Master GUGULOTH MANVITH JAI
24-08-2025 0 Y 10 M 28 D (M)
Dr. ALISHA BABBAR

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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 OAD ~~Biopsy~~

2 .....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. 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)
Diagnostic.	

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

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

a. Abrasion, Bleeding, perforation, injury to adjacent structure

b.

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

Patient / Patient Attendant:

Signature: G. Venkatesh

Name: G. Venkatesh

Relationship with patient: Father

Date & Time: 22/7/26 @ 1pm

Witness:

Signature:

Name: Rama

Date & Time: 22/7/26 @ 12pm

Doctor (who is taking consent):

Signature: Name: Dr. Kunal. Date 22/7/26 Time: 12 p.m.

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్‌బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, 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.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాషలో 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. Abshu
Asst. Surgeon :
Anaesthetist : Dr. Ravi
Scrub Nurse : Sravani

Patient Name : Manvith Jai Age : 1 m Gender : M
UHID No. : BAH-00660777 Surgery Name : UGI Endosca
Date : 22/7/25 In-time : 2.15 pm Out-time : 2.30 pm

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Dr. ALISHA BABBAR

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2 pm

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 : Sravana
Name : Dr Sravana

Before Skin Incision ➤➤

TIME OUT Time: 2.20 pm

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, Anticipated Blood Loss? ☑ 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 :
Name :

Before Patient Leaves Operating Room

SIGN OUT Time: 2.28 pm

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 : for Dr Alisha
Name : Dr. Alisha

SURGICAL SAFETY CHECKLIST

Surgeon : .....
Asst. Surgeon : .....
Anaesthetist : .....
Scrub Nurse : .....

Patient Name : ..... Age : ..... Gender : .....
UHID No. : ..... Surgery Name : .....
Date : ..... In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time:.....

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 :.....

Name :.....

Before Skin Incision ➤ ➤

TIME OUT Time:.....

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, Anticipated Blood Loss? ☐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 :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

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 :.....

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 22/7/26

To Be Filled In By Assigned Nurse :

Department : Ped. ST Duration of Procedure : 1/2 hour

Name of Surgeon : Dr. Alisha. Date of Admission : .....

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 :	
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	
3.	Patient's body temperature immediately post operation (Recovery Room) 37. °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : — Date & Time of antibiotic administration : — Date & Time procedure started : 22/7/26 @ 2.21pm	

- 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

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Patien

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OPERATION THEATER NOTES

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

UHID No.: ..... Weight : ..... Height : .....

Surgeon : Dr. Alisha.	Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:
Pre-Operative Diagnosis:		
Surgical Procedure : OGD		
Indications for Surgery : Persistent vomiting / FTT / GDD		
Date :	Start Time :	End Time :

Pre Operative Preparations:

NPO

Post Operative Diagnosis: (N)

Peri-Operative Complications: Nil

Operation Notes:

Esophagous - (N)
Stomach - (N).
G.E junction - (N)

Pylorous - (N)
Duodenum - (N)

No Biopsy

Amount of Blood Loss: Nil	Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

Nil

Peri-Operative Complications: Nil

Antireflux medication

1) T-Lanzol Sr. 15mg (1 tab to mix in 5ml & give 2ml)

2) Domstal drops. (1ml/1mg) - 1ml/Thrice daily

Suspension

before food

full follow up

for

Name of the Surgeon: Dr. Alisha

Signature of the Surgeon: .....

Date & Time: .....

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Patient S

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POST-SURGICAL CARE PLAN FORM

Procedure Done: OGD

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

1 hrly

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

—

When to Start Mobilization:

Immediately

Special Referrals:

—

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

for

Treating Surgeon
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176759 **Admit Date** : 22-Jul-2026 **Admit Time** : 10:38 AM **UHID** : BAH-00660777

Patient Details :

Patient Name	: Master GUGULOTH MANVITH JAI	**Age**	: 0 Y 10 M 28 D
Guardian	: Mr GUGULOTH VENKATESH	**DOB**	: 24-08-2025 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 6-16, DANTAKUNTA THANDA , Marripeda Warangal Telangana INDIA 506315	**Phone No**	: 9502837837/ 9398114157
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 411 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 411 **Admission Type** : First Visit

Contact Details :

Name : Mr GUGULOTH VENKATESH **Relationship** : Father

Contact Address : H NO - 6-16, DANTAKUNTA THANDA , Marripeda Warangal Telangana INDIA 506315 **Phone No** : 9502837837 / 9398114157

Signature

Doctor Details :

Doctor Name : Dr. ALISHA BABBAR **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. Prashant Bachina

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Manvith Jai Age: 10/12 Sex: Male UHID.No :

Date: 21/2/26 Time: 2:10 PM Proposed Operation: UGI Endoscopy

Diagnosis: GERD

B.P / CRT: 2 secs H.R: 120 Weight: 5 kg ASA Physical Status: ☐1 ☐2 ☑3 ☐4 ☐5

Laboratory Data:

Hgb:	Glucose:	Protein: 6.3	HIV:	X-Ray:
PCV:	Urea:	Alb: 4.1	HBS Ag:	ECG:
WBC:	Creat: 0.1	Total Bill: 0.2	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos: 133	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS :

RESP : Frequent URI's (Multiple Hospital Admissions) Diabetes :

CNS :

Renal :

Hepatic / GE : Frequent vomittings. Physical Activity: Poor

Others : Delayed Milestones.

Past Anaesthetic History: — Nil — . MRI & Sedation.

Physical Exam: Dehydrated.

Airway: MP 1 2 3 4 ? Mouth Opening: (N) Mentohyoid Distance: (N) Neck: (N) Teeth: (N)

Lungs : WNL.

Heart:

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : Hand Spine Exam for regional : NA.

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

Signature: Name: Dr M. Subrahmanyam

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

BAH-00660777 IP5-00176759
Master GUGULOTH MANVITH JAI
24-08-2025 0 Y 10 M 28 D (M)
Dr. ALISHA BABBAR

CONSENT FORM FOR ANAESTHES

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Patient Name : Manvith Jai Age : 10/12 Gender : Male ☐ Female ☐

UHID NO: ..... Surgeon Name: Dr. Prashant Bachina

Anaesthesiologist : M. Subrahmanyam Operative procedure planned : Upper GI Endoscopy

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 arid 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. Nil

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : .....

- 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 the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☑ Monitored Anesthesia Care as considered appropriate by the anaesthesia 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 anaesthesia 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 anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

~~Patient~~ / Patient Attendant :
Signature : G. Venkatesh
Name : G. Venkatesh
Relationship with Patient: Father
Date & Time : 21-7-2026 @ 2pm

Witness :
Signature : .....
Name : Teena
Date & Time : 21/7/26 @ 2pm

Doctor (who is taking the consent) :
Signature : M. Subrahmanyam Name : M. Subrahmanyam Date & Time : 21/7/26 2.40

Docu. No. : RCH / FRM / CLINICAL / 021

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00660777 IP5-00176759 Master GUGULOTH MANVITH JAI 24-08-2025 0 Y 10 M 28 D (M) Dr. ALISHA BABBAR	22/07/26 at 10:38Am	22/07/26 @ 11:54Am
	Transfer Ordered by Dr. Balaji	Reason for Transfer procedure
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 22	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ G. vebtesh If Yes, what? OP file	Patient shifted with ID band: Yes ☒ No ☐ If No: .....
Number of Imaging Films —		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	's' gown	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nr. Keerthi	Dr. Balaji

Patient & Clinical Records Received by : Tanveer

Date & Time of Patient Received : 22/7/26 @ 12pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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24-08-2025 0 Y 10 M 28 D (M)
Dr. ALISHA BABBAR

Date of Admission: _____ Ti arge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/07	11:54 AM	ER	OT	Kavitha

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
22/7	CBP	3502	Abhishek
22/7	RBS :- 78mg/dl	73510	Abhishek

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7	Iv placement	1	6061	Abhishek
	PPL op			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Master GUGULOTH MANVITH JAI
24-08-2025 0 Y 10 M 28 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

wt: 4.8 kgs

Date & Time	Progress Notes	Doctor's Order
22/7/26	C/O/B Resident / Dr. Balaji	
	D - ? CMPI / ? GERD / , Metabolic disease	
	c/o decreased vomiting & evaluation failure to thrive Global development delay	
	o/e Child Alert, Afebrile CRT < 3 sec pulses well felt	
	vitals HR - 115 bpm SpO2 - 100% RA RR - 22/min Temp - 98.4°F	Plan 1) NPO as advised 2) RVF DNS 3) Serum Lactate 4) CBP / ~~RFT-LFT-LYTS~~ 5) monitor vitals 6) Inj Syp Cef 7) PAC - Done.
	S/E - BAE (+) S1 S2 (+) P/A - soft	
	→ Last feed (milk) @ 9 AM on 22/7/26	

N/B Abhishek

BAH-00660777 IP5-00176759
Master GUGULOTH MANVITH JAI (M)
24-08-2026 0 Y 10 M 28 D
Dr. ALISHA BABBAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12:15PM	C/O/B - Cardio Team	
		Plan
		1) IV. cannula
		2) send CBP
		3) IV. fluids
		Dr. Kaif

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DRUG CHART

Date of Admission: 22/7/26 .... 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name .... Signature ....

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Master GUGULOTH MANVITH JAI
24-08-2025 0 Y 10 M 28 D (M)
Dr. ALISHA BABBAR

REGULAR PRESCRIPTIONS

Weight. 4.8 kgs Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Master GUGULOTH MANVITH JAI
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Dr. ALISHA BABBAR

Weight. 4.8 kg Ward. .....

	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.		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

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/7	12pm	25% DEXTROSE	8ml	P/O		

Signature .....

VERIFIED BY : Name .....

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24-08-2025 0 Y 10 M 28 D (M)
Dr. ALISHA BABBAR

I.V. FLUIDS CHART

Weight. 4.8 kgs Ward. .....

		Composition of I.V. Fluid (Infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/8/26		IVF DNS	IV	16 ml/hr		Not connected			

VERIFIED BY : Name ..... Signature .....

Patie

BAH-00660777 IPS-00176759
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MEDI... ON 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: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Balaji

Date & Time : 22/7/26, 10:45 am

Nurse Name & Signature: Abhishek

Date & Time : 22/7/26 @ 10:50 am