

BAH-00654800 IP5-00175902
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D (M)
Dr. KOKKULA PRANEETH



Booth

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SURGERY DETAILS

Verbal

Date : 3/7/26

Patient Name: B/o Nagula Neenasi Date of Birth: 12/4/2026 Age: 2 months

Gender: Male Ward: P.O.T UHID No.: BAH-00654800

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

Name of the Surgery : Programmable VP shunt

Time in : 7:30 AM

Time Out : 9:20 AM

	NAME	AMOUNT
1. Surgeon	Dr. Praneeth	
2. Anaesthetist	Dr. Ravi Chandra	
3. Assistant Surgeon		
4. OT Technician	Nishanth	
5. Circulating Nurse	Benjamin	
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: 9685626

Order by: Y. Ramadevi

3/7/8

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3/7/8

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3/7/8

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BAH-00654800

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CONSUMABLES OF OT

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Technician :

Date :

Time :

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube	25	30.35	11/4	01		Inj Vit.K		
LMA	1/1	1/1	Sutures	5003, 5085	2/2	Cord Clamp		
ECG leads : A / P / N	01	01	Proline 3.0.40	2/2		Suction Catheter		
HME filter : A / P / N	01	01	Vicryl 3.0.40 50	2/2		Feeding Tube		
Syringes : 10 cc	20	04	PDS (3-0)	1	1	Vaccum Suction Set		
05 cc	20	04	Gloves	6.6.5.7.7.5	2/2	Surgical Gloves		
02 cc	20	04	6.6.5.7.7.5	2/2	1/2	Gauze Pack		
01 cc	5	1				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	1	Surgical blade	11.85	1/1	Surgical Blade # 20		
IV set + Blood set	01	1	NG tube			Koochies (S)		
RL + 2/1 NS + 25/1 D	11/4	1	Cautery pencil	1	1	NS 500 ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	5/4/2	1/1	Koochies P. XL	1	1	Transonic	1	1
mgw spike	01	01	Ointments			Shunt Drape	1	1
Gauze	03	03	Suction Catheter			100% Sterile 50	1	1
Fentanyl	01	01	Cap, Mask	1/1	1/1	programmed shunt	1	1
Morphine			Gauze Pack	2/2	3/1			
Ketamine			Mop Pack	1	1	Atropine + APR	1/1	1/1
Propofol	02	01	Steristrip			Midal + epidural	1/1	1/1
Rocuronium	01	01	Underpad	1	1	20x40x1 Jelly	1/1	01/1
Glycopyrolate	01	01	Draw sheet	1	1	NG tube all	10	1
Myopyrolate	02	2/1	Abgel	1	1	suction tube all	10	1
Ondansetron	01	01	Foleys catheter			Nose Airway		
Pencan 25g/ Spinal Needle 22			Urobag			12, 14	1/1	1
Bupivacaine 0.25%			Chest Drainage Catheter			oral Airway		
Bupivacaine 0.25% (Heavy)			Romodrain bag			000, 00	1/1	1
Antibiotics Taxine 250mg	01	1	Bandage			50cm tpm tube	1/1	1
Amikacine 250mg	01	1	Tegaderm			stopcock	02	01
Suppositories			Ioban			soft role 4, 6	2/2	1/1
Anamol : 80mg / 250mg / 170 mg			Double J Stent			in catheter 22, 24	2/2	1
Supridol : 100mg			Vaccum Suction set	1	1	9 set + splinter	1/1	1
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet	1	1	Transpare plate	01	01
Tab. Misoprost : 200mg			Betadine Solution	1	1	Gauze (P)	1	1
Vaccines	01	01	Microshield	1	1			
Dexat + Dexmid	1/1	1	Cotton Balls	1	1			
tranaxa + pm	1/1	1	Latex Gloves	1	1			
Gloved + teloneon	5/1	1	Ramdione Scrub	1	1			
room therm 300	1/1	1	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. :

Ordered by :

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

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ 1 _____ Charge : _____ Time: _____

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

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
03/04/26	6 am	ER	OT	Alexander
3/7/26	1 pm	OT	121A	Teeva

Cross Consultation Visit

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

[illegible]

Date _____

Investigations

Order No.

Signature

02/07	CBP Done on of Bar
-------	--------------------

Samsky

96

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7/26	IV placement	①	5029	
	PAC done op care	①	5036	Samohy

ANY OTHER INFORMATION

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Date : 4/07/26 Time : @ War Prepared By : Ankothe

Staff Nurse 	Shift / Ward C-11	Billing Assistant	Billing Supervisor
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ADMISSION SHEET

Registration Details :

Admission No : IP5-00175902

Admit Date : 03-Jul-2026

Admit Time : 05:21 AM **UHID** : BAH-00654800

Patient Details :
Patient Name : Baby Of NAGULA NEENASRI

Age : 0 Y 2 M 21 D

Guardian : Mr BHANU PRASAD GOUD

DOB : 12-04-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO - 1-13/1, DEGAON, Armoor Nizamabad
 Telangana INDIA 503224

Phone No : 8374691977/ 9553365843

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : DAY CARE

Bed No : PRE OP 401

Ward Name : 4F-OT COMPLEX

Room No : PRE OP 401

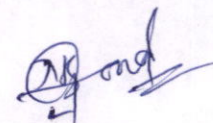
Admission Type : First Visit

Contact Details :
Name : Mr BHANU PRASAD GOUD

Relationship : Father

Contact Address : H NO - 1-13/1, DEGAON, Armoor Nizamabad
 Telangana INDIA 503224

Phone No : 8374691977 / 9553365843


Signature
Doctor Details :
Doctor Name : Dr. KOKKULA PRANEETH

Specialisation : PEDIATRIC NEURO SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

B/o NAGULA NEENASRI

UHID ID:

BAH-00654800 IPS-00175902
Baby Of NAGULA NEENASRI
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Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Admitted for programmable VP shunt

Sp omaya left + Right subgaleal shunt

History of present illness :

No Hb fever cough cold.

H/o Hydrocephalus → left omaya reservoir + Right ventriculo p. subgaleal shunt in Ruxon 30/4/26.

on Intraventricular vancomycin + CSF tapping on alternate days

02/7/26 CBP - Hb-9.1

WBC-12-78

PC-486.

N/L-27/56.

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Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Extreme prem / LBW / N/W stay
- Hypoxaemia of prematurity. Atheria

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Immunization History :



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 1.96 (Centile _____)

On Examination :

Temperature : 97.5°F Pulse Rate : 126/min B.P. _____ SP02 98% ERLA
Resp. rate and type of breathing : 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : _____

Spine : _____ External Genitalia : _____

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

IPB-000
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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

CTA - good.

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:

Correl ventriculitis
placental peramniotic vs shunt
placement



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: antibiotic

Desired goals of the treatment: surgical relieving symptoms

Planned Labs:

CBP done on 2/7/26.

Planned Management

NPO - from 2am formula milk
PAC - done
IVF
Sgt Programmable VP shunt
Reactive ~~7-11-26~~
NB closed.

Signature of the Doctor: N.P.

Name of the Doctor: N. Praneeth

Date & Time: 3/7/26, 4am.

Signature of the Consultant: Dr. Kokkula Praneeth

Name of the Consultant: Dr. Kokkula Praneeth

Date & Time: 3/7/2026 2pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. K. Praneeth
Asst. Surgeon : Dr. Ravi
Anaesthetist : Ramadevi
Scrub Nurse : Ramadevi

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Age : 2m Gender : M
Primary Name : V.P. Shweta Place

Date : 3/7/26 In-time : 7:20 AM Out-time : 9:20 am

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Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: <u>7 AM</u>
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>Amr</u>		
Name : <u>Dr. Amr</u>		

Before Skin Incision ➤ ➤

TIME OUT		Time: <u>7:40 AM</u>
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>Nothing</u> <u>1hr</u> <u>5m</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>Praneeth</u>		
Name : <u>Praneeth</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>8:58 am</u>
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>Praneeth</u>		
Name : <u>Dr. Praneeth</u>		

Dr. KOKKULA PRANEETH
Reg. No: APMC/FMR/92741

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 3/7/26

Department : P.O.R. Duration of Procedure : 1 hour

Name of Surgeon : Dr. K. Praneeth Date of Admission : 3/7/26

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 : inj. Vancomycin 20mg	
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	
3.	Patient's body temperature immediately post operation (Recovery Room) 37 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Benam Date & Time of antibiotic administration : 3/7/26 @ 7:30 AM Date & Time procedure started : 3/7/26 @ 7:50 AM	

- 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

3/1/8

1/1/8

3/1/8

10.9.01

D. K. Brown

3/1/8

10.9.01

3/1/8

3/1/8

3/1/8

3/1/8 @ 1.30pm
3/1/8 @ 1.30pm
3/1/8 @ 1.30pm



OPERATION THEATER NOTES

Patient's Name : B/o Nagula Neenasri Age : 2 M Gender : ☒ Male ☐ Female

UHID No.: BAH-00.654800 Weight : 1.9 kg Height :

Surgeon : Dr. Praneeth Asst. Surgeon :

Anesthetist : Dr. Ravi OT Nurse : Ramadevi, Beyer OT Technician : Nishanth

Pre-Operative Diagnosis: Post-infective Hydrocephalus

Surgical Procedure :

(Rt) parietal programmable VP shunt + Ommaya and VSG removal

Indications for Surgery :

Raised ICP

Date : 3/7/26 Start Time : 7.50 AM End Time : 8:58 AM

Pre Operative Preparations:

Betameth + chlorhexidine + Betadine x 3

Post Operative Diagnosis: Same

Peri-Operative Complications: nil

Operation Notes:

- ① Right parietal 'U' shaped scalp incision given
- ② Burr hole made. ~~Done~~
- ③ ~~Abdominal~~ Abdominal incision given. Tunneling done
- ④ Dura and pia coagulated and pia
- ⑤ ventricle hit and catheter advanced till 7cm
- ⑥ Shunt assembly completed. Free flow of CSF seen at abdominal end
- ⑦ Abdominal end internalised
- ⑧ ~~etc~~ wound closed in layers
- ⑨ Ommaya and VSG removed ~~an~~ wounds closed in layers.

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POST-SURGICAL CARE PLAN FORM

Procedure Done: *VP Shunt*

Post-Surgical Diagnosis: *Hydrocephalus*

Post-Operative Monitoring Parameters /Frequency:

Vitals , ACS

Wound Care:

—

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

Prop up

Nutritional Instructions:

Orally allowed

When to Start Mobilization:

—

Special Referrals:

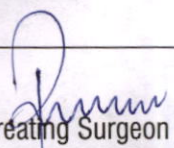
—

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: *3/7/2026* Time: *9am*

Note: Plan of care will be readjusted if necessary.

REF 82-3113

LOT 7525844

2030-02-28

CODMAN® HAKIM® Programmable Valve Micro Valve with RICKHAM Reservoir and Unitized
Distal Catheter Programmable in steps of 10mm H₂O (98 Pa): 30mm H₂O to 200mm H₂O (294 Pa
- 1960 Pa)

LCN-82-3113
Rev R 2024-02



(01)10381780519164
(11)250319
(17)300228
(10)7525844



Integra LifeSciences Production Corporation
11 Cabot Boulevard
Mansfield, MA 02048 USA
integralife.com

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 6pm.	C/S/B Neuroteam A: Post infective hydrocephalus. S/p - VP shunt (R) programmable VP shunt + Omaya and VSG removal. <u>Issues:</u> 1) No fever spikes 2) Urine Output - (N) 3) Accepting feeds - (N) 4) Stools - didnot pass yet <u>O/E:</u> Child conscious Vitals - stable Activity - good B/E pupils NSRL Tone - (N) B/E symmetrical antigravity movements (+) AF flat open.	Ad ① vitals monitoring

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/07/26 8:30am	CLS/B Neuroteam	
	A: Post Infective hydrocephalus S/p (RT) programmable VP shunt placement + Omaya and VSG removal	
	Issues: Irritability (+) yesterday No fever spikes / seizures Urine Output (+) Stools - didn't pass yet	HE:
	O/E: Child conscious C/T/A - good peripheries - cool CFT < 3 sec Tone - (NI) B/L symmetrical antigravity movements (+) AF flat open	Adv vital monitoring warm care Ophthal evaluation E. BERA @ discharge } Hold plan discharge today
		IV Vanco / Levoflox x 5 days Rumin on Monday Jm A. Jm
		Dr. KOKKULA PRANEETH Reg. No: APMC/FM



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ESS NOTES AND DOCTOR'S ORDER

Abhishek

[illegible]

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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						

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 :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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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: 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	inj. vancomycin	15mg	IV			☐ C ☐ DC
2	sip Cefepime (250/100mg)	0.15ml	PO			☐ 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 : N. Praneeth, M.D.

Date & Time : 02/04/26, 4:45 AM

Nurse Name & Signature : Prasanna

Date & Time : 02/04/26 12:50 AM



Sheet No: ①

REGULAR PRESCRIPTIONS

Weight 1.96kg Ward

DRUG : <u>Tab. PARACETOMOL</u>				Date Time	<u>3/1</u>	<u>4/8</u>													
Dose	Route	Frequency	Start Dt.																
<u>25mg</u>	<u>W</u>	<u>9 8thly</u>	<u>3/7</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Praneeth</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

BAH-00654800
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D
Dr. KOKKULA PRANEETH
(F)



Sheet No: 1

REGULAR PRESCRIPTIONS

Weight 1.96 kg Ward

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

[illegible][illegible][illegible]



DRUG CHART

Date of Admission: 3/7/26 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 **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

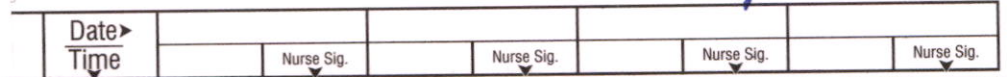
VERIFIED BY : Name Signature

REGULAR PRESCRIPTIONS

Weight. 1.96kg Ward.



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 : <u>Inj. VANCOMYCIN</u>															
Dose															
Route															
Frequency															
Start Date															
Name & Signature of the Doctor															
Starting the Drugs:															
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															
DRUG : <u>Inj. LEVOFLOXACIN</u>															
Dose															
Route															
Frequency															
Start Date															
Name & Signature of the Doctor															
Starting the Drugs:															
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															
DRUG : <u>Syr. LEVOPIL</u>															
Dose															
Route															
Frequency															
Start Date															
Name & Signature of the Doctor															
Starting the Drugs:															
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															



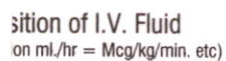
VARIABLE DOSE

STAT / ONCE ONLY DRUGS[illegible]

Weight. 1.98 kg Ward.

Weight. 1.98 kg

Ward



Route

Flow Rate ml/hr	
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Doctor
Sign

Nurse
Sign

Date of Stopping

Doctor
Sign

Nurse
Sign

3/7/78. 5:45
A4

10.1. 150 - p
(TV - 150 ml/kg/day)
(3/4 maintenance)

IV

9

N. p.

QPH Law

B. K. K. K.

3/7

2

Now

Done

$$\frac{25 \text{ ml}}{\text{hr}}$$

Signature

VERIFIED BY: Name:

BAH-00654800
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D (M)
Dr. KOKKULA PRANEETH

IP5-00175902

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pa Patient Language: *telugu* 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		
<i>04/04</i>	<i>5 AM</i>	<i>A</i>	<i>procedures.</i>	<i>M</i>	<i>1</i>	<i>0</i>	<i>1</i>	<i>1</i>	<i>ntk</i>	<i>Praneeth</i>

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:		<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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:		<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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

Diagn

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
03/17/24	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	S/P anuraya + Rt subgaleal hemat	Hemodynamic stability	Regressive upstunt	N.P.S	☒ Nursing ☐ Others:
03/10/24 5am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Anuraya desu	Stunt	VP Shunt placement	A. Suresh	☒ 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:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 6.17a Mode of Arrival: walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 1.98 Kg

..... nil Height: cm

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

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

Family History:

no Signifier

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: 1.98 Length: Head Circumference (< 2 years):

Temp.: 98.24 HR: 130 bpm RR: 32 bpm BP: 66/44 (50)

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 17 (Document in the Humpty Dumpty Sheet)

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

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With familySiblings 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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to MotherNurse Signature: BeyanNurse Name: BeyanDate: 3/7/26Time: 6-25-AM

BAH-00654800 IP5-00175902
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D (M)
Dr. KOKKULA PRANEETH



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

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/2	Time:				
Doctor/Nurse/Family Concern?	2pm	6pm	10pm	2am	6am
Temperature (°F)	98.8°F	98.4°F	98.1°F	98.6°F	96.8°F
Heart Rate (bpm)	132b/m	145b/m	125b/m	112b/m	138b/m
Blood Pressure (mmHg) *	118/78	115/71		110/67	110/62
Resp. Rate (bpm) (over 1 Minute) *	31b/m	32b/m	33b/m	30b/m	35b/m
Resp Distress	Mod	Mod	Mod	Mod	Mod
Receiving O ₂ (l/min)	0.0	0.0	0.0	0.0	0.0
O ₂ Saturations (%)	99.1	97.1	98.1	100.1	99.1
Conscious Level	Normal	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1	1
Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials	o	o	o	o	o

ACTIONS

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

NB: Scores 3 should be recorded overleaf

* 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)

FLUID CHART

Sheet No. : 1

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	Iso-p		9ml/hr								
	10:00 am											
	11:00 am	Formula	5ml									
	12:00 pm		5ml									
	01:00 pm											
Total Intake :						Total Output :						
3/7	02:00 pm	Formula									0	APPR
	03:00 pm	Feeds	30ml								0	APPR
	04:00 pm										0	APPR
	05:00 pm	Neolact									0	APPR
	06:00 pm		30ml								0	APPR
	07:00 pm											
Total Intake :						Total Output :						
3/7	08:00 pm										0	
	09:00 pm	Formula	30ml								0	Swal
	10:00 pm										0	
	11:00 pm	Formula									0	Swal
	12:00 am	Neolact	30ml								0	
	01:00 am										0	Sw
Total Intake :						Total Output :						
4/7	02:00 am		25ml								0	
	03:00 am		25ml								0	Swal
	04:00 am	Formula		25ml							0	
	05:00 am										0	Swal
	06:00 am		30ml								0	
	07:00 am										0	Swal
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: 3/7/26

Assessment: Acute pain related to Surgical Procedure

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
9 ³⁰ am	Assess the baby's general condition	9 ³⁵ am	Assessed the baby's general condition, underwent up shunt & ommaya Removal	vitals are
9 ⁴⁰ am	Maintain Airway & oxygenation	9 ⁵⁵ am	Baby is on 3l & through nasal cannula	Stable
10 ¹⁰ am	Maintain Fluid balance	10 ¹⁵ am	Maintained fluid balance by connecting ISO-p 9ml/hr	Maintaining
10 ³⁵ am	Monitor vitals	10 ⁴⁰ am	Monitored vital signs	Saturation on
10 ⁴⁵ am	Maintain good nutritional status	10 ⁵⁰ am	Maintained good nutritional status by starting oral fluid. (Formula milk)	Room air
11 am	Administer Antibiotic & Anti epileptic			
12 pm	Seen by Dr. Praneeth advised to shift to ward	12 ⁰⁰ pm	Shifted to ward	

Re-Assessment: Baby vitals are stable. Wound for bleeding at surgical site

Special Notes: GCS monitoring, wound for bleeding

Nurse Signature: [Signature]

Nurse Name: Teena

Date & Time: 3/7/26 @ 12⁰⁰ pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby Having discomfort.

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
2pm	→ Assess the Baby General Condition, monitor vitals & Record	3pm	→ Assessed the Baby General Condition, monitored vitals & Recorded	By Anitha's done pt condition is improved
4pm	→ Give formula feeds 3rd hourly 30ml/hr	4:30pm	→ Given formula feeds 3rd hourly 30ml/hr	
5pm	→ provide comfortable position	6pm	→ provided comfortable position	
7pm	→ Administer medication as per doctor order	8pm	→ Administer medication as per doctor order	

Re-Assessment:

Special Notes: Formula feeds 3rd hourly 30ml/hr

Nurse Signature:

Nurse Name: Aparajitha (021261)

Date & Time: 3/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 03/7/26

Assessment: Baby having dull Activity

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
8pm	→ Assess the general condition of the baby.	8:10 pm	→ Assessed the general condition.	By done all the procedure baby is condition improve
10pm	→ Monitor the vital's sign	10:15 pm	→ Monitored the vital's signs.	
12am	→ provide comfortable position	2am	→ provided comfortable	
5am	→ formula feed Newcastel 1:30	5am	→ 3rd hourly feed Bolus.	
6am	→ Maintain I/Q chart	6:30 am	→ Feed	
7:30 am	→ Administer medication as per doctor order.	8am	→ Administered medication as per doctor order.	

Re-Assessment: Activity ..

Special Notes: Formula feed 3rd hourly

Nurse Signature: [Signature]

Nurse Name: Swarna

Date & Time: 4/7/26 @ 8am

BAH-00654800 IP5-00175902
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D (M)
Dr. KOKKULA PRANEETH



NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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. Praneeth Department: OT Date of Admission: 03/07/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>prograde VP shunt placed</u>		If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>6am</u>	<u>12-1</u>	<u>1-4 PM</u>	<u>4-8 PM</u>	
	Medical Condition (Any special condition to be noted):		<u>nil</u>	<u>nil</u>	<u>nil</u>	<u>nil</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.1°F</u>	<u>98.4°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	
		Res:	<u>35b/m</u>	<u>26b/m</u>	<u>32b/m</u>	<u>30</u>	
		SpO ₂ :	<u>97%</u>	<u>100%</u>	<u>98%</u>	<u>94%</u>	
		Pulse:	<u>160b/m</u>	<u>180b/m</u>	<u>132b/m</u>	<u>130</u>	
		BP:	<u>82/49</u>	<u>79/60</u>	<u>80/47</u>	<u>99/67</u>	
	Fall Risk Score:	<u>17</u>	<u>18</u>	<u>15</u>	<u>11</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>nil</u>	<u>-</u>	<u>nil</u>	<u>nil</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>nil</u>	<u>Levamisole Painkillers</u>	<u>nil</u>	<u>nil</u>		
Post Operative Procedure Special Orders:		<u>nil</u>	<u>nil</u>	<u>nil</u>	<u>nil</u>		
Handed Over By Name :		<u>Praneeth</u>	<u>Teena</u>	<u>Aravindhan</u>	<u>Swaraj</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>03/07/26</u>	<u>3/7/26</u>	<u>3/7</u>	<u>3/7</u>		
Time:		<u>6:08am</u>	<u>1pm</u>	<u>2PM</u>	<u>8PM</u>		
Taken Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>3/7/26</u>	<u>3/7</u>	<u>3/7</u>	<u>4/7</u>		
Time:		<u>6:15am</u>	<u>1:30pm</u>	<u>8PM</u>	<u>9:30am</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							
BACKGROUND	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:						
	Pain 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

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4	4	4			
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3	3	3			
	Forget Limitations	2					
	Oriented to own Ability	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	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	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	1			
TOTAL			17	17			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	4				
Call device within reach	Yes	✓				
Wheels Locked	Yes	✓				
Room free of clutter	Yes	✓				
Adequate Lighting	Yes	✓				
Wheel Chair Support	No	X				
Other Intervention(s) Specify	No	X				
Nurse's Name :	Suma	Suma				
Signature :	[Signature]	[Signature]				
Date :	03/7	4.7				
Time :	5.4	6.4				



BRADEN 'Q' SCALE

				Date : 03/04/19			
				Time : 5a	6a		
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	1
"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.	1	1	1
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	4	0
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	4	2
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	4	1
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	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	4	
				TOTAL SCORE	25	25	
				Evaluator's Name	Musun		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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

BAH-00854800 IP5-00175902
 Baby Of NAGULA NEENASRI
 12-04-2026 0 Y 2 M 21 D (M)
 Dr. KOKKULA PRANEETH

PAIN ASSESSMENT FORM

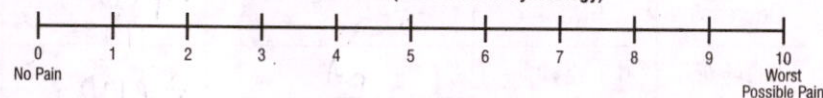
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
03/04/26	5am	0	neck	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil.	reassured
3/7	1pm	0	local	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	na	Dr
3/7	3pm	0/10	rtA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appv
3/7	5pm	0/10	rtA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appv
3/7	7pm	0/10	rtA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appv
4/7	3AM	0/10	N	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Lu
				☐ 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 pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



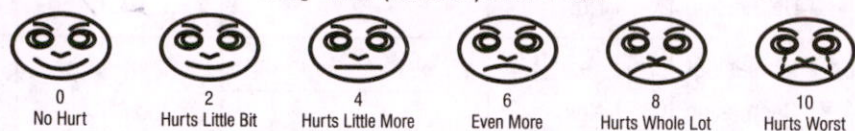
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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 drawn 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

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





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	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	0	-	-	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	-	-	-						
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	0	-	-	-						
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	0	-	-	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	-	-	-						
Signature of the Nurse				For Appu			Sul			40			

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 : Praneeth

Signature of Ward In Charge :

Signature : [Signature] Name : Praneeth

PRE - OPERATIVE CHECK LIST

Patient's Name : Sl. Leena Sri Age : 2M Gender : ☒ M ☐ F

Blood Group : UHID : BH4-00654900

Planned Surgery : vp shunt placements Surgeon : Dr. Kothala praveen

Anesthetist : Dr. Subramanyam Date & Time of Operation : 3/2/26 @ 7:00AM

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

S.No.	INSTRUCTIONS	ER/Ward,Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
	Weight checked recorded ? <u>wt:1.98kg</u>	☒	☐	☐	☒	☐	☐
2	Is the patient fasting for over 6 hours Pre-Operatively ? <u>1am</u>	☒	☐	☐	☒	☐	☐
3	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screening, CXR etc) Available before starting the procedure	☐	☒	☐	☐	☒	☐
4	Enema given / Bowel Preparation	☐	☒	☐	☐	☒	☐
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☒	☐	☐	☒	☐	☐
6	Sterile Gown Given	☒	☐	☐	☒	☐	☐
7	Is Blood arranged as required ?	☐	☐	☒	☐	☒	☐
8	If Blood has been ordered - is Blood bag ready ?	☐	☐	☒	☐	☒	☐
9	IV Cannula to be placed / IV fluids if Indicated	☒	☐	☐	☒	☐	☐
10	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐	☒	☐	☐
11	Pre Medications Given ? (Sedatives / etc)	☐	☒	☐	☐	☒	☐
12	Skin Preparation	☐	☒	☐	☐	☒	☐
13	Site is marked	☐	☒	☐	☐	☒	☐
	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☐	☒	☐	☒	☐	☐
15	Implants are available	☐	☒	☐	☐	☒	☐
16	Equipment is available	☐	☒	☐	☐	☒	☐
17	Antibiotic Prophylaxis is given within the last 60 minutes	☐	☒	☐	☐	☒	☐
18	Other (if any)	☐	☒	☐	☐	☒	☐

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☒ Yes ☐ No

Billing Executive Name : OT Nurse Name : [Signature] ER/Ward Nurse Name : Bhargava

Billing Executive Signature : [Signature] Signature of OT Nurse : [Signature] Signature of ER/Ward Nurse : [Signature]

Date & Time : Date & Time : 3/2/26 Date & Time : 3/2/26 @ 5AM

Doc. No. : RCHB/ FRM / CLINICAL / 107

INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY

Name: BLO NAGULA NEENASRI Age: 2m20d Gender: ☒ Male ☐ Female

UHID.No: BAH-00654800 Date: 1-7-2026

I / We have been explained by Dr. Praneth about the medical condition and the proposed procedure.

I / We have been told that our patient BLO NAGULA NEENASRI has the following Medical Conditions / Diagnosis:

POST INFECTION HYDROCEPHALUS

Proposed Treatment / Procedure / Operation:

PROGRAMMABLE V.P. SHUNT + OMMAYA RESERVOIR REMOVAL

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned above and that our patient has following risks involved during the hospital stay

CSP LEAK, SHUNT BLOCK, SHUNT INFECTION, ADD SURGERY WOUND DEHISCENCE, ECT ADHESIONS IN INTRAVENTRICLES

I / We have been explained risk, benefits and alternatives of the procedure.

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results, complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

I / We have understood the consequences of not undergoing the proposed treatment.

I / We hereby give (my / our) full consent for the above – mentioned treatment.

I / We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences arising from the treatment.

Patient (Or Patient Relative / Guardian):

Signature: [Signature]

Name: N. Bhooma Goud

Date & Time: 1/7/26 4 PM

Doctor (Who is talking the consent)

Signature: [Signature]

Name: Dr. Praneth

Date & Time: 1-7-2026 4 PM

Witness

Signature: [Signature]

Relative / Legal Guardian: (Relationship with Patient) Mother

Address:

Date & Time: 3/7/26 @ 6.17 AM



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Programmable VP Shunt

Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Praneeth

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 Bronchospasm, Laryngospasm, Bradycardia

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: [Signature]
Name: N. Neena Sri
Relationship with patient: Mother
Date & Time: 3/7/26 @ 6 AM

Witness:

Signature: [Signature]
Name: Anusree
Date & Time: 3/7/26 @ 6 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Anusree Date 3/7/26 Time: 6 AM

ప్రసవ కఠినత అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీసియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీసియా కఠినత మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీసియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థానం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీసియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీసియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీసియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీసియా లేదా నార్మల్ బిట్ 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 ☐ బహుశ అవయవ వైఫల్యం

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీసియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీసియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రీజనల్ అనస్థీసియా ☐ జనరల్ అనస్థీసియా ☐ మానిటర్ అనస్థీసియా కేర్
- అనస్థీసియా 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, సపోజిటలీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, రీజనల్ అనస్థీసియా నుండి జనరల్ అనస్థీసియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీసియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీసియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీసియా 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

CSA-39 weeks
 2 1/2

Name: B/o Neenasri Age: 2 months Sex: F UHID.No: BAH-00654800
 Date: 21/7/26 Time: 5 PM Proposed Operation: Programmable VP shunt
 Diagnosis: S/p - Omomya + (R) Subgaleal shunt
 B.P / CRT: _____ H.R: _____ Weight: 1.96 kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

21/7/26

Hgb: 9.1 Glucose: _____ Protein: _____ HIV: _____ X-Ray: _____
 PCV: _____ Urea: _____ Alb: _____ HBS Ag: _____ ECG: _____
 WBC: 12.78 Creat: _____ Total Bill: _____ HCV: _____ 2D Echo: _____
 Plate: 481 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: _____

Medical History: CVS: (-)

RESP: no vmt

CNS: on CSF tapping & Intraventricular

Renal: vancomycin on
 Hepatic / GE: ant-diary

Others: _____

→ Extreme Protein - 28 weeks / LAW
 Twin Diabetes: ICV → stay → > 1 month
21 Suspected sepsis.
 → Hyponatremia of prematurity (R)
 Anemia Physical Activity: Active

Past Anaesthetic History: H/o Hydrocephalus → omomya reservoir + (R) ventriculo subgaleal

Physical Exam: afebrile, alert on 30.04.2026 shunt → in RCH
 Teeth: _____

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

Lungs: Bare, chest clear

Heart: S2

CNS: could not assess

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: (P) Spine Exam for regional: _____

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

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

w/o from 1 AM

CURRENT MEDICATIONS	DOSAGE
<u>S/p. VANCOMYIN</u>	<u>15mg</u>
<u>Syrup. LEVITIL</u>	<u>0.15 ml</u>
<u>(1ml/100mg)</u>	

Pre-Operative Instructions:

- DVT Prophylaxis: FM → 6 hrs
- NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☐ Standard ☒ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions: CBP on cannulation
Consent pending
to continue medications

Signature: Am Name: Dr. Amreen

$$\begin{array}{r} 25 \\ \hline 50 \end{array} \quad \begin{array}{r} 102 \\ \hline 65 \end{array}$$

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



Fasting Status: confirmed

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

H.R:	156	B.P / CRT:	58/39	SpO ₂ :	100	R.R:	26	Last Feed:	14M
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Pre-OP Diagnosis: <u>Hydrocephalus / Spontaneous</u>	Operation: <u>VP shunt</u>	Date: <u>3/7/20</u>
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Surgeon: Dr. Praneeth Date: 31/12/2023
Anaesthesiologist: Dr. Ravikumar Technician: Nisha

TIME	720	750	820	850	900	930	960	990	1020	1050	1080	1110	1140	1170	1200	1230	1260	1290	1320	1350	1380	1410	1440	1470	1500	1530	1560	1590	1620	1650	1680	1710	1740	1770	1800	1830	1860	1890	1920	1950	1980	2010	2040	2070	2100	2130	2160	2190	2220	2250	2280	2310	2340	2370	2400	2430	2460	2490	2520	2550	2580	2610	2640	2670	2700	2730	2760	2790	2820	2850	2880	2910	2940	2970	3000	3030	3060	3090	3120	3150	3180	3210	3240	3270	3300	3330	3360	3390	3420	3450	3480	3510	3540	3570	3600	3630	3660	3690	3720	3750	3780	3810	3840	3870	3900	3930	3960	3990	4020	4050	4080	4110	4140	4170	4200	4230	4260	4290	4320	4350	4380	4410	4440	4470	4500	4530	4560	4590	4620	4650	4680	4710	4740	4770	4800	4830	4860	4890	4920	4950	4980	5010	5040	5070	5100	5130	5160	5190	5220	5250	5280	5310	5340	5370	5400	5430	5460	5490	5520	5550	5580	5610	5640	5670	5700	5730	5760	5790	5820	5850	5880	5910	5940	5970	6000	6030	6060	6090	6120	6150	6180	6210	6240	6270	6300	6330	6360	6390	6420	6450	6480	6510	6540	6570	6600	6630	6660	6690	6720	6750	6780	6810	6840	6870	6900	6930	6960	6990	7020	7050	7080	7110	7140	7170	7200	7230	7260	7290	7320	7350	7380	7410	7440	7470	7500	7530	7560	7590	7620	7650	7680	7710	7740	7770	7800	7830	7860	7890	7920	7950	7980	8010	8040	8070	8100	8130	8160	8190	8220	8250	8280	8310	8340	8370	8400	8430	8460	8490	8520	8550	8580	8610	8640	8670	8700	8730	8760	8790	8820	8850	8880	8910	8940	8970	9000	9030	9060	9090	9120	9150	9180	9210	9240	9270	9300	9330	9360	9390	9420	9450	9480	9510	9540	9570	9600	9630	9660	9690	9720	9750	9780	9810	9840	9870	9900	9930	9960	9990	10020	10050	10080	10110	10140	10170	10200	10230	10260	10290	10320	10350	10380	10410	10440	10470	10500	10530	10560	10590	10620	10650	10680	10710	10740	10770	10800	10830	10860	10890	10920	10950	10980	11010	11040	11070	11100	11130	11160	11190	11220	11250	11280	11310	11340	11370	11400	11430	11460	11490	11520	11550	11580	11610	11640	11670	11700	11730	11760	11790	11820	11850	11880	11910	11940	11970	12000	12030	12060	12090	12120	12150	12180	12210	12240	12270	12300	12330	12360	12390	12420	12450	12480	12510	12540	12570	12600	12630	12660	12690	12720	12750
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[illegible]

1. MIDAZOLAM 0.1mg
 2. FENTANYL 1mg
 3. KETAMINE 2mg

1. KETAMINE 2mg
2. ATROPIUM 1mg.

[illegible][illegible][illegible]

ECG	44	40	40	46	68	44	41	43
Temperature	35	35	35	35.3	36	36	36	36

Urine Output	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485
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Polystyrene P@25nm (12.5nm) MINIMUM

[illegible][illegible][illegible]

Heart Rate	180	160
Tourniquet on Time		

Throat Pack In

Turnout on Time

A blank grid for drawing a graph. The vertical axis is labeled with 80 and 100. The horizontal axis is labeled with 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100.

Time in minutes	Number of people in room
0	80
1	70
2	90
3	70
4	60
5	65
6	70
7	65
8	70
9	70
10	70

[illegible]

GRBS	

Others			
Equipment Checked and	Temp:	Induction	Regional:

Equipment Checked and Functional	☒ HME ☒ Cling Film	☐ Fluid Warmer ☒ OH Warmer	☒ Inhal ☐ BGI	Regional: Extremity	Specify:
----------------------------------	---	--	---	-------------------------------	----------

☒ Pre O₂ ☐ RSI
☐ Others

Art Site:
EKG Lead
Temp Site:
Times:
Other:
Position:

Temp Site oral Times: 7:20 AM
 FIO₂ Monitor Anaes Start: 7:20 AM ☐ Airway ☐ Oral ☐ Nasal
 ETT # 25 at 9 cm Site: _____
 Needle Size: _____ Depth: _____

OP Start: 11:30 at 1 cm
OP End: 12:30
☒ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Tonal
Needle Size: 25 Depth: 1
Paresthesia ☐ Yes ☐ No

Pulse Oximeter _____ OP End: _____
Capnograph _____ Leave OR: 9:20 AM
Ventilator _____
☐ Tracheostomy ☐ Topical
☐ Drug: Atropine
Catheter at skin _____ cm
Drug Name & Conc: _____

Ventilator _____
Nerve Stimulator _____

Anaesthesia:
☒ GA
☐ Awake
☐ Video Laryngoscopy
☒ Direct Vision
☐ Stilette / Bougie

Drug Name & Conc: _____
Bolus: _____

☒ Monitored Anaesthesia Care
☐ Regional
☐ Video Laryngoscopy
☐ Stylette / Bougie
☐ Fiberoptic
 Infusion: _____
 Block Level: _____

Pressure Points Checked	☐ Regional	Blade# <u>M101</u> Attempts: <u>1</u>	Block Level:
Line (Size & Location)		Difficulty Why?	Comments:

Care: Oint

Line (Size & Location)

☐ CVP:

☒ Bilat = BS

Transportation to

☒ PACU ☐ ICU ☐ Other

☐ ART: _____
☒ IV: RL 24g

☐ IV:
☐ IV:
☐ IV:

☒ Closed Circle
☐ Other

Name of the Doctor: Ravi

Signature of the Doctor : Paul



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: am Neena

Time Received: 9:30 am

Time Discharged: 9:00 am

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 BLOOD PRESSURE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 PULSE	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 RESP	IV Cannula Site: <u>(R) IL 24A</u> ☐ O₂ Mask ☒ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting: ☐ Yes ☒ No NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: <u>10% Iso - P 9ml/hr</u> Oral Feeds: <u>Formula milk - w</u>

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	0	0	1		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	RESPIRATION	2	2	2			
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION	2	2	2			
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1							
BP $\pm$ 50 of Pre Anaesthetic leve	= 0							
Fully awake	= 2	CONSCIOUSNESS	0	1	1			
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2			
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			6	1	8			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/7	11am	3/10	Inj. Paracetamol 25mg	Pr

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

Anaesthesiologist Name: Pravi

Anaesthesiologist Signature: Pravi

Date & Time: 03/7/26 @ 10:00 am

PACU Nurse Name: Neena

PACU Nurse Signature: Pr

Date & Time: 3/7/26 @ 9:50 am

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): Swanna

Date & Time: 3/7/26 @ 9:00 am

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

BAH-00654800 IP5-00175902
Baby Of NAGULA NEENASRI
12-04-2026 0 Y 2 M 21 D (M)
Dr. KOKKULA PRANEETH



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

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: Post-op Care

☐ Patient's Educational Topic/s discussed with the:
☐ Patient ☒ Family Member ☐ Others:

Nurse Signature: [Signature]

Nurse Name: Deena

Date and Time: 3/7/26 @ 1pm

NPO - 2:00 AM (Formula Milk)

EMERGENCY ROOM TRIAGE FORM

Patient's Name: B/O Neenasri Age: 2 1/2 m Gender: ☒ Male ☐ Female
Date: 3/7/26 Time of Arrival: 4:50 AM Triage Completion Time: 4:52 AM
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): see ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify) _____
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.2f PR: 130bpm BP: 66/44 RR: 32bpm SpO₂: 97%
Chief Complaints: came for surgery programmable vp shunt

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☒ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]

Communicable Disease Triage Screening

RT A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location: _____
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Ramadevi

Date & Time: 3/7/26 at 4:52 AM

Docu. No.: RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse: Ramadevi



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/7/26 Time of arrival : 4:54 AM up shut
Chief Complaints : came for surgery programmable RBS: NA
Height : Weight : 1.98 kg BMI : NA Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify NA
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

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

- ☐ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair
- Uses furniture for support

☐ Yes ☒ No

☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No

☐ Yes ☒ No

☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With parents

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

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

Time of Initial assessment completed by ER Nurse : 4:56 AM

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

Time	Nursing Notes
4:55 a	- Assessed the baby by Mr. Prathiba
6am	- IV placement done
	- Shifted to OT.

Samples collected by: Prathiba

Time: 5:45am

Samples sent by :

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>135b/min</u> BP: <u>42/44</u> CFT: <u><3sec</u> RR: <u>35b/min</u> SPO ₂ : <u>97%</u> GCS: <u>5/5</u> Temperature: <u>98.0°F</u> Pain Score: <u>0/10</u> Repeat RBS (if applicable): <u>-</u>	Shift - out from ER to: <u>OT</u> Time of Shift - out: <u>6:05am</u> Handover given to: <u>Bapu</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

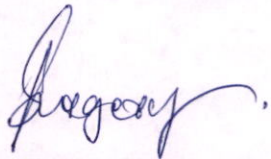
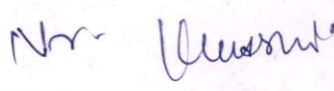
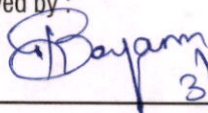
Procedures done with details (if any): IV placement

Name of the Nurse: Prathiba

Signature of the Nurse: [Signature]

Date & Time: 03/04/2020 6:5am

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00654800 IP5-00175902 Baby Of NAGULA NEENASRI 12-04-2026 0 Y 2 M 21 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 03/07/26 @ 5:21 am	Date & Time of Transfer Order 03/07/26 @ 8 am
		Transfer Ordered by Dr. prathiba	Reason for Transfer 
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	10% BOP in 50 cc	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. prathiba	
Patient & Clinical Records Received by :  3/7/26 @ 6:17 AM			
Date & Time of Patient Received :			

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

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

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00654800 IP5-00175902 Baby Of NAGULA NEENASRI 12-04-2026 0 Y 2 M 21 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 3/7/26 @ 5 ²¹ am	Date & Time of Transfer Order 3/7/26 @ 1pm
		Transfer Ordered by Dr. kokkula Praneeth	Reason for Transfer Post-op Recovery
From Unit OT	To Unit ICU A	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films 9	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op file CT	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Praneeth		Name of Person Ordered Transfer Dr. Praneeth	
Patient & Clinical Records Received by : Srishe			
Date & Time of Patient Received : 3/7/26 1pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready