

BAH-00660300 IP5-00175958
Master VIHAAN BAJAJ
11-01-2025 1 Y 5 M 23 D (M)
Dr. HARISH JAYARAM



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 : 4/7/26

Patient Name: Master Vihaan Date of Birth: 11-01-2025 Age: 1 boy

Gender: Male Ward: OT UHID No.: 660300

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

Name of the Surgery : CYSTOSCOPY + LEFT DJ STENT REMOVAL + CIRCUMCISION

Time in : 11:55 AM

Time Out : 12 PM

	NAME	AMOUNT
1. Surgeon	Dr. Harish Jayaram	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Shrisha	
5. Circulating Nurse	Sugan	
6. Assistant Nurse	Thejas	

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

Signature of the Surgeon
Dr. Harish Jayaram

Signature of Circulating Nurse
Sugan

Order No: 9687343

Order by: Dr. Jayaram



Circulating staff : Technician : Date : 4/7 Time : 11 AM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube (3.0, 3.5, 4.0)	14	14	Major Pack	1	1	Inj Vit.K	1	1
LMA	1	1	Sutures			Cord Clamp		
ECG leads : A/P/N	5	5	Prolin-5.0	2	2	Suction Catheter		
HME filter : A/P/N	01	01	Gloves 6.6.5-7.7.5	2	2	Feeding Tube		
Syringes : 10 cc	20	06				Vaccum Suction Set		
05 cc	20	06				Surgical Gloves		
02 cc	20	04				Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A/P/N	01	—	Surgical blade 15+11	1	1	Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil	1	—	NS Foam	1	1
NS : 10ml / 100ml / 500ml / 1000ml	5	5	Koochies P.XL	1	1	Transfix	1	1
	01	00	Ointments			10cc. BCC	1	1
	01	01	Suction Catheter			Cellulose 10x10	1	1
Fentanyl	01	01	Cap, Mask	5	5	Jell	1	1
Morphine			Gauze Pack (NAR)	2	2	Dermi marker	1	1
Ketamine			Mop Pack	1	—	Cameloven	1	1
Propofol	03	02	Steristrip			fluid mark	2	2
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	1			
Myopyrolate 1pc	02	—	Abgel					
Ondansetron	01	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22	01	01	Urobag					
Bupivacaine 0.25%	01	01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Suppositories	01	01	Tegaderm					
Anamol : 80mg / 250mg / 170 mg	01	—	Ioban					
Supridol : 100mg			Double J Stent					
Justin : 12.5 mg / 25mg / 100mg	01	—	Vaccum Suction set	1	—			
Tab. Misoprost : 200mg			Plastic Bed Sheet					
2.5mg + 100mg	1	01	Betadine Solution	1	1			
Gave + 4.0mg	5	3	Microshield	1	1			
Perc + 1.0mg	1	—	Cotton Balls	1	1			
IV cath. 22	1	01	Latex Gloves	10	10			
Q. ster. splines	1	1	Ramdone Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9682277

Ordered by : [Signature]

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175958 Admit Date : 04-Jul-2026 Admit Time : 08:48 AM UHID : BAH-00660300

Patient Details :

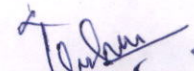
Patient Name	: Master VIHAAN BAJAJ	Age	: 1 Y 5 M 23 D
Guardian	: Mr DARSHAN BAJAJ	DOB	: 11-01-2025 02:02 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO : 59, WORD NO 29, KAILASH NAGAR , NEAR OLD BUS STAND, INDRA NAGAR RAJNANDGAON Chhattisgarh INDIA 491441	Phone No	: 8959490333/
		E-mail	: 8959490333@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 404 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 404 Admission Type : First Visit

Contact Details :

Name : Mr DARSHAN BAJAJ Relationship : Father
Contact Address : H NO : 59, WORD NO 29, KAILASH NAGAR ,
NEAR OLD BUS STAND, INDRA NAGAR Phone No : / 8959490333
RAJNANDGAON Chhattisgarh INDIA 491441


Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM Specialisation : PEDIATRIC SURGERY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4-7-26	9:26am	ER	OT	[Signature]
4-7	1:25pm	OT	bill lug	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION	
------------------------------	--

[illegible]

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

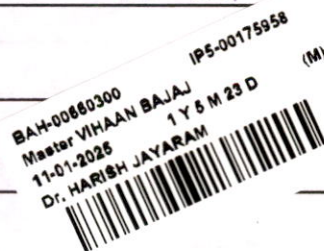
PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ *Vihaan* _____

UHID ID: _____

Department: _____

Consultant: _____





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Recurrent episodes of febrile UTI.

S/p DJ stent on 31st May & Klebsiella the urine Cx.



Now came for DJ Stent removal + Cystoscopy + Circumcision

History of present illness :

NO H/o fever, cold, cough, vomiting, loose stools,

No fresh complaints.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term / LSCS / 2.5kg / C2A2 / NICU admission
for 1 day.



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____
Upper middle class

Developmental History :

② development

Immunization History :

Vaccination till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 8.7kg (Centile _____)

On Examination :

Temperature : 97.9° F Pulse Rate : 106/min B.P. 119/71(82) SPO2 97% on RA

Resp. rate and type of breathing : RR = 26/min

Rash _____

Lymphadenopathy _____

Oedema : Nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE (7)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 (4)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT.

Auscultation : _____

Spine : _____ External Genitalia : _____

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

BAH-00660300

IP5-00175958

Master VIHAAN BAJAJ

11-01-2025

1 Y 5 M 23 D

(M)

Dr. HARISH JAYARAM



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 2

Cranial Nerves : N

Motor System:

Nutrition : 2

Power

Tone: N

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Plantars

Sensory System :

Bladder / Bowel :

Superficials:

Clinical Summary & Diagnostic:

Left Grade 5 VUR

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP on coagulation

Planned Management

- NPO to continue
- IV fluids
- Sye

Signature of the Doctor: Dr. Remya

Signature of the Consultant: Dr. Harish Jayaram

Name of the Doctor: Dr. Remya

Name of the Consultant: Dr. Harish Jayaram

Date & Time: 4/7/26, 9am

Date & Time: 4/7/26 10-30 AM

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. CYSTOSCOPY AND LEFT DJ STENT REMOVAL
2. CIRCUMCISION

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Reduction in urine infections.	

- 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:

- Bleeding, Infection
- Recurrence

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

Patient / Patient Attendant:

Signature: [Signature]
Name: DARSHAN BAJAJ
Relationship with patient: Father
Date & Time: 4/7/26, 9:52 AM

Witness:

Signature: [Signature]
Name: Kiran Bajaj
Date & Time: 4/7/26, 9:52 AM

Doctor (who is taking consent):

Signature: Nalika Name: Dr. Nalika Date: 4/7/26 Time: 9:52 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్ బిల్డెన్ 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

- విదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ కు 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:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. H. Jayaram
 Asst. Surgeon :
 Anaesthetist : Dr. Sundhar
 Scrub Nurse : Thirai

Patient Name : Master Vihaan Age : 1y Gender : M
 UHID No. : 660200 Surgery Name : Cystoscopy Left
 Date : 4/7/26 In-time : 11:50am Out-time : 1:30pm



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>10:45am</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☒ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☒ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Ayesh</u>	

Before Skin Incision >>

TIME OUT	Time: <u>11:21am</u>
Confirm all team members have introduced themselves by Name and Role	
	☒ Yes ☐ No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, 30 min	
Anticipated Blood Loss? 2ml	☐ Yes ☒ No ☐ NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed?	
	☐ Yes ☐ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No	
Signature : <u>[Signature]</u>	
Name : <u>Sigath</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>1:30pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☐ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No	
Signature :	
Name :	

Patient



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 4/7/26

Department : OT Duration of Procedure : 30 min

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 4/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : <u>Augmentin 260mg</u>	<u>Singal</u>
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	<u>Singal</u>
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Sundhara</u> Date & Time of antibiotic administration : <u>4/7/26 @</u> Date & Time procedure started : <u>4/7/26 @ 10:22AM</u>	<u>Singal</u>

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



OPERATION THEATER NOTES

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

UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:		OT Technician:
Pre-Operative Diagnosis:			
Surgical Procedure : ① CYTOSCOPY + LEFT DJ STENT REMOVAL ② CIRCUMCISION.			
Indications for Surgery : Left Grade-IV VUR.			
Date : 4/7/26	Start Time : 11:22 AM		End Time :
Pre Operative Preparations : - position : Lithotomy - 5% betadine			
Post Operative Diagnosis:			
Left Grade IV VUR			
Peri-Operative Complications:			
Nil			
Operation Notes:			
I Cystoscopy done -			
① Urethra : ① Caliber , patent			
② Bladder mucosa - smooth , no trabeculations			
③ Left ureteric orifices			
③ Left DJ stent noted insitu . DJ stent removal done			
II Circumcision done (by dorsal slit method)			

Amount of Blood Loss: <u>≤ 1ml</u>	Blood Transfused (in ML) <u>-Nil-</u>
Name and Number of Surgical Specimen sent for examination: <u>-Nil-</u>	
Peri-Operative Complications: <u>-Nil-</u>	
<u>DAY CARE</u>	
① SYP AUGMENTIN DUO 4ml P/O Twice daily x 5 days followed by ↓ SPORIDEX drops 0.9ml once daily at night	
② Syp CROCIN DS 3ml P/O Thrice daily for 3 days (240mg = 5ml)	
③ CIPROFLOXACIN EYE DROPS 1/1 at circumcision site.	

Name of the Surgeon: A. Harish Jayan

Signature of the Surgeon: [Signature]

Date & Time: 4/7/26 12:30 PM

BAH-00660300 IP5-00175958
Master VIHAAN BAJAJ
11-01-2025 1 Y 5 M 23 D (M)
Dr. HARISH JAYARAM




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POST-SURGICAL CARE PLAN FORM

Procedure Done: Cystoscopy + Left DJ stent removal + Circumcision

Post-Surgical Diagnosis: Left Grade I VUR.

Post-Operative Monitoring Parameters /Frequency:

Temp monitoring every 15m for 1st 1h.

Wound Care:

Dressing

n /Special Lines/Catheters:

-Nil-

Special Patient Positioning and Requirements:

-Nil-

Nutritional Instructions:

Full feeds as soon as child is awake.

When to Start Mobilization:

-Nil- As soon as possible

Special Referrals:

-Nil-

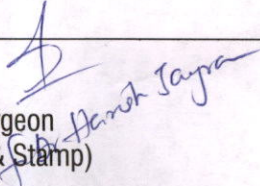
The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

-or-

Treating Surgeon
(Signature & Stamp)


Dr. Harish Jayaram

Date: 4/3/26 Time: 12:20pm

Note: Plan of care will be readjusted if necessary.



DRUG CHART

Date of Admission: 4/5/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

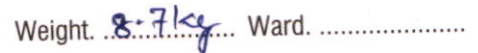
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

REGULAR PRESCRIPTIONS

Weight. 8.7kg Ward.



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																			



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

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

STAT / ONCE ONLY DRUGS[illegible]

[illegible]

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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: HAD 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
						☐ 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. Ramya

Date & Time : 4/7/26 ; 9am

Nurse Name & Signature : Mr. Seemita

Date & Time : 4/7/26 @ 9am

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RESULT SHEET

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

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

Culture and Sensitivities :

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.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :

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Patient Sticker

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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
G/A	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	H ₂ O	-	-	-	-	-	-	-	0	Diap	
Total Intake :						Total Output :						
G/A	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 Sticker

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							

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THE HUMPTY DUMPTY SCALE 2/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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				
	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					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	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			14				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		1				
Call device within reach		yes				
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support		NO				
Other Intervention(s) Specify		NO				
Nurse's Name :		Submith				
Signature :		GR				
Date :		2/7/26				
Time :		8:42				



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Harish Jayaram Department: OT Date of Admission: 4/7/26

SITUATION	Diagnosis: <u>② grade V WUR</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	<u>ER</u>						
	Shift Time	<u>9:27 am</u>						
	Medical Condition (Any special condition to be noted):	<u>Nil</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>97.9°F</u>						
	Res:	<u>26 bpm</u>						
	SpO ₂ :	<u>97%</u>						
	Pulse:	<u>106 bpm</u>						
	BP:	<u>119/71 (82)</u>						
	Fall Risk Score:	<u>14</u>						
	Pain Score:	<u>0</u>						
Recommendations	Safety Needs:	<u>yes</u>						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>Nil</u>						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>Nil</u>						
	Post Operative Procedure Special Orders:	<u>Nil</u>						
	Handed Over By Name :	<u>Susmita</u>						
	Signature :	<u>[Signature]</u>						
	Date:	<u>4/7/26</u>						
	Time:	<u>9:27 am</u>						
	Taken Over By Name :	<u>Peena</u>						
	Signature :	<u>[Signature]</u>						
	Date:	<u>4/7/26</u>						
	Time:	<u>4:30 am</u>						

Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BRADEN 'Q' SCALE

					Date : 4/7/26			
					Time : 8:42am			
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			
"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			
FRICITION-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 of 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. : RCHB/FRM / CLINICAL / 119					Evaluator's Name	Dr. Harish Jayaram		

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

BAH-00660300
Master VIHAAN SAJJAJ
11-01-2025 1 Y 6 M 23 D
Dr. HARISH JAYARAM (M)

PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/26	8:42am	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	AK
4/7/26	12:10 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Durg
				☐ 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:

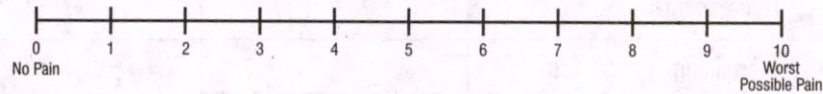
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

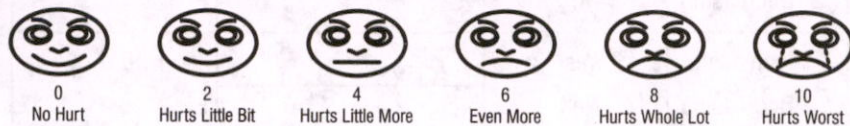
Numerical Pain Scale (Obstetric and Gynecology)



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



BAH-00660300 IP5-00175958
Master VIHAAN BAJAJ
11-01-2025 1 Y 5 M 23 D (M)
Dr. HARISH JAYARAM



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent

5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures

9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights

13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4.7.20	8:42 am	8.	Diagnostic procedure	M	1	0	1	1	—	

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

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/17/26 @8:45 an	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	DJ stant Removal	H. Stalsel	Npo IVC	(Signature)	☐ Nursing ☐ Others:
4/17/26 @8:45 an	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	DJ stant Removal	H. Stalsel	Npo - IVF	(Signature)	☒ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Vihaan Bajaj Age: 1y 5m Sex: Male UHID.No: BAH 00660300
Date: 3/7/2025 Time: 3:15 pm Proposed Operation: Cystoscopy + D.I. stone removal + ureteric stent
Diagnosis: Grade IV VUR
B.P./CRT: <3sec H.R: Weight: 8.6kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	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: nil

Medical History: CVS: (-) Tam/LSG/2.5kg/CIAB/NICU admission Per id
RESP: (-) no mouth breathing Diabetes:
CNS: (-) Developmental nil
Renal: VUR
Hepatic / GE: Physical Activity: active, Feeding well
Others:

Past Anaesthetic History: Cystoscopy force + GA

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mento-hyoid Distance: Neck: Teeth:

Lungs: chest clear

Heart: S.S.W

CNS: GCS - Full

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional: W

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL Breast milk → 4hr (G: 00am)
Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: DR. SHOBAN



ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status:	Confirmed
Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed

H.R: 100bpm	B.P / CRT: 90/60	SpO ₂ : 98% on RA	R.R: 24/min	Last Feed: 7hms
Pre-OP Diagnosis: Lt Grade II VUP		Operation: Circumcision + DS skin removal		Date: 4.1.26
Surgeon: Dr. Harish		Anaesthesiologist: Dr. P. S. Surya / Dr. Sridhar / Dr. Aysha		Technician: Sreedha

TIME	11:05	11:10	11:20	11:45	12:00
N ₂ O / AIR (O ₂) LPM	2lt				
HALO / ISO / SEVO					
Drugs:					
MIDAZOLAM	0.6mg				
PROPOFOL	10mg				
ETCO ₂	41	42	44	44	43
ECG	NSR	NSR	NSR	NSR	NSR
Temperature					
Urine Output					
Fluids					
Blood					
B.P	100/60	98/60	98/60	100/60	100/60
V Systolic	100	98	98	100	100
A Diastolic	60	62	64	64	63
X Mean	60	62	64	64	63
Heart Rate	100	98	98	100	100
Tourniquet on Time					
Tourniquet off Time					
Throat Pack In					
Throat Pack Out					
LAB Values					
ABG					
GRBS					
Others					

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: Rt UL ☐ Art Site: ☒ EKG Lead ☒ Temp Site: axilla ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: Lithotomy Pressure Points Checked	Temp: ☐ HME ☐ Cling Film ☐ Hugger's ☐ Other Times: Anaes Start: 11:05 AM OP Start: 11:05 AM OP End: 12:00 PM Leave OR: 12:00 PM Anaesthesia: ☐ GA ☒ Monitored Anaesthesia Care ☒ Regional	Induction ☒ IV ☒ Pre O ₂ ☐ Others ☐ Mask ☐ Airway ☐ ETT # at cm ☐ Oral ☐ Tracheostomy ☐ Drug: ☐ Awake ☐ Video Laryngoscopy ☐ Fiberoptic Blade # Attempts: Difficulty Why? ☒ Bilat = BS ☐ Semi-Closed Circle ☐ Closed Circle ☐ Other	Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☒ Caudal Others: Position: Lateral decubitus Site: Sacral hiatus Needle Size: 25G Depth: 5cm Paresthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: 0.25% Bupivacaine Bolus: 8ml Infusion: Block Level: Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: Dr. P. S. Surya Signature of the Doctor: [Signature]
--	--	--	--



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. J Time Received : 12:50pm Time Discharged : 1:30pm

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 BLOOD PRESSURE	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>225</u>
		☐ O ₂ Mask ☒ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
RESPIRATION	PULSE	Vomiting : ☐ Yes ☒ No
		Drug: _____
SPO₂	RESPIRATION	NG Tube : ☐ Yes ☒ No
		Drain: ☐ Yes ☒ No
SPO₂	SPO₂	Urinary Catheter: ☐ Yes ☒ No
		Chest Tube: ☐ Yes ☒ No
SPO₂	SPO₂	Nil Oral ☐ Yes ☒ No
		IV Fluids: _____
SPO₂	SPO₂	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 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	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1						
BP $\pm$ 50 of Pre Anaesthetic leve	= 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
4/7	12:50pm	1/10	—	Dr. J

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

Anaesthesiologist Name : Dr. Bandaru

Anaesthesiologist Signature: [Signature]

Date & Time: 4/7/2025 @ 1:30pm

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 4/7/2025 @ 1:30pm

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): bill hug

Date & Time: 4/7/2025 @ 1:30pm

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 :

Patient St

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 Master VIHAAN BAJAJ
 11-01-2026 1 Y 5 M 23 D (M)
 Dr. HARISH JAYARAM



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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Cystoscopy + DJ stent removal + Circumcision

Anaesthesiologist: Dr. SHOBNA Surgeon: Dr. Harish 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: Desaturation, Bronchospasm, Laryngospasm

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: Darshan

Name: DARSHAN BAJAJ

Relationship with patient: FATHER

Date & Time: 03-07-26 @ 2:30 pm

Witness:

Signature: Kiran

Name: KIRAN BAJAJ

Date & Time: 03-07-26 @ 3:30 pm

Doctor (who is taking consent):

Signature: Shobna Name: Dr. SHOBNA

Date: 3/7/26 Time: 3:30 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.

లిజనల్ 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 లిస్ట్:

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.
☐ లిజనల్ 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 సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ 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:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం: