

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission: _____

Room / Bed No : _____

IP5-00178254
BAH-00639037
Master AYANSH VANDANANICKAL (M)
8 Y 3 M 21 D
20-03-2018
Dr. PILLARISETTI NAVEEN SARADHI

tant: _____ Dept : _____

Discharge : 12/7 Time: 10:30am

ward : 307 Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	11:00am	ER	OT	Abhishek
11/7/26	1:30pm	OT	ICU	Diya

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7	iv placements	(1)	7664	Ramy
	PAC OP			
11/7	NHA	(1)	9699059	A

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 12/7

Time : 10:20 AM

Prepared By : Sourav

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sourav	Morning		

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176254 **Admit Date** : 11-Jul-2026 **Admit Time** : 10:27 AM **UHID** : BAH-00639037

Patient Details :

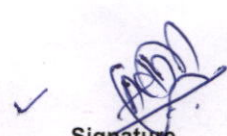
Patient Name : Master AYANSH VANDANANICKAL	Age : 8 Y 3 M 21 D
Guardian : Mr ADHARSH A. VANDANANICKAL	DOB : 20-03-2018
Gender : Male	Religion :
Occupation :	Martial Status : Single
Address (H) : FLAT NO - 501A , AKSHAYA CLASSIC APARTMENTS , BRUNDAVAN COLONY NADARGUL Telangana INDIA 501510	Phone No : 9846015687/ 9400953437
	E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE	Bed No : PRE OP 405	Ward Name : 4F-OT COMPLEX
Room No : PRE OP 405	Admission Type : First Visit	

Contact Details :

Name : Mr ADHARSH A. VANDANANICKAL	Relationship : Father
Contact Address : FLAT NO - 501A , AKSHAYA CLASSIC APARTMENTS , BRUNDAVAN COLONY NADARGUL Telangana INDIA 501510	Phone No : 9846015687 / 9400953437


Signature

Doctor Details :

Doctor Name : Dr. PILLARISETTI NAVEEN SARADHI	Specialisation : PULMONOLOGY
Referral Doctor : Self	Phone No :
Co-Consultant : Dr. SHRUTI KOTAPALLI	

Payment Details :

Payment Mode : Cash	Deposit Amount : 0.00
	Payor Name : VIDAL HEALTH INSURANCE TPAPVT LTD

112

DEFICIENCY CHECK LIST OF CASE SHEET

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

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



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00639037 IPS-00176254
Master AYANSH VANDANANICKAL
20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISETTI NAVEEN SARADHI





Pediatric Multiorgan History & Physical Examination

Name : Ayanish Age/Sex 8y/M

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

No fresh issues
K/C/O Bronchial Asthma with right middle
lobe syndrome

Now admitted for Bronchoscopy

History of present illness :

No fresh issues
K/C/O Bronchial Asthma with
right middle lobe syndrome
↓

Now admitted for Bronchoscopy



Pediatric Multiorgan History & Physical Examination

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

U/C/O Bronchial Asthma. Since Dec-2021
↓
5 times ICU admission i/v/o Asthma
exacerbations.

Birth & Neonatal History:

- Vacuum assisted VD term /Delayed cry
NICU stay i/v/o Resp. distress

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

- Achieved as per ages in all domains

Immunization History :

- ~~As~~ As per schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 30 kg (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 102 bpm B.P. 100/60 mmHg SPO2 97% RA
Resp. rate and type of breathing : 26 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): Dust + allergy

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____

External Genitelia : _____

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 : 3 10

Motor System:

Nutrition : 3 10

Tone: 3 10

Co-ordinator : 3 10

Posture : 3 10

Involuntary Movements : 3 10

Reflexes :

DTR 3 10

Superficials: 3 10

Plantars 3 10

Sensory System :

Bladder / Bowel : 3 10

Clinical Summary & Diagnostic:

Bronchial Asthma with right
middle lobe syndrome.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Respiratory Distress

Desired goals of the treatment :

Hemodynamic Stability

Planned Labs:

- CBP

NO/B/D
Abw

Planned Management

- NPO as advised

- IVF DNS

- SyP. Augmentin-PRs

- SyP. Azee

- MDE Forocort

- MDE - Levolin

- Flo mist - F Nasal spray

- SyP. Bilazap-M

DR. PILLARISETTI NAVEEN SARADHI
Registration No: 38883

Signature of the Doctor: Nandani

Signature of the Consultant: N

Name of the Doctor: Dr. Nandan

Name of the Consultant: Dr. Naveen Saradhi

Date & Time: 11/07/2026, 10.20AM

Date & Time: 11/7/26

Date & Time	Progress Notes	Doctor's Order
9/26 pm	US/B Pulmo team Afebrile Vitals stable SpO₂ - 99% (RA) Chest - B/L clear	<u>Adv</u> - Trace BAC reports - continue others
		A.
12/7/26 9:00am	US/B Dr. Naveen Saradhi EP Bronchoscopy. No fever. No cough. vitals stable. Chest: clear. Cue: S/S (+) PA: soft. peripheries warm	<u>Advise:</u> - Trace BAC reports - Symp. Augmentin - Symp. Azithromycin } x1 week - MDI Foracort → 3 months - MDI levoflo → 5 days - Flomist F nasal spray - Symp. Bilaxap. - Chest physio. - Incentive spirometry.
		B.



