

MAH-00390606 IP5-00175924
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)
Dr. P V L N MURTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

80944

Date : 3/7/26

Patient Name: Zainab Fathima Date of Birth: 26-10-2019 Age: 6y

Gender: F Ward: P. 5 UHID No.: 0390606

Date of Surgery: 03/07/26 ☐ OT -1 ☐ OT -2 ☒ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Adeno to milletsomy & Adenoma

Time in : 4:45 pm

Time Out : 5:40 pm

	NAME	AMOUNT
1. Surgeon	Dr. P V L N Murthy	
2. Anaesthetist	Dr. Ashu	
3. Assistant Surgeon		
4. OT Technician	On Site Tech	
5. Circulating Nurse	Akhil	
6. Assistant Nurse	Bikhi	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others : CO2lator - 9686113

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9686112

Order by: Dr. P



CONSUMABLES OF OT

Technician : Shireeely Date : _____ Time : 3:30 p

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Qty			Qty			Qty		
Issued	Used		Issued	Used		Issued	Used	
ET tube <u>5.5/5.6</u>	1H	1	Major Pack <u>Drape</u>	1	1	Inj Vit.K		
LMA <u>8.5</u>	01	1	Sutures			Cord Clamp		
ECG leads : A/P/N	5	3				Suction Catheter		
HME filter : A/P/N	01	1				Feeding Tube		
Syringes : 10 cc	10	5				Vaccum Suction Set		
05 cc	10	5	Gloves <u>6.6-8.7-7.5</u>	2H	1	Surgical Gloves		
02 cc	10	5	<u>6.6-5.7-7.5</u>	2H	2	Gauze Pack		
01 cc	1	1				Syringe 1ml / 2ml		
Cautery plate : A/P/N	01	1	Surgical blade			Surgical Blade # 20		
IV set	01	1	NG tube <u>6. NO</u>	2	2	Koochies (S)		
RL	1	1	Cautery pencil			<u>NS 500 ml</u>	2	1
NS : 10ml / 100ml / 500ml / 1000ml	1H	1H	Koochies			<u>Transfix</u>	1	1
<u>mini spike</u>	01	1	Ointments			<u>Suction</u>	1	1
<u>Guan</u>	03	1	Suction Catheter			<u>loc. 5cc</u>	2H	2
Fentanyl	01	1	Cap, Mask	1H	1H	<u>Sopgud gel</u>	1	1
Morphine			Gauze Pack <u>MR</u>	2H	2H	<u>Adrenalin</u>	5	3
Ketamine			Mop Pack	1	1			
Propofol	03	2	Steristrip			<u>Fluid shield</u>	2	2
Rocuronium	01	1	Underpad	1	1	<u>mider</u>	01	1
Glycopyrolate	01	1	Draw sheet			<u>Nasal Airway</u>		1
Myoprolate <u>+Neo</u>	0H	1	Abgel			<u>18.20</u>	1H	1
Ondansetron	01	1	Foleys catheter			<u>oral Airway</u>		1
Pencan 25g/ Spinal Needle 22			Urobag			<u>011.2</u>	1H	1
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			<u>iv cannula 20, 22</u>	1H	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			<u>02 mask (P)</u>	01	1
Antibiotics <u>Netolar 2mg</u>	1	1	Bandage			<u>metaprolol</u>	01	1
<u>Agmelen 1.2 gm</u>	01	1	Tegaderm			<u>Dis-abrions</u>	2	2
Suppositories			Ioban			<u>Transfore</u>	01	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	2	1			
Justin : 12.5 mg / 25mg / 100mg	1H	1	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
<u>Valcum set</u>	01	1	Microshield	1	1			
<u>Dexa + Dexmedetomidine</u>	1H	1H	Cotton Balls					
<u>tranax + pm</u>	1H	1H	Latex Gloves	10P	10P			
<u>Glowall + clonex</u>	5H	1	Ramdone Scrub					
<u>10cm 100cm 3way</u>	1H	1	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9686097

Ordered by : Sh

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

ESTIMATION SLIP

Date : 29/Jun/26 UHID / IP No. : max-00390606 SI No. 80944
 Name of Patient : Baby Zainab Fathima Age: 6y/8m Gender: F
 Father's / Husband's Name : Mrs. Mammuna Corporate / Occupation : AI/RS
 Address : _____ Phone : 9367213660 Email: Marina.Denis
 Procedure / Plan : Adenofornixlectomy & Coelation

MODE OF PAYMENT : ☐ SELF ☒ TPA : ICICI Lombard ☐ GIPSA : _____ OTHERS _____

TARIFF INFORMATION : D. Pravin Murthy

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges	<u>pr 25</u>			<u>pr 25</u>						
Doctor's Fee				<u>pr 25</u>						
L. Tax				<u>pr 25</u>						

PARTICULARS		AMOUNT (₹)
Surgeon's / Anesthetists's Fee / O.T. Charges		<u>in play</u>
O.T. Consumables		Subject to approval by TPA / Insurance Company
Instrument Charges <u>Coelation</u>		Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations		As per actual - Not Included in Estimation
Equipment Charges	Monitor :	Oxygen :
	Ventilator :	Conventional :
	Phototherapy :	Single Surface :
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.		As per actual - Not Included in Estimation
Package <u>St. 28/ table 1</u>		<u>80,000/-</u>
Others		
Initial Minimum Deposit		<u>As 15,000/- for dms cleaning</u>

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.

I M/s. Mammuna 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 Relationship

Signature of the Financial Counselor

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175924 Admit Date : 03-Jul-2026 Admit Time : 01:26 PM UHID : MAH-00390606

Patient Details :

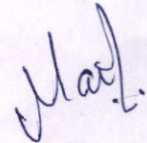
Patient Name	: Baby ZAINAB FATHIMA	Age	: 6 Y 8 M 7 D
Guardian	: Mrs MAIMOONA	DOB	: 26-10-2019
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: H NO 17-1-388/5/L , MAHER RESIDENCY, BESIDE TELANGANA BC STUDY CIRCLE , LAXMI NAGAR COLONY, VINAYAK NAGAR COLONY, SAROOR NAGAR WEST Saidabad Hyderabad Telangana INDIA 500059	Phone No	: 9347213660/ 8106570889
		E-mail	: maimoona.al@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 401 Ward Name : 4F-OT COMPLEX
 Room No : PRE OP 401 Admission Type : First Visit

Contact Details :

Name	: Mrs MAIMOONA	Relationship	: MOTHER
Contact Address	: H NO 17-1-388/5/L , MAHER RESIDENCY, BESIDE TELANGANA BC STUDY CIRCLE , LAXMI NAGAR COLONY, VINAYAK NAGAR COLONY, SAROOR NAGAR WEST Saidabad Hyderabad Telangana INDIA 500059	Phone No	: 9347213660



Signature

Doctor Details :

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

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: ICICI LOMBARD GENERAL INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ (F) charge : _____ Time: _____

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

MAH-00390606
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D
Dr. P V L N MURTHY
IPS-00175924

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	2:15 PM	ER	OT	
3/7/26	9:10 PM	OT	234	Quigley

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. faisal	4/6/26	9686946.	Quigley
2				
3				
4				
5				
6				
7				
8				
9				
10				

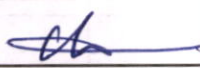
INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7/26	Ev Placement PAC (OP BASIS)	(1)	5638	
4/12/26	NHA	(1)	9686940	(72)

ANY OTHER INFORMATION

Nil

Date : 04/6/26 Time : @ 9 AM

Prepared By : 

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Hanifa	2nd floor		



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PEDIATRIC IN-PATIENT MEDICAL RECORD

MAH-00390606 IP5-00175924
Baby ZAINAB FATHIMA
26-10-2019 8 Y 8 M 7 D (F)
Dr. P V L N MURTHY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

MAH-00390606
Baby ZAINAB FATHIMA
28-10-2019
Dr. PVL N MURTHY
8 Y 8 M 7 D
IPS-00175924
(F)

Pediatric

History & Physical Examination

Name: ZAINAB FATHIMA Age/Sex 6 y / F

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Open mouth breathing }
Snoring } x 1 year

History of present illness :

Open mouth breathing }
Snoring } x 1 year

↓
Grade IV Tonsils

↓
Now admitted for coblation
adenotonsillectomy.

Patient Sticker

MAH-00390606
Baby ZAINAB FATHIMA
26-10-2019 8 Y 8 M 7 D (F)
Dr. P. V. L. N. MURTHY
IP5-00175924

Pediatric Multiorgan

ination

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

Not significant

Birth & Neonatal History:

Full term / C/S / 3.8 Kg
NO H/O NICU admission

Birth & Socio Economic History:

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

Developmental History :

Achieved as per age

Immunization History :

As per schedule.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 26 kg (Centile _____)

On Examination :

Temperature : 98.3°F Pulse Rate : 94 bpm B.P. 100/60 mmHg SPO2 98.1% RA

Resp. rate and type of breathing : 23 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L A/E, clear

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1, S2+

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : Soft, nondistended

Spine : _____ External Genitalia : _____

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

Patient Sticker

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Baby ZAINAB FATHIMA
26-10-2019 8 Y 8 M 7 D (F)
Dr. P V L N MURTHY

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness / AVPU/GCS score : 15 / 15

Cranial Nerves : 2

Motor System:

Nutriton : 2

Tone: 2

Power 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes :

DTR 2

Superficials: 2

Plantars 2

Sensory System :

Bladder / Bowel : 2

Clinical Summary & Diagnostic:

Adeno tonsillitis → for coblation
adenotonsillectomy.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

sepsis, Bleeding

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

Planned Management

- NPO as advised
- IVE DNS
- Shift to OT

W/B
Ragub
3/7/26

Signature of the Doctor: N. Nandan

Name of the Doctor: Dr. Nandan

Date & Time: 03/07/2026, 1:15 PM

DR. P V L N MURTHY
Registration No: 47267

Signature of the Consultant: Dr. P. V. L. N. Murthy

Name of the Consultant: Dr. P. V. L. N. Murthy

Date & Time: 3/7/26

Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications:	
1. Symp. AUGMENTIN → DDS 5ml BID 2wky	
2 Symp. KYTALON 5ml BID 2wky	
3 Symp. OMNACEPTIL 5ml BID - 1wky	
4 Symp. CROUWDS 5ml TID - 2wky	
5 T. LANAZOLEDT 15ml BID 2wky	
6. T. TRANEXA 500mg 4 tabs BID 2wky	
7 salt-water gargle TID 2wky	

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

Signature of the Surgeon: DR. P. V. L. N. MURTHY
 Registration No: 47267

Date & Time: 3/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/06 12pm	CS is Resistant <u>Atenolol</u> Jawing well 40 ps no intake vitals (W) stasis Mg / P10	Ask ↓ DNRs @ 50 ml/hr all day then stop Shunt

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

MAH-00390606 IP5-00175924

Baby ZAINAB FATHIMA

26-10-2019 6 Y 8 M 7 D (F)

Dr. P V L N MURTHY



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CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

Adenotomies i Coablation.

Cough reduced.

Afebrile.

No vomiting

No fever.

Paracetamol control

Aspirin only use.

Can be discharged
today.

Consultant :

DR. FAISAL B NAHDI
Registration No: 66228

Name :

MKN

Signature :

And

Date & Time :

04/July/20.

MAH-00390606 IP5-00175924
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)
Dr. P V L N MURTHY

Patient Sticker

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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: ER

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: Neelika, Dr. Nandan

Date & Time: 03/07/2026, 1:25 PM

Nurse Name & Signature: Renuka

Date & Time: 3/7/26 & 1:30 PM



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : T. LAMOL Jr DT				Date Time	3/7	4/7													
Dose	Route	Frequency	Start Dt.																
15 mg	PO	OD	3/7		X	DIPA													
Name & Signature of the Doctor Starting the Drugs:				6am		Rosa													
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : T. TRANCAP				Date Time	3/7	4/7													
Dose	Route	Frequency	Start Dt.																
1/2 tab	PO	BD	3/7		10am	X													
Name & Signature of the Doctor Starting the Drugs:				10pm		X													
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : SALT WATER GARGLE				Date Time	3/7	4/7													
Dose	Route	Frequency	Start Dt.																
gargle		TID	3/7		6am														
Name & Signature of the Doctor Starting the Drugs:				2pm															
Additional Instructions:				10pm		DIPA													
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																			

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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																				

VERIFIED BY : Name Signature

Weight. 26kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	4:55pm	Inj. PARACETAMOL	375mg	IV		Bibali Akhi
3/7	4:45pm	Inj. TRANEXAMIL Acid	400mg	IV		Akhi Bibali
3/7	4:50pm	Inj. DEXAMETHASONE	2.5mg	IV		Akhi Bibali
3/7	4:50pm	Diclofenac Suppository	25mg	PR		Akhi Bibali
3/7	5pm	Inj. AUGMENTIN	750mg	IV		Akhi Bibali

I.V. FLUIDS CHART

Weight. 26 kg Ward.

[illegible]



REGULAR PRESCRIPTIONS

Weight. 26kg Ward.

DRUG : <u>SYP. AUGMENTIN</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>5ML</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>	<u>10am</u>	<u>X</u>	
Name & Signature of the Doctor Starting the Drugs:						
<u>Shankha</u>				<u>10pm</u>	<u>X</u>	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>SYP. XYZAL-M</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>5ML</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>	<u>10am</u>	<u>X</u>	
Name & Signature of the Doctor Starting the Drugs:						
<u>Shankha</u>				<u>10pm</u>	<u>X</u>	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>SYP. OMNACORTIL 1</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>5ML</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>	<u>10am</u>	<u>X</u>	
Name & Signature of the Doctor Starting the Drugs:						
<u>Shankha</u>				<u>10pm</u>	<u>X</u>	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>SYP. CROUN DS-</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>8ML</u>	<u>PO</u>	<u>TID</u>	<u>3/7</u>	<u>6am</u>	<u>X</u>	
Name & Signature of the Doctor Starting the Drugs:						
<u>Shankha</u>				<u>2pm</u>	<u>X</u>	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						



INAB

DRUG CHART

Date of Admission: 03/07/20 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Rainbow[®]
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It takes a lot to treat the little.

BirthRight[™]
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Your Right to a Safe Delivery

AAH-00390606 IP5-00175924

Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)

Dr. P V L N MURTHY



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

1. Treatment and Care Plan
3. Pain Management
4. Informed Consent

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/7/20	2:10pm	8	procedure	M	4	0	1	1	~	Pench
9/7/20	8am	9	soft diet	M	1	0	1	1	- 1	Witth

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

MAH-00390606 IP5-00175924
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)
Dr. PVL N MURTHY



	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/12/19 2-10P	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillectomy	H-Stability	IV fluids	☒ Nursing ☐ Others:
3/12/19 2-10P	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Adenotonsillectomy	H-stability	procedure	☒ Medical ☐ Others:
4/12/19 8am	☐ Medical ☐ Nursing ☒ Others: Dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Adenotonsillectomy	soft diet	<u>RDA</u> E 1450 kcal/d P 25g/d	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op				☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op				☐ Medical ☐ Nursing ☐ Others:

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2:30 PM Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct
 Allergy / Adverse Reaction Body Weight: 26 Kg
 NA Height: cm

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

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

Family History: 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:

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

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

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

Temp.: 98.4°F HR: 88 bpm RR: 20 bpm BP: 90/50 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 Findings

Unusual 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 ☒ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☒ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse Signature: [Signature]

Nurse Name: Leanne

Date: 3/7/26

Time: 3pm

MAH-00390606
Baby ZAINAB FATHIMA
28-10-2019
Dr. P V L N MURTHY
6 Y 8 M 7 D
IP5-00175924
(F)

EMERGENCY ROOM TRIAGE FORM

NPO < 9:15 AM (Solid)
12:55 PM (water)
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Gender: ☐ Male ☒ Female

Triage Completion Time: 12:56 PM

Patient's Name: Zainab Fathima
Date: 03/07/2019
Allergies: ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify):
Arrival: ☐ Ambulatory ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☒ Normal ☐ Sick Looking
Circulation / Colour: ☒ Normal ☐ Abnormal ☐ Bleeding
Work of Breathing: ☒ Normal ☐ Increased ☐ Gasping / Apnea
Decreased

INITIAL PHYSIOLOGICAL STATUS

☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 97.97

Chief Complaints: came for surgical procedure

Triage Classification

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

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.
* CTAS - Canadian Triage and Acuity Scale

Communicable Disease Triage Screening

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

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

PART B. For patients reporting fever and respiratory/rash symptoms:

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

PART C. A positive communicable disease triage considered for any patient who meets the following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / D and Cough
- ☐ Any patient with fever and respiratory symptoms "YES" to any of the questions on epidemic "PART B" of the triage screening above.

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

- ☐ Patients should be immediately isolated in a room or a single room (as appropriate)
- ☐ The patient should be given a surgical mask already wearing one.
- ☐ Both patient and triage staff should wear PPE (as appropriate)
- ☐ The staff should use PPE (as appropriate)

Name of Triage Nurse: J. V. V.

Date & Time: 03/07/2019 @ 12:56 PM

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

Inform consultant for positive criteria.

(P.T.O.)

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

Nursing Notes

Time	
12:20	→ case seeing by Dr-Akar
	→ vitals are checked
	→ IV placement done
	→ shifted to O?

Time: /
Time: /

Samples collected by: /
Samples sent by: /

Medication given in ER:

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

Condition of patient at time of shift - out :

HR: 147b BP: 105/56 CFT: 120
RR: 20b SPO₂: 100%
GCS: 15/15 Temperature: 98.2°
Pain Score: dr
Repeat RBS (if applicable):

Details of Shift - out

Shift - out from ER to: OT
Time of Shift - out: 2:10
Handover given to: Sujata
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DE

Procedures done with details (if any):

IV placement

Name of the Nurse :

Date & Time : 03/06/2024

Signature of the Nurse :

* 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)

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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		
	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 :						
	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			120ml			Total 24 hrs. Output			M-0 U-5			



FLUID CHART

Sheet No. :

4/7/28

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						



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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	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:								

MAH-00390608
IP5-00175924
Baby ZAINAB FATHIMA
6 Y 8 M 8 D
26-10-2019
Dr. P. V. L. N. MURTHY
(F)

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: baby having painful surgical site

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
10pm	Assess the baby's general condition	10:10pm	Assessed the baby's general condition	All plan as per doctor's order.
12Am	Maintain Fluid Balance	12:10pm	Maintained Fluid Balance	
2Am	provide comfortable position	2:10am	provided comfortable position	
4am	Maintain personal Hygiene	4:10am	Explained about Hand Hygiene	
7am	Administer Medication as per doctor's advice.	7:30am	Administer Medication as per drug chart.	

Re-Assessment: Reduce the pain

Special Notes: W/R fever spike.

Nurse Signature: Rosna Nurse Name: Rosna Date & Time: 4/7/26 at 8am

Patient Sticker

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment:

Acute pain related to 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
5:50	Assess the pt General Condition.	5:55	Assessed the pt General Condition.	pt is Conscious & oriented
6pm	Relieve pain & Discomfort	6:5	Relieved pain & Discomfort	as vital recorded
6:10	monitor vital signs	6:15	monitored vital signs	no bleeding
6:20	monitor for bleeding	6:25	monitored for bleeding	maintained
6:30	maintain npo status	6:35	maintained in chart	no vomiting
6:40	provide Psychological Support	6:38	npo broken, water given	shifted
7pm	pt shift to the ward	7:5	pt shifted to the ward	

Re-Assessment:

after surgery pt is conscious & oriented

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

3/7/26

Patient Sticker

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

CHECKLIST FOR THROMBOPHLEBITIS

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

MAH-00390606 IPS-00175924
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 26-10-2019 8 Y 8 M 7 D (F)
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PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/20	1:55 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Reassess
3/7	5:45 PM	1/10	SS	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Reassess
3/7	11 PM	2/10	surgical site	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Syp. Cocin given	Reassess
4/7/20	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Re. Assessment was done Reduction	Reassess
4/7	6 AM	2/10	surgical site	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Syp. Cocin given	Reassess
4/7/20	7 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Re. Assessment was done. Reduction	Reassess
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

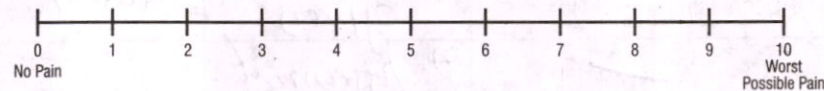
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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

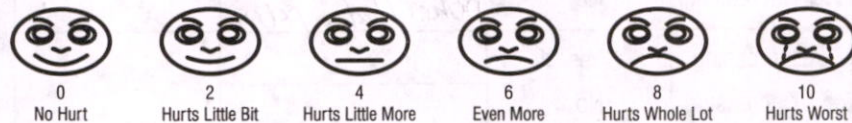
Numerical Pain Scale (Obstetric and Gynecology)



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



BRADEN 'Q' SCALE

MAH-00390606
Baby ZAINAB FATHIMA
26-10-2019
Dr. P V L N MURTHY
IP5-00175924
(F)
6 Y 8 M 7 D

				Date : 01/11/2019		
				Time : 8:28 AM		
	1. Completely immobile: Patient cannot 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
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4	4
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				Renu	RORR	

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

MAH-00390606 IP5-00175924
 Baby ZAINAB FATHIMA
 26-10-2019 6 Y 8 M 7 D (F)
 Dr. P V L N MURTHY

Patient St



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE 3/7/25 4/7

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					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication 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			6	10			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	Yes			
Call device within reach		✓	Yes			
Wheels Locked		✓	Yes			
Room free of clutter		✓	Yes			
Adequate Lighting		✓	Yes			
Wheel Chair Support		✓	No			
Other Intervention(s) Specify		✓	No			
Nurse's Name :			Peni	2004		
Signature :			R	R2		
Date :			03/10	4/7/25		
Time :			2:20P	6am		

MAH-00390606 IP5-00175924
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)
Dr. P V L N MURTHY

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Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: Adenotomectomy & Tonsillectomy

Post-Surgical Diagnosis: Chronic Adenotonsillitis

Post-Operative Monitoring Parameters /Frequency:

Bleeding, Vital signs

Wound Care:

Mouth hygiene

Drain /Special Lines/Catheters:

—

Special Patient Positioning and Requirements:

Lateral posture

Nutritional Instructions:

reg soft diet

When to Start Mobilization:

after 1 hr

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

2 wks

Treating Surgeon
(Signature & Stamp)

Date: 3/7/26 Time:

Note: Plan of care will be readjusted if necessary.

PATIENT TRANSFER FORM

Patient Name & UHID No. MAH-00390606 IP5-00175924 Baby ZAINAB FATHIMA (F) 26-10-2019 6 Y 8 M 7 D Dr. P V L N MURTHY 		Date & Time of Admission 3/7/26 @ 1:30pm	Date & Time of Transfer Order 3/7/26 @ 9:10am
		Transfer Ordered by Dr. P V L N MURTHY	Reason for Transfer POST-OP
From Unit OT	To Unit 23A	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 2x	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Op file — @		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. P V L N MURTHY	
Patient & Clinical Records Received by : ROOOS			
Date & Time of Patient Received : 3/7/26 9:20pm			

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

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. Adenotomyllectomy & Tonsillectomy
2. _____

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Good feeding</u>	

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

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

- a. Bleeding, change in voice, vocal regression
- b. rec of adenoids

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

Patient / Patient Attendant:

Signature: [Signature]

Name: Haimona

Relationship with patient: Mother

Date & Time: 03/07/2026 @ 4:30

Witness:

Signature: [Signature]

Name: [Signature]

Date & Time: 3/7/26 @ 4:30 pm

Doctor (who is taking consent):

Signature: Dr P V L N MURTHY Registration No. 47267 Date 3/7/26 Time 4:30 pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు జాణ్ నుండి కచ్చితమైనదిగా తెలుసుకోవాలి)

1

REF EIC5874-01
LOT 2201075

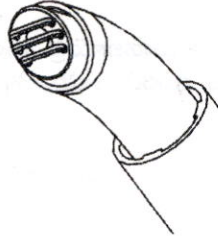
SmithNephew
QTY: (1)

2

EVAC® 70 XTRA HP
WITH INTEGRATED CABLE

నేను కింది విషయాలను అంగీకరిస్తున్నాను

- క్లినికల్ పరిశీలనలు మరియు/లే వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న



అవసరం మరియు ప్రయోజనాల గురించి నాకు

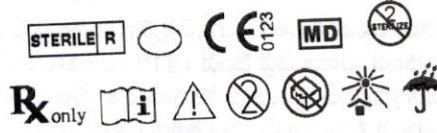
స్పష్టంగా వివరించబడ్డాయి.
నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్

శస్త్ర / ప్రాసీజర్ ప్రత్యామ్నాయాలు



- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లోగా థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోసిస్, పై శస్త్రచికిత్స / ప్రాసీజర్ రోగి/నా కోసం అవసరమని వైద్యుడు



వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ సర్కాశం ఉందని నాకు తెలుసు. లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, నుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల

2025-10-21 2028-10-21

బడ్డాయి:

a.

ArthroCare Corporation
7000 West William Cannon Drive
Austin, TX 78735 USA

b.

EC/REP Smith & Nephew Operations B.V.,
Bloemlaan 2, 2132 NP Hoofddorp,
Netherlands

NL18H0000MD_V2

4. డాక్టర్ _____ యు 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:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. P.V.L.N. Murthy
Asst. Surgeon :
Anaesthetist : Dr. Anisha
Scrub Nurse : B. K. S. S.

Patient Name :
UHID No. :
Date : 02/07/20

Baby ZAINAB FAITHIMA
26-10-2019 Y 8 M 7 D (F)
Dr. P V L N M Y



Gender :
Adams
In-time : 4:45pm Out-time : 5:40p



Before Induction of Anaesthesia ➤ ➤

Before Skin Incision ➤ ➤

Before Patient Leaves Operating Room

SIGN IN		Time: <u>4:38pm</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. SHOBNA</u>		

TIME OUT		Time: <u>5pm</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?		
	☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?		
	☐ Yes ☒ No ☐ NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?		
	☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed?		
	☒ Yes ☐ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.		
	☒ Yes ☐ No	
Signature : <u>[Signature]</u>		
Name : <u>B. K. S. S.</u>		

SIGN OUT		Time: <u>5:20p</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☒ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?		
	☐ Yes ☒ No	
DR. P V L N MURTHY Registration No: 47267		
Signature : <u>[Signature]</u>		
Name : <u>Dr. P V L N MURTHY</u>		

MAH-00390606 IP5-00175924
 Baby ZAINAB FATHIMA
 26-10-2019 6 Y 8 M 7 D (F)
 Dr. P V L N MURTHY

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 03/08/20

Department : P.07 Duration of Procedure : 4hr

Name of Surgeon : Dr. P.V.L. Murthy Date of Admission : 03/08/20

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 : Augmentin (2500) 5m	b
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	2
3.	Patient's body temperature immediately post operation (Recovery Room) 36°C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Wise
4.	Name of doctor or staff administering the antibiotic : Dr. P.V.L. Murthy Date & Time of antibiotic administration : 03/08/20 Date & Time procedure started : 03/08/20	B.V.

- 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

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Coablation - Adenotonsillectomy

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

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 Laryngospasm, Bronchospasm, Bradycardia

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Maimoona

Name: Maimoona

Relationship with patient: Mother

Date & Time: 2/7/26 @ 3:15 PM

Witness:

Signature: Ameera Begum

Name: Ameera Begum

Date & Time: 3:15 PM 2/7/26

Doctor (who is taking consent):

Signature: Dr. Anwar Name: Dr. Anwar Date: 2/7/26 Time: 3:15 PM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ 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 ☐ పొక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ 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:

Department of Anaesthesiology
PRE ANAESTHETIC EVALUATION

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

MAH-00390606 IP5-0017
Baby ZAINAB FATHIMA
26-10-2019 6 Y 8 M 7 D (F)
Dr. P V L N MURTHY

Name: Baby Zainab Age: 6y Sex: F UHID.No: BA MAH-00390606
Date: 2/7/26 Time: 3pm Proposed Operation: Adenotonsillectomy Coablation
Diagnosis: Grade IV Tonsillitis
B.P / CRT: H.R: Weight: 26kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 9.9 Glucose: Protein: HIV: X-Ray:
PCV: 27 Urea: Alb: HBS Ag: ECG:
WBC: 8200 Creat: Total Bill: HCV: 2D Echo:
Plate: 381000 Na: Dir. Bill: Blood group: Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
vit-D -19.40 Cl-: SGOT/SGPT:

Allergies: NK

Medical History: CVS: ⊖ Birth H/o → LCS / 3.8kgs / NO NIEU Stay /
RESP: → stuff nose, open mouth breathing Diabetes: ⊖ Development: Immune } ⊖
CNS: → no snoring
Renal: → no disturbed sleep
Hepatic / GE: ⊖ Physical Activity: Active
Others: ⊖

Past Anaesthetic History: Nil

Physical Exam: apetite

Airway: MP 1 2 3 4 Mouth Opening: 23f Mento-hyoid Distance: 3f Neck: normal Teeth: normal
Lungs: BATE
Heart: S1S2
CNS: NRM

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: Water / ORS 2 Hours / Solid 5-6 hrs
- NIL ORAL: Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature: Amr Name: Dr Amreen



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No Fasting Status: Adequate

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

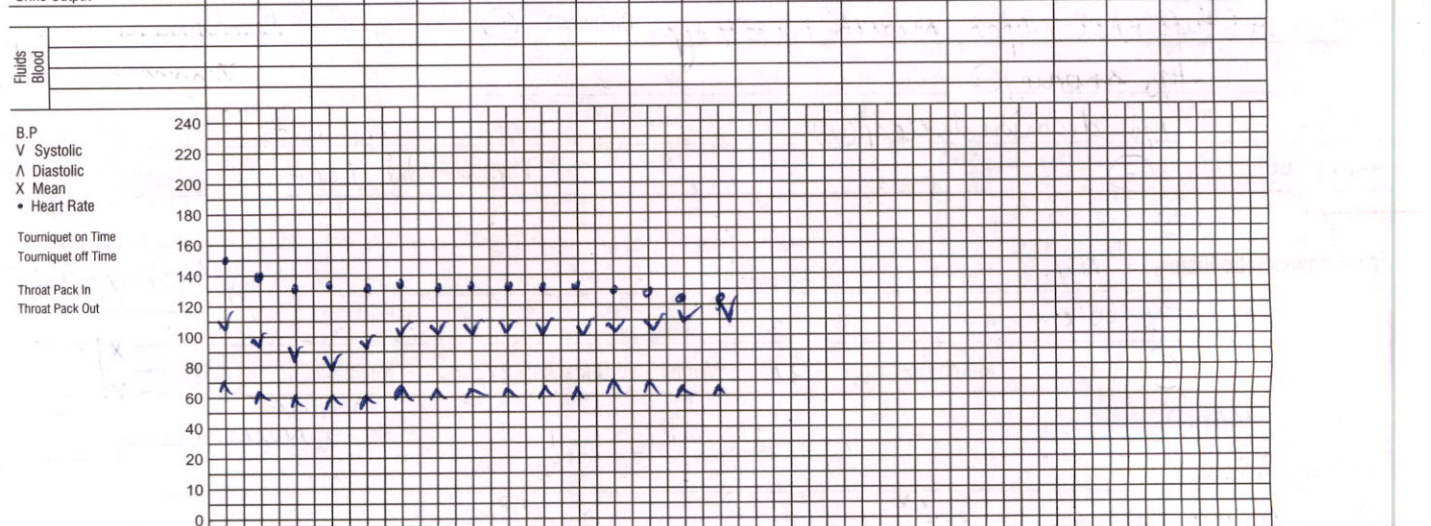
H.R: 142/min B.P / CRT: 106/56 SpO₂: 98% on RA R.R: 20/min Last Feed: > 6hr

Pre-OP Diagnosis: Cervical IV Torsion Operation: Adenotomylectomy Date: 03/07/20

Surgeon: Dr. P. V. L. N. Murthy Anaesthesiologist: Dr. Ayesha Cobbold Technician: Sivaleela

TIME: 4:45 5:10 5:10 5:20 5:30 5:45
N₂O AIR 100% 100% 100% 100% 100% 100%
HALO / SO / BEVO: MAC
Drugs:
1. MIDAZOLAM 1mg IV
2. PROPOFOL 40 (20+20) 20mg IV
3. FENTANYL 50mcg IV
4. ROCURONIUM 15mg IV
5. PARACETAMOL 325mg IV
6. MYOXYPEROLATE 2.5mg IV

Antibiotic: AMOXICILLIN 750mg IV
Suppository: DICLOFENAC 75mg
Blood Loss: PR



LAB Values
ABG
GRBS
Others

☒ Equipment Checked and Functional
☒ BP
☒ Cuff Site: Bleed
☒ Art Site: Arterial
☒ EKG Lead
☒ Temp Site: Arterial
☐ FIO₂ Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator
Position: Supine
☒ Pressure Points Checked
Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake
Temp:
☐ HME ☐ Fluid Warmer
☐ Clip/Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other
Times:
Anaes Start: 5:45pm
OP Start: 5:05pm
OP End: 5:20pm
Leave OR: 5:20pm
Anaesthesia:
☒ GA
☐ Monitored Anaesthesia Care
☐ Regional
Line (Size & Location)
☐ CVP: 22G IV on RUL
☐ ART:
☐ IV:
☐ IV:
Induction:
☒ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others
Mask ☐ SGA
Airway ☐ Oral ☐ Nasal
ETT # 5.5 at 14 cm
Oral ☐ Nasal ☐ Cuff
Tracheostomy ☐ Topical
Drug: ROCURONIUM
Awake ☐ Direct Vision
Video Laryngoscopy ☐ Stylette / Bougie
Fiberoptic
Blade # 2 Attempts: 1
Difficulty Why?
Bilat = BS
Semi-Closed Circle
Closed Circle
Other
Regional:
Extremity ☒ Specific: RA
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: 27 Depth:
Parasthesia ☐ Yes ☒ No
Catheter at skin 2 cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:
Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☒ Yes ☐ No ☐ NA
Name of the Doctor: Dr. Ayesha
Signature of the Doctor: [Signature]



Patient

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. S. Ayesha Time Received : 5:45 PM Time Discharged : 6:30 PM

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 SP0 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>22G</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	1	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	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP ± 20 of Pre Anaesthetic level	= 2	2	2	2	2		
BP ± 20-50 of Pre Anaesthetic level	= 1						
BP ± 50 of Pre Anaesthetic level	= 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

Date	Time	Pain Score	Intervention	Signature
3/7	5:45 PM	1/10	—	Dr. S. Ayesha

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

Anaesthesiologist Name : Dr. S. Ayesha

Anaesthesiologist Signature: [Signature]

Date & Time: _____

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 3/7/2019 @ 6:30 PM

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): Bixheli

Date & Time: 3/7/2019 @ 6:30 PM

Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

Date and Time :

PATIENT TRANSFER FORM

Patient Name & UHID No. MAH-00390606 IP5-00175924 Baby ZAINAB FATHIMA 28-10-2019 8 Y 8 M 7 D (F) Dr. P V L N MURTHY 		Date & Time of Admission <i>3/6/20 @ 12:20 PM</i>	Date & Time of Transfer Order <i>3/6/20 @ 2:15 PM</i>
		Transfer Ordered by <i>Dr. Akhila</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>OT</i>	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File <i>20</i>	Number of Imaging Films <i>NO</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ <i>of the</i> If yes, what? <i>Hand</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	<i>protect Gown</i>	<i>1</i>	
2.	<i>Evac</i>	<i>1</i>	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring <i>Dr. Renuka</i>		Name of Person Ordered Transfer <i>Dr. Akhila</i>	
Patient & Clinical Records Received by : <i>Singh</i>			
Date & Time of Patient Received : <i>3/6/20 @ 2:29 PM</i>			

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

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 4/9/20 Time: 8am

Weight: 26 kgs Centile: >75th

Height: 118 cms Centile: >25th

Inference: Overweight child

RDA: Calories: 1450 kcal/d Protein: 25g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, Scentide foods

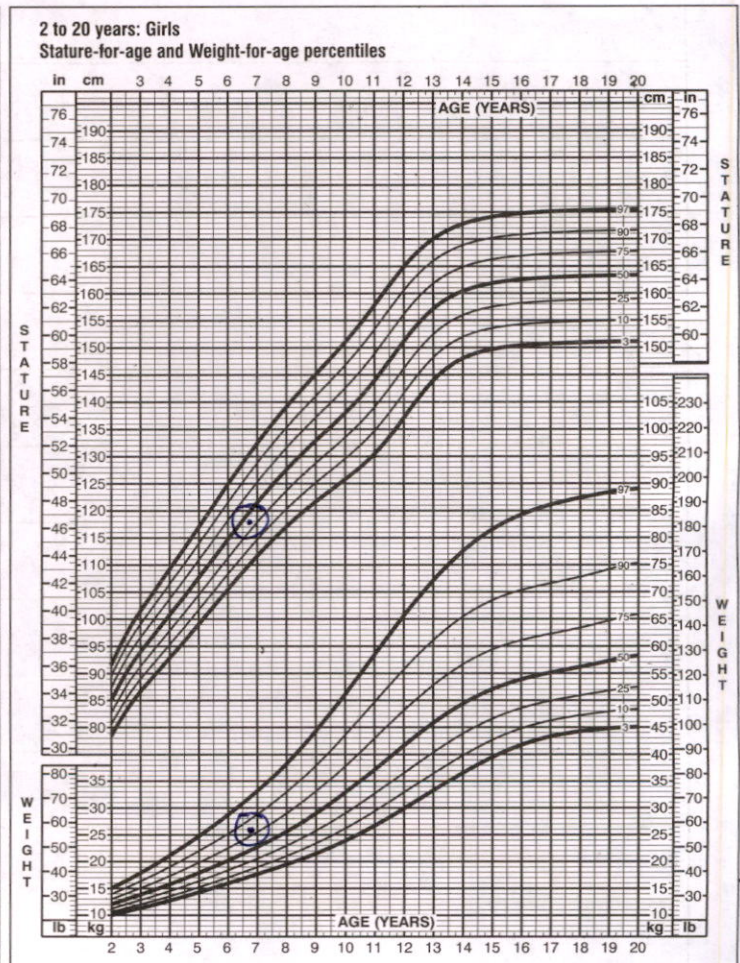
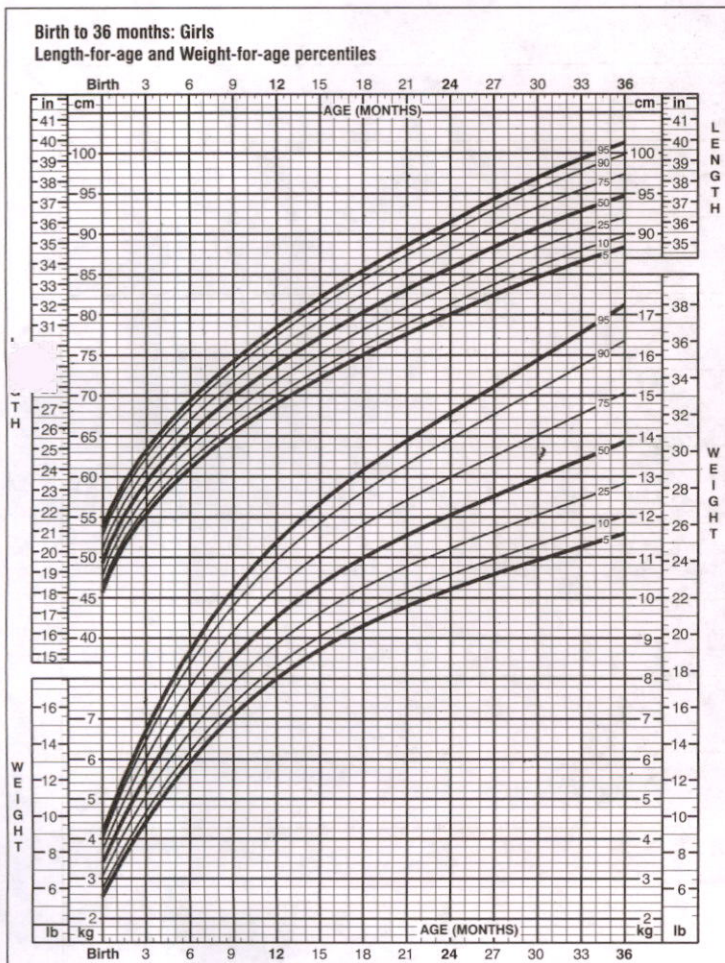
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Adenotomylectomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha Dietician's Signature: [Signature]

Daily Notes:

Blank lined paper with horizontal ruling lines.