

BAH-00656681 IP5-00174646
Baby SIDRAFATIMA MEHADALI
26-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI



ENTERED
SURGERY DETAILS

80324

Date : 2/6/26

Patient Name: Baby - Sidra Fatima Mehadali Date of Birth: 26/1/2019 Age: 7 year

Gender: Female Ward: P.O.T UHID No.: BAH-00656681

Date of Surgery: 2/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Extraocular muscle surgery

Time in : 2.30 PM
~~2.30 PM~~

Time Out : 4.10 PM

	NAME	AMOUNT
1. Surgeon	Sushma Reddy	
2. Anaesthetist	Dr. Sindhra	
3. Assistant Surgeon		
4. OT Technician	BARU	
5. Circulating Nurse	Benjamin	
6. Assistant Nurse	Bobi Tyoti	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9639622

Order by: Benjamin

DART SIDI FATIMA SAMUD
 BAH-00656681
 22/4

SCRIPT SURGERY



6484

CONSUMABLES OF OT

Circulating staff: Benjamin Technician: J. Sapu Date: 2/8/26 Time: 2 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube (4.5-5.5)	14	—	Major Pack Drape	1	1	Inj Vit.K		
LMA (2)	14	1	Sutures			Cord Clamp		
ECG leads : A/P/N	05	3	Viagl- 2348	2	1	Suction Catheter		
HME filter : A/P/N	01	1	2670	2	2	Feeding Tube		
Syringes : 10 cc	20	4				Vaccum Suction Set		
05 cc	20	4	Gloves 6.6 1/2 7.7 1/2	2+2+2	1	Surgical Gloves		
02 cc	20	0	Pf-6.6 1/2 7.7 1/2	2+2+2	2	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A/P/N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube			Koochies (S)		
RL	01	1	Cautery pencil			NS 500 ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	01	1	Koochies			transofix	1	—
oil eye	01	1	Ointments			jelly	1	—
oil eye	01	1	Suction Catheter			5cc, 2cc, 10cc	2+2+2	1
Fentanyl	01	1	Cap, Mask (NAR)	1	2	sig, Dexmed	2	1
Morphine			Gauze Pack	1				
Ketamine			Mop Pack	1				
Propofol	03	1	Steristrip					
Rocuronium	01	—	Underpad					
Glycopyrolate	01	—	Draw sheet					
Myopyrolate (neo)	01	—	Abgel					
Ondansetron	01	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			0.2-0.1	14	—
Bupivacaine 0.25%	9	—	Chest Drainage Catheter			2.7 20cc	14	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			0.2mcc (P)	01	—
Antibiotics			Bandage			FABRASS	01	01
Ed pom	01	1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent	1	—			
Supridol : 100mg			Vaccum Suction set	1	—			
Justin (12.5 mg / 25mg) 100mg	14	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
3way 10cm + 100cm	14	1	Microshield	1	1			
Gauze + gloves	50	10	Cotton Balls	1	—			
Dee + force	14	10	Latex Gloves	10	10			
T.V cable - 22, 14	14	—	Ramdione Scrub	1	0			
D. cable, split 10	14	—	Saral					

Surgeon

Dr. Swidhana
 Anaesthesiologist

Benjamin
 Nurse

[Signature]
 OT Technician

Order No. : 9639716

Ordered by : [Signature]

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

12:45 PM

ESTIMATION SLIP

Date: 19/05/26 UHID / IP No.: TRAH 02686681 SI No. 80324
 Name of Patient: Baby Sidra Fatima Sayyed Age: 7y Gender: X
 Father's / Husband's Name: Mr. Abdul Ali Corporate / Occupation: Insurance
 Address: MDA Phone: 9730089978 Email: Hospital Chairman
 Procedure / Plan: Squint Surgery

MODE OF PAYMENT: SELF TPA GIPSA OTHERS

TARIFF INFORMATION: Dr. Fathima Abdul / Dr. ... base - 18k / 10/12/26

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee										
L. Tax										

PARTICULARS	AMOUNT (₹)															
Surgeon's / Anesthetists's Fee / O.T. Charges	33,880 + 12,320 + 2,664															
O.T. Consumables	Subject to approval by TPA / Insurance Company															
Instrument Charges	Not Covered by TPA / Insurance company															
Pharmacy, Consumables & Investigations	As per actual - Not Included in Estimation															
Equipment Charges	<table border="1"> <tr> <td>Monitor :</td> <td>Oxygen :</td> <td>Infusion pump / Syringe pump :</td> </tr> <tr> <td>Ventilator :</td> <td>Conventional :</td> <td>HFO-SLE 5000 :</td> </tr> <tr> <td>Phototherapy :</td> <td>Single Surface :</td> <td>Double Surface :</td> </tr> <tr> <td></td> <td></td> <td>HFO Sensormedix :</td> </tr> <tr> <td></td> <td></td> <td>Triple Surface :</td> </tr> </table>	Monitor :	Oxygen :	Infusion pump / Syringe pump :	Ventilator :	Conventional :	HFO-SLE 5000 :	Phototherapy :	Single Surface :	Double Surface :			HFO Sensormedix :			Triple Surface :
Monitor :	Oxygen :	Infusion pump / Syringe pump :														
Ventilator :	Conventional :	HFO-SLE 5000 :														
Phototherapy :	Single Surface :	Double Surface :														
		HFO Sensormedix :														
		Triple Surface :														
Blood/ Blood products / Implants / IP or OP Procedures / Cross-Consultations, Etc.	As per actual - Not Included in Estimation															
Package																
Others																
Minimum Deposit	Rs. 125,000/7 fund dues cleaning.															

- REMARKS:
- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
 - The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
 - In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
 - Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
 - Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
 - For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
 - During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
 - Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
 - Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I, Mr. Abdul Sayyed, have attended the Financial Counseling desk and understood the charges and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client: Mr. Abdul Sayyed
 Signatory/Relationship: Mother
 Signature of the Financial Counselor: (Signature)

ADMISSION SHEET



Registration Details :

Admission No : IP5-00174646 Admit Date : 02-Jun-2026 Admit Time : 01:05 PM UHID : BAH-00656681

Patient Details :

Patient Name	: Baby SIDRAFATIMA MEHADIALI SAYYAD	Age	: 7 Y 4 M 7 D
Guardian	: Mr MEHADIALI SAYYAD	DOB	: 26-01-2019
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: VTC:252 MOULALI CHOWK SOLAPUR, VTC: SOLAPUR NORTH, PO: Zilla Nayalaya Sholapur Maharashtra INDIA 413003	Phone No	: 9730089978/ 9175858330
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 403 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 403 Admission Type : First Visit

Contact Details :

Name	: Mr MEHADIALI SAYYAD	Relationship	: Father
Contact Address	: VTC:252 MOULALI CHOWK SOLAPUR, VTC:SOLAPUR NORTH, PO: Zilla Nayalaya Sholapur Maharashtra INDIA 413003	Phone No	: 9730089978 / 9175858330


Signature

Doctor Details :

Doctor Name	: Dr. SUSHMA REDDY KATUKURI	Specialisation	: OPHTHALMOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. FAISAL B NAHDI		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

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26-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI



Consultant: _____ Dept : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/19	2:50pm	CK	OT	Randey
2/6/19	5:30pm	OT	334	

Cross Consultation Visit

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



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Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

BAH-00656681 IP5-00174646
Baby SIDRAFATIMA MEHADIALI
26-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI



Patient Name:

Si

UHID ID:

Department:

Consultant:

BAH-00856681 IP5-00174646
Baby SIDRAFATIMA MEHADIALI
28-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____
Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Squint since 3 months
Pain & hardness in eyes occasionally since 3 months.

History of present illness :

Child is apparently normal 3 months ago. Child developed
above mentioned symptoms since 3 months.



Child planned for squint repair surgery. LGA

No H/o fever, cold, cough, vomiting, loose stools,
burning micturition

No H/o fresh complaints.

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Baby SIDRAFATIMA MEHADIALI
28-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI



Pediatric medicine

Physical Examination

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

Birth & Neonatal History:

NVD / Term / 2.5kg / NO NICU stay.

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} Upper middle class

Developmental History :

(A) development as per age

Immunization History :

Not vaccinated since birth



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs) 21.73 kg (Centile _____)

On Examination :

Temperature : 98.4 °F Pulse Rate : 102/min B.P. 100/57 (67) mmHg SPO2 100% on RA

Resp. rate and type of breathing : RR = 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

} Nil

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AEC

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft INT.

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Rd Squint Surgery



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP on cannulation.

Planned Management

Sp @ 2pm

NPO to continue

IV fluids.

noted by
Radney
2/6/26
2:00pm

Signature of the Doctor: Radney
Name of the Doctor: Dr. Radney
Date & Time: 2/6/26

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

DR. SUSHMA REDDY KATUKURI
Registration No: APMC/FMR/63999



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			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
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	1			
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	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation	1			
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)	1			
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				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart	10			
42	Rch ED doctors note				
43	BP Monitoring chart	1			
44	RBS monitoring chart				
Total No. of Pages		37			

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 6pm	<p><u>C/S/B Resident</u></p> <p>Δ: Exotropia <u>post BE EOM surgery</u></p>	
-	no issues	<u>Adv:</u>
	<p>O/E: alert stable vitals dressing no leakage</p>	<p>1.) (B) 4m</p> <p>2.) Medications as charted</p> <p>3.) Remove eye patch at 8pm</p>
		<p><i>Akhile</i> Dr. Akhile</p>
3/6 8am	<p><u>C/S/B Resident</u></p> <p>no issues</p>	<u>Adv:</u>
	<p>O/E alert stable vitals B/E: (N) VA</p>	<p>(B) today</p> <p>Akhile</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6	<p>cl/s Resident</p>	
	<p>Di: Exotropia</p>	
	<p>Post BE from surgery</p>	
	<p>unable to open eye, pain</p>	
	<p>no fresh complaint</p>	<p>den</p>
	<p>ok</p>	<p>- of same treatment</p>
	<p>vital - stable</p>	
	<p>Hemodynamic - stable</p>	<p>monitor vtd</p>
		<p>Pup</p>
	<p>Post op day 1</p>	
	<p>SL: Exotropia Sur</p>	
		<p>do</p>
		<p>① Pred forte eye drops</p>
		<p>1 drop 6 times a week</p>
	<p>Balm in</p>	
		<p>② Moxicip eye drops</p>
		<p>1 drop 4 times a week</p>
	<p>1/2</p>	
	<p>1 week.</p>	
	<p>Discharge today</p>	
	<p>DR. SUSHMA REDDY KATUKURI</p>	
	<p>Registration No: APNCFMR/63999</p>	

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Baby SIDRAFATIMA MEHADIALI
26-01-2019 7 Y 4 M 7 D (F)
Dr. SUSHMA REDDY KATUKURI



Rainbow
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Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ON THEATER NOTES

Patient's Name : Age : 7 year Gender : Male Female

UHID No.: Weight : 22 kg Height :

Surgeon : Asst. Surgeon :

Anesthetist : Dr. Sunidha OT Nurse: Bobi, Latha, Banya OT Technician: BAPU

Pre-Operative Diagnosis: Exotropia

Surgical Procedure : Both eyes extraocular muscle surgery

Indications for Surgery : Deviation of eyes

Date : 2/6/26 Start Time : 2.45 pm End Time : 3:50 pm

Pre Operative Preparations:
Under aseptic precautions
both eyes cleaned & draped

Post Operative Diagnosis: Exotropia

Peri-Operative Complications:
-

Operation Notes:
Right eye followed by left eye
Eye speculum kept
Inferolateral conjunctival incision
given
Lateral Rectus muscle hooked
& secured with 6-0 vicryl
Dis inserted from original insertion
& Reinserted at 8mm with
1/2 tendon up shift.

Conjunctival incision closed
with 8-0 vicryl.

1cc dexte subconjunctival
give

Eye patched

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

After 4 hours

ie 7:30pm

remove the eye patch
& start

① pred forte eye drops
1 drop 6 times/day

② MOXICIP eye drops
1 drop 4 times/day

Both
eye

Rla
1 day

Name of the Surgeon: Sushama Reddy

Signature of the Surgeon: [Signature]

Date & Time: 2/6/26 4:pm

Pat

BAH-00658881
Baby SIDRAFATIMA MEHADIALI
26-01-2019
Dr. SUSHMA REDDY KATUKURI
7 Y 4 M 7 D
IPS-00174646
(F)

SRGICAL CARE PLAN FORM

Procedure Done: <u>Both Eyes Lateral Tarsal Recession</u>
Post-Surgical Diagnosis: <u>Strabismus (8mm)</u>
Post-Operative Monitoring Parameters /Frequency:
Wound Care:
Drain /Special Lines/Catheters:
Special Patient Positioning and Requirements:
Nutritional Instructions:
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Any Other Post-Operative Care Needed including Required Follow Up
Treating Surgeon (Signature & Stamp) <u>[Signature]</u>
Date: <u>2/6/26</u> Time: <u>1.30</u>
Note: Plan of care will be readjusted if necessary.



