BAH-00498779 Weight : 12kg Height :

Surgeon : <u>DR. Venkat Ram Thyalapalli</u>	Asst. Surgeon : <u> </u>
Anesthetist : <u>DR. K. Ranga</u>	OT Nurse : <u>Akhil, Tejas, Jyoti</u>
Technician : <u>Baper</u>	
Pre-Operative Diagnosis : <u>Bilateral equinovarus deformity (Congenital)</u>	
Surgical Procedure : <u>percutaneous TA tenotomy + plantar fascia release + TA transfer + plaster cast</u>	
Indications for Surgery : <u>deformity of B foot</u>	
Date : <u>6/7/26</u>	Start Time : <u>9:50 am</u>
End Time : <u>10:20 am</u>	
Pre Operative Preparations :	
Post Operative Diagnosis : <u>same</u>	
Peri-Operative Complications :	
Operation Notes :	
- L. GA & Caudal Block, tourniquet applied - After thorough scrub & drapes - percutaneous plantar fascia release & TA tenotomy - Anterior medial & lateral incision, Tibialis Anterior released & transferred to 2nd cuneiform - Anchors - Anterior applied to the sole - Tourniquet down & leg down - Dressing done - GA plantar cast applied - Shift to BWH in stable condition	



POST-SURGICAL CARE PLAN FORM

Procedure Done: *DA bagin + peritonectomy + glutaraldehyde fixation + glutaraldehyde*

Post-Surgical Diagnosis: *7. epimorax dily (symmetric hypoplasia)*

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

plate care & elute - 1 week

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

[Signature]
Treating Surgeon
(Signature & Stamp)

Date: *6/7/2026* Time: *11:00 am*

Note: Plan of care will be readjusted if necessary.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: MD Faraz Age: 5y Sex: M UHID.No: BAH-60496779
Date: 1/7/26 Time: 4:00 pm Proposed Operation: TA bumper
Diagnosis: B/L Recurrent club foot.
B.P / CRT: H.R: 96 Weight: 17kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.9 Glucose: Protein: HIV: X-Ray:
PCV: 34.1 Urea: Alb: HBS Ag: ECG:
WBC: 10.3/k Creat: Total Bill: HCV: 2D Echo:
Plate: 3.29/kh Na: Dir. Bill: Blood group: Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl -: SGOT/SGPT:

Allergies: NADA

Medical History: CVS: * NVD / Term / 3.1kg / No NICU admission
RESP: Diabetes:
CNS: * Vaccinated upto date
Renal: * Milestones achieved as per age
Hepatic / GE: Physical Activity: Active
Others: No febrile seizures - 3 years back
Past Anaesthetic History: 2022 LGA clubfoot correction (uneventful).

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: adequate Mento-hyoid Distance: (2) Neck: (N) Teeth: All teeth intact
Lungs: BAE+, clear
Heart: S1 S2+
CNS: Grossly Intact
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Accessible Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: Coarctation of explanation
- NIL ORAL $\begin{cases} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{cases}$
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: CRP on decontamination

Signature: Dr. K. S. Sanyal Name: Dr. K. S. Sanyal

Patient Sticker

ANAESTHESIA CHART

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It takes a lot to treat the little.

BirthRight™
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Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ NoFasting Status: Confirmed

Physical Status:

☒ Patient Identified☒ Consent Present☒ Chart ReviewedH.R.: 77B.P./CRT: 83/53(4)SpO₂: 98%R.R.: 18Last Feed: 6/1hrPre-OP Diagnosis: bilateral club footOperation: bilateral club footDate: 6/1hrSurgeon: Dr. Venket RamAnaesthesiologist: Dr. Shrip / Dr. DineshTechnician: Deepa

TIME	N ₂ O / AIR / O ₂ / LPM	SpO ₂	HR	B.P.	CRT	Temp	ECG	Urine Output	Antibiotic	Suppository	Blood Loss	NOTES
8:30 AM	100% / 100%	98%	77	83/53	4	36.5	Normal	0	100mg	100mg	0	Right club foot
9:30 AM	100% / 100%	98%	77	83/53	4	36.5	Normal	0	100mg	100mg	0	Left club foot
10:30 AM	100% / 100%	98%	77	83/53	4	36.5	Normal	0	100mg	100mg	0	End of surgery

LAB Values

- ☒ Equipment Checked and Functional
- ☒ BP
- ☒ Cuff Site: Left
- ☒ Art Site: Left
- ☒ EKG Lead: Lead II
- ☒ Temp Site: Rectal
- ☒ FIO₂ Monitor
- ☒ Agent Monitor
- ☒ Pulse Oximeter
- ☒ Capnograph
- ☒ Ventilator
- ☐ Nerve Stimulator
- Position: Supine
- ☒ Pressure Points Checked

Eye Care:

- ☐ Oint
- ☐ Tape
- ☐ Padding
- ☐ Awake

Temp:

- ☐ HME
- ☐ Fluid Warmer
- ☐ Cling Film
- ☐ OH Warmer
- ☒ Hugger's
- ☐ Cotton Wool
- ☒ Other: Blanket

Times:

Anaes Start: 8:30 AM

OP Start: 8:50 AM

OP End: 10:30 AM

Leave OR: 10:30 AM

Anaesthesia:

- ☒ GA
- ☐ Monitored Anaesthesia Care
- ☒ Regional

Line (Size & Location)

- ☐ CVP: Left
- ☐ ART: Left
- ☒ IV: Left
- ☐ IV: Left
- ☐ IV: Left

Induction

- ☒ IV
- ☒ Inhal
- ☐ Pre O₂
- ☐ RSI
- ☐ Others

- ☐ Mask
- ☒ SGA 2.0 LMA Supreme
- ☐ Airway
- ☐ Oral
- ☐ Nasal
- ETT# 7.0 at 20 cm
- ☐ Oral
- ☐ Nasal
- ☐ Cuff
- ☐ Tracheostomy
- ☐ Topical
- ☐ Drug: None

- ☐ Awake
- ☐ Direct Vision
- ☐ Video Laryngoscopy
- ☐ Stylette / Bougie
- ☐ Fiberoptic
- Blade# 1 Attempts: 1
- Difficulty Why? None

☒ Bilat = BS

- ☐ Semi-Closed Circle
- ☒ Closed Circle
- ☐ Other

Regional:

- Extremity
- Specify: Caudal
- ☐ Spinal
- ☐ Epidural
- ☒ Caudal

Others:

Position: Supine

Site: Left

Needle Size: 22G Depth: 10cmParasthesia ☐ Yes ☐ NoCatheter at skin 10cmDrug Name & Conc: 0.25% BupivacaineBolus: 1ml + 10mlInfusion: 10ml/hrBlock Level: T8Comments: None

Transportation to

- ☒ PACU
- ☐ ICU
- ☐ Other
- Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. DineshSignature of the Doctor: Dr. Dinesh



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ThiyasTime Received : 10.45 AMTime Discharged : 2 PM

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>2 2 G R U L</u>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway
< RESP > PULSE < BLOOD PRESSURE		Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : <u>nil</u> Oral Feeds : <u>nil</u>
		Drug : _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	0	1	1	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2			
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2			
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	0	1	2			
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2			
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			6	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
6/7/26	10:35 AM	10	—	Thiyas

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPSAnaesthesiologist Name : DR SHINYAnaesthesiologist Signature : ThiyasDate & Time : 06/07/26 10:45 PMPACU Nurse Name : ThiyasPACU Nurse Signature : ThiyasDate & Time : 6/7/26 12:28 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): ThiyasDate & Time : 6/7/26 @ 10.45 AM

Date and Time :

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure:

Anaesthesiologist: Dr. Subhramanyam Surgeon: Dr. Venkat Ram

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

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: Raziya
Name: RAZIYA
Relationship with patient: Grand Parent
Date & Time: 1-7-26 4:30 pm

Witness:

Signature: [Signature]
Name: MD. AYUB
Date & Time: 1/7/26 4:50 PM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. K. S. Sanyal Date: 1/7/26 Time: 6:50 pm

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 తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ 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 ☐ మూత్రపిండాలు 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.
☐ రిజనల్ 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, శాస్త్రానికి శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, రిజనల్ 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: