

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP5-00174498      Admit Date : 29-May-2026      Admit Time : 02:41 PM      UHID : BAH-00657550

**Patient Details :**

Patient Name	: Master GANGAPRASAD RAM GORE	Age	: 2 Y 0 M 26 D
Guardian	: Mr RAM GANGADHAR GORE	DOB	: 03-05-2024
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: NEAR WATER TANK , OLD KOUTHA NANDED CIDCO Nanded Maharashtra INDIA 431603	Phone No	: 9975020860/ 9607160012
		E-mail	: RAMGORE255@GMAIL.COM

**Admission Details :**

Bed Type : SEMI PRIVATE      Bed No : SPVT 203      Ward Name : 2F-SECOND FLOOR  
 Room No : SPVT 203      Admission Type : First Visit

**Contact Details :**

Name	: Mr RAM GANGADHAR GORE	Relationship	: Father
Contact Address	: NEAR WATER TANK , OLD KOUTHA NANDED CIDCO Nanded Maharashtra INDIA 431603	Phone No	: 9975020860

  
Signature

**Doctor Details :**

Doctor Name	: Dr. KAPIL BHAGWATRAO SACHANE	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

**Payment Details :**

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: STAR HEALTH AND ALLIED INSURANCE CO LTD

BAH-00657550 IP5-00174498  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



### ACTIVITY RECORD FOR BILLING

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

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

Date of Admission: \_\_\_\_\_ T \_\_\_\_\_ Charge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Wa \_\_\_\_\_ Billable bed type : \_\_\_\_\_

BAH-00657550 IP5-00174498  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	4:05pm	ER	Ward	Aphishel
30/5/26	6:40pm	203	301	Nihar
1/6/26	2pm	Post	301	Keya

### Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Naveen	30/5/26	9635126	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				







BAH-00657550      IPS-00174498  
Master GANGAPRASAD RAM GORE  
03-05-2024      2 Y 0 M 26 D (M)  
Dr. KAPIL BHAGWATRAO SACHANE



# Rainbow<sup>®</sup> Children's Hospital

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Gangaprasad Ram Gore.

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

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

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

BAH-00657550      IPS-00174498  
Master GANGAPRASAD RAM GORE  
03-05-2024      2 Y 0 M 28 D (M)  
Dr. KAPIL BHAGWATRAO SACHANE



Pati: IP5-00174498  
BAH-00657550  
Master GANGAPRASAD RAM GORE (M)  
03-05-2024 2 Y 0 M 26 D  
Dr. KAPIL BHAGWATRAO SACHANE



Pet General History & Physical Examination

**Anthropometry :**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)  
Weight (kgs) ) 12.6 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 98°F Pulse Rate : 102/min B.P. \_\_\_\_\_ SPO2 94% RA  
Resp. rate and type of breathing : \_\_\_\_\_ 31/min maintaining  
\_\_\_\_\_ on 4/min  
\_\_\_\_\_ low flow

Rash \_\_\_\_\_ 0  
Lymphadenopathy \_\_\_\_\_  
Oedema : \_\_\_\_\_  
Allergies (if any): \_\_\_\_\_

**Respiratory System :**

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

**Cardiovascular System :**

Inspection of procordium : \_\_\_\_\_  
Heart Sounds : \_\_\_\_\_ S1S2  
Any murmur : \_\_\_\_\_ 0  
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_  
Palpation : \_\_\_\_\_ Soft, non tender, no hepatomegaly  
Ausculation : \_\_\_\_\_ Bowel sounds  
Spine : \_\_\_\_\_ 0 External Genitalia : \_\_\_\_\_  
Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : (2)

#### Motor System:

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

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

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

Posture : NAA

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

#### Reflexes :

DTR

Superficials:

Plantars \_\_\_\_\_

#### Sensory System :

Sentient

Bladder / Bowel : Regular

#### Clinical Summary & Diagnostic:

AFLE LPTI



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent distress

Desired goals of the treatment: hemodynamic stability

**Planned Labs:**  
CBP, CRP, ESR  
montoux test  
Gastric lavage for TB  
cytospin  
LFT  
CVE  
blood c/s  
Chest x ray  
Etchen (SOs)

**Planned Management**  
Low flow O<sub>2</sub> - 1/min  
Inj Ceftriaxone  
Syp. Azithromycin  
NEB = LEVOLIN  
BUDECORT  
IV fluids  
NB  
Rash

Signature of the Doctor: [Signature]  
Name of the Doctor: Sahitni  
Date & Time: 29/5/26 5PM

Signature of the Consultant: [Signature]  
Name of the Consultant: [Signature]  
Date & Time: 30/5/26

DR. KAPIL BHAGWATRAO SACHANE  
Registration No.: 2002/03/1356



# PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Kapil Date : 29/5/25  
 Type of Admission:  OPD  ER  Referral (if referral, Doctor's Name: Dr. Sachane)  
 Start Time of Assessment: 1:50pm Weight: 12.6kg  
 Allergic History: nil

Chief Complaints:  
do cough & cold x 7 days  
fever - moderate to high grade according to parents  
7 day duration, intermittent  
Progressive

Pediatric Assessment Triangle

A Appearance - TICLS

B Breathing

C Circulation

Normal  
 Abnormal

Pallor   
 Cyanosis   
 Mottling   
 Bleeding

Breathing

↑ WOB  
 ↓ WOB  
 Normal  
 Gasping / Apnea

Initial Physiological Status:  Stable  Unstable  
 Life Threatening   
 Non Life Threatening

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

Significant Past History: Recurrent LRTI - 3 admissions in 1 year  
 Medication History: nebulisation  
 Relevant Investigations: .....

Primary Assessment

Airway  Open  
 Maintainable  
 Not Maintainable

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

Breathing

Rate: 31/min SpO<sub>2</sub> on FiO<sub>2</sub> 94% @ RA  
 Rhythm: .....

Any urgent interventions needed:  Yes  No  
 If Yes O<sub>2</sub> by low flow @ 4/min

Retractions:  Suprasternal  ICR  SCR  
 Sternal  Supraclavicular  Nasal Flaring

Respiratory Noises:  Stridor  Wheezing  Grunting

Air Entry: .....

Palpation Findings (if necessary): .....



**Circulation**

HR: 102/min

CFT  Central .....  Peripheral ..... < 3sec

Any urgent interventions needed:  Yes  No

If Yes .....

BP: ..... mmHg

Pulse Volume:  Central .....  Peripheral ..... Good

Murmurs:  Yes  No

Liver Span: .....

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

ECG: .....

Any Signs of Heart Failure:  Yes  No

Muffled Heart Sound:  Yes  No

Engorged Neck Veins:  Yes  No



**Disability**

GCS: 15/15 AVPU: .....

Any urgent interventions needed:  Yes  No

If Yes .....

Pupils:  Responsive  Non-Responsive   
Size  Right .....  Left .....

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

Signs of Neurological compromise .....

**Exposure**



Temp.: 98.1°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: .....

**Labs Planned:**

CRP, CRP, GSR, monox test  
Gaibic lavage for Te gene expect  
LFT  
CVC Chest Xray  
Blood clt  
CT chest (501) NB

**Treatment Planned:**

- 1) O<sub>2</sub> by low flow 14min
- 2) IV Ceftriaxone 600mg w Ro
- 3) Syp. Azithromycin (5mg/200mg) 3ml Ploa
- 4) Neb: Levofloxacin 1.2mg 8th key  
Rudecart armay 12th key
- 5) Inf. Dns @ 30ml/hr 6) Syp. edentolur 3ml plo B.

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

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by  
 Name of the Doctor: Cai  
 Signature: [Signature]  
 Date & Time: 29/5/26

Sr. Doctor on Duty (If necessary)  
 Name of the Sr. Doctor: .....  
 Signature: .....  
 Date & Time: .....

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 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/24 6pm	C/S/B PICU Resident	
	Cough & cold x 8 day Fever (undocumented) 1 day Noisy breathing x 8 day.	Plenic ① Trace ESR, Blood c/s. ② Send Gastric lavage for TB GeneXpert.
	H/O recurrent LRTI 3 WCD admission requiring oxygen since last year.	③ Send CUE. ④ Cont antibiotics.
	<del>Child on room air.</del> Child on 1L/min oxygen	⑤ 2 Neb Levolin 0.63mg (back to back) Neb Budecort 0.5mg.
	SpO <sub>2</sub> : 100% PR: 130/min RR: 30/min BP: 92/60	⑥ Reasses after nebulisation ⑦ Cont nebulisation ⑧ Encourage oral intake.
	Chest: B/L air entry ⊕ B/L wheeze ⊕	
	EVS: S2 ⊕	
	ENS: GUS 15/15	
	Pupils: 2T 2P.	
	Tm: ⊕	
	PA: soft NT.	

*Signature*

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 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	c/s/b	PICU Fellow (Dr. K. Setty)	Doctor's Order
30/5/26	WALRI			
8AM	H/o recurrent episodes			plan
	No fever spikes after admission			- w/t fever spikes
				- w/t distress
	on room air			
	Hemodynamically stable			- Trace CUE
	HR - 116/min			Gene Xpert MTB
	RR - 30/min			Mentoux
	SpO <sub>2</sub> - 100%			BL ch.
	BP - 100/60 mmHg			- continue antibiotics
	Chest - air entry B/C ⊕			
	conducing sound ⊕			
	wheeze better			
	PIA - soft			
	CVS - S <sub>1</sub> /2 ⊕			
	CNS - alert, active			
	Inj. ceftriaxone			
	Syr - Azee			
	Neb levolin			
	Budecort			
	Inj - Hydrocortisone			

Dr. KAPIL BHAGWATRAO SACHANE  
 Registration No. 200210311356

BAH-00657550 IP5-00174498  
 Master GANGAPRASAD RAM GORE (M)  
 03-05-2024 2 Y 0 M 26 D  
 Dr. KAPIL BHAGWATRAO SACHANE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26 10AM	<p>WALRT            H/o recurrent episodes            on room air            Hemodynamically stable.            chest - air entry BL ⊕            conducting sounds ⊕            wheeze better.</p>	<p>c/s/B Dr. Kapil            Plan            - NPO            - IV Fluid to start            - CECT chest            - SOS bronchoscopy            - Dr. Narcan consult            - PID<sub>2</sub> panel to send (now)            - AEB            - Sr coactive to send.</p>
<p>Noted By Nita            SSA</p>		
30/5/26 5PM	<p>Bronchial litr. / WALRT            H/o recurrent episodes            on room air            Hemodynamically stable.            chest - air entry BL ⊕            conducting sounds ⊕            wheeze ⊕.</p>	<p>c/s/B Dr. K. Sathya PICU Fellow            Plan            - plan Bronchoscopy on Monday            - Trace PID<sub>2</sub> panel.            - Wt ↑ distress            - encourage orally            - Trace gene x pest</p>
<p>Noted by            Sathya</p>		
	<p>on ceftriaxone            azithromycin</p>	<p>SSA</p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>3/15/24</del> 8a	<u>C/SIB PICU Resident.</u>	
	Δ: WAURI.	<u>Plan:</u>
	Child on room air. SpO <sub>2</sub> : 97%. PR: 86/min RR: 24/min BP: 96/60 Afebrile.	① Cont Antibiotics Ceftriaxone D3 Azithromycin D3
	Chest: BTL air entry ⊕ conducted sounds ⊕ CNS: S/S ⊕ Where noted.	② Cont nebulisation Levoflox & Budecort.
	<del>CNS: WNL</del> PA: soft NT.	③ Cont Hydrocortisone.
	CNS: GCS 15/15	④ Bronchoscopy - Hum.
	Power: $\frac{575}{575} / \frac{95}{95}$	⑤ Trace PID 2 panel.
	Pupils: 2+ 2+	
	Chest chest: Rt middle lobe medial segment & apical segment of lg lower lobe atelectasis.	
	Mild reduced AP diameter of mid & distal trachea. PTDR lg level: Normal.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5/24	c/s/B Dr. Kapil	
	<p>Δ: WARI (recurrent)</p> <p>Cough ⊕</p> <p>Child on room air.</p> <p>SpO<sub>2</sub>: 97% PR: 88/min</p> <p>RR: 24/min BP: 96/60</p> <p>Afebrile.</p> <p>Chest: conducted sounds ⊕ where better.</p> <p>CNS: S<sub>1</sub>, S<sub>2</sub> ⊕</p> <p>CNS: 4x15/15</p> <p>Pupils: 2+ 2+</p> <p>Tone (N)</p> <p>PA: soft, NT.</p> <p>Ig level: normal.</p>	<p>Plan:</p> <p>① Bronchoscopy tm.</p> <p>② NPO for 4hr tm</p> <p>③ Start iv fluids for 4hr tm</p> <p>④ Cont. antibiotics.</p> <p>⑤ Cont. nebulisation.</p> <p style="text-align: right;">DR. KAPIL BHAGWATRAO SACHANE          Registration No: 20021031336</p>
21/5/24 5:00 PM	<p>c/s/B p/w fellow Dr. Vikas</p> <p>Δ: Recurrent WARI</p> <p>Cough ⊕</p> <p>No fresh complaints</p> <p>Tachypnoea w/fev</p> <p>Hemodynamically stable.</p> <p>chest. B/c conducted sounds ⊕</p>	<p>Plan</p> <p>① Bronchoscopy tomorrow</p> <p>② NPO from morning 9:00 AM</p> <p>③ Continue Antibiotics</p> <p>Nebulisation</p> <p style="text-align: right;">Dr. Vikas          Marked by Sachane</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/24 7-304		<u>C/S/B PICO Pillow (Dr. Sabayal)</u>
	A: Recurrent WARI	<u>Plan:</u>
	Afebrile.	① NPO till Bronchoscopy
	Child on room air	② Cont. iv fluids
	SpO <sub>2</sub> : 99% PR: 107/min	③ Cont antibiotic
	RR: 24/min	④ Cont nebulisation
	Chest: BIL ex entry ⊕	⑤ Trace lymphocytes subset.
	No wheeze	
	Conducted sound better.	
		July
		<u>C/S/B Dr. Kapil.</u>
1/6/24	A: Recurrent WARI	<u>Plan:</u>
	Afebrile.	- Bronchoscopy today
	Child on room air.	- Repeat any chest tomorrow
	SpO <sub>2</sub> : 99% PR: 106/min	- A Dexta stat of bronchoscopy
	RR: 24/min	- Serial
	Chest: BIL air entry ⊕	- Bronchoscopy (1st) & 2nd
	No wheeze	- BT Hptals & V
	Conducted <sup>sound</sup> better	

DR. KAPIL BHAGWATRAO SACHANE  
 Registration No: 200210311



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/06/2025 2:30pm	<p>clsb PICU fellow (Dr. Karthik)</p> <p>post procedure            vital - stable            alert, active            accents orally</p> <p>findings:            - Grade II Adenoid enlargement            - lower tracheomalacia            - lt main bronchus bronchomalacia</p>	<p>Plan</p> <p>1) stop IV fluids if no vomiting            2) Trace sample sent while doing Bronchoscopy            3) Inj. Dexamethasone 1.8mg IV stat</p>
1/6/25 6pm	<p>clsb PICU resident</p> <p>Asst - recurrent WARI / s/p bronchoscopy</p> <p>on room air            No respiratory distress            RR - 26/min            SpO<sub>2</sub> - 99%            Rx - BAE (+) clear            P/A - soft            CNS - NAD</p>	<p>Plan</p> <p>1) chest X-ray tomorrow morning            a) Trace BAL 4s            BAL Genxpert MTB            BAL biofire pneumo panel            3) Trace lymphocyte subset analysis            4) w/t respiratory distress            5) Allow orally            6) Stop IV fluids if taking well orally</p> <p>Noted by Aruga</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/24 8a	<p style="text-align: center;"><u>C/SIR PLW Resident -</u></p> <p>Δ Recurrent WARRS          s/p Bronchoscopy          Afebrile.          Hemodynamically stable          on room air          SpO<sub>2</sub>: 99%, RR: 24/min          Chest: BIL clear          CVS: S1S2@.</p>	<p style="text-align: center;"><u>Plan:</u></p> <p>① Cont antibiotic          ② Cont antibiotic - Ceftriaxone          ③ Trace BAL C/S.          BAL Biofire panel          BAL GeneXpert          ④ Monitor vitals</p> <p style="text-align: right;"><i>[Signature]</i></p>
21/6/24 10a	<p style="text-align: center;"><u>C/S/B Dr Kapil</u></p> <p>Δ Recurrent WARRS/          s/p Bronchoscopy          Afebrile.          Hemodynamically stable on          room air.          Chest: BIL clear.          CVS: S1S2@.</p>	<p style="text-align: center;"><u>Plan: Discharge:</u></p> <p>Budecort 0.8mg TID <sup>2nd</sup> 3days          Levoflox 0.6g TID these 3          Cefprozil 1000          Piv 1000          Trace Biofire 4 C/S.          FU after 5 days.</p> <p style="text-align: right;"><i>[Signature]</i></p>

Dr. KAPIL BHAGWATRAO SACHANE  
 Registration No: 20021021358









BAH-00657550 IP5-00174498  
Master GANGAPRASAD RAM GORE  
03-06-2024 2 Y 0 M 28 D (M)  
Dr. KAPIL BHAGWATRAO SACHANE



Pat

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## OPERATION THEATER NOTES

Patient's Name : Master. GANGA PRASAD RAM Age : 2y Gender :  Male  Female

UHID No.: BAH-00657550 Weight : Height :

Surgeon : DR NAVJEEV Asst. Surgeon :

Anesthetist : DR TEJASWANI OT Nurse: BR TGTU OT Technician: Smtan

Pre-Operative Diagnosis:

Surgical Procedure :

Flexible bronchoscopy ± BAL

Indications for Surgery :

Date : 1/6/25 Start Time : 11:40 AM End Time : 12:20 PM

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: Flexible bronchoscopy done via nose -

- Adenoids enlarged gr 5
- Epiglottis, vocal cords & their movements, subglottis normal.
- Trachea → lower tracheomalacia - moderate to severe. No TEF. Carina sharp.
- Rt main bronchus → upper lobe normal, thick mucus in middle & lower lobes.
- Lt main bronchus → bronchomalacia noted. Few secretions in lower lobe. Upper lobe & lingula normal.

- No foreign body
- BAL done & samples collected

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

BAL fluid —

- ① CBS      ② GeneXpert TB      ③ Biofire panel

Peri-Operative Complications:

Adv

- Chest physiotherapy + incentive spirometry
- Syr Azel (200/5) 3ml once on alternate day x 1 month (Mon-wed-Fri)
- MDI Budesort (100) 2 puffs BD x 3 mon
- MDI Lenolin (50) 2 puffs 6hly SOS
- Tobamist neb. (300mg) 1/2 respule BD x 1 month

- Plan :
- To discuss w Radiologist about ! vascular compression
  - Repeat bronchoscopy after 6 mon.

Name of the Surgeon: ..... Dr. Naveen Saradhi

Signature of the Surgeon: ..... Naveen Saradhi

Date & Time: ..... 1/6/25

Patient S

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Master GANGAPRASAD RAM GORE (M)  
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## POST-SURGICAL CARE PLAN FORM

Procedure Done: ..... *flexible bronchoscopy ± BAL* .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

Yes  No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon  
(Signature & Stamp)

*Naveen Savadri*

Date: ..... *1/6/25* ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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 Master GANGAPRASAD RAM GORE  
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 Dr. KAPIL BHAGWATRAO SACHANE

CROSS CONSULTATION FORM

Doctor Name : Dr. Navan Sachde Date : 30/5/26 Time : .....

Diagnosis : .....

Hospital : Relt Bonehara

Type of Referral :

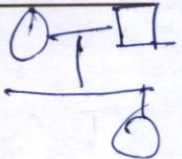
- Emergency
- Urgent
- Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

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

Signature:

Findings and Recommendations :

Handed 

- From 1 year ↓  
 3 admum ⊕ → flu

Wt loss ⊕ was on MD → Not well controlled with MD, midgheller only

BRG over 1 year O/E chest B/L wheeze ⊕

Chest  
RML infiltrates

11-4/9290/A-3L ade

CRP=E  
 ESR=12

- QECF chest
- S. IgE, ABPA panel
- PID2 panel, DHR

Rfor 30/5/2026

AEC → M1

→ May need Bronchscopy

→ Plan Bronchscopy on Monday mny

Consultant :

Name : ..... Signature :  Date & Time : .....

31/5/26

10am . meet cough ④

o/e

chest symphy

Adv

pan Bronchiectasis tumours

Serial

*[Faint, mostly illegible handwritten notes and diagrams follow, including a large circular diagram with arrows and various scribbles.]*

EAH-00657550 IP5-00174498  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



## RESULT SHEET

Date	29/4/26				
Time	4pm.				
Hb	11.4				
PCV	35.8				
RBC	5.10				
WBC	9290				
N/L	59/36				
Platelets	4,32,000				
CRP	5				
ESR	12				
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.4				
ALP	134				
SGPT	17				
SGOT	26				
T.Bill/Conj	0.2/0.1				
T.Protein	6.9				
S.Albumin	4.3				
S.Globulin	2.6				
A/G Ratio	1.6				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	30/5/20				
Time					
CUE - Alb	Trace				
CUE - Sugar	Nil				
CUE - Ketones	-ve				
CUE - PUS Cells	2-3				
CUE - RBC Cells	0				
CUE epithelial	1-2				
Self, bile pigment	absent				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
TLC -	11.1	(5-15)			
absolute lymphocyte count	5.8	(3-9)	CD4 %	33.9	(28-47)
			CD8 %	19.2	(16-30)
absolute CD3 count	3252	(1600-4200)			
CD3 %	57	(56-75)			
absolute CD19+	2155	(370-1400)			
CD19 %	36	(14-33%)			
absolute CD56/16	179	(130-720)			
CD56/16 %	3.04	(4-17)			
absolute CD4	1932	(500-1500)			

Culture and Sensitivities : TB gene xpert - negative

PTD-2 panel -

BL c/s -

Radiology : USG : IgA : 51.6 mg/dL (14-123)

X-Ray : IgG : 831 mg/dL (424-1051)

ECHO : IgM : 118 mg/dL (48-168)

CT : IgE : 711 n/ml (0.31-29.5)

MRI

Others (ECG, Contrast Studies etc.) :

BAH-00657550 IP5-00174498  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



## 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: 203

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

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Sul

Date & Time: 30/5/26

Nurse Name & Signature: Nilevi J NF

Date & Time: 30/5/26 @ 10 AM

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 Master GANGAPRASAD RAM GORE  
 03-06-2024 2 Y O M 28 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



Sheet No: ..... REGULAR PRESCRIPTIONS Weight ..... Ward .....

DRUG: Neb. LEVOLIN				Date															
Dose	Route	Frequency	Start Dt.	Time															
1.2mg	Neb	Q8H	29/5																
Name & Signature of the Doctor Starting the Drugs:				Sai															
Additional Instructions:				1 respule = 1.2 mg															
Daily Doctor's Endorsement by a Sign																			
DRUG: Neb. BUDECORT				Date															
0.5mg	Neb	Q12H	29/5	6am															
Name & Signature of the Doctor Starting the Drugs:				Sai															
Additional Instructions:				1 respule = 0.5mg															
Daily Doctor's Endorsement by a Sign																			
DRUG: NEB LEVOLIN				Date															
0.63mg	Neb	Q8H	29/5	6am															
Name & Signature of the Doctor Starting the Drugs:				Suby..															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG: INT HYDRO CORTISONE				Date															
25mg	iv	TID	29/5	6am															
Name & Signature of the Doctor Starting the Drugs:				Suby..															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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

BAH-00657550  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 28 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight .....

Ward .....

<b>DRUG : NEB BUDECORT</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	11/6/26																	
1mg	Neb	Q12H	1/6	10am																	
Name & Signature of the Doctor Starting the Drugs: <i>Sachane</i>																					
Additional Instructions: <i>10PM</i>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG : 3% NS NEBULISATION</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	1/6																	
3ml	Neb	Q8H	1/6	6am																	
Name & Signature of the Doctor Starting the Drugs: <i>Sachane</i>																					
Additional Instructions: <i>2PM 3PM 10PM</i>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG : TOBAMIST</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	1/6																	
1/2 respule	Neb	BD	1/6	10am																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Pradyumn</i>																					
Additional Instructions: <i>1 respule = 300 mg 10PM</i>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG : SUP. AZITHROMYCIN</b>				Date Time																	
Dose	Route	Frequency	Start Dt.	1/6	2/6	3/6															
3ml	PO	once every alternate day	1/6																		
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Pradyumn</i>																					
Additional Instructions: <b>ONCE EVERY ALTERNATE DAY</b>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

Signature  
VERIFIED BY : Name

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 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



# DRUG CHART

Date of Admission: 29/5/26 Drug Allergies: None  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)

<b>DRUG :</b> <u>Syp. CROCIN DS</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>4ml</u>	<u>PO</u>	<u>SOS</u>	<u>29/5</u>																		
Doctor's Signature		Valid Period	Pharm.																		
<u>Sai</u>																					
Additional Instructions: <u>5ml = 240mg</u>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

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



REGULAR PRESCRIPTIONS

Weight. 12.6 kg... Ward. ....

<b>DRUG :</b> Inj. CEFTRIAXONE				Date Time	29/5	30/5	31/5	1/6												
Dose	Route	Frequency	Start Date	AM																
600mg	IV	Q12H	29/5	AM																
Name & Signature of the Doctor Starting the Drugs:				Sai																
Additional Instructions:				100mg/kg/day																
Daily Doctor's Endorsement by a Sign				[Signatures]																
<b>DRUG :</b> Inj. ECOMEPRAZOLE				Date Time	29/5	30/5	31/5	1/6	2/6											
Dose	Route	Frequency	Start Date	AM																
12mg	IV	Q24H	29/5	AM																
Name & Signature of the Doctor Starting the Drugs:				Sai																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				[Signatures]																
<b>DRUG :</b> Sup. AZITHROMYCLIN				Date Time	29/5	30/5	31/5	1/6												
Dose	Route	Frequency	Start Date	AM																
3ml	PO	Q24H	29/5	AM																
Name & Signature of the Doctor Starting the Drugs:				Sai																
Additional Instructions:				5ml = 200mg																
Daily Doctor's Endorsement by a Sign				[Signatures]																
<b>DRUG :</b> SUP: RELENT PLUS				Date Time	29/5	30/5	31/5	1/6												
Dose	Route	Frequency	Start Date	AM																
5ml	PO	Q12H	29/5	AM																
Name & Signature of the Doctor Starting the Drugs:				Sai																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				[Signatures]																

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 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



Weight. .... Ward. ....

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
		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.

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
		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
29/8/24	6pm	NEB BUDECORT	0.5mg	Neb	[Signature]	Narsing Kobari
29/8/24	6pm	NEB LEVULIN	0.63mg x 3 times	Neb	[Signature]	Nasima Rajay
01/06/26	2:30pm	INJ. DEXAMETHASONE	1.8mg	IV SLT	[Signature]	Imantel Duorge 3Am

Signature  
VERIFIED BY: Name



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 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 27 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE



## NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
31/5/26	00.00	Neb - Budecort 9:30pm	Pooja	
31/5/26	01.00	Neb - Levolin 10pm	Pooja	9637236
1/6/26	02.00	Neb - Levolin 7AM	Pooja	
1/6/26	03.00	Neb - Budecort - 11AM	Jyoti	
	04.00	Neb - levolin 2:20pm	Durga	9637798
	05.00	3% NS. 3PM	Durga	
1/6/26	06.00	Neb - Levolin 10PM	Pooja	
1/6/26	07.00	Neb - Tobramycin 9:15	Pooja	
	08.00	Neb - Budecort 10:30pm	Pooja	
	09.00	Neb - 3% NS 6AM	Pooja	
	10.00	Neb - Levolin 8AM		
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

BAH-00557550 IP5-00174498  
 Master GANAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 28 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE

No. : RCH/ FRM / CLINICAL / 125

29/5/26

**PRESCHOOL (1-5 years)**  
 Children's Observation &  
 Early Warning Scoring Chart

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

Date : ..... Time: 4:00 PM 6:00 PM 10:00 PM 2 AM 6 AM

Doctor / Nurse / Family Concern? ER

Temperature (F)	104				
	103				
	102				
	101				
	100				
	99				
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm)	190				
	180				
and Blood Pressure (mmHg) *	170				
	160				
Note: BP does not score in early warning scoring	150				
	140				
	130				
	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				

Heart Rate (Number)					
		120	121	123	120

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
Resp Rate (Number)	50				
	40				
	30				
	20				
	10				

Resp Distress	Mod/ Severe				
	None / Mild				
Receiving O <sub>2</sub> (l/min)		1.0	1.0	1.0	1.0
O <sub>2</sub> Saturations (%)		99	99	98	97
Conscious Level	Normal	C	C	C	C
	Altered				
GCS *		15/15	15/15	15/15	15/15

<b>TOTAL SCORE</b>					
Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>

**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.

below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

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

BAH-00657550  
 Master GANGAPRASAD RAM GORE (M)  
 03-05-2024 2 Y 0 M 26 D  
 Dr. KAPIL BHAGWAT RAO SACHANE

30/5/26

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

PRESCHOOL (1-5 years)  
 Children's Observation &  
 Early Warning Scoring Chart

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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .....	Time: <u>10am</u>	<u>2pm</u>	<u>6pm</u>	<u>10</u>	<u>2</u>	<u>6</u>
Doctor / Nurse / Family Concern?				<u>pm</u>	<u>Am</u>	<u>Am</u>
Temperature (°F)	<u>98.9</u>	<u>98.9</u>	<u>98.9</u>	<u>98.9</u>	<u>99.6</u>	<u>98.9</u>
Heart Rate (bpm)	<u>122</u>	<u>120</u>	<u>122</u>	<u>120</u>		<u>90</u>
Blood Pressure (mmHg) *	<u>102/54</u>	<u>105/62</u>	<u>112/54</u>	<u>109/62</u>		<u>*</u>
Heart Rate (Number)	<u>122b/m</u>	<u>120b/m</u>	<u>122b/m</u>	<u>120b/m</u>		<u>90b/m</u>
Resp Rate (Number)	<u>29</u>	<u>30</u>	<u>27</u>	<u>25</u>		<u>25</u>
Receiving O <sub>2</sub> (/min)	<u>R/A</u>	<u>R/A</u>	<u>R/A</u>	<u>R/A</u>		<u>R/A</u>
O <sub>2</sub> Saturations (%)	<u>98%</u>	<u>96%</u>	<u>97%</u>	<u>99%</u>		<u>97%</u>
GCS *	<u>15/15</u>	<u>15/15</u>	<u>15/15</u>	<u>15/15</u>		<u>15/15</u>
TOTAL SCORE	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		<u>0</u>
Observer's Initials	<u>NF</u>	<u>NF</u>	<u>NF</u>	<u>NF</u>		<u>NF</u>

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

\* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

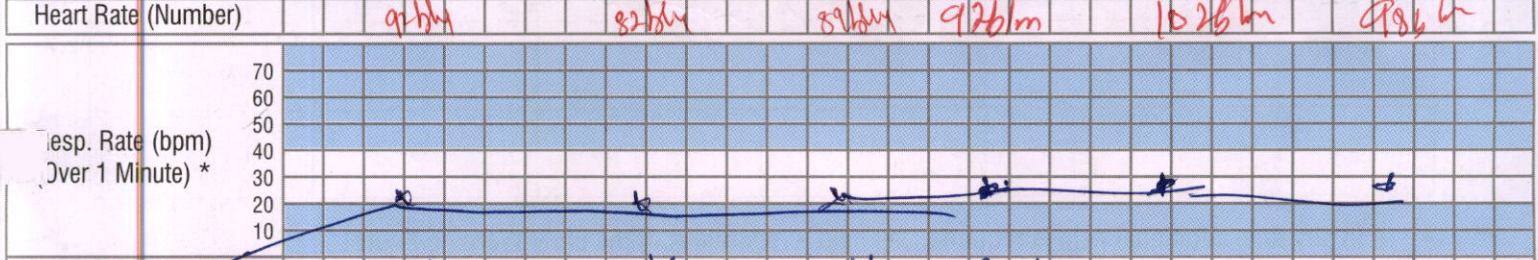
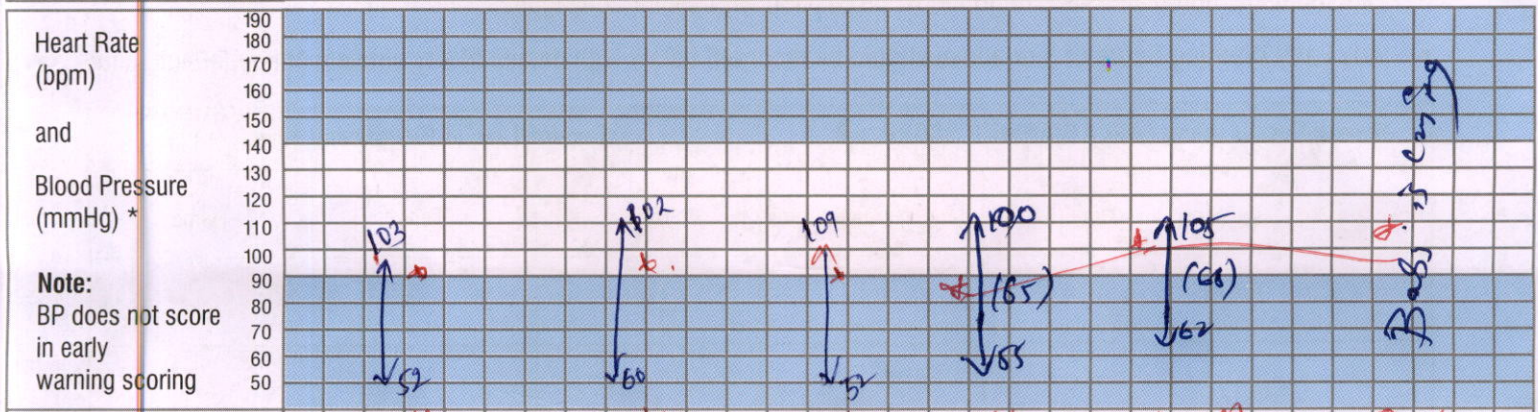
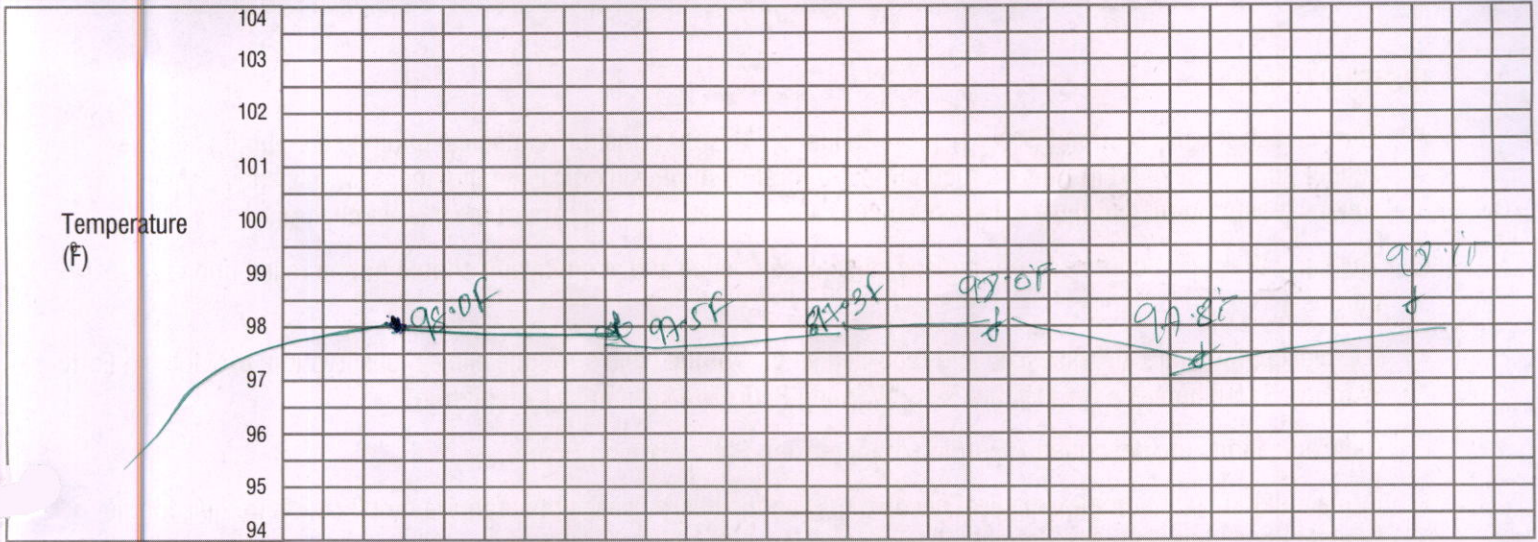
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

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

Date : ..... Time: 8 AM 12 AM 4 PM 11 PM 2 AM 6 AM

Doctor / Nurse / Family Concern? \_\_\_\_\_



Heart Rate (Number) 97 bpm 82 bpm 89 bpm 92 bpm 102 bpm 98 bpm

Resp Rate (Number) 29 bpm 28 bpm 23 bpm 24 bpm 28 bpm 23 bpm

Resp Distress: Mod/ Severe None / Mild

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

Conscious Level: Normal Altered

GCS \* (E4/V5/S5) (E4/V5/S5) (E4/V5/S5) 6/ster 6/ster 6/ster

**TOTAL SCORE**

Number of shaded boxes 0 0 0 0 0 0

Pain Score 0 0 0 0 0 0

Observer's Initials Sy Sy Sy Sy Sy Sy

**ACTIONS**

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant (till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

\* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

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

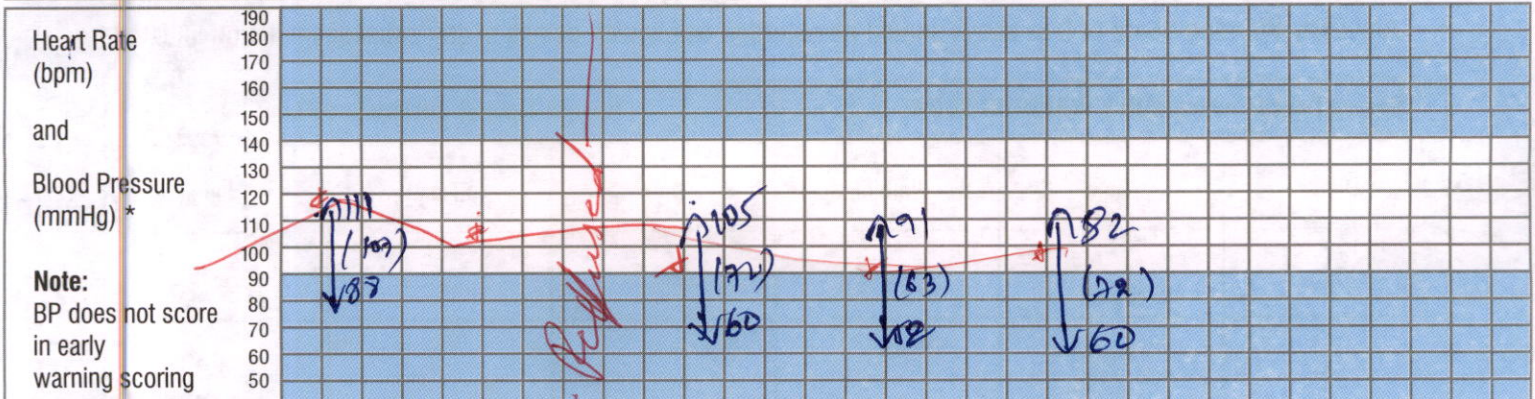
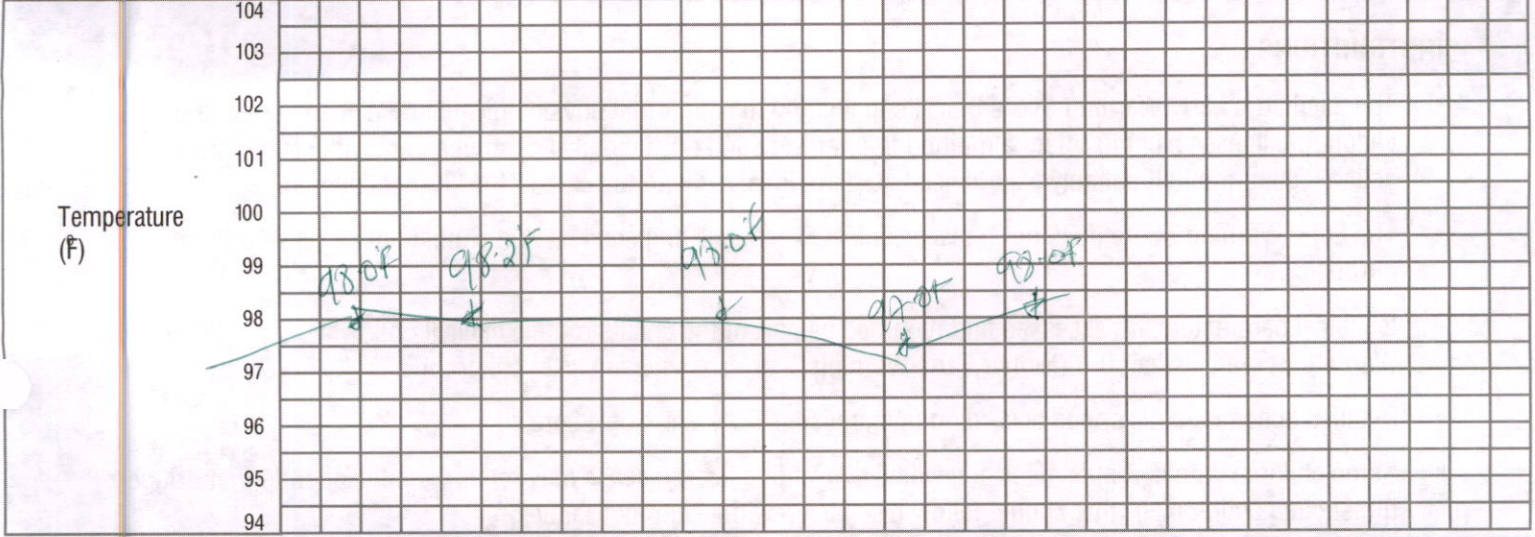


1/6/24

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

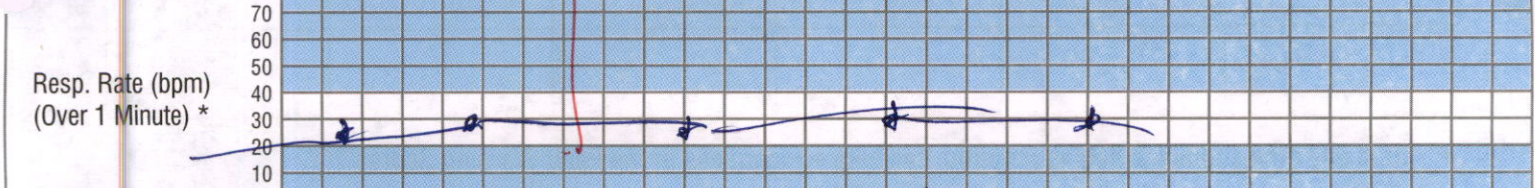
Date : ..... Time: 9AM 3PM 6PM 10PM 2AM

Doctor / Nurse / Family Concern? \_\_\_\_\_



**Note:**  
 BP does not score in early warning scoring

Heart Rate (Number) 116b/m 105b/m 98b/m 90b/m 100b/m



Resp Rate (Number) 23b/m 24b/m 23b/m 25b/m 24b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 98% 99% 97% 98% 99%

Conscious Level Normal / Altered

GCS \* 15/15 15/15 15/16 16/15 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 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

\* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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

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

Patient S

BAH-00657550  
 Master GANGAPRASAD RAM GORE  
 03-05-2024 2 Y 0 M 26 D (M)  
 Dr. KAPIL BHAGWATRAO SACHANE

**UID CHART**

Sheet No. : ..... P

29/5/26

- All measurements in ml.
- 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											
<b>Total Intake :</b>					<b>Total Output :</b>							
	02:00 pm											
	03:00 pm	↓										
	04:00 pm											
	05:00 pm	NO IVP		—							0	Rosng
	06:00 pm			—							0	Rosng
	07:00 pm	↓		—							0	Rosng
<b>Total Intake :</b>					<b>Total Output :</b>							
	08:00 pm	↓										
	09:00 pm											
	10:00 pm			30ml								
	11:00 pm	DN		30ml								
	12:00 am	↓		30ml								
	01:00 am	↓		30ml								
<b>Total Intake :</b>					<b>Total Output :</b>							
	02:00 am	↓		30ml								
	03:00 am	↓		30ml								
	04:00 am			30ml								
	05:00 am	DN		30ml								
	06:00 am	↓		30ml								
	07:00 am	↓		30ml								
<b>Total Intake :</b>					<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>		30ml			<b>Total 24 hrs. Output</b>		= 0-2 M-0					



# FLUID CHART

Sheet No. : 2

30/5/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	↑									0	Nitesh
	09:00 am	↑									0	Nitesh
	10:00 am	↑		30ml							0	Nitesh
	11:00 am	↑		30ml							0	Nitesh
	12:00 pm	↓ DNS		30ml							0	Nitesh
	01:00 pm	↓		-							0	Nitesh
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm	↑		-							0	Nitesh
	03:00 pm	↑		-							0	Nitesh
	04:00 pm	NO I.V		-							0	Nitesh
	05:00 pm	↓		-							0	Nitesh
	06:00 pm	↓		-							0	Nitesh
	07:00 pm	↓		-							0	Nitesh
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm	↑		-							0	Alexy
	09:00 pm	↑		-							0	Alexy
	10:00 pm	NO I.V		-							0	Alexy
	11:00 pm	↑		-							0	Alexy
	12:00 am	↑		-							0	Alexy
	01:00 am	↑		-							0	Alexy
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am	↑		-							0	Alexy
	03:00 am	↑		-							0	Alexy
	04:00 am	NO I.V		-							0	Alexy
	05:00 am	↑		-							0	Alexy
	06:00 am	↑		-							0	Alexy
	07:00 am	↑		-							0	Alexy
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake** 90ml

**Total 24 hrs. Output** 5ml



# FLUID CHART

Sheet No. : 5 .....

31/5/26

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 Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am									0	Sangee	
	09:00 am	No	H <sub>2</sub> O							0	Sangee	
	10:00 am	IV							✓	0	Sangee	
	11:00 am	fluid	H <sub>2</sub> O						✓	0	Sangee	
	12:00 pm								✓	0	Sangee	
	01:00 pm		H <sub>2</sub> O							0	Sangee	
<b>Total Intake :</b>					<b>Total Output :</b>					U-2	m-1	
	02:00 pm									0	Sangee	
	03:00 pm	No	H <sub>2</sub> O						✓	0	Sangee	
	04:00 pm								✓	0	Sangee	
	05:00 pm	IV	H <sub>2</sub> O							0	Sangee	
	06:00 pm	fluid								0	Sangee	
	07:00 pm		H <sub>2</sub> O							0	Sangee	
<b>Total Intake :</b>					<b>Total Output :</b>					U-1	m-1	
	08:00 pm									0	Pooja	
	09:00 pm		milk						✓	0	Pooja	
	10:00 pm									0	Pooja	
	11:00 pm									0	Pooja	
	12:00 am		milk						✓	0	Pooja	
	01:00 am									0	Pooja	
<b>Total Intake :</b>					<b>Total Output :</b>					U-2	m-0	
	02:00 am									0	Pooja	
	03:00 am									0	Pooja	
	04:00 am	?	NPO	30ml						0	Pooja	
	05:00 am	?	NPO	30ml					✓	0	Pooja	
	06:00 am	?	NPO	30ml						0	Pooja	
	07:00 am	?	NPO	30ml						0	Pooja	
<b>Total Intake :</b>					<b>Total Output :</b>					U-1	m-0	
<b>Total 24 hrs. Intake</b>					<b>Total 24 hrs. Output</b>					U-7	m-3	



# FLUID CHART

Sheet No. : ..... *11/6/26*

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
<i>11/6/26</i>	08:00 am		<i>WFO</i>	<i>30ml</i>						<input checked="" type="checkbox"/>	0	<i>Jullu</i>	
	09:00 am	<i>DNS</i>	<i>WFO</i>	<i>30ml</i>							0	<i>Jullu</i>	
	10:00 am	<i>DNS</i>	<i>WFO</i>	<i>30ml</i>							0	<i>Jullu</i>	
	11:00 am	<i>DNS</i>									0	<i>Jullu</i>	
	12:00 pm										0	<i>Jullu</i>	
	01:00 pm										<input checked="" type="checkbox"/>	0	<i>Jullu</i>
<b>Total Intake :</b>						<b>Total Output :</b>						<i>U-1</i>	<i>M-0</i>
	02:00 pm	<i>AZO</i>					<i> </i>				0	<i>Durga</i>	
	03:00 pm	<i>Sally</i>					<i> </i>			<input checked="" type="checkbox"/>	0	<i>Durga</i>	
	04:00 pm		<i>stop</i>				<i>mp</i>				0	<i>Durga</i>	
	05:00 pm						<i> </i>				0	<i>Durga</i>	
	06:00 pm						<i> </i>			<input checked="" type="checkbox"/>	0	<i>Durga</i>	
	07:00 pm						<i> </i>				0	<i>Durga</i>	
<b>Total Intake :</b>						<b>Total Output :</b>						<i>U-</i>	<i>M-</i>
	08:00 pm						<i> </i>				0	<i>poopi</i>	
	09:00 pm						<i> </i>				0	<i>poopi</i>	
	10:00 pm		<i>stop</i>				<i>mp</i>			<input checked="" type="checkbox"/>	0	<i>poopi</i>	
	11:00 pm						<i> </i>				0	<i>poopi</i>	
	12:00 am						<i> </i>				0	<i>poopi</i>	
	01:00 am						<i> </i>			<input checked="" type="checkbox"/>	0	<i>poopi</i>	
<b>Total Intake :</b>						<b>Total Output :</b>						<i>U-2</i>	<i>m-0</i>
	02:00 am										0	<i>poopi</i>	
	03:00 am										0	<i>poopi</i>	
	04:00 am		<i>stop</i>								0	<i>poopi</i>	
	05:00 am									<input checked="" type="checkbox"/>	0	<i>poopi</i>	
	06:00 am						<input checked="" type="checkbox"/>				0	<i>poopi</i>	
	07:00 am										0	<i>poopi</i>	
<b>Total Intake :</b>						<b>Total Output :</b>						<i>U-1</i>	<i>m-1</i>

**Total 24 hrs. Intake**

**Total 24 hrs. Output** *U-6 m-4*

**Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION**

BAH-00657550 IP5-00174498  
Master: GANGAPRASAD RAM GORE  
03-05-2024 2 Y 0 M 27 D (M)  
Dr. KAPIL BHAGWATRAO SACHANE



Name: Gangaprasad Ram Gore Age: 2y Sex: M UHID.No: BAH-00657550  
Date: 21/5/26 Time: 5:45pm Proposed Operation: Bronchoscopy  
Diagnosis: wheeze Ass. lower respi infection (WARI)  
B.P: 96/60 H.R: 86 Weight: 12.6kgs ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

Hgb: 11.4 Glucose: ..... Protein: ..... HIV: ..... X-Ray: .....  
PCV: ..... Urea: ..... Alb: ..... HBS Ag: ..... ECG: .....  
WBC: 2290 Creat: 0.4 Total Bill: ..... HCV: ..... 2D Echo: .....  
Plate: 432 Na: ..... Dir. Bill: ..... Blood group: ..... Stress/Anglo: .....  
PT: ..... K: ..... LDH: ..... T3: ..... Other: .....  
PTT: ..... Ca++: ..... Alk phos: ..... T4: ..... CECT chest - 1 @ ML & L  
INR: ..... Mg++: ..... Amylase: ..... TSH: ..... atelectasis  
Cl -: ..... SGOT/SGPT: .....

Allergies: NIL

Medical History: CVS: -  
RESP: Admission for recurrent LRTI & Diabetes: nil  
CNS: admission for the same  
Renal: /  
Hepatic / GE: nil Physical Activity: active  
Others: /

Past Anaesthetic History: CECT & sedation / rhinoscopy

Physical Exam:  
Airway: MP 1 2 3 4 Mouth Opening: ..... Mentohyoid Distance: ..... Neck: ..... Teeth: .....  
Lungs: conducted sounds (+) SpO2 - 96-98% on RA  
Heart: 4hr (+)  
CNS: active

Pregnant:  Yes  No  NA Venous Access Site: access site Spine Exam for regional: well felt  
Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
<u>Neb Revolin</u>	
<u>Budecort</u>	

- Pre-Operative Instructions:**
- DVT Prophylaxis: Water / ORS 2 Hours → 8AM
  - NIL ORAL → Others 6 Hours → 4AM
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions: → TO continue nebulisation

Signature: [Signature] Name: Dr. Akhilesh K









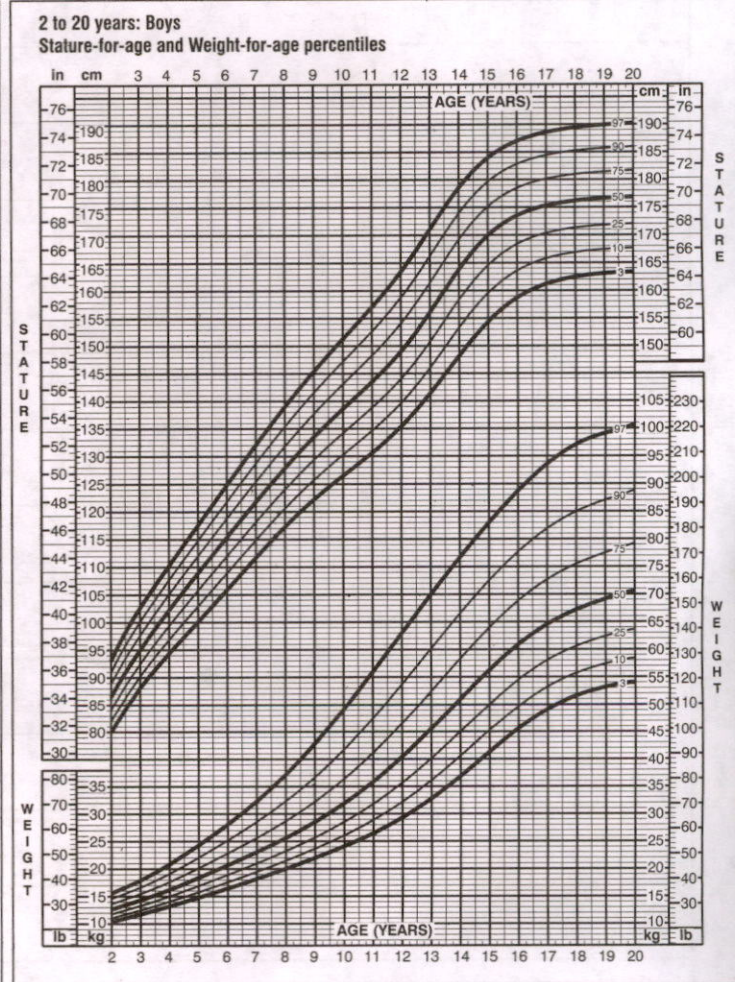
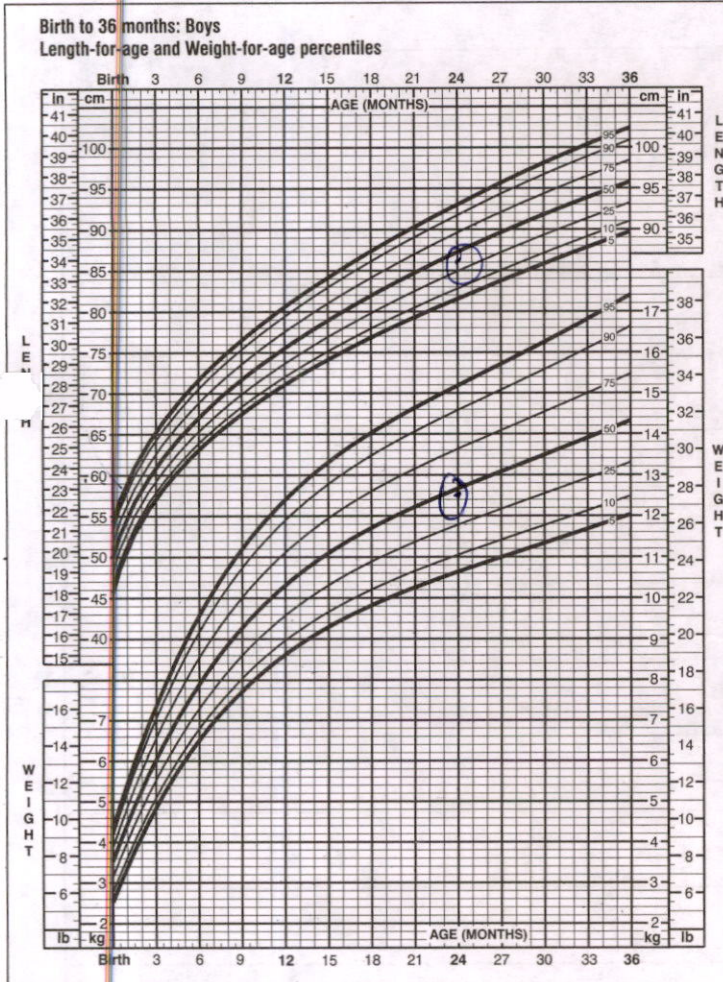
203 → 201 → 301

## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 29/5/26 Time: 5pm

Weight: 12.58 kgs Centile: >25<sup>th</sup>  
 Height: 86 cms Centile: >25<sup>th</sup>  
 Inference: Well child  
 RDA: - Calories: 1200 kcal/d Protein: 21g/d  
 Diet Recommendations: Soft high protein diet  
 Re-Assessment: Avoid spicy, Chilled, outside foods  
 Food Allergies: No Veg/Non-veg: Non-Veg  
 Diagnosis: LRTI  
 Nutritional Intervention -  Oral  Enteral  Parenteral  
 Patient's Signature: *P. Gore*

### GROWTH CHART (BOYS)



Dietician's Name: *Nikitha*

Dietician's Signature: *Nikitha*

Daily Notes:

30/5/26  
10am

Child is stable. Child is on NPO

Hospital

31/5/26

Child is stable, can start f

10am

soft high protein diet

saip

**Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION**

BAH-00657550 IP5-00174498  
Master GANGAPRASAD RAM GORE  
03-05-2024 2 Y 0 M 26 D (M)  
Dr. KAPIL BHAGWATRAO SACHANE



Name: MASTER GANGAPRASAD Age: 2 Y 0 M 26 D Sex: M UHID No: BAH 00657558

Date: 30/5/26 Time: 12.53 Proposed Operation: CECT

Diagnosis: LRTT HD recurrent episodes

B.P / CRT: 100/69 H.R: 120/min Weight: 12.6 ASA Physical Status:  1  2  3  4  5

20/11/24

**Laboratory Data:**

Hgb: 11.4 Glucose: ..... Protein: 6.9 HIV: ..... X-Ray: .....  
PCV: 35.8 Urea: ..... Alb: 4.3 HBS Ag: ..... ECG: .....  
WBC: 9290 Creat: 0.5 Total Bill: 17.02/0.1 HCV: ..... 2D Echo: .....  
Plate: 4,32,000 Na: ..... Dir. Bill: 0.2 Blood group: ..... Stress/Angio: .....  
PT: ..... K: ..... LDH: ..... T3 ..... Other: .....  
PTT: ..... Ca++: ..... Alk phos: ..... T4 .....  
INR: ..... Mg++: ..... Amylase: ..... TSH .....  
CRP: 5 Cl: ..... SGOT/SGPT: 17/24

Allergies: No known allergy

Medical History: CVS: -

RESP: recurrent 3 times on O2 Diabetes: -

CNS: - Pneumonia admission

Renal: - frequent

Hepatic / GE: - Physical Activity: Playful Ndu

Others: -

Past Anaesthetic History: pneumonia - uneventful

Physical Exam:

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

Lungs: RRBBB, conducted sound

Heart: S1S2

CNS: SVAD

Pregnant:  Yes  No  NA Venous Access Site: UL Spine Exam for regional: 200

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

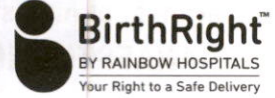
Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
HYDROCLORT	IID 15mg
CEFRITAXONE 800mg	BD
Inj AZITHROMYCIN	Q24
Neib Budenort	-
ferolem	-

- Pre-Operative Instructions:**
- DVT Prophylaxis :
  - NIL ORAL  $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions:

Signature: Adeli Name: Dr Adeli

**ANAESTHESIA CHART**



**Pre Induction Assessment:**

**Change in Patient Condition:**  Yes  No      **Fasting Status:** confirmed

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

H.R: 106/min      B.P / CRT:      SpO<sub>2</sub>: 100.1      R.R: 20/min      Last Feed: 6 hrs.  
 Pre-OP Diagnosis: Recurrent LRTI      Operation: CECT chest      Date: 30/05/2026

Surgeon: \_\_\_\_\_      Anaesthesiologist: Dr. Tejaswini      Technician: Prashanth

TIME											
N <sub>2</sub> O / AIR / O <sub>2</sub> LPM	<u>2pm 2:15pm</u>										Antibiotic
HALO / SO / SEVO											Suppository
Drugs:											Blood Loss
<u>MIDAZOLAM 0.6mg</u>											
<u>PROPOFOL 30mg</u>											
<u>GLYCOPROLATE 60mcg</u>											
<u>KETAMINE 5mg</u>											
FiO <sub>2</sub> / SaO <sub>2</sub>	<u>99 100</u>										
ETCO <sub>2</sub>											
ECG	<u>▶</u>										
Temperature											
Urine Output											
Fluids											
Blood											
B.P											
V Systolic											
A Diastolic											
X Mean											
• Heart Rate											
Tourniquet on Time											
Tourniquet off Time											
Throat Pack In											
Throat Pack Out											

**LAB Values**  
 ABG: \_\_\_\_\_  
 GRBS: \_\_\_\_\_  
 Others: \_\_\_\_\_

<input type="checkbox"/> Equipment Checked and Functional <input type="checkbox"/> BP <input type="checkbox"/> Cuff Site: _____ <input type="checkbox"/> Art Site: _____ <input type="checkbox"/> EKG Lead <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO <sub>2</sub> Monitor <input type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator  <b>Position:</b> <u>Supine</u> <input type="checkbox"/> Pressure Points Checked  <b>Eye Care:</b> <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input type="checkbox"/> Awake	<b>Temp:</b> <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other .  <b>Times:</b> Anaes Start: <u>2pm</u> OP Start: _____ OP End: _____ Leave OR: <u>2:15pm</u>  <b>Anaesthesia:</b> <input type="checkbox"/> GA <input checked="" type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional  <b>Line (Size &amp; Location)</b> <input type="checkbox"/> CVP: _____ <input type="checkbox"/> ART: _____ <input type="checkbox"/> IV: _____ <input checked="" type="checkbox"/> IV: <u>22G 10 UL</u> <input type="checkbox"/> IV: _____	<b>Induction</b> <input type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI <input type="checkbox"/> Others  <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____ <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	<b>Regional:</b> Extremity _____ Specify: _____ <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: _____ Position: _____ <b>Site:</b> Needle Size: _____ Depth: _____ Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: _____ Bolus: _____ Infusion: _____ Block Level: _____ Comments: _____ Transportation to <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input checked="" type="checkbox"/> Other <u>ward</u> Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Name of the Doctor: <u>Dr. Tejaswini</u> Signature of the Doctor: _____
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Patient Sticker

### POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....

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

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0						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:
Ability to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0						
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0						
Fully awake = 2 Arousable on calling = 1 Not responding = 0						
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0						
TOTAL						

#### PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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 relieving intervention
  - d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

Transferred to Unit by (PACU): .....

Date & Time: .....



Patient

BAH-00657550 IP5-00174498  
Master GANGAPRASAD RAM GORE (M)  
03-05-2024 2 Y 0 M 28 D  
Dr. KAPIL BHAGWATRAO SACHANE



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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

80551

### SURGERY DETAILS

Sketcher

Date : 1/6/26

Patient Name: Master Ganga Prasad Ram Date of Birth: 3/15/24 Age: 2 Y

Gender: M Ward: P. OT UHID No: 00657550

Date of Surgery: 1/6/25  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Flexible bronchoscopy & BAL

Time in : 11:40 AM

Time Out : 12:20 AM

	NAME	AMOUNT
1. Surgeon	<u>Dr Naveen Saradhri</u>	
2. Anaesthetist	<u>Thirajuni</u>	
3. Assistant Surgeon		
4. OT Technician	<u>Prashant</u>	
5. Circulating Nurse	<u>Divya</u>	
6. Assistant Nurse	<u>Arjun</u>	

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

Signature of the Surgeon Naveen Saradhri

Signature of Circulating Nurse Divya

Order No: 9637851

Order by: Divya

IP5-00174498  
 Master GANGAPRASAD RAM GORE (M)  
 13-05-2024 2 Y 0 M 29 D  
 Dr. KAPIL BHAGWATRAO SACHANE

BRONCHOSCOPY Flexible

CONSUMABLES OF OT



Technician: Prashanth Date: 01/6/2026 Time: 10AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 3.5, 4, 4.5	44	—	Major Pack			Inj Vit.K		
LMA 1 1/2, 2	14	—	Sutures			Cord Clamp		
ECG leads : A, P, N	05	—				Suction Catheter		
HME filter : A, P, N	01	—				Feeding Tube		
Syringes : 10 cc	10	3				Vacuum Suction Set		
05 cc	10	3	Gloves 6.6 1/2 7-7 1/2	2+2	3	Surgical Gloves		
02 cc	10	3	Pf. 6.6 1/2 7-7 1/2	2+2	—	Gauze Pack		
01 cc	05	—				Syringe 1ml / 2ml		
Cautery plate : A, P, N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			Inj. Adrenaline	1	—
NS : 10ml / 100ml / 500ml / 1000ml	01	1	Koochies			Int. Mucomix	1	1
Mini Spike	01	1	Ointments			Mucus extractor	2	2
O2 mask (P)	01	—	Suction Catheter			NS 500ml	1	1
Fentanyl	01	1	Cap, Mask	5	3/5	100cc + 5cc	2+2	3
Morphine			Gauze Pack	5	3	Jelly	1	1
Ketamine			Mop Pack	1	—			
Propofol	03	2	Steristrip					
Rocuronium	01	—	Underpad					
Glycopyrolate	01	0	Draw sheet	1	1	Gauze + Gloves all	4+4	—
Myopyrolate / New	1+2	—	Abgel			Deza + Tranexa	1+1	1+1
Ondansetron	01	—	Foleys catheter			Dermed 50mg	1	1
Pencan 25g / Spinal Needle 22			Urobag			50cc + pmo line	1+1	1+1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			Midazolam	01	1
Bupivacaine 0.25% (Heavy)			Romodrain bag			Nasal pronz etes (P)	01	1
Antibiotics IV pcm	01	—	Bandage			Adrenaline + Atropine	1+1	—
			Tegaderm			Ephedrine	01	—
Suppositories			loban			Loz 2% + Jelly	1+1	—
Anamol : 80mg / 250mg / 170 mg			Double J Stent			NG tubes all	6	—
Supridol : 100mg			Vacuum Suction set	1	1	Suction catheters all	5	—
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	1	Orsite + Sptent 1,3	1+1	—
Tab. Misoprost : 200mg			Betadine Solution					
Vacuum set	01	1	Microshield	1	—			
Oral airway 1,2	1+1	—	Cotton Balls					
Nasal airway 16,18	1+1	1+1	Latex Gloves	10	10			
IV cannula 22,24	1+1	—	Ramdone Scrub					
Zway wamt 100cm	1+1	—	Saral					

Surgeon: \_\_\_\_\_ Anaesthesiologist: 9637617  
 Order No.: \_\_\_\_\_ Ordered by: Nurse Thya  
 Doc. No.: RCH / FRM / GENERAL / 125 OT Technician: \_\_\_\_\_

**ESTIMATION SLIP**

(F/C for only)  
 no ledger led

80551

Date: 01/06/2026 WHID / IP No.: BAH-0065755 Sl No. 80551  
 Name of Patient: Master. Ganga Prasad Rom Age: 6yr Gender: \_\_\_\_\_  
 Father's / Husband's Name: Mr. Rom Ganga Prasad Rom Corporate / Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: 9975020860 Email: \_\_\_\_\_  
 Procedure / Plan: Medialux + Bronchoscopy + BAL

MODE OF PAYMENT:  SELF  TPA: Star health  GIPSA: \_\_\_\_\_  OTHERS: C/S (Government)

**TARIFF INFORMATION :**

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE	
											AMOUNT (₹)
Room Rent & Nursing Charges											
Doctor's Fee				✓							
L. Tax											
PARTICULARS						AMOUNT (₹)					
Surgeon's / Anesthetists's Fee / O.T. Charges						Act. SF + ASF = 25341					
O.T. Consumables						Subject to approval by TPA / Insurance Company					
Instrument Charges						Not Covered by TPA / Insurance company					
Pharmacy, Consumables & Investigations						As per actual - Not Included in Estimation					
Equipment Charges	Monitor :			Oxygen			Infusion pump / Syringe pump :				
	Ventilator :		Conventional :		HFO-SLE 5000 :		HFO Sensormedix :				
	Phototherapy :		Single Surface :		Double Surface :		Triple Surface :				
	Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.						As per actual - Not Included in Estimation				
Package						15,000 ₹ Final bill clear.					
Others											
Initial Minimum Deposit											

REMARKS: Int 206. C.B. 1.90L

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicinals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm.
- Difference, if any between the final bill amount and amount permitted, approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and P+T Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

**DECLARATION**  
 I, Mr. Rom Ganga Prasad Rom have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client: \_\_\_\_\_ Signature of the Financial Counselor: \_\_\_\_\_