



81022.

SURGERY DETAILS

Date : 06/07/26

Patient Name: Blo. manipalli Kiranmai Date of Birth: 14-09-2023 Age: 2y 9m 22D

Gender: male Ward : P-01-112 UHID No.: BAH-00561537

Date of Surgery: 06/07/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Right High Ligation of Sac

Time in : 11 Am

Time Out : 12pm

	NAME	AMOUNT
1. Surgeon	Dr. Nabeel	
2. Anaesthetist	Dr. Shilpa / Dr. Surya	
3. Assistant Surgeon		
4. OT Technician	Leawthani	
5. Circulating Nurse	Swarna	
6. Assistant Nurse	B.K.H. Lee	

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: 9690263

Order by: J. Ramdani



Highligation

CONSUMABLES OF OT

Circulating start : Technician : Date : Time : 10:30 AM

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube 3.5, 4.0, 4.5	1+1	-		Major Pack Drape	1	1		Inj Vit.K			
LMA 2	1	1		Sutures				Cord Clamp			
ECG leads : A/P/N	5	5		Vicryl 3-0, 4-0	2+2	1		Suction Catheter			
HME filter : A/P/N	1	1		Calgut	2+2			Feeding Tube			
Syringes : 10 cc	10	3		Rapid vinyl 50	2+2	2		Vacuum Suction Set			
05 cc	10	3		Gloves				Surgical Gloves			
02 cc	10	2		6.6, 12, 2, 2 1/2	2+2	2+2		Gauze Pack			
01 cc	2	-		PF 6.6, 12, 2, 2 1/2	2+2	2+2		Syringe 1ml / 2ml			
Cautery plate : A/P/N	1	1		Surgical blade 11, 15	4	1		Surgical Blade # 20			
IV set	1	-		NG tube				Koochies (S)			
RL	1	-		Cautery pencil	1	1		NS 500ml	2+2	1	
NS : 10ml / 100ml / 500ml / 1000ml	3+1	10+1		Koochies				Tramexol	2+2	1	
02 mask (P)	1	1		Ointments				10cc, 5cc, 2cc	2+2	1	
Airway 0.1	1+1	-		Suction Catheter				Jelly	1	1	
Fentanyl	1	1		Cap, Mask	5/5	10/10		Dypr	1	1	
Morphine				Gauze Pack	5/5	5/5		micropore	1	1	
Ketamine				Mop Pack	1	1					
Propofol	2	2		Steristrip							
Rocuronium	1	-		Underpad	1	1		IV canula 22, 24	1+1	-	
Glycopyrolate	1	-		Draw sheet	1	1		Dexa	1	-	
Myopyrolate + Neostigmine	2	-		Abgel				Tramexol	1	-	
Ondansetron	1	-		Foleys catheter				Mimisplu	1	-	
Pencan 25g/ Spinal Needle 22	1	1		Urobag				NG 5-6 7 8 9 10		-	
Bupivacaine 0.25%	1	1		Chest Drainage Catheter				Suction cath 6-8 10		-	
Bupivacaine 0.25% (Heavy)				Romodrain bag				Dextormide 50	1	-	
Antibiotics				Bandage				Clonidine	1	-	
				Tegaderm				50cc + pmoline	1+1	-	
Suppositories				Ioban				Sobt Paul 4 + 6 1m	1+1	-	
Anamol : 80mg / 250mg / 170 mg	1+1	-		Double J Stent				5 + 102 Nasal pump sp	1	-	
Supridol : 100mg				Vacuum Suction set	1	1		Nasal Airway (6 + 8 10 12)	1+1	-	
Justin : 12.5 mg / 25mg / 100mg	1+1	-		Plastic Bed Sheet	1	1					
Tab. Misoprost : 200mg				Betadine Solution	1	1					
Vacuum set	1	1		Microshield	1	1					
Gauze	3	2		Cotton Balls	1	1					
Gloves all	4	2		Latex Gloves	1	20					
Sup cm	1	1		Ramdione Scrub							
3-way 100 + 100 cm	1+1	-		Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9090257

Ordered by : [Signature]

ESTIMATION SLIP

Date : 02/Jul/26 UHID / IP No. : TTA4100561537 SI No. 81022
 Name of Patient : Baby of Mungai/Kirammai Age: 2y/9m Gender: M
 Father's / Husband's Name : Mr. Ramesh Corporate / Occupation : Marketing Manager
 Address : _____ Phone : 9652106269/9398607614 Email : _____
 Procedure / Plan : Right High Ligation of Sac - 2nd Dec/20 Jul

MODE OF PAYMENT : ☐ SELF ☐ TPA : _____ ☒ GIPSA: MA/NIA OTHERS

TARIFF INFORMATION :

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
per Day)	Room Rent & Nursing Charges	1200	1200								
	Doctor's Fee	1200				1200					
	L. Tax										
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				12000							
O.T. Consumables				Subject to approval by TPA / Insurance Company							
Instrument Charges				Not Covered by TPA / Insurance company							
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation							
Equipment Charges	Monitor :			Oxygen :				Infusion pump / Syringe pump :			
	Ventilator :		Conventional :	HFO-SLE 5000 :				HFO Sensormedix :			
	Phototherapy :		Single Surface :	Double Surface :				Triple Surface :			
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation							
Package				40,000/-							
Others											
Initial Minimum Deposit				Dep 1st / As per requirements of							

REMARKS:

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

DECLARATION

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

Signature of the Client

Signature of the Financial Counselor

Signature of the Financial Counselor

ACTIVITY RECORD FOR BILLING

Name : Vigantb

UHID No. : _____ IP **BAH-00561537** **IP5-00176012** ant: _____ Dept : _____
Baby Of MUNIPALLI KIRANMAI
14-09-2023 **2 Y 9 M 22 D** (M)

Date of Admission: _____ Discharge : _____ Time: _____
Dr. NABEEL ALAM QADRI



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/12/26	9:55 AM	ER	OT	Pooja
6/12/26	1:40 PM	OT	116	Devi

Cross Consultation Visit

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

[illegible]

Signature

Enoch

[illegible]

Date

[illegible]

Connecting Time

Disconnecting
Time

Order No.

Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	iv phumut PAC (op Bari)	1	89754	Tanf
07/07	NHA	1	9691269	Niktha

ANY OTHER INFORMATION

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Date :

7/7/26

Time.:

9:00

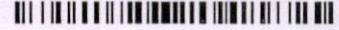
Prepared By :

Saitose

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Saitose	6:00-1 116		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176012

Admit Date : 06-Jul-2026

Admit Time : 09:08 AM UHID : BAH-00561537

Patient Details :

Patient Name : Baby Of MUNIPALLI KIRANMAI (SHAGANTI VIANSH)

Age : 2 Y 9 M 22 D

Guardian : MR. SHAGANTI RAMESH

DOB : 14-09-2023

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : PLOT NO A-213/J, SATYANARAYANAPURAM COLONY, RD NO 1, MEDIPALLY Hyderabad Telangana INDIA 500098

Phone No : 9398607414/ 9652106269

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 401

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 401

Admission Type : First Visit

Contact Details :

Name : MR. SHAGANTI RAMESH

Relationship : Father

Contact Address : PLOT NO A-213/J, SATYANARAYANAPURAM COLONY, RD NO 1, MEDIPALLY Hyderabad Telangana INDIA 500098

Phone No : / 9398607414

[Signature]
Signature

Doctor Details :

Doctor Name : Dr. NABEEL ALAM QADRI

Specialisation : PEDIATRIC SURGERY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00561537 IP5-00176012
Baby Of MUNIPALLI KIRANMAI
14-09-2023 2 Y 9 M 22 D (M)
Dr. NABEEL ALAM QADRI



Pediatric Multiorgan History & Physical Examination

Name : B/O Munipalli Kiranmai Age/Sex 2y 9m/M

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

C/O Swelling of right side of
scrotum x 2 months

History of present illness :

No form issues.

Premorbidly well child

↓

C/O swelling right side of scrotum
x 2 months

↓

Dxed → Right sided hydrocele

↓

Now came for high high ligation
of sac.



Pediatric Multiorgan History & Physical Examination

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

1+10 TAPVC ~~was~~ repair done
in neonatal period

Birth & Neonatal History:

FT / LSCS / GAB

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} lower mid die class

Developmental History :

As per ~~sch~~ age

Immunization History :

As per schedule

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.87kg (Centile _____)

On Examination :

Temperature : 98.4°f Pulse Rate : 106bpm B.P. 100/64mmHg SPO2 100.1% RA

Resp. rate and type of breathing : 24 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NADA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : Right cystic

Relevant data from outside (CT, USG etc.,) transilluminant scrotal swelling



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

15/15

Cranial Nerves :

Motor System:

Nutriton :

Tone :

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Right sided Hydrocele



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Bleeding, Infection

Desired goals of the treatment: _____

Hydrocoelo repair

Planned Labs:

CBP

1 plain } sample
1 EDTA }

Planned Management

- Review PAC
- INJ. CEFTRIAZONE
650mg IV STAT
1 hour before surgery
(I-E Prophylaxis)
- IV fluid-DNS

N/B poofa
6/7/26 @ 9:30 am

Signature of the Doctor: Nabeel

Name of the Doctor: Dr. Nabeel

Date & Time: 06/07/2026, 9:30 AM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Nabeel Alam Qadri

Date & Time: 6/7/26 @ 6:45 pm



Pat

OPERATION THEATER NOTES

Patient's Name : B/o. Munipalli. Kiranmai Age : 2y Gender : ☒ Male ☐ Female
UHID No.: BAIT-00561537 Weight : Height :

Surgeon : <u>Dr. Nabeel</u>		Asst. Surgeon :	
Anesthetist <u>Dr. S. P. / Dr. Surya</u>	OT Nurse: <u>Bikhlai</u>	OT Technician: <u>Growtham</u>	
Pre-Operative Diagnosis: <u>Right Hydrocele</u>			
Surgical Procedure : <u>Right High Ligation of Sac</u>			
Indications for Surgery : <u>Right Hydrocele</u>			
Date : <u>06/07/26</u>	Start Time : <u>11:25am</u>	End Time :	
Pre Operative Preparations:			
Post Operative Diagnosis: <u>Right Hydrocele</u>			
Peri-Operative Complications:			
Operation Notes:			
<u>FINDINGS:-</u>			
1) Thin sac, encysted hydrocele of sac			
2) Vas + vessels normal			
<u>PROCEDURE:-</u>			
Right lower groin incision made. External			

oblique aponeurosis opened, sac identified, dissected of the cord and the hydrocele sac was delivered into the incision. Sac was dissected proximally, transfixed, ligated w 3-0 vicryl sutures and cut.

Distal sac laid open.

Wound closed in layers

Amount of Blood Loss: ~1ml

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination: —

Peri-Operative Complications: —

DAYCARE

1) Syrup CEFIXIME (5ml=100mg) ml
Twice daily for 3 days

2) Syrup CROCIN DS (5ml=240mg) ml
thrice daily for 2 days then SOS

Review in OP w Dr-Nabeel on Thursday 9/7/26

Name of the Surgeon: Dr-Nabeel

Signature of the Surgeon: 

Date & Time: 6/7/26 11:43 AM

BAH-00561537 IP5-00176012
Baby Of MUNIPALLI KIRANMAI
14-09-2023 2 Y 9 M 22 D (M)

Dr. NABEEL ALAM QADRI



Patient S

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Right High Ligation of Sac

Post-Surgical Diagnosis: Right Hydrocele

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

n /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

As early as possible

Special Referrals:

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

☐ Yes ☒ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 6/7/26 Time: 11:44 AM

Note: Plan of care will be readjusted if necessary.

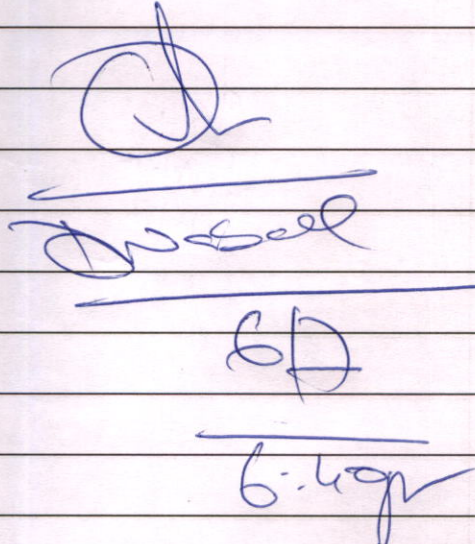
BAH-00561537 IP5-00176012
 Baby Of MUNIPALLI KIRANMAI
 14-09-2023 2 Y 9 M 22 D (M)
 Dr. NABEEL ALAM QADRI

Patient

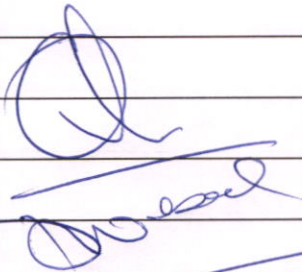
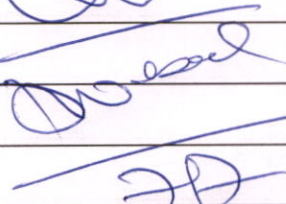
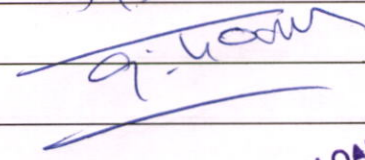
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 4:00pm	C/S/B Dr. Malika / Dr. Nikhita	
	POD-0 (R) High ligation of sac.	
	O/E -	Rx
	R Afebrile	
	vitals - stable	- Full feeds as tolerated
	P/A - soft	
	Dressing - intact	
		Dr. Nikhita 6/7/26 4:00pm
	6:40pm	
	Dr. NABEEL ALAM QADRI Reg No: 73241	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/12/26 8:05 AM	C/S/R Dr Nabeel	
	(100-1) (R) High ligature of sac	
	No episode of fever.	Adv
	Child active	(1) Full feeds as tolerated
	Accepting feeds	(2) Plan D/C today
	Afebrile	
	Vitals - stable	
	Stool - soft	
	Dressing - intact	
		Dr Nabeel 7/12/26 8:05 AM
		
		
	Dr. NABEEL ALAM QADRI Reg. No: 75241	

BAH-00561537 IP5-00176012
 Baby Of MUNIPALLI KIRANMAI
 14-09-2023 2 Y 9 M 22 D (M)
 Dr. NABEEL ALAM QADRI



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6/7/26

RESULT SHEET

Date						
Time						
Hb	11.8					
PCV	36.8					
RBC	5.14					
WBC	7.47					
N/L	31/62					
Platelets	204.					
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						

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: ICU Shifted to: OT

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Nandan

Date & Time: 06/07/2020, 9:40 AM

Nurse Name & Signature: Pooja S

Date & Time: 6/2/2020 9:45 AM



DRUG CHART

Date of Admission: 06/07/2026 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
Additional Instructions:				

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

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

VERIFIED BY: Name Signature



REGULAR PRESCRIPTIONS

Weight. 12.82kg... Ward.

DRUG : SYRUP CEFIXIME				Date Time																
Dose	Route	Frequency	Start Date																	
6ml	PO	Q12h																		
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions: (5ml = 100mg)																				
Daily Doctor's Endorsement by a Sign																				

DRUG : SYRUP CEFIXIME				Date Time	6/7															
Dose	Route	Frequency	Start Date																	
3ml	PO	Q12h	6/7/26		10:00 AM															
Name & Signature of the Doctor Starting the Drugs:																				
Malika Dr-Malika																				
Additional Instructions: Syrup ZIPRAX (5ml = 100mg)																				
Daily Doctor's Endorsement by a Sign																				

DRUG : SYRUP PARACETAMOL				Date Time																
Dose	Route	Frequency	Start Date																	
200mg	PO	Q8h	6/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Malika Dr-Malika																				
Additional Instructions: Syrup CROCIN DS (5ml = 240mg)																				
Daily Doctor's Endorsement by a Sign																				

DRUG : SYRUP PARACETAMOL				Date Time	6/7															
Dose	Route	Frequency	Start Date																	
4ml	PO	Q8h	6/7/26		11:30 AM															
Name & Signature of the Doctor Starting the Drugs:																				
Malika Dr-Malika																				
Additional Instructions: Syrup CROCIN DS (5ml = 240mg)																				
Daily Doctor's Endorsement by a Sign																				

7 kg

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

[illegible]

Weight. 12.87kg Ward.

BAH-00561537 IP5-00176012
Baby Of MUNIPALLI KIRANMAI
14-09-2023 2 Y 9 M 22 D (M)
Dr. NABEEL ALAM QADRI



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™
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	07/09/23	Time:	2am	6am	
Doctor / Nurse / Family Concern?					
Temperature (F)	104				
	103				
	102				
	101				
	100				
	99				
	98				
	97				
	96				
	95				
94					
Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Note: BP does not score in early warning scoring	90				
	80				
	70				
	60				
	50				
	Heart Rate (Number)	108bpm	105bpm		
	Resp. Rate (bpm) (Over 1 Minute) *	70			
		60			
		50			
		40			
30					
20					
10					
Resp Rate (Number)		26bpm	28bpm		
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	J	O			

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)

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.
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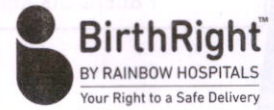
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00561537 IP5-00176012
 Baby Of MUNIPALLI KIRANMAI
 14-09-2023 2 Y 9 M 22 D (M)
 Dr. NABEEL ALAM QADRI

Patient St



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
17/9	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm	H2O											
Total Intake :						Total Output :							
17/9	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
17/9	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
21/9	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							

BAH-00561537 IP5-00176012
 Baby Of MUNIPALLI KIRANMAI (M)
 14-09-2023 2 Y 9 M 22 D
 Dr. NABEEL ALAM QADRI

FLUID CHART

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Sheet No. :

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

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment:

Acute pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the pt General Condition.	8am	Assessed the pt General Condition.	pt as
9am	Relieve pain & Discomfort	9am	Relieved Pain & Discomfort	
10am	monitor vital signs	10am	monitored vital signs	
12pm	monitor for bleeding	12pm	monitored for bleeding	
1pm	maintain nro status	1pm	nro broken, water given	
	provide Psychological Support		provided Psychological Support	
1pm	pt shift to the ward	1pm	pt shifted to the ward	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: *Qadri*

Date & Time: 6/7/26 @ 2pm

BAH-00561537 IP5-00176012
 Baby Of MUNIPALLI KIRANMAI
 14-09-2023 2 Y 9 M 22 D (M)
 Dr. NAREEL ALAM QADRI



NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/24

Assessment: pt having Dis Comfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	pt is stable
4pm	→ Check the Vital Signs	4:10pm	→ Checked the Vital Signs	
6pm	→ Plan for Administration Medication	6:10pm	→ Providing medication as per doctor Order	
8pm	→ Plan for I/O Chart	8:10pm	→ Strictly I/O Chart	
	→ plan for Comfortable Position		→ Providing Comfortable Position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: *Cy*

Nurse Name: Chandana

Date & Time: 6/7/24 @ 8pm

BAH-00561537
Baby Of MUNIPALLI KIRANMAI
14-09-2023 2 Y 9 M 22 D (M)
Dr. NABEEL ALAM QADRI

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/07/2024

Assessment: Baby having dull activity & pain at the site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the baby general condition and monitor the vitals and record.	8:10 pm	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
10pm	→ Doctor advice continue medication as per chart	10:10 pm	→ Doctor advised continued medication as per chart	
12am	→ full feeds as tolerate	12:10 am	→ full feeds as tolerated	
6am	→ Provide comfortable position.	6:30 am	→ Provided comfortable position	
8am	→ Ensure the safety needs.	8:10 am	→ Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: n/a

Nurse Signature: Nikytha

Nurse Name: Niketha

Date & Time: 07/07/2024 @ 8am

Patient Sticker

NURSING CARE RECORD

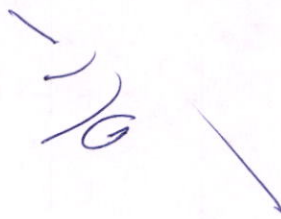
Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
				

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nabeel Alam Qadri Department: OT Date of Admission: 14/09/23

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>Right sided hydrocele.</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>HR</u> <u>9:15 AM</u>	<u>OT</u> <u>9:15 AM</u>	<u>OT</u> <u>9:15 AM</u>	<u>OT</u> <u>9:15 AM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.2F</u>	<u>98.6F</u>	<u>98.5F</u>	<u>98F</u>
	Res:	<u>28bpm</u>	<u>25bpm</u>	<u>26bpm</u>	<u>22bpm</u>	
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	
	Pulse:	<u>109bpm</u>	<u>105bpm</u>	<u>111bpm</u>	<u>110bpm</u>	
	BP:	<u>92/53</u>	<u>91/61</u>	<u>98/60</u>	<u>100/80</u>	
	Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sushmita</u>	<u>Quish</u>	<u>Chand</u>	<u>Nikish</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/23</u>	<u>6/7/23</u>	<u>6/7/23</u>	<u>6/7/23</u>	
Time:		<u>9:55am</u>	<u>10am</u>	<u>10am</u>	<u>8am</u>	
Taken Over By Name :		<u>Tan</u>	<u>Chand</u>	<u>Nikish</u>	<u>Shalaja</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/23</u>	<u>6/7/23</u>	<u>6/7/23</u>	<u>6/7/23</u>	
Time:		<u>10am</u>	<u>10am</u>	<u>10am</u>	<u>8am</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



THE HUMPTY DUMPTY SCALE 6/7 7/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			12	12			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes			
Call device within reach		yes	yes			
Wheels Locked		yes	yes			
Room free of clutter		yes	yes			
Adequate Lighting		yes	yes			
Wheel Chair Support		no	no			
Other Intervention(s) Specify		no	no			
Nurse's Name :		poorja	ntul			
Signature :		poorja	ntul			
Date :		6/7	7/7			
Time :		8:58 Am	6:00			



BRADEN 'Q' SCALE

				Date :	6/7	7/7		
				Time :	9 AM	8 AM		
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
TOTAL SCORE					28	28		
Evaluator's Name					poorja			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	9AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poofs
6/7	12:15 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Deeg
6/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	NA
07/07	4am	0/10	ND	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Evanes
				☐ 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:

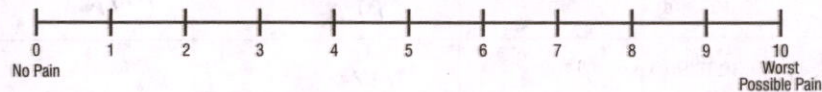
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

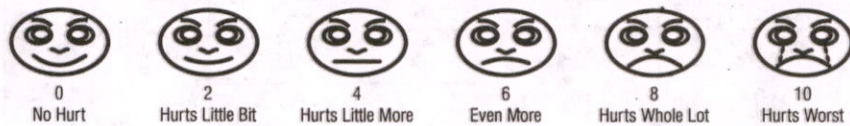
Numerical Pain Scale (Obstetric and Gynecology)



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





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Relugul English 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	9 AM	8	Diagnostic test / procedures	F	4	0	1	1	NA	Pugs
6/7/26	2:30 PM	9	Soft diet	F	1	0	1	1	-	Nabeel

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:

Right high ligation of sac.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 9:40 am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Right Hydrocele	Hydrocele repair	Right High ligation of sac	<i>[Signature]</i>	☒ Nursing ☐ Others:
6/8/26 9:40 am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Right hydrocele	U - Stability	Right high ligation of sac	<i>[Signature]</i>	☒ Medical ☐ Others:
6/7/26 2:30 pm	☐ Medical ☐ Nursing ☒ Others: <i>[Signature]</i>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Right sided Hydrocele	Soft diet	<u>RDA</u> E:- 1250Kcal/d P:- 21g/d	<i>[Signature]</i>	☐ 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:



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9³⁰ am Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction: NKDD Body Weight: 12.9 Kg
Height: — cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>intentionally A&Sed</u> <u>SupraCardiac</u> <u>TAPVC</u>	<u>Pericardial patch</u> <u>Closure of ASD</u> <u>+ Stent extraction</u> <u>done</u> <u>open Cardiac for</u> <u>2023</u>	<u>Stent extraction</u> <u>2023</u>

Family History: Nothing significant

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

If Yes, please list:

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

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

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

Observations: Weight: 12.5 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4 F HR: 88 b/m RR: 28 b/m BP: 90/60 mmHg

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

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

Risk of Pressure Sore (Braden Q Score 9.8) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: — Location: — Frequency: — Duration: —

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.Social History: Lives With ParentsSiblings in household ☐ Yes ☒ No (if yes How Many?) 1All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to Mother FatherNurse Signature: [Signature]Nurse Name: ReenaDate: 6/7/26Time: 9:35 am

BAH-00561537 IP5-00176012
Baby Of MUMPALLI KIRANMAI 2 Y 9 M 22 D (M)
14-09-2023
Dr. NABEEL ALAM QADRI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Aish

Date and Time: 6/7/26 @ 12:00

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



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Your Right to a Safe Delivery

Name: Baby of M. Kiranmai Age: 24/9m Sex: M UHID.No:

Date: 5/12/26 Time: 12:50 PM Proposed Operation: Right High ligation of sac

Diagnosis: Right sided Hydrocele

B.P / CRT: H.R: Weight: 12.87kg ASA Physical Status: 1 2 3 4 5

80/6, CUE - 2.3 weeks Laboratory Data:
Hgb: 12.6 Glucose: 85 Protein:
PCV: 38.2 Urea: 23 Alb:
WBC: 7100 Creat: 0.27 Total Bill:
Plate: 2.47 Na: Dir. Bill:
PT: 15.7 K: LDH:
PTT: 33.5 Ca++: ALK phos:
INR: 1.18 Mg++: Amylase:
BT - 2/5-4 Cl-: SGOT/SGPT:

HIV:
HBS Ag: JNR
HCV:
Blood group: A+ve
T3:
T4:
TSH:

X-Ray:
ECG: T1 V1, V2, V3, NRR
2D Echo: Pulm. Congestive to LA
Stress/Angio: NO MR, NO TR
Other: Intact Atrial septum
mild turbulence

Allergies: N/K/A/D

Medical History: CVS: FT. LSCS / CIAB / NIW stay for Antenatally Acd Supraaortic TAPVC

RESP: Hence of D2 of life - start done & Diabetes: On D2 of life - Sp: Re-routing of TAPVC to LA

CNS: Pericardial patch closure of ASD + stent extraction done

Renal: Review done @ Dr. BHARGAVA @ Heart Institute on 20/6/26 mvlodp. (N) echo

Hepatic / GE: Physical Activity: Active

Others:
Past Anaesthetic History: D2 of life & D2 of life open Cordae sy & GA (VLC) 2023

Physical Exam: No complaints after the sy

Airway: MR 2 3 4 Mouth Opening: > 1FB Mentohyoid Distance: (N) Neck: (N) Teeth: NLT

Lungs: BAC (N) - No developmental delay

Heart: S1, S2 (N) No murmurs - vaccinated all to age

CNS: Intact

Pregnant: ☐ Yes ☐ No ☒ N/A Venous Access Site: Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:
1. DVT Prophylaxis :
2. NIL ORAL -> Water / ORS 2 Hours Explained
Others 6 Hours
3. Informed Consent: ☒ Standard ☐ High Risk
4. Post Operative Pain Management: ☒ Discussed with Patient
5. Other Instructions:
✓ Review PACE before admission
✓ I.E Prophylaxis - 650mg IV, CEFTRIAXONE
1 hour prior to op.

Signature: Dr. SEMA Name: Dr. SEMA



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: 18:50pm

Time Received: Dr. Qadri

Time Discharged:

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>22G Port</u>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway
Vomiting: ☐ Yes ☒ No NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral: ☐ Yes ☒ No		Drug: IV Fluids: Oral Feeds:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
6/7	12:50pm	1/10	—	Dr. Qadri

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

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

Anaesthesiologist Name: Dr. Sumaira Ansari

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 6/7/2023 @ 2pm

Transferred to Unit by (PACU): [Signature]

Date & Time: 6/7/2023 @ 2pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

BAH-00561537 IP5-00176012
Baby Of MUNIPALLI KIRANMAI
14-09-2023 2 Y 9 M 22 D (M)
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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Right High Ligation of sac.

Anaesthesiologist: Dr. SRINAA Surgeon: Dr. Harsh Jayaram

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 Bradycardia / Tachycardia, Hypotension

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: S. Ramesh

Name: S. Ramesh

Relationship with patient: Son

Date & Time: 05/07/2026 @ 10:30 AM

Witness:

Signature: M. Chandrasekar

Name: M. Chandrasekar

Date & Time: 5/7/2026 @ 10:30 AM

Doctor (who is taking consent):

Signature: Dr. SRINAA Name: Dr. SRINAA

Date 5/7/26 Time: 1:10 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 శిరస్రావం 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 నార్కటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్స్ బ్లాకులు, 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:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00561537 IP5-00176012 Baby Of MUNIPALLI KIRANMAI 2 Y 9 M 22 D (M) 14-09-2023 Dr. NABEEL ALAM QADRI 		Date & Time of Admission <i>6/7/26 @ 9:50 AM</i>	Date & Time of Transfer Order <i>6/7/26 @ 2 PM</i>
		Transfer Ordered by <i>Dr. nabeel</i>	Reason for Transfer <i>POST-OP</i>
From Unit <i>OT</i>	To Unit <i>116</i>	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File <i>92</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring <i>[Signature]</i>		Name of Person Ordered Transfer <i>Dr. nabeel</i>	
Patient & Clinical Records Received by : <i>Chander</i>			
Date & Time of Patient Received : <i>6/7/26 @ 2 PM</i>			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 2:30pm

Weight: 12.87kgs Centile: 76th

Height: 92cms Centile: 72.5th

Inference: underweight child

RDA: — Calories: 1250Kcal/d Protein: 2g/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled and outside foods

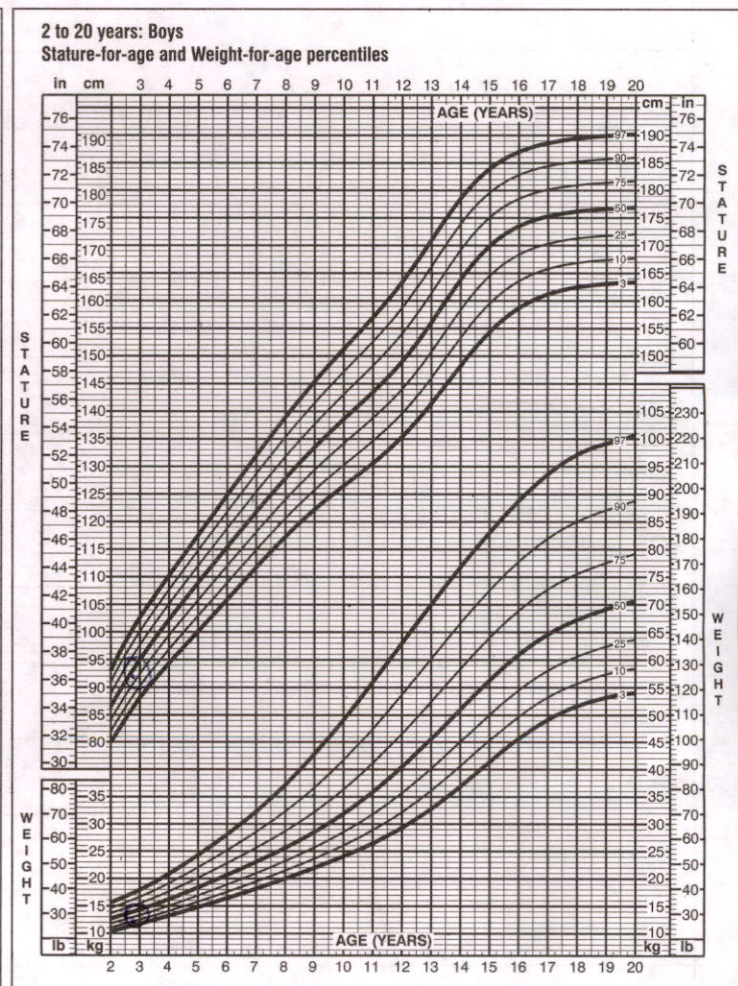
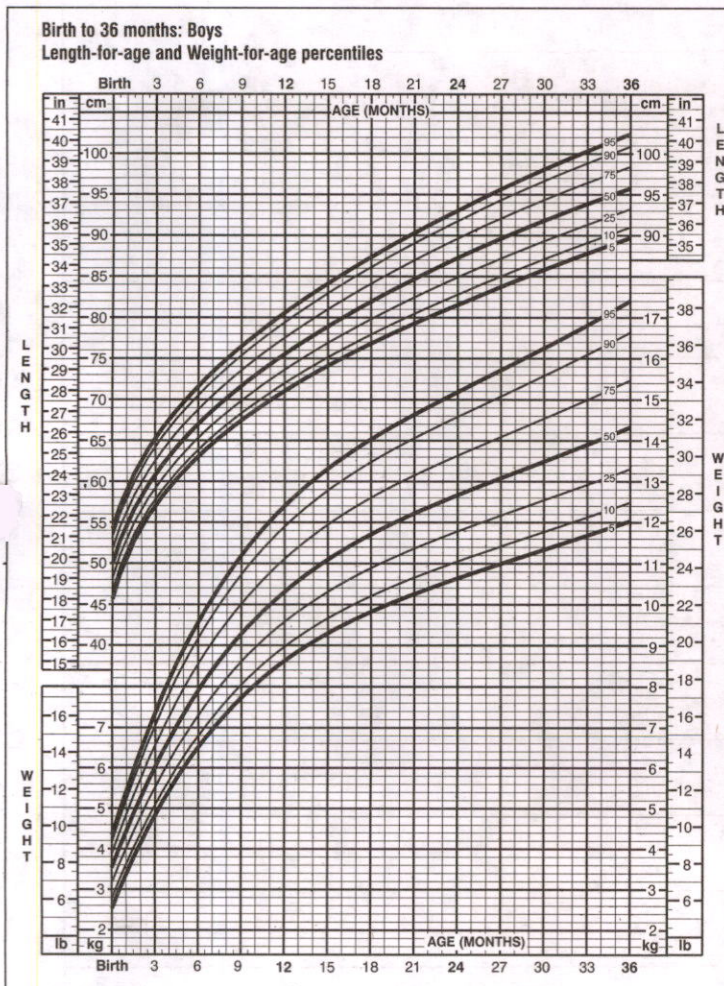
Food Allergies: NO Veg/Non-veg non-veg

Diagnosis: Right sided Hydronephrosis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

[illegible]