DRUG CHART

Date of Admission: 2/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Sym crocin DS</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>8/8</u>	<u>3/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>																				
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:																					

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 22kg Ward. 05

DRUG : PREDFORTE eye drops				Date Time	2/6	3/6																
Dose	Route	Frequency	Start Date	12Am	X	3Pm	X															
10	each eye	9/4	2/6	4Am	X	6Pm	X															
Name & Signature of the Doctor Starting the Drugs: <i>Akhile</i>				8Am	X	8Pm	X															
				12Pm	X	4Pm	X															
				Additional Instructions:																		
				8Pm. call. 4																		
Daily Doctor's Endorsement by a Sign																						

DRUG : MOXICIP eye drops				Date Time	2/6	2/5														
Dose	Route	Frequency	Start Date	9Am	X	8Pm	X													
10	each eye	QID	2/6	9Am	X	3Pm	X													
Name & Signature of the Doctor Starting the Drugs: <i>Akhile</i>				3Pm	X	Additional Instructions:														
				9Pm	X	8Pm 82														
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/6	2 ³⁰ pm	INJ. DEXAMETHASONE	3mg	IV	[Signature]	[Nurses]
2/6	2 ³⁰ pm	INJ. ONDANSETRON	3mg	IV	[Signature]	[Nurses]
2/6	2 ³⁰ pm	INJ. PARACETAMOL	330mg	IV	[Signature]	[Nurses]

VERIFIED BY : Name Signature

BAH-00656681 IP5-00174646
 Baby SIDRAFATMA MEHADIALI (F)
 26-01-2019 7 Y 4 M 7 D
 Dr. SUSHMA REDDY KATUKURI

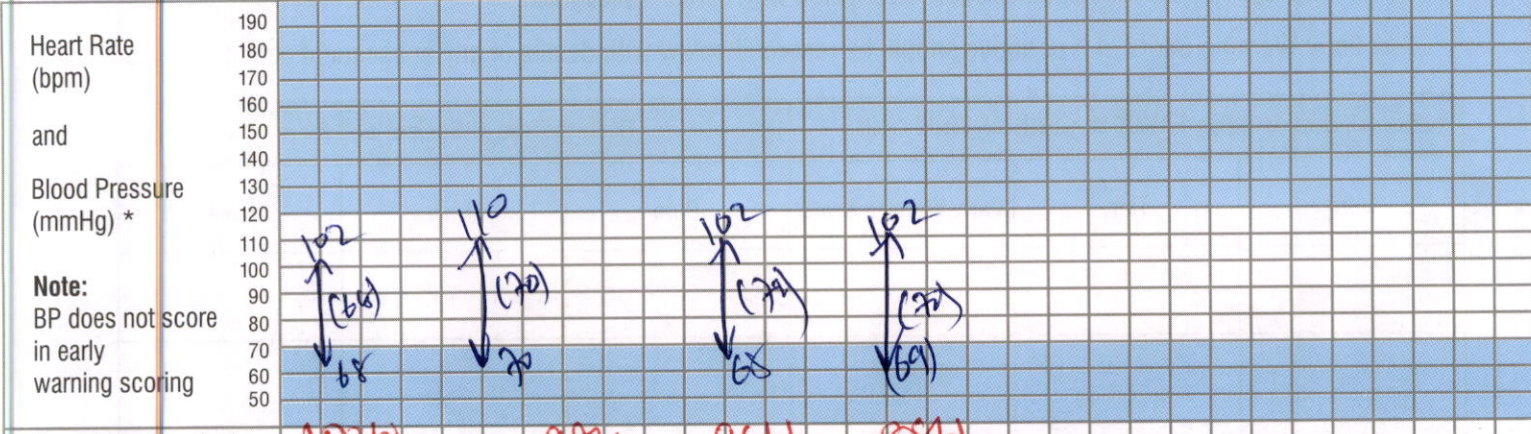
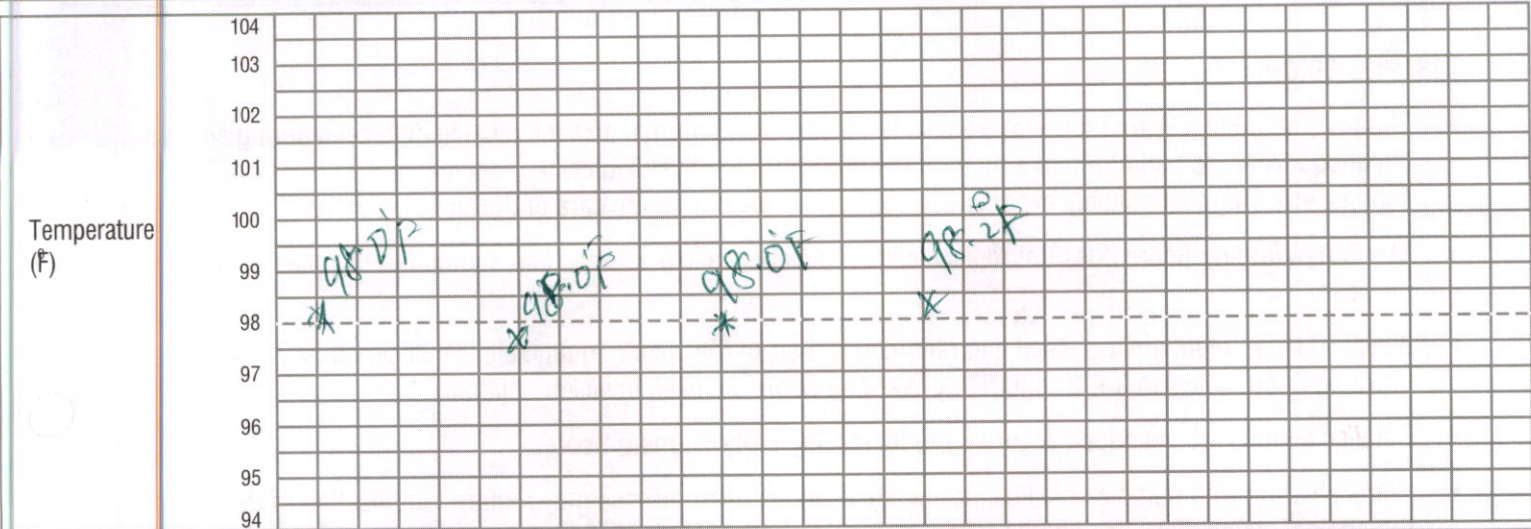
2/6/25

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 6Am 10Pm 2Am 6Am
 Doctor / Nurse / Family Concern? _____



Heart Rate (Number) 104bpm 98bpm 96bpm 88bpm



Resp Rate (Number) 28bpm 30bpm 30bpm 26bpm

Resp Distress Mod/ Severe None / Mild N N N N

Receiving O₂ (l/min) O₂ Saturations (%) 0.1 0.1 0.1 0.1

Conscious Level Normal Altered N N N N

GCS * 15/15 15/15 15/15 15/15

TOTAL SCORE
 Number of shaded boxes 0 0 0 0
 Pain Score 0 0 0 0
 Observer's Initials C C Z Z

- ACTIONS**
- 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 Stic

BAH-00656681 IP5-00174646
 Baby SIDRAFATIMA MEHADIALI
 26-01-2019 7 Y 4 M 7 D (F)
 Dr. SUSHMA REDDY KATUKURI



FLUID CHART

Sheet No.

2/8/26

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.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		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 : u-0 m-0							
	08:00 pm											
	09:00 pm		Water									
	10:00 pm											
	11:00 pm		Water									
	12:00 am											
	01:00 am											
Total Intake :					Total Output : u-1 m-0							
	02:00 am		Water									
	03:00 am											
	04:00 am		Water									
	05:00 am											
	06:00 am		Water									
	07:00 am											
Total Intake :					Total Output : u-1 m-0							
Total 24 hrs. Intake		Takes										
Total 24 hrs. Output		u-2 m-0										

BAH-00656681 IP5-00174646
 Baby SIDRAFATIMA MEHADIALI
 26-01-2019 7 Y 4 M 7 D (F)
 Dr. SUSHMA REDDY KATUKURI



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			
	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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Baby Sidapatima Scyyed Age: 7.4m Sex: Female UHID No: BAM-00656681

Date: 1/06/2026 Time: 12:50pm Proposed Operation: Squint Surgery

Diagnosis: Squint

B.P / CRT: 3sec H.R: 86/min Weight: 22kgs ASA Physical Status: 1 2 3 4 5

Laboratory Data:

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

Allergies: NKDA

Medical History: CVS: ?

Diabetes: Term MVD CIAD. B.Wt: 2.5kg NO NICU admission

CNS: NOT significant. NOT immunised since birth.

Renal: Development (N)

Hepatic / GE: Physical Activity: Active

Others:

Past Anaesthetic History: -

Physical Exam: (N)

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mento-hyoid Distance: 2FB Neck: (N) Teeth: intact

Lungs: BAE (+) clear

Heart: S1S2 (+)

CNS: MMF (+)

Pregnant: Yes No NA Venous Access Site: accessite Spine Exam for regional: (N)

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

- Pre-Operative Instructions:**
- DVT Prophylaxis: explained.
 - NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: CBP during cannulation

Signature: [Signature] Name: Dr. Tejaswini



ANAESTHESIA CHART



Induction Assessment: 2:30pm

Change in Patient Condition: Yes No Fasting Status: confirmed

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 90/nt B.P / CRT: 90/50 SpO₂: 100% R.R: 18/nt Last Feed: che

Pre-OP Diagnosis: Squint eye Operation: Squint eye Date: 26/26

Surgeon: Dr. Sushma Anaesthesiologist: Dr. Sundhar Technician: Bapu

TIME	NO. AIR / O ₂ LPM	HA. O ₂ / SPO ₂ (%)	DRUGS	ANTIBIOTIC	SUPPOSITORY	BLOOD LOSS	NOTES
2:30	2	100	Propofol 50 mg				
2:35	2	100	DEXAMETHASONE 3mg CALCIUM GLUCONATE 120 mg				
2:40	2	100	PANACEPAMOL 330 mg ONDANSETRON 3mg				
2:45	2	100					
2:50	2	100					
2:55	2	100					
3:00	2	100					
3:05	2	100					
3:10	2	100					
3:15	2	100					
3:20	2	100					
3:25	2	100					
3:30	2	100					
3:35	2	100					
3:40	2	100					
3:45	2	100					
3:50	2	100					
3:55	2	100					
4:00	2	100					
4:05	2	100					
4:10	2	100					
4:15	2	100					
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4:25	2	100					
4:30	2	100					
4:35	2	100					
4:40	2	100					
4:45	2	100					
4:50	2	100					
4:55	2	100					
5:00	2	100					
5:05	2	100					
5:10	2	100					
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5:50	2	100					
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9:35	2	100					
9:40	2	100					
9:45	2	100					
9:50	2	100					
9:55	2	100					
10:00	2	100					

LAB Values

ABG

GPBS

Others

Equipment Checked and Functional

BP nt

Cuff Site: nt

Art Site: nt

EKG Lead

Temp Site skin

FIO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: Supine

Pressure Points Checked

Eye Care:

Oint

Tape removed during

Padding during

Awake

Temp:

HME Fluid Warmer

Cling Film OH Warmer

Hugger's Cotton Wool

Other

Times:

Anaes Start: 2:30 pm

OP Start: 2:41 pm

OP End: 4:00 pm

Leave OR: 4:00 pm

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP: _____

ART: _____

A: 22g nt

IV: _____

IV: _____

Induction

IV Inhal

Pre O₂ RSI

Others

Mask SGA # 2.5

Airway Oral Nasal

ETT# _____ at _____ cm

Oral Nasal Cuff

Tracheostomy Topical

Drug: _____

Awake Direct Vision

Video Laryngoscopy Stylette / Bougie

Fiberoptic

Blade# _____ Attempts: _____

Difficulty Why? _____

Bilat = BS

Semi-Closed Circle

Closed Circle

Other

Regional:

Extremity Specify: _____

Spinal Epidural Caudal

Others: _____

Position: _____

Site: _____

Needle Size: _____ Depth: _____

Parasthesia 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: Sundhar

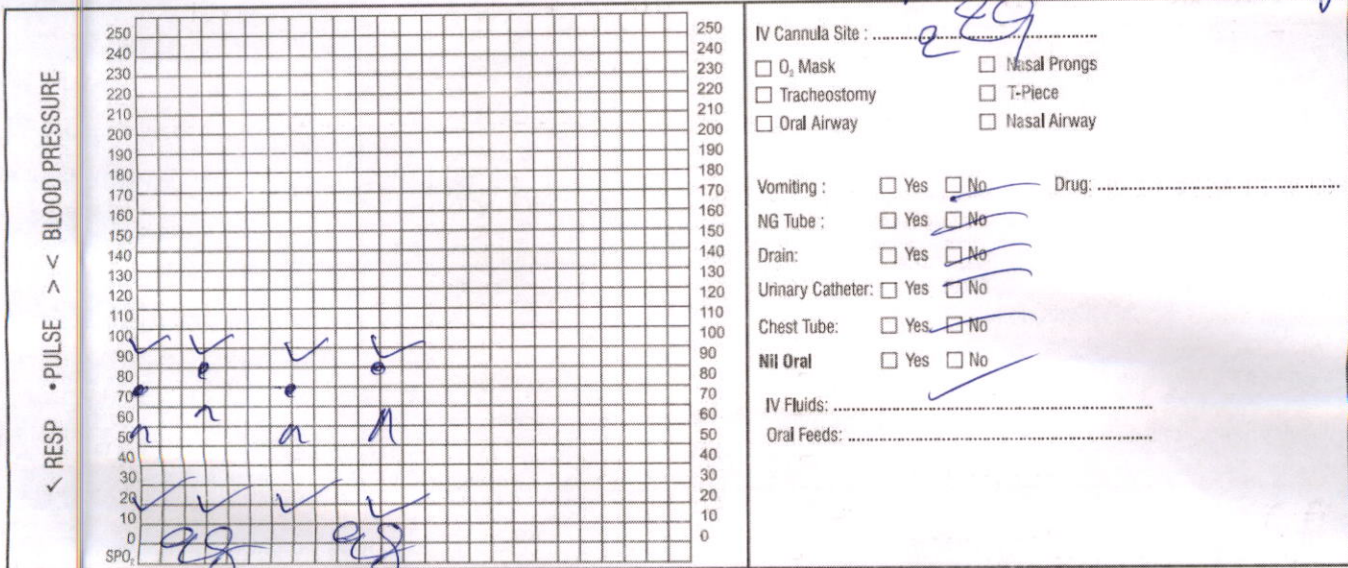
Signature of the Doctor: Sundhar

BAH-00656881 IP5-00174646
 Baby SIDRAFATIMA MEHADIALI
 26-07-2019 7 Y 4 M 7 D (F)
 Dr. SUSHMA REDDY KATUKURI



POST-ANAESTHESIA UNIT RECORD

Received in PACU by : Dr. Sushma Time Received : 2:15pm Time Discharged : 5:30pm



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	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 deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	1	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
TOTAL		8	8	9	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
<u>2/6</u>	<u>2:15pm</u>	<u>1</u>	<u>—</u>	<u>[Signature]</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

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

Anaesthesiologist Name : Dr. Kiran

Anaesthesiologist Signature: [Signature]

Date & Time: 2/6/2019 @ 5:35

PACU Nurse Name : [Signature]

Transferred to Unit by (PACU): 334

PACU Nurse Signature: [Signature]

Date & Time: 2/6/2019 @ 5:35pm

Date & Time: 2/6 @ 5:30pm



334

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 3/6/26 Time: 9am

Weight: 22kg Centile: 25th

Height: Centile: 25th

Inference: locu child

RDA: - Calories: 1500kcal/d Protein: 26gm/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid Spig, chilled & outside foods

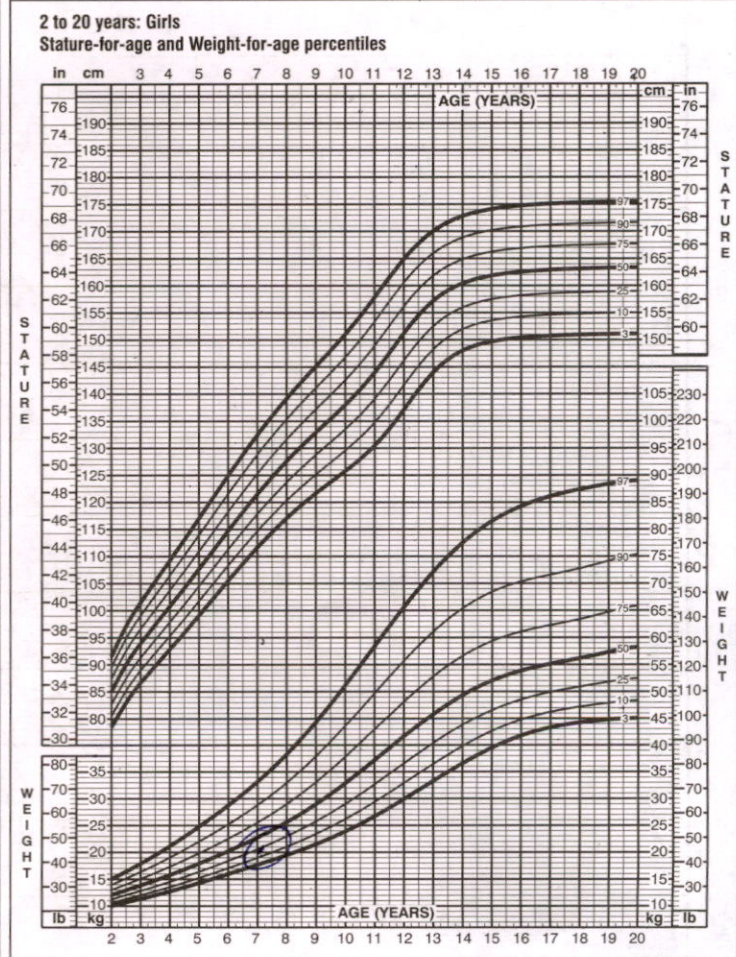
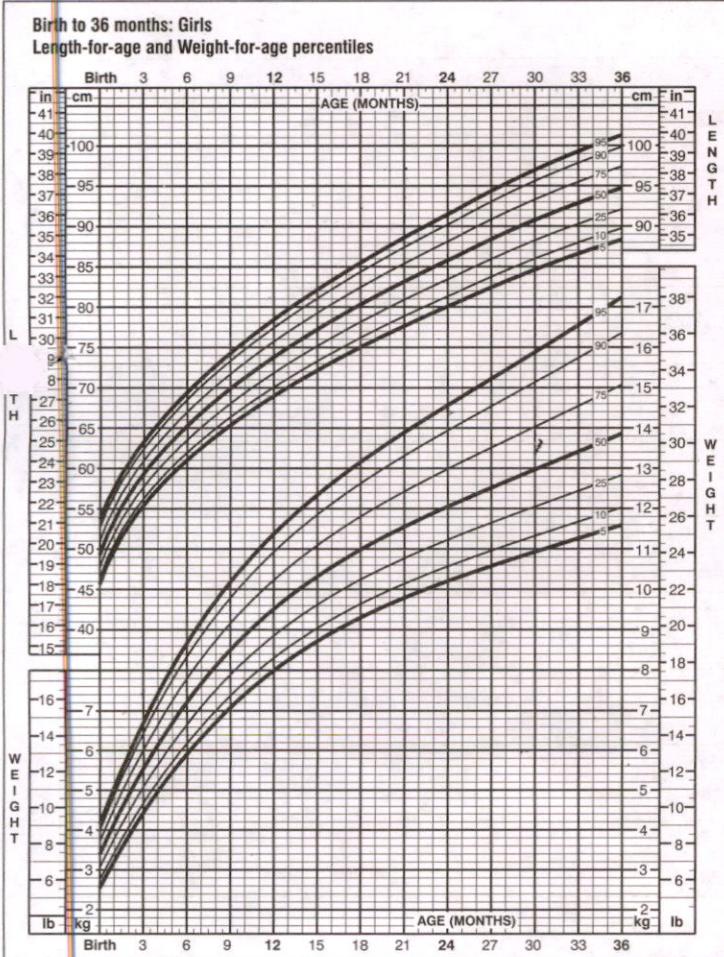
Food Allergies: Veg/Non-veg

Diagnosis: Erythropia post BC EOM Surgery

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)



Dietician's Name: Salma

Dietician's Signature: Salma

