

BAH-00661568
Baby ZIA MAIRA
09-01-2020
Dr. MANCHUKONDA SANTHOSH (F)
6 Y 6 M 11 D
IP5-00176625

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

81124
Date : 20/07/20
Patient Name: ZIA Maira Date of Birth: 09-01-2020 Age: 6Y
Gender: Female Ward: P OT UHID No.: 00661568
Date of Surgery: 20/07/20 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Mammoplasty of Female left

Time in : 10:15 AM

Cash
Pvt

Time Out : 11:30 AM

	NAME	AMOUNT
1. Surgeon	Dr. M. Santosh	
2. Anaesthetist	Dr. Santhosh	
3. Assistant Surgeon		
4. OT Technician	Chowdhury	
5. Circulating Nurse	Teenu	
6. Assistant Nurse	Bhargava	

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: 9712482

Order by: Y. Ramakrishna

20/05/02

04-09-00-00

00000000

P 9

10/05/02

20/05/02

10/05/02

10/05/02

10/05/02



10/05/02

10/05/02

10/05/02



10/05/02

10/05/02

10/05/02

BAH-00661568 IP5-00176625
Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH

Patient



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SURGERY DETAILS

Date : 20/07/26

Patient Name: ZIA Maira Date of Birth: 09-01-2020 Age: 6Y

Gender: Female Ward: P-OT UHID No.: 00661568

Date of Surgery: 20/07/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Comprehensive oral Rehab following

Time in : 10:15 AM

Time Out : 11:30 AM

	NAME	AMOUNT
1. Surgeon	Dr. Sriwala	D.P.T
2. Anaesthetist	Dr. Sankar	
3. Assistant Surgeon		
4. OT Technician	Bowling	
5. Circulating Nurse	Teena	
6. Assistant Nurse	Bikali	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others 5000/- for CUSA

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9712484

Order by: y Ramani

ESTIMATION SLIP

Date : 15/07/2026 UHID / IP No. : BAH-00661568 SI No. 81114
Name of Patient : Baby. Zia. Mairan Age: 64 60 Gender: F.
Father's / Husband's Name : Mr. Smithan Mairan Corporate / Occupation :
Address : Phone : 8106734996 Email :
Procedure / Plan : Max supubisation / Ruv Excision of Pannul

MODE OF PAYMENT : ☒ SELF ☐ TPA : ☐ GIPSA : ☐ OTHERS : NO EQUI

TARIFF INFORMATION :

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
OP (Day)	Room Rent & Nursing Charges										
	Doctor's Fee										
	L. Tax				21850 Nursing						
PARTICULARS				AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges				SF 1000 7.07. 45430 16520 33040							
O.T. Consumables				Subject to approval by TPA / Insurance Company							
Instrument Charges				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											
Others											
Initial Minimum Deposit				Approx - 1.60,000. & Final Reimbursement							

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- 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.
- 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.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- 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.
- 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.
- 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.
- 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.
- 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.

DECLARATION

I, Mrs. Smithan, 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.

Signature of the Client

Signature of the Signatory Relationship

Signature of the Financial Counselor

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176625 Admit Date : 20-Jul-2026 Admit Time : 06:56 AM UHID : BAH-00661568

Patient Details :

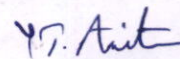
Patient Name	: Baby ZIA MAIRA	Age	: 6 Y 6 M 11 D
Guardian	: Mr IMTIAZ MOHAMMAD	DOB	: 09-01-2020
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: FLAT NO 202, V 4 HOMES MITHILANAGAR PRAGATHI NAGAR Kukatpally Hyderabad Telangana INDIA 500072	Phone No	: 8106734996 / 8106734059
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 404 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 404 Admission Type : First Visit

Contact Details :

Name : Mr IMTIAZ MOHAMMAD Relationship : Father
Contact Address : FLAT NO 202, V 4 HOMES MITHILANAGAR Phone No : 8106734996 / 8106734059
PRAGATHI NAGAR Kukatpally Hyderabad
Telangana INDIA 500072


Signature

Doctor Details :

Doctor Name : Dr. MANCHUKONDA SANTHOSH KUMAR Specialisation : EAR NOSE AND THROAT
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI / Dr. SRINIVAS NAMINENI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAAY

ACTIVITY RECORD FOR BILLING

Name : _____

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

BAH-00661568 IP5-00176625
Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH

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



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7	7:45A	ED	OT	df
20/7	12:35pm	OT	303	Quig

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Anupama	20/7		Jessie
2	P.R. Annapoorna	21/7		
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH



BAH-00661568

IP5-00176625

Baby ZIA MAIRA

09-01-2020

6 Y 6 M 11 D

(F)

Dr. MANCHUKONDA SANTHOSH

**Pediatric Multiorgan History & Physical Examination**

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o mouth breathing : 1 yr

History of present illness :o/c Swelling below the tongue
mouth breathing : 6 m

o/c Ranula ⊕

Now planned for Ranula excision

BAH-00651568
Baby ZIA MAIRA
08-01-2020
Dr. MANCHUKONDA SANTHOSH
6 Y 6 M 11 D
IP5-00176625
(F)

Pediatric

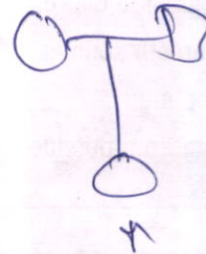
/ & Physical Examination

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

NIL

Birth & Neonatal History:

NO / 2 Vaccines / Full term / 2.95 kg
No NICU Admission



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Upper middle class

Developmental History :

As per Age

Immunization History :

As per Age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) _____ (Centile _____)

On Examination :

Temperature : 97.5 Pulse Rate : 104/min B.P. 119/81/76 SP02 100%

Resp. rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

15/15

Cranial Nerves : _____

3/20

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

3/20

Reflexes :

DTR

Plantars _____

Superficials:

3/20

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Ranula for excision.

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pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

~~CBP~~
Noted by
Kethu
20/7
@TA

Planned Management

NPO advised
IVF DMS
Shift to OT

Signature of the Doctor: _____

Name of the Doctor: T. Pavan

Date & Time: 20/07/20

Signature of the Consultant: _____

Name of the Consultant: Dr. P. R.

Date & Time: 21/2/20

Dr. Tejavathi Annapoorna
Reg No: 53054

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OPERATION THEATER NOTES

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

UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist : Dr. Sariful	OT Nurse: Bihalli, Diya	OT Technician: Gowha	
Pre-Operative Diagnosis:			
Surgical Procedure : Mammaplasty of Ramula			
Indications for Surgery :			
Date : 20/08/20	Start Time : 10:20 AM	End Time : 11:20 AM	
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes:			
- Left Ramula Identified			
- Mammaplasty done			

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7 4:35 pm	C/S/B Resident <u>post op marsupialisation of ranula</u> doing well	<u>Adv.</u>
	O/E: alert- vitals stable S/E: NAD - oral cavity	→ Allow orally → Zytex gel application → Monitor vitals
		Akhile
		n/B jessie
20/7 9 am	C/S/B Resident no complaints	<u>Adv.</u>
	O/E: stable vitals alert S/E: NAD	① today.
		Akhile

IP5-00176625

6Y6M11D

09-01-2020

6 Y 6 M 11 D (F)

09-01-2020 6 1 6 M 1 5
Dr. MANCHUKONDA SANTHOSH



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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Patient



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RESULT SHEET

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

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

Shifting From: ICU Shifted to: OT

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: T. Pavani

Date & Time: 22/07/26

Nurse Name & Signature: Reetha

Date & Time: 20/7 @ 7:40A

DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Weight. 20.6 Ward.

Page: 2/4



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

[illegible]

I.V. FLUIDS CHART

Weight. 20.6 kg Ward.



position of I.V. Fluid
 (mention ml/hr = Mcg/kg/min. etc)

Route

Flow Rate
 ml/hr

Doctor
 Sign

Nurse
 Sign

Date of
 Stopping

Doctor
 Sign

Nurse
 Sign

20/07/20

IVF DMS

IV

50ml

R.

not given

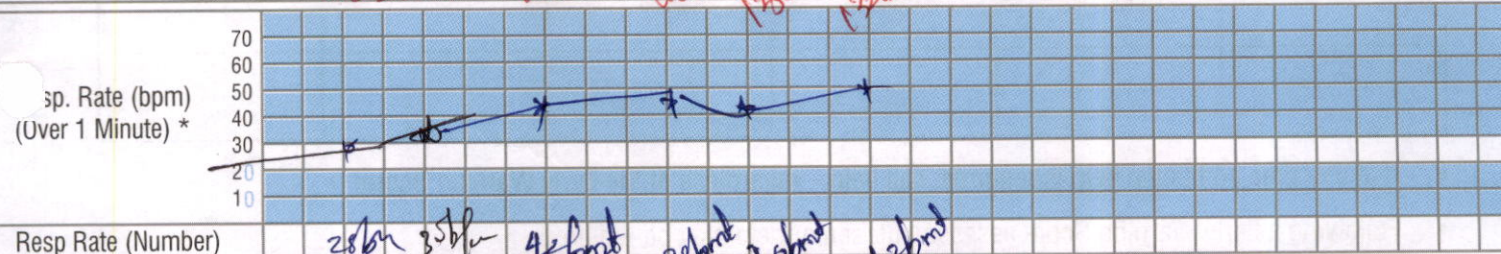
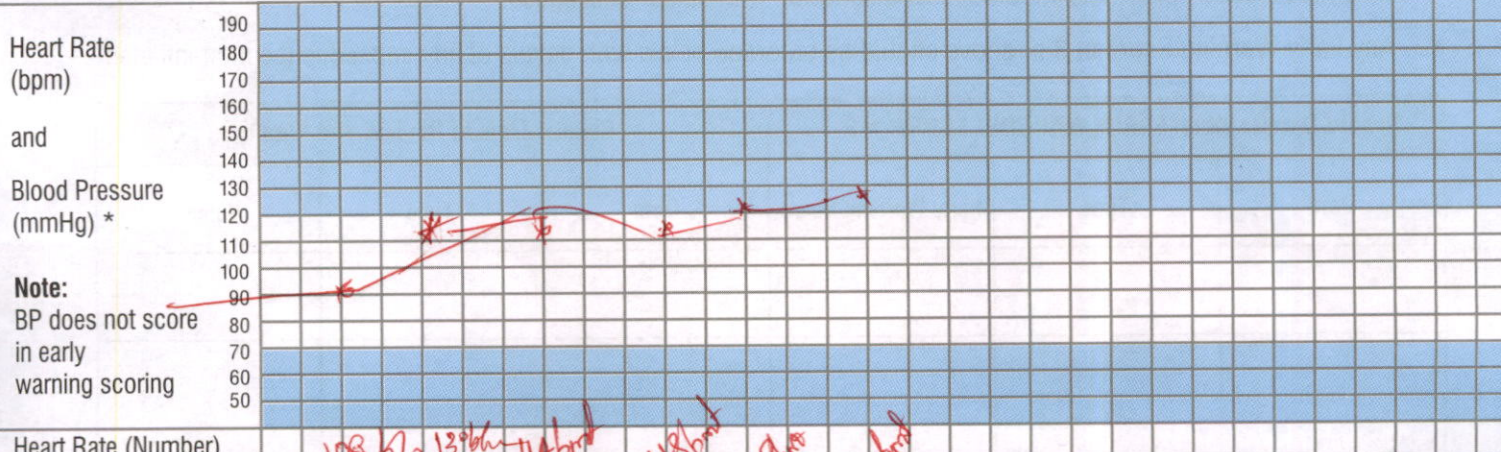
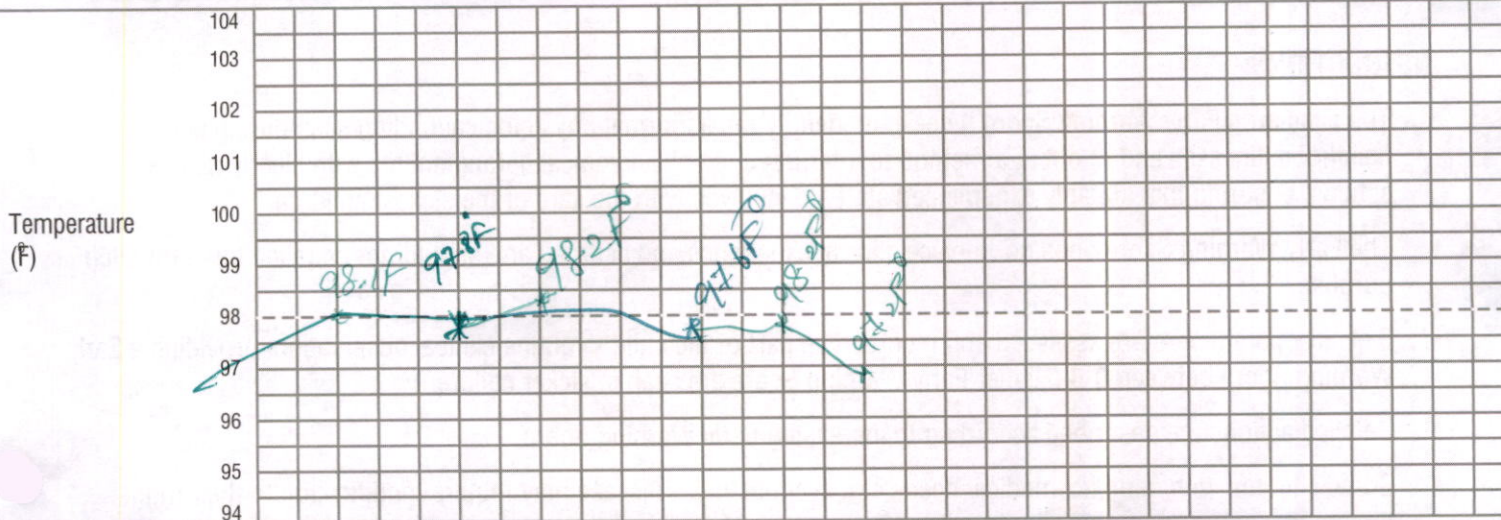
Signature

VERIFIED BY : Name

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 1pm 5pm 9pm 12am 3am 6am
 Doctor / Nurse / Family Concern?



Resp Rate (Number) 28bpm 35bpm 42bpm 38bpm 42bpm 42bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 98% 98% 99% 98% 99% 98%

Conscious Level Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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



FLUID CHART

Sheet No. : 20/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	H ₂ O										
	01:00 pm	100ml										
Total Intake :						Total Output :						
	02:00 pm	H ₂ O										Jessie
	03:00 pm	H ₂ O										Jessie
	04:00 pm	NA										Jessie
	05:00 pm											Jessie
	06:00 pm	Soup										Jessie
	07:00 pm											Jessie
Total Intake :						Total Output : 0-1 m-1						
	08:00 pm	H ₂ O										Sueh
	09:00 pm	H ₂ O										Sueh
	10:00 pm	H ₂ O										Sueh
	11:00 pm	H ₂ O										Sueh
	12:00 am	H ₂ O										Sueh
	01:00 am	H ₂ O										Sueh
Total Intake :						Total Output : M-0 2-2						
	02:00 am	H ₂ O										Sueh
	03:00 am	H ₂ O										Sueh
	04:00 am	H ₂ O										Sueh
	05:00 am	H ₂ O										Sueh
	06:00 am	H ₂ O										Sueh
	07:00 am	H ₂ O										Sueh
Total Intake :						Total Output : M-0 2-3						

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
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							



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/7/20

Assessment:

Pain related to the procedure

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the pt General Condition	8:30 am	Assessed the pt General Condition.	pt is Conscious & oriented
10:30 am	Relieve pain & Discomfort	12pm	Relieved pain & Discomfort	vital stable
1pm	monitor vital signs		monitored vital signs	
	monitor for bleeding	2:30 pm	monitored for bleeding	no bleeding
4:30 pm	maintain I/O chart		maintained I/O chart	maintained
6:30 pm	urpo broken, water given	6pm	urpo broken, water given	no vomiting
	pt shift to the ward	7:30 pm	provided psychological support	shifted
			pt shifted to the ward	

Re-Assessment:

pt is stable

Special Notes:

NA

Nurse Signature:

Nurse Name:

Date & Time: 20/7/20



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Patient is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the patient condition and vitals check	8:30 pm	* Assessed the patient condition and vitals checked	* now patient condition is
10pm	* monitor the D/o chart	10:30 pm	* monitored the D/o chart	
12AM	* Check the Fever spikes	12:30 AM	* checked the Fever spikes	
3AM	* Assess the pain and discomfort	3:30 AM	* Assessed the pain and discomfort	
6AM	* Administer medicine as per chart	6:30 AM	* Administered medicine as per chart	
7AM	* Ensure safety	7:30 AM	* Ensured safety	

Re-Assessment: Assess the patient condition now it is stable

Special Notes: Nil

Nurse Signature: Sushu Nurse Name: Sushu -607635 Date & Time: 20/7/26 @ 8pm

Patient Stick

BAH-00661566
Baby ZIA MAIRA
09-01-2020
Dr. MANCHUKONDA SANTHOSH (F)
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NURSING

HAND OVER FORM - WARD

Treating Doctor: Dr. Santhosh Department: ENT Date of Admission: 20/7

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>Marsupial skin excision</u>		If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>EN 7:45A</u>	<u>OT 8am-4:30pm</u>	<u>3rd floor 8pm-8pm</u>	<u>Scrub floor 8pm to 8:30pm</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</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°F</u>	<u>98.6°F</u>	<u>98.2°F</u>	<u>97.6°F</u>	
		Res:	<u>24bpm</u>	<u>25bpm</u>	<u>25bpm</u>	<u>28bpm</u>	
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	
		Pulse:	<u>112bpm</u>	<u>84bpm</u>	<u>85bpm</u>	<u>88bpm</u>	
		BP:	<u>96/52</u>	<u>96/52</u>	<u>96/52</u>	<u>91/65</u>	
		Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>4</u>	
Pain Score:	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>NA</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Bharve</u>	<u>Devi</u>	<u>jesie</u>	<u>Suh</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>		
Time:		<u>7:45A</u>	<u>2:30pm</u>	<u>8pm</u>	<u>8pm</u>		
Taken Over By Name :		<u>Kalyan</u>	<u>jesie</u>	<u>Suh</u>	<u>Suh</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/7</u>	<u>20/7</u>	<u>20/7/26</u>	<u>21/7</u>		
Time:		<u>2:30pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>		

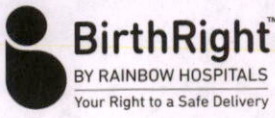
NURSING SHIFT HAND OVER FORM - WARD

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:						



CHECKLIST FOR THROMBOPHLEBITIS



20/7/26 21/7/26

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	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-							
Signature of the Nurse													

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

Signature of Shift In Charge :
Signature : Name :

Signature of Ward In Charge :
Signature : Name :

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Baby ZIA MAIRA
09-01-2020
Dr. MANCHUKONDA SANTHOSH
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THE HUMPTY DUMPTY SCALE 20/7/21

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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	2	2			
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			11	11			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes				
Call device within reach	yes	yes				
Wheels Locked	yes	yes				
Room free of clutter	yes	yes				
Adequate Lighting	yes	yes				
Wheel Chair Support	no	no				
Other Intervention(s) Specify	no	no				
Nurse's Name :	Kelle Suresh					
Signature :	Kelle Suresh					
Date :	20/7/21					
Time :	7A 8AM					

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PAIN ASSESSMENT FORM

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Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20th 7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	H
20/7 10/30	2/10	SS	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Q
20/7 5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
20/7/26 9am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
20/7/26 12Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
20/7/26 3Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
20/7/26 6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

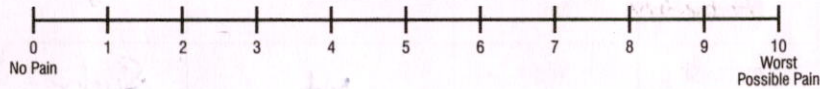
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

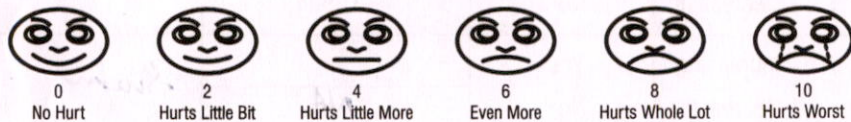
Numerical Pain Scale (Obstetric and Gynecology)



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



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Dr. Mandeep

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BRADEN 'Q' SCALE

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				Date :	20/7	21/7		
				Time :	7A	1P		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity 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					HL	Such		

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

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Baby ZIA MAIRA
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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

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Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
IP5-00176625

Patient S

Dr. MANCHUKONDA SANTHOSH



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Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 20/07/26

Department : P.OT Duration of Procedure : 2W

Name of Surgeon : Dr. Santosh Date of Admission : 20/07/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : <u>Aug - Augmentin</u>	<u>M</u>
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	<u>Ru</u>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36</u> °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<u>Ru</u>
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Santosh</u> Date & Time of antibiotic administration : <u>20/07/26 at</u> Date & Time procedure started : <u>20/07/26 at 10:20</u>	<u>Ru</u>

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

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

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. Marsupialization of Pilonid
2. + Sublingual gland Excision

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>- Swallowing difficulty</u>	<u>None</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. Pain

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

Patient / Patient Attendant:

Signature: T. Kate

Name: ANITHA THUGU

Relationship with patient: Mother

Date & Time: 20/7/26 @ 9:50 am

Witness:

Signature: [Signature]

Name: Teena

Date & Time: 20/7/26 @ 9:50 am

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. M. Santhosh Date: 20/7/26 Time: 9:50 am

(26)

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.	
b.	

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. S. Nival
Asst. Surgeon : Dr. Santosh
Anaesthetist : Dr. Saritha
Scrub Nurse : Shilpa

BAH-00661568 IP5-00176625
Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH

Age : 6y Gender : F
Name : Dental +
In : 10:15 AM Out-time : 11:30 AM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia ➤ ➤

Before Skin Incision ➤ ➤

Before Patient Leaves Operating Room

SIGN IN		Time: <u>10:08 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. SARITHA</u>		

TIME OUT		Time: <u>11:20 AM</u>
Confirm all team members have introduced themselves by Name and Role		
	☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>not there</u>	
	☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	<u>not there</u>	
	☒ 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>Bibi</u>		

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

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. COMPREHENSIVE RBHAB FOLLOWING
2. PRELIMINARY EXAMINATION

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>PREVENT DENTAL INFECTION</u>	<u>NONE</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. PAIN / BLEEDING
b.

- I authorize Dr. SRINIVAS - N 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: T. Ant

Name: ANITHA THUGU

Relationship with patient: MOTHER

Date & Time: 20/Jul/2026 @ 1am

Witness:

Signature: [Signature]

Name: [Name]

Date & Time: 20/7/26 @ 1am

Doctor (who is taking consent):

Signature: [Signature] Name: SRINIVAS - N Date: 20/7 Time:

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 ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female
UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:		OT Technician:
Pre-Operative Diagnosis:			
Surgical Procedure :			
Indications for Surgery :			
Date :	Start Time :		End Time :
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes:			
- PULPECTOMY ON 64 FOLLOWED			
BY CROWN INSERTION			
- RESTORATIONS ON 65, 75 DONE			

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Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH

Patient




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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per Doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

yes

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: medication

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 20/7/20 @ [Signature]

Docu. No. : RCHBH /FRM / CLINICAL / 191

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		
20/1/26	9 AM	7	Infection control measures	M	1	0	1	1	NA	LF
20/1/26	1pm	9	soft diet	M	1	0	1	1	-	Saima

Part - III: CODES

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

Learning Barriers:

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

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

Mechanism/s to overcome barrier/s:

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

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7 7:30pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	nausea	stability	surgery	perat	☐ Nursing ☒ Others:
20/7 7:30pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	nausea	stability	excision - MPD	dp	☒ Medical ☐ Others:
20/7/26 3pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Ranula cyst excision	soft diet	<u>RDA</u> E: 1450 Kcal/D P: 25gm/D	sainme	☐ 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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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 8 am Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 20.6 Kg

..... NIC DR Height: cm

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

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

Family History: nothing significant

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

If Yes, please list,

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

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

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

Observations: Weight: 20.6 Length: Head Circumference (< 2 years):

Temp.: 98.4 F HR: 90 b/m RR: 20 b/m BP: 90/50 mmHg

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

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

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

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 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 *Parents*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: *20/7/20*Time: *8:05 am*

CONSENT FORM FOR ANAESTHESIA



It takes a lot to treat the little.



Patient Name : Baby Zia Maira Age : 6y Gender : Male ☐ Female ☒
UHID NO: BAH 00661568 Surgeon Name: Dr. Santosh Kumar
Anaesthesiologist : Dr. K. Sri Sanyal Operative procedure planned : Marsupialisation / Excision of Ranula

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 : deceleration

- 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 the above mentioned operation / Diagnostic / Therapeutic procedures.

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

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [Signature]
Name : ANITHA THUGU
Relationship with Patient : MOTHER
Date & Time : 18/Jul/2026 4:39 PM

Witness :

Signature : [Signature]
Name : Shavan
Date & Time : 18/Jul/2026 4:39 PM

Doctor (who is taking the consent) :

Signature : [Signature] Name : Dr. K. Sri Sanyal Date & Time : 18/Jul/2026 4:39 PM

Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

BAH-00661568
Baby ZIA MAIRA
09-01-2020 6 Y 6 M 11 D (F)
Dr. MANCHUKONDA SANTHOSH

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Name: Zia Maira Age: 04 Sex: F UHID.No: BAH-00661568
Date: 18/12/20 Time: 4:25pm Proposed Operation: Marupalisation / Excision of Pouch.
Diagnosis: Maru
B.P / CRT: _____ H.R: _____ Weight: 20.2kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: _____	Glucose: _____	Protein: _____	HIV: _____	X-Ray: _____
PCV: _____	Urea: _____	Alb: _____	HBS Ag: _____	ECG: _____
WBC: _____	Creat: <u>0.3</u>	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: NKDA

Medical History: CVS:

RESP: Not

CNS: Significant

Renal: _____

Hepatic / GE: _____

Others: _____

* NVD & Vaccum / Full / 2.95 kg / No NICU admission

Diabetes: Nil

* Vaccinated upto date (Australian)
* Milestones achieved as per age

Physical Activity: _____

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4

Mouth Opening: > 4cm

Mentohyoid Distance: _____

Neck: (N)

Teeth: loose lateral incisor on IP up

Lungs: BAE (+)

Heart: SS (+)

CNS: Grossly Intact

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: Accessible 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: Coconut water
- NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: CRP on De cannulation
Nebulization

Signature: [Signature] Name: Dr. K. S. Sanyal

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition:		☐ Yes ☒ No	Fasting Status: Confirmed	
Physical Status:		☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed
H.R.: 120/min	B.P./CRT: <3 sec	SpO ₂ : 100%	R.R.:	Last Feed: Spontaneous
Pre-OP Diagnosis: Ramulus + Dental cavity		Operation: Maxillary Anterior Extension of Ramulus		Date: 20/7/26
Surgeon: Dr. Jambhikar / Dr. Sunil Kumar		Anaesthesiologist: Dr. R.C. / Dr. Sarita	Technician: Ms. Gautam	

TIME	N/O / AIR / O ₂ LPM	HALO / SO SEVO	Drugs:	Antibiotic	Suppository	Blood Loss	NOTES
10 AM	10	10	Ch Midazolam 0.5mg				
10:15	10	10	W. Fentanyl 0.4mg				
10:30	10	10	W. Propofol 10mg				
10:45	10	10	W. Rocuronium 10mg				
11:00	10	10	W. Paracetamol 300mg				

FI O ₂ / SaO ₂	ETCO ₂	ECG	Temperature	Urine Output
100% / 100%	34	SR	36	SR
100% / 100%	33	SR	36	SR
100% / 100%	35	SR	36	SR
100% / 100%	36	SR	36	SR
100% / 100%	36	SR	36	SR

Fluids	Blood
RL @ 200ml/hr	

B.P.	V Systolic	A Diastolic	X Mean	* Heart Rate
120/80	120	80	80	120
120/80	120	80	80	120
120/80	120	80	80	120
120/80	120	80	80	120
120/80	120	80	80	120

Tourniquet on Time	Tourniquet off Time	Throat Pack In	Throat Pack Out

LAB Values	ABG	GRBS	Others

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: (R) UL ☒ Art Site: ☒ EKG Lead ☒ Temp Site ☒ ECG Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: Supine ☒ Pressure Points Checked Eye Care: ☐ Oint ☐ Tape ☐ Padding ☐ Awake	Temp: ☒ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☒ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: 10:15AM OP Start: 10:25AM OP End: 11:30AM Leave OR: Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ABT: ☒ IV: 22G (UL) ☐ IV: ☐ IV:	Induction ☒ IV ☐ Inhal ☒ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# 4.5 at 15 cm ☒ Oral ☐ Nasal ☒ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade # 2 Attempts: Boyle Difficulty Why? ☐ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity ☐ Spinal Specify: 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. SARITA Signature of the Doctor:
--	--	---	---

IP5-00176625

BAH-00661509
Baby ZIA MAIRA

09-01-2020

6 Y 6 M 11 D (F)

09-01-2020 6 Y 6 M 11 D
Dr. MANCHUKONDA SANTHOSH



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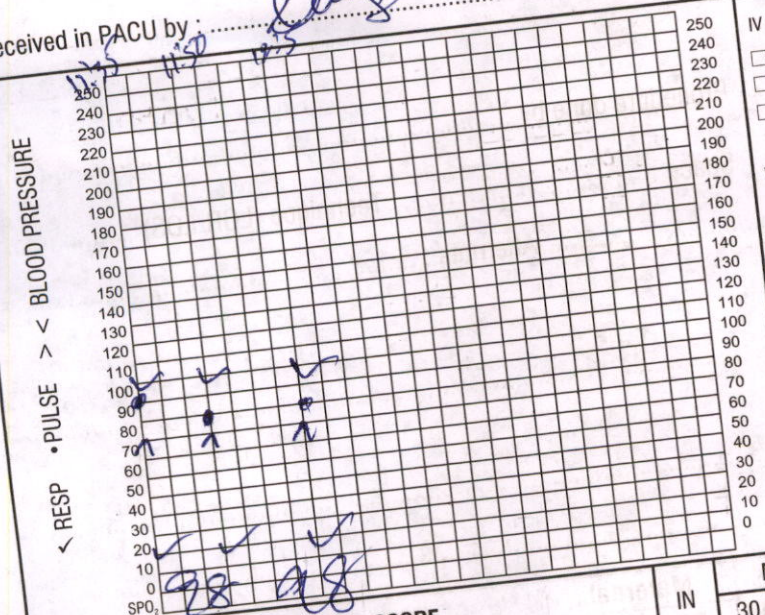
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by:

Time Received :

Time Discharged :



IV Cannula Site : 8

☐ O₂ Mask

☐ Tracheostomy

☐ Oral Airway

- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

Vomiting :

☐ Yes ☒ No

Drug:

MC Tube :

☐ Yes ☒ No

Drain:

☐ Yes ☒ No

Urinary Catheter

☐ Yes ☒ No
☐ Yes ☒ No

Chest Tube

☐ Yes ☐ No

IV Fluids

Oral Feeds

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

PAIN ASSESSMENT AND MANAGEMENT FORM				Signature
Date	Time	Pain Score	Intervention	
2d7	11:38	1/10		

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

Anaesthesiologist Name : POO SHARMA

Anaesthesiologist Signature: _____

Date & Time: _____

PACU Nurse Name :

PACU Nurse Signature: _____

Date & Time: 4.17.20

Reassessment Frequency

1. Every eight hours for all hospitalized patients
2. For pre-surgery patient, patient with chest pain

MANCHUKONDA SANTHOSH

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD



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a)

b)

Time	Infusion Rate
------	---------------

[illegible]

GAR: SVD / Instrumental / LSCS (if LSCS Details)

1100

...ected



303

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/07/26 Time: 1pm

Weight: 20.6kg's Centile: >25th

Height: 116cm Centile: >25th

Inference: well child

RDA: - Calories: 1450 Kcal/D Protein: 25gm/D

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled & outside foods

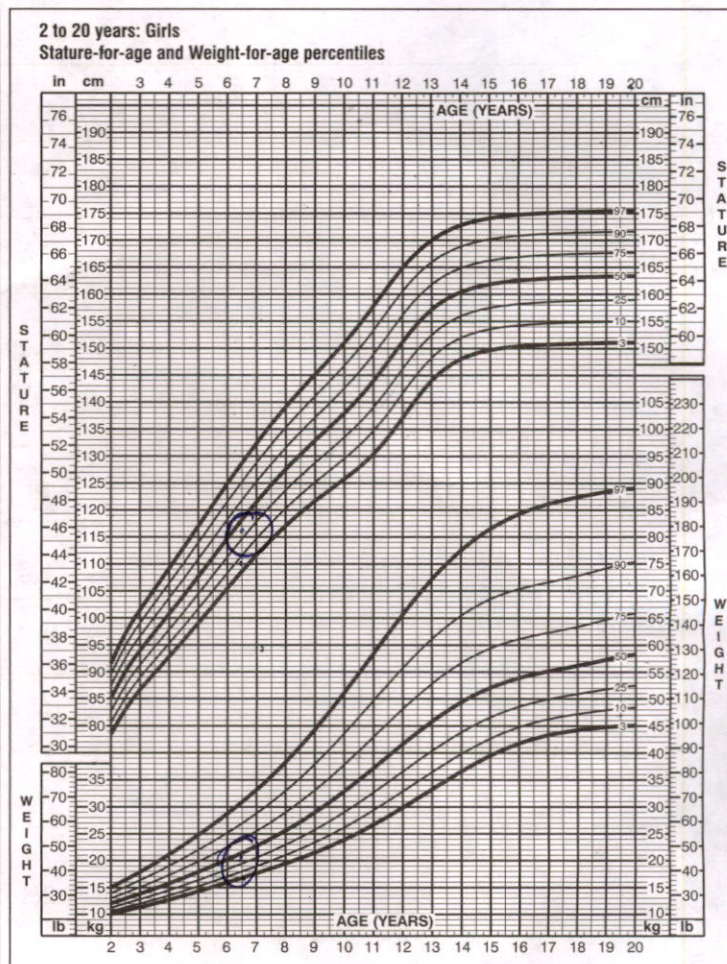
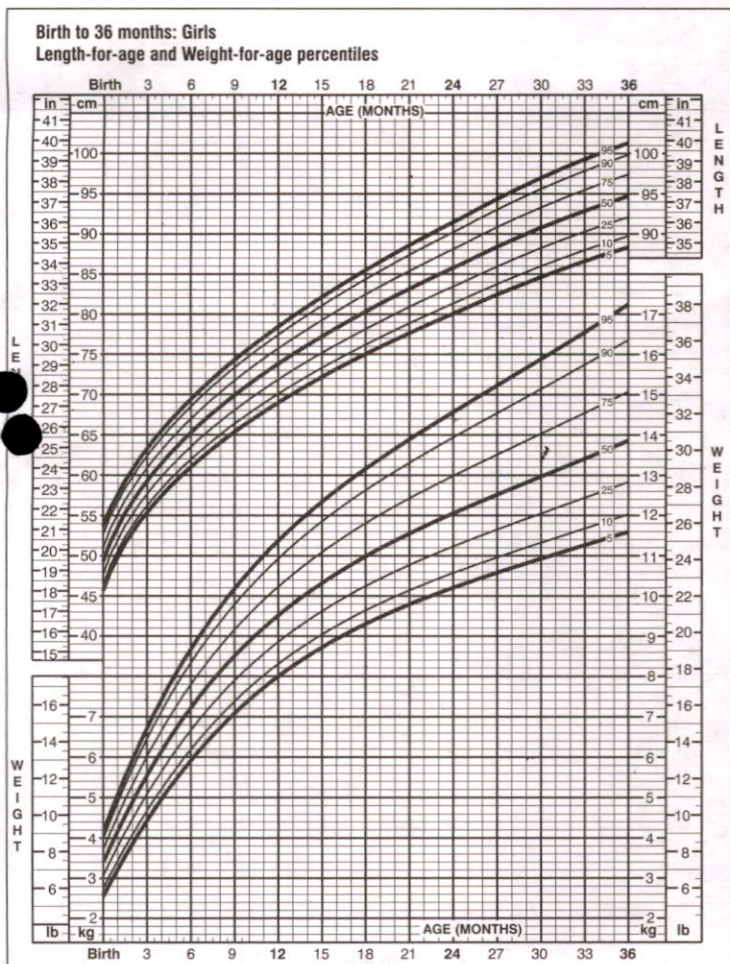
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: Ranula cyst excision

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: T. Antu

GROWTH CHART (GIRLS)



Dietician's Name: Saima

Dietician's Signature: Saima

