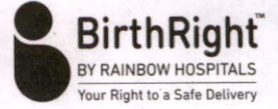


BAH-00530706 IP5-00174642  
Master CH PRATEEK  
Pa 09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



80562



### SURGERY DETAILS

Date : 21/6/21

Patient Name: Master CH PRATEEK Date of Birth: 09-09-2021 Age: 4Y

Gender: M Ward: P.OT UHID No.: 0184642

Date of Surgery: 21/6/21  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Coblation Adenotonsillectomy

Time in : 2:15 PM

Time Out : 3:30 PM

	NAME	AMOUNT
1. Surgeon	Dr. Santhosh	
2. Anaesthetist	Dr. Aisha	
3. Assistant Surgeon		
4. OT Technician	Vijay	
5. Circulating Nurse	Ashwini	
6. Assistant Nurse	Deborah	

Special Equipment:  Laparoscopy  Bronchoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others ..... Coblator ID: 9639540

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9639539

Order by: Y. Ramakrishna

BAH-00530706 IP5-00174642

Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



AD 40



**CONSUMABLES OF OT**

Circulating staff ..... Technician : ..... Date : 2/6 Time : 2:00 PM

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
		Issued	Used			Issued	Used			Issued	Used
ET tube	45 x 0.55	1+1	0	Major Pack	Drape	1	1	Inj Vit.K			
LMA	23	01	-	Sutures				Cord Clamp			
ECG leads : A	P/N	05	3					Suction Catheter			
HME filter : A	P/N	01	1					Feeding Tube			
Syringes : 10 cc		10	6					Vaccum Suction Set			
05 cc		10	4+2	Gloves	6.6 1/2 7-7 1/2	2+2+2		Surgical Gloves			
02 cc		10	0		PT-6.6 1/2 7 1/2	2+2+2	1+1+1	Gauze Pack			
01 cc		5	-					Syringe 1ml / 2ml			
Cautery plate : A	P/N	01	-	Surgical blade				Surgical Blade # 20			
IV set		01	1	NG tube				Koochies (S)			
RL		01	1	Cautery pencil	6	2	2	NS 500ml	1	1	
NS : 10ml / 100ml / 500ml / 1000ml		1H	1+1	Koochies				transofix	1	1	
	with spice	01	1	Ointments				Savlon	1	1	
	valley sr	01	1	Suction Catheter				Adriline	3	3	
Fentanyl		01	1	Cap, Mask	N+R	5	5				
Morphine				Gauze Pack		5	5				
Ketamine				Mop Pack		1	1				
Propofol		03	2	Steristrip							
Rocuronium		01	0	Underpad							
Glycopyrolate		01	1	Draw sheet							
Myopyrolate		02	1+1	Abgel							
Ondansetron		01	1	Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag					0.9. 0.1	1H	-
Bupivacaine 0.25%		01	-	Chest Drainage Catheter					NA-2022	1H	-
Bupivacaine 0.25%(Heavy)				Romodrain bag					O2max (P)	01	1
Antibiotics Augmentin	1.25 600		1	Bandage					ORAM (100)	01	-
	IV pcm	01	1	Tegaderm					Al Phorbess	1	1
Suppositories				loban					Nasal splint	1	1
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set		1	1				
Justin : 12.5 mg / 25mg / 100mg		01	1	Plastic Bed Sheet		1	1				
Tab. Misoprost : 200mg				Betadine Solution		1	-				
200mg local anesthetic		1H	1	Microshield		1	1				
Cocaine + 4/1000 ml 5ml			-	Cotton Balls		1	1				
IV cable 22ml		1H	-	Latex Gloves		10P	10P				
Duke + 5ml		1H	1H	Ramdione Scrub							
Blue splint 13		1H	-	Saral							

Surgeon ..... Anaesthesiologist ..... Nurse ..... OT Technician .....

Order No. : 9639755 ..... Ordered by : [Signature]

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

# ESTIMATION SLIP

80562

Date: 20-June-06 UHID / IP No.: BAH-00530706 SI No. \_\_\_\_\_  
 Name of Patient: Magt. Ch Prateek Age: 5yrs Gender: Male  
 Father's / Husband's Name: Mr. Gopikrishna Corporate / Occupation: Business  
 Address: \_\_\_\_\_ Phone: 7506108918 Email: \_\_\_\_\_  
 Procedure / Plan: Coblation Adenotonsillectomy + GA

MODE OF PAYMENT:  SELF  TPA: \_\_\_\_\_  GIPSA: \_\_\_\_\_ OTHERS \_\_\_\_\_

TARIFF INFORMATION:

Dr. Paritosh Kumar (S-5)

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee			<u>16715</u>							
L. Tax			<u>per day</u>							
PARTICULARS				AMOUNT (₹)						
Surgeon's / Anesthetists's Fee / O.T. Charges				<u>(811ASF) 45430</u>						
O.T. Consumables				<u>TSW → 7500</u>						
Instrument Charges				<u>Coblator → 7500</u>						
Pharmacy, Consumables & Investigations				<u>Extra Oxygen</u>						
Equipment Charges	Monitor :						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.				<u>Extra</u> As per actual - Not Included in Estimation						
Package										
Others										
Initial Minimum Deposit				<u>Area Intend → 2,000/-</u> <u>Approx → 1,90000/-</u>						

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission. TPA after 12 hrs @ 12 room cycle
- 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-Medicinals, 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, Vivek Gopal 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: K. Veer Signatory Relationship: Inde Signature of the Financial Counselor: Durga

### ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time: \_\_\_\_\_ ge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/21	12 <sup>rr</sup> pm	OT	OT	E
2/6	11:40 pm	OT	107	angl

### Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. V. S. Jwal	3/6/2026	9640558	[Signature]
2	DC			
3				
4				
5				
6				
7	DC			
8				
9				
10				



**MEDICAL EQUIPMENT (WARD & ICU)**

PROCEDURE

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

Handwritten initials in blue ink: "D C" and a checkmark-like symbol.

**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
2/6/20	IV placement	1	39130	Rent
	PAC (Done in op Basis)			
3/6/20	NHA	1		AD

**ANY OTHER INFORMATION**

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

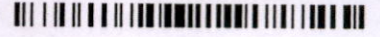
NHA

Date : 3/06/20      Time : @ 10am      Prepared By : Ankiha

Staff Nurse <i>Ankiha</i>	Shift / Ward <i>spot</i>	Billing Assistant	Billing Supervisor
------------------------------	-----------------------------	-------------------	--------------------

## ADMISSION SHEET

## Registration Details :



Admission No : IP5-00174642 Admit Date : 02-Jun-2026 Admit Time : 12:26 PM UHID : BAH-00530706

## Patient Details :

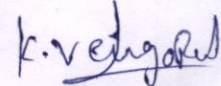
Patient Name : Master CH PRATEEK Age : 4 Y 8 M 24 D  
Guardian : Mr GOPI KRISHNA DOB : 09-09-2021  
Gender : Male Religion :  
Occupation : Martial Status : Single  
Address (H) : PLOT NO 103, FLAT NO 501, SRI BALAJI  
GRANDEUR SIDDHARTHA NAGAR, NEAR  
MADHURA NAGAR HANUMAN TEMPLE,  
Madhura Nagar Hyderabad Telangana INDIA  
500038 Phone No : 9908095999 / 7506108918  
E-mail : GOPICGK99999@GMAIL.COM

## Admission Details :

Bed Type : DAY CARE Bed No : POST OP 412 Ward Name : 4F-OT COMPLEX  
Room No : POST OP 412 Admission Type : First Visit

## Contact Details :

Name : Mr GOPI KRISHNA Relationship : Father  
Contact Address : PLOT NO 103, FLAT NO 501, SRI BALAJI  
GRANDEUR SIDDHARTHA NAGAR, NEAR  
MADHURA NAGAR HANUMAN TEMPLE,  
Madhura Nagar Hyderabad Telangana INDIA  
500038 Phone No : 9908095999 / 7506108918

  
Signature

## Doctor Details :

Doctor Name : Dr. MANCHUKONDA SANTHOSH KUMAR 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



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## PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



Patient Name: Ch. Prateek

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_

### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

Nose block }  
Mouth breathing } since 1 year  
Snoring }  
Use of multiple antibiotics .

#### History of present illness :

Bel child is apparently normal 1yr ago. Child is having above mentioned complaints since 1yr

↓  
Xray neck done ⇒ Grade 3 Adenoids hypertrophy .  
cep

child was planned for Adenotonsillectomy

CSP - 12.3 / 12880 / 5.76L  
38.2 / 42/52

S-IgE = 54.0

Aso titre - Negative

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH

## Pediatric Multiorgan History & Physical Examination

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

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**Birth & Neonatal History:**

Term / LSCs / CIAB / 2-2kg / NO NICU admission

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**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_ } Upper middle class  
Any additional Information : \_\_\_\_\_

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**Developmental History :**

Ⓝ development

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---

---

**Immunization History :**

immunization till date

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BAH-00530706 IP5-00174642  
Master CH PRATEEK (M)  
09-09-2021 4 Y 8 M 24 D  
Dr. MANCHUKONDA SANTHOSH

### Pediatric Multiorgan History & Physical Examination

#### **Anthropometry :**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)  
Weight (kgs) ) 22.8kg (Centile \_\_\_\_\_)

#### **On Examination :**

Temperature : 98.2°F Pulse Rate : 106/min B.P. 100/57/63 SpO2 100% on RA  
Resp. rate and type of breathing : RR = 24/min

Rash \_\_\_\_\_  
Lymphadenopathy } NI  
Oedema : \_\_\_\_\_  
Allergies (if any): \_\_\_\_\_

#### **Respiratory System :**

Inspection (any s/o distress) : \_\_\_\_\_  
Air entry & breath sounds : BILAB F  
Any addes sounds : \_\_\_\_\_  
Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

#### **Cardiovascular System :**

Inspection of procordium : \_\_\_\_\_  
Heart Sounds : S1S2(1)  
Any murmur : \_\_\_\_\_  
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : \_\_\_\_\_

#### **Per Abdomen :**

Inspection \_\_\_\_\_  
Palpation : Soft, NT  
Ausculation : \_\_\_\_\_  
Spine : \_\_\_\_\_ External Genitelia : \_\_\_\_\_  
Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

BAH-00530706 IP5-00174642  
Master CH PRATEEK (M)  
09-09-2021 4 Y 8 M 24 D  
Dr. MANCHUKONDA SANTHOSH

**Pediatric Multiorgan History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

}  
N

**Motor System:**

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

}  
N

**Reflexes :**

**DTR**

**Superficials:**

Plantars \_\_\_\_\_

}  
N

**Sensory System :**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bladder / Bowel :** \_\_\_\_\_

**Clinical Summary & Diagnostic:**

Chronic adenotonsillar hypertrophy.  
Planned for Coblation adenotonsillectomy.

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH

**Pediatric Multiorgan History & Physical Examination**

Preventive aspects of the treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Desired goals of the treatment : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Planned Labs:**

CBP on ~~transmission~~  
S. IgE done on OPD basis  
ASO titre

**Planned Management**

NPO from  
IV fluids  
Sx @  
NIB  
Remyka  
2/6/24

Signature of the Doctor: Ramy

Signature of the Consultant: .....

Name of the Doctor: Dr. RAMYA

Name of the Consultant: .....

Date & Time: 2/6/26; 12 pm.

Date & Time: .....

BAH-00530706  
 Master CH PRATEEK  
 08-09-2021 4 Y 8 M 24 D (M)  
 Dr. MANCHUKONDA SANTHOSH

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/06/2026	S/B Resident	
5 PM	<p>Δ: Grade-IV Adenoid hypertrophy          Grade-III Tonsillar hypertrophy</p>	<p>Plan          soft diet as advised</p>
	<p>- On room Air          - Hemodynamically stable</p>	<p>- continue medications as charted</p>
	- Pain & Control	- Monitor vitals
	- No fever / vomiting / bleeding	- w/ bleeding / vomiting
		Inform SOS.
3/6/26 8 AM	S/B Resident	Nanda
	<p>Δ: s/p adenotonsillectomy          no major post op issues          O/E: alert active          throat healthy          chest clear</p>	<p>Adv:          1) (B) today.          2) Flup ENT.          [Signature]</p>

BAH-00530706      IPS-00174642  
Master CH PRATEEK  
09-09-2021      4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



  
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# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order



# CROSS CONSULTATION FORM

Doctor Name : ..... Date : 03/06/2026 Time : .....

Diagnosis : Grade-4 Adenoid hypertrophy / Grade-3 Tonsillar hypertrophy

Hospital : RCH Banicwa

**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: [Signature]

**Findings and Recommendations :**

S/P - Coblation Adenotonsillectomy (POD-1)

Or Room Air

Hemodynamically stable

Plan

Pain ↓ Control

No fever / vomiting / bleeding

Oral intake - OK

- Can be discharged
- Syp IBUGESIC SOS.

**Consultant :**

Name : Drujwan

Signature : [Signature]

Dr. K. WALAKESAI  
Registration No: 90599

Date & Time : 03/06/2026

BAH-00530706 IPS-00174642  
 Master CH PRATEEK  
 09-09-2021 4 Y 8 M 24 D (M)  
 Dr. MANCHUKONDA SANTHOSH

Patient Stick



## RESULT SHEET

Date	1/6/26				
Time	3 pm				
Hb	12.2				
PCV	38.2				
RBC	5.06				
WBC	12.88				
N/L	42/52				
Platelets	576				
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.) : .....

Prateek  
Patient Stu

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



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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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<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. RAMYA .....

Date & Time : ..... 2/6/26 ; 12pm .....

Nurse Name & Signature: ..... Renuka .....

Date & Time : ..... 2/6/26 & 12:20 PM .....



# DRUG CHART

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

## FOR THE SAFETY OF THE PATIENT

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

## SOS / PRN (As Required Medication)

DRUG :				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:				

VERIFIED BY : Name .....



REGULAR PRESCRIPTIONS

Weight. 23kg. Ward. ....

<b>DRUG :</b> INS. AUGMENTIN				Date/Time
				2/6/16
Dose	Route	Frequency	Start Date	
600mg	IV	q 8 <sup>th</sup> hrs	02/06	
Name & Signature of the Doctor Starting the Drugs:				
Dr. Nandan				6AM X <sup>Qas</sup> <sub>Divya</sub>
Additional Instructions:				2pm OT <sup>Qas</sup> <sub>Divya</sub> 10pm <sup>Qas</sup> <sub>Divya</sub>
<b>Daily Doctor's Endorsement by a Sign</b>				

<b>DRUG :</b> INS. PARACETAMOL				Date/Time
				2/6/16
Dose	Route	Frequency	Start Date	
300mg	IV	q 8 <sup>th</sup> hrs	02/06	
Name & Signature of the Doctor Starting the Drugs:				
Dr. Nandan				6AM X <sup>Qas</sup> <sub>Chandni</sub>
Additional Instructions:				2pm <sup>Qas</sup> <sub>OT</sub> 10pm <sup>Qas</sup> <sub>Divya</sub>
<b>Daily Doctor's Endorsement by a Sign</b>				

<b>DRUG :</b> INS. TRANEXAMIC ACID				Date/Time
				2/6/16
Dose	Route	Frequency	Start Date	
250mg	IV	q 12 hrs	02/06	
Name & Signature of the Doctor Starting the Drugs:				
Dr. Nandan				10AM <sup>2:30 pm</sup> <sub>OT</sub>
Additional Instructions:				10pm <sup>Qas</sup> <sub>Divya</sub>
<b>Daily Doctor's Endorsement by a Sign</b>				

<b>DRUG :</b> NASOLLEAR NID				Date/Time
				2/6/16
Dose	Route	Frequency	Start Date	
2°/12°	IN	q 4 hrs	02/06	
Name & Signature of the Doctor Starting the Drugs:				
Dr. Nandan				12AM X ✓ 6AM X X 8AM X ✓ 12PM X 4PM X 8PM <sup>Qas</sup> <sub>Divya</sub>
Additional Instructions:				
<b>Daily Doctor's Endorsement by a Sign</b>				

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 Master CH PRATEEK  
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 Dr. MANCHUKONDA SANTHOSH



Signature ..... **REGULAR PRESCRIPTIONS** Weight ..... Ward .....

**DRUG :** BETADINE <sup>MOUHA</sup> <sub>GARGLE</sub> **Date/Time** 2/6

Dose	Route	Frequency	Start Dt.
-	For gargling	BD	07/06

Name & Signature of the Doctor Starting the Drugs:  
*Dr. Nandan.* 10AM X

Additional Instructions:  
 10pm / 12am / Divya

**Daily Doctor's Endorsement by a Sign**

**DRUG :** INJ. ESOMEPRAZOLE **Date/Time** 2/6 3/6

Dose	Route	Frequency	Start Dt.
20mg	IV	OD	02/06

Name & Signature of the Doctor Starting the Drugs:  
*Dr. Nandan.* 6AM Pratik Divya

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

**DRUG :** **Date/Time**

Dose	Route	Frequency	Start Dt.
------	-------	-----------	-----------

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

**DRUG :** **Date/Time**

Dose	Route	Frequency	Start Dt.
------	-------	-----------	-----------

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

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

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 Dr. MANCHUKONDA SANTHOSH



St. .... **REGULAR PRESCRIPTIONS** Weight ..... Ward .....

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

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



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/6	2:30pm	Sj. AMOXICILLIN	600mg	IV	<i>[Signature]</i>	<i>[Signature]</i> Verkat
2/6	2:35pm	Sj. PARACETAMOL	350mg	IV	<i>[Signature]</i>	<i>[Signature]</i> Verkat
2/6	2:30pm	Sj. DEXAMETHASONE	2.5mg	IV	<i>[Signature]</i>	<i>[Signature]</i> Verkat
2/6	2:30pm	Sj. TRANEXAMIC ACID	1gm	IV	<i>[Signature]</i>	<i>[Signature]</i> Verkat
2/6	2:30pm	DICLOFENAC suppository	25mg	PR	<i>[Signature]</i>	<i>[Signature]</i> Verkat

Signature

VERIFIED BY : name



I.V. FLUIDS CHART

09-09-2021  
Master CH PRATEEK  
IP-5-00174642  
BAH-00530706

Weight. 42.5 kg Ward. 10

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
2/6/26		DNS (2/3rd maintenance)	IV	45	<i>[Signature]</i>	not		<del>connected</del>	

Signature  
VERIFIED BY : Name

BAH-00530706 IP5-00174642  
 Master CH PRATEEK 4 Y 8 M 24 D (M)  
 09-09-2021  
 Dr. MANCHUKONDA SANTHOSH

HBH/FRM/CLINICAL/126

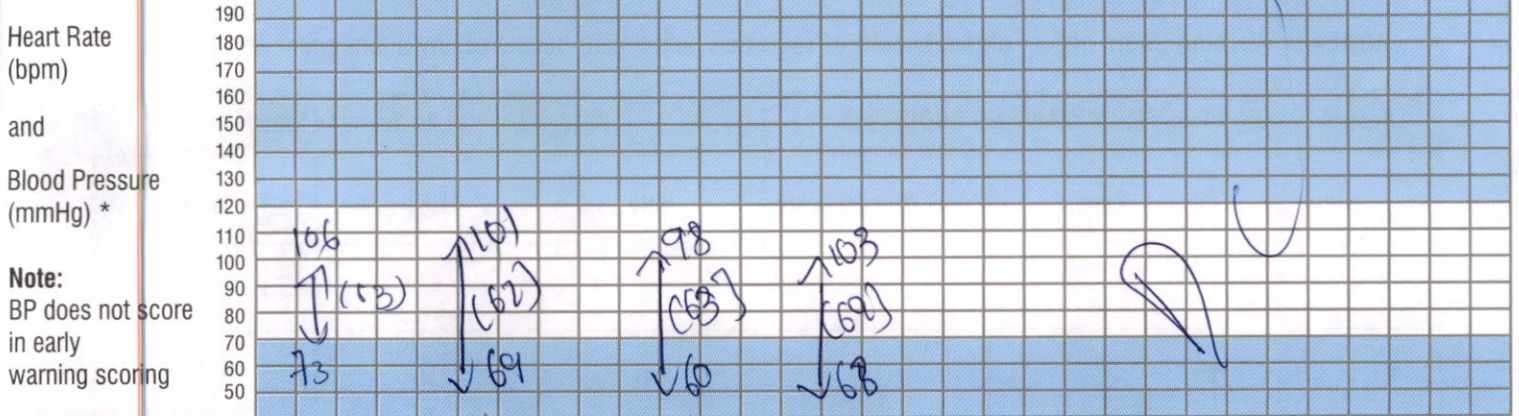
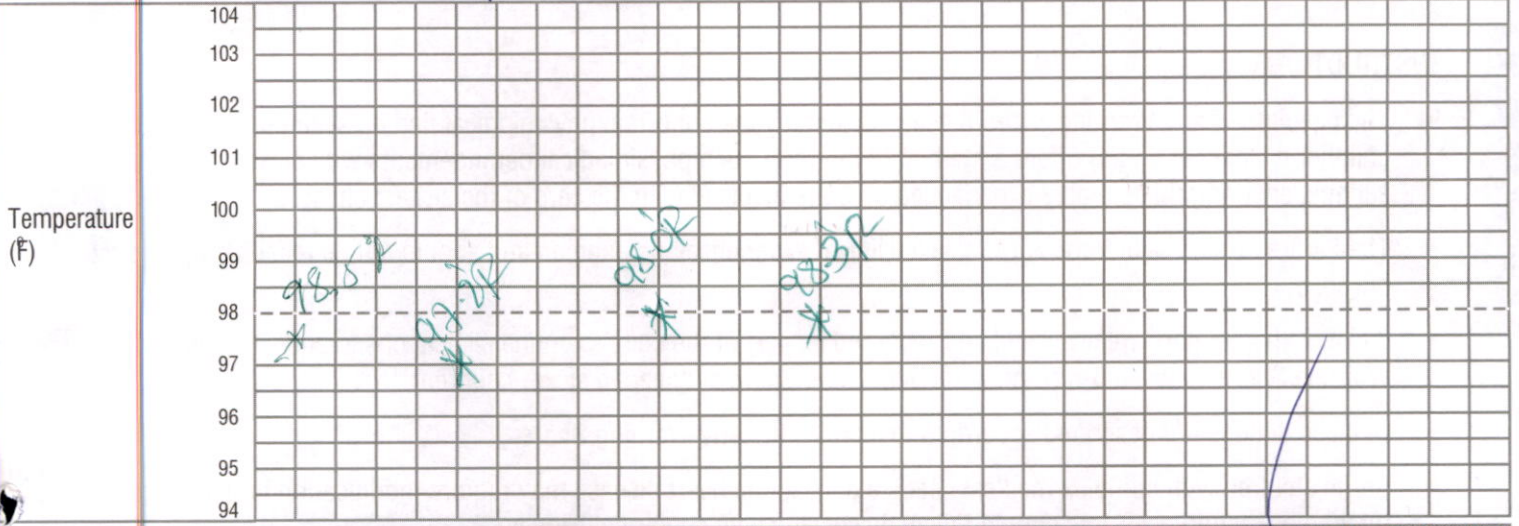
**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**



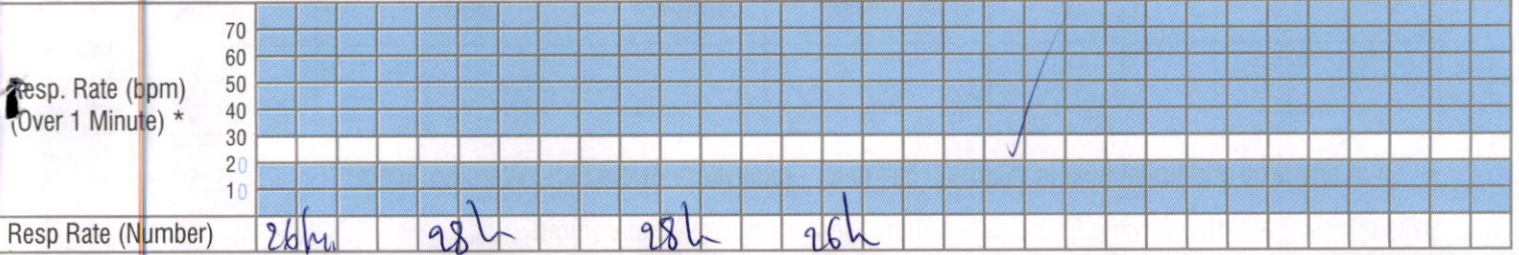
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 2/10 Time:

Doctor / Nurse / Family Concern? SH 10P 9AM 6AM



Heart Rate (Number) 102b 110b 118b 110b



Resp Rate (Number) 26b 28b 28b 26b

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 99% 99% 98% 99%

Conscious Level Normal/Altered

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

TOTAL SCORE Number of shaded boxes 1 1 1 1

Pain Score 1 0 0 0

Observer's Initials SH 10P 9AM 6AM

- 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient Sticker

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



# 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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm	H <sub>2</sub> O									0		Devi	
	06:00 pm	no WP									0		Chen	
	07:00 pm										0			
<b>Total Intake :</b>						<b>Total Output :</b>								
	08:00 pm										0			
	09:00 pm										0		Janya	
	10:00 pm										0		Janya	
	11:00 pm										0		Janya	
	12:00 am										0		Janya	
	01:00 am										0		Janya	
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 am										0		Janya	
	03:00 am										0		Janya	
	04:00 am										0		Janya	
	05:00 am										0		Janya	
	06:00 am										0		Janya	
	07:00 am										0		Janya	
<b>Total Intake :</b>						<b>Total Output :</b>								
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>								

BAH-00530706 IP5-00174642  
 Master CH PRATEEK  
 09-09-2021 4 Y 8 M 24 D (M)  
 Dr. MANCHUKONDA SANTHOSH

# FLUID CHART



Sheet No. : .....

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

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

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# 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. coblation Adenoidectomy  
 2. 8 Tonsillectomy

**I acknowledge the following:**

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Nose block snoring Breathing</u>	<u>- Nil -</u>

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

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

- a. Bleeding  
 b.

I authorize Dr. M. Santosh Kumar and his / her team to perform the procedural sedation upon the patient / myself.

- I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

**Patient / Patient Attendant:**

Signature: K. Venugopal  
 Name: K. Venugopal  
 Relationship with patient: uncle  
 Date & Time: 2.00 pm

**Witness:**

Signature: K. Rajitha  
 Name: K. Rajitha  
 Date & Time: 2.00 pm

**Doctor (who is taking consent):**

Signature: [Signature] Name: Dr. M. Santosh Date ..... Time: .....

## శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు:  రోగి  రోగి అటెండెంట్

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

- 1 .....
- 2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

- a.
- b.

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Anshosh  
 Asst. Surgeon : .....  
 Anaesthetist : Dr. Arjun  
 Scrub Nurse : Bikhal

Patient Name : Master CH PRATEEK  
 UHID No. : 09-09-2021 4 Y 8 M 24 D (M)  
 Date : .....  
 Dr. MANCHUKONDA SANTHOSH

Gender : M  
 me : .....



## Before Induction of Anaesthesia >>

## Before Skin Incision >>

## Before Patient Leaves Operating Room

**SIGN IN** Time: 2:10pm

**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 : Arjun  
 Name : Dr. ARSHWARYA

**TIME OUT** Time: 2:30pm

**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? NA  Yes  No  NA

**Anaesthesia Team Reviews:**

Are There Any Patient-specific Concerns?  Yes  No  NA

**Nursing Team Reviews:**

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?  Yes  No  NA

**Is Essential Imaging Displayed?**  Yes  No  NA

Power Supply, Earthing, Power Backup and functioning of equipment checked.  Yes  No

Signature : Akhal  
 Name : Akhal

**SIGN OUT** Time: 3:20pm

**Nurse Verbally Confirms with the Team:**

The Name of the Procedure Recorded  Yes  No  
 That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)  Yes  No  NA  
 The Specimen is Labelled (including patient name)  Yes  No  NA  
 Whether there are any Equipment Problems to be addressed  Yes  No  NA

**To Surgeon, Anaesthetist and Nurse:**

What are the key concerns for recovery and management of this patient?  Yes  No

Signature : [Signature]  
 Name : .....

P BAH-00530706  
 Master CH PRATEEK  
 09-09-2021  
 Dr. MANCHUKONDA SANTHOSH (M)  
 4 Y 8 M 24 D  
 IP5-00174642



## BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

**To Be Filled In By Assigned Nurse :**

Date : 2/06/26

Department : P.O.T. Duration of Procedure : 1hr

Name of Surgeon : Dr. Santhosh Date of Admission : 2/06/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic or <input checked="" type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic : <u>200mg Augmentin Coames</u>	
2.	Hair Removal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No if Yes : <u>Surgical Clipper</u> Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Patient's body temperature immediately post operation (Recovery Room) <u>37.0°C</u> <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : <u>Vijay 2/06/26</u> Date & Time of antibiotic administration : <u>2/06/26</u> Date & Time procedure started : <u>2/06/26 @ 2:30pm</u>	

- 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

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## RATION THEATER NOTES

Patient's Name : Master CH PRATEEK Age : 4y Gender :  Male  Female

UHID No. : 0124642 Weight : ..... Height : .....

Surgeon : Dr. Santhosh Asst. Surgeon :

Anesthetist : Dr. Ajsha OT Nurse : S. S. S. / A. C. W. OT Technician : ...

Pre-Operative Diagnosis:

Surgical Procedure : Excision Adenotonsillectomy

Indications for Surgery :

Date : 26/06/26 Start Time : 2:30pm End Time : 3:30pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

- Grade 4 Adenoid hypertrophy
- Grade 5 tonsillar hypertrophy
- Excision Adenotonsillectomy

OPERATION NOTES

Amount of Blood Loss: \_\_\_\_\_ Blood Transfused (in ML) \_\_\_\_\_

Name and Number of Surgical Specimen sent for examination: \_\_\_\_\_

Peri-Operative Complications: \_\_\_\_\_

1. Ily. Augmentin  
600mg IV BD

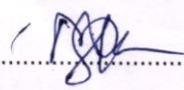
2. Ily. PCM 300mg  
IV TID

3. Ily. Tranexa 250mg IV BD

4. Nasoclean n/a  
3° / 3° / 3°

5. Betadine mouth gargle  
2 times daily

Name of the Surgeon: .....

Signature of the Surgeon:  .....

Date & Time: .....

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Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



## POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

*NPO for 2hr - Ice cream & soft diet*

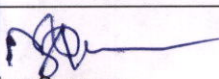
When to Start Mobilization:

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: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

BAM-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



Name: Master CH PRATEEK Age: 4Y 8M Sex: male UHID.No: BAM-00530706

Date: 1/06/2026 Time: 12:30pm Proposed Operation: Coblation Adenotonsillectomy

Diagnosis: chronic Adenotonsillar Hypertrophy

B.P / CRT: sec H.R: ..... Weight: 23.5kg ASA Physical Status:  1  2  3  4  5

Laboratory Data:

Hgb: <u>12.3</u>	Glucose: .....	Protein: .....	HIV: .....	X-Ray: .....
PCV: <u>38.2</u>	Urea: .....	Alb: .....	HBS Ag: .....	ECG: .....
WBC: <u>12880</u>	Creat: .....	Total Bil: .....	HCV: .....	2D Echo: .....
Plate: <u>5.76laks</u>	Na: .....	Dir. Bil: .....	Blood group: .....	Stress/Anglo: .....
PT: .....	K: .....	LDH: .....	T3 .....	Other: .....
PTT: .....	Ca++: .....	Alk phos: .....	T4 .....	
INR: .....	Mg++: .....	Amylase: .....	TSH .....	<u>ASO Titre - Negative</u>
Cl-: .....	SGOT/SGPT: .....			

Allergies: NICDA

Medical History: CVS: - Telm / LSCS / CIAB

RESP: moeth breathing ⊕ sucking ⊕ Diabetes: Bwt: 2.2kg

CNS: y NO NICU admission

Renal: y immunised till date

Hepatic / GE: NOT significant Physical Activity: Development ⊕

Others: .....

Past Anaesthetic History: -

Physical Exam:

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

Lungs: BAE ⊕ clear

Heart: S1S2 ⊕

CNS: HMF ⊕

Pregnant:  Yes  No  NA Venous Access Site: accessible Spine Exam for regional: (2)

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. Neelamini

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 Dr. MANCHUKONDA SANTHOSH

IP5-00174642

ANAESTHESIA CHART



Change in Patient Condition:  Yes  No Fasting Status: Adequate

Physical Status:  Patient Identified  Consent Present  Chart Reviewed

H.R: 108/min B.P / CRT: 87/45 SpO<sub>2</sub>: 98% - CRA R.R: 20/min Last Feed: > 6hr  
 Pre-OP Diagnosis: Chronic Adenotonsillar Hypertrophy Operation: ADENOTONSILLECTOMY Date: 02/6/26

Surgeon: Dr. Santosh Anaesthesiologist: Dr. Ayesha Technician: Vijay

TIME	N <sub>2</sub> O (AIR) (%)	O <sub>2</sub> (LPM)	HALO (SQ) (SEVO)	Drugs	Antibiotic	Suppository	Blood Loss	NOTES
2:15pm	50	MACI						
2:30pm				MIDAZOLAM 1.5mg IV				
2:45pm				FENTANYL 50mcg IV				
2:55pm				PROPOFOL 80mg IV				
3:05pm				ROCURONIUM 12mg IV				
3:15pm				DEXMEFENASONE 20mg IV				
3:25pm				TRIAMETERIC ACID 100mg IV				
3:30pm				PARACETAMOL 350mg IV				
3:35pm				MYOPYRROLATE 3ml IV				
3:40pm								
3:45pm								
3:50pm								
3:55pm								
4:00pm								
4:05pm								
4:10pm								
4:15pm								
4:20pm								
4:25pm								
4:30pm								
4:35pm								
4:40pm								
4:45pm								
4:50pm								
4:55pm								
5:00pm								

FiO <sub>2</sub> (SaO <sub>2</sub> )	100/100/100/100/100/100/100/100/100/100
ETCO <sub>2</sub>	30 34 36 32 31 32
ECG	SR SR SR SR SR SR
Temperature	
Urine Output	

Fluids Blood: RI @ 230ml/h

B.P: 240  
 V Systolic: 220  
 A Diastolic: 200  
 X Mean: 180  
 \* Heart Rate: 160

Tourniquet on Time: 160  
 Tourniquet off Time: 140

Throat Pack In: 120  
 Throat Pack Out: 100

LAB Values: ARB, GRBS, Others

Equipment Checked and Functional:  BP,  Cuff Site: RT, UL,  Art Site,  EKG Lead,  Temp Site,  FIO<sub>2</sub> Monitor,  Agent Monitor,  Pulse Oximeter,  Capnograph,  Ventilator,  Nerve Stimulator

Position:  Pressure Points Checked

Eye Care:  Oint,  Tape,  Padding,  Awake

Temp:  HME,  Fluid Warmer,  Clear Film,  OH Warmer,  Hugger's,  Cotton Wool,  Other

Times: Anaes Start: 2:15pm, OP Start: 2:30pm, OP End: 3:30pm, Leave OR: 3:30pm

Anaesthest:  GA,  Monitored Anaesthesia Care,  Regional

Line (Size & Location):  CVP,  ART,  IV: 22G on RT ul,  IV,  IV

Induction:  IV,  Inhal,  Pre O<sub>2</sub>,  RSI,  Others

Mask:  Mask,  SGA,  Airway,  Oral,  Nasal,  Tracheostomy,  Topical,  Drug: ROCURONIUM

Awake:  Awake,  Direct Vision,  Video Laryngoscopy,  Stylette / Bougie,  Fiberoptic

Blade #: 2 Attempts: 1

Difficulty Why?

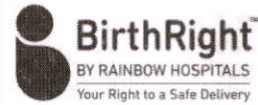
Regional:  Bilat = BS,  Semi-Closed Circle,  Closed Circle,  Other

Regional: Extremity  Spinal,  Epidural,  Caudal

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. Ayesha  
 Signature of the Doctor: [Signature]

BAH-00530706  
 Master CH PRATEEK  
 08-09-2021 4 Y 8 M 24 D (M)  
 Dr. MANCHUKONDA SANTHOSH



POST-AN

RECORD

Received in PACU by : Durg Time Received : 3:35 pm Time Discharged : .....

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	BLOOD PRESSURE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>99G</u>	<input type="checkbox"/> O <sub>2</sub> Mask	<input type="checkbox"/> Nasal Prongs
				<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> T-Piece
250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	PULSE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	Vomiting : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Drug : .....	
				250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	RESPIRATION
<input type="checkbox"/> Oral Airway	<input type="checkbox"/> Nasal Airway				
250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	RESPIRATION	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	SPO <sub>2</sub>	Drain : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Oral Feeds : .....
				<input type="checkbox"/> Urinary Catheter	
250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	RESPIRATION	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	SPO <sub>2</sub>	Chest Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Nil Oral : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				<input type="checkbox"/> Nil Oral	

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	2	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	1	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		8	8	9	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/10	3:35 pm	4/10	—	Durg

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Reassessment Frequency:

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature: [Signature]

Date & Time: .....

PACU Nurse Name : Durg

PACU Nurse Signature: [Signature]

Date & Time: 2/6/2020 pm

Transferred to Unit by (PACU): 107

Date & Time: 2/6/2020 pm

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 Master CH PRATEEK  
 09-09-2021 4 Y 8 M 24 D (M)  
 Dr. MANCHUKONDA SANTHOSH



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 : .....

Patient

BAH-00530706 IP5-00174642  
Master CH PRATEEK  
09-09-2021 4 Y 8 M 24 D (M)  
Dr. MANCHUKONDA SANTHOSH



# CONSENT FOR ANAESTHESIA

Authorization By:  Patient  Patient Attendant

Operative Procedure: coblation Adenotonsillectomy

Anaesthesiologist: Dr. Tejaswini Surgeon: Dr. Santhosh Kumar

### Please read this before you consent for Anaesthesia

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

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

Heart Disease  Hypertension  Diabetes  Renal Failure  Multi Organ Failure  Hepatic Disorders

Shock  Obesity  Chronic Obstructive Pulmonary Disease

Others Desaturation, 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: K. Venugopal  
Name: K. Venugopal  
Relationship with patient: uncle  
Date & Time: 1/6/26 12:35pm

### Witness:

Signature: K. Rajitha  
Name: K. Rajitha  
Date & Time: 1/6/26 12:35pm

### Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Tejaswini Date 01/06/2026 Time: 12:35pm

## 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.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మోటిక్ 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.  
 లిజనల్ అనస్థీషియా  జనరల్ అనస్థీషియా  మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటలీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన 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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# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/4/26 Time: 9 AM

Weight: 22.8 kgs Centile: 90<sup>th</sup>

Height: 110 cms Centile: 25<sup>th</sup>

Inference: Overweight child

RDA: — Calories: 1350 kcal/d Protein: 23g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy and outside foods.

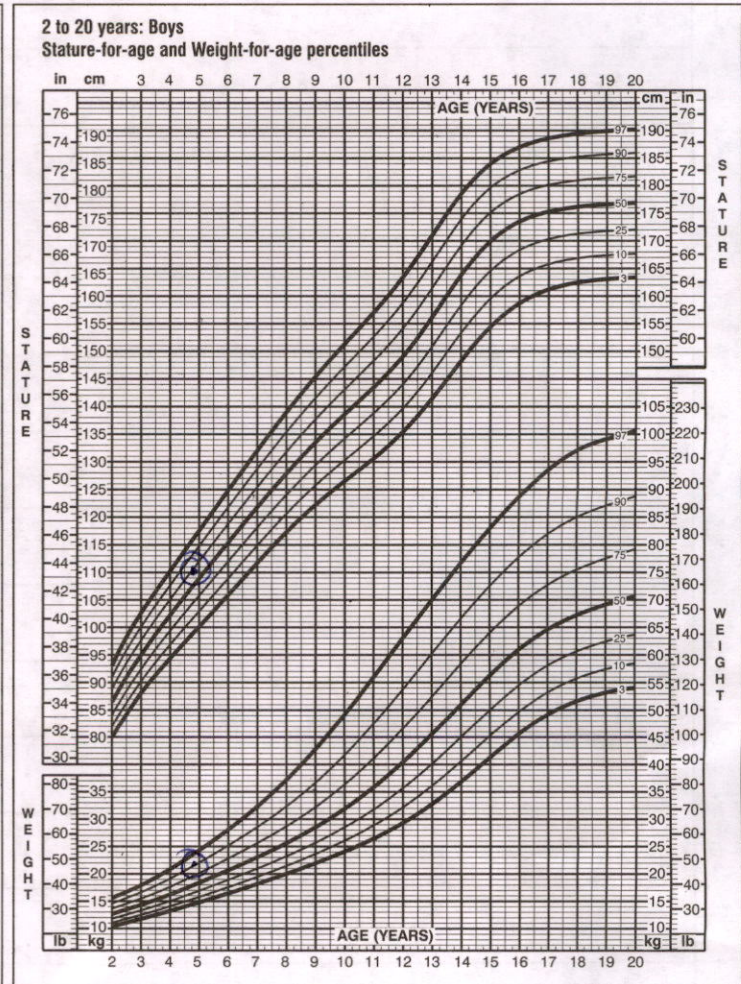
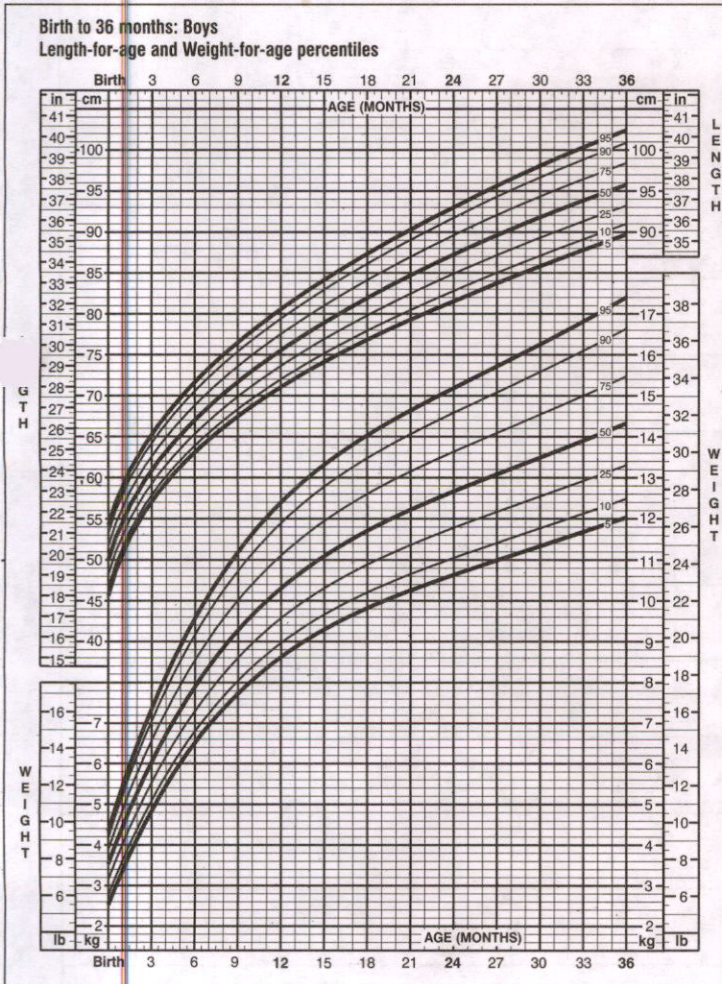
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Chronic malnutrition, hypotrophy

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: K. Venkatesh

## GROWTH CHART (BOYS)



Dietician's Name: Manuella

Dietician's Signature: Manuella

