LBH-00073554 IP5-00176185
Baby K DRUTHI
24-05-2022 4 Y 1 M 16 D (F)
Dr. SRINIVAS NAMINENI

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SURGERY DETAILS

Date : 10/7/26

Patient Name: Baby . K. Druthi Date of Birth: 24/5/2022 Age: 4years

Gender: Female Ward : OT-II UHID No.: LBH-00073554

Date of Surgery: 10/7/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB

Time in : 8:30Am Time Out : 9:45Am

		NAME	AMOUNT
1.	Surgeon	SRINIVAS . N	D . R . T
2.	Anaesthetist	DR. Durga Bhavani	
3.	Assistant Surgeon		
4.	OT Technician	Gowtami	
5.	Circulating Nurse	Jyothi	
6.	Assistant Nurse	Divya	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others COLLECT 9000/- FOR CROWNS

Signature of the Surgeon

Jyothi
Signature of Circulating Nurse

Order No: 969873 Order by: Ramani

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

Patient Sticker

6606 4 | 15Kg
Dr Bruthi

Comprehensive Oral Rehabilitation

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CONSUMABLES OF OT

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

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4 / 4.5 / 5-5	1+1+1	1	Major Pack Drape	1	1	Inj Vit.K		
LMA	01	–	Sutures			Cord Clamp		
ECG leads : A / P / N	05	3				Suction Catheter		
HME filter : A / P / N	01	1				Feeding Tube		
Syringes : 10 cc	15	8				Vaccum Suction Set		
05 cc	15	8	Gloves			Surgical Gloves		
02 cc	15	[illegible]	6, 6½, 7, 7½	2+2	1+1	Gauze Pack		
01 cc	02	[illegible]	DF 6, 6½, 7, 7½	2+2		Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	[illegible]	Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube			Koochies (S)		
RL	01	1	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	4+1	1	Koochies			Inj. [illegible] c 10K	1	1
Kaini & spike	01	1	Ointments			26 g needle	1	1
O2 Mask (P)	01	1	Suction Catheter			10cc, 2cc, 5cc	2+2	0
Fentanyl	01	1	Cap, Mask	5/5	4/8	Throat pack	1	1
Morphine			Gauze Pack	5+5	4			
Ketamine			Mop Pack	1				
Propofol	03	1	Steristrip					
Rocuronium	01	1	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1	1			
Myopyrolate (Neo)	02	2	Abgel					
Ondansetron	01	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22	01	–	Urobag					
Bupivacaine 0.25%	01	–	Chest Drainage Catheter			Adrenaline + Atropine	1+1	1+1
Bupivacaine 0.25%(Heavy)	[illegible]		Romodrain bag			Midaz + Ephedrine	1+1	1+1
Antibiotics Inj pm	01	1	Bandage			NG + suction	all	–
			Tegaderm			QSet + Spike [13]	1+1	–
Suppositories			Ioban			gauge + gloves	4+4	–
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Dexa + Tranexa	1+1	1
Supridol : 100mg			Vaccum Suction set	1	1	Dexmed	01	–
Justin : 12.5 mg / 25mg / 100mg	01	–	Plastic Bed Sheet	1	0			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Vaccum set	01	1	Microshield	1	0			
2 ways 10 + 100cm	1+1	1	Cotton Balls	1	0			
O.A [0, 1]	1+1	–	Latex Gloves	1	1+0			
N.A [16, 20]	1+1	1	Ramdione Scrub					
IV Cannula [20, 24]	1+1	–	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9695896 Ordered by : ....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176185 **Admit Date** : 10-Jul-2026 **Admit Time** : 06:54 AM **UHID** : LBH-00073554

Patient Details :

Patient Name	: Baby K DRUTHI	**Age**	: 4 Y 1 M 16 D
Guardian	: Mr K SIVA KUMAR	**DOB**	: 24-05-2022
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: B-1366, NGO'S COLONY Vanasthalipuram Hyderabad Telangana INDIA 500070	**Phone No**	: 9398506866
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 404 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 404 **Admission Type** : First Visit

Contact Details :

Name : Mr K SIVA KUMAR **Relationship** : Father

Contact Address : B-1366, NGO'S COLONY Vanasthalipuram Hyderabad Telangana INDIA 500070 **Phone No** : 9398506866

Signature

Doctor Details :

Doctor Name : Dr. SRINIVAS NAMINENI **Specialisation** : DENTAL

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : Druthi

LBH-00073554 IPS-00176185
Baby K DRUTHI
24-05-2022 4 Y 1 M 16 D (F)
Dr. SRINIVAS NAMINENI

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	7:30pm	ER	OT	Druthi
10/7	11:Am	OT	billing	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
10/7/26	CBR	8857	Charan

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/4/26	IV placement PAC OP basis.	(1)	5624	Charan

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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OPERATION THEATER NOTES

Patient's Name : Baby K. Druthi Age : 4year Gender : ☐ Male ☑ Female

UHID No.: LBH-00073554 Weight : 15.31kg Height : ....

Surgeon : Dr. Srinivas Namineni	Asst. Surgeon :	
Anesthetist : Dr. Durga Bhavani	OT Nurse: Durga/Jyothi	OT Technician: Gowtami

Pre-Operative Diagnosis:

Surgical Procedure :
COMPREHENSIVE ORAL REHAB.

Indications for Surgery :
EARLY CHILDHOOD CARIES.

Date : 10/7/26	Start Time : 8.42am	End Time :

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:
U/G G.A WITH NTI
RADIOGRAPHIC EXPOSURE

- RESTORATIONS ON 54,64
- ZIRCONIA CROWNS IN [illegible]
on 52,51,61
- EXTRACTION OF 62

SOFT DIET
GENTLE BRUSH | 3 DAYS

& BUDS IN 3 DAYS.

& SYRUP ISUPRIC PLUS
5ml 1-1-1 x 3 DAYS.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: SRINIVAS.

Signature of the Surgeon: .....

Date & Time: .....

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POST-SURGICAL CARE PLAN FORM

Procedure Done: .....

Post-Surgical Diagnosis: .....

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: ..... Time: .....

Note: Plan of care will be readjusted if necessary.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	SIB Resident-	
10/5/22	Dental caries for	Plan.
	D: comprehensive oral	(1) Cont. NPO
	Rehabilitation.	(2) IV Fluids
		(3) Shift to OT on call
	No c/o cold, cough,	(4) CBP
	fever	(5) IV cannulation
	O/E- child alert	
	vitals stable	
	CVS- S1S2 (N)	
	RS- BIL AE (+)	
	P/A- Soft	
		Madhu

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

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 : T. Pavani

Date & Time : 10/7/26 @ 7 AM

Nurse Name & Signature: Rakesh KG

Date & Time : 10/7/26 @ 7:30 AM

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DRUG CHART

Date of Admission: 10/7/26 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:				

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

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REGULAR PRESCRIPTIONS

Weight. 15.38kg Ward. ....

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

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

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

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

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IP5-00176185
4 Y 1 M 16 D (F)

Weight. ..... 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
10/7	8:35AM	INJ PARACETAMOL	225MG	IV		
10/7	8:40AM	INJ. DEXAMETHASONE	1.5MG	IV		
10/7	9:35AM	INJ ONDANSETRON	1.5MG	IV		

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

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I.V. FLUIDS CHART

Weight. 15.38 kgs Ward. .....

		Name of I.V. Fluid (ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
10/7/26		DNS	I/V	40ml/hr					
10/7	8:30AM	RINGER LACTATE	IV	150			10/7		

Signature .....

VERIFIED BY : Name .....

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RESULT SHEET

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

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake				Output						
		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**	

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FLUID CHART

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Sheet No. : .....

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

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

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

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Baby K Druthi Age: 4yr Sex: f UHID.No: RBH 00073554

Date: 8/7/26 Time: 5:55pm Proposed Operation: Comprehensive Oral Rehabilitation

Diagnosis: Dental Caries

B.P / CRT: 100/61 H.R: 113 Weight: 15.2kg ASA Physical Status: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.8	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC: 10.86K	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 3.18Lakh	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: NKDA

Medical History: CVS: (-)

RESP: (-)

CNS: (-)

Renal: (-)

Hepatic / GE: (-)

Others: (-)

FT/NVD/AGA/CLAB/No NICU/NNJ phototherapy, Immunisation updated/Milestones updated

Diabetes: (-)

Physical Activity: Active & healthy

Past Anaesthetic History: (-)

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 3F (+) Mentohyoid Distance: (N) Neck: (N) Teeth: No loose teeth Dental Caries.

Lungs: BAE (+), clear

Heart: RRS (-)

CNS: Clear, Oriented

Pregnant: ☐ Yes ☐ No ☑ NA

Venous Access Site: (+)

Spine Exam for regional: Spine palpable

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 (NBM >6hrs solids, >2 hrs clear liquids)
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions: CDP - Consultation

Signature: Name: Dr. Durga Bhavani

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ANAESTHESIA CHART

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Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Confirmed
Physical Status:	☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 106 | B.P / CRT: 90/68 | SpO_2: 100% | R.R: 26 | Last Feed: >6 hrs

Pre-OP Diagnosis: Dental Caries | Operation: Comprehensive Oral Rehabilitation | Date: 10/7/22

Surgeon: Dr. Srinivas Naminemi | Anaesthesiologist: Dr. Ravi / Dr. Durga Bhavani | Technician: Chanthoni

TIME	8:30AM		9:30AM	
N_2O (AIR /O_2 LPM)	3/.	→	→	→
HALO /SO (SEVO)	3/.	→	→	→
Drugs:				
IV. MIDAZOLAM				
IV. FENTANYL 30MG iv				
IV. PROPOFOL 50MG + 20MG iv.				
IV. DEXAMETHASONE 1.5MG iv				
IV. ROCURONIUM 7MG iv				
IV. PARACETAMOL 222.5MG iv				
IV. ONDANSETRON 1.5MG iv.				
FIO_2 / SaO_2	99%	99%	99%	99%
$ETCO_2$	33	33	32	33
ECG	NSR	NSR	NSR	NSR
Temperature	36.5	36	36	
Urine Output				
Fluids / Blood	RL @ 150ml/hr			

Antibiotic

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: RLL
☐ Art Site:
☑ EKG Lead Checked
☑ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: SUPINE
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 8:30AM
OP Start: 8:45AM
OP End:
Leave OR: 9:45AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: LUL
☐ IV:
☐ IV:

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 4.5 at 19 cm
☐ Oral ☑ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: Rocuronium

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 1
Difficulty Why?

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

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor Dr. Durga Bhavani
Signature of the Doctor

LBH-00073554 IP5-00176185
Baby K DRUTHI
24-05-2022 4 Y 1 M 16 D (F)
Dr. SRINIVAS NAMINENI

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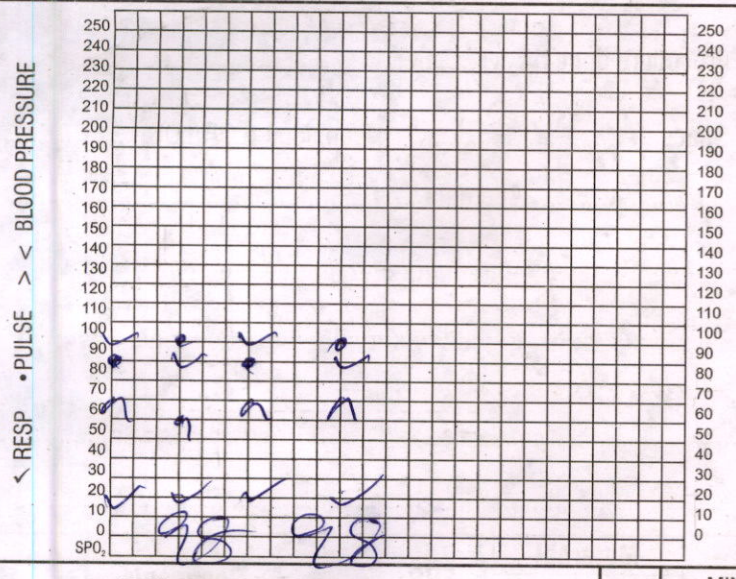
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 9:50Am Time Discharged : .....



IV Cannula Site : RFG

- ☐ O_2 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: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	1	2	2	
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	1	1	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2	
		TOTAL	8	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
10/7	9:50A	1/10	—	

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

Anaesthesiologist Name : Dr. Durga Bhavani
Anaesthesiologist Signature: .....
Date & Time: 10/7/26

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 10/7/26 1PM

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

Transferred to Unit by (PACU): billing
Date & Time: 10/7/26 1PM

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

Patient Sticker

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: Comprehensive Deaf Rehabilitation

Anaesthesiologist: Dr. Durga Bhavani Surgeon: Dr. Srinivas Nanireni

Please read this before you consent for Anaesthesia

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

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Hemodynamic changes, O_2 support

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☑ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: K. Sivakumar

Name: KOMARA SIVA KUMAR

Relationship with patient: father

Date & Time: 8/7/26 6:20pm

Witness:

Signature: Ch. Durga Bhavani

Name: Durga Bhavani

Date & Time: 8/7/26 6:20pm

Doctor (who is taking consent):

Signature: Name: Dr. Durga Bhavani Date 8/7/26 Time: 6:20pm

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

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

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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