Patient Sticker

BAH-00522093 IP5-00175960
Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 04/07/22

Patient Name: G. Keerthana Date of Birth: 06-11-2009 Age: 1.6Y

Gender: Female Ward : P.OT UHID No.: BAH-00522093

Date of Surgery: 04/07/22 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Colonoscopy + biopsy

Time in : 11:30 Am Time Out : 1pm

		NAME	AMOUNT
1.	Surgeon	: Dr Alekha	
2.	Anaesthetist	: Dr. Brunda	
3.	Assistant Surgeon	:	
4.	OT Technician	: Kulsum	
5.	Circulating Nurse	: Sravani	
6.	Assistant Nurse	: Bikila	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others colonoscopy :- 9687409

Signature of the Surgeon

Bikila
Signature of Circulating Nurse

Order No: 9687409 Order by: J. Ramesh

Docu. No. : RCHBH/FRM/GENERAL/114

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Colposcopy

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CONSUMABLES OF OT

Circulating staff : .... Technician : .... Date : 4/7 .... Time : 10:30

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube (5.5 · 6.0 · 6.5	1+1+1	—	Major Pack			Inj Vit.K		
LMA 3	01	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5	5				Suction Catheter		
HME filter : A / P / N	4	—1				Feeding Tube		
Syringes : 10 cc	10	03				Vaccum Suction Set		
05 cc	10	03	Gloves 6, 6.5, 7, 7.5	2+2	1+1	Surgical Gloves		
02 cc	10	—	6, 6.5, 7, 7.5	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	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			NS 500ml	1	0
NS : 10ml / 100ml / 500ml / 1000ml	2+1	1+1	Koochies			Transofix	1	1
mini spike	01	0	Ointments			Jelly	1	1
vaccum set	01	1	Suction Catheter			50cc	1	0
Fentanyl	01	1	Cap, Mask	5/5	5/5	Plastic Apron	1	2
Morphine			Gauze Pack N	2	2	[illegible]	1	2
Ketamine			Mop Pack	1	0	50cc	1	1
Propofol	04	3	Steristrip					
Rocuronium	01	—	Underpad	1	2			
Glycopyrolate	01	0	Draw sheet					
Myopyrolate	01	—1	Abgel					
Ondansetron	01	—	Foleys catheter			O.A. 1,2	1+1	—
Pencan 25g/ Spinal Needle 22			Urobag			N.A. 22,24	1+1	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			O2 mask (A)	01	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			EtCO2 nasal p.(A)	01	01
Antibiotics			Bandage					
IV PCM	01	—	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	0			
Justin : 12.5 mg / 25mg / 100mg	02	—	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	—			
3 way 10cm + 100cm	1+1	—	Microshield	1	—			
[illegible]	[illegible]	—	Cotton Balls					
[illegible] + Towel	1+2	—	Latex Gloves	10p	10			
IV cath. 22, 24	1+1	—	Ramdione Scrub					
O. Side splint 1,3	1+1	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9687435 Ordered by : [signature]

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175960 **Admit Date** : 04-Jul-2026 **Admit Time** : 09:11 AM **UHID** : BAH-00522093

Patient Details :

Patient Name	: Ms G KEERTHANA	**Age**	: 16 Y 7 M 28 D
Guardian	: Mr G GANESH	**DOB**	: 06-11-2009
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: BANK COLONY, PYRAMID OPP, Mandapeta Bazar East Godavari Andhra Pradesh INDIA 533308	**Phone No**	: 9989255661
		E-mail	: na123@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 405 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 405 **Admission Type** : First Visit

Contact Details :

Name : Mr G GANESH **Relationship** : Father

Contact Address : BANK COLONY, PYRAMID OPP, Mandapeta Bazar East Godavari Andhra Pradesh INDIA 533308 **Phone No** : 8886439199 / 9989255661

Signature

Doctor Details :

Doctor Name	: Dr. Prashant Bachina	**Specialisation**	: PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00522093 IP5-00175960
Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina
onsultant: _____ Dept : _____

Date of Admission: ___ ate of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
04/07/26	9:50 Am	ER	OT	
4/7/26	3:20 pm	OT	billing	

Cross Consultation Visit

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

INVESTIGATIONS			
Date	Investigations	Order No.	Signature
4/7/26	CBP	6918	Chargan

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7/26	IV placement PAC op	①	7030	Charan

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Prasanth Bachina Date : 4/7/26

Type of Admission: ☑ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: 8:20 am Weight: 37.2kg

Allergic History: .....

Chief Complaints:
F/up case of Crohn's disease
↓
Now came for colonoscopy

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

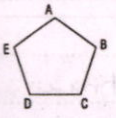
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing

Rate: 20/min SpO_2 on FiO_2 100% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE (+)
Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 78/min

CFT — Central .... — Peripheral ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

BP: 93/72(77) mmHg

Pulse Volume: — Central .... — Peripheral ....

If in Shock: — Compensated .... — Hypotensive ....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15

AVPU: ....

Pupils: — Responsive ☑ Non-Responsive ☐ — Size — Right .... — Left ....

Active Seizures: ☐ Yes ☑ No Sugars: ....

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Exposure

Temp.: 98.2°F

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned:

CBP on communication

Treatment Planned:

NPO to continue

Proctoclysis before procedure

Need for Oxygen: ☐ Yes ☑ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): K/c/o Cronh's disease — Came for Colonoscopy

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: [signature]

Date & Time: 4/7/26; 8:30am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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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	T. WYSOLONE	5mg	PO	OD	03/07/26 10AM	☐ C ☐ DC
2	T. AZORAN	50mg	PO	OD	03/07/26 10AM	☐ C ☐ DC
3	PENTASA	1g	PO	OD	03/07/26 1PM	☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

cont. once daily above

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Nandan

Date & Time : 04/07/2026, 9.30 AM

Nurse Name & Signature: Keerthi. KJ

Date & Time : 04/07/26 @ 10Am

Docu. No. : RCHBH /FRM / GENERAL / 090

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.
b.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేర్లు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 Colonoscopy + Biopsy

2 .....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Diagnostic &	

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

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

a. Abrasion, bleeding, perforation,
b. Infection

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

Patient / Patient Attendant:

Signature: .....
Name: GHANESH
Relationship with patient: Father
Date & Time: 04/7/26 @ 11.10 am

Witness:

Signature: .....
Name: Teena
Date & Time: 4/7/26 @ 11.12 am

Doctor (who is taking consent):

Signature: ..... Name: Dr. Kunal. Date 04/07/26 Time: 11.10 a.m.

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. isha
Asst. Surgeon :
Anaesthetist : Dr. Bounda
Scrub Nurse : Bikadi

Patient Name : G. Keerthana Age : 16Y Gender : F
UHID No. : 522093 Surgery Name : USG Lap
Date : 04/09/26 In-time : 11:30Am Out-time : 1pm

BAH-00522093 IP5-00175960
Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 11:10 Am

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 : [signature]
Name : Dr. Tejaswini

Before Skin Incision ➤ ➤

TIME OUT Time: 11:40pm

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? Nothing 2hrs Will ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews: Nothing
- 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 : Bindai
Name : Dr

Before Patient Leaves Operating Room

SIGN OUT Time: 12:50p

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

for [signature]
Signature :
Name : Dr. Keerthana

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 04/02/26

To Be Filled In By Assigned Nurse :

Department : P. OT Duration of Procedure : 2hrs

Name of Surgeon : Dr. Alisha Date of Admission : 04/02/26

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 : ..... 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. Alisha Date & Time of antibiotic administration : ~~04/02/26~~ 10 Date & Time procedure started : 04/02/26 at 11 am	

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

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OPERATION THEATER NOTES

Patient's Name : .... Age : 16 yrs Gender : ☐ Male ☑ Female

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

Surgeon : Dr. Alisha.	Asst. Surgeon :	
Anesthetist : Dr. Suridhara	OT Nurse: Bikhlai	OT Technician: Srvishn
Pre-Operative Diagnosis: IBD		
Surgical Procedure : Colonoscopy + biopsy.		
Indications for Surgery : Persistent loose stools / Nausea / wt. loss / ↓ appetite		
Date : 04/07/22	Start Time : 11:40 pm	End Time : 12:50 pm

Pre Operative Preparations:

Bowel preparation.

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Colonoscopy by Dr Alisha.

. Seen till 40 cm of ileum.

Ileum, cecum, IC valve, asc. colon (N)

Patchy LOV in transverse colon

Rest (N) throughout till rectum

Perianal tag (+) (not inflamed .

Bx taken
(1) Ileum
(2) Colon
(3) area with LOV.

Doc. No. : RCHBH/ FRM / CLINICAL / 099 (P.T.O.)

Amount of Blood Loss: Ø | Blood Transfused (in ML) Ø

Name and Number of Surgical Specimen sent for examination:

(3).

Peri-Operative Complications:

×

Name of the Surgeon: Dr Alisha

Signature of the Surgeon: Aisha

Date & Time: 4/7/26

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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Ikely.

Wound Care:

–

Drain /Special Lines/Catheters:

–

Special Patient Positioning and Requirements:

–

Nutritional Instructions:

–

When to Start Mobilization:

1

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

Treating Surgeon
(Signature & Stamp)

Date: 4/7/25 Time: 1 pm

Note: Plan of care will be readjusted if necessary.

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DRUG CHART

Date of Admission: 4/7/26. Drug Allergies; ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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:				

Signature .....

VERIFIED BY : Name .....

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Dr. Prashant Bachina

REGULAR PRESCRIPTIONS

Weight. 37.2 kg Ward. ....

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				

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				

Dr. Prashant Bachina   Y / M 28 D   (F)

IPS-00175960   BAH-00522093

Weight. 37.2 kg Ward. ....

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7/26.	12pm	INJ-GLYCOPYRROLATE	0.2mg	IV	[signature]	[signature] Bikhali

Dr. Prashant Bachina

BAH-005220B3
Mr. G KEERTHANA
IP5-0017596O
06-11-2009

I.V. FLUIDS CHART

Weight. 37.2 Kgs Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/7/26	10:00am	D/NS (75% maint amena)	IV	57					

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

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Keerth

Patient Stic

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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: OT.

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 4/7/26 ; 8:40am

Nurse Name & Signature: NUR. Seesmita

Date & Time : 4.7.26 @ 8:42am

ASSESSMENT FORM

Character

Month to 7 Years)

IP5-00175960

Y 7 M 28 D (F)

Frequent to constant frown, quivering chin, clenched jaw

Kicking, or legs drawn up

Arched, rigid, or Jerking

Steadily, screams or sobs, complaints

Comfort

Chronic	☐ Sharp	
☐ Acute	☐ Aching	
☐ Chronic	☐ Sharp	
Continuous	☐ Acute	☐ Aching
Intermittent	☐ Chronic	☐ Sharp
☐ Continuous	☐ Acute	☐ Aching
☐ Intermittent	☐ Chronic	☐ Sharp
☐ Continuous	☐ Acute	☐ Aching
☐ Intermittent	☐ Chronic	☐ Aching

hours.

minutes after pain relief intervention.

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BRADEN 'Q' SCALE

					Date : 04/7 Time : 8:30am			
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			
"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			
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			
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			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	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			
				TOTAL SCORE	28			
				Evaluator's Name	Keeti			

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	
15-18	At Risk	• Regular Turning Sc • Enable as much activ • Protect the heels • Use pressure redistributi • Manage moisture, friction • Advance to a higher level of factors are present
13-14	Moderate Risk	• Use the Same Protocol as for **"At R** • Position patient at 30 degree lateral in
10-12	High Risk	• Follow the same protocol as for **"Moderat** • In addition to regular turning schedule • Make small shifts in their position frequently
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients wi severe pain or with additional risk factors.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASS

CATEGORY	0
Face	No Particular expression or smile
Legs	Normal Position or Relaxed
Activity	Laying quietly normal position, moves easily
Cry	No Cry (Awake or asleep)
Consolability	Content, relaxed

Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

Wong - Baker (Pediatrics) Above 7 Years

0 No Hurt — 2 Hurts Little Bit — 4 Hurts Little More — 6 Even More — 8 Hurts Whole Lot — 10 Hurts Worst

Neonatal Pain, Agitation and

Assessment Criteria	Sedation		
	-2	-1	
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropri irritable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropria gestationa
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed A
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed ha feet Normal To
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within bas normal for gestationa

Ms G KEERTHANA
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
01/7	8:30Am	2	Treatment & care plan	F	1	1	1	0	-	

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
04/7/26 8:30Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Colonoscopy + Biopsy.	H. stability.	NPO & Procedure.	Reshi	☐ Nursing ☐ Others:
04/7/26 8:30Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Colonoscopy + Biopsy.	H. Stability	Ir fluids & Antibiotics.	Kuthi	☐ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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RESULT SHEET

Date	4/1/26					
Time	9am					
Hb	9.8					
PCV	33.4					
RBC	4.67					
WBC	6.47					
N/L						
Platelets	542					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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06-11-2009 15 Y 7 M 28 D (F)
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Patient

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

Patient Sticker

FLUID CHART

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Sachins

Patient S

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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					
	7 to less than 13 years old	2					
	13 years old and above	1	1				
Gender	Male	2					
	Female	1	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
	TOTAL		06				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓			
	Call device within reach		✓			
	Wheels Locked		✓			
	Room free of clutter		✓			
	Adequate Lighting		✓			
	Wheel Chair Support		✓			
	Other Intervention(s) Specify		—			
Nurse's Name :			Keerthi			
Signature :			Ki			
Date :			06/7			
Time :			8:30 AM			

Docu. No. RCHBH / FRM / CLINICAL / 005

BAH-00522093 IP5-00175960
Ms Q KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

Patient S

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. prashant Department: pediatric Date of Admission: 04/7/26

SITUATION	Diagnosis: colonscopy	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	ER 9:30AM					
	Medical Condition (Any special condition to be noted):	NIA					
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°F					
	Res:	22b/m					
	SpO_2:	100%					
	Pulse:	125b/m					
	BP:	103/59					
	Fall Risk Score:	09					
	Pain Score:	0/10					
Recommendations	Safety Needs:	✓					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	NIA					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NIA					
Post Operative Procedure Special Orders:		NIA					
Handed Over By Name :		Keerthi					
Signature :		K.					
Date:		04/7					
Time:		9:30AM					
Taken Over By Name :		Reena					
Signature :							
Date:		4/7					
Time:		10 am					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00522093 IP5-00175960
Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Colonoscopy.

Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Prasanth

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 Laryngospasm, bronchospasm.

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: G. GANESH
Name: G. Ganesh
Relationship with patient: Father
Date & Time: 3/7/26 2:30pm

Witness:
Signature: G. GANESH
Name:
Date & Time: 03/07/26 2:30pm

Doctor (who is taking consent):
Signature: Name: Dr. Archana. K Date 3/7/26 Time: 2:30pm

Patient Sticker

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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 అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రీజనల్ 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 నార్కోటిక్ 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 ☐ మూత్రపిండాల 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.
  ☐ రీజనల్ 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, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ 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 స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Ms. G. KEERTHANA Age: 16y 1M Sex: Female UHID.No: BAH 00522093

Date: 03/07/26 Time: 2:15pm Proposed Operation: COLONOSCOPY

Diagnosis: FUC of IBD - CROHNS

B.P / CRT: <3 sec H.R: 84/min Weight: 37.1kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: ...
PCV: ...
WBC: ...
Plate: ...
PT: ...
PTT: ...
INR: ...

Glucose: ...
Urea: ...
Creat: ...
Na: ...
K: ...
Ca++: ...
Mg++: ...
Cl-: ...

Protein: ...
Alb: ...
Total Bill: ...
Dir. Bill: ...
LDH: ...
Alk phos: ...
Amylase: ...
SGOT/SGPT: ...

HIV: ...
HBS Ag: ...
HCV: ...
Blood group: ...
T3 ...
T4 ...
TSH ...

X-Ray: ...
ECG: ...
2D Echo: ...
Stress/Anglo: ...
Other: ...

Allergies: NIL

Medical History: CVS: } Nil sign
Diabetes: NO

RESP: }
CNS: }
Renal: } Physical Activity: active

IBD - Crohns ds 8-9 yrs

Hepatic / GE: c/o Loose stools,

Others: H/o kochs neck node (ATT 1yr) @ age of 3yrs.

Past Anaesthetic History: H/o Lap. Appendectomy (2018) ↓GA
Colonoscopy & sedations →

Physical Exam: Teeth: (N)

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

Lungs: BAE(+), clear

Heart: S1S2 (+)

CNS: NAD Venous Access Site: Peripheral Spine Exam for regional: Midline

Pregnant: ☐ Yes ☑ No ☐ NA

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

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

CURRENT MEDICATIONS	DOSAGE
T. WYSOLONE	5mg OD
T. AZORAN	50mg OD
PENTASA	1g sachet

Pre-Operative Instructions:

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

Signature: [signature] Name: Dr. Ayesha

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Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

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ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Adequate

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 80bpm	B.P / CRT: 100/60 mmHg	SpO₂: 99% on RA	R.R: 18/min	Last Feed: >6hrs

Pre-OP Diagnosis: IBD - Crohn's | Operation: Colonoscopy c Biopsy + Upper GI Endoscopy + Biopsy | Date: 4/7/26

Surgeon: Dr. Alisha | Anaesthesiologist: Dr. Brunda | Technician: Kulsum

TIME: 11:30, 12, 12:30, (↑)

N_2O / AIR / O_2 LPM: 4 →

HALO / ISO / SEVO

Drugs:
Inj - MIDAZOLAM 1mg IV
FENTANYL 40mcg IV
PROPOFOL 40 + 40 + 20mg + 50 + 50mg IV
DEXMED INFUSION @ 10 ml/hr →

FIO_2 / SaO_2: 100 100 100 100 100 100

$ETCO_2$

ECG: NSR NSR NSR NSR NSR NSR

Temperature

Urine Output

Fluids / Blood: DNS → →

Antibiotic

Suppository

Blood Loss

NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (scale 0–240)

Tourniquet on Time / Tourniquet off Time

Throat Pack In / Throat Pack Out

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: Rt UL
☐ Art Site:
☑ EKG Lead: 3 lead
☑ Temp Site: Skin
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Left lateral
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☑ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 11:30am
OP Start:
OP End:
Leave OR: 1pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 22G left UL
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others
☑ Mask O_2 @ 4 l/min ☐ SGA
☐ 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: Dr. Brunda
Signature of the Doctor: [signature]

BAH-00522093 IP5-00175960
Ms G KEERTHANA
06-11-2009 16 Y 7 M 28 D (F)
Dr. Prashant Bachina

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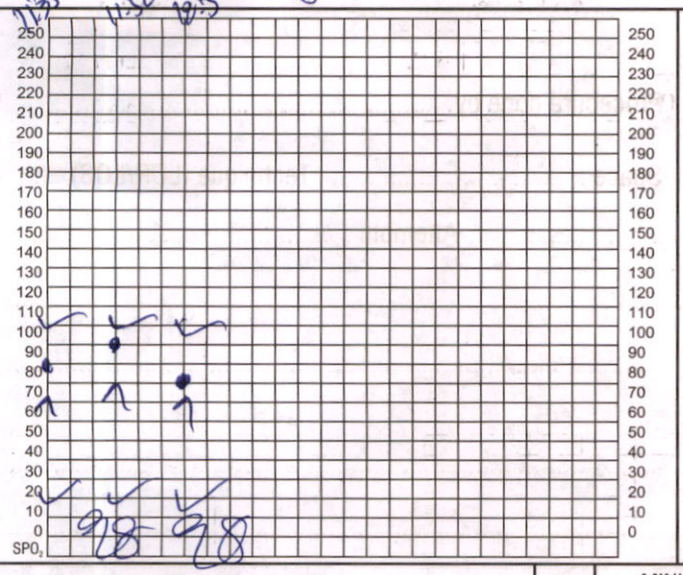
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 1:15pm Time Discharged : .....



IV Cannula Site : 22G RT

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

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 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 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 Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2	2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	1	1	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2		
	TOTAL	8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/7	1:15pm	-/10	—	

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

Anaesthesiologist Name : Dr K. Sri Surya
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 4/7/26

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): .....
Date & Time: 4/7/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	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 : .....