

VIH-00202542 IP-00060173
Master ARAMAAN KRISHNA
22-07-2019 6 Y (M)
Dr. JYOTI BOTHRA



ACTIVITY RECORD FOR BILLING

Name: -----
UHID No : ----- IP No : ----- Consultant : ----- Dept : L-22
Date of Admission : 29/5/26 Time : 11:36 am Date of Discharge : ----- Time: -----
Room / Bed No : O.T Ward : O.T Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	12:40 pm	L-22	O.T	(10)
29/05/26		O.T	Recovery room	JL

Cross Consultation Visit

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



SURGERY DETAILS

Date : 29/5/20

Patient Name: Mast. Aramaan Krishna Date of Birth: 22/07/2019 Age: 6yrs

Gender: male Ward : OT UHID No.: 202542

Date of Surgery: 29/5/20 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2

Name of the Surgery : (R) Open Herniorrhaphy

Time in : 1:50 pm

Time Out : 2:30 PM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Jyoti Bothra</u>	<u>OT-charges</u>
2. Anaesthetist	<u>Dr. Shilpa / Dr. Brunda</u>	
3. Assistant Surgeon		
4. OT Technician	<u>Tech. Rakesh</u>	
5. Circulating Nurse	<u>Dr. Macia</u>	
6. Assistant Nurse	<u>Sr. Bhavani / Prasanna</u>	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 3085238 / 3085239

Order by: Dr. Shilpa

CONSUMABLES
OF OT
Herniotomy
② 29/5/26



Circulating Staff :

Technician :

Anaesthesia Disposables	Qty		Surgical disposables	Qty		Disposables (Baby side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack			Inj. Vit. K		
LMA			Sutures			Cord Clamp		
ECG leads : A/P/N		3	2437		1	Suction Catheter		
HME filter : A/P/N			9315w		1	Feeding Tube		
Syringe 10 cc		3				Vaccum Suction Set		
05 cc		3	Gloves 6pp/6sh		2/1	Surgical Gloves		
02 cc						Gauze Pack		
01 cc						Syringe 1 m/ 2 ml		
Cautery Plate : A/P/N			Surgical blade 15		1	Surgical Blade # 20		
IV set		1	NG tube			Koochies (S)		
RL		1	Cautery Pencil					
NS : 10ml/100 ml/ 500ml/1000ml		2	Koochies			pro/10 gauze		2
Boxing bandage			Ointments					
nasal capnography (P)		1	Suction Catheter					
Fentanyl medical		1	Cap. Mask		7+7			
Morphine			Gauze Pack		1			
Ketamine			Mop Pack					
Propofol		2	Steristrip Adesorb		1			
Rocuronium			Underpad					
Glycopyrolate			Draw Sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys Catheter					
Pencan 25g/Spinal Needle 22 (Head Urogen)		1	Urobag					
Bupivacine 0.25%			Chest Drinage Catheter					
Bupivacine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg/250mg/170 mg			Double J Stent					
Supridol 100 mg			Vaccum Suction set					
Justin : 12.5 mg/25 mg/ 100 mg		1	Plastic Bed Sheet					
Tab. Misoprost : 200 mg			Betadine Solution		1			
Glove (1/2 PP)		1	Microshield		1			
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon

Dr. Jyoti Bothra

Anaesthesiologist

Dr. Shilpa

Nurse

Blavani

Premanu

OT Tech

Order No. :

3085255

Ordered by :

**Rainbow
Children's
Hospital**



RAINBOW CHILDREN'S MEDICARE LIMITED
Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,
Kakaguda, Karkhana Hyderabad Telangana INDIA 500009
Tel No : 040-42462200, Ext 2000,2001,2002

VAT TIN : 36920283145

CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034,
Telangana.



INPATIENT ISSUES AGAINST ORDERS

IP No	IP-00060173	Ward	N 0 GF-EMERGENCY
Patient Name	Master ARAMAAN KRISHNA BANERJEE	Bed Name	ER 103
Age/Sex	6 Y / Male	Order No	0003085255
Date	29/05/2026 14:49	Prescription No	PRIP-1289234
Payor	SELPAY	Dispensed Date	29/05/2026 14:50
UHID	VIH-00202542		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ALLESORB CORE TURNAROUND COVER 40x60IN		General	250922J	12/30	1	425.00	425.00
2	BACTOPREP SOLUTIONS 100 ML	RAMAN & WEIL PVT LTD		RTBP26002	02/29	1	229.00	229.00
3	BETADINE SOLUTION 10% 100 ML	WIN MEDICARE PVT. LTD	General	MD01426	03/28	1	103.95	103.95
4	CAPNOGRAPHY NASAL CANNULA-PEAD		GENERAL	CGBMD01	03/29	1	200.00	200.00
5	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26CO3K92	01/31	3	28.13	84.39
6	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C03K96	02/31	3	21.56	64.68
7	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	77160326	02/28	3	34.64	103.92
8	Encore Microptic gloves- 6.5		H	26020311T	02/29	2	128.00	256.00
9	ENCORE MICROPTIC GLOVES-6 PF	ELITE MEDICALS	GENERAL	260300751T	03/29	2	128.00	256.00
10	FACE MASK-3LAYER THREADED	Sunrise		VI02012026	12/99	7	10.00	70.00
11	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	17O724	06/27	1	100.00	100.00
12	INTRAFIX(TRANSFLO)	Bbraun Medical PvtLtd		25K27K8901	09/30	1	333.09	333.09
13	JUSTIN SUPPOSITORIES 12.5 MG 5 S	Neon Laboratories Ltd	H	BLNP278009	02/28	1	12.14	12.14
14	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353002	07/27	2	69.10	138.20
15	MEZOLAM INJ 5 MG 5 ML	Neon Laboratories Ltd	H1	V304625	12/27	1	31.55	31.55
16	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS		26FB001	01/29	10	23.43	234.30
17	NS IV 10 ML AMPULE	MEDLIFE HEALTH SOLUTIONS	GENERAL	7219038	06/30	2	16.14	32.28
18	PROTO GOWN (ADULT) (PROTECTCARE)		General	VI20052026	12/30	2	450.00	900.00
19	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1C261729	02/29	1	69.39	69.39
20	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	VYGON		030725AG	07/30	1	302.00	302.00
21	SURGEON CAP(FEMALE) (PROTECTCARE)		General	2110300042026	12/29	7	10.00	70.00
22	SURGICAL BLADE 15	Surgeon	GENERAL	160625	05/30	1	7.67	7.67
23	VICRYL 3-0 VP 2437	ETHICON SUTURES-J&J C1		TT5035	04/30	1	663.00	663.00
24	VICRYL RAPIDE 5-0 9915W	ETHICON SUTURES-J&J C1		AW6665	04/30	1	885.00	885.00
Total :							4,280.79	5,571.56

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : SHEEPA PALANI

Name	Master ARAMAAN KRISHNA BANERJEE	UHID	VIH-00202542
Father/Guardian	Mr RUPAM BANERJEE	Age/Gender	6 Y /Male
Address	Sainikpuri, Sainikpuri, Hyderabad, Telangana, INDIA, 500094		
IP No	IP-00060173	Admission Date	29-05-2026
Ref Doctor	Self	Discharge Date	29-05-2026

DISCHARGE SUMMARY

Consultant:

Dr. JYOTI BOTHRA

DNB, MCh (Pediatric Surgery), FMAS

SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY

Diagnosis: Right inguinal hernia

Surgical Procedure: Right Open Herniotomy done on 29.05.2026

History: Master ARAMAAN KRISHNA BANERJEE is a 6 Y boy presented with history of right inguinal hernia. For the above complaints, he was admitted at Rainbow Children's Hospital for right open herniotomy.

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. Heart rate was 112/min, BP 97/48 (63) mmHg and RR - 26/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Neurologically, he was conscious and oriented. Other systemic examination was normal.

Weight on admission : 17.8 kgs.

Management: He was admitted in the ward.

Name	Master ARAMAAN KRISHNA BANERJEE	UHID	VIH-00202542
------	------------------------------------	------	--------------

His complete blood picture showed Hb 12.5 gm%, WBC count of 5,050 cells/cumm, platelet count of 2.50 lakhs/cumm.

Surgical Procedure: Right Open Herniotomy done on 29.05.2026

Operative Notes :

- Right mid-inguinal lower crease incision
- Right hernial sac dissected, transfixed and ligated at base
- Distal sac laid open
- Incision closed in layers

Post Operative notes : Post operative period was uneventful. He was started orally on liquid feeds which he accepted and tolerated well and he is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Advice:

1. Diet as advised.
2. Remove dressing on Monday (01.06.2026) and daily bath
3. Syp. Crocin-DS(5ml/240mg), 4ml thrice daily for 3 days and then SOS.
4. Kindly consult with Dr. Jyoti Bothra, Consultant Pediatric Surgeon, after 7 days in OPD with prior appointment (This consultation will be charged).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

In Case of Emergency for increasing breathing difficulty, dullness or high fever, Contact 040-42462200 Extn: 2010 (or) 7337357870.

Name

Master ARAMAAN
KRISHNA BANERJEE

UHID


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

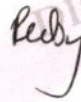
Name : *Rupam Banerjee*

Signature :



Relationship with patient : *Father*

This summary has been explained by :



Summary prepared by: Dr. Shivam
Typist : Kalyan



Registrar/Resident/C.M.O

Dr. JYOTI BOTHRA

DNB, MCh (Pediatric Surgery), FMAS
SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY
TSMC/FMR/02962

DEFECIENC

VIH-00202542 IP-00060173
 Master ARAMAAN KRISHNA
 22-07-2019 6 Y (M)
 Dr. JYOTI BOTHRA

ICAL CASE SHEET



Patient Name :

IP. No :

Ward :



DOD :

Sl.No.	LIST OF RECORDS	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1	✓	✓	
2	Discharge Summary	2	✓	✓	
3	Nursing Initial assessment.	1	✓	✓	
4	Patient Transfer form	2	✓	✓	
5	In-patient Medical record	1	✓	✓	
6	Doctors progress sheets	1	✓	✓	
7	Nursing plan of care and handover sheets	1	✓	✓	
8	Consultation sheet	1	✓	✓	
9	General consent for treatment	1	✓	✓	
10	Consent for Surgery	1	✓	✓	
11	Consent for blood transfusion	1	✓	✓	
12	Consent for chemotherapy	1	✓	✓	
13	Consent for high risk	1	✓	✓	
14	Consent for Restraint	1	✓	✓	
15	LAMA consent	1	✓	✓	
16	Consent for special procedure/Sedation	1	✓	✓	
17	Consent for Formula feed	1	✓	✓	
18	Consent for MTP	1	✓	✓	
19	Consent for Radiological Investigations	1	✓	✓	
20	Consent for HIV test	1	✓	✓	
21	Anaesthesia notes (Pre Anaesthesia& post)	1	✓	✓	
22	Neonatal Admission/Delivery/Physical Exam	1	✓	✓	
23	Medication Reconciliation	1	✓	✓	
24	Emergency Triage record	1	✓	✓	
25	Pre operative check list	1	✓	✓	
26	Surgical safety checklist	1	✓	✓	
27	Operation Theatre notes	1	✓	✓	
28	Nurses clinical Presentation	1	✓	✓	
29	TPR & BP chart	1	✓	✓	
30	Intake and Out take chart (fluid chart)	1	✓	✓	
31	Drug chart (Regular Prescription)	1	✓	✓	
32	Investigation Values (result sheet)	1	✓	✓	
33	Nebulization chart <i>Pain Assessment</i>	1	✓	✓	
34	Nutritional review chart <i>Thrombophleb</i>	1	✓	✓	
35	Intensive care unit (ICU Charts) <i>isolation policy</i>	1	✓	✓	
36	Consent for Admission in PICU/NICU	1	✓	✓	
37	The Humpty dumpty scale	1	✓	✓	
38	Braden Q Scale	1	✓	✓	
39	Bed side check list <i>Attendant informed</i>	1	✓	✓	
40	PICU bed formula Dilution feeds <i>85</i>	1	✓	✓	
41	Gastro monitoring chart <i>Admission</i>	1	✓	✓	
42	Rch ED doctors note <i>Estimation</i>	1	✓	✓	
43	BP Monitoring chart <i>Estimation</i>	1	✓	✓	
44	RBS monitoring chart <i>Adhar</i>	1	✓	✓	

Total No. of Pages **31**

Signature and Date :

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060173

Admit Date : 29-May-2026

Admit Time : 11:36 AM **UHID** : VIH-00202542

Patient Details :

Patient Name : Master ARAMAAN KRISHNA BANERJEE

Age : 6 Y

Guardian : Mr RUPAM BANERJEE

DOB : 22-07-2019

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : Sainikpuri Sainikpuri Hyderabad Telangana INDIA 500094

Phone No : 7286064034/

E-mail : BANERJEERUPAM4@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 103

Ward Name : N 0 GF-EMERGENCY

Room No : ER 103

Admission Type : First Visit

Contact Details :

Name : Mr RUPAM BANERJEE

Relationship : S/O

Contact Address : Sainikpuri Sainikpuri Hyderabad Telangana INDIA 500094

Phone No : 7286064034

Signature

Doctor Details :

Doctor Name : Dr. JYOTI BOTHRA

Specialisation : PEDIATRIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

Patient Name : Mast. ARAMAAN KRISHNA BANERJEE UHID : VIH-00202542 IPD : IP-00060173 Gender : Male Age : 6 Y

VIH-00202542 IP-00060173
 Master ARAMAAN KRISHNA
 22-07-2019 6 Y (M)



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/07/2019 Time of arrival : 11:30 AM.
 Chief Complaints : e/o. Come for Surgery @ Open Herniotomy RBS: -
 Height : 114cm Weight : 17.80kg BMI : - Head Circumference (<2 years) : -
 Allergies: Yes No Medications Blood Transfusion Food Other: -
 If yes, identify -
 Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character - Location - Frequency - Duration -

<p>RISK FOR FALL:</p> <p><input checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <p><input type="checkbox"/> Escort while ambulating</p> <p><input type="checkbox"/> Assist Patient</p> <p><input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <p><input type="checkbox"/> Mobility Problem</p> <p><input type="checkbox"/> Walking Problem</p> <p><input type="checkbox"/> Developmental Delay</p> <p><input type="checkbox"/> Musculoskeletal Congenital Abnormality</p> <p>Inform consultant for positive criteria</p> <p>.....</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <p><input type="checkbox"/> Underweight</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Feeding Problem</p> <p><input type="checkbox"/> Special diet</p> <p><input type="checkbox"/> Special feeding method</p> <p>Inform consultant for positive criteria</p>
--	--

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: - (Date/Time): -

Social History: Lives With Parents

Siblings in household Yes No (if yes How Many?) 1 sister, 1 brother

Time of Initial assessment completed by ER Nurse : @ 11:36 AM.

Patient Name : Mast. ARAMAAN KRISHNA BANERJEE UHID : VIH-00202542 IPD : IP-00060173 Gender : Male Age : 6 Y

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

Time	Nursing Notes
11:25A	Patient came to ER, vitals checked & recorded
11:30A	Dr. Shivam Seen the patient and given the intubation slip. Admission done.
@ 11:48	* NPO from @ 8:30 pm Solid, Liquid - 8:30pm.
11:55A	IV placement done.
12:00A	Sample collecting and send to Lab.
12:40A	Patient shifted to OT.

Samples collected by: } Dr. Shivam.
 Samples sent by: } Dr. Revathy.

Time: @ 11:48 Am.

Time: @ 11:54 Am.

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
17/11					


Condition of patient at time of shift - out :	Details of Shift - out
HR: 112 bpm, BP: 96/45 CF, RR: 24 bpm, SPO ₂ : 99%, GCS: 4, 5, 2, Temperature: 98.1° F, Pain Score: 0, Repeat RBS (if applicable): -	Shift - out from ER to: OT Time of Shift - out: 29/5/26 @ 11:32 pm Handover given to: Dr. Mariya (Nurse's Name) by Sr Swagatika

Tick as applicable: MLC LAMA BROUGHT DEAD

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

Name of the Nurse: Swagatika, Signature of the Nurse: [Signature]
 Date & Time: 29/5/26 @ 12:40 pm

PATIENT TRANSFER FORM

Patient Name / I.P. No. VIH-00202542 IP-00060173 Master ARAMAAN KRISHNA (M) 22-07-2019 6 Y Dr. JYOTI BOTHRA 		Date & Time of Admission 29/5/26 @	Date & Time of Transfer Order 29/5/26 @ 2:40 PM
		Transfer ordered by Dr. Brunda.	Reason for Transfer Post Op Care
From Unit 01	To Unit Recovery Room	Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in clinical file 30	Number of Imaging films nil	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / notes written by Doctor :

Dr. Jyoti

Name & Signature of Person who is Transferring

Sr. Maina

Name of Person Ordered Transfer

Dr. Brunda.

Patient & Clinical records received by :

Ruby

Date & Time of Patient Received:

29/5/26

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

PATIENT TRANSFER FORM



VIH-00202542 IP-00060173 Master ARAMAAN KRISHNA 22-07-2019 6 Y (M) Dr. JYOTI BOTHRA 	Date & Time of Admission <p style="text-align: center; font-size: 1.2em;">29/5/2020 11:36 AM</p>	Date & Time of Transfer Order <p style="text-align: center; font-size: 1.2em;">29/5/2020 12:40 PM</p>
	Transfer Ordered by <p style="text-align: center; font-size: 1.2em;">Dr Shivam</p>	Reason for Transfer <p style="text-align: center; font-size: 1.2em;">Admission</p>
From Unit <p style="text-align: center; font-size: 1.2em;">ER</p>	To Unit <p style="text-align: center; font-size: 1.2em;">O.T</p>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <p style="text-align: center; font-size: 1.2em;">21</p>	Number of Imaging Films <p style="text-align: center; font-size: 1.2em;">-</p>	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <p style="text-align: center; font-size: 1.2em;">Shivam (Signature)</p>	Name of Person Ordered Transfer <p style="text-align: center; font-size: 1.2em;">Dr Shivam</p>	
Patient & Clinical Records Received by : <p style="text-align: center; font-size: 1.2em;">Ruby</p>		
Date & Time of Patient Received : <p style="text-align: center; font-size: 1.2em;">29/5/2020 12:40 PM</p>		

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



**Rainbow[®]
Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

VIH-00202542 IP-00060173
Master ARAMAAN KRISHNA
22-07-2019 6 Y (M)
Dr. JYOTI BOTHRA



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K/O Right Inguinal Hernia
for RT open Hernia tummy

History of present illness :

NPO Status :

Solid and Liquid 8:30 pm, yesky

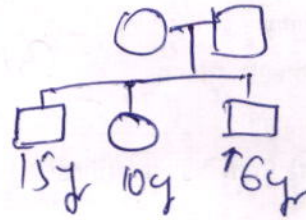


Pediatric Multiorgan History & Physical Examination

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

no + signs

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

normal for age

Immunization History :

Vaccines complete for age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs) 17.8kg (Centile _____)

On Examination :

Temperature : 98.3F Pulse Rate : 64/min B.P. 97/48(63) SpO2 98%
Resp.rate and type of breathing : 26/min

Rash _____
Lymphadenopathy _____
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : BLAB
Any addes sounds : _____
Relevant data from outside (Chest X-Ray, ABG,etc.,) _____

Cardiovascular System :

Inspection of procordium : _____
Heart Sounds : S1 S2
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____
Palpation : RT hypal liver
Ausculation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials: _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

RT Inguinal Hernia



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Planned Management

CBP ✓

- NPO

- Shift 1007

~~Noted by Dr. Hiran 24/5/20
29/5/20 @ 12:30pm~~

Signature of the Doctor: _____
Name of the Doctor: _____
Date & Time: _____

Signature of the Consultant: _____
Name of the Consultant: _____
Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>29/8/20</u>		
		S/B Dr. Jyoti
		of clo (R) Open Hematology
		Stable
		<u>Adv</u>
		W/C today
		S/B



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure: Open Herniotomy	Post OP Day:						
BACKGROUND	Date	29/12/26						
	Shift	Morning						
	Medical Condition (Any special condition to be noted):	-						
	Diet:	NPO.						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA.						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.2°P					
		Res:	23b/m.					
		SpO ₂ :	100%.					
		Pulse:	112b/m.					
		BP:	97/83(74)					
		LOC:	-					
	Fall Risk Score:	-						
Pain Score:	0							
Skin Integrity	Intact.							
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	NPO						
	Critical Lab Test / Values:	-						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	Dependent.							
Post Operative Procedure Special Orders:		-						
Handed Over By Name :		Suganya.						
Signature / ID :		[Signature]						
Date:		29/12/26						
Time:		@ 12:40P						
Taken Over By Name :		[Signature]						
Signature / ID :		[Signature]						
Date:		29/12/26						
Time:		12:40PM						

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	Shift	/	/	/	/	/	
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

GENERAL CONSENT FOR TREATMENT

Patient Name: Master ARAMAAN KRISHNA BANERJEE Age : 6 Y
IP No: IP-00060173 Sex: Male
Consultant: Dr. JYOTI BOTHRA Ward/Bed No: N 0 GF-EMERGENCY/ER 103

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the life of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

- 1 We do not allow use of medication brought from outside by the patient.
- 2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

Receivers Signature:.....

- 3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
- 4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Mr. Rupam Banerjee.

Relationship: Father.

Date: 29/5/26

Witness Name: Shilpa

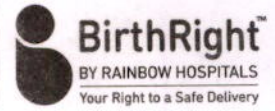
Witness Signature:

Patient Address:

Sainikpuri Sainikpuri Hyderabad
Telangana INDIA 500094

Time: 11:36 AM.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Asamaan Krishna Gender: Male Female Age : 6yr
 UHID No : 60173 Date : 29/5/26

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avpid technical terms)

(R) Open Hemiorrhaphy
 upon
 (Name of the Patient) Asamaan Krishna

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized 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. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Infection

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Sashi Botla

Consentee :

Signature : _____
 Name : _____
 Date & Time : _____

Witness : (NA)

Signature : _____
 Name : _____
 Date & Time : _____

Patient Attendant :

Signature : _____
 Name : Rupam Benerge
 Relationship with Patient: Father
 Date & Time : 27/05/26, 1pm

Doctor (who is taking the consent) :

Signature : _____
 Name : Dr. Sashi Botla
 Date & Time : 29/5/26, 1pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Master Armaan Krishna Banerjee Age : 6 yr. Gender : Male Female

UHID NO: Surgeon Name: Dr. Jyoti Bhatia.

Anaesthesiologist : Dr. M. Vinetha

Operative procedure planned : Right open Hemiotomy.

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 without numbness can be achieved by infusing weak solutions of local anesthetics 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 mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : Desaturation, Knee/shoulder pain, laryngospasm

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master Armaan Krishna Banerjee the above mentioned operation / Diagnostic / Therapeutic procedures Right-open Hemiotomy.

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature :

Name : Rupam Rongjee

Relationship with Patient: Father

Date & Time : 27/05/26

Witness :

Signature :

Name :

Date & Time :

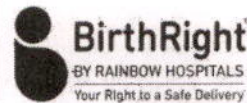
Doctor (who is taking the consent) :

Signature :

Name : DR. M. VINAYAK

Date & Time : 27/05/26

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Master ARMAAN KRISHNA BANERJEE Age: 6 y.r. Sex: Male UHID.No:

Date: 27/05/26 Time: Proposed Operation: Right open Herniotomy.

Diagnosis:

B.P / CRT: 88/56 H.R: 108 Weight: 17.93 kg 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: NKDA

Medical History: CVS: no active cardio respiratory complaints

RESP: Diabetes: (-)

CNS: LSCS/FT / Twin 1 / BWT - ? / NO NICU admission

Renal: (-) No developmental delays / Promised till date

Hepatic / GE: Physical Activity: Active CIAB

Others:

Past Anaesthetic History: (-)

Physical Exam: tongue tie (+)

Airway: MP 1 (2) 3 4 Mouth Opening: 3F Mentohyoid Distance: (n) Neck: (n) Teeth: Intact

Lungs: BLAE (+), clear.

Heart: S2 (+)

CNS: conscious, Alert.

Pregnant: Yes No NA Venous Access Site: accessible Spine Exam for regional: normal midline spaces felt.

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

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

CURRENT MEDICATIONS	DOSAGE

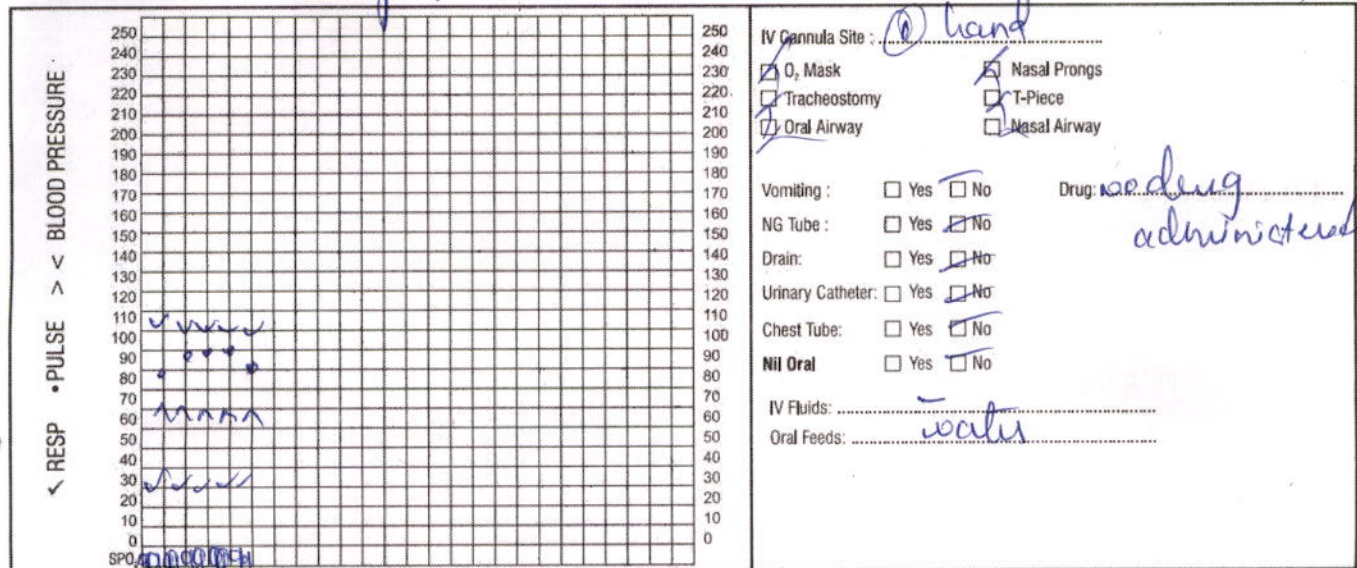
- Pre-Operative Instructions:**
- DVT Prophylaxis:
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / DRS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$ / explained.
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient parents.
 - Other Instructions: v. CBP after cannulation.

Signature: [Signature] Name: DR. M. VINAYETHA.



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Ruby P Time Received : 12:40 PM Time Discharged : 5 PM



IV Cannula Site : Hand

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting : Yes No Drug : nothing administered
 NG Tube : Yes No
 Drain : Yes No
 Urinary Catheter : Yes No
 Chest Tube : Yes No
 Nil Oral Yes No
 IV Fluids : water
 Oral Feeds : water

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29/5/26	3 PM	0	-	<u>[Signature]</u>

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 Brunda
 Anaesthesiologist Signature: [Signature]
 Date & Time: 29/5/26 5 PM
 PACU Nurse Name : Ruby P
 PACU Nurse Signature: [Signature]
 Date & Time: 29/5/26 5 PM

Transferred to Unit by (PACU): Ruby
 Date & Time: 29/5/26 5 PM

MEDICATION RECONCILIATION FORM

Drug Allergies: Nil 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: O.T.

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4		Nil				<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shivam R. [Signature]

Date & Time : 29/5/26 @ 11 AM

Nurse Name & Signature: Sr. Laxmi R. [Signature]

Date & Time : 29/5/26 @ 11 AM

Master ARAMAAN KRISHNA
22-07-2019 6 Y (M)
Dr. JYOTI BOTHERA



wt - 17.80 kgs.



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Armaan Krishna Age : 6 Yr. Gender : Male Female

Date : 29/5/20 Time of Arrival : 11:28 AM

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): _____ Not known

Source of Information: Parents Others (Specify) _____

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 98.3 F PR: 64b/m BP: 97/48(63) RR: 26b/m SpO₂: 98%

Chief Complaints: elo. Came for Surgery. C @ Open Herniotomy

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening	
---	--	--	--	---	--

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 11:28 AM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
If yes, State Location: _____
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)


- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Swagatika

Signature of Triage Nurse : _____

Date & Time : 29/5/20 @ 11:28 AM

PRE - OPERATIVE CHECK LIST

VIH-00202542 IP-00060173
 Master ARAMAAN KRISHNA
 22-07-2019 6 Y (M)
 Patient's Dr. JYOTI BOTHRA
 Blood Gr 
 Date: 29/5/26
 Age: 6 Y Gender: M F
 I.P. No.: 202542
 Planned Surgery: Right open Hemimiotomy Surgeon: Dr. Jyoti Bothra
 esthetist: Right open Hemimiotomy Date & Time of Operation: 29/5/26

Tick appropriate boxes :
 To be filled by Nurse Incharge / Senior Nurse :

S.No.	Instructions	YES	NO
1	Weight checked and recorded? <u>17.8 kg</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2	Is the patient fasting for over 6 hours pre-operatively? <u>J</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3	Check Pre-OP investigations & Results (CBP, Blood Group, BT, CT, PT/APTT, Viral Screening, CXR etc.) Discuss with Registrar / Consultant	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4	Enema given / Bowel Preparation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5	Remove all ornaments, etc and sterile gown given	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6	Is Blood arranged as required?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7	If Blood has been ordered - is Blood bag read?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8	IV Cannula to be placed / IV fluids if indicated	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Pre Anaesthetic consultation with anesthesiologist	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10	Pre medications given? (Sedative / etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11	Skin Preparation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operation Surgeon only)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13	Other (if any)	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NOTE: If any of above is ticked "No" Discuss with the registrar / Consultant immediately

Date: 29/5/26 Time: 12 PM

 Signature of Nurse in-charge: Sr/Anam

SURGICAL SAFETY CHECKLIST

VIH-00202542 IP-00060173
 Master ARAMAAN KRISHNA
 22-07-2019 6 Y (M)
 Dr. JYOTI BOTHA



Surgeon : Dr. Jyoti Bothra
 Asst. Surgeon : Dr. Braunda
 Anaesthetist : Dr. Braunda
 Scrub Nurse : Bhavana / Prasanna

Age : Gender :
 Primary Name : Open Herniotomy
 In-time : 1:30pm Out-time : 2:30pm



Before Induction of Anaesthesia ➤ ➤

SIGN IN	Time: <u>1:40pm</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>B. de</u>	
Name : <u>Dr. Braunda</u> <u>29/8/26</u>	

Before Skin Incision ➤ ➤

TIME OUT	Time: <u>1:50pm</u>
Confirm all team members have introduced themselves by Name and Role	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	<u>Open Herniotomy</u>
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>20 min</u> <u>5ml</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Sr. Vanitha</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>2:30pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Jyoti Bothra</u>	

Rainbow Children's Medicare Ltd.

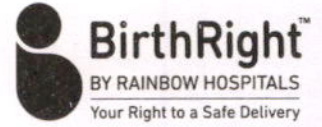
3-7-222 & 3-7-223, Sy. No. 51 & 54, Opp. New Karkhana Police Station

Karkhana Main Road, Kakaguda, Secunderabad - 500009.

Tel : +91-40-4246 2200, 2789 5050, 2789 6060.

GST: 36AABCR4014M1ZE email: vrchbilling@rainbowhospitals.in

CIN: L85110TG1998PLC029914 www.rainbowhospitals.in



OPERATION THEATER NOTES

Patient's Name : Master ARAMAAN KRISHNA BANERJEE	Age : 6 Y	Gender : Male
UHID : VIH-00202542	I.P. NO. 00060173	WEIGHT :17.8kg s
Surgeon : Dr.. JYOTI BOTHRA	Asst surgeon : Dr	
Anaesthetist : Dr Rama Brunda	OT Nurse : S/N	
Surgical Procedure :. RIGHT OPEN HERNIOTOMY		
Indications for Surgery : Right inguinal hernia		
Anaesthesia - GA		
PRE-OPERATIVE PREPARATION- Betadine skin preparation		
OPERATIVE NOTES: - Right mid-inguinal lower crease incision - Right hernial sac dissected, transfixed and ligated at base - Distal sac laid open - Incision closed in layers Anaesthesia Uneventful recovery.		
POSTOPERATIVE ORDERS 1. Diet as advised 2. Remove dressing on (01/06/2026) and daily bath 3. Syp Crocin 4ml twice a day for 2 days and then SOS for pain/fever (maximum 6th hourly) 4. Kindly consult Dr. Jyoti Bothra, Consultant Pediatric Surgeon, after one week in OPD with prior appointment (This consultation will be charged)		

**Consultants Surgeon's Name
Signature**

Dr. JYOTI BOTHRA

Date : 24/05/26

Consultant Surgeon's

Time :

Bothra
2:30 pm



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis 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		NBM								0	LP	
	01:00 pm		NBM	el: 150ml							0	LP	
Total Intake :						Total Output :							
	02:00 pm		NBM								0	LP	
	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	
-----------------------------	--



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					

