HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

SURGERY DETAILS

Date : 21/5/26

Patient Name: Baby Himanshi Date of Birth: 4/5/2025 Age: 1y/17m

Gender: Female Ward : OT UHID No.: HNH - 00015531

Date of Surgery: 21/5/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (Lt) Eye Outer canthus laceration → Primary Suturing

Time in : 9:00 Am Time Out : 9:30 Am

		NAME	AMOUNT
1.	Surgeon	: Dr. Swapna. P	
2.	Anaesthetist	: Dr. Samir	
3.	Assistant Surgeon	:	
4.	OT Technician	: Pallavi / Saraswathi	
5.	Circulating Nurse	: Sangeetha	
6.	Assistant Nurse	: Sandhya	

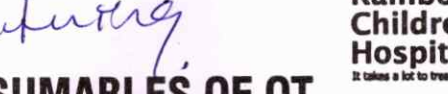
Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

Signature of the Surgeon Signature of Circulating Nurse

Order No: 26-000020096 Order by: Sushila 21/5/26 @ 10:58 Am.

Docu. No. : RCH /FRM / GENERAL / 114

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY



Suturing

CONSUMABLES OF OT

Circulating staff :........ Technician : Saraswathi........ Date :........ Time :........

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
~~LMA~~ I gel 1.5		01	Sutures 9575		01	Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		04	Gloves Encore 6½		02	Surgical Gloves		
02 cc		02				Gauze Pack		
01 cc		01				Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
			Ointments Megaheal		01			
Midaz		01	Suction Catheter					
Fentanyl		01	Cap, Mask	5+5				
Morphine			Gauze Pack		02			
Ketamine			Mop Pack					
Propofol		02	Steristrip					
Rocuronium			Underpad		1			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag 10N Jelly		01			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Inj. Augment 300mg		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg		01	Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield		01			
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. 26-00002010791080. Ordered by : Sangeetha

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar Hyderabad Telangana INDIA 500029
Tel No : 040-48873000

VAT TIN : **CIN :**

DL NO :

Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP26-00006394	**Ward**	4F -OT
Patient Name	Baby HIMANSHI	**Bed Name**	PPO-418
Age/Sex	1 Y 0 M 17 D / Female	**Order No**	26-0000201080
Date	21/05/2026 09:16	**Prescription No**	PRIP26-0087100
Payor	SELFPAY	**Dispensed Date**	21/05/2026 10:58
UHID	HNH-00015531		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ADVENT INJ VAIL 300MG	CIPLA LTD	H	AQVV04A1A	07/27	1	132.42	132.42
2	BACTOPREP SOLUTIONS 100 ML	RAMAN & WEIL PVT LTD		RTBP26002	02/29	1	229.00	229.00
3	DSYRINGE 1ML (NIPRO)	NIPRO	GENERAL	0124310	10/29	1	27.00	27.00
4	Encore Microptic gloves-6.5		H	260200311T	02/29	2	117.00	234.00
5	FACE MASK 3 LAYER -ELASTIC	Local		02260402	03/29	5	16.00	80.00
6	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353002	07/27	2	69.10	138.20
7	MEZOLAM INJ 5 MG 5 ML	Neon Laboratories Ltd	H1	V304622	10/27	1	31.55	31.55
8	NEOMOL SUPPOSITORIES 170 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP487045	05/28	1	8.46	8.46
9	SURGEON CAP(FEMALE) (PROTECTCARE)		General	211526022026	02/29	5	10.00	50.00
10	THEMIPYRRNOM 0.2MG INJ	Themis Medicare Ltd	H1	THP240O4	09/26	1	15.24	15.244
11	VICRYL 6-0 W9575	ETHICON SUTURES-J&J		SPMDPZ	11/27	1	1,021.88	1,021.875
						Total :	**1,677.65**	**1,967.75**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GUVVALA VIJAYA SUSHEELA

DISCHARGE SUMMARY

Name	Baby HIMANSHI	UHID	HNH-00015531
Father/Guardian	Mr R MANOHAR	Age/Gender	1 Y 0 M 17 D/ Female
Address	6-1-585/B/2 , PLOT8,MARUTHI NAGAR, Khairatabad, Hyderabad, Telangana, INDIA, 500004		
IP No	IP26-00006394	Admission Date	21-05-2026
Ref Doctor	Self.		
Discharge Date	21.05.2026		

Consultant:
Dr. SWAPNA PALAKURTHY
Others
PEDIATRIC SURGERY

DIAGNOSIS	ICD CODE
PRIMARY SUTURING OF LEFT EYE OUTER CANTHUS LACERATION	

Procedure : PRIMARY SUTURING DONE ON 21.05.2026.

History: Baby HIMANSHI, 1 Y 0 M 17 D child presented with complains of fall

Name	Baby HIMANSHI	UHID	HNH-00015531
IP No	IP26-00006394	Admission Date	21-05-2026

from height causing laceration to left lower eyelid prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 123 /min and Respiratory rate - 28/min. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 8.2 kilo grams.

Investigations: Enclosed reports.

Procedure : PRIMARY SUTURING DONE ON 21.05.2026.

Surgery Notes:
* Z shaped left eye outer canthus laceration of 3 x 0.5 x 0.5 cm size with inferior flap avulsion present.
* Primary suturing done with 6-0 vicyrl.
* Haemostasias secured
* Port procedure uneventful.

Post-Operative Notes: Post operative period was uneventful. Child was initiated on oral feeds gradually which child tolerated well. She remained hemodynamically stable during the hospital stay and operated site remained healthy. Child is being discharged with the following advice.

Advice:
* Diet as advised.

Name	Baby HIMANSHI	UHID	HNH-00015531
IP No	IP26-00006394	Admission Date	21-05-2026

* Avoid head down portion.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DDS (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	3 ml	8am-8pm (after food)	For 5 days
2	Syrup. Ibugesic	2 ml	thrice daily	For 3 days
3	Regen D ointment for local application twice daily for 3 days			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SWAPNA PALAKURTHY on Monday(25.05.2026) in OPD at 5-6pm, at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Follow up immediately in Emergency Room if high grade fever, vomiting,

Name	Baby HIMANSHI	UHID	HNH-00015531
IP No	IP26-00006394	Admission Date	21-05-2026

breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor .... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122.**

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

RAINBOW CHILDREN'S MEDICARE LIMITED * HYDERABAD

Registrar/Resident/C.M.O

Dr. SWAPNA PALAKURTHY
Others
PEDIATRIC SURGERY

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006394 **Admit Date** : 21-May-2026 **Admit Time** : 07:33 AM **UHID** : HNH-00015531

Patient Details :

Patient Name : Baby HIMANSHI
Guardian : Mr R MANOHAR
Gender : Female
Occupation :
Address (H) : 6-1-585/B/2 , PLOT8,MARUTHI NAGAR Khairatabad Hyderabad Telangana INDIA 500004

Age : 1 Y 0 M 17 D
DOB : 04-05-2025 01:00 AM
Religion :
Martial Status :
Phone No : 9581883032
E-mail : na@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY
Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr R MANOHAR
Contact Address : 6-1-585/B/2 , PLOT8,MARUTHI NAGAR Khairatabad Hyderabad Telangana INDIA 500004

Relationship : Father
Phone No : 9581883032

M. Jyothi

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA PALAKURTHY
Referral Doctor : Self.
Co-Consultant :

Specialisation : PEDIATRIC SURGERY
Phone No :

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 40000.00
Payor Name : SELFPAY

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: Baby HIMANSHI Age: 1Y Sex: F UHID.No : HHN 000 15531

Date: 21/5/26 Time: 8.14 Proposed Operation: Suturing

Diagnosis: eyelid laceration

B.P / CRT: <3sec H.R: 114/min Weight: 8.2 ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5 (1 ticked)

Laboratory Data:

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

Allergies: No known allergy

Medical History: CVS : —

csection →
CIAB :- Birth 3.9 k
No NICU admission

RESP : Snoring (+) slight cold no runny nose

Diabetes : —

CNS : —

Renal : —

Hepatic / GE : —

Physical Activity: Active playful

Others : —

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: — Neck: — Teeth: —

Lungs : AEBE

Heart: S1S2+

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA (NA ticked) Venous Access Site : RUL Spine Exam for regional : —

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA (MAC ticked)

Peri-Operative Plan Explained to the Patient: ☐ Yes ☐ No (Yes ticked)

CURRENT MEDICATIONS	DOSAGE
—	—
—	
	—

FOOD :- 12PM
5AM :- WATER

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours (ticked)
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

:- can be taken for SX

Signature: Achita Name: Dr Adel

Docu. No. : RCH /FRM / CLINICAL / 044

Patient Sticker

ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: >6hrs → Adequate

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

H.R: 121/min · B.P / CRT: 75/33 mmHg · SpO_2: 100 on RA · R.R: 16 · Last Feed: >6hrs

Pre-OP Diagnosis: eyelid laceration · Operation: suturing · Date: 21/5/26

Surgeon: Dr Swapna · Anaesthesiologist: Dr Samir Dikshit · Technician: Saraswati

TIME: 9 · 9:30

N_2O /AIR /O_2 LPM: via 2lit

HALO /SO /SEVO

Drugs: INJ PROPOFOL 20+5+5+5+5+5

INJ FENTANYL 10+5 MCG

INJ MIDAZOLAM 0.4 MG

FIO_2 / SaO_2	100	100
$ETCO_2$	33	33
ECG	30	84
Temperature		
Urine Output		

Fluids / Blood

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 · 220 · 200 · 180 · 160 · 140 · 120 · 100 · 80 · 60 · 40 · 20 · 10 · 0

Antibiotic: Inj Augmentin 250mg

Suppository: paracetamol

Blood Loss: —

NOTES: —

LAB Values: ABG · GRBS · Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: LLL
☐ Art Site:
☑ EKG Lead 3 lead
☑ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: ....

☑