Patient Sticker

BAH-00659780 IP5-00176264
Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BABBAR

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SURGERY DETAILS

Date : 11/2/26

Patient Name: FARDOSO MD YUSUF Date of Birth: 01-01-2010 Age: 16Y

Gender: Female Ward : P-OT UHID No.: 659780

Date of Surgery: 11/2/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Colonoscopy + Endoscopy

Time in : 3pm Time Out : 4.pm

	NAME	AMOUNT
1. Surgeon	: Alisha	
2. Anaesthetist	: Dr. Amrin	
3. Assistant Surgeon	:	
4. OT Technician	: Kulsum	
5. Circulating Nurse	: Bikash	
6. Assistant Nurse	: Prabhavati	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others Endoscopy * Colonoscopy 9698151

Signature of the Surgeon

Signature of Circulating Nurse Bikash

Order No: 9698151 Order by: Bikash

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

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Baby FARDOSO MOHAMED YUSUF
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29/4 Endoscopy + colonscopy
F 54Kg

CONSUMABLES OF OT

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Circulating staff :..... Technician : ..... Date : ..... Time :.....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7.5	HH	-	Major Pack			Inj Vit.K		
LMA 3, 4	HH	-	Sutures			Cord Clamp		
ECG leads : A / P / N	02	03				Suction Catheter		
HME filter : A / P / N	01	01				Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	04	Gloves 6, 6½, 7, 7½ 2½			Surgical Gloves		
02 cc	10	03	P 6½ 7½ 2½	2½	HHH	Gauze Pack		
01 cc	05	-				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	-	Surgical blade			Surgical Blade # 20		
IV set	01	01	NG tube			Koochies (S)		
RL	01	01	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	04H	01	Koochies			100, 50cc 50cc Jelly	2½	1
Mini spike	01	01	Ointments				1	1
O2 Mask (A)	01	-	Suction Catheter			20cc	1	1
Fentanyl	01	01	Cap, Mask	5/5	5/5	50cc	1	1
Morphine		-	Gauze Pack R F M	5/5	5/5	Abdomen	1	2
Ketamine		-	Mop Pack	1p	1			
Propofol	03	05	Steristrip	1p				
Rocuronium	01	-	Underpad	1	1			
Glycopyrolate	01	-	Draw sheet	1	0			
Myopyrolate	01	-	Abgel			Dexart Tramexa	1½	-
Ondansetron	01	-	Foleys catheter			Dexmed	01	01
Pencan 25g/ Spinal Needle 22	01	-	Urobag			500 TPmolol	2½	01+01
Bupivacaine 0.25%	01	-	Chest Drainage Catheter			Gauze + gloves	4½	03+01
Bupivacaine 0.25%(Heavy)		-	Romodrain bag			Ekg, nasal		01
Antibiotics Iv pcm	01	-	Bandage			(A) prongs	01	
MIDAZOLAM			Tegaderm					
Suppositories		-	Ioban					
Anamol : 80mg / 250mg / 170 mg		-	Double J Stent					
Supridol : 100mg		-	Vaccum Suction set	HH	1			
Justin : 12.5 mg 25mg 100mg	HH	-	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg		-	Betadine Solution		.			
Vaccum set	01	01	Microshield	1	1			
Sways 10+(100) ml	HH	01	Cotton Balls					
O.A [2,3]	HH	-	Latex Gloves	10p	1p			
N.A [28, 30]	HH	-	Ramdione Scrub					
IV Cannula (20+18)	HH	-	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 969820 Ordered by : .....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176264 **Admit Date** : 11-Jul-2026 **Admit Time** : 12:57 PM **UHID** : BAH-00659780

Patient Details :

Patient Name	: Baby FARDOSO MOHAMED YUSUF	**Age**	: 16 Y 6 M 10 D
Guardian	: Mrs SHUKRI MOHAMED SALEBAN	**DOB**	: 01-01-2010
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: SURYA NAGAR , BAHAR RESIDENCY , Tolichowki Hyderabad Telangana INDIA 500008	**Phone No**	: 7337502250/ 7337502250
		E-mail	: NA@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 : Mrs SHUKRI MOHAMED SALEBAN **Relationship** : MOTHER

Contact Address : SURYA NAGAR , BAHAR RESIDENCY , Tolichowki Hyderabad Telangana INDIA 500008 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. ALISHA BABBAR **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. Prashant Bachina

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : _____

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

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Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BASSAR

Date of Admission: _____ Tir _____ arge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	2 pm	ER	OT	
11/7/26	5 pm	OT	Billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
11/07	CRP	6945	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/07	iv placement PAC (OP Basis)	1	97943	Ismail

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

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

1 Colonoscopy + Endoscopy + Biopsy

2 .....

I acknowledge the following:

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

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

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

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

a. Bleeding, Perforation, Abrasion, infection.

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

Patient / Patient Attendant:
Signature: .....
Name: Asiya
Relationship with patient: relative (Sister)
Date & Time: 11/7/26 at 2:15pm.

Witness:
Signature: .....
Name: Sai
Date & Time: 11/7/26 @ 3pm

Doctor (who is taking consent):
Signature: ..... Name: Dr. Kunal Date 11/7/26 Time: 2:18pm.

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.

b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే 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. ALISA
Asst. Surgeon :
Anaesthetist : DR. Amrin
Scrub Nurse : Prabhavathi

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Age : 16y Gender : F
y Name : Colonoscopy + Endoscopy
3pm Out-time : 4pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2:48 pm

Patient Has Confirmed
- Identity ☑Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☐Yes ☐No ☑NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐Yes ☑No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☑No ☐NA
- Blood Units Reserved ☐Yes ☐No ☑NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☐Yes ☐No ☑NA

Signature : [signature]
Name : Dr. K Sri Surya

Before Skin Incision ➤➤

TIME OUT Time: 3:10 pm

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? No key Nil ☐Yes ☑No ☐NA

Anaesthesia Team Reviews: No link
- 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 :
Name :

Before Patient Leaves Operating Room

SIGN OUT Time: 3:50 pm

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 : for Dr. Alisha
Name : Dr. Alisha

Patient Sticke

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 11/07/26

To Be Filled In By Assigned Nurse :

Department : P.OT Duration of Procedure : 1hr

Name of Surgeon : Dr. Alisha Babbar Date of Admission : 11/07/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☑ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☑ No Name of the Antibiotic :	Bsiew
2.	Hair Removal ☐ Yes ☑ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☑ No	Bsiew
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Bsiew
4.	Name of doctor or staff administering the antibiotic : Dr. Alisha Date & Time of antibiotic administration : 11/7/26 AM Date & Time procedure started : 11/7/26 AM	Bsiew

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

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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: Colonoscopy + OGD + biopsy

Post-Operative Monitoring Parameters /Frequency:

Hourly

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

—

Plan to Start Mobilization: Immediately.

Special Referrals:

—

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 11/7/25 Time: .....

Note: Plan of care will be readjusted if necessary.

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Dr. ALISHA BABBAR

Patient

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OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender : ☐ Male ☐ Female

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

Surgeon : Dr. Alisha	Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:
Pre-Operative Diagnosis:		
Surgical Procedure : OGD + Colonoscopy + biopsy		
dications for Surgery : Persistent pain abdomen, persistent vomiting		
Date : 11/7/26	Start Time :	End Time :

Pre Operative Preparations:

Bowel preparation
NPO.

Post Operative Diagnosis: ? H. pylori gastritis

Peri-Operative Complications: Nil

Operation Notes: Colonoscopy
very poor preparation
seen till 30 cm — (N)
Biopsy taken

Upper endoscopy
E - lower esophagus - irregular Z line
minor exudates @ GE junction +

S → follicular gastritis in body +
nodularity in antrum + hiatal hernia +

D- (N) villi.

Biopsy all segment

Amount of Blood Loss: 5ml	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination: ×

(4) (1) Rectum

Peri-Operative Complications: Duo Stom Stop

×

Name of the Surgeon: Dr Aisha

Signature of the Surgeon:

Date & Time: 11/3/25

Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BABBAR

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Upper GI Endoscopy + colonoscopy

Anaesthesiologist: Dr: Tejaswini Surgeon: Dr. Alisha.

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

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: Asiya
Name: Asiya
Relationship with patient: sister.
Date & Time: 10/7/26 3:30pm

Witness:
Signature:
Name:
Date & Time: 10/7/26 @ 5pm

Doctor (who is taking consent):
Signature: Name: Dr: Tejaswini Date 10/7/26 Time: 3:30pm.

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

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BAH-00659780 IP5-0017626
Baby FARDOSA MOHAMED YUSUF (F)
01-01-2010 16 Y 6 M 10 D
Dr. ALISHA BABBAR

PRE-ANESTHETIC EVALUATION

Name: Fardosa Mohamed Yusuf Age: 16Y Sex: Female UHID.No : BAH-00659780

Date: 10/02/2026 Time: 3pm Proposed Operation: Upper GI Endoscopy + Colonoscopy

Diagnosis: GERD ? H.Pylori Gastritis. Weight: ~~23.27kg~~ WT: 54.1kg BMI: ~~23.27kg/m²~~

B.P / CRT: ☐1 ☑2 ☐3 ☐4 ☐5 ASA Physical Status:

Laboratory Data:

Hgb: 12	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Pl:	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
	K:	LDH:	T3	Other:
	Ca++:	Alk phos:	T4	
	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

History: CVS : -

Diabetes : -

: -

: -

Renal : -

Hepatic / GE : c/o Constipation 4 to 5 yrs Physical Activity: Active.

Others : H/o Left breast hypoplasia; USG breast : ↓ed Fibrofatty tissue.

Past Anaesthetic History: – left side Ipsilateral absence of sweating, pa hair & Hyperpigmented Ma

Physical Exam: -

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

Lungs : BAE (+)

Heart: S1S2 (+) HMF (+)

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : accessible Spine Exam for regional : (N).

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with P
5. Other Instructions:

CBP

Signature: Name: Dr. Tejaswini

Docu. No. : RCHBH /FRM / CLINICAL / 044

BAH-00659780 IP5-00176264
Baby FARDOSO MOHAMED YUSUF
01-01-2010 15 Y 6 M 10 D (F)
Dr. ALISHA BABBAR

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Physical Status: ☑ Patient Identified

H.R: 78 bpm

B.P / CRT: 100/70 ☑ Consent Present

Fasting Status: Confirmed

Pre-OP Diagnosis: ....

SpO2: 98% on RA

Surgeon: Dr. Alisha

R.R: 14/min

Operation: Colonoscopy

Anaesthesiologist: Dr. Ravi / Dr. Suraj / Dr. Ameera

Chart Reviewed

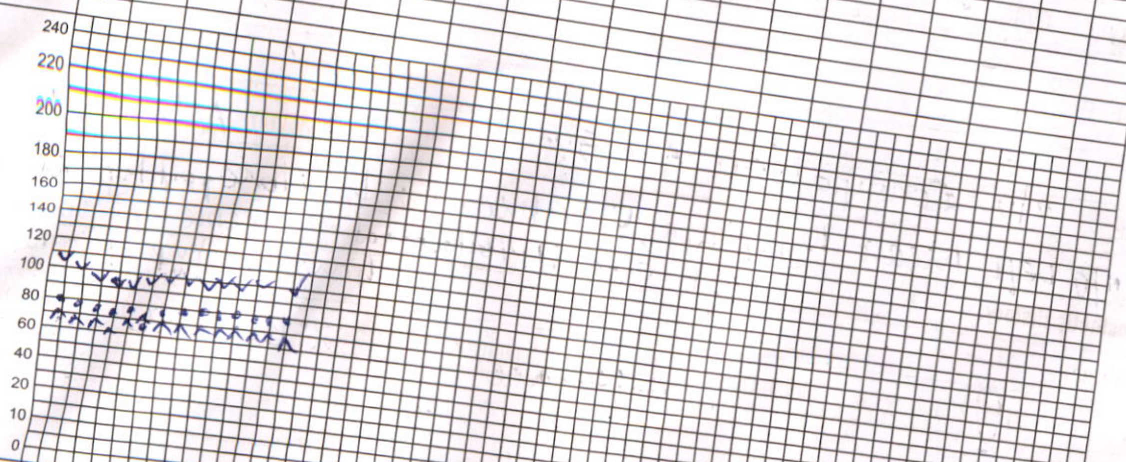
Last Feed: >6hrs 11/7/25

Tec...

TIME	3:00	3:15	3:20	3:45	4:00
N_2O / AIR / O_2 LPM	2L+				
HALO / SO / SEVO					
Drugs:					
Inj MIDAZOLAM					
Inj FENTANYL 20mg					
Inj PROPOFOL 100mg + 30ml/hr infusion → 20ml/hr infusion.					
FIO_2 / SaO_2					
$ETCO_2$	100	100	100	100	
ECG	NSR	NSR	NSR	NSR	
Temperature					
Urine Output					
Fluids / Blood: RINGER LACTATE 300ML.					

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out



ABG

GRBS

Others

NOTES

...t Checked and ... DUL ...

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

Times:
Anaes Start: 3:00pm
OP Start: ↓
OP End: ↓
Leave OR: 4PM.

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: 22G (Rt) forearm
☐ IV: ....
☐ IV: ....

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

4L O_2.

☐ Mask ☐ SGA — Nasal prongs
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ....
☐ Awake
☐ Video Laryngoscopy ☐ Direct Vision
☐ Fiberoptic ☐ Stylette / Bougie
Blade# .... Attempts: ....
Difficulty Why? ....

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

Regional:
Extremity
☐ Spinal ☐ Epidural ☐ Caudal
Specify: ....
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. Ameera

Signature of the Doctor: [signature]

BAH-00659780 IP5-00176264
Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BABBAR

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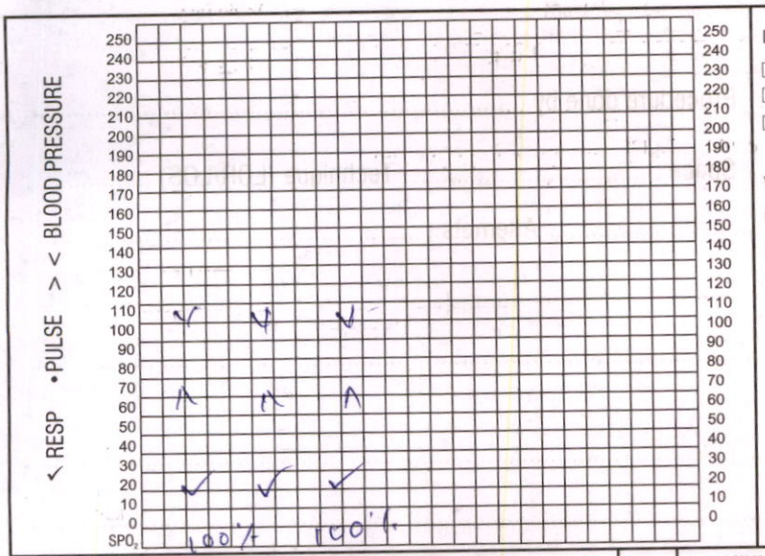
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sravi Time Received : 2 Pm Time Discharged : .....



IV Cannula Site : 2nd

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

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7	@ 4 Pm	0/10	Nil	

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

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

Anaesthesiologist Name : Dr. Tejashwini
Anaesthesiologist Signature: Dr. Tejashwini
Date & Time: 11/7/26 @ 4Pm
PACU Nurse Name : Sravi
PACU Nurse Signature:
Date & Time: 11/7/26 @ 3Pm

Transferred to Unit by (PACU): Billing
Date & Time: 11/7/26 @ 4Pm

01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BASSAR

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

BAH-00659780 IP5-00176264
Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
Dr. ALISHA BABBAR

Fardoso Mohamed

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Alisha Babbar Date : 11/07/2026

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

Start Time of Assessment: 1 PM Weight: 15.4 Kg

Allergic History: N.K.D.A

Chief Complaints:

C/O Pain in epigastrium with burning in retrosternal area & sour eructations in the mo with × 3 months. Pt on & off nausea & vomiting. Now admitted for UGI endoscopy & biopsy & colonoscopy.

Pediatric Assessment Triangle

A Appearance - TICLS Normal

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

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

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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Significant Past History: Suspected retodermal dyspraxia

Medication History: Nil

Relevant Investigations: PT - 14 / INR - 1

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Breathing

Rate: 22 br/min SpO_2 on FiO_2 100%

Rhythm: Normal

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AEE, clear

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Circulation

HR: 92 b/m CFT [Central <3 sec / Peripheral <3 sec]

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 180/70 mmHg

Pulse Volume: [Central Good / Peripheral Good]

If in Shock: [Compensated ..... / Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: A

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: [Responsive ☑ Non-Responsive ☐] Size [Right 3mm / Left 3mm]

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

Signs of Neurological compromise .....

—

Exposure

Temp.: 98.4°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

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: Normal

Labs Planned:

CBP

Treatment Planned:

- NPO as advised
- IVF: DNS

NB
Sagar
11/7/26

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

Final Diagnosis with possible Differential Diagnosis (If necessary): ? GERD

Assessment done by

Name of the Doctor: Neelu

Signature: Dr. Nanedar

Date & Time: 11/07/2026, 10:15 PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Nandan

Date & Time : 11/07/2026, 1 PM

Nurse Name & Signature: Sagar

Date & Time : 11/7/26 @ 1:20 pm

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DRUG CHART

Date of Admission: 11/07/2026 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As required Medication)

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

VERIFIED BY : Name ..... Signature

BAH-00659780 IPS-0017620
Baby FARDOSO MOHAMED YUSUF
01-01-2010 16 Y 6 M 10 D (F)
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REGULAR PRESCRIPTIONS

Weight. 54 kg Ward. ....

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

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

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

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

BAH-00659780 IP5-00176264
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01-01-2010 16 Y 6 M 10 D (F)
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Weight. 54 kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
14/07/16	5PM	PROCTOCLYSIS ENEMA	10	PR		Sneni Banu

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

BAH-00659780 IP5-00176264
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I.V. FLUIDS CHART

Weight. 54 kg. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
31/7/25	1.15PM	IVF. DNS	IV	90 ml/hr	[signature]	[signature]	NOT	comment	

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00659780 IP5-00176264 Baby FARDOSO MOHAMED YUSUF 01-01-2010 16 Y 6 M 10 D (F) Dr. ALISHA BABBAR	11/7/26 @ 1:02 pm	11/7/26 @ 2 pm
	Transfer Ordered by Dr. Nandan	Reason for Transfer surgery
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ? op file

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	proto GOWN	(1)
2.	KOOCHE	(1)
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR. Sagar	Dr. Nandan

Patient & Clinical Records Received by : Renuka 11/7/26 at 2 pm.

Date & Time of Patient Received :

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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RESULT SHEET

Date	4/7/26					
Time						
Hb	12.8					
PCV	39.6					
RBC	4.62					
WBC						
N/L						
Platelets	276					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

FLUID CHART

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Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	