

BAH-00661158 IP5-00176176
Master KIAANSH RAO BANDIKOLLA
22-01-2023 3 Y 5 M 18 D (M)
Dr. M N V POUHYA SAI



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 : 10/07/22
Patient Name: KIAANSH RAO Date of Birth: 22-01-2023 Age: 34
Gender: male Ward : P. OT UHID No.: 661158
Date of Surgery: 10/07/22 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : OGD + PB removal.

Time in : 8:45 AM

Endoscopy
NSA

Time Out : 9:20 AM

	NAME	AMOUNT
1. Surgeon	Dr. Pouhya	
2. Anaesthetist	Dr. Shabna	
3. Assistant Surgeon		
4. OT Technician	Ramesh	
5. Circulating Nurse	Geetha	
6. Assistant Nurse	Bhiksha	

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

for
Signature of the Surgeon

Endoscopy
Basket

9695783

Signature of Circulating Nurse

Order No: 9695783

Order by: Geetha



FB Removal

CONSUMABLES OF OT

Rainbow Children's Hospital
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Circulating staff : Technician : Date : Time : 8 Am

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 4.5	14	0	Major Pack			Inj Vit.K		
LMA 27	0	1	Sutures			Cord Clamp		
ECG leads : A/P/N	5	3				Suction Catheter		
HME filter : A/P/N	0	1				Feeding Tube		
Syringes : 10 cc	10	3				Vaccum Suction Set		
05 cc	10	3	Gloves			Surgical Gloves		
02 cc	10	0	Gloves 1/2 1/2 + 1/2 242			Gauze Pack		
01 cc	1	0	Gloves 1/2 1/2 + 1/2 242			Syringe 1ml / 2ml		
Cautery plate : A/P/N	0	1	Surgical blade			Surgical Blade # 20		
IV set	0	1	NG tube			Koochies (S)		
RL	0	0	Cautery pencil			MS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	0	0	Koochies			Transopix	1	1
Wire spike	0	1	Ointments			100cc syringe	24	1
Gauze	02	1	Suction Catheter			Jelly 200cc	1	1
Fentanyl	01	1	Cap, Mask					
Morphine			Gauze Pack					
Ketamine			Mop Pack					
Propofol	02	1	Steristrip					
Rocuronium	01	1	Underpad					
Glycopyrolate	0	1	Draw sheet			niclan	01	1
Myopyrolate	02	2	Abgel			ETCO2 nasal CP	01	1
Ondansetron	01	1	Foleys catheter			Nasal spray		
Pencan 25g/ Spinal Needle 22			Urobag			18.20	14	1
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			Oral spray		
Bupivacaine 0.25%(Heavy)			Romodrain bag			0.1	14	1
Antibiotics			Bandage			IV cannula		
02 mask CP	0	1	Tegaderm			24.24	14	1
Suppositories			Ioban			ATRACURUM Bg	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	0			
Justin : 12.5mg / 25mg / 100mg	14	1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Valium	0	1	Microshield	1	1			
Doxat Peroxide	14	1	Cotton Balls	1	1			
Toraxan + pan	14	1	Latex Gloves	1	1			
Gloves + Clonex	54	1	Ramdione Scrub					
100ml 1000ml 3cc	14	1	Saral					

Surgeon : Anaesthesiologist : Nurse : OT Technician :
Order No. : 9695790 Ordered by :
Doc. No. : RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time _____ e : _____ Time: _____

Room / Bed No : _____ Ward : _____ ble bed type : _____

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	12:35 Am	ER	144	Annab
10/7/26	8:20 Am	144-C	OT	soorayathi
10/7/26	10 Am	OT	144-C	Quig

Cross Consultation Visit

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

[illegible]

Signature

Auswahl



MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

Date	Procedure	Quantity	Order No.	Signature
10/7/26	Jv placement	(1)	5418	Anur
10/7	PAC	1	G961m	Teeem
10/7	M/A A	1	BZLH	A

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176176

Admit Date : 10-Jul-2026

Admit Time : 12:07 AM UHID : BAH-00661158

Patient Details :

Patient Name : Master KIAANSH RAO BANDIKOLLA

Age : 3 Y 5 M 18 D

Guardian : Mr BANDIKOLLA VIKRAM BABU

DOB : 22-01-2023

Gender : Male

Religion :

Occupation :

Martial Status : Single

 Address (H) : H.NO:24-1500 ARUNDATHI NAGAR NEAR
 GAMIDI STATUE Jai Jawahar Nagar Hyderabad
 Telangana INDIA 500087

Phone No : 9542151051 / 8390747732

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW144(C)

Ward Name : 1F-GENERAL WARD II

Room No : GW144(C)

Admission Type : First Visit

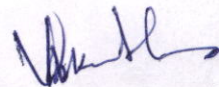
Contact Details :

Name : Mr BANDIKOLLA VIKRAM BABU

Relationship : Father

 Contact Address : H.NO:24-1500 ARUNDATHI NAGAR NEAR
 GAMIDI STATUE Jai Jawahar Nagar Hyderabad
 Telangana INDIA 500087

Phone No : 9542151051 / 8390747732



Signature

Doctor Details :

Doctor Name : Dr. M N V POUHYA SAI

 Specialisation : PEDIATRIC GASTROENTEROLOGY AND
 HEPATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : ERICSON INSURANCE TPA PVT LTD



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Dr. M N V POUISHYA SAI





History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

A/I/H/O coin ingestion on 09/07/2026 at
around 3.30 PM at home, located near
seunderabad

History of present illness :

A/I/H/O coin ingestion on 09/07/2026
at around 3.30 PM at home located
near seunderabad

↓
No H/O breathing difficulty / cyanosis

↓
X-ray neck & chest

↓
S/O

coin in esophagus

↓
Admitted for endoscopic removal

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P

Physical Examination

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

Not Significant

Birth & Neonatal History:

Not Significant

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

Achieved as per age in all 4 domains

Immunization History :

Immunized as per schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs) 15.5 kg (Centile _____)

On Examination :

Temperature : 98.4 f Pulse Rate : 102 bpm B.P. 98/56 SP02 100% RA

Resp. rate and type of breathing : 26 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AEB, clear.

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2@

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft; non distended

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System:

Nutriton :

Tone :

Power :

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Foreign body in esophagus.



pediatric multiorgan History & Physical Examination

Preventive aspects of the treatment:

Bleeding
Infection

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

CBP

N/B Annals
10/7/26

Planned Management

- NPO as advised
+ (Groom - 2 AM)
6 hrs for solid
4 hrs for milk
2 hrs for water
- IVF - DNS Groom
2 AM 10/07/26

N/B Annals
10/7/26

Signature of the Doctor: Dr. Nandan

Name of the Doctor: Dr. Nandan

Date & Time: 09/07/2026, 11.45 AM

Signature of the Consultant:

Name of the Consultant:

Date & Time:



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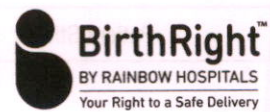
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(P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]





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[illegible]

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RESULT SHEET

Date	10/7					
Time						
Hb	11.1					
PCV	33.3					
RBC	4.44					
WBC	14.45					
N/L						
Platelets	300					
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						

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. H. Rama
Asst. Surgeon :
Anaesthetist : Dr. Shabbana
Scrub Nurse : R. K. Chari

Patient Name : K. Anand Age : 34 Gender : M
UHID No. : 661152 Surgery Name : Upper GI Endoscopy
Date : 10/12/26 In-time : 8:45 AM Out-time : 9:20 AM

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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>8 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>SL</u>		
Name : <u>DR. SHABBANA</u>		

Before Skin Incision >>

TIME OUT		Time: <u>8:55 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, 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 : <u>Dr. Anand</u>		
Name : <u>Dr. Anand</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>9:20 AM</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>Dr. Pouchya</u>		
Name : <u>Dr. Pouchya</u>		



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 10/7/26

Department : P.O.T. Duration of Procedure : 20 min

Name of Surgeon : Dr. Heema Date of Admission : 10/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic :	
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : NA Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Dr. Heema Date & Time of antibiotic administration : 10/07/26 NA Date & Time procedure started : 10/7/26 5:58 PM	

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



OPERATION THEATER NOTES

Patient's Name : MAST. KIAANSH RAO Age : 3 years Gender : ☒ Male ☐ Female

UHID No.: BAH-00661158 Weight : 15.5kg Height :

Surgeon : <u>Dr. Pouhya / Dr. Kema</u>	Asst. Surgeon : <u> </u>
Anesthetist : <u>Dr. Shabara</u>	OT Nurse: <u>Bhakla / Jyothi</u>
OT Technician: <u>Ranesh</u>	
Pre-Operative Diagnosis: <u>PB in stomach.</u>	
Surgical Procedure : <u>OGD + PB.</u>	

Indications for Surgery : Recurrent PB in stomach

Date : 10/7/26 Start Time : 8.47am End Time : 9.15am

Pre Operative Preparations:

NPO.

Post Operative Diagnosis:

Peri-Operative Complications: Nil

Operation Notes: Under strict aseptic precautions an endoscope was passed from the mouth into the esophagus and further advanced into the stomach.

foreign body visualized in the stomach (coin)

coin removed using a mesh net.

check endoscopy done - normal

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POST-SURGICAL CARE PLAN FORM

Procedure Done: *OGD + FB removal*

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

1hly

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

—

When to Start Mobilization:

immediately

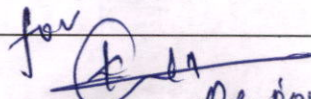
Special Referrals:

—

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 *Dr. pouhya s.*
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: ward

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Nandan

Date & Time: 10/07/2026, 12:20 AM

Nurse Name & Signature: Anneel

Date & Time: 10/7/26 12:20 A



DRUG CHART

Date of Admission: 10/07/2026 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

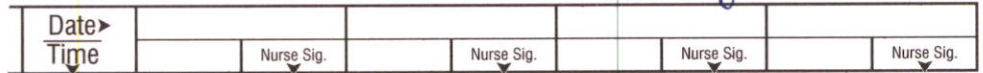
SOS / PRN (As Required Medication)

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

Page: 2/4



VARIABLE DOSE	Date					
	Time	Nurse Sig.	Nurse Sig.		Nurse Sig.	Nurse Sig.

STAT / ONCE ONLY DRUGS[illegible]

I.V. FLUIDS CHART

Weight. 15.5kg Ward.



sition of I.V. Fluid
 (ion ml/hr = Mcg/kg/min. etc)

Route

Flow Rate
 ml/hr

Doctor
 Sign

Nurse
 Sign

Date of
 Stopping

Doctor
 Sign

Nurse
 Sign

10/07/
 2026

2 AM

I.V.F. DNS

Iv

60
 ml/hr

Male

chandra
 chandra

not
 connected.

NK
 Pinto

Signature

VERIFIED BY : Name



PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/1/26 Time:	
Doctor / Nurse / Family Concern? 2PM 6PM	
Temperature (F)	104
	103
	102
	101
	100
	99
	98
	97
	96
	95
	94
Heart Rate (bpm)	190
	180
	170
	160
	150
	140
	130
	120
	110
	100
	90
Blood Pressure (mmHg) *	90
	80
	70
	60
	50
	40
	30
	20
	10
	0
	0
Note: BP does not score in early warning scoring	
Heart Rate (Number) 100bpm 109bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70
	60
	50
	40
	30
	20
	10
	0
	0
	0
	Resp Rate (Number) 29bpm 28bpm
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%) 99% 100%	
Conscious Level Normal Altered	
GCS * 15/15 15/15	
TOTAL SCORE	
Number of shaded boxes 1 1	
Pain Score 0 0	
Observer's Initials 6 6	

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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Master KJAANSH RAO BANDIKOLLA
22-01-2023 3 Y 5 M 18 D (M)
Dr. M N V POUISHYA SAI



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

PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7/26 Time: 6pm	
Doctor / Nurse / Family Concern? 1am 6am 12pm 6pm 10pm	
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94 98.3 97.9 97.6 97.5 97.6
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 98 107 107 107 97 97
Blood Pressure (mmHg) *	120 110 100 90 80 70 60 50 98 107 107 107 97 97
Note: BP does not score in early warning scoring	
Heart Rate (Number)	96b/m 84b/m 118b 100b/m 106b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10 26b/m 28b/m 28b/m 23b/m 29b/m
Resp Rate (Number)	26b/m 28b/m 28b/m 23b/m 29b/m
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	100% 99% 98% 99% 98%
Conscious Level Normal Altered	15/15 15/15 15/15 15/15 15/15
GCS *	15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	0 0 1 1 1
Number of shaded boxes	0 0 1 1 1
Pain Score	0 0 0 0 0
Observer's Initials	Qy Qy Qy Qy Qy

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)

Patient Sticker

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D 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 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 :							
	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							

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/7	08:00 am				61							
	09:00 am											
	10:00 am	H2O										
	11:00 am											
	12:00 pm	NO IVP										
	01:00 pm											
	Total Intake :			Total Output :								
10/7	02:00 pm											
	03:00 pm											
	04:00 pm	NO IVP										
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :			Total Output :									
10/7/2023	08:00 pm											
	09:00 pm											
	10:00 pm	NO IVP										
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :			Total Output :									
11/7/2023	02:00 am											
	03:00 am											
	04:00 am	NO IVP										
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :			Total Output :									
Total 24 hrs. Intake			Total 24 hrs. Output									

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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 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							