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[illegible]

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 Master AYANSH VANDANANICKAL (M)
 20-03-2018 8 Y 3 M 21 D
 Dr. PILLARISETTI NAVEEN SARADHI

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	11/7					
Time						
Hb	14.8					
PCV	45.3					
RBC	5.56					
WBC	14.33					
N/L	31.8/59					
Platelets	487					
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 :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

DRUG CHART

Date of Admission: 11/07/2020 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. 30kg Ward.

DRUG : <u>Syp. AUGMENTIN DDS</u>				Date Time	<u>11/2</u>
Dose	Route	Frequency	Start Date		
<u>7.5ml</u>	<u>PO</u>	<u>BD</u>	<u>11/2/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ranga</u>				<u>10am</u>	<u>30</u>
Additional Instructions: <u>Amoxicillin + clavulanic acid</u> <u>(400mg/5ml)</u>				<u>10pm</u>	<u>30</u>
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syp. AZITHROMYCIN</u>				Date Time	<u>11/2</u> <u>12/2</u> <u>13/2</u>
Dose	Route	Frequency	Start Date		
<u>7.5ml</u>	<u>PO</u>	<u>OD</u>	<u>11/2/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ranga</u>				<u>10am</u>	<u>X</u>
Additional Instructions: <u>on Mon, wed, Friday</u> <u>(200mg/5ml)</u> <u>Alternate</u> <u>day only</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>MDI FORACORT (100/6)</u>				Date Time	<u>11/2</u> <u>12/2</u>
Dose	Route	Frequency	Start Date		
<u>2puffs</u>	<u>Nasal</u>	<u>BD</u>	<u>11/2/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ranga</u>				<u>6am</u>	<u>X</u>
Additional Instructions: <u>with spacer</u>				<u>6pm</u>	<u>30</u>
Daily Doctor's Endorsement by a Sign					
DRUG : <u>MDI LEVOLIN (50mg)</u>				Date Time	<u>11/2</u> <u>12/2</u>
Dose	Route	Frequency	Start Date		
<u>2puffs</u>	<u>Nasal</u>	<u>TID</u>	<u>11/2/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ranga</u>				<u>6am</u>	<u>X</u>
Additional Instructions:				<u>2pm</u>	<u>3:30</u>
Daily Doctor's Endorsement by a Sign				<u>6pm</u>	<u>30</u>

Sheet No:

REGULAR PRESCRIPTIONS

Weight 3.0 kg Ward

DRUG : <u>FLUMIST - F Nasal Spray</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>1 spray</u>	<u>Each Nostril</u>	<u>QHS</u>	<u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rangan</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syp BILAZAP.M</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>5ml</u>	<u>PO</u>	<u>HS</u>	<u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rangan</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>FLUMIST F NASAL SPRAY</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>1 spray</u>	<u>in each nostril</u>	<u>Q.D</u>																		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rangan</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Signature

VERIFIED BY : Name

Weight 356 Ward

(P.T.O)

Weight. 30kg Ward.

Page: 4/4



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ~~ICU~~ 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	SYP. AUGMENTIN-M	7.5ml	PO	BD	10/7/26 9 PM	☐ C ☐ DC
2	SYP. AZEE (200mg/5ml)	7.5ml	PO	OD	10/7/26 on alter natedays	☐ C ☐ DC
3	MDI FORACORT (100/16)	2 puff	MDI	BD	10/7/26 9 AM	☒ C ☐ DC
4	MDI ILEROLIN	2 puff	MDI	TID	10/7/26 9 AM	☒ C ☐ DC
5	FLONIST-FN/S	1 spray	I/N	OP HS	10/7/26 9 PM	☒ C ☐ DC
6	SYP. BELAZAP-M	5ml	PO	OD HS	10/7/26 10 PM	☒ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

Continue
only
oral
allow

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Nandan

Date & Time: 11/07/2026, 10:50 AM

Nurse Name & Signature: Abhishek

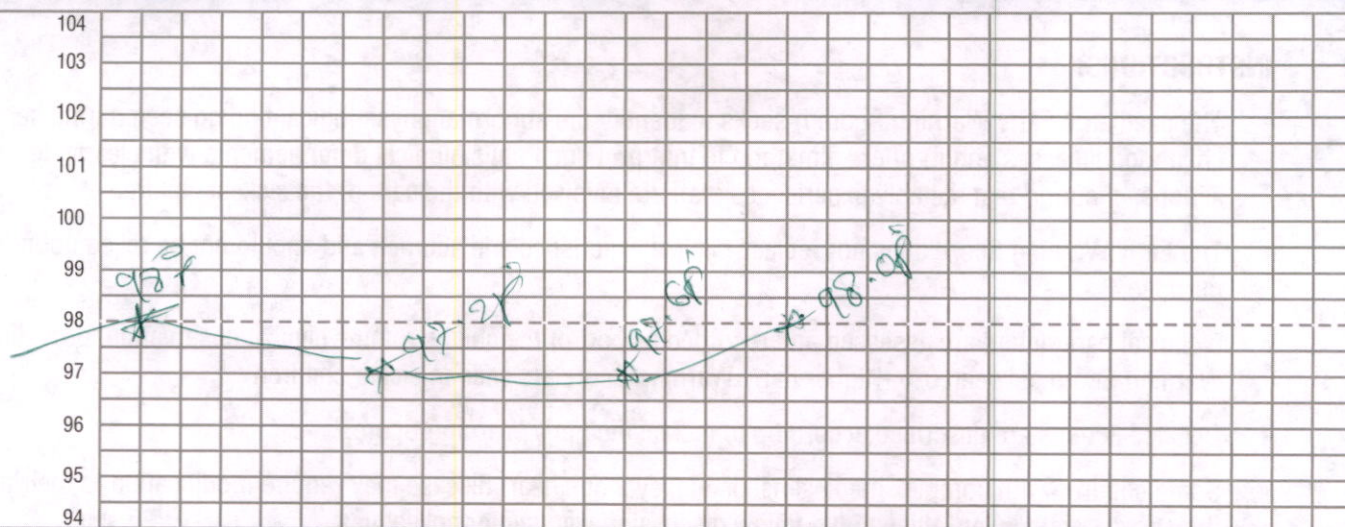
Date & Time: 11/7/26 @ 10:50 AM

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 01/2 Time: 6pm 10pm 2AM 6AM

Doctor / Nurse / Family Concern?

Temperature
(F)

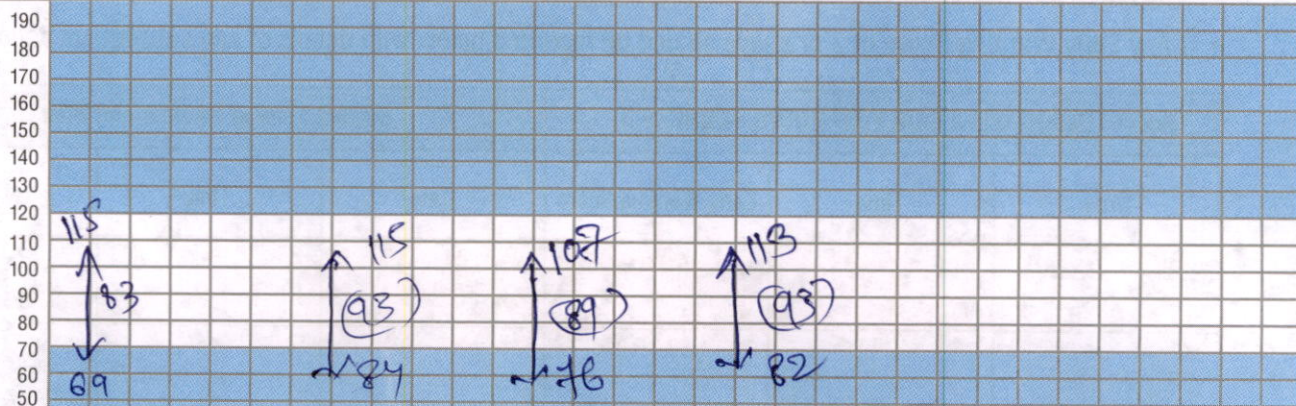


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

Resp Rate (bpm)
(over 1 Minute) *

Resp Rate (Number)

Resp Distress Mod/ Severe
None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
11/2	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm										
	Total Intake :					Total Output :					
11/2	02:00 pm	240								0	Devi
	03:00 pm									0	
	04:00 pm									0	Jayika
	05:00 pm	200								0	
	06:00 pm									0	Jayika
	07:00 pm									0	
	Total Intake :					Total Output :					
11/2	08:00 pm									0	
	09:00 pm									0	Ana
	10:00 pm	No								0	
	11:00 pm	500								0	Ana
	12:00 am									0	
	01:00 am									0	Ana
	Total Intake :					Total Output :					
12/2	02:00 am									0	
	03:00 am									0	Ana
	04:00 am	No								0	Ana
	05:00 am	500								0	Ana
	06:00 am									0	Ana
	07:00 am									0	Ana
	Total Intake :					Total Output :					
Total 24 hrs. Intake		Total 24 hrs. Output									

FLUID CHART

Sheet No. :

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

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment:

Acute pain related to the procedure

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
11:20	Assess the pt General Condition.	11:25	Assessed the pt General Condition.	pt is Conscious & oriented
11:30	Relieve pain & Discomfort.	11:35	Relieved pain & Discomfort	pain reduced
12:00	monitor vital signs	12:15	monitored vital signs	vital recorded
12:50	monitor for bleeding	12:15	monitored for bleeding	no bleeding
	maintain I/O chart		maintained I/O chart	maintained
1pm	maintain NPO status	12:55	NPO broken, water given	no vomiting
			provided psychological support	shifted
1:10	pt shift to the ward	1:20	pt shifted to the ward	

Re-Assessment:

After surgery pt is conscious & oriented

Special Notes:

Nurse Signature:

Nurse Name: Dineel

Date & Time: 11/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/2/26

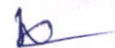
Assessment: Baby having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
2m	Assess the general condition of the patient	2:30 pm	Assessed the general condition of the	Baby condition is good
3m	monitor the vitals signs	3:30 pm	monitored the vitals signs	
4m	maintain I/O chart	4:30 pm	maintained I/O chart	
5m	Administer medication as per as chart	5:30 pm	Administered medication per as chart	
6m	maintain personal Hygiene	6m	maintained personal hygiene	
	Ensure the patient safety		Ensured the patient safety	

Re-Assessment: Re-Assessment

Special Notes:

Nurse Signature: 

Nurse Name: Nikita

Date & Time: 11/2/26 @ 3pm

Docu. No.

BAH-00639037 IP5-00176254
Master AYANSH VANDANANICKAL (M)
20-03-2018 8 Y 3 M 21 D
Dr. PILLARISETTI NAVEEN SARADHI



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING CARE RECORD

Date: 12/7/26

Shift: ☐ Morning ☐ Afternoon ☒ Night

Assessment:

pt having dull activity

- Goals
- ☒ Maintain Airway and Oxygenation
 - ☒ Maintain Personal Hygiene
 - ☒ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
- ☒ Prevent Infection
- ☐ Any Others. Specify

- ☒ Maintain Fluid Balance
- ☒ Meet Elimination Needs

- ☒ Improve Activity Tolerance
- ☒ Ensure Safety

- ☒ Maintain Good Nutritional Status
- ☒ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity
- ☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the Vital Signs	10:10pm	→ Checked the Vital Signs	
12am	→ plan for administration medication	12:10am	→ Providing medication as per doctor Order	
2am	→ plan for I/O Chart	2:10am	→ maintaining I/O Chart	
4am	→ plan for nebulization	6:10am	→ Providing Nebulization	
6am	→ plan for Ensure Safety	8:10am	→ Providing Ensure Safety	
	→ plan for			
	Re-Assessment every 4th hourly			

Re-Assessment:

Special Notes:

Date & Time: 12/7/26 2pm

Nurse Name:

Anura

Re-As
Special
Nurse Sit

Nurse Name:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Naveen Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis:	<u>Bronchial Asthma & Right middle lobe syndrome</u>				Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area	Shift Time	<u>ER</u> <u>11:00AM-1:00PM</u>	<u>OT</u> <u>9am-4:30pm</u>	<u>1st floor</u> <u>8pm-8am</u>	<u>1st floor</u> <u>8pm-8am</u>				
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.6°F</u>	<u>98.4°F</u>	<u>98.3°F</u>				
		Res:	<u>25bpm</u>	<u>25bpm</u>	<u>28h</u>	<u>28bpm</u>				
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>				
		Pulse:	<u>80bpm</u>	<u>86bpm</u>	<u>112h</u>	<u>116bpm</u>				
		BP:	<u>100/65</u>	<u>96/62</u>	<u>100/69</u>	<u>99/62</u>				
		Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>				
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>					
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>				
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>					
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Abhishek</u>	<u>Deep</u>	<u>Nikita</u>	<u>Chandam</u>					
Signature :		<u>Abhishek</u>	<u>Deep</u>	<u>Nikita</u>	<u>Chandam</u>					
Date:		<u>11/7/26</u>	<u>11/7/26</u>	<u>11/7</u>	<u>12/7</u>					
Time:		<u>11:00AM</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>					
Taken Over By Name :		<u>Teena</u>	<u>Nikita</u>	<u>Anur</u>	<u>Swarna</u>					
Signature :		<u>Teena</u>	<u>Nikita</u>	<u>Anur</u>	<u>Swarna</u>					
Date:		<u>11/7</u>	<u>11/7</u>	<u>11/7</u>	<u>12/7</u>					
Time:		<u>11:00am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>					

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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 :	11/7	12/7		
					Time :	10 AM	6 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	9		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Skin must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	0		
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	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
TOTAL SCORE					28	28			
Evaluator's Name					Abhishek	Cy			

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/2/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Diveya
11/2	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Qy
12/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	An
				☐ 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:

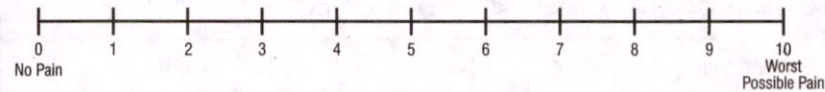
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

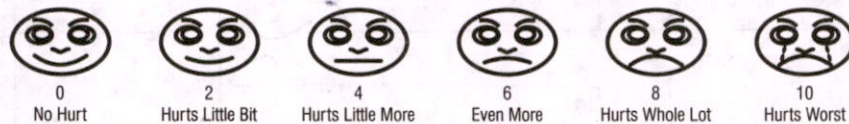
Numerical Pain Scale (Obstetric and Gynecology)



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





CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/7	10:15 AM	8	prouduary	M	1	0	1	1	NA	ABH
11/7	2pm	9	normal high protein diet	M	1	0	1	1		nikita

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 10:20AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Asthma + Rt middle lobe syndrome	Hemodynamic stability	Bronchoscopy	[Signature]	☒ Nursing ☐ Others:
11/7/26 10:30AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Asthma + Rt middle lobe syndrome	Hemodynamic stability	Bronchoscopy	Abhishek	☒ Medical ☐ Others:
11/7/26 2pm	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Asthma	Normal high protein diet	RDA E - 1550 kcal/d P - 27g/d	[Signature]	☐ 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:



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 flexible bronchoscopy with bronchoalveolar lavage

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)
<u>Diagnostic & Therapeutic</u>	

- 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:

- Hypoxia, laryngospasm, bronchospasm
-

- I authorize Dr. Naveen Saradhi 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: Ghika

Name: GOPIKA BABU

Relationship with patient: MOTHER

Date & Time: 11/7/26 @ 11:15 am

Witness:

Signature: [Signature]

Name: Reem

Date & Time: 11/7/26 @ 11:15 am

Doctor (who is taking consent):

Signature: [Signature] Name: DR. SOMASHEER Date: 11/7/26 Time: 11:15 am

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

 అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ గానా, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.
b.

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Naveen Saradhi
Asst. Surgeon : Dr. Shilpa
Anaesthetist : Dr. Shilpa
Scrub Nurse : Suman

Patient Name : Master. Ayansh Age : 8 Y Gender : M
UHID No. : BAH-00639037 Surgery Name : Bronchoscopy + BAL
Date : In-time : 11:15 AM Out-time : 12:15 PM

BAH-00639037 IP5-00176254
Master AYANSH VANDANANICKAL
20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>11:33 AM</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>Dr. Shilpa</u>		
Name : <u>Dr. Shilpa</u>		

TIME OUT		Time: <u>11:22 AM</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, <u>30 min</u> Anticipated Blood Loss? <u>NA</u>		
	☐ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? <u>Laryngospasm / Bronchospasm</u>		
	☐ Yes ☐ No ☐ NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) <u>Yes</u> Been Confirmed? are there Equipment issues or any Concerns? <u>NO</u>		
	☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed?		
	☒ Yes ☐ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.		
	☒ Yes ☐ No	
Signature : <u>Alom</u>		
Name : <u>Alom</u>		

SIGN OUT		Time: <u>12:09 pm</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 : <u>Naveen Saradhi</u>		
Name : <u>Dr. Naveen Saradhi</u>		

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20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISETTI NAVEEN SARADHI

Patient



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/7/2018

Department : P. OT Duration of Procedure : 1hr 15

Name of Surgeon : Dr. Naveen Saradhi Date of Admission : 11/7

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 : _____	Alan
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	Alan
3.	Patient's body temperature immediately post operation (Recovery Room) 37.6°C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Alan
4.	Name of doctor or staff administering the antibiotic : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 11/07/2018 @ 11:23 AM	Alan

- 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

Docu. No. : RCHBH/ FRM / CLINICAL / 038



Pa

OPERATION THEATER NOTES

Patient's Name : Master. Ayanish Age : Gender : ☒ Male ☐ Female

UHID No. : BAH-00639037 Weight : Height :

Surgeon : Dr. ~~Srin~~ Naveen Asst. Surgeon : —
Anesthetist : Dr. Sripa OT Nurse : 11:23 AM Suman OT Technician : 12:09 PM Gowtham

Pre-Operative Diagnosis:

Surgical Procedure : flexible bronchoscopy ± BAL

Indications for Surgery :

Date : 11/7/26 Start Time : 11:23 AM End Time : 12:09 PM

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: flexible bronchoscopy done via nose —

- Turbinates swollen, pharynx normal
- Epiglottis, vocal cords & their movements, subglottis normal
- ^{normal,} Trachea → no tracheomalacia, no TEF
- Carina sharp
- Rt main bronchus → upper lobe normal, deep seated secretions in middle & lower lobes.
- Lt main bronchus → mild bronchomalacia. few secretions in upper lobe & lingula. lower lobe normal

- No foreign body, no laryngeal cleft
- BAL done & samples collected

child tolerated the procedure well

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

BAL fluid —

① UES

② GeneXpert TB

③ Biofire panel

Peri-Operative Complications:

Name of the Surgeon: Dr. Naveen Saradhi

Signature of the Surgeon: Naveen Saradhi

Date & Time: 11/7/26

BAH

BAH-00639037 IP5-00176254
Master AYANSH VANDANANICKAL
20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISSETTI NAVEEN SARADHI



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Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

Name: Master Ayanish Vandananickal Age: 8 Y 3 M Sex: Male UHID.No: BAH-00639037

Date: 10/7/26 Time: 2:35pm Proposed Operation: Bronchoscopy

Diagnosis: Recurrent Asthmatic attacks Rt. middle lobe Syndrome

B.P / CRT: <3sec H.R: 106/min Weight: 30kgs ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

SpO₂: 100 J. J RA

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/Anglo:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: Dust Allergy

Medical History: CVS: ⊖

RESP: K/C/O B. Asthma Since 2021 Dec. Diabetes: Vaccines assisted w/d term.

CNS: ⊖ ICU admission for 5 times 1/v/o severe wheeze drop in SpO₂ delayed by NIV stay 1/v/o Resp

Renal: ⊖ At least once in 2 to 3 months last ICU admission was in Oct 2025.

Hepatic / GE: ⊖ Since 2021 Dec. Physical Activity: Active.

Others: ⊖ Recent asthmatic attack last week. currently mild cough ⊕; cold ⊖.

Past Anaesthetic History: ⊖

Physical Exam: ⊖

Airway: MP 1 ⊖ 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 2FB Neck: ⊖ Teeth: No loose teeth.

Lungs: BAE ⊕ clear

Heart: S1S2 ⊕

CNS: HMF ⊕.

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

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

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

CURRENT MEDICATIONS	DOSAGE
<u>MDI LEVOLIN 2 puffs 4th hely since 3 days</u>	
<u>FLUMIST NASAL SPRAY</u>	

Pre-Operative Instructions:

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

CBP during Cannulation
Nebulization c. BUDENORT before shifting to
Continue MDI

Signature: [Signature] Name: Dr. Tejaswini

Docu No: ACHBH/FRM/CLINICAL/044

[illegible]

Discharge /Shifting ordered by
 Doctor Signature:
 Doctor Name:
 Date and Time :

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctor order

2. Destination Post Discharge: ☐ Home
 Family Members Notified (Person Contacted)
☐ Transfer
 Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☒ Yes	☐ No
☐ Eating	☒ Yes	☐ No
☐ Walking	☒ Yes	☐ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☒ Yes	☐ No

yes

4. Nutritional Plan:
☐ Dietary Instruction Discussed with the:
☐ Patient ☒ Family Member ☐ Others:

5. Discharge Planning Discussed with the:
☐ Patient ☒ Family Member ☐ Others:

6. Patient/Family Educational Plan:
☐ Educational Topic/s: medication
☐ Patient's Educational Topic/s discussed with the:
☐ Patient ☒ Family Member ☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 11/7/26 @ 11am

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10:27 AM Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA Body Weight: 30 Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Family History: nothing significant

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

If yes please list,

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

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

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

Observations: Weight: 30 kg Length: Head Circumference (< 2 years):

Temp.: 98.6 F HR: 84 RR: 22 BP: 105/64

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

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

Risk of Pressure Sore (Braden Q Score 94) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

Siblings in household ☐ Yes ☐ No (if yes How Many?)

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☐ Yes ☒ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to mother

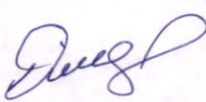
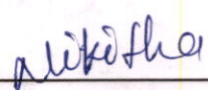
Nurse's Name: Dugh

Date: 8/7/26

Time: 1:29pm

D
Signature

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00639037 IP5-00176254 Master AYANSH VANDANANICKAL 20-03-2018 8 Y 3 M 21 D (M) Dr. PILLARISSETTI NAVEEN SARADHI 		Date & Time of Admission 11/7/26 @ 10:30 AM	Date & Time of Transfer Order 11/7/26 @ 1:20 PM
		Transfer Ordered by Dr. Naveen S	Reason for Transfer Post-Op
From Unit OT	To Unit 110	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	op file @ 9		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Naveen S	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 11/7/26 @ 1:20 PM			

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

1. Name of insured person Mr. John Doe	2. Date of birth 12/15/1950	3. Social Security Number 123-45-6789
4. Name of policy Blue Cross of California	5. Policy Number 123456789	6. Date of issue 01/01/1998
7. Name of agent Mr. John Doe	8. Agent's License Number 123456789	9. Date of renewal 12/31/1998
10. Name of insured person Mr. John Doe	11. Date of birth 12/15/1950	12. Social Security Number 123-45-6789
13. Name of policy Blue Cross of California	14. Policy Number 123456789	15. Date of issue 01/01/1998
16. Name of agent Mr. John Doe	17. Agent's License Number 123456789	18. Date of renewal 12/31/1998
19. Name of insured person Mr. John Doe	20. Date of birth 12/15/1950	21. Social Security Number 123-45-6789
22. Name of policy Blue Cross of California	23. Policy Number 123456789	24. Date of issue 01/01/1998
25. Name of agent Mr. John Doe	26. Agent's License Number 123456789	27. Date of renewal 12/31/1998
28. Name of insured person Mr. John Doe	29. Date of birth 12/15/1950	30. Social Security Number 123-45-6789
31. Name of policy Blue Cross of California	32. Policy Number 123456789	33. Date of issue 01/01/1998
34. Name of agent Mr. John Doe	35. Agent's License Number 123456789	36. Date of renewal 12/31/1998
37. Name of insured person Mr. John Doe	38. Date of birth 12/15/1950	39. Social Security Number 123-45-6789
40. Name of policy Blue Cross of California	41. Policy Number 123456789	42. Date of issue 01/01/1998
43. Name of agent Mr. John Doe	44. Agent's License Number 123456789	45. Date of renewal 12/31/1998
46. Name of insured person Mr. John Doe	47. Date of birth 12/15/1950	48. Social Security Number 123-45-6789
49. Name of policy Blue Cross of California	50. Policy Number 123456789	51. Date of issue 01/01/1998
52. Name of agent Mr. John Doe	53. Agent's License Number 123456789	54. Date of renewal 12/31/1998
55. Name of insured person Mr. John Doe	56. Date of birth 12/15/1950	57. Social Security Number 123-45-6789
58. Name of policy Blue Cross of California	59. Policy Number 123456789	60. Date of issue 01/01/1998
61. Name of agent Mr. John Doe	62. Agent's License Number 123456789	63. Date of renewal 12/31/1998
64. Name of insured person Mr. John Doe	65. Date of birth 12/15/1950	66. Social Security Number 123-45-6789
67. Name of policy Blue Cross of California	68. Policy Number 123456789	69. Date of issue 01/01/1998
70. Name of agent Mr. John Doe	71. Agent's License Number 123456789	72. Date of renewal 12/31/1998
73. Name of insured person Mr. John Doe	74. Date of birth 12/15/1950	75. Social Security Number 123-45-6789
76. Name of policy Blue Cross of California	77. Policy Number 123456789	78. Date of issue 01/01/1998
79. Name of agent Mr. John Doe	80. Agent's License Number 123456789	81. Date of renewal 12/31/1998
82. Name of insured person Mr. John Doe	83. Date of birth 12/15/1950	84. Social Security Number 123-45-6789
85. Name of policy Blue Cross of California	86. Policy Number 123456789	87. Date of issue 01/01/1998
88. Name of agent Mr. John Doe	89. Agent's License Number 123456789	90. Date of renewal 12/31/1998
91. Name of insured person Mr. John Doe	92. Date of birth 12/15/1950	93. Social Security Number 123-45-6789
94. Name of policy Blue Cross of California	95. Policy Number 123456789	96. Date of issue 01/01/1998
97. Name of agent Mr. John Doe	98. Agent's License Number 123456789	99. Date of renewal 12/31/1998
100. Name of insured person Mr. John Doe	101. Date of birth 12/15/1950	102. Social Security Number 123-45-6789



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/7/26 Time: 2pm

Weight: 30kgs Centile: > 75th

Height: 131cm Centile: > 50th

Inference: Overweight child

RDA: - Calories: 1850 kcal/d Protein: 27g/d

Diet Recommendations: Normal high protein diet

Re-Assessment: Avoid spicy, chilled outside foods

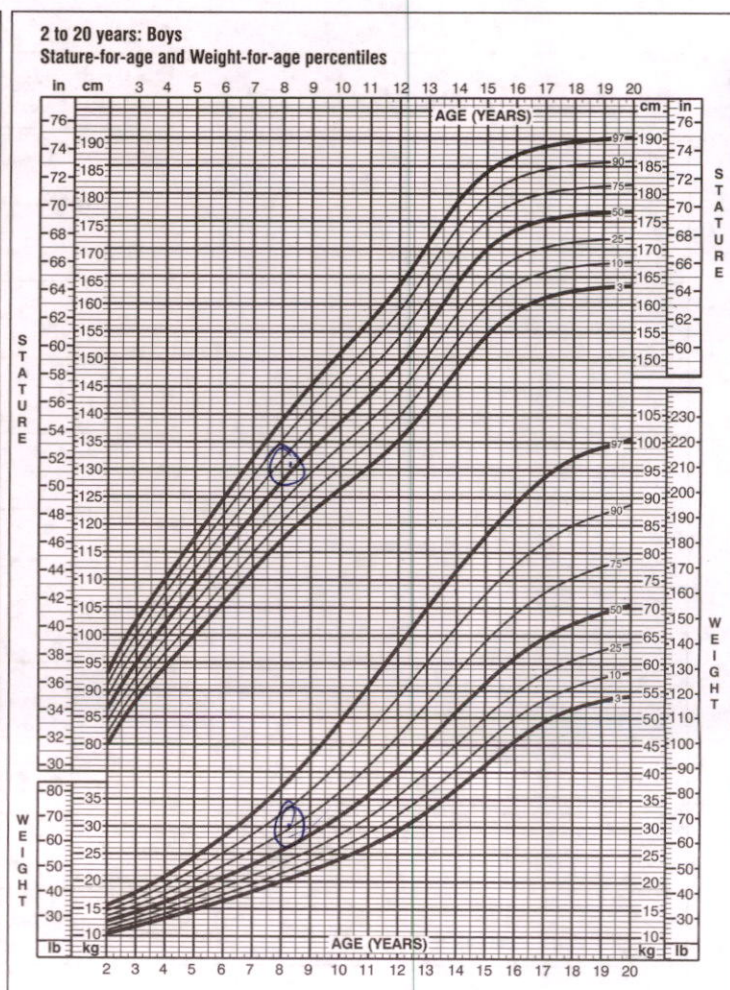
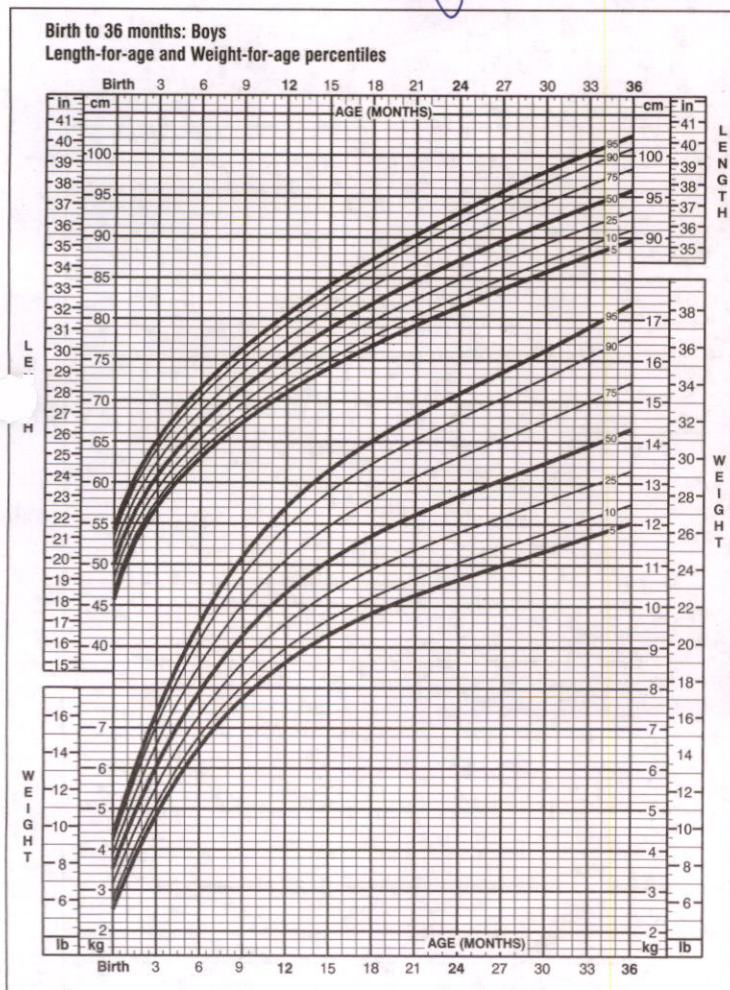
Food Allergies: Sea food Veg/Non-veg: Non-veg

Diagnosis: Bronchial Asthma & (R) Middle lobe syndrome

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

[illegible]

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00639037 IP5-00178254 Master AYANSH VANDANANICKAL (M) 20-03-2018 8 Y 3 M 21 D Dr. PILLARISETTI NAVEEN SARADHI		Date & Time of Admission 11/07/26 at 10:27 AM	Date & Time of Transfer Order 11/7/26 at 11:00 AM
		Transfer Ordered by Dr. Nandan	Reason for Transfer Surgery
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 24	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant OP file Yes ☒ No ☐ If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Neb Chamber	1	
2.	Gown	1	
3.	kochem	1	
4.	OP Files	1	
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Abhishek		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Geeva			
Date & Time of Patient Received : 11/7/26 @ 11 AM			

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

BAH-00639037 IP5-00176254
Master AYANSH VANDANANICKAL
20-03-2018 8 Y 3 M 21 D (M)
Dr. PILLARISSETTI NAVEEN SARADHI



Patient

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 : 11/07/26

Patient Name: Mast. Ayansh Date of Birth: 20-03-2018 Age: 8y

Gender: male Ward: P-OT UHID No.: BAH-00639037

Date of Surgery: 11/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Flexible bronchoscopy + BAL

Time in : 11:15 AM

Time Out : 12:15 pm

	NAME	AMOUNT
1. Surgeon	Dr. Naveen Saradhi	
2. Anaesthetist	Dr. Shilpa	
3. Assistant Surgeon	—	
4. OT Technician	Gowthami	
5. Circulating Nurse	Alan	
6. Assistant Nurse	Suman	

Special Equipment: ☐ Laparoscopy ☒ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others 9697848

Naveen Saradhi
Signature of the Surgeon

Alan
Signature of Circulating Nurse

Order No: 9697847

Order by: Alan



Bronechoscopy

CONSUMABLES OF OT

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

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube	14	1	1	Major Pack				Inj Vit.K			
LMA	1	1	1	Sutures				Cord Clamp			
ECG leads : A/P/N	3	3	3					Suction Catheter			
HME filter : A/P/N	01	1	1					Feeding Tube			
Syringes : 10 cc	10	3	3					Vaccum Suction Set			
05 cc	10	3	3	Gloves	6, 6/2, 7, 7/2	2+2	2+2	Surgical Gloves			
02 cc	10	2	2					Gauze Pack			
01 cc	5	1	1					Syringe 1ml / 2ml			
Cautery plate : A/P/N	01	1	1	Surgical blade				Surgical Blade # 20			
IV set	01	1	1	NG tube				Koochie (S)			
RL	01	1	1	Cautery pencil				2 2			
NS : 10ml / 100ml / 500ml / 1000ml	14	1	1	Koochie				1 1			
	01	0	0	Ointments				2 2			
	01	1	1	Suction Catheter				1 1			
Fentanyl	01	1	1	Cap, Mask				2+2 3			
Morphine				Gauze Pack				1 1			
Ketamine				Mop Pack				2 2			
Propofol	03	2	2	Steristrip				1 1			
Rocuronium	01	1	1	Underpad							
Glycopyrolate	01	1	1	Draw sheet							
Myopyrolate	01	1	1	Abgel							
Ondansetron	01	1	1	Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag							
Bupivacaine 0.25%	01	1	1	Chest Drainage Catheter							
Bupivacaine 0.25%(Heavy)				Romodrain bag							
Antibiotics				Bandage							
	01	1	1	Tegaderm							
Suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set							
Justin : 12.5 mg / 25mg / 100mg	01	1	1	Plastic Bed Sheet							
Tab. Misoprost : 200mg				Betadine Solution							
	14	1	1	Microshield							
	524	1	1	Cotton Balls							
	14	1	1	Latex Gloves							
	14	1	1	Ramdione Scrub							
				Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9697867

Ordered by : [Signature]

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