

BAH-00651141 IP5-00176018
Baby Of RANIYA ASLAM
21-02-2026 0 Y 4 M 15 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

Fc not done

SURGERY DETAILS

Date : 8/7/26

Patient Name: Baby of Raniya Aslam Date of Birth: 21-02-2026 Age: 4M

Gender: M Ward: P.OT UHID No.: BAH-651141

Date of Surgery: 06/07/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☒ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : RIGHT PROGRAMMABLE VP SHUNT

Time in : 1:15PM

Time Out : 3PM

	NAME	AMOUNT
1. Surgeon	Dr. PRANEETH V	
2. Anaesthetist		
3. Assistant Surgeon	Dr. SRIPATHA Y	
4. OT Technician	Remesh	
5. Circulating Nurse	Srawi	
6. Assistant Nurse	Shruti	

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: 9698402

Order by: Y. Ramana

Baby of RANITA ASIA
 Patient Sticker
 BAA-066114/5228 4M/2 Day up shunt

CONSUMABLES OF OT

Circulating staff : Technician : Date : Time : 12:30 PM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube 10.5.30.35	1	1	Major Pack (Drape)	1	1	Inj Vit.K	1	1
LMA	1	1	Sutures pack 50,60	2	1	Cord Clamp	1	1
ECG leads : A / P (N)	1	1	Monocyl 3-0,4-0	2	1	Suction Catheter	1	1
HME filter : A / P (N)	1	1	Monocyl 3-0,4-0	2	1	Feeding Tube (Monocyl)	1	1
Syringes : 10 cc	10	5	Silk 3-0,4-0,5-0	2	1	Vaccum Suction Set	1	1
05 cc	10	6	Gloves 9/15	2	1	Surgical Gloves	1	1
02 cc	10	4	Gloves 2, 1/2	2	1	Gauze Pack	1	1
01 cc	2	1	Gloves 2, 1/2	2	2	Syringe 1ml / 2ml	1	1
Cautery plate : A / P (N)	1	1	Surgical blade 11/15	1	1	Surgical Blade # 20	1	1
IV set	1	1	NG tube	1	1	Koochies (S)	1	1
RL	1	1	Cautery pencil	1	1	Paj. Anaero 0.001	1	1
NS : 10ml / 100ml / 500ml / 1000ml	3	2	Koochies	1	1	NS 500ml	1	1
02 mask (P)	1	1	Ointments	1	1	Tranex	1	1
Airway 000.00	1	1	Suction Catheter	1	1	Tranex	1	1
Fentanyl	1	1	Cap, Mask	1	1	Tranex	1	1
Morphine	1	1	Gauze Pack 21+P	1	1	Tranex	1	1
Ketamine	1	1	Mop Pack	1	1	Tranex	1	1
Propofol	2	1	Steristrip	1	1	Tranex	1	1
Rocuronium	1	1	Underpad	1	1	Tranex	1	1
Glycopyrolate	1	1	Draw sheet	1	1	Tranex	1	1
Myopyrolate + Neostigme	2	1	Abgel	1	1	Tranex	1	1
Ondansetron	1	1	Foleys catheter, 6, 8, 10	1	1	Tranex	1	1
Pencan 25g/ Spinal Needle 22	1	1	Urobag	1	1	Tranex	1	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter	1	1	Tranex	1	1
Bupivacaine 0.25% (Heavy)	1	1	Romodrain bag	1	1	Tranex	1	1
Antibiotics Taxim 500	1	1	Bandage	1	1	Tranex	1	1
Amikacin 100	1	1	Tegaderm	1	1	Tranex	1	1
Suppositories	1	1	Ioban	1	1	Tranex	1	1
Anamol : 80mg / 250mg / 170 mg	1	1	Double J Stent	1	1	Tranex	1	1
Supridol : 100mg	1	1	Vaccum Suction set	1	1	Tranex	1	1
Justin : 12.5 mg / 25mg / 100mg	1	1	Plastic Bed Sheet	1	1	Tranex	1	1
Tab. Misoprost : 200mg	1	1	Betadine Solution	1	1	Tranex	1	1
Vaccum set	1	1	Microshield	1	1	Tranex	1	1
Gauze	3	1	Cotton Balls	1	1	Tranex	1	1
Gloves	4	1	Latex Gloves	1	1	Tranex	1	1
Ev p.cm	1	1	Ramdione Scrub	1	1	Tranex	1	1
3-way 100 (100mm)	1	1	Saral	1	1	Tranex	1	1

Surgeon : Anaesthesiologist : Nurse : OT Technician : 9690499

Order No. : Ordered by : 9690499

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

ACTIVITY RECORD FOR BILLING

Name : B/2001-10/19/20

BAH-00651141 IP5-00176018
Baby Of RANIYA ASLAM
21-02-2026 0 Y 4 M 15 D (M)
Dr. KOKKULA PRANEETH

UHID No. : 21-02-2026 Consultant: Dr. KOKKULA PRANEETH Dept :

Date of Admissior 21-02-2026 Date of Discharge : Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	11:30AM	ER	OT	<u>[Signature]</u>
6/7/26	4PM	OT	121	<u>[Signature]</u>

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

06/07	PT/APTT, RBS (POCE) (105)
	Stroke power

67532

8

Temp

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07 6/7	pac op (bain) iv placement	5 (1)	30461	Shailaja Shailaja

ANY OTHER INFORMATION

(11/11)

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Date : 8/7/20

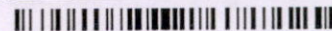
Time : 10am

Prepared By : Shailaja

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Shailaja	40-1		

**Rainbow Children's Hospital - Banjara Hills**

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

ADMISSION SHEET**Registration Details :**

Admission No : IP5-00176018 Admit Date : 06-Jul-2026 Admit Time : 10:53 AM UHID : BAH-00651141

Patient Details :

Patient Name	: Baby Of RANIYA ASLAM	Age	: 0 Y 4 M 15 D
Guardian	: Mr ASLAM	DOB	: 21-02-2026 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO-3-5-44 SULTANA Yadgiri Gulbarga Karnataka INDIA 585201	Phone No	: 9986099496/ 9886740509
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : POST OP 409 Ward Name : 4F-OT COMPLEX
Room No : POST OP 409 Admission Type : First Visit

Contact Details :

Name : Mr ASLAM Relationship : Father
Contact Address : H.NO-3-5-44 SULTANA Yadgiri Gulbarga Phone No : 9986099496 / 9886740509
Karnataka INDIA 585201

ASLAM
Signature

Doctor Details :

Doctor Name : Dr. KOKKULA PRANEETH Specialisation : PEDIATRIC NEURO SURGERY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. ABHISHEK RAVINDRA JAIN

Payment Details :

Payment Mode : Cash Deposit Amount : 100000.00
Payor Name : SELFPAY



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Sh. Raniya Aslam

UHID ID:

Department:

Consultant:

BAH-00651141
Baby Of RANIYA ASLAM
21-02-2026
Dr. KOKKULA PRANEETH
IP5-00176018
0 Y 4 M 15 D
(M)

BAH-00651141

IP5-00176018

Baby Of RANIYA ASLAM

21-02-2026

0 Y 4 M 16 D

(M)

Dr. KOKKULA PRANEETH

**Pediatric Multiorgan History & Physical Examination**

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Course of g/p Dist programmed vs stunt
retractilis with hydrocephalus with h/d dual
Eupyrer

History of present illness :

Admitted for Programmed
vs stunt

No H/o fever ~~retractilis~~ cold,
cough &

CRP (04/7/26)

Hb-12.8 / WBC-11.26 / PL-814

N/L - 25.4 / 32.8.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term / Bwt. 2.9 kg / N/W stay dt MLI +
R2, ventilator support, N/W 22 days.

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)) 2.8 (Centile _____)

On Examination :

Temperature : 98.6°F Pulse Rate : 128/min B.P. _____ SPO2 98.1% RA

Resp.rate and type of breathing : 28/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.,) _____

BLAEE

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

S/S 2P

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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

Free 100



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

fontaine.

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

8/8 Right periantheliosis, vpsuunt / vpsuunt with
Hydrocephalus with bilateral Empyem.

Admission periantheliosis
vpsuunt



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: injection

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CRP-Done (Hb-12-8)
PT APTT INR, RBS) today.

Planned Management

→ NPO ^{continue} PAC-done - Re-eval PAC.
→ PEG placement vs shunt today
→ WF - Y2DUS.

Signature of the Doctor: N. Praneeth

Name of the Doctor: N. Praneeth

Date & Time: 06/11/26
11am

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

Signature of the Consultant: [Signature]

Name of the Consultant: D. Praneeth

Date & Time: _____

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 Baby Of RANIYA ASLAM 0 Y 4 M 15 D (M)
 21-02-2026
 Dr. KOKKULA PRANEETH



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 6:20pm	C/S/B Neuroteam O/C/O Empyema & ventriculitis S/p empyema reservoir placement S/p VP shunt removal now admitted for (RT) programmable VP shunt & (RT) empyema reservoir removal.	
	Issues: ① No fever spikes / seizures ② Urine Output / Stools passed ③ Accepting feeds - (N) (C/O? sound while acceptance of feed) Ⓢ	
	O/E: child conscious, alert B/L pupils NSRL Tone - (N) power - B/L symmetrical antigravity movements (+) AF flat open vitals - stable HR: 134/min RR: 32/min SpO₂: 100% on RA	Adv vitals monitoring



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/1/20 aguan	<u>C/S/B Neuroteam</u>	
	H/O Empyema + ventriculitis (Amenorrhoea + nasal S/P Omaxa. Reservoir placement S/P shunt removed R/P programmable VP shunt + Omaxa removed (POD-7)	
	No fever 1 p/fever	pl → Hold
	Accepting 30ml/2nd half	① back of counter
	If more feed than vto - Adeq vAd - stable	② tabs Longol JA Domstal
	fix - 1/2 fresh purp B/L N/R	③ feeding every half 30ml
	no fecal/bulbar webbing LL - hypertonic goat agn @ no fecal defects	④ monitor vitals ⑤ PICC line care ⑥ HC monitoring
		Abusalek

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 Dr. KOKKULA PRANEETH



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/9/2026	cls/B Dr. Praneeth	
	Dolby mild no. fever	Re ① Discharge today ↓
	AP flat, mild sunken Baby active	Continue IV antibiotics till IV line is patent +16 cefixime Total 5 days Levopid Vit-D Ossapan-D Dexamet Buvan Flu on Thursday → Fundus / visual assessment after discharge → Flu c Dr. Nalinikant
		Dr. KOKKULA PRANEETH Reg. No: APMC/FMR/92741
		Dr. Praneeth

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date	4/7/26				
Time	7:40pm				
Hb	12.8				
PCV	36.3				
RBC	4.83				
WBC	11.26				
N/L					
Platelets	814				
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	<u>Hy. Ceftriaxone</u>	<u>25mg</u>	<u>IV</u>	<u>8H</u>		☒ C ☐ DC
2	<u>stp. Cefepime</u>	<u>0.3ml</u>	<u>IV</u>	<u>8H</u>		☒ C ☐ DC
3	<u>Dexamethasone suspension</u>	<u>1ml</u>	<u>PO</u>	<u>8am</u>		☒ 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. Praneeth N. Pr

Date & Time : 06/2/26, 11 am

Nurse Name & Signature : Pranitha

Date & Time : 6/2/26 4:05 am

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Tab LANZOL JR				Date Time															
Dose	Route	Frequency	Start Dt.																
1/4 tab	PO	OD	7/7																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : Syb DOMISTAL				Date Time															
Dose	Route	Frequency	Start Dt.																
0.5ml	PO	TID	7/7																
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																			

VERIFIED BY : Name Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

Signature
VERIFIED BY : Name

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																				
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 CHART

Date of Admission: 6/7/26 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:																			



REGULAR PRESCRIPTIONS

Weight. 2.8 Kg. Ward.

DRUG : <u>Inj. VANCOMYCIN</u>				Date Time	<u>6/7</u>	<u>11</u>														
Dose	Route	Frequency	Start Date																	
<u>30mg</u>	<u>IV</u>	<u>q 8th hly</u>	<u>6/7</u>	<u>6AM</u>	<u>X</u>	<u>Praneeth</u>	<u>Praneeth</u>													
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. Praneeth</u>				<u>2pm</u>	<u>0-7</u>															
Additional Instructions:																				
				<u>10pm</u>	<u>Praneeth</u>	<u>Praneeth</u>														
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj. CEFTAROLINE</u>				Date Time	<u>6/7</u>	<u>2/7</u>														
Dose	Route	Frequency	Start Date																	
<u>25mg</u>	<u>IV</u>	<u>q 8th hly</u>	<u>6/7</u>	<u>6AM</u>	<u>X</u>	<u>Praneeth</u>	<u>Praneeth</u>													
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. Praneeth</u>				<u>2pm</u>	<u>X</u>															
Additional Instructions:																				
				<u>10pm</u>	<u>Praneeth</u>	<u>Praneeth</u>														
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj. PARACETOMOL</u>				Date Time	<u>6/7</u>	<u>7/7</u>														
Dose	Route	Frequency	Start Date																	
<u>40mg</u>	<u>IV</u>	<u>TDS</u>	<u>6/7</u>	<u>6AM</u>	<u>X</u>	<u>Praneeth</u>	<u>Praneeth</u>													
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. Praneeth</u>				<u>2pm</u>	<u>0-7</u>															
Additional Instructions:																				
				<u>10pm</u>	<u>Praneeth</u>	<u>Praneeth</u>														
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SYR. LEVITIL</u>				Date Time	<u>6/7</u>	<u>7/7</u>														
Dose	Route	Frequency	Start Date																	
<u>0.3ml</u>	<u>PO</u>	<u>BD</u>	<u>6/7</u>	<u>6AM</u>	<u>X</u>	<u>Praneeth</u>	<u>Praneeth</u>													
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. Praneeth</u>				<u>4:15pm</u>																
Additional Instructions:				<u>6pm</u>	<u>Praneeth</u>	<u>Praneeth</u>														
Daily Doctor's Endorsement by a Sign																				



Weight. 2.8 Kg. Ward.

		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
8/2/26	2:PM	Ig. VANCOMYCIN	30mg	IV	1mm	<i>[Signature]</i>
6/2/26	2pm	Ig. PARACETAMOL	20mg	IV	1mm	<i>[Signature]</i>

Signature

VERIFIED BY : Name

Weight. 2.8 kg Ward.

[illegible]

BAH-00651141 IP5-00176018
Baby Of RANIYA ASLAM
21-02-2026 0 Y 4 M 15 D (M)
Dr. KOKKULA PRANEETH



RCM / 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
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 2am 6am

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU 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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:													
Doctor/Nurse/Family Concern?		COPM												
Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98	98.3												
	97													
	96													
	95													
Heart Rate (bpm)	190													
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
Blood Pressure (mmHg) *	90													
	80													
	70													
	60													
	50													
	40													
	30													
	20													
	10													
	0													
Note: BP does not score in early warning scoring														
Heart Rate (Number)		135.6/min												
sp. Rate (bpm) (Over 1 Minute) *	70													
	60													
	50													
	40													
	30													
	20													
	10													
	0													
	Resp Rate (Number)		29.6/min											
	Resp Distress	Mod/ Severe None / Mild												
Receiving O ₂ (l/min)														
O ₂ Saturations (%)		100%												
Conscious Level	Normal Altered													
GCS *		15/18												
TOTAL SCORE														
Number of shaded boxes		0												
Pain Score		0												
Observer's Initials		S												

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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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)

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
6/2	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :			Total Output :								
6/2	02:00 pm	1										
	03:00 pm	1	milk									
	04:00 pm	1	no milk									
	05:00 pm	1	Stufe									
	06:00 pm	1	milk									
	07:00 pm	1										
	Total Intake :			Total Output :								
6/2	08:00 pm	1	milk									
	09:00 pm	1	milk									
	10:00 pm	1	no milk									
	11:00 pm	1	milk									
	12:00 am	1										
	01:00 am	1										
	Total Intake :			Total Output :								
7/2	02:00 am	1										
	03:00 am	1	milk									
	04:00 am	1	no milk									
	05:00 am	1										
	06:00 am	1	milk									
	07:00 am	1										
	Total Intake :			Total Output :								
Total 24 hrs. Intake			Total 24 hrs. Output									

BAH-00651141
Baby Of RANIYA ASLAM
21-02-2026 0 Y 4 M 15 D (M)
Dr. KOKKULA PRANEETH

FLUID CHART

Rainbow®
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EarthRight™
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Your Right to a Safe Delivery

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												

BAH-00651141
 Baby Of RANIYA ASLAM
 21-02-2026 0 Y 4 M 15 D
 Dr. KOKKULA PRANEETH (M)
 IP5-00176018

NURSING CARE RECORD

Shift: ☐ Morning

☐ Night

Date: 5/7/26
 @ 4pm

Assessment: Pain, Irritability

Goals

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

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

- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
- ☐ Ensure Safety

- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8AM	* Assess the patient general condition.	8AM	* Assessed the patient general condition.	
10AM	* Maintain I/O chart	10AM	* Maintained I/O chart	
12PM	* Monitoring the vital signs.	12PM	* Monitoring the vital signs.	
2PM	* ensure safety.	2PM	* ensured the safety.	
5PM	* Administering the medications AS per orders.	5PM	* Administering the medications AS per orders.	
7PM		7PM		* All Plannings Are implemented.

Re-Assessment: Re Assessment done

Special Notes: keep in warm

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 6/7/26 @ 4pm

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
2pm	⇒ Assess the pt general condition	2pm	⇒ Assessed pt general condition	All planning are implemented.
3pm	⇒ Vitals monitored	3pm	⇒ Vitals monitored	
6pm	⇒ comfortable position provide to pt	6pm	⇒ provided comfortable position	
8pm	⇒ Administer the medication as per doctor order.	8pm	⇒ Administered the medication as per doctor.	

Re-Assessment: Re assessment done

Special Notes:

Nurse Signature: *Jamuna*Nurse Name: *Jamuna*Date & Time: *06/07/16 @ 8pm*

BAH-00651141 IP5-00176018
 Baby Of RANIYA ASLAM
 21-02-2026 0 Y 4 M 15 D (M)
 Dr. KOKKULA PRANEETH



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/07/26

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 baby general condition and monitor the vitals and record.	8:10pm	Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
10pm	Administer medication as per chart to continue	10:10pm	Administered to give medication as per chart	
2am	Provide comfortable position.	2:10am	Provided comfortable position	
6am	Allow full feeds tolerate.	6:10am	Allow full feeds tolerated	
8am	Ensure the safety needs	8:10am	Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes:

Nurse Signature: Niketha Nurse Name: Niketha 607652 Date & Time: 07/07/26 @ 8am

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kokkula praneeth Department: OT Date of Admission: 6/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>vp shunt placement</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	ER 11:30 PM	OT 8 PM - 2 PM	1st floor 8 PM - 11 PM	2nd floor 8 PM - 11 PM
	Medical Condition (Any special condition to be noted):		<u>nil</u>	<u>nil</u>	<u>NA</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>98.2 F</u>	<u>97.8 F</u>	<u>98.2 F</u>	<u>98.0</u>
	Res:	<u>32 bpm</u>	<u>32 bpm</u>	<u>26 C</u>	<u>28</u>	
	SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100 F</u>	<u>99%</u>	
	Pulse:	<u>132 bpm</u>	<u>131 bpm</u>	<u>129 bpm</u>	<u>128</u>	
	BP:	<u>115/60</u>	<u>115/60</u>	<u>101/60</u>	<u>101/60</u>	
	Fall Risk Score:	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	
Pain Score:	<u>0</u>	<u>0</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	
	Others Specify:	<u>nil</u>	<u>nil</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>nil</u>	<u>nil</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Susmitha</u>	<u>Sarini</u>	<u>Chandana</u>	<u>Saravanthi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>7/7</u>	
Time:		<u>11:35 PM</u>	<u>8 PM</u>	<u>8 PM</u>	<u>3 AM</u>	
Taken Over By Name :		<u>Teerana</u>	<u>Chandana</u>	<u>Saravanthi</u>	<u>Shashin</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7</u>	<u>7/7</u>	
Time:		<u>11:40 PM</u>	<u>8 PM</u>	<u>8 PM</u>	<u>3 AM</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:							
	Temp:							
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
	Fall Risk Score:							
	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:							



Pa

THE HUMPTY DUMPTY SCALE

6/7/26 2/17

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					
	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					
	History of Falls or Infant - Toddler Placed in Bed	4	4	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			15	15			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		1	4			
Call device within reach		2	4			
Wheels Locked		E	4			
Room free of clutter		S	4			
Adequate Lighting			4			
Wheel Chair Support		NO	NO			
Other Intervention(s) Specify		NO	NO			
Nurse's Name :		Sudhitha	Nir			
Signature :		R	N			
Date :		6/7/26	2/17			
Time :		10:49 am	6m			

BRADEN 'Q' SCALE

BAH-00651141

IP5-00176018

Baby Of RANIYA ASLAM

21-02-2026

0 Y 4 M 15 D

(M)

Dr. KOKKULA PRANEETH



				Date : 6/2/26 7/2		
				Time : 10:52 AM		
	completely immobile: Unable to 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	Subhika	

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

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-00651141
Baby Of RANIYA ASLAM
21-02-2026 0 Y 4 M 15 D (M)
Dr. KOKKULA PRANEETH

PAIN ASSESSMENT FORM

Date	Time	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign	
6/2/26	10:15 am	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil.	Dr
6/2	3:15 pm	Y/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Dr
6/2	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sam
7/2	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sam
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

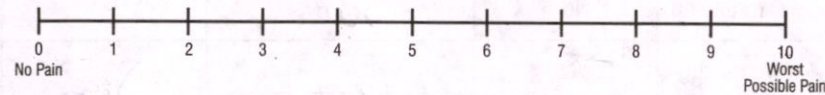
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

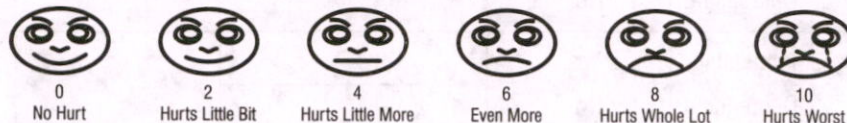
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00651141 IPS-00176018
 Baby Of RANIYA ASLAM
 21-02-2026 0 Y 4 M 15 D (M)
 Dr. KOKKULA PRANEETH

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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BirthRight
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 Your Right to a Safe Delivery

Hindi

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/7/26	10:50 am	8	Diagnostic Test / Procedure	m	9	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

Diagnosis: vp shunt placement

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/2/26 11:00 am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	vp shunt placement			Dr. Prad	☒ Nursing ☐ Others:
6/2/26 11:00 am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	vp shunt placement	16- stability	vp shunt placement	Pooja	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	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							
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	0	1							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	1							
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	0	1							
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	0	1							
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	0	1							
Signature of the Nurse				<i>[Signature]</i>									

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 : *Rama* Name : *Rama*

Signature of Ward In Charge :

Signature : *Kunal* Name : *Kunal*

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00651141 IP5-00176018 Baby Of RANIYA ASLAM 21-02-2026 0 Y 4 M 15 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 6/7/26 @ 10:53 AM	Date & Time of Transfer Order 6/7/26 @ 11:30 AM
		Transfer Ordered by Dr. prathika	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 ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Gown(s)	①	
2.			
3.	→ No cannula		
4.	→ ID Band in place		
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Susmita		Name of Person Ordered Transfer Dr. prathika	
Patient & Clinical Records Received by : Teem			
Date & Time of Patient Received : 6/7/26 @ 11:30 AM			

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

BAH-00651141 IP5-00176018
Baby Of RANIYA ASLAM (M)
21-02-2026 0 Y 4 M 15 D
Dr. KOKKULA PRANEETH



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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 2/7/26

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:

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

Remarks

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Swan

Date and Time: 2/7/26 @ 7 PM

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:35 AM Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NKA Body Weight: 2.8 Kg

Height: 70 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
- MSL + Respiratory distress - Pneumonia - Sepsis - hyponatremia, - hypoalbumin	- S/P @ omaya Reservoir & post empyema drainage @ Programmable VP	@ omaya Reservoir @ Programmable VP shunt

Family History: Nothing Significant

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

If Yes, please list:

Was the child's birth normal? ☒ Yes ☒ No If No, please describe problems: MSL + Respiratory distress

NILU admission

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

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

Observations: Weight: 2.8 Length: 70 Head Circumference (< 2 years): 26

Temp: 98.4 HR: 90 bpm RR: 26 bpm BP: 90/60 mmHg

Pain Score: 0/10 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 20) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 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 *Partner*Siblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☐ NoInformation given to *Mother*Nurse Signature: *[Signature]*Nurse Name: *Teena*Date: *6/7/26*Time: *11:05 pm*



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: PROGRAMMABLE VP SHUNT

Anaesthesiologist: DR SHINY Surgeon: _____

Please read this before you consent for Anaesthesia

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

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

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others BRONCHOSPASM, LARYNGOSPASM, REQUIREMENT OF BLOOD
TRANFUSION

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: Raniya Aslam
Relationship with patient: Mother
Date & Time: 06/07/26, 11:41 AM

Witness:

Signature: [Signature]
Name: Peem
Date & Time: 06/07/26 @ 11:41 AM

Doctor (who is taking consent):

Signature: [Signature] Name: DR SHINY Date: 06/07/26 Time: 11:40 AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్:

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

- ☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం
- ☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)
- ☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00651141 IP5-00176018
Baby OI RANIYA ASLAM
21-02-2026 0 Y 4 M 15 D (M)
Dr. KOKKULA PRANEETH

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: B/O Raniya Aslam Age: 4M 15D Sex: Male UHID No: Programable VP Shunt
Date: 04/07/26 Time: 11:26 Proposed Operation: Ventriculitis with hydrocephalus with Subdural Emphysema
Diagnosis: S/P right programmable VP shunt ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5
B.P / CRT: 16/03/26 H.R: 69 Weight: 2.8 kg

Laboratory Data:
Protein: 0.4 Glucose: 112
Alb: 3.8 Urea: 11
Total Bill: 112 Creat: 1.2
Dir. Bill: 112 LDH: 112
Alk phos: 112 Amylase: 112
SGOT/SGPT: 112

HIV: — X-Ray: —
HBS Ag: — ECG: —
HCV: — 2D Echo: —
Blood group: O +ve Stress/Anglo: —
T3: — Other: —
T4: —
TSH: —

Allergies: —
Diabetes: —
Term (37 wk) But = 2.9 kg / NICU stay d/t Resp distress, Ventilator stay, p sepsis Hosp stay → 22 d
Multiple antibiotics, Baby developed coagulopathy → Normalised. Treated for Hyponatremia, hyp left against Medical

History: CVS: —
NS: —
Renal: —
Hepatic / GE: —
Others: —
Past Anaesthetic History: S/P Raniya Reservoir & post Emphysema drainage, S/P R programmable VP shunt Removal

Physical Exam:
Airway: MP 1 2 3 4 Mouth Opening: — Mentohyoid Distance: — Neck: — Teeth: —
Lungs: B/L A2 (+)
Heart: S, S2 (+)
CNS: — Venous Access Site: central Spine Exam for regional: —
Pregnant: ☐ Yes ☐ No ☒ NA
Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☒ GA-ETT ☐ LMA
Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
<u>Ty Ceftazidime</u>	<u>long 1kg TID</u>
<u>Ty Group levipil</u>	<u>0.3ml 10mg/kg TID</u>
<u>Domstal suspension</u>	<u>1ml - 0.37 mg/kg</u>

Pre-Op Instructions:
1. DV laxis: Water / ORS 2 Hours
2. Nil: Others 6 Hours
3. Infnsent: ☒ Standard ☐ High Risk
4. Pce Pain Management: ☒ Discussed with Patient
5. Otioms: —
P.T., APTT, INR, RBS → 105
refuse PRBC if Hb < 10
w. PAC

Signature: DR SHINY Name: DR SHINY
Docu. No.: RCHBH / FRM / CLINICAL / 044
(C/O Dr. SHILPANA) reading

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:

Physical Status:

☐ Yes ☒ No

☒ Patient Identified

Fasting Status: Admitted

☒ Consent Present

☐ Chart Reviewed

Last Feed: 5hr

Date: 10/10/10

Technician: Anaest

Antibiotic
IV VANCOMYCIN 30mg IV
Suppository

NOTES

1st side of
Bradycardia
@ 75/min
3. Adrenaline
10mcg IV.

H.R: 106

B.P / CRT: 85/50mmHg SpO₂: 100%

Pre-OP Diagnosis: Ventriculitis with Hydrocephalus

Surgeon: Dr. Parneeth

Operation: L.P. Proximal VP Shunt

R.R: 28/min

Anaesthesiologist: Dr. GSN/Dr. SHYAM

TIME

N₂O/AIR/O₂ RPM

HALO/ISO (SEVO)

Drugs:

PRIMIDOL

PANTHOL

ROCURONIUM

PARACETAMOL

FI_{O2}/SaO₂

ETCO₂

ECG

Temperature

Urine Output

TIME

0700

0730

0800

0830

0900

0930

1000

1030

1100

1130

1200

1230

1300

1330

1400

1430

1500

1530

1600

1630

1700

1730

1800

1830

1900

1930

2000

2030

2100

2130

2200

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2300

2330

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13700

13730

13800

13830

13900

13930

14000

14030

14100

14130

14200

14230

14300

14330

14400

14430

14500

14530

14600

14630

14700

14730

148

BAH-00651141
Baby Of RANIYA ASLAM
21-02-2026
Dr. KOKKULA PRANEETH
IP5-00176018
(M)
0 Y 4 M 15 D

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ANESTHESIA CARE UNIT RECORD

Received in PACU by : 8:10 PM

Time Received : 8:20 PM

Time Discharged : Up

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 SPO ₂	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	IV Cannula Site : <u>2ax</u> ☐ O ₂ 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 : _____ Oral Feeds : _____

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
6/7/26	@ 4pm	0/10	Nil	<u>[Signature]</u>

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

Anaesthesiologist Name : Dr. Ganther

Anaesthesiologist Signature : [Signature]

Date & Time : 6/7/26 @ 4pm

PACU Nurse Name : [Signature]

PACU Nurse Signature : [Signature]

Date & Time : 6/7/26 @ 4pm

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): 121

Date & Time : 6/7/26 @ 4pm

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 :



OPERATION THEATER NOTES

Patient's Name : Baby of. Raniya Aslam Age : 4 M Gender : ☐ Male ☒ Female

UHID No.: BAH - 00651141 Weight : Height :

Surgeon : <u>Dr. PRANEETH K</u>		Asst. Surgeon : <u>Dr. SRIPATHA Y</u>
Anesthetist : <u>Dr. SKILPA</u>	OT Nurse :	OT Technician :
Pre-Operative Diagnosis: <u>O/C/O EMPYEMA WITH VENTRICULITIS s/p OMMAYA RESERVOIR PLACEMENT</u> <u>S/P VP SHUNT REMOVAL</u>		
Surgical Procedure : <u>RIGHT PROGRAMMABLE VP SHUNT (HAKIM ERICKHAM RESERVOIR)</u> <u>AND RIGHT OMMAYA OMMAYA RESERVOIR REMOVAL</u>		
Indications for Surgery : <u>RAISED INTRACRANIAL PRESSURE</u>		
Date : <u>06-07-2026</u>	Start Time :	End Time :
Pre Operative Preparations: <u>3x BETADINE</u>		
Post Operative Diagnosis: <u>O/C/O EMPYEMA WITH VENTRICULITIS s/p OMMAY RESERVOIR PLACEMENT</u> <u>S/P VP SHUNT REMOVAL</u>		
Peri-Operative Complications: <u>NONE</u>		
Operation Notes: <u>1. Patient laid supine under GA. Ports painted and draped.</u> <u>2. Previous Right Frazier's point incision and abdominal incisions opened.</u> <u>3. Tunneling of shunt done.</u> <u>4. Ventricular catheter inserted in 1st attempt. CSF-clear under high pressure.</u> <u>5. Shunt assembly done. Distal flow confirmed and catheter placed in peritoneum.</u> <u>6. SHUNT PRESSURE SET AT 50 mm H2O</u> <u>7. Wound closed in layers.</u>		

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)

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Mansfield, MA 02048 USA

Integralife.com

SHUNT PRESSURE SET
AT 50mm H₂O

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

NONE

Name of the Surgeon:

Dr. SAIPARHAN

Signature of the Surgeon:

Date & Time:

01/04/26 2:45 pm



POST-SURGICAL CARE PLAN FORM

Procedure Done: (R) PROGRAMMABLE VP SHUNT AND OMMAYA RESERVOIR REMOVAL

Post-Surgical Diagnosis: O/C/O EMPYEMA WITH VENTRICULITIS & OMMAYA RESERVOIR PLACEMENT

Post-Operative Monitoring Parameters /Frequency: VITALS @ 2H

Wound Care: DRESSING

Drain /Special Lines/Catheters: NONE

Special Patient Positioning and Requirements: NONE

Nutritional Instructions: ORALY ALLOWED ONCE ALERT

.....en to Start Mobilization: NA

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) JAIPARTHA

Date: 06/07/26 Time: 2:45 pm

Note: Plan of care will be readjusted if necessary.