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	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			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: 10/7/24

Assessment: pt having clear 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
1am	→ Assess the pt General Condition	11:10am	→ Assessed the pt General Condition	pt is stable
4am	→ Check the Vital signs	4:10am	→ Checked the Vital signs	
6am	→ plan for administration medication	6:10am	→ providing medication as per doctor Order	
8am	→ plan for I/O Chart	8:10am	→ strictly I/O Chart	
	→ plan for Emox Safety		→ providing the Emox Safety	

Re-Assessment: Re-Assessed Every 4th hrs

Special Notes: Foreign Body Removal 8:30am Npo 2am

Nurse Signature: Cy

Nurse Name: Chandana

Date & Time: 10/7/24 @ 8am

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 17/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10:30am	Assess the pt General Condition.	10:30am	Assessed the pt General Condition.	pt is Conscious & oriented
11am	Relieve pain & Discomfort	11am	Relieved Pain & Discomfort	vital stable
11:30am	monitor vital signs	11:30am	monitored vital signs	no bleeding
12pm	monitor for bleeding	12pm	monitored for bleeding	maintained
12:30pm	maintain I/O chart	12:30pm	maintained I/O chart	no vomiting
1pm	maintain nro status	1pm	nro broken, water given	shifted
	apt shift to the ward		pt shifted to the ward	

Re-Assessment:

monitor vitals.

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time: 17/26

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/07/2023

Assessment: Baby having good activity

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
2 ^{pm}	Assess the baby general condition and monitor the vitals and record.	2:30 ^{pm}	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
3 ^{pm}	→ Continue the medication as per chart	3:30 ^{pm}	→ Continued the same medication as per chart.	
4 ^{pm}	→ maintain personal hygiene	4:30 ^{pm}		
5 ^{pm}	→ Provide nutritional diet	5:30 ^{pm}	→ Provided nutritional diet.	
	→ Provide Comfortable position.		→ Provided Comfortable position.	
6 ^{pm}	→ Ensure the safety needs.	7 ^{pm}	→ Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: monitor the vitals

Nurse Signature: (Signature)

Nurse Name: Nikitha ID: 605571

Date & Time: 10/07/2023 @ 8pm

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: Baby having good 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 baby general condition. monitor vital signs	8pm	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly.
10pm	* provide comfortable position	10pm	* provided comfortable position	
12AM	* maintain I/O charting	12AM	* maintained I/O charting	
4AM	* Encourage take orally well	4AM	* encouraged take orally well	
6AM	* Ensure safety side rails	6AM	* ensured safety side rails	

Re-Assessment: Re assessment not done.

Special Notes:

Nurse Signature: [Signature] Nurse Name: Sruelha (021086) Date & Time: 11/7/26 @ 8 am

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. M N V POUISHYA SAI Department: Date of Admission: 10/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>foreign body</u>							
BACKGROUND	Area	Shift Time	EP 12:30-2:30	1st floor 8:00-8:30	1st floor 8:30-9:00	1st floor 9:00-9:30	1st floor 9:30-10:00	1st floor 10:00-10:30
	Medical Condition (Any special condition to be noted):		NO	NA	NA	NA	NA	NA
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:	98.7 F	98.5 F	98.5 F	99.5 F	99.1 F	98.2 F
		Res:	24 bpm	28 bpm	24	24	28 bpm	24
		SpO ₂ :	99%	100%	99%	99%	99%	99%
		Pulse:	106 bpm	105 bpm	108 bpm	110 bpm	110 bpm	110 bpm
		BP:	104/51	100/59	101/62	103/69	104/68	104/65
		Fall Risk Score:	12	12	12	12	12	12
Pain Score:	0/0	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NO	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NO	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NO	NA	NA	NA	NA	NA	
Handed Over By Name :		<u>Anus</u>	<u>Sourav</u>	<u>Pray</u>	<u>Pray</u>	<u>Pray</u>	<u>Pray</u>	
Signature :		<u>A</u>	<u>S</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>	
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7/26</u>	<u>11/7/26</u>	
Time:		<u>12:30</u>	<u>8:20</u>	<u>8:20</u>	<u>1</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Chandana</u>	<u>Pray</u>	<u>Pray</u>	<u>Nikita</u>	<u>Pray</u>	<u>Pray</u>	
Signature :		<u>C</u>	<u>P</u>	<u>P</u>	<u>N</u>	<u>P</u>	<u>P</u>	
Date:		<u>10/7/26</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7/26</u>	<u>11/7</u>	
Time:		<u>12:30</u>	<u>8:20</u>	<u>8:20</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:					
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:							

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22-01-2023 3 Y 5 M 18 D (M)
Dr. M N V POUHYA SAI

CHECKLIST FOR THROMBOPHLEBITIS

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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							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-							
Signature of the Nurse					Nikhil	Swah							

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 : Krishnendu Name : Krishnendu

Signature of Ward In Charge :

Signature : Neeraj's Name : Neeraj's

Patient S

BAH-00661158 IP5-00176176
 Master KIAANSH RAO BANDIKOLLA
 22-01-2023 3 Y 6 M 18 D (M)
 Dr. M N V POUISHYA SAI



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes			
Call device within reach		yes	yes			
Wheels Locked		yes	yes			
Room free of clutter		yes	yes			
Adequate Lighting		yes	yes			
Wheel Chair Support		no	no			
Other Intervention(s) Specify		no	no			
Nurse's Name :		Aul	sc			
Signature :		82				
Date :		10/1	11/7			
Time :		12:17	am			



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	12:12 P	0/0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Anne
10/7	9:15 A	4/10	SS	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
10/07	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
10/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

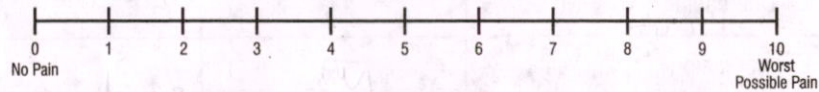
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain r intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

BAH-00681158
Master KIAANSH RAO BANDIKOLLA
22-01-2023 3 Y 5 M 18 D
Dr. M N V POUISHYA SAI (M)

BRADEN 'Q' SCALE

				Date :	10/1	11/12/26		
				Time :	12:20	6:00		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
TOTAL SCORE					28	28		
Evaluator's Name					Arun	Sun		

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



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		
10/7/20	12:20	10	For Risk Education	mother	1	oral	1	1	no	Acid
10/7/20	7:30 am	9	child is on NPO	M	<	0	1	2	-	no

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							

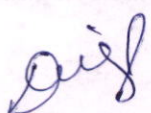


MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	foreign gut	4-5 Ste	NPO IV		☐ Nursing ☒ Others:
10/7/20	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	foreign body	A - Stable	NPO IV	Annub	☐ Medical ☒ Others:
10/7/20 7:30 am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	foreign body ingestion	child is on NPO	NPO till further advice	NT Kulla	☐ 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:

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00661158 IP5-00176176 Master KIAANSH RAO BANDIKOLLA 22-01-2023 3 Y 5 M 18 D (M) Dr. M N V POUISHYA SAI 		10/7/26 @ 12:30 PM	10/7/26 @ 10 AM
Name		Transfer Ordered by	Reason for Transfer
		Dr. Shabne	Post-op
From Unit	To Unit	Information to Attendant	
OT	ICU - C	Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
		Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	op file + (U)		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
		Dr. Shabne	
Patient & Clinical Records Received by : Nikhil			
Date & Time of Patient Received : 10/7/26 @ 10 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

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

Explain to parent

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: hand hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Chandana

Nurse Name: Chandana

Date and Time: 10/7/2023



LIST

Date : 10/7/2026

Patient's Name : M. Kjaansh Rao Age : 3y Gender : ☒ M ☐ F
Blood Group : F UHID : BAH-006158
Planned Surgery : Forebrain Body Surgeon : DR. Pouishya Sai
Anesthetist : DR. Subhramanyam Date & Time of Operation : 10/7/2026

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse : 8:30 AM

S.No.	INSTRUCTIONS	ER/Ward, Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
	Weight checked recorded ?	☒	☐	☐	☒	☐	☐
2	Is the patient fasting for over 6 hours Pre-Operatively ?	☒	☐	☐	☒	☐	☐
3	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screening, CXR etc) Available before starting the procedure	☐	☒	☐	☐	☒	☐
4	Enema given / Bowel Preparation	☐	☒	☐	☐	☐	☒
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☒	☐	☐	☒	☐	☐
6	Sterile Gown Given	☒	☐	☐	☒	☐	☐
7	Is Blood arranged as required ?	☐	☒	☐	☐	☐	☒
8	If Blood has been ordered - is Blood bag ready ?	☐	☒	☐	☐	☐	☒
9	IV Cannula to be placed / IV fluids if Indicated	☒	☐	☐	☒	☐	☐
10	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐	☒	☐	☐
11	Pre Medications Given ? (Sedatives / etc)	☐	☒	☐	☒	☐	☐
12	Skin Preparation	☐	☒	☐	☐	☐	☒
13	Site is marked	☐	☒	☐	☐	☐	☒
14	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☐	☒	☐	☒	☐	☐
15	Implants are available	☐	☒	☐	☐	☐	☒
16	Equipment is available	☐	☒	☐	☐	☐	☐
17	Antibiotic Prophylaxis is given within the last 60 minutes	☐	☒	☐	☐	☐	☐
18	Other (if any)	☐	☒	☐	☐	☐	☒

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☒ Yes ☐ No

Billing Executive Name : OT Nurse Name : ER/Ward Nurse Name :

Billing Executive Signature : Signature of OT Nurse : Signature of ER/Ward Nurse :

Date & Time : 10/7/26 Date & Time : 10/7/26 Date & Time : 10/7/26

Doc. No. : RCHB/ FRM / CLINICAL / 107

8:30 AM @ 10 PM



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. OGD + FB Removal

2. _____

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>Therapeutic.</u>	

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. Infection, Abrasion, perforation, injury to adjacent structure
Stippage of FB in duodenum

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

Patient / Patient Attendant:

Signature: [Signature]
Name: Shivani Bandikolla
Relationship with patient: Mother
Date & Time: 10/7/26 @ 8:40 am

Witness:

Signature: [Signature]
Name: Bandikolla V. Venk
Date & Time: 10/7/26 @ 8:40 am

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Kunal Date: 10/7/26 Time: 8:40 am



శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

 అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రన్ 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 లాగానే, 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 ను 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.	

- 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 భావ 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:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00661158 IPD-001/01/0
Master KJAANSH RAO BANDIKOLLA
22-01-2023 3 Y 5 M 18 D (M)
Dr. M N V POUISHYA SAI



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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Kjaanish Rao Age: 3.5 Sex: male UHID.No: 00651158

Date: 10/7/2026 Time: 8.15 a.m Proposed Operation: Foreign body gastroscopy.

Diagnosis: Foreign body (coin) ingestion

B.P / CRT: H.R: 55 Weight: 15 kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: NI

Medical History: CVS: (-)

- Term LGS / 3.5 kg / CIAB / No NICU

RESP: (-)

Diabetes: - Normal nil data

CNS: (-)

Renal: (-)

Hepatic / GE: (-)

Physical Activity: active

Others: (-)

Past Anaesthetic History: (-)

Physical Exam: No obvious facial anomaly

Airway: MP 1 (2) 3 4 Mouth Opening: Mento-hyoid Distance: Neck: Teeth: nil loose

Lungs: chest clear

Heart: S₁ S₂ nl

CNS: GCS full

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: +

Spine Exam for regional: not done

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

22g hand

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

NPO from 1.30 am

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

C7C8BP

Signature: [Signature] Name: M. SHARND

BAH-00661158 IP5-00176176
Master KIAANSH RAO BANDIKOLLA
22-01-2023 3 Y 5 M 18 D (M)
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ANAESTHESIA CHART

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Pre Induction

oam

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status: adequate

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R: 95

B.P / CRT: 95/46

SpO₂: 100

R.R: 16

Last Feed: >6h

Pre-OP Diagnosis: Foreign body

Operation: Endoscopy

Date: 10/7/2026

Surgeon: Dr. Poushya

Anaesthesiologist: Mr. C. M. Shobana

Technician: Pamela Vign

TIME 8:45
N₂O / AIR / O₂ LPM 0.5 → 1.5
HALOGEN SEVO MAC 1 → 2
Drugs:

Ty PROPOFOL 30+20
FENTANYL 30
ATACURIUM 7.5mg

FiO₂ / SaO₂ 100 100 100
ETCO₂ 33 35 35
ECG SR SR
Temperature
Urine Output

Fluids
Blood
RINGER
LACTATE

B.P 240
V Systolic 220
A Diastolic 200
X Mean 180
Heart Rate 160
Tourniquet on Time 160
Tourniquet off Time 140
Throat Pack In 120
Throat Pack Out 100

LAB Values

☒ Equipment Checked and Functional

☐ BP @ leg
☐ Cuff Site: @ leg
☐ Art Site: @ leg

☐ EKG Lead

☒ Temp Site skin

☐ FIO₂ Monitor

☐ Agent Monitor

☐ Pulse Oximeter

☐ Capnograph

☒ Ventilator

☐ Nerve Stimulator

Position: lateral

☒ Pressure Points Checked

Eye Care:

☐ Oint
☒ Tape
☐ Padding
☐ Awake

Temp:

☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Huggers ☐ Cotton Wool
☐ Other

Times:

Anaes Start: 8:45 am

OP Start: 1

OP End: 1

Leave OR: 1

Anaesthesia: 9:20 am

☒ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)

☐ CVP
☐ ART
☒ IV: 22g @ hand
☐ IV
☐ IV

Induction

☒ IV ☐ Inhal
☒ Pre O₂ ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 4 at 13 cm

☐ Oral ☐ Nasal ☒ End
☐ Tracheostomy ☐ Topical
☐ Drug: ATACURIUM 7.5mg

☐ Awake ☒ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic

Blade# 2 Attempts: 1
Difficulty Why?

☐ Bilat = BS
☐ Semi-Closed Circle
☒ Closed Circle
☐ Other

Regional:

Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal

Others:

Position:

Site:

Needle Size: Depth:

Paresthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU ☐ ICU ☐ Other

Relaxant Reversed ☒ Yes ☐ No ☐ NA

Name of the Doctor: Dr. SHARMA

Signature of the Doctor: S



E UNIT RECORD

Received in PACU by : Tyetho Time Received : 9.30am Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>22 D hand</u>
		☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
< RESP • PULSE > BLOOD PRESSURE	< RESP • PULSE > BLOOD PRESSURE	Vomiting : ☐ Yes ☒ No Drug: NG Tube : ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: Oral Feeds:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/7	9.50am	1/100	—	D

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

Anaesthesiologist Name : M. Shahn

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 10/7/26

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): Tyetho

Date & Time: 10/7/26

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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		FHR	Comments
					BP	Pulse		

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Upper GI Endoscopy

Anaesthesiologist: Dr. SHARDA

Surgeon: Dr. Pouishya

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☒ Others Desaturation, Bronchospasm, Laryngospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Shivani

Name: Shivani

Relationship with patient: Mother

Date & Time: 10/7/2023 8:30 am

Witness:

Signature: [Signature]

Name: Bandikolla Vikram Babu

Date & Time: 10/7/2023 8:30 am

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. SHARDA Date: 10/7/2023 Time: 8:30 am



అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థాపం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాలు వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వేచ్ఛగా భావించి, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00681158 IP5-00176176 Master KIAANSH RAO BANDIKOLLA 22-01-2023 3 Y 5 M 18 D (M) Dr. M N V POUHYA SAI 		Date & Time of Admission 10/7/26 12:07AM	Date & Time of Transfer Order 10/7/26 @
		Transfer Ordered by Dr. Poushya Sai	Reason for Transfer foreign body removal
From Unit 144-C	To Unit DT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films 2 film	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	①	
2.			
3.			
4.	Received with 2D band and		
5.		cannula taped	
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐ time			
Name & Signature of Person who is Transferring Saxanthi		Name of Person Ordered Transfer Dr. Poushya Sai	
Patient & Clinical Records Received by : Teena			
Date & Time of Patient Received : 10/7/26 @ 8 ²⁰ am			

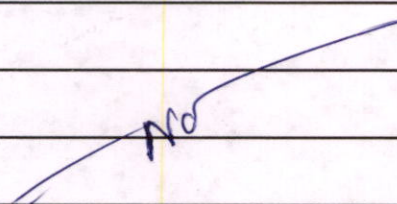
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & ID BAH-00651158 IP5-00175176 Master KIAANSH RAO BANDIKOLLA 22-01-2023 3 Y 5 M 18 D (M) Dr. M N V POUISHYA SAI 		Date & Time of Admission 9/7/26 12:00 PM	Date & Time of Transfer Order 9/7/26 12:30 PM
		Transfer Ordered by Dr. Nandaz	Reason for Transfer Admission
From Unit ER	To Unit 144	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films NO - X-Ray given to parents	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what? (OPFW) X-Ray with	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Annab		Name of Person Ordered Transfer Dr. Nandaz	
Patient & Clinical Records Received by : Chandan			
Date & Time of Patient Received : 10/7/26 @ 1 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

144C

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/7/26 Time: 7:30am

Weight: 15.5kgs Centile: 75th

Height: 97cm Centile: 75th

Inference: well child

RDA: Calories: 1300kcal/d Protein: 22g/d

Diet Recommendations: child is on NPO

Re-Assessment:

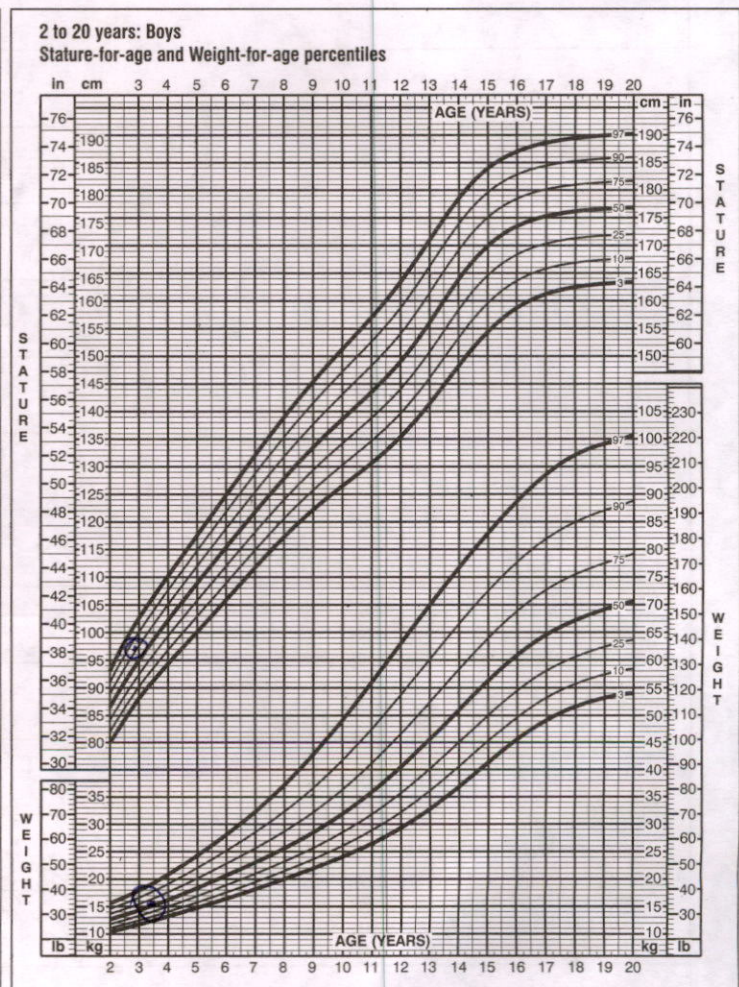
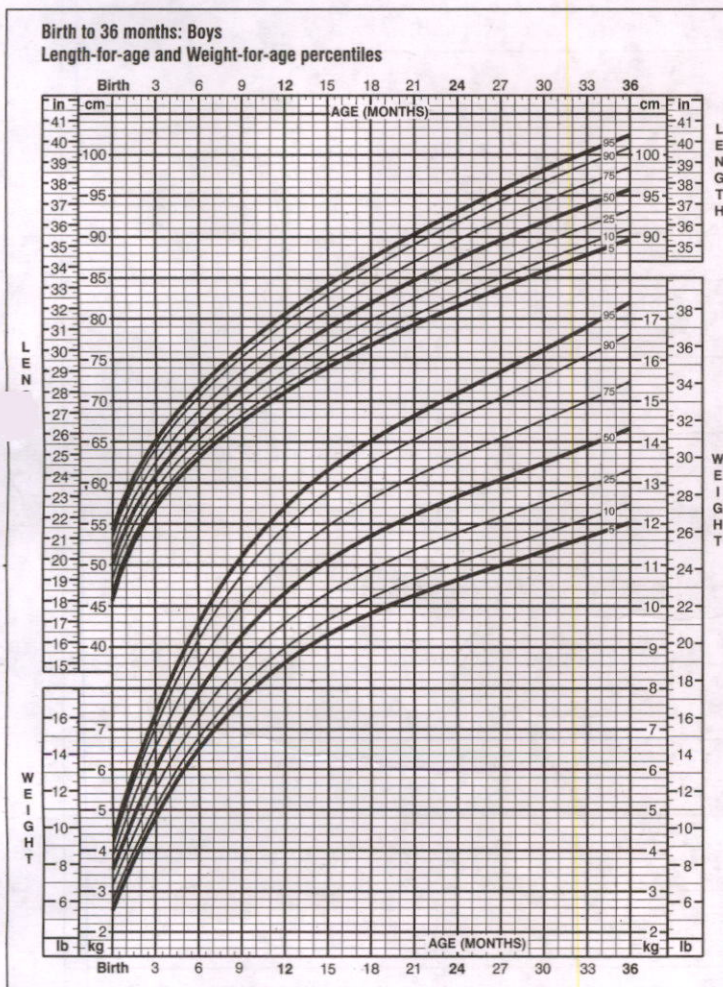
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: Fomieg Body in esophagus

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: [Signature]

Dietician's Signature: [Signature]

Daily Notes:

11/8/26
9am

child is stable Intake is fair

continue on soft diet

Nibbles