OPERATION THEATER NOTES

Patient's Name : Baby of Bhavani Age : 2m Gender : ☑ Male ☐ Female

UHID No.: BAH- 00654828 Weight : 5.61kgs Height : ....

Surgeon : Dr. Harish Jayaram		Asst. Surgeon : Dr. Nikitha.	
Anesthetist : DR. Nikitha	OT Nurse: Alam. Akhil		OT Technician: Ravi

Pre-Operative Diagnosis: (L) Hydronephrosis.

Surgical Procedure : Lap (L) Pyeloplasty

Indications for Surgery : (L) Hydronephrosis.

Date : 13/05/26	Start Time : 9:03 Am	End Time : 11:25 pm

Pre Operative Preparations: Betadine skin prep

Post Operative Diagnosis: (L) Hydronephrosis.

Peri-Operative Complications: None

Operation Notes: Findings - (L) grossly dilated extra renal pelvis with narrow (L) PUJ and upper ureter.
Procedure: Three port laparoscopy done, findings noted, (L) transmesocolic approach, (L) PUJ segment identified, dissected & resected & ureteropelvic tapered, spatulated anastomosis done over a 3F DJ stent. Port sites closed.

vetra UROCARE Scan QR Code
DOUBLE J STENT
REF : DD3014CE
LOT : BD250708

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

Amount of Blood Loss: 1ml	Blood Transfused (in ML) —
Name and Number of Surgical Specimen sent for examination: —	
Peri-Operative Complications: None	

Name of the Surgeon: Dr Harish Jayaram

Signature of the Surgeon: DR. HARISH JAYARAM Registration No: 66254

Date & Time: 13/5/26 11.10 AM

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

POST-SURGICAL CARE PLAN FORM

Procedure Done: Lap (L) Pyeloplasty

Post-Surgical Diagnosis: (L) Hydronephrosis

Post-Operative Monitoring Parameters /Frequency:

TPR 15 mins x 1hr.

Wound Care:

Watch for bleeding

Drain /Special Lines/Catheters:

Foley's catheter - 2nd holy UOP

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

NBM until fully awake

When to Start Mobilization:

~~As soon as~~ ______

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

—

DR. HARISH JAYARAM
Registration No: 66254

Treating Surgeon
(Signature & Stamp)

Date: 13/5/26 Time: 11.10 AM

Note: Plan of care will be readjusted if necessary.

Docu. No. : RCHBH /FRM / CLINICAL / 106

BAH-00[illegible]54828 IP5-00173755
Baby O[illegible] BHAVANI
24-02-2[illegible]26 0 Y 2 M 19 D (M)
Dr. HA[illegible]ISH JAYARAM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26. 5:40pm	C/S/B Dr. Maliha	
	POD - (0)	Adv
	Afebrile Vitals stable	1) Full feeds.
	P/A - soft	2) Urine output chart 3 hrly.
	L/E - dressing no soakage.	
	U.O - 2.85 cc/kg/hr.	
	[signature] Dr. Harish 13/5/26 PM DR. HARISH JAYARAM Registration No: 66254	Maliha 13/5/26 5:40pm

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14.5.26.	C/S/B Dr. Maliha.	
8 AM	POD - (1).	
		Adv
	Afebrile	
	Vitals stable	1) Full feeds.
	P/A - soft.	
	L/E - dressing no soakage	
	U.O - 3.25 cc/kg/hr	
DR. HARISH JAYARAM Registration No: 66254 [signature] Dr. Harish 14/5/26 8.30 AM		Maliha Dr. Maliha 14/5/26 8 AM.

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5/26 4:04 pm	C/S/B Dr. Maliha.	
	POD - ①	Adv
	afebrile Vitals stable	1) Full feeds
	P/A - soft passed stool. L/E - dressing no soakage	
	U.O - 1.58 cc/kg/hr	
	[signature] T40 5:40 pm	Dr. Maliha Maliha 14/5/26 4:04 pm

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 21 D (M)
Dr. HARISH JAYARAM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15 ~~14~~/5/26 7:58 AM	C/S/B Dr. Maliha	
	POD - ②	Adv
	Afebrile Vitals stable	1) Full feeds.
	P/A - soft	
	U.O - 2.27cc/kg/hr.	
DR. HARISH JAYARAM Registration No: 66254 15/5/26 8:40 AM		Maliha Dr - Maliha 15 ~~14~~/5/26 7:58 AM
15/5/26 5:17pm	C/S/B. Dr. Nabeel.	
	POD-2	
	Afebrile vitals - stable P/A - soft	Adv 1) Full feeds.
15/5 6:20pm	U/O - 2.9 cc/kg/hr	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26 9:05am	c/e/B Dr. Maliha	
	POD-3	
	Pt c/c/c GC-fair	
	Afebrile	Adv
	Vitals-stable	1) Full feeds.
	S/E - P/A - soft	2) Plan discharge today
		3) Remove foley's catheter
	U/O - 2.9cc/kg/hr	Maliha 16/5/26 9:05 AM
	Dr Harish 16/5/26 10AM	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

RESULT SHEET

Date	13/5/26					
Time	8am					
Hb	10.6					
PCV	31.8					
RBC	3.88					
WBC	8.83					
N/L	24/65					
Platelets	432					
CRP						
ESR						
PCT						
RBS						
Na	137					
K	4.6					
Cl	107					
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.4					
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.,) : ....

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

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 : Akhila [signature]

Date & Time : 13/5/26 @ 8am

Nurse Name & Signature: [signature]

Date & Time : 13/5/26 @ 7:55 am

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 : IP5-00173755 **Admit Date** : 13-May-2026 **Admit Time** : 06:51 AM **UHID** : BAH-00654828

Patient Details :

Patient Name : Baby Of BHAVANI
Guardian : Mr N VEERADAS
Gender : Male
Occupation :
Address (H) : #9-58, POCHANNAPET, Buchinnapet Warangal Telangana INDIA 506221

Age : 0 Y 2 M 19 D
DOB : 24-02-2026 06:49 AM
Religion :
Martial Status : Single
Phone No : 9966492235/ 9963683256
E-mail : nomailid@gmail.com

Admission Details :

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

Contact Details :

Name : Mr N VEERADAS
Contact Address : #9-58, POCHANNAPET, Buchinnapet Warangal Telangana INDIA 506221

Relationship : Father
Phone No : 9966492235 / 9963683256

N Veeradas

Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM
Referral Doctor : Self
Co-Consultant :

Specialisation : PEDIATRIC SURGERY
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : SELFPAY

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment : to Relieve obstruction

Planned Labs:

CBP
S. electrolytes
S. creatinine

NB [illegible]
019586
13/05 @ 7:15am

Planned Management

NPO
IVF DNS
Inj. Piptaz

NB [illegible]
019586

DR. HARISH JAYARAM
Registration No: 66254

Signature of the Doctor: [signature]
Name of the Doctor: Dr. Harike
Date & Time: 13/5/26 8am

Signature of the Consultant: [signature]
Name of the Consultant: Dr. Harish
Date & Time: 13/5/26 8:30AM

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

DRUG CHART

Date of Admission: 13/5/26 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 / 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:																		

BAH-00654826 IP3-00175795
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

REGULAR PRESCRIPTIONS

Weight. 5.6 kg Ward. ....

VERIFIED

DRUG : Inj PIPERACILLIN TAZOBACTAM

Dose	Route	Frequency	Start Date
550 mg	IV	Q8H	13/5

Name & Signature of the Doctor Starting the Drugs: Dr. Harish — 11.10 AM

Additional Instructions:

Date / Time	13/5	14/5	15/5	16/5
6am	X	Dipa Rosna	Dipa Rosna	Dipa Rosnana
2pm	3pm Nikil	Nihal	Nihal	
10pm	11pm Dipa Rosna	Dipa Rosna	Dipa Rosnana	
Daily Doctor's Endorsement by a Sign	[signature]	[signature]	[signature]	[signature]

VERIFIED

DRUG : Inj PARACETAMOL

Dose	Route	Frequency	Start Date
80 mg	IV	Q8H	13/5

Name & Signature of the Doctor Starting the Drugs: Dr. Harish — 11.10 AM

Additional Instructions:

Date / Time	13/5	14/5	15/5	16/5
6am	X	Dipa Rosna	Dipa Rosna	X
2pm	3pm Nikil	Nihal	Nihal	
10pm	11pm Dipa Rosna	Dipa Rosnana	Dipa Rosnana	
Daily Doctor's Endorsement by a Sign	[signature]	[signature]	[signature]	[signature]

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time

Daily Doctor's Endorsement by a Sign

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

Weight. 5.6kg Ward. ......

DRUG :		Date ▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
			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
13/5	8:30 am 1 hr before surgery	Inj. PIPTAZ	500mg	IV	[signature]	Teena Ravi (8:40 Am)
~~13/5~~		~~Inj PARACETAMOL~~	~~50mg~~	~~IV~~	~~NA~~	

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

Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

I.V. FLUIDS CHART

Weight. 5.6 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
			~~IV~~	~~25~~	[signature]				
13/5	6 am	DNS	IV	25	[signature]	[signature] [signature]	13/5/26	Malika	[signature] [signature]
13/5	8:30 AM	RINGER LACTATE	IV	50ml/hr	[signature]	[signature] [signature]	13/5	[signature]	[signature] [signature]
13/5/26	1:03pm	DNS (full maintainance)	IV	24 ml/hr	Malika	[signature] [signature]	13/5	[signature]	Nikee [signature]
13/5/26	5:40 PM	DNS.	IV	16	[signature] Dr Harish	Nitai [signature]	14/5/26	Malika	[signature] [signature]
14/5/26.	8:30 AM	DNS	IV	12 ml/hr	Malika	Nitai Swathi	15/5/26	[signature]	Swathi [signature]

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: ______

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
13/5	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	(L) HDN	Surgery	lap. pyeloplasty	[signature]	☐ Nursing ☑ Others:
13/5 4:20	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☑ Modified ☐ Per-Op ☐ Post Op	(L) Hydronephrosis	Surgery	lap. pyeloplasty	[signature]	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Docu. No. : RCHBH /FRM / CLINICAL / 040

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

RY PATIENT / FAMILY EDUCATION RECORD

Part - I,

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

Identified Education Needs :

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Trerapy (safety, effects/side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others..........

Part - II

Date	Time	Need Indentified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
13/05	7:45 am	8	procedures	M	1	O	1	1	Nil	[illegible]
15/4	8am	7	Infection Control Measures	M	1	O	1	1	—	[illegible]

Part - III : CODES

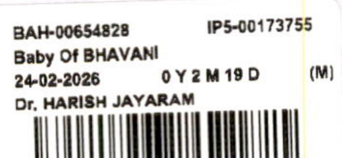
Who was taught : PT : Patient F : Father M : Mother S : Spouse Sn : Son D : Daughter C : Caregiver O : Other (Specify)..........

Learning Barriers :
1. No Learning Barries
2. Physical Impairment
3. Emotional Barries
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process / Cognitive limitations
8. Responsibilities at Home
9. Cultural Difference
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision / or Hearing
13. Cultural / Religion Practice
14. Others (Specify) ....

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

Mechanism/s to overcome barrier/s :
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify..........

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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 7:30 am Mode of Arrival: Mother taken Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil Body Weight: 5 kg Kg

Height: .... cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) ....

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Family History: Nil

Has the child or close family member had recent contact with a communicable disease? Yes ☐ No ✓

If yes please list, ...

Was the child's birth normal? ✓ Yes ☐ No If No, please describe problems: ....

Are the child's immunization up to date? ✓ Yes ☐ No

Current Medication: ✓ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 5 kg Length: .... Head Circumference (< 2 years): ....

Temp.: 98.6°F HR: 136 bpm RR: 30 BP: 95/65

Pain Score: 0/10 Specify Site: .... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ✓ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 24) (Document in the Braden Q Assessment Sheet)

Pain Screening: ✓ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ✓ FLACC ☐ Wong Baker

Character of Pain .... Location .... Frequency .... Duration ....

FUNCTIONAL SCREENING: ✓ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ✓ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Special Feeding Method
- ☐ Feeding Problem
- ☐ Special diet
- ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: .... (Date/Time): ....

Social History: Lives With ....Family..

Siblings in household ☐ Yes ☐ No (if yes How Many?) ....

All Information Obtained From ☐ Patient ☐ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☐ Yes ☐ No   Waste Disposal Explained: ☐ Yes ☐ No

Infusion Pump : ☐ Yes ☐ No   Hand hygiene Explained: ☐ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to ....

Nurse's Name: ....Kalyan.... Date: ....13/05/26.... Time: ....7.30am.... Signature

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 13/05/26 Time of arrival : 6:20 am

Chief Complaints: Came for Laparoscopic Pyeloplasty RBS: —

Height : — Weight : 5.6 Kg BMI : — Head Circumference (<2 years) : —

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: —

If yes , identify Nil.

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character nil ☐ Location nil ☐ Frequency nil ☐ Duration nil

RISK FOR FALL:

☑ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☑ Escort while ambulating
☑ Assist Patient
☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NA

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

Siblings in household ☐ Yes ☐ No (if yes How Many?) NA

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 6:22am

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
	- Dr. Harika assessed the child.
	- IV placement done.
	- Sample collected.
	- Shifted to OT.

Samples collected by: Shambu

Samples sent by :

Time: 7:00 a

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	nil		nil		

Condition of patient at time of shift - out :	Details of Shift - out
HR: 135 b/m BP: 94/52 CFT: < 3 sec	Shift - out from ER to: OT
RR: 28 b/m SPO$_2$: 97% RA	Time of Shift - out: 8:20
GCS: 15/15 Temperature : 98°F	Handover given to: (Nurse's Name) Teena
Pain Score: 0/10	
Repeat RBS (if applicable): nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

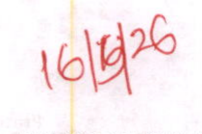
Procedures done with details (if any): IV placement

Name of the Nurse : Nurshid

Signature of the Nurse :

Date & Time : 13/05/26 @ 7 am

BAH-006[illegible]4828 IP5-00173755
Baby Of [illegible]HAVANI
24-02-202[illegible] 0 Y 2 M 21 D (M)
Dr. HARI[illegible]H JAYARAM



c. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: .... Time:		
Doctor/Nurse/Family Concern?		
Temperature (°F)	104	
	103	
	102	
	101	
	100	
	99	
	98	
	97	
	96	
	95	
	94	
Heart Rate (bpm) and Blood Pressure (mmHg) *	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
Note: BP does not score in early warning scoring	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)		
Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)		
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2(l/min)		
O_2Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE Number of shaded boxes		
Pain Score		
Observer's Initials		

ACTIONS		
NB: Scores 3 should be recorded overleaf	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 incharge and PICU /NICU fellow or PICU/NICU 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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

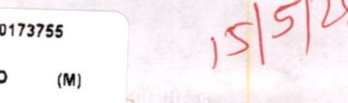
- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE >3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



15/5/26

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: .... Time:	10 AM	2 PM	6 PM	10 pm	2 AM	6 Am
Doctor/Nurse/Family Concern?						
Temperature (F) (104–94)	98.0°F	98.7°F	98.3°F	98.6°F	98.4°F	98.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)				74 (61) 48		96 (72) 64
Heart Rate (Number)	130 b	126 b	126 B/m	121 B/m	126 B/m	124 B/m
Resp. Rate (bpm) "Over 1 Minute) * (70–10)						
Resp Rate (Number)	30 b	32 b	32 b/m	30 B/m	28 B/m	26 B/m
Resp Distress Mod/ Severe / None / Mild						
Receiving O_2 (l/min)				RA	RA	RA
O_2 Saturations (%)	99%	98%	100%	99%	100%	99%
Conscious Level Normal / Altered	C					
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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 incharge and PICU /NICU fellow or PICU/NICU 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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

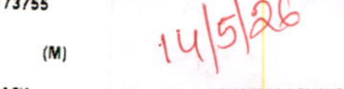
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 20 D (M)
Dr. HARISH JAYARAM



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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	10AM	2pm	6 pm	10pm	2Am	6Am
Doctor / Nurse / Family Concern?						
Temperature (F) (104–94)	*98.5°F	*98.7°F	*98.1°F	*98.8°F	*98.3°F	*96.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	99/50	101/62 (75)	89/51 (64)	86/48 (61)	81/46 (58)	74/51 (51)
Heart Rate (Number)	156b/m	132b/m	135b/m	130B/m	129B/m	122B/m
Resp. Rate (bpm) Over 1 Minute) * (70–10)						
Resp Rate (Number)	24b/m	27b/m	35b/m	30B/m	28B/m	26B/m
Resp Distress — Mod/ Severe						
Resp Distress — None / Mild						
Receiving O_2 (l/min)						
O_2 Saturations (%)	99%	98%	100%	99%	100%	99%
Conscious Level — Normal	C	C	C	C	C	C
Conscious Level — Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS		
NB: Scores 3 should be recorded overleaf	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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			**Record Time of Review and Plan**		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	2pm	6pm	10pm	2Am	6Am
Doctor / Nurse / Family Concern?					
Temperature (F) (94–104)	98.2	97.8	98.3°F	98.5°F	98.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190) Note: BP does not score in early warning scoring	86/50 (68)	92/49 (64)	90/56 (67)	94/59 (68)	84/50 (61)
Heart Rate (Number)	130 B/m	138 B/m	134 B/m	139 B/m	131 B/m
Resp. Rate (bpm) Over 1 Minute) * (10–70)					
Resp Rate (Number)	26 B/m	24 B/m	28 B/m	26 B/m	28 B/m
Resp Distress: Mod/ Severe					
Resp Distress: None / Mild					
Receiving O_2 (l/min)	RA	RA	RA	RA	RA
O_2 Saturations (%)	99%	100%	99%	100%	100%
Conscious Level: Normal					
Conscious Level: Altered					
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	[signature]	[signature]	[signature]	[signature]	[signature]

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE >3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

FLUID CHART

Sheet No. : 1 3/5/26

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	–	–	DNS	–	–	–	–	–	–	0	[signature]
Total Intake :						Total Output :						
13/5	02:00 pm	water	50ml	DNS 24ml/hr	–	–	–	–	–	100	0	[signature]
	03:00 pm			24ml						25ml	0	[signature]
	04:00 pm	DNS	milk	24ml							0	[signature]
	05:00 pm			24ml			NP				0	[signature]
	06:00 pm			24ml						10ml	0	[signature]
	07:00 pm			16ml							0	[signature]
Total Intake :				136ml		Total Output : 100ml						135ml
	08:00 pm	DNS	milk	16ml							0	Rosng
	09:00 pm			16ml						50ml	0	Rosng
	10:00 pm			16ml							0	Rosng
	11:00 pm			–			NP				0	Rosng
	12:00 am			–						65ml	0	Rosng
	01:00 am			16ml							0	Rosng
Total Intake :				64ml		Total Output :						
	02:00 am	DNS	milk	16ml							0	Rosng
	03:00 am			16ml						30ml	0	Rosng
	04:00 am			16ml							0	Rosng
	05:00 am			–			NP.				0	Rosng
	06:00 am			–						60ml	0	Rosng
	07:00 am			16ml							0	Rosng
Total Intake :				64ml		Total Output :				M-0	V-	

Total 24 hrs. Intake	264 ml

Total 24 hrs. Output	340 ml

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 20 D (M)
Dr. HARISH JAYARAM

FLUID CHART

Sheet No. : 16/5R

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						0	Saravat
14/5/26	08:00 am			16ml							0	Saravat
	09:00 am	DNS		–						25ml	0	Saravat
	10:00 am			–							0	Saravat
	11:00 am			12ml			✓				0	Saravat
	12:00 pm			12ml						25ml	0	Saravat
	01:00 pm			12ml							0	Saravat
Total Intake :				52ml		**Total Output :**				M-0 - U-50ml		
14/5	02:00 pm	DNS		–							0	Harika
	03:00 pm		milk	–						30ml	0	Harika
	04:00 pm			12ml			NP				0	Harika
	05:00 pm			12ml						20ml	0	Harika
	06:00 pm		milk	12ml							0	Harika
	07:00 pm			12ml						20ml	0	Harika
Total Intake :				88ml		**Total Output :**				M-0 U-70ml		
	08:00 pm	DNS		–							0	Rosny
	09:00 pm			12ml							0	Rosny
	10:00 pm			12ml			✓			30ml	0	Rosny
	11:00 pm			–							0	Rosny
	12:00 am			12ml							0	Rosny
	01:00 am			12ml						25ml	0	Rosny
Total Intake :				48ml		**Total Output :**				M- U 55		
	02:00 am	DNS		12ml							0	Rosny
	03:00 am			12ml						30ml	0	Rosny
	04:00 am			12ml			✓				0	Rosny
	05:00 am			–							0	Rosny
	06:00 am			–						100ml	0	Rosny
	07:00 am			–							0	Rosny
Total Intake :				36ml		**Total Output :**				M, U 130ml		

Total 24 hrs. Intake	224 ml	Total 24 hrs. Output	305 ml

Docu. No. : RCHBH/FRM/CLINICAL/092

FLUID CHART

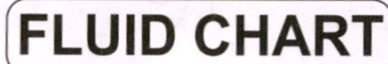
Sheet No. : ....

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
[illegible]	08:00 am			–							0	[illegible]
	09:00 am	NO IVF	milk	–						50ml	0	[illegible]
	10:00 am			–			✓				0	[illegible]
	11:00 am			–							0	[illegible]
	12:00 pm		milk	–						50ml	0	[illegible]
	01:00 pm			–							0	[illegible]
Total Intake :		Good				**Total Output :**				M-1	U-100ml	
[illegible]	02:00 pm			–			✓				0	Mouni
	03:00 pm	NO IVF	milk	–						30ml	0	Mouni
	04:00 pm			–			✓				0	Mouni
	05:00 pm			–							0	Mouni
	06:00 pm		milk	–						30ml	0	Mouni
	07:00 pm			–			✓				0	
Total Intake :						**Total Output :**				60ml	M-3	
	08:00 pm	NO IVF		–							0	Rosna
	09:00 pm			–						60ml	0	Rosna
	10:00 pm		milk	–			✓				0	Rosna
	11:00 pm			–							0	Rosna
	12:00 am		milk	–						75ml	0	Rosna
	01:00 am			–							0	Rosna
Total Intake :						**Total Output :**				135		
	02:00 am	NO IVF		–							0	Rosna
	03:00 am			–						50ml	0	Rosna
	04:00 am		milk	–							0	Rosna
	05:00 am			–			NP				0	Rosna
	06:00 am			–							0	Rosna
	07:00 am									50ml	0	Rosna
Total Intake :						**Total Output :**				M-0 - U-100ml		

Total 24 hrs. Intake		Total 24 hrs. Output	395 ml M-5

Patient Sticker



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	

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: B/o Bhavani Age: 2m Sex: M UHID.No: BAH00654828.

Date: 27.4.26 Time: 6 PM. Proposed Operation: Laparoscopic (L) Pyeloplasty

Diagnosis: (L) Hydronephrosis due to PUJO.

B.P / CRT: 92/56 mmHg H.R: 148/min Weight: 5kgs. ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 10.6	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC: 8,800	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4.11 lakh	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:	**Allergies:** NK.	

Medical History: CVS: No cold/cough/fever. NVD/3.16kg/No NICU admission.

RESP: Diabetes: ⊖

CNS: —

Renal: - H/o PUJ obstruction on USG.

Hepatic / GE: — Physical Activity: Active.

Others: —

Past Anaesthetic History: ⊖

Physical Exam:

Airway: MP 1 2 3 4 — Mouth Opening: — Mentohyoid Distance: — Neck: — Teeth: —

Lungs:
Heart: NAD
CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: ⊕ Spine Exam for regional: —

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 — Breast milk x4 hrs.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

- ~~CBP on cannulation~~
- ~~T 2D~~
- + CBP, on cannulation

Signature: [signature] Name: Dr. Ameen.

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

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

ANAESTHESIA CHART

Pre Induction Assessment: 8:30AM

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: Confirmed

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

H.R: 148bpm	B.P / CRT: 80/40	SpO₂: 100%	R.R: 28/min	Last Feed: @3AM

Pre-OP Diagnosis: (L) HDN d/t PUJO Operation: Lap pyeloplasty Date 13/5/26

Surgeon: Dr. Harish Anaesthesiologist: Dr. Nikita / Dr. Ali Technician: Ravi

TIME	8:30	9		10		
N_2O/AIR/O_2 LPM	0.3/0.3L/min					
HALO/SO/SEVO	2-3%					
Drugs:						
Inj. MIDAZOLAM 0.2mg/iv						
Inj. FENTANYL 30ug/iv						
Inj. PROPOFOL 20mg						
Inj. ROCURONIUM 2.5mg/iv						
FIO_2 / SaO_2	100	100	100	100	100	100
$ETCO_2$	[illegible]	25	28	28	30	30
ECG	NSR	NSR	NSR	NSR	NSR	NSR
Temperature	35	35	36	36	36	36
Urine Output						
Fluids / Blood	RL @ 50ml/hr	"	"			

Antibiotic: Inj. PIPTAZ 500mg/iv

Suppository: —

Blood Loss

NOTES

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

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

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

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

Position: Lateral
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 8:30 AM
OP Start: 8:50 AM
OP End: ....
Leave OR: 11:30 AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: (L) 24G hand
☐ IV: ....
☐ IV: ....

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

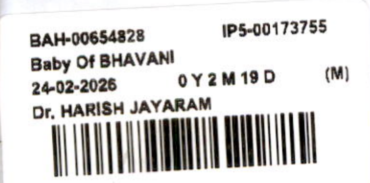
☐ Mask ☐ SGA
☐ Airway ☑ Oral ☐ Nasal
☐ ETT# 3.5 at 10 cm
☑ Oral ☐ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: Rocuronium 2.5mg/iv
☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 1 Attempts: 1
Difficulty Why? —

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

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☑ Caudal
Others: ....
Position: Lateral
Site: Sacral hiatus
Needle Size: 22G Depth: —
Parasthesia ☐ Yes ☐ No
Catheter at skin — cm
Drug Name & Conc: 0.25% Bupivacaine
Bolus: 5cc [illegible]
Infusion: —
Block Level: —
Comments: ....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA

Name of the Doctor: NIKITA
Signature of the Doctor: [signature]



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Geena   Time Received : 11.35 Am.   Time Discharged : 1.36 pm

Times: 11.35, 11.50, 12.10, 12.25, 12.40

✓ RESP • PULSE > < BLOOD PRESSURE (chart 0–250)

SPO2: 99%, 99%, 99%, 100%, 100%

IV Cannula Site : ....

☐ O2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

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

IV Fluids: DNS
Oral Feeds: ....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	30	60	90	OUT
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	0	0	1	2	2
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apnea = 0		RESPIRATION	2	2	2	2	2
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0		CIRCULATION	2	2	2	2	2
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS	0	1	1	2	2
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0		COLOR	2	2	2	2	2
		TOTAL	6	7	8	10	10

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
13/5	1.15 pm	1/10	Nil	Thejas

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. Shalini
Anaesthesiologist Signature: [signature]
Date & Time: 13/05/26 @ 1.36 pm

PACU Nurse Name : Thejas
PACU Nurse Signature: [signature]
Date & Time: 13/05/26 @ 1.36 pm

Transferred to Unit by (PACU): Akul
Date & Time: 13/05/26 @ 11.35 am

Patient Sticker

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 : ....

ACTIVITY RECORD FOR BILLING

BAH-00654828 IP5-00173755
Baby Of BHAVANI
24-02-2026 0 Y 2 M 19 D (M)
Dr. HARISH JAYARAM

Name : ______________________

UHID No: __________ Consultant: __________ Dept : __________

Date of Admission: __________ Time : __________ Date of Discharge : __________ Time: __________

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/05/26	8:20 am	ER	OT	Mushed
13/05/26	1.45 pm	OT	236.	Thejas.

Cross Consultation Visit

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

Docu. No. RCHBH/FRM/GENERAL/145

INVESTIGATIONS

Date	Investigations	Order No.	Signature
13/05	CBP	8517	[signature]
.	S/E, creat	8542	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
13/5/	Infusion pump	13/5/26	2pm	606852	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
13/05	IV Placement	1	5620	[illegible]
13/05	PAC	1	5654	[illegible]
13/5	Catheterisation	1	9606194	[illegible]
14/5	NHA	1	9607460	[illegible]

ANY OTHER INFORMATION

CBP - 1

Date : 16/5/16 Time : 8:10 am Prepared By : [illegible]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[illegible]	—	—	—