



Entered

FC not done **SURGERY DETAILS**

Date : 6/7/26

Patient Name: Mr. Aayush Rathod Date of Birth: Age: 9y

Gender: Male Ward : P.O.T UHID No.:

Date of Surgery: 6/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Desmolt + Reconstruction of upper lip & lateral of gingiva + HA

Time in : 10:30am Time Out : 11:30am

	NAME	AMOUNT
1. Surgeon	Dr. G. S. Gnaneshwar	11,20,000 + Emergency for general ward
2. Anaesthetist	Dr. Sri Ramya	
3. Assistant Surgeon		
4. OT Technician	Nishantha	
5. Circulating Nurse	Kalyan	
6. Assistant Nurse	Ramadevi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9691138

Order by: Kalyan

MLC

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission: _____

Room / Bed No : _____

BAH-00349164 IP5-00176054
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR



Consultant: _____

Dept : _____

Date of Discharge : _____

Time: _____

Ward : _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/12/26	10:15pm	ER	OT	Lachel
7/12/26	12:30am	OT	102	Kel

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Duttala man	4/11/26	9691222	id
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Signature

CBP

777

Phorum

CONSUMABLES OF OT

Circulating staff :

Technician :

Date :

Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 5.5-5.6	144	—	Major Pack			Inj Vit.K		
LMA 3	01	—	Sutures			Cord Clamp		
ECG leads : A/P/N	575	03	PDS 6-0, 7-0	252		Suction Catheter		
HME filter : A/P/N	141	—	Wet 5-0, 6-0 (4-0)	20	1	Feeding Tube		
Syringes : 10 cc	80	6	9915	1	1	Vaccum Suction Set		
05 cc	80	4	Gloves			Surgical Gloves		
02 cc	80	4	6, 6 1/2, 7, 7 1/2	242		Gauze Pack		
01 cc	10	—	PF 6, 6 1/2, 7, 7 1/2	20	14	Syringe 1ml / 2ml		
Cautery plate : A/P/N	01	—	Surgical blade 115	141	1	Surgical Blade # 20		
IV set + blood set	141	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil	1		NS 500ml	1	1
NS 10ml / 100ml / 500ml / 1000ml	541	0	Koochies			Tranex	1	1
mini spike	01	01	Ointments			1000, 500, 250	242	1
Gauze	03	02	Suction Catheter			Ang. line catheter	1	1
Fentanyl	01	01	Cap, Mask	5/8	5/8	26 g needle	1	1
Morphine			Gauze Pack	545	3/2	5th	1	—
Ketamine			Mop Pack	1	1			
Propofol	03	02	Steristrip					
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	01	Draw sheet	1	1			
Myopyrolate + NEO	142	—	Abgel					
Ondansetron	01	—	Foleys catheter			Nasal probe (P)	01	01
Pencan 25g/ Spinal Needle 22	01	—	Urobag			nida2	01	01
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			Nasal Airway		
Bupivacaine 0.25% (Heavy)			Romodrain bag			22124	141	—
Antibiotics			Bandage			oral Airway		
O2 mask (P) (A)	141	—	Tegaderm			142	141	—
Suppositories			Ioban			tr catheter		
Anamol : 80mg / 250mg / 170 mg			Double J Stent			20122	141	—
Supridol : 100mg			Vaccum Suction set	1	—			
Justin : 12.5 mg (25mg / 100mg)	141	—	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
vaccum set	01	01	Microshield	1	1			
Dex9 + Dexmide	141	—	Cotton Balls	1	1			
Tranex + (P)	141	OT	Latex Gloves	100	100			
Gloveall + Chlorhex	541	—	Ramdione Scrub					
Worm truss 300g	141	—	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. :

Ordered by :

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

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/2/14	IV placement	①	0907.	Chara
6/2	PAC	①	ginc RD	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 6/2/14 Time : 0930am Prepared By : Chara

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Chara	Spot		

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176054

Admit Date : 06-Jul-2026

Admit Time : 09:19 PM UHID : BAH-00349164

Patient Details :

Patient Name : Master AAYUSH RATHOD

Age : 9 Y 2 M 20 D

Guardian : Mr PRAVEEN RATHOD

DOB : 16-04-2017

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO : 202, SRI SAI NB ELEGANCE , HT
ROAD Shahpur Nagar Hyderabad INDIA
500055

Phone No : 8466959908/ 9346665995

E-mail : PRATHOD1920@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : PRE OP 402

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 402

Admission Type : First Visit

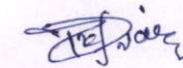
Contact Details :

Name : Mr PRAVEEN RATHOD

Relationship : Father

Contact Address : FLAT NO : 202, SRI SAI NB ELEGANCE , HT
ROAD Shahpur Nagar Hyderabad INDIA 500055

Phone No : 8466959908 / 9346665995



Signature

Doctor Details :

Doctor Name : Dr. GYANESHWAR

Specialisation : PLASTIC SURGERY

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. NALINIKANTA PANIGRAHY

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : NIVA BUPA HEALTH INSURANCE
COMPANY LTD



PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00349164 IP5-00176054
Master AAYUSH RATHOD 1
16-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR



Patient Name: Hayush Rathod.

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Accidental hit by bike @ 3:30pm on 6/7/26.

3 sustained secretion on left upper lip.

History of present illness :

Child is apparently well ~~on~~ till today. Had sustained above mentioned complaints.

No H/o fever, cold, cough, vomitings, loose stools, headaches

LOCs seizure activity.

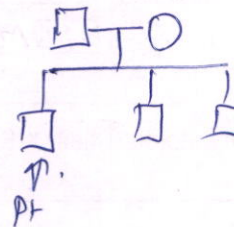


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

2-32w NVD/ NICU stay for 11 days, @ RDS,
O₂ by NP for 3-4 days)
VSD - CHD.



Birth & Socio Economic History:

About Father : _____
About Mother : _____ } upper middle class
Any additional Information : _____

Developmental History :

Immunization History :

Vaccination till date (IAP)



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 25.16 kg (Centile _____)

On Examination :

Temperature : 98.6 °F Pulse Rate : 127/min B.P. 101/75 (85) SPO2 98% on RA

Resp. rate and type of breathing : RR = 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE (+)

Any addles sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : _____

Spine : _____ External Genitalia : _____

Relevant data from outside (CT, USG etc.,) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

R1A with ? # premanilla with lip lesion



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP on cannulation.

CT scan - facial bone } Done on
OPD
basis

Planned Management

• NPO

• IV fluids

• Upper lip reconstruction surgery - today.

Noted by
Dr. Sachet

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 6/2/26; 9:45 pm

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☐ Patient Attendant

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

1. debent + resection of upper lip
2. _____

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>→ lip correction</u>	

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

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

- a. defect of lip
- b. scar

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

Patient / Patient Attendant:

Signature: [Signature]

Name: proveen Kathod

Relationship with patient: FATHER

Date & Time: 6/7/26 10pm

Witness:

Signature: [Signature]

Name: Kalyan

Date & Time: 6/7/26 @ 10pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Gyaneshwar Date: 6/7/26 Time: 10-25pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.	
b.	

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



Surgeon : Dr. G. Vishwan
Asst. Surgeon : Dr. Ramya
Anaesthetist : Rama
Scrub Nurse : Rama

Patient Name : Mr. Arjun Age : 2y Gender : F
UHID No. : 6/7/26 Surgery Name : Delidement of lip
Date : 6/7/26 In-time : 11:00 Out-time : 12:00

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☒ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>DR. K. SR. RAMYA</u>		

TIME OUT		Time:.....
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>none</u> <u>some</u>	
	☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	☐ Yes ☒ No ☐ NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☐ Yes ☒ No ☐ NA	
Is Essential Imaging Displayed?	☐ Yes ☒ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☐ Yes ☒ No	
Signature : <u>[Signature]</u>		
Name : <u>Ramya</u>		

SIGN OUT		Time:.....
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?	☐ Yes ☐ No	
Signature : <u>[Signature]</u>		
Name : <u>A. S. Gnanendran</u>		

Patient Sticker

BAH-00349164 IP5-00176054
 Master AAYUSH RATHOD
 16-04-2017 9 Y 2 M 20 D (M)
 Dr. GYANESHWAR



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 6/8/26

Department : Duration of Procedure : 30 min

Name of Surgeon : Dr. Gyaneshwar Date of Admission : 6/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic : Nil	ky
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	ky
3.	Patient's body temperature immediately post operation (Recovery Room) 38 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	ky
4.	Name of doctor or staff administering the antibiotic : Nil Date & Time of antibiotic administration : Nil Date & Time procedure started : 6/7/26 @ 10:30 pm	ky

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

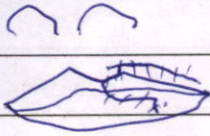
Docu. No. : RCHBH/ FRM / CLINICAL / 038

Patient

OPERATION THEATER NOTES

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

UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:	
Pre-Operative Diagnosis:			
Surgical Procedure : Resect + Reconstruction of Rt, upper lip + suture of Gingiva + Lt			
Indications for Surgery : RTA c Avulsion Injury Lt, upper lip c loss of upper incisor c gingival avulsion			
Date :	Start Time :	End Time :	
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: of Lt, Lt, Submental nerve block is given			
			
- avulsion of Lt, upper lip ant 4x2x1mm . upto upper lip sulcus			
- Resect done.			
- Suture done in layers.			
- Gingival avulsion - suture done			

BAH-00349164 IP5-00176054
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR

Patient Sticker




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: 6/7/2026 Time:

Note: Plan of care will be readjusted if necessary.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 9:00 pm	C/SIB Resident	
	RTA E Avulsion Injury <u>Plan</u>	
	④ upper lip E LOB of upper incisor E gingival avulsion	① Syb Zipmax BID 100
		② Syb Ibuprofen Plus BID
	- Pain @ procedure site	③ monitor vitals.
	- oral feed (+)	
	- hemodynamically stable	Sohulw
	O/E	
	child is alert & active	
	vitals - stable	
9/7/26 8 AM	SIB Resident	
	1: RTA	plan
	- Avulsion injury	① cont. same
		② Discharge today.
	vitals stable	
	feeding orally	
		Madhu

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Date : 7/7/16 Time :

Diagnosis : Anterior upper limb

Hospital : Kln Bangara

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:

Anterior upper limb

Signature: Madhu

Findings and Recommendations :

A: RFA
Anterior injury

Child alert
vitals stable

O/E -
- Child alert

Plan:

① cont. same

② discharge today

Discharge today,
after insurance cleared

Consultant :

Name : Dr. Ujjwal Date : 7/7/16
Signature : Date & Time :

DR. UJJWAL DEB
Registration No. 90550

BAH-00349164 IP5-00176054
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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						

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.,) :



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: ICU

Shifted to: OT

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 6/7/26 : 9:45pm

Nurse Name & Signature: Rachel

Date & Time : 6/7/26 @ 10pm



DRUG CHART

Date of Admission: 6/2/20 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Weight. 25-3kg Ward.

Page: 2/4



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.	

[illegible]

Weight. 25-3kg Ward.

[illegible]

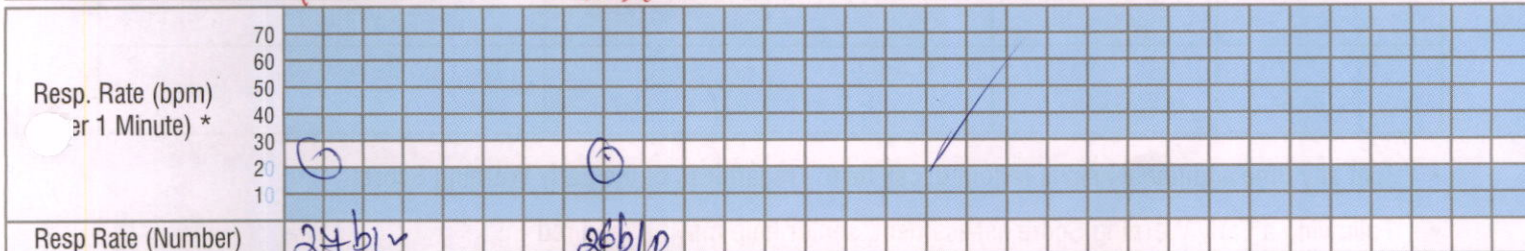
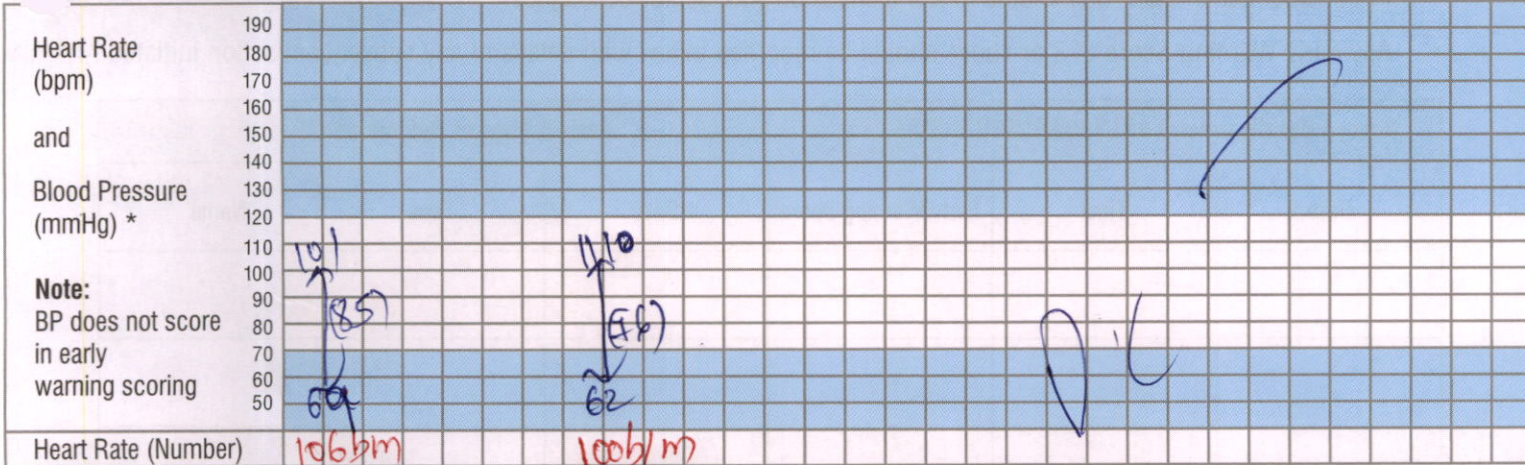
Signature



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/7/20 Time: 10:00

Doctor / Nurse / Family Concern? 20m 6am



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 100%

Conscious Level Normal / Altered

GCS * 15/15 15/15

TOTAL SCORE

Number of shaded boxes 1 1

Pain Score 0 0

Observer's Initials 0 0

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.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

BAH-00340184 IP5-00178054
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 20 D (M)
Dr. QYANESHWAR

Patient :

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	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														
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



FLUID CHART

Sheet No. :

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

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	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											
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						



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: pain related to surgery as evidenced by upper lip reconstruction

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☒ Improve Activity Tolerance
☒ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
1pm	Assess the pt condition	1:10 pm	Assessed the pt Condition	Other plan of care pt condition improved
	monitor vitals		monitored vitals	
2am	maintain I/O chart	2:50pm	maintained I/O chart	
5am	provide comfortable position	4am	provided comfortable position	
7:30	Administer medication as per chart	8am	Administered medication as per chart	

Re-Assessment: ~~Alt plan of care p~~ Re-Assessment done

Special Notes:

Nurse Signature:

Nurse Name: Kalyan

Date & Time: 7/7/26 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | | | | | |
| ☐ Any Others. Specify..... | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Gyaneshwar Department: Plastic Surgery Date of Admission: 6/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known				
	<u>lip laceration</u>		If Yes Specify:				
BACKGROUND	Area	<u>CL</u>	<u>of</u>	<u>Dr. Gyaneshwar</u>			
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>no</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:						
	Temp:	<u>98.3°F</u>	<u>98.0</u>	<u>96.3°</u>			
	Res:	<u>22b/m</u>	<u>22b/m</u>	<u>24</u>			
	SpO ₂ :	<u>99% RA</u>	<u>99%</u>	<u>100% x</u>			
	Pulse:	<u>115b/m</u>	<u>115b/m</u>	<u>105</u>			
	BP:	<u>102/68 (AO)</u>	<u>102/68</u>	<u>101/64</u>			
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>			
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>side rails</u>	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>no</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>	<u>no</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>no</u>	<u>NA</u>			
Handed Over By Name :		<u>Lachar</u>	<u>Kalyan</u>	<u>Suman</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/7/26</u>	<u>7/6</u>	<u>7/7/26</u>			
Time:		<u>10pm</u>	<u>12:30</u>	<u>8am</u>			
Taken Over By Name :		<u>Kalyan</u>	<u>Suman</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/7</u>	<u>7/7/26</u>	<u>7/7</u>			
Time:		<u>1pm</u>	<u>1pm</u>	<u>2pm</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

THE HUMPTY DUMPTY SCALE

6/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2				
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	.				
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			10				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes				
Call device within reach		Yes				
Wheels Locked		Yes				
Room free of clutter		Yes				
Adequate Lighting		Yes				
Wheel Chair Support		No				
Other Intervention(s) Specify		No				
Nurse's Name :		Lachl				
Signature :		[Signature]				
Date :		6/7				
Time :		8pm				

CHARTER

1/2

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

BAH-00349164 IPS-00176054
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR



BRADEN 'Q' SCALE

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date : 6/1/20			
				Time : 9 PM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Q	

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/9/20	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

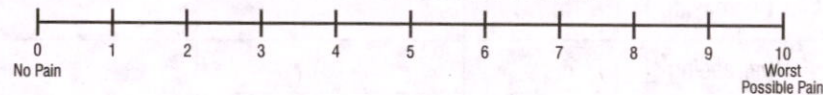
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

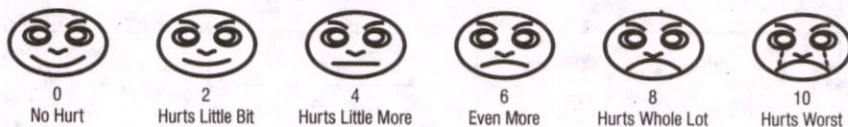
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/7/22	9 PM	7	Infection control measures	M	1	0	1	1	NA	Rachel

Part - III: CODES

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

Learning Barriers:

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

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

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 10:00	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Lip laceration	Hemodynamic stability	lip reconstruction surgery.	[Signature]	☐ Nursing ☐ Others:
6/7/26 10:10	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	lip reconstruction	stability	NPO IVF	[Signature]	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1				-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2				-						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3				-						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4				-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5				-						
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : Kalyan

Signature of Ward In Charge :

Signature : [Signature] Name : Kumar

BAH-00349164
Master AAYUSH RATHOD
16-04-2017 9 Y 2 M 21 D
Dr. QYANESHWAR (M)

ONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: laparotomy

Anaesthesiologist: DR. K. R. RAMYA Surgeon: _____

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: EXAGGERATION, Hypotension

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: Praveen
Name: Praveen Rathod
Relationship with patient: Father
Date & Time: 6/7/26 @ 10:10

Witness:

Signature: [Signature]
Name: Kalyan
Date & Time: 6/7/26 @ 10:10

Doctor (who is taking consent):

Signature: [Signature] Name: DR. K. R. RAMYA Date: 6/7/26 Time: 10:10

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 శరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ టిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Ayub Khalid Age: 10y Sex: M UHID.No:
Date: 6/2/20 Time: 10:22PM Proposed Operation: Cephalorachn
Diagnosis: RTA -

6/2/2020
FF-66%

B.P / CRT: H.R: Weight: 22kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12+ Glucose: Protein: HIV: X-Ray:
PCV: 45.3 Urea: Alb: HBS Ag: ECG:
WBC: 11.8 Creat: Total Bill: HCV: 2D Echo:
Plate: Na: Dir. Bill: Blood group: Stress/Angio:
PT: K: LDH: T3: Other:
PTT: Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
Cl-: SGOT/SGPT:

2PGGO - membranous
VSD PARTIALY
Closed By Aneurysm
still having VSD
MILD TR. (+)
L > R heart
Good BI VENTRICO
LAR

Allergies: N/A PA

Medical History: CVS:

RESP:

Diabetes:

CNS:

Renal:

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mento-hyoid Distance: Neck: Teeth:

Lungs: RAE (+) clear

Heart: 4.5 (+) murmur (+)

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Last meal - 2 PM
RCU

Signature: Name:



ANAESTHESIA CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre-Operative Assessment:

Change in Patient Condition: ☐ Yes ☒ No

Physical Status: ☒ Patient Identified ☐ Consent Present ☒ Chart Reviewed

Fasting Status: Continued

H.R: 84 bpm B.P / CRT: 90/60/16 SpO₂: 98% R.R: 20 BPM Last Feed: 20 hrs

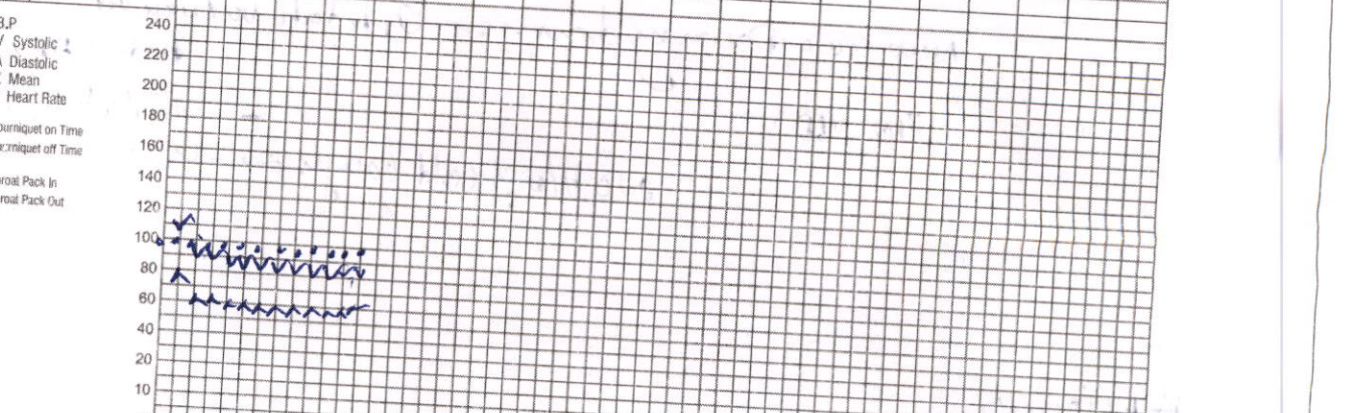
Pre-OP Diagnosis: Gyaneshwar Operation: Debridement & Reconstruction Date: 21/7/16

Surgeon: 10:30 AM Anaesthesiologist: Gyaneshwar Technician: Gyaneshwar

TIME: 10:30 AM N.O / AIR / O₂ LPM: 10 L HALO / SO / SEVO: 10 L Drugs: 10 L

Antibiotic: 10 L Suppository: 10 L Blood Loss: 10 L

ABG: 98% 98% 98% ETCO₂: 40 40 40 ECG: 40 40 40 Temperature: 36 36 36 Urine Output: 26 26 26



LAB Values: ABG GRBS Others

Equipment Checked and Functional: ☒ BP ☒ Cuff Site: 2 Lead ☒ Art Site: Secure ☒ EKG Lead ☒ Temp Site ☒ FIO₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☒ Nerve Stimulator

Position: Spine ☒ Pressure Points Checked

Eye Care: ☒ Oint ☒ Tape ☒ Padding ☒ Awake

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

Times: Anaes Start: 10:30 PM OP Start: 11:30 PM OP End: 11:30 PM Leave OR: 11:30 PM

Anaesthesia: ☒ GA ☒ Monitored Anaesthesia Care ☐ Regional

Line (Size & Location): ☒ CVP: 10 mm ☒ ART: 10 mm ☒ IV: 10 mm ☒ IV: 10 mm ☒ IV: 10 mm

Induction: ☒ IV ☐ Inhal ☐ Pre O₂ ☐ RSI ☐ Others

Mask: ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ☐ ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: 10 mm

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

Regional: ☐ Extremity ☐ Spinal ☐ Epidural ☐ Caudal ☐ Others: Specify: 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: Signature of the Doctor:



POST-ANAESTHESIA UNIT RECORD

Received in PACU by : Kalyan

Time Received : 11:30

Time Discharged : 12:30

RESPIRATORY RATE < RESP > PULSE < BLOOD PRESSURE >	IV Cannula Site : <u>2m</u> ☐ O₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☒ No Drug: NG Tube : ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: Oral Feeds:
---	---

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	2		2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2	2		2	
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2		2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	1	2	2		2	
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2		2	
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	9	10		10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name : DR. SRI RAMYA

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name : Kalyan

PACU Nurse Signature: [Signature]

Date & Time: 6/7/26 12:30

Reassessment Frequency:

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

Transferred to Unit by (PACU): 10A

Date & Time: 6/7/26

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Patient Satisfaction :

Date and Time :

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:30 AM Mode of Arrival: 2 wheel chair Admitting From: ☐ ER ☐ OPD ☐ Direct of

Allergy / Adverse Reaction

Body Weight: 25 Kg

NA

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: No significant family history

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

If yes please list,

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

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

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

Observations: Weight: 25 kg Length: Head Circumference (< 2 years):

Temp.: 98.4°F HR: 101 bpm RR: 26 bpm BP: 101/67

Pain Score: 1/10 Specify Site: sk site (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 1/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain Location lips Frequency Duration

FUNCTIONAL SCREENING:

☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse's Name: Swarne Date: 7/7/26 Time: 1 Am

Signature [Signature]

BAH-00349164
Master AAYUSH RATHOD
18-04-2017 9 Y 2 M 20 D (M)
Dr. GYANESHWAR

DISCHARGE PLANNING FORM

Nationality: India

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: As per doctor's order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☒ Yes	☐ No
☐ Eating	☒ Yes	☐ No
☐ Walking	☒ Yes	☐ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☒ Yes	☐ No

Yes

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Kalyan

Date and Time: 6/2/26 @ 11:27

DISCHARGE PLANNING FORM

Admission # 123456

Discharge date and time 12/15/2011 10:00 AM

Admission type Emergency

Discharge location Home

Discharge status Stable

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status

Discharge date

Discharge time

Discharge location

Discharge status