

Pa BAH-00300147 IP5-00174419
 Master K. CHARVIK
 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P. V. L. N. MURTHY

SmithNephew
 EVAC[®] 70 XTRA HP
 WITH INTEGRATED CABLE
 REF EIC5874-01
 LOT 2201074
 2028-10-21



SURGERY DETAILS

80ms

Date: *23/5/26*

Patient Name: *Mr. K. Charvik* Date of Birth: *23/12/2012* Age: *13y*

Gender: *male* Ward: *P.O.T* UHID No.: *BAH-00300147*

Date of Surgery: *23/5/26* OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery: *Adenotomylectomy, Tonsillectomy + Bilateral Adenopecty
 septoplasty + spur excision, (4) maxillary sinus cyst excision
 conchoplasty*

Time in: *8:50 AM* Time Out: *10:50 AM*

	NAME	AMOUNT
1. Surgeon	<i>P. V. L. N. Murthy</i>	
2. Anaesthetist	<i>Dr. Shiba</i>	
3. Assistant Surgeon		
4. OT Technician	<i>Venkat</i>	
5. Circulating Nurse	<i>Kalyan, Jyothi</i>	
6. Assistant Nurse	<i>Bobi, Kalyan</i>	

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others *Coagulator used - 9631489*

[Signature]
 Signature of the Surgeon

[Signature]
 Signature of Circulating Nurse

Order No: *9631488* Order by: *Jyothi*
personal equipment used 1010007

BAH-000300147

Patient Sticker

137117

Charity 0423

Adno + Endoscopy Sinus Surgery

CONSUMABLES OF OT



Circulating staff : Technician : Date : Time 9:30 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 5 15 15 16 16 15	HHH	01	Major Pack doqP	1	1	Inj Vit.K		
LMA		—	Sutures			Cord Clamp		
ECG leads (A/P/N)	5	03	2304	1	1	Suction Catheter		
HME filter (A/P/N)	1	01				Feeding Tube		
Syringes : 10 cc	10	4				Vaccum Suction Set		
05 cc	10	2	Gloves			Surgical Gloves		
02 cc	10	2	G, 6 2 7 7	2+2		Gauze Pack		
01 cc	5	1	PF 6, 6 2 7 7	2+2	2+1	Syringe 1ml / 2ml		
Cautery plate (A/P/N)	1	—	Surgical blade 15	1	1	Surgical Blade # 20		
IV set	1	01	NG tube GNO	2	2	Koochies (S)		
RL	1	01	Cautery pencil			NS 500 ml	2	2
NS : 10ml / 100ml / 500ml / 1000ml	HHH	HHH	Koochies			1000 See	2+2	2+2
minipicu	1	01	Ointments Sabal gauze	1	1	Sarlon	1	1
ORMate (A)	1	01	Suction Catheter			Adrenaline inj	3	2
Fentanyl	1	01	Cap, Mask	5/5	5/5	Bootoelok drop	1	1
Morphine			Gauze Pack NHR	3+3	3+3			
Ketamine			Mop Pack	1	1			
Propofol	3	02	Steristrip					
Rocuronium	1	01	Underpad	1	1			
Glycopyrolate	1	01	Draw sheet	1	1			
Myopyrolate	1	01	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)			Romodrain bag			Gauche	3	0
Antibiotics AUG 12	HH	01	Bandage			Glaucray	4	—
Joupin		01	Tegaderm			Dexamid	1	01
Suppositories			loban			Dexamfrancell	HH	14
Anamol : 80mg / 250mg / 170 mg	HHH	—	Double J Stent			Soe + pm line	HH	14
Supridol : 100mg			Vaccum Suction set	2	2	metaprolol	HH	01
Justin (12.5 mg / 25mg / 100mg)	HH	—	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution					
Vaccum set	1	01	Microshield	1	0			
Oral airway 213	HH	—	Cotton Balls					
nasal airway 218 22	HH	—	Latex Gloves	SP	7			
Spacy 10cm + 10cm	HH	01	Ramdione Scrub					
Dox Camula 2018	HH	—	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9630945

Ordered by : [Signature]

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

ESTIMATION SLIP

(SI. 29491.15 + 99.5)

Date: 25/04/20 UHID / IP No.: BA1-80300147 SI No. 80446
 Name of Patient: Madh R. Charvita Age: 13y Gender: M
 Father's / Husband's Name: Mr. KVS Chandrababu Corporate / Occupation: _____
 Address: _____ Phone: 9790215000 Email: _____
 Procedure / Plan: Embryonic Sac Surgery + Endoscopic distal Spine Excision + Tubenostomy + Adhesiolysis + Fertilization + Coblation
 MODE OF PAYMENT: SELF TPA: _____ GIPSA: _____ OTHERS _____

TARIFF INFORMATION:

Dr. Arav Muthy

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						RA: <u>403076</u> + <u>37486</u> + <u>74964</u>				
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	Monitor :		Oxygen :			Infusion pump / Syringe pump :				
	Ventilator :		Conventional :			HFO-SLE 5000 :		HFO Sensormedix :		
	Phototherapy :		Single Surface :			Double Surface :		Triple Surface :		
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.						As per actual - Not Included in Estimation				
Package						Evac Wand: 27h				
Others										
Initial Minimum Deposit						RA: Rs. 335,000 / 7 band lines cleaning.				

REMARKS:

RA: 40/2/10

Dr. Adv. special.

- 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.

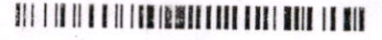
DECLARATION

I Dr. Arav Muthy have attended the Financial Counseling desk and understood the expected costs 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: [Signature] Signatory Relationship: Mother Signature of the Financial Counselor: [Signature]

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174419 Admit Date : 28-May-2026 Admit Time : 06:38 AM UHID : BAH-00300147

Patient Details :

Patient Name	: Master K .CHARVIK	Age	: 13 Y 5 M 5 D
Guardian	: Mr K.V.S.CHANDRA SEKHAR	DOB	: 23-12-2012
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: FLAT NO - L 903, OPAL TOWER , PBEL CITY , NEAR TSPA , PEERAMCHERUVU , HYDER SHAHKOTE , AP Police Academy PO Hyderabad Telangana INDIA 500091	Phone No	: 9790215500/ 9843128174
		E-mail	: NOMAIL@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 K.V.S.CHANDRA SEKHAR Relationship : Father
Contact Address : FLAT NO - L 903, OPAL TOWER , PBEL CITY Phone No : 9790215500
NEAR TSPA , PEERAMCHERUVU , HYDER
SHAHKOTE , AP Police Academy PO Hyderabad
Telangana INDIA 500091

Swarna Swati
Signature

Doctor Details :

Doctor Name : Dr. P V L N MURTHY Specialisation : EAR NOSE AND THROAT
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. : kr charvi IP BAH-00300147 IP5-00174419
Maeter K .CHARVI 13 Y 6 M 6 D (M)
23-12-2012
Dr. P V L N MURTHY

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/05/26	7:03Am	FR	OT	Annub
28/5/26	2:30pm	OT	318	Suman

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Annapurna . T	29/5/26	4632613	Soubharmi
2				
3				
4				
5				
6				
7				
8				
9				
10				



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Master K .CHARVIK
23-12-2012 13 Y 5 M 5 D (M)
Dr. P V L N MURTHY



Dr. pvn murthy

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

do - Recurrent cough, cold since 2 years
- Oral breathing and snoring since 1 1/2 year
- Head ache since 1 year
Throat pain since 1 year

History of present illness :

Child apparently asymptomatic 2 years ago, later
child developed
Cough, cold → Recurrent in nature, increased frequency
aggravated with ~~cold~~, cold item ~~make~~
Relieved on medication

Oral breathing }
Snoring } since 1 1/2 year
associated with cough, cold
more aggravated in night
now interrupting daily activities

Headache since 1 year, more aggravated in
early morning, associated with cough, cold
Relieved with symptomatic relief of cough, cold

Throat pain since 1 year
↓

OLF diagnosed with Grade IV Adenoid with
tonsillar hypertrophy with hypertrophied turbinate
and sinusitis

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History & Physical Examination

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

Similar episodes of illness since 2 years

Birth & Neonatal History:

Term / CIAB / NO NICU

Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____

Developmental History :

Appropriate for age

Immunization History :

Immunized till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 46.2 kg (Centile _____)

On Examination :

Temperature : 98.1 f Pulse Rate : 91/min B.P. 117/64 (73/44) SPO2 99.1 RA

Resp. rate and type of breathing : 21/min
Regular

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : BAG ⊕

Any addes sounds : clear

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1 S2 ⊕

Any murmur : NO

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

Per Abdomen :

Inspection (N)

Palpation : soft

Ausculation : RS ⊕

Spine : _____ External Genitelia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

_____ (N)

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____ (A)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____ flexor

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Chronic Adenotonsillitis with hypertrophied turbinates
DORS with maxillary sinusitis & bony spur

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

Planned Management

1) ~~MAPPO~~ to continue
2) Ivf. DNS @ 7am/1hr
3) shift to O7
4) Robtation assisted Adenotonsillectomy with Turbinateplasty with Endoscopic sinus surgery with spur excision

M/B Annaab
28/05/26

Signature of the Doctor: [Signature]
Name of the Doctor: Cari
Date & Time: 28/5/26 Bay

Signature of the Consultant: [Signature]
Name of the Consultant: DR. P. V. L. N. MURTHY
Date & Time: 28/5/26

DR. P. V. L. N. MURTHY
Registration No: 4126

CUV-00097096 IP5-00174422
 Baby DUNNAPOTHULA HITIKA
 13-09-2020 5 Y 8 M 15 D (F)
 Dr. P V L N MURTHY



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	1			
9	General consent for treatment	2			
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	2			
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)	2			
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	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart	1			
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	22			

[Handwritten Signature]

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

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 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P. V. L. N. MURTHY



PEDIATRIC DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. p.v.l.n. murthy Date : 28/5/26

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

Start Time of Assessment: 6am Weight: 48.2 kg

Allergic History:

Chief Complaints:

do s cough, cold since 2 years
oral breathing since 1 1/2 year
snoring

Headache since 1 year
Throat pain since 1 year

Pediatric Assessment Triangle

A Appearance - TICLS

B Breathing

C Circulation

Normal
 Abnormal

Pallor
 Cyanosis
 Mottling
 Bleeding

↑ WOB
 ↓ WOB
 Normal
 Gaspings / Apnea

Initial Physiological Status: Stable Unstable

Any urgent interventions needed: Yes No

Life Threatening
 Non Life Threatening

Significant Past History: Similar episodes since 2 years

Medication History:

Relevant Investigations:

Primary Assessment

Airway

Open
 Maintainable
 Not Maintainable

Any urgent interventions needed: Yes No

If Yes

Breathing

Rate: 21/min SpO₂ on FiO₂ 99.1% RA

Rhythm: Regular

Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: BAG ⊕

Palpation Findings (If necessary).....



Circulation

HR: 91/min

CFT Central Peripheral JCS see

Any urgent interventions needed: Yes No

BP: 112/64 (73) mmHg

Pulse Volume: Central Peripheral J Good

Murmurs: Yes No

Liver Span:

If in Shock: Compensated Hypotensive

ECG:

Any Signs of Heart Failure: Yes No

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No



Disability

GCS: 15/15 AVPU:

Any urgent interventions needed: Yes No

Pupils: Responsive Non-Responsive
Size Right Left

If Yes

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Exposure



Temp.: 98.1°F

Any urgent interventions needed: Yes No

Any Rash: Yes No

If Yes

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

- 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:

Treatment Planned:
1) NPO
2) IV: DM @ 7am/hr
3) Shift to 07
4) coblation assisted Adenotonsillectomy with Endoscopic sinus surgery with Turbinoplasty with spur excision

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Chronic Adenotonsillitis with HITS

Assessment done by Sr. Doctor on Duty (If necessary)

Name of the Doctor: Sai

Name of the Sr. Doctor: DWS with sinusitis

Signature: [Signature]

Signature:

Date & Time: 28/5/26

Date & Time:

Date & Time:

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 Dr. P V L N MURTHY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/12 7 pm	C/S/B Resident	
	<u>Chr. Adenotomillike & B1/F, DMS & Smush</u>	
	No fever No vomiting Mild pain ⊕ No bleed.	Plan • Plan of c T/M • Cont medication • W/f fever
	Child is hemodynamically stable	Ajushman
29/12/26 9:15 AM	C/S/B Resident	M.R. (Durg) 60 HT 4 PM
	no active complaints O/E. alert stable vitals	Adv: ⊕ today.
		Dr. Akhile

SURGICAL SAFETY CHECKLIST

Surgeon: Dr. P.V.L.N. Murthy
 Asst. Surgeon: _____
 Anaesthetist: Dr. Ashwarya
 Scrub Nurse: Bobbi Kalpana

Patient Name: Mr. K. Shankar Age: 134 Gender: M
 UHID No.: BAH-0030014 Surgery Name: Adenoidectomy
 Date: 28/5/20 In-time: 8:45 am Out-time: _____

23-12-2012 13 Y 5 M 5 D (M)
 Dr. P.V.L.N. MURTHY


Before Induction of Anaesthesia

SIGN IN Time: 9:40 AM

- Patient Has Confirmed**
- Identity Yes No
 - Site Yes No
 - Procedure Yes No
 - Consent Yes No NA
- Site Marked**
- 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 No
 - Yes, & Equipment / Assistance Available Yes No
 - Risk of > 500ml Blood Loss (7ml/kg In Children)? Yes No NA
 - 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: Ashwarya
 Name: Dr. ASHWARYA

Before Skin Incision

TIME OUT Time: 9:04 am

- 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? Plan & steps
 Yes No NA
- Anaesthesia Team Reviews:**
- Are There Any Patient-specific Concerns? no 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?**
- Power Supply, Earthing, Power Backup and functioning of equipment checked. Yes No
- Signature: Bobbi Kalpana
 Name: Bobbi Kalpana

Before Patient Leaves Operating Room

SIGN OUT Time: 10:30 am

- 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

DR. P.V.L.N. MURTHY
 Registration No: 47267

Signature: [Signature]
 Name: P.V.L.N. Murthy

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 Dr. P V L N MURTHY



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: CR

Shifted to: O.I.

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						<input type="checkbox"/> C <input type="checkbox"/> DC
						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: *Dr. Sai*

Date & Time: 28/5/26

Nurse Name & Signature: *Anneeb*
(Signature)

Date & Time: 28/05/26 6:40 AM

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 Master K . CHARUK
 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P V L N MURTHY

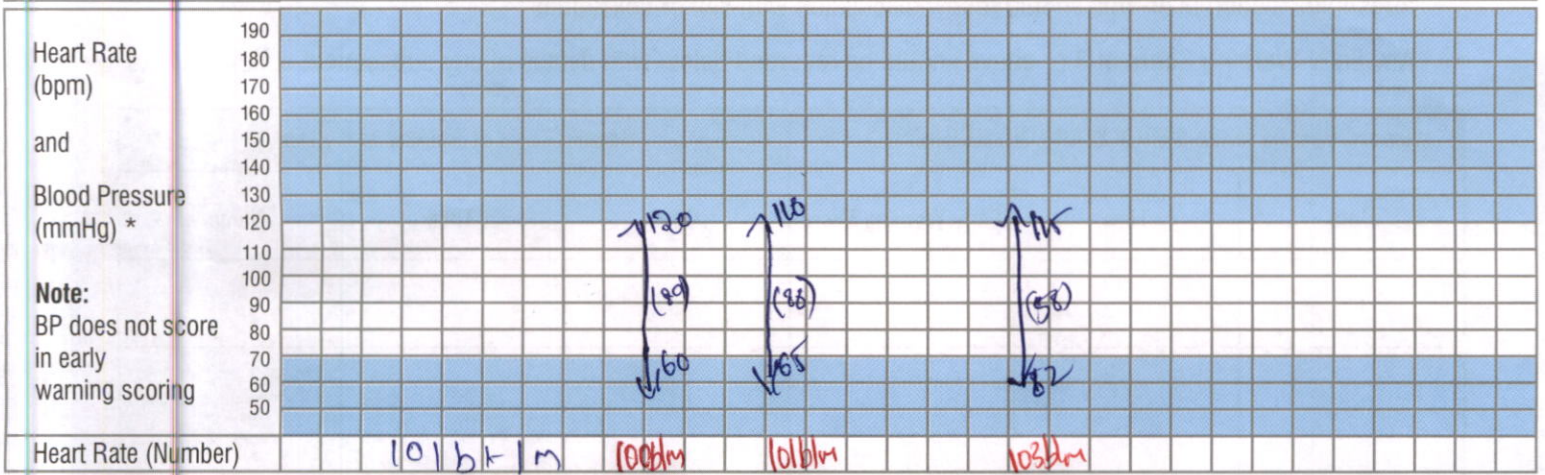
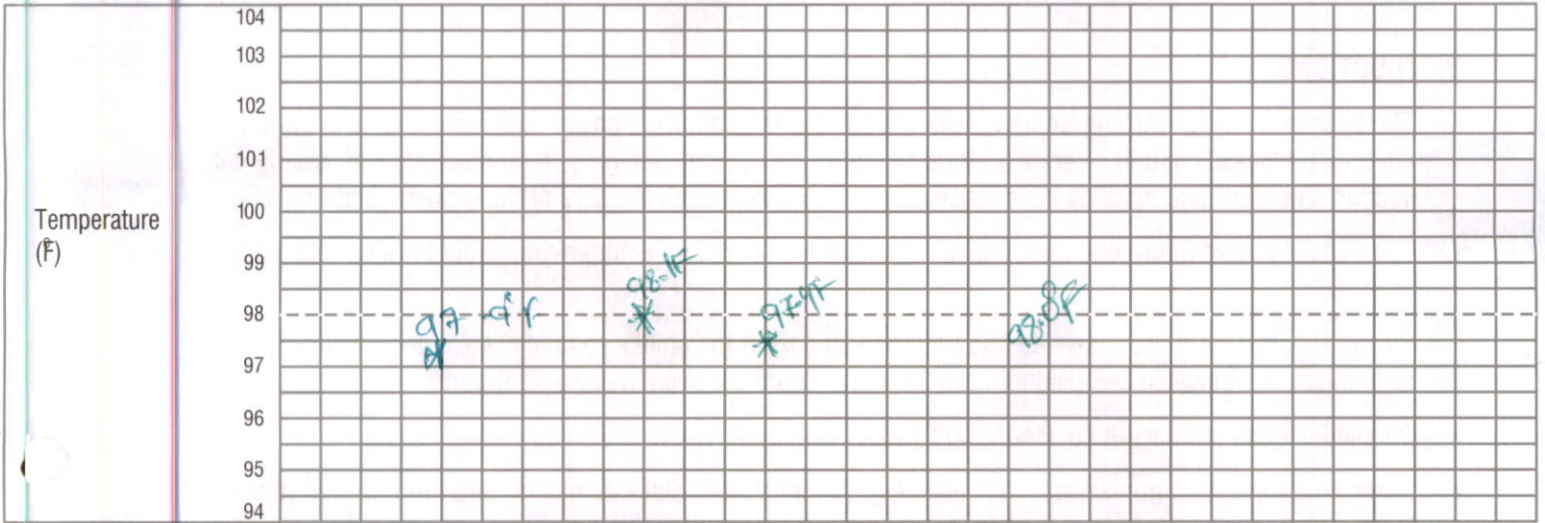
Doc. No. : RCHBH/ FRM / CLINICAL / 126

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 23/12/12 Time: 3pm 10pm 2AM 6AM
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)		99%	100%	99%	100%
Conscious Level	Normal Altered				
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					

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 Sticker

BAH-00300147 IP5-00174419
 Master K .CHARVIK
 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P V L N MURTHY



LUID CHART

Sheet No : ①

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									✓	0	} [Signature]
	09:00 am	AL NPO	300ml								0	
	10:00 am	AL NPO	300ml								0	
	11:00 am	H ₂ O	50ml								0	
	12:00 pm	Feed									0	
	01:00 pm	Idli									0	
Total Intake :		600ml			Total Output : M-O-U-V							
	02:00 pm	H ₂ O									0	} [Signature]
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm	H ₂ O									0	
	06:00 pm										0	
	07:00 pm	H ₂ O									0	
Total Intake :					Total Output : M-O-U-V							
	08:00 pm	Food									0	} [Signature]
	09:00 pm										0	
	10:00 pm	H ₂ O									0	
	11:00 pm										0	
	12:00 am	H ₂ O									0	
	01:00 am										0	
Total Intake :					Total Output : M-O-U-V							
	02:00 am										0	} [Signature]
	03:00 am	H ₂ O									0	
	04:00 am										0	
	05:00 am	H ₂ O									0	
	06:00 am										0	
	07:00 am	H ₂ O									0	
Total Intake :					Total Output : M-O-U-V							

Total 24 hrs. Intake

Total 24 hrs. Output M-O-U-V

BAH-00300147 IP5-00174419
 Master K .CHARVIK
 23-12-2012 13 Y 5 M 6 D (M)
 Dr. P V L N MURTHY



FLUID CHART



Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

**Department of Anaesthesiology
 PRE-ANAESTHETIC EVALUATION**

Name: MASTER CHARVIK Age: 13 Y 5 M Sex: M UHID No: BAH 00300147
 Date: 27/5/26 Time: 3:54 Proposed Operation: ENDOSCOPIC SINUS SURGERY
SINUS EXCISION
 Diagnosis: DNS + MAXILLARY SINUS TUBANOPLASMY + ADENOIDITIS
ADENOIDITIS
ADENOIDITIS
 B.P / CRT: 130/80 H.R: 64/min Weight: 46.84 ASA Physical Status: 1 2 3 4 5
Coccyx

Laboratory Data:
 Hgb: 13.1 Glucose: / Protein: / HIV: / X-Ray: /
 PCV: 40.1 Urea: / Alb: / HBS Ag: / ECG: /
 WBC: 8500 Creat: / Total Bill: / HCV: / 2D Echo: /
 Plate: 2199000 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: NO KNOWN DRUG ALLERGY

Medical History: CVS: - Diabetes: -
 RESP: - mouth breathing, snoring
 CNS: -
 Renal: - Physical Activity: Playful Active
 Hepatic / GE: -
 Others: -

Past Anaesthetic History: -
Physical Exam:
 Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: NO 100% teeth

Lungs: AERB
 Heart: S1 S2 (P)
 CNS: WAD
 Pregnant: Yes No NA Venous Access Site: LUL Spine Exam for regional: RUE
Anaesthetic Plan: MAC REGIONAL GA-ETT LMA
 Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>

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

Signature: Adithi Name: Dr Adithi
- CBC, EV cancellation
- can be taken



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 28/5/26 Time: 2:50 pm.

Weight: 46 kg's Centile: >25th

Height: 148 cm Centile: >5th

Inference: well child

RDA: Calories: 1800 kcal/d Protein: 32 gm/d

Diet Recommendations: soft diet

Re-Assessment: avoid - spicy, and outside foods

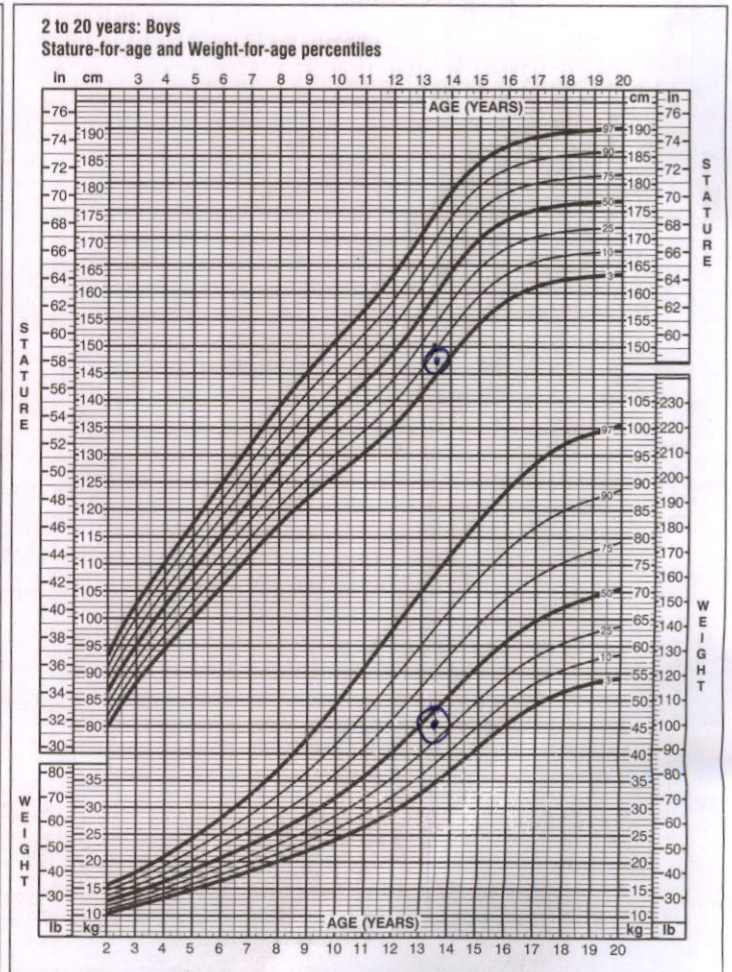
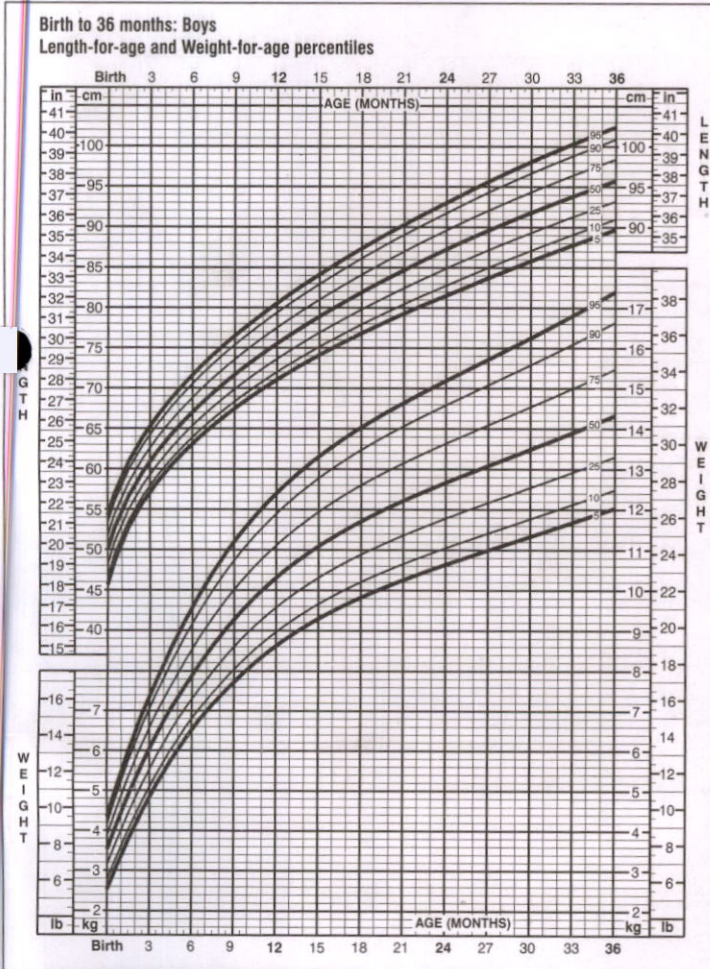
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: Adenotonsillectomy

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (BOYS)



Dietician's Name

Dietician's Signature



CROSS CONSULTATION FORM

Doctor Name : Dr. Annapoorna T. Date : 29/5 Time : 9:10 am

Diagnosis : Sp adenotonsillectomy + endoscopic septoplasty
spur excision + turbinoplasty + conchoid

Hospital : + (D) maxillary sinus
yst excision

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

no fever
no bleeding (significant)
no vomiting

accepting orally.

O/E: alert
stable vitals
throat healthy
chest clear

Advs
→ Can (D)
→ Flup - ENT
→ Add Tab IBU
→ i

Consultant :

Name : Dr. Annapoorna Signature : _____

Date & Time : 29/5



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: MASTER CHARVIK Age: 13 Y 5 M Sex: M UHID No: BAH 00300147
 Date: 9/7/20 Time: 3:54 Proposed Operation: ENDOSCOPIC SINUS SURGERY
 Diagnosis: DNS + MAXILLARY SINUS TUBING PLASMY + ADENOID TONSILLECTOMY
 B.P / CRT: 130/80 H.R: 64 Weight: 46.84 ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 13.1 Glucose: / Protein: / HIV: / X-Ray: /
 PCV: 40.1 Urea: / Alb: / HBS Ag: / ECG: /
 WBC: 8500 Creat: / Total Bill: / HCV: / 2D Echo: /
 Plate: 2,19,000 Na: / Dir. Bill: / Blood group: / Stress/Anglo: /
 PT: / K: / LDH: / T3: / Other: /
 PTT: / Ca++: / Alk phos: / T4: /
 INR: / Mg++: / Amylase: / TSH: /
 Cl-: / SGOT/SGPT: /

Allergies: NO KNOWN DRUG ALLERGY

Medical History: CVS: -
 RESP: - mouth breathing, snoring Diabetes: -
 CNS: -
 Renal: -
 Hepatic / GE: - Physical Activity: playful Active
 Others: -

Past Anaesthetic History: -

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Thyroid Distance: 2 Neck: 2 Teeth: NO 100% health
 Lungs: AEBE
 Heart: S1 S2
 CNS: NAD

Pregnant: Yes No NA Venous Access Site: LUL RUE Spine Exam for regional: -

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>
<u>-</u>	<u>-</u>

Pre-Operative Instructions:

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

Signature: Aditi Name: Dr Aditi

- CBC, IV Cannulation
- can be taken



ANAESTHESIA CHART



Pre Induction Assessment: 8:10 AM

Change in Patient Condition: Yes No

Fasting Status: CONFIRMED

Physical Status: Patient Identified

Consent Present

Chart Reviewed

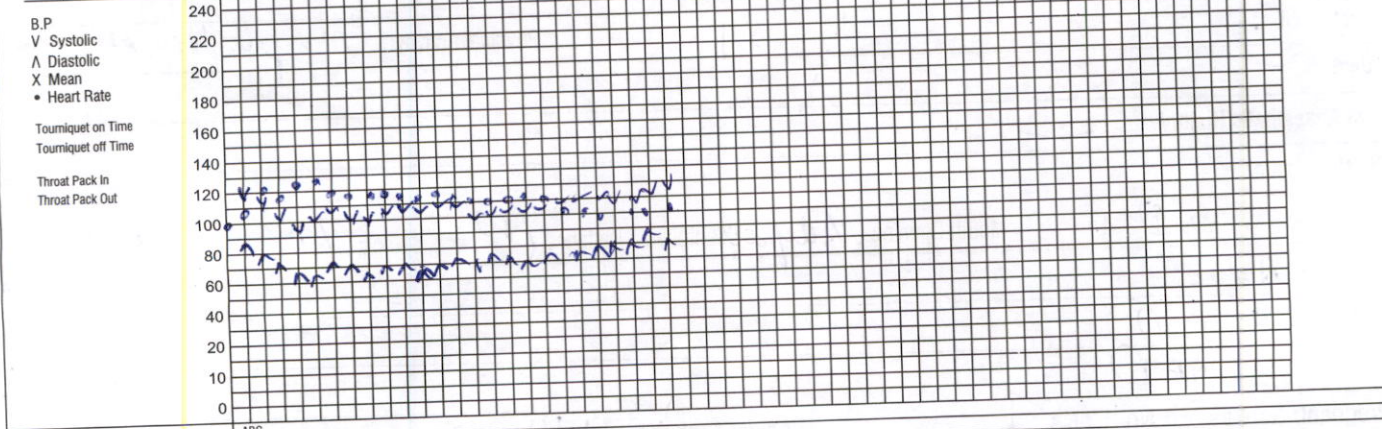
H.R: 100/min B.P / CRT: 120/80 SpO₂: 100% R.R: 20/min Last Feed: > 8hrs

Pre-OP Diagnosis: DNS + MAXILLARY SINUS Operation: ADENOTONSILLECTOMY + FESS + TURBINOPLASTY + SEPTAL RESECTION Date: 28.5.2012

Surgeon: Dr. Murthy Anaesthesiologist: Dr. RC, Dr. AL Technician: VAJRAI

TIME	Drugs	Antibiotic	Suppository	Blood Loss	NOTES
8:10 AM	FENTANYL 100mcg				
8:15 AM	PROPOFOL 120mg				
8:20 AM	ROCURONIUM 3.5mg				
8:25 AM	DEXAMETHASONE 2mg				
8:30 AM	TRANEPTMIL 70mg				
8:35 AM	DICLOFENAC ACID 50mg				
8:40 AM	PARACETAMOL 750mg				
8:45 AM	MYDOPRILATE 2mg				
8:50 AM	DEYMED 50ml/hr → 12ml/hr				
8:55 AM	FiO ₂ / SaO ₂				
9:00 AM	ETCO ₂				
9:05 AM	ECG				
9:10 AM	Temperature				
9:15 AM	Urine Output				

Fluids: Blood 300ml/hr



LAB Values: ABG, GRBS, Others

- Equipment Checked and Functional
- BP
- Cuff Site:
- Art Site:
- EKG Lead
- Temp Site
- FiO₂ Monitor
- Agent Monitor
- Pulse Oximeter
- Capnograph
- Ventilator
- Nerve Stimulator
- Position: Supine
- Pressure Points Checked
- Eye Care:
 - Oint
 - Tape
 - Padding
 - Awake

Temp:

- AWE
- Cling Film
- Hugger's
- Other
- Fluid Warmer
- OH Warmer
- Cotton Wool

 Times:

- Anaes Start: 8:50 AM
- OP Start: 9 AM
- OP End: 10:30 AM
- Leave OR: 10:50 AM

 Anaesthesia:

- GA
- Monitored Anaesthesia Care
- Regional

 Line (Size & Location):

- CVP:
- ART:
- IV: 20G (C.V.L)
- IV:
- IV:

Induction:

- IV
- Pre O₂
- Others
- Mask
- Airway
- Tracheostomy
- Drug: Rocuronium
- Awake
- Video Laryngoscopy
- Fiberoptic
- Blade# 3 Attempts: 1
- Difficulty Why?

 Regional:

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

Regional:

- Extremity
- 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. ANSHWARAYA
- Signature of the Doctor: [Signature]

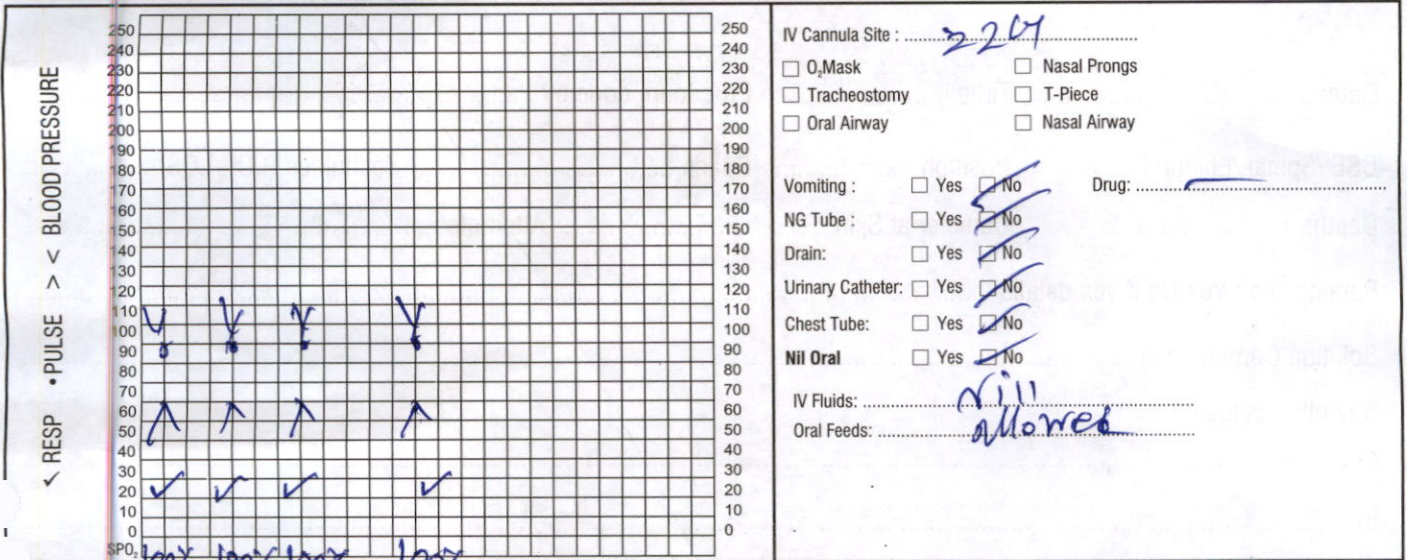
BAH-00300147 IP5-00174419
 Master K. CHARVIK
 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P V L N MURTHY



E UNIT RECORD



Received in PACU by : Suman Time Received : 10:52 AM Time Discharged : 2:30 PM



IV Cannula Site : 22G

O₂ 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 : Nil
 Oral Feeds : allowed

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	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		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	1	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		8	8	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
28/5	12 PM	02/10	nil	<u>Suman</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name : Dr. Subhasran
 Anaesthesiologist Signature : [Signature]
 Date & Time : 28/5/2012 at 2 PM

PACU Nurse Name : Suman
 PACU Nurse Signature : [Signature]
 Date & Time : 28/5/2012 at 12:48 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): Suman
 Date & Time : 28/5/2012 at 12:48 PM

BAH-00300147 IP5-00174419
 Master K .CHARVIK
 23-12-2012 13 Y 5 M 5 D (M)
 Dr. P V L N MURTHY



gy



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 :

CROSS CONSULTATION FORM

Doctor Name : Dr. Annapoorna T. Date : 29/5 Time : 9:10 am

Diagnosis : sp adenotonsillectomy + endoscopic septoplasty
spur excision + turbinoplasty + conchoplasty

Hospital : + (D) maxillary sinus cyst excision

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

no fever
no bleeding (significant)
no vomiting
accepting orally.

O/E: alert
stable vitals
throat healthy
chest clear

Advs
→ Can (D)
→ Flup - ENT.
→ Add Tab IBUPROFEN 400mg
→ si

Consultant :

Name : Dr. Annapoorna Signature : [Signature] Date & Time : 29/5

BAH-00300147 IP5-00174419
Master K .CHARVIK
P 23-12-2012 13 Y 5 M 5 D (M)
Dr. P V L N MURTHY



POST-SURGICAL CARE PLAN FORM

Procedure Done: Adeno Tomy, laryngectomy + septo + Gulleroplasty

Post-Surgical Diagnosis: ltr. Ad 5 S + DSS E Tube + HIV

Post-Operative Monitoring Parameters /Frequency:

Bleeding, vitals

Wound Care:

mouth wash, nasal saline wash

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

lateral

Nutritional Instructions:

veg soft diet

When to Start Mobilization:

after 1 wk

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

2 wk

Treating Surgeon
(Signature & Stamp)

Date: 28/5/20 Time: 10:00 am

Note: Plan of care will be readjusted if necessary.

Patient :



OPERATION THEATER NOTES

Patient's Name : Mr. K. Charvik Age : 13y Gender : Male Female

UHID No. : BAH-00300147 Weight : 46kg Height :

Surgeon : Dr. P.V.L.N. Murthy Asst. Surgeon :

Anesthetist : Dr. Ravi Chandra OT Nurse : Bobi, Kalyan OT Technician : Venkat

Pre-Operative Diagnosis : Ch. Adenotomillectomy + DNS + HT + concha

Surgical Procedure : Adenotomillectomy + collection + endoscopic septoplasty + Spue Excision + turbinateplasty + concha plasty + (4) maxillary sinus cyst excision

Indications for Surgery :

Date : 28/5/26 Start Time : 8am End Time : 10:30am

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:
Adenotomillectomy + collection
endoscopic septoplasty + Spue Excision
turbinateplasty + concha plasty.
(4) maxillary sinus cyst excision

