

MAH-00390607
Master VELPULA VARSHIL
12-04-2016 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

81012

Date : 3/7

Patient Name: maha. v. varshil Date of Birth: 12/4/2016 Age: 10y/1m

Gender: M Ward: P-OT UHID No.: 390607

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

Name of the Surgery : Adeno tonsillectomy & Coblation
B/C myeloma tonsil + adenoids

Time in : 5:35pm

Time Out : 6:20pm

	NAME	AMOUNT
1. Surgeon	Dr. P. V. L. N. Murthy	
2. Anaesthetist	Dr. Shabram	
3. Assistant Surgeon		
4. OT Technician	Siva/leela	
5. Circulating Nurse	Omaya	
6. Assistant Nurse	AKA	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : Cobulator. → 9686367

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9686366

Order by: Sufata

MAH-00390607 IP5-00175925
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CONSUMABLES OF OT

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Technician : Shivuleela Date : _____ Time : _____

PAC

	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 6.5	14	1	Major Pack Drapes	1	1	Inj Vit.K		
LMA 3	01	—	Sutures			Cord Clamp		
ECG leads A/P/N	5	3				Suction Catheter		
HME filter A/P/N	01	1				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	5	Gloves 6.6+7	272		Surgical Gloves		
02 cc	10	5	PF (11.5)	272	181	Gauze Pack		
01 cc	1	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube 6 no	2	2	Koochies (S)		
RL	01	1	Cautery pencil			Supbroad gel	1	1
NS : 10ml / 100ml / 500ml / 1000ml	142	141	Koochies			NS 500ml	2	2
newi spike	01	0	Ointments			Transfix	1	1
Guar	03	01	Suction Catheter			100-500	272	2
Fentanyl	02	1	Cap, Mask	10/10	10/10	Saulon	1	1
Morphine			Gauze Pack N4R	272	2	ly. Anesth.	5	3
Ketamine			Mop Pack	1	1	Grommet	2	2
Propofol	03	2	Steristrip			Nidlar	01	1
Rocuronium	01	1	Underpad	1	1	Nasal Apraesg		—
Glycopyrolate	01	—	Draw sheet			22/24	14	—
Myopyrolate	01	1	Abgel			oral Apraesg		—
Ondansetron	01	—	Foleys catheter			213	14	—
Pencan 25g/ Spinal Needle 22			Urobag			14 cannula		—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			2014	14	—
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Agmetin			Bandage			02 mask CA)	01	—
1-2 gm	01	1	Tegaderm			Fluidshield mask	2	2
Suppositories			Ioban			D/S Abrons	2	2
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	1			
Justin : (2.5 mg / 25mg / 100mg)	142	—	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
Vacuum	01	1	Microshield	1	1			
Dext + Dextrode	14	14	Cotton Balls					
Tranexa + pcm	14	24	Latex Gloves	109	109			
Glowall Helowen	54	—	Ramdione Scrub					
Wcm (1000ml) 3cc	14	1	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9686249

Ordered by : [Signature]

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

ESTIMATION SLIP

Date : 01/07/2024 UHID / IP No. : MAH-00390607 SI No. 81012

Name of Patient : Mst. V. Vagshid Age: 104 Gender: M

Father's / Husband's Name : Mr. V. A. Mahalingam Corporate / Occupation : Ret.

Address : _____ Phone : 9550346019 Email: _____

Procedure / Plan : Adams Fertilization & Coelation

MODE OF PAYMENT : ☐ SELF ☒ TPA : NA / New India ☐ GIPSA: ☐ OTHERS

TARIFF INFORMATION :

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
P (Day)	Room Rent & Nursing Charges	/	/	X	/						
	Doctor's Fee				1 Day						
	L. Tax				Empty	1/1A					

PARTICULARS				AMOUNT (₹)			
Surgeon's / Anesthetists's Fee / O.T. Charges				In play.			
O.T. Consumables				7500 Subject to approval by TPA / Insurance Company			
Instrument Charges				7500 Not Covered by TPA / Insurance company			
Pharmacy Consumables & Investigations				As per actual - Not Included in Estimation			
Equipment Charges	Monitor :		Oxygen :		Infusion pump / Syringe pump :		
	Ventilator :	Conventional :		HFO-SLE 5000 :		HFO Sensormedix :	
	Phototherapy :	Single Surface :		Double Surface :		Triple Surface :	
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation			
Package				IPNE 002 + IPNE 11 = 68,700.			
Others				Note:- EMAC Mand. 28,000 Self purchase			
Initial Minimum Deposit				15,000 ₹. EMAC Mand. 28,000			

REMARKS:

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

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

DECLARATION

Signature of the Client

Signatory Relationship

Signature of the Financial Counselor

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175925 Admit Date : 03-Jul-2026 Admit Time : 01:50 PM UHID : MAH-00390607

Patient Details :

Patient Name	: Master VELPULA VARSHIL	Age	: 10 Y 2 M 21 D
Guardian	: Mr VELPULA ANJANEYULU	DOB	: 12-04-2016
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO 102, DIAMOND D1, ARAMBH TOWNSHIP Serilingampally Hyderabad Telangana INDIA 500019	Phone No	: 9550346019/ 9704050708
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

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

Contact Details :

Name	: Mr VELPULA ANJANEYULU	Relationship	: Father
Contact Address	: FLAT NO 102, DIAMOND D1, ARAMBH TOWNSHIP Serilingampally Hyderabad Telangana INDIA 500019	Phone No	: 9550346019


 Signature

Doctor Details :

Doctor Name	: Dr. P V L N MURTHY	Specialisation	: EAR NOSE AND THROAT
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. FAISAL B NAHDI		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: MEDI ASSIST INSURANCE TPA PVT LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

MAH-00390607 IP5-00175925
Master VELPULA VARSHIL
12-04-2018 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY

Attendant: _____ Dept : _____

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



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	2:50 pm	ER	OT	[Signature]
3/7	10:10 pm	OT	320	[Signature]

Cross Consultation Visit

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

[illegible]

Signature

Chore

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Date : _____ Time : _____ Prepared By : _____

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Pediatric Multiorgan History & Physical Examination

Name : Varshil Age/Sex 10/M
Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

epo: recurrent URTI
snoring | x 6 mon
poor sleep

History of present illness :

↓
evaluated on OP basis
found to have adenotonsillar
hypertrophy

↓
now admitted for surgical management
no epo fever/cough/cold/vomiting
NPO adequate



Pediatric Multiorgan History & Physical Examination

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

[Handwritten: No]

Birth & Neonatal History:

[Handwritten: @ perinatal transition]

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : *[Handwritten: @]*

Developmental History :

[Handwritten: developmentally @]

Immunization History :

[Handwritten: immunised]



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 30kg (Centile _____)

On Examination :

Temperature : 97.9°F Pulse Rate : 102/min B.P. 96/60 SPO2 100%

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 addles 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 : _____

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 :

Alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

(2)

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

chronic adenotonsillitis
OME

now for surgical management-



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

bleeding

Desired goals of the treatment :

surgical mx

Planned Labs:

1.) CBP

*Noted
for test sent*

Planned Management

1.) Cont NPO

2.) IVF DNS

3.) Shift to OT

Signature of the Doctor:

Dr. Ashile

Name of the Doctor:

Dr. Ashile

Date & Time:

23/7/26

Signature of the Consultant:

12/7

Name of the Consultant:

Date & Time:

*Dr. P V L N MURTHY
Reg. No: 47267*

CROSS CONSULTATION FORM

Doctor Name : Dr. Faisal Date : 4/7/26 Time :

Diagnosis :

Hospital : Reh B. H.

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

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

Signature:

Findings and Recommendations :

Post adenotonsillectomy +
BL myringotomy + grommet
insertion

Good early work

Absent :

Adequately work ..

No vomit

No fever 1.

Can be discharged
from medical unit

Consultant :

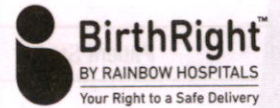
Name : M. FN Signature : Dr. Faisal B. Nahdi Date & Time : 4/07/26



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Date & Time	Progress Notes	Doctor's Order
1/2/20	CSB Resident 1 AM. Ch. Dehydration S/P No fresh issues Vitals (N) Sts (N) ews ms pp (N)	1) <u>As</u> as per chart <u>Shankar</u>

[illegible]

[illegible]

1

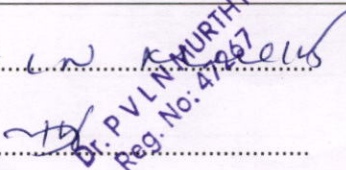


PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1 T. AUGMENTIN 625mg BID - 2wks	
2 T. DEECORT 6mg BID - 1wk	
3 T. SINAREST BID - 2wks	
4 T. RAND- 40mg BID - 1wk	
5 CIPROX-D Edecom 500mg / 2 times - 1wk	
6 T. TRAMEXA 500mg BID - 2wks	
7. Salt water gargle TID 2wks	

Name of the Surgeon: Dr. P. V. L. MURTHY

Signature of the Surgeon: 

Date & Time: 3/7/26 @ 6pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. PVL N. MURTHY
 Asst. Surgeon :
 Anaesthetist : Dr. Anish
 Scrub Nurse : Anish

Patient Name : Master Velpula Varshil
 UHID No. : 0195925 Surgery No :
 Date : 12/04/2018 In-time : 5:35 PM

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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>5:45 PM</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>[Signature]</u>		
Name : <u>Dr. Anish</u>		

Before Skin Incision >>

TIME OUT		Time: <u>5:50 PM</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>NA</u>		
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>Dr. Anish</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>6:10 PM</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>[Signature]</u> Dr. P V L N MURTHY Reg. No: <u>47267</u>		
Name : <u>P V L N MURTHY</u>		

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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

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. Akhile

Date & Time : 3/7/26

Nurse Name & Signature: Nr. Srusmita

Date & Time : 3-7-26 @ 2:20 pm

Ward

Sheet No:

REGULAR PRESCRIPTIONS

Weight 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						

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						

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						

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						



DRUG CHART

Date of Admission: 3/7 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:																			



REGULAR PRESCRIPTIONS

Weight. 50.42 kg Ward.

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

DRUG : T. AUGMENTIN				Date
Dose	Route	Frequency	Start Date	Time
625mg	PO	BD	4/7	10 AM
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : T. PEFORT				Date
Dose	Route	Frequency	Start Date	Time
4mg	PO	BD	4/7	10 AM
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : T. SINAREST				Date
Dose	Route	Frequency	Start Date	Time
1wb	PO	BD	4/7	6 AM
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	5:45pm	Tab. PARACETAMOL	1gm	IV	<i>[Signature]</i>	AKhil Siva
3/7	5:45pm	Tab. AMOXICILLIN	1.2gm	IV	<i>[Signature]</i>	AKhil Durg
3/7	5:40pm	Tab. TRANEXAMIC ACID	750mg	IV	<i>[Signature]</i>	AKhil Durg
3/7	5:40pm	Tab. DEXAMETHASONE	6mg	IV	<i>[Signature]</i>	AKhil Durg



Weight. 30kg Ward.

[illegible]

Signature

VERIFIED BY: Name:

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		
3/7/24	2.50 pm	8.	Diagnostic Procedure	m	4	0	1	1	—	<i>[Signature]</i>
4/8/26	8 am	9	Soft diet	m/t	1	0	1	1	—	<i>[Signature]</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: 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

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
03/07/2026 2:15 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adeno tonsillitis	Resolution	Adenotomies Tonsillectomy	<i>[Signature]</i>	☒ Nursing ☐ Others:
3/7/26 2:55 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adeno tonsillitis	Resolution	Adeno tonsillectomy	<i>[Signature]</i>	☐ Medical ☐ Others:
4/7/26 8 AM	☐ Medical ☐ Nursing ☒ Others: <i>[Signature]</i>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Adenotonsillectomy	Soft diet	RPA E- 1650 kcal/d P- 29 gwt/d	<i>[Signature]</i>	☐ 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:

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Master VELPULA VARSHIL
12-04-2016 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY




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RESULT SHEET

3/7

Date					
Time					
Hb	12-6				
PCV	38-9				
RBC	4-93				
WBC	9-17				
N/L	60/34				
Platelets	375				
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.,) :

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Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

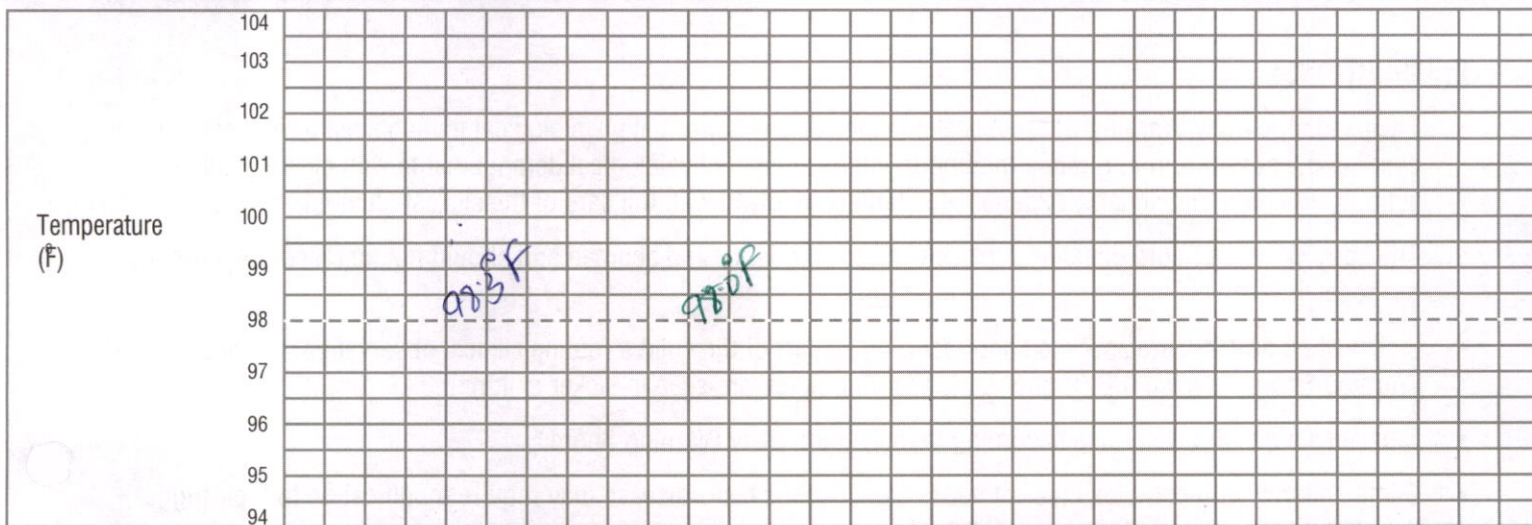
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/3/2016 Time: 11 PM 6 PM

Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190
	180
	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
Heart Rate (Number)	120 bpm 120 bpm

Resp Rate (bpm)	70
	60
	50
	40
	30
	20
	10
Resp Rate (Number)	20 bpm 20 bpm

Resp Distress	Mod/ Severe
	None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	99% 100%

Conscious Level	Normal
	Altered
GCS *	15/15 15/15

TOTAL SCORE	
Number of shaded boxes	0 0
Pain Score	0 0
Observer's Initials	PV 6

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 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)

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.

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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)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

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
6:25R	Assess the pt General Condition.	6:30R	Assessed the pt General Condition.	pt is Conscious & oriented
6:40R	Relieve pain & Discomfort	6:45R	Relieved pain & Discomfort	vital recorded
7pm	monitor vital signs	7:10R	monitored vital signs	no bleeding
	monitor for bleeding		monitored for bleeding	maintained
	maintain I/O chart		maintained I/O chart	no vomiting
7:10R	maintain NPO status	7:20R	NPO broken, water given	shifted
10 pm	pt shift to the ward	10R	pt shift to the ward	

Re-Assessment: _____

Special Notes: After surgery pt is Conscious & oriented

Nurse Signature: _____

Nurse Name: _____

Date & Time: 3/7/26 18:10 Pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: patient pain & 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
10 pm	⇒ Assess the patient General condition	10:10 pm	⇒ Assessed the patient General condition	patient is comfortable
12 pm	⇒ Assess the patient vitals signs	12:20 pm	⇒ Assessed the patient vitals signs	
2 AM	⇒ To maintain I/O chart	2:20 AM	⇒ maintained I/O chart	
4 AM	⇒ To provide comfortable position	4:20 AM	⇒ provided comfortable position	
6 AM	⇒ To encourage oral intake	6:20 AM	⇒ encourage oral intake	

Re-Assessment: patient is comfortable

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: [Signature]

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

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NURSING CARE RECORD


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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:

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NURSING CARE RECORD


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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:

Patient Sticker

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:

Patient Sticker

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:

Patient



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. P.V.L.N. Murthy Department: OT Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Chronic Adenotonsillitis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area	<u>ER</u>	<u>OT</u>				
	Shift Time	<u>2:50 PM</u>	<u>10:00 AM</u>				
	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>NA</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>97.9°F</u>	<u>98.6°F</u>			
		Res:	<u>23 b/m</u>	<u>20 b/m</u>			
		SpO ₂ :	<u>100%</u>	<u>100%</u>			
		Pulse:	<u>85 b/m</u>	<u>86 b/m</u>			
		BP:	<u>95/70/62</u>	<u>101/62</u>			
	Fall Risk Score:	<u>10</u>	<u>10</u>				
	Pain Score:	<u>0</u>	<u>10</u>				
	Safety Needs:	<u>yes</u>	<u>yes</u>				
Physiotherapy	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
Others Specify:	<u>Nil</u>	<u>NA</u>					
Recommendations	Special Diet:	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>Nil</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>NA</u>				
Handed Over By Name :		<u>Susmitha</u>	<u>Durga</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>3/7/26</u>	<u>3/7/26</u>				
Time:		<u>2:50 PM</u>	<u>10:00 AM</u>				
Taken Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>3/7/26</u>	<u>3/7/26</u>				
Time:		<u>2:10 PM</u>	<u>2:10 PM</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	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Recommendations		Pain Score:						
	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ 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	☐ 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:								

BRADEN 'Q' SCALE

				Date :	21/04/2018			
				Time :	2:15 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	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	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	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	4		
FRICION-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		
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					28	28		
Evaluator's Name					Sugan Reddy			

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



PAIN ASSESSMENT FORM

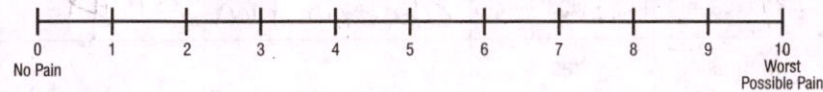
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/4/26	2:50 PM	0	ovr	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A N/A	JA
3/7	6:30 PM	1/10	SS	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	N/A	Diya
4/7	7 AM	0/10	SLs	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Drugs
				☐ 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:

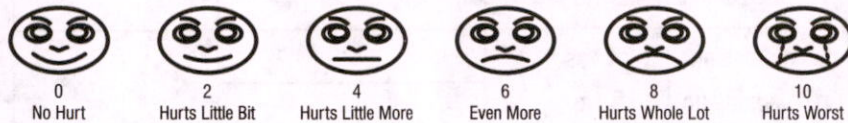
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

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

MAH-00390607 IP5-00175925
Master VELPULA VARSHIL
12-04-2018 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY

Patient S



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE 3/7/25 u/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	2			
	13 years old and above	1					
Gender	Male	2	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	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	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 sage	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			10	10			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		1	✓			
Call device within reach		1	✓			
Wheels Locked		1	✓			
Room free of clutter		1	✓			
Adequate Lighting		1	✓			
Wheel Chair Support		1	✓			
Other Intervention(s) Specify		1	✓			
Nurse's Name :		25/04/25	✓			
Signature :		25/04/25	✓			
Date :		3/7/25	✓			
Time :		2:20 PM	✓			



CHECKLIST FOR THROMBOPHLEBITIS

3/7/26

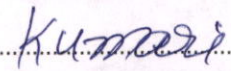
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs 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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	—							
Signature of the Nurse				Devi Princy									

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 :  Name : 

Signature of Ward In Charge :

Signature :  Name : 

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. Adenotomectomy + Tonsillectomy + BIC myelography
2. Glands

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>Good healthy</u> <u>Good healthy</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. Bleeding, change in voice, vocal registration
b.

- I authorize Dr. P V L N Murthy 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: V. Shrinisha

Name: V. Shrinisha

Relationship with patient: Mother

Date & Time: 3/7/2016 @ 4:30 pm

Witness:

Signature: [Signature]

Name: Team

Date & Time: 3/7/2016 @ 4:30 pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. P V L N Murthy Date: 3/7/2016 Time: 4:30 pm

శస్త్రచికిత్స / ప్రాసీజర్కు 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 / ప్రాసీజర్కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, 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 / ప్రాసీజర్కు 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.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేముని 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:

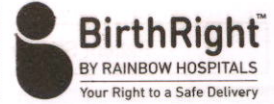
తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

MAH-00390807 IP5-00175925
Master VELPULA VARSHIL
12-04-2018 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY



Name: MAH. V. VARSHIL Age: 10y 2m Sex: male UHID.No :
Date: 2/7/26 Time: 12:37 pm Proposed Operation: Abdominal Hernia Repair & Cystectomy
Diagnosis: _____

B.P / CRT: _____ H.R: _____ Weight: 49.3 kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: _____	Glucose: _____	Protein: _____	HIV: _____	X-Ray: _____
PCV: _____	Urea: _____	Alb: _____	HBS Ag: _____	ECG: _____
WBC: _____	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: _____		

Allergies: NADA

Medical History: CVS: _____

RESP: _____ Diabetes: _____

CNS: _____

Renal: _____

Hepatic / GE: _____ Physical Activity: (10) miles per week

Others: HT: 150cm / full term / B.Wt: 2.6 kg / unscarred female / no cervical spine issues as per clinical.

Past Anaesthetic History: _____

Physical Exam: mod. built

Airway: MP 1 2 3 4 Mouth Opening: adequate Mento-hyoid Distance: 10 Neck: 10 Teeth: fine

Lungs: _____

Heart: _____

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

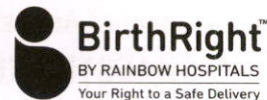
Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. SHIVA



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No

Fasting Status: Adequate

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R: 100/min

B.P / CRT: 105/66

SpO₂: 98% RA

R.R: 14/min

Last Feed: > 6 hrs

Pre-OP Diagnosis: ADENOTONSILITIS

Operation: ADENOTONSILLECTOMY

Date: 3/2/21

Surgeon: Dr. P.V.L.N. Murthy

Anaesthesiologist: Dr. Arjun Kumar Sharma

Technician: Siraleeb

TIME: 5:30 * 6:30 *

N₂O / AIR / O₂ / VPM

HALO / SO / SEVO

Drugs:

3ml MIDAZOLAM 2mg
2ml FENTANYL 100
5ml PROPOFOL 100
5ml POLYURONUM 25mg
5ml PARACETANOL 750mg
TRANXIA 750mg
DEXONA 5mg

FI_{O₂} / SaO₂

ETCO₂

ECG

Temperature

Urine Output

Antibiotic

Suppository

Blood Loss

NOTES

Fluids: RINGER LACTATE

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site: RT UL

☒ Art Site:

☒ EKG Lead: 3 lead

☒ Temp Site: RT Axilla

☒ FIO₂ Monitor

☒ Agent Monitor

☒ Pulse Oximeter

☒ Capnograph

☒ Ventilator

☒ Nerve Stimulator

Position:

☒ 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: 5:35pm

OP Start: 5:45pm

OP End: 6:20pm

Leave OR: 6:20pm

Anaesthesia:

☒ GA

☒ Monitored Anaesthesia Care

☒ Regional

Line (Size & Location)

☒ CVP:

☒ ART:

☒ IV: 20G IV on RT UL

☒ IV:

☒ IV:

Induction

☒ IV

☒ Pre O₂

☒ Others

Inhal

Oral

SGA

Nasal

ETT # 6 at 15 cm

☒ Oral

☒ Nasal

☒ Cuff

☒ Tracheostomy

☒ Topical

Drug: POLYURONUM

Awake

Direct Vision

Video Laryngoscopy

Stylette / Bougie

Fiberoptic

Blade # 3 Attempts: 1

Difficulty Why?

☒ Bilat = BS

☒ Semi-Closed Circle

☒ Closed Circle

☒ Other

Regional:

Extremity

Specify:

☒ Spinal

☒ Epidural

☒ Caudal

Others:

Position:

Site:

Needle Size:

Depth:

Parasthesia ☐ Yes ☒ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU

☒ ICU

☒ Other

Relaxant Reversed ☐ Yes ☒ No ☒ NA

Name of the Doctor: Dr. Arjun Kumar Sharma

Signature of the Doctor: [Signature]



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dingel Time Received: 6:28pm Time Discharged:

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 RES PULSE > < 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 SPO₂	IV Cannula Site: <u>226</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: <u>Orally Allow</u>																																																		
	POST ANAESTHESIA SCORE (Modified Aldrete Score) <table border="1"> <thead> <tr> <th rowspan="2"></th> <th rowspan="2">IN</th> <th colspan="3">MINUTES</th> <th rowspan="2">OUT</th> <th rowspan="2">SCORING INTERPRETATION</th> </tr> <tr> <th>30</th> <th>60</th> <th>90</th> </tr> </thead> <tbody> <tr> <td>Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0</td> <td>ACTIVITY</td> <td>1</td> <td>1</td> <td>2</td> <td>2</td> <td rowspan="5"> 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: </td> </tr> <tr> <td>Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0</td> <td>RESPIRATION</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0</td> <td>CIRCULATION</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>Fully awake = 2 Arousable on calling = 1 Not responding = 0</td> <td>CONSCIOUSNESS</td> <td>1</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0</td> <td>COLOR</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td colspan="2">TOTAL</td> <td>8</td> <td>9</td> <td>10</td> <td>10</td> <td></td> </tr> </tbody> </table>					IN	MINUTES			OUT	SCORING INTERPRETATION	30	60	90	Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	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 deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	2	2	2	Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	TOTAL		8	9	10	10
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PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/7	6:28pm	1/10	—	Dingel

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

Anaesthesiologist Name: Dr. SK. Aysha

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: Dingel

PACU Nurse Signature: [Signature]

Date & Time: 3/7/2016 @ 10:20pm

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): Aysha

Date & Time: 3/7/2016 @ 10:20pm

Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

MAH-00390607 IP5-00175925
Master VELPULA VARSHIL
12-04-2016 10 Y 2 M 21 D (M)
Dr. P V L N MURTHY
title.



Patient Name: Master VELPULA VARSHIL Age: 10y Gender: Male ☒ Female ☐

UHID NO: MAH-00390607 Surgeon Name: Dr. P.V.L.N. Murthy

Anaesthesiologist: Dr. Ayisha

Operative procedure planned: ADENOTONSILLECTOMY & COBLATION

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 without numbness can be achieved by infusing weak solutions of local anesthetics 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 mellitus ☐ Renal failure
- ☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
- ☐ Incapacitating Chronic Obstructive Pulmonary Disease
- ☒ Others: Laryngoparum, Bronchoparum, Varshil
- Comments:

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master VELPULA VARSHIL the above mentioned operation / Diagnostic / Therapeutic procedures ADENOTONSILLECTOMY & COBLATION

I authorize and give consent for anaesthesia (☐ Regional / ☒ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : V. Arun

Name : V. Arun

Relationship with Patient : Uncle

Date & Time : 03/07/26, 4:28pm

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Sr. Ayasha

Date & Time : 03/07/26, 4:30pm



EMERGENCY ROOM TRIAGE FORM

Patient's Name : V. Varshil Age : 10yr. Gender : ☒ Male ☐ Female

Date : 03/07/06 Time of Arrival : 1:06pm Triage Completion Time : 1:28pm

Allergies : ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies

Source of Information : ☒ Parents ☐ Others (Specify)

Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

- ☐ Normal
☐ Sick Looking

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

- ☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

- ☐ Not - Life - Threatening
☐ Life -Threatening

Initial Vital Signs: Temp: 97.99 PR: 85b/m BP: 95/79(62) RR: 23b/m SpO₂: 100%

Chief Complaints: Came for surgical procedure
Abdominal surgery - colitis

Triage Classification

- ☐ Level 1 : Resuscitation
☐ Level 2 : EMERGENT : Life or limb threatening
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening
☐ Level 4 : LESS URGENT : Significant illness but not life threatening
☐ Level 5 : NON - URGENT : May receive care when convenient

CTAS

- ☐ Immediate
☐ < 15 min
☐ 30 min
☐ 60 min
☒ 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

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. 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

1. 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: _____
2. 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 : Larange

Signature of Triage Nurse : Larange

Date & Time : 03/07/06 @ 1:28pm

1960
11/20/60
11/20/60

11/20/60

11/20/60

11/20/60

11/20/60

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11/20/60	11/20/60	11/20/60	11/20/60
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11/20/60	11/20/60	11/20/60	11/20/60

11/20/60

11/20/60

11/20/60

11/20/60

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/4/26 Time of arrival : 1:29 pm
Chief Complaints : Come for Surgical Procedure Adang Silakan RBS :
Height : Weight : 50.4 kg BMI : Head Circumference (<2 years) : nil
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify
Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character nil ☐ Location nil ☐ Frequency nil ☐ Duration nil

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☒ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☒ Yes ☐ No
Ambulatory Aids:
• Wheelchair ☒ Yes ☐ No
• Uses furniture for support ☒ Yes ☐ No
Gait/Transferring:
• Bedrest / immobile ☒ Yes ☐ No
• Weak ☒ Yes ☐ No
• Impaired ☒ Yes ☐ No
Mental Status: Forgets limitations ☒ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

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

Time of Initial assessment completed by ER Nurse : 3/4/26 @ 1:30 pm

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

Time	Nursing Notes
2pm	Seen by dr. Akhila Assess pt vital Signs checked & record Iv placement done Blood sample collection done

Samples collected by:

Time: 2.20 pm

Samples sent by : Arnab

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: 85/min BP: 95/49 (62) CFT: < 2 Sec RR: 23/min SPO ₂ : 100% GCS: 15/15 Temperature: 97.9°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: OT Time of Shift - out: 2.50 pm Handover given to: [Signature] (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

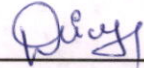
Procedures done with details (if any):

Iv placement done

Name of the Nurse : Mr. Susanta Signature of the Nurse : [Signature]

Date & Time : 31/7/20 @ 1.55pm

PATIENT TRANSFER FORM

Patient Name & UHID No. MAH-00390607 IP5-00175925 Master VELPULA VARSHIL (M) 12-04-2016 10 Y 2 M 21 D Dr. PVLN MURTHY 		Date & Time of Admission 3/7/26 @ 10:00 pm	Date & Time of Transfer Order 3/7/26 @ 10:10 pm
		Transfer Ordered by Dr. PVLN MURTHY	Reason for Transfer Post-OP
From Unit OT	To Unit 320	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	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.	OP file - 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. PVLN MURTHY	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 3/7/26 10:30 pm			

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. MAH-00390607 IP5-00175925 Master VELPULA VARSHIL 12-04-2016 10 Y 2 M 21 D (M) Dr. PVLN MURTHY 		Date & Time of Admission 3/7/26 @ 1:50 PM	Date & Time of Transfer Order 3/7/26 @ 3:00 PM
		Transfer Ordered by Dr. Akhila	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant OP file Yes ☒ No ☐ Dresses If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Photo Gown	①	
2.	Keuchi	①	
3.	E vac	①	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Sushita		Name of Person Ordered Transfer Dr. Akhila	
Patient & Clinical Records Received by : Ganesapathy			
Date & Time of Patient Received : 03/07/26 @ 3:00 PM			

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



320

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 4/7/26 Time: 8:00am

Weight: 30kg Centile: 72^{sd}

Height: 100cm Centile: 72^{sd}

Inference: well child

RDA: — Calories: 1650kcal/d Protein: 29g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spic, & outside foods

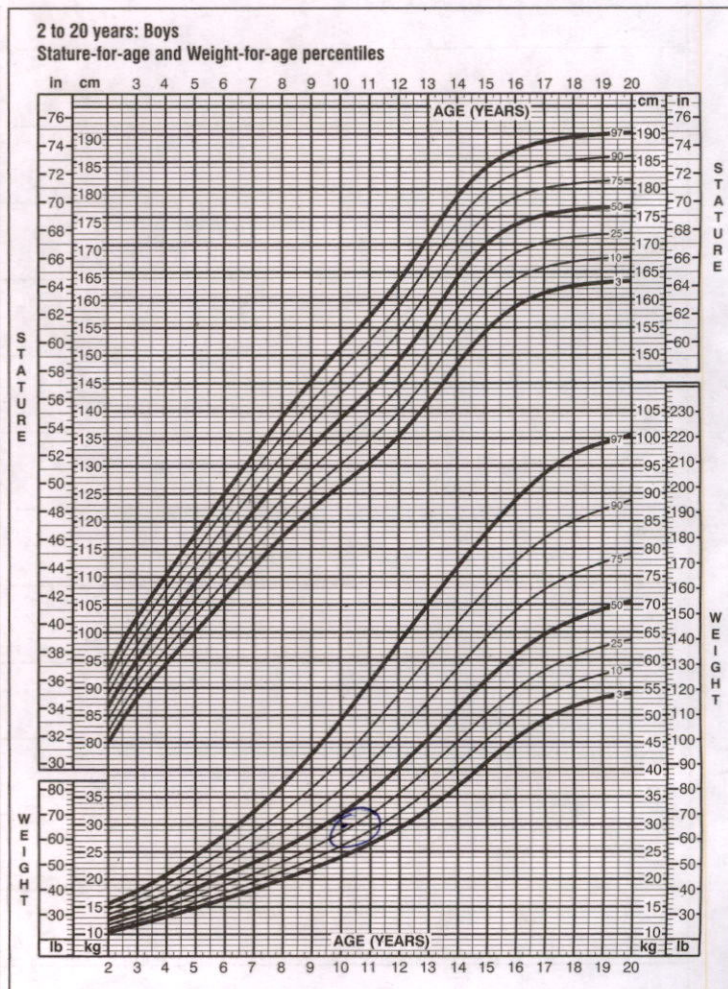
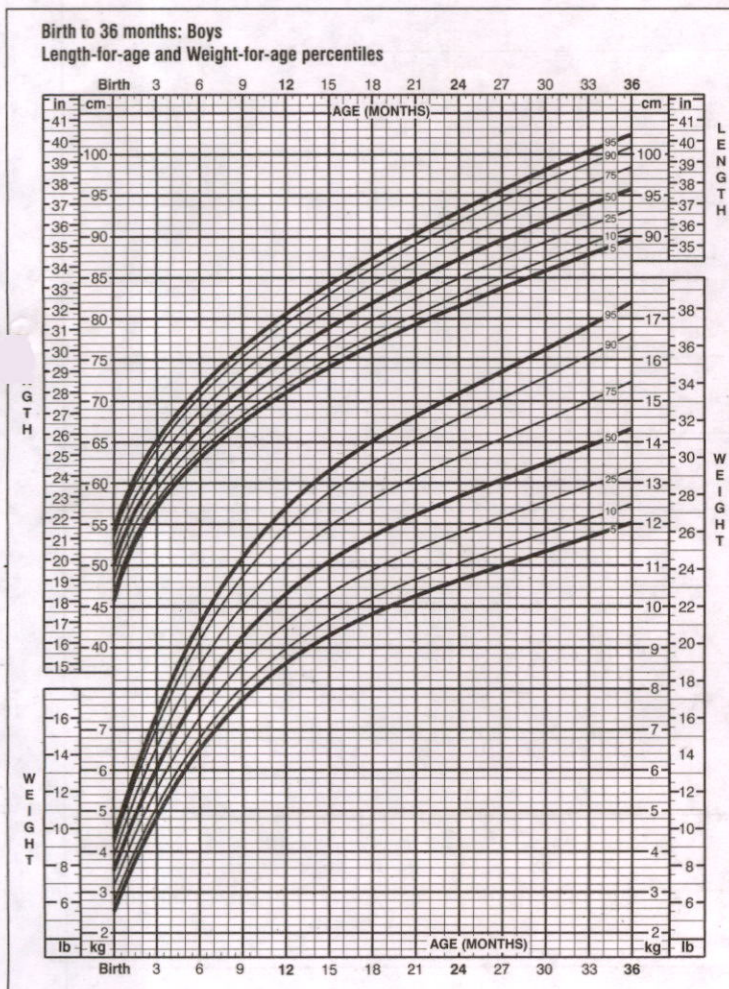
Food Allergies: No Veg/Non-Veg: Non-veg

Diagnosis: Adenotomectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: V. Arun

GROWTH CHART (BOYS)



Dietician's Name: Lalima

Dietician's Signature: Lalima

Daily Notes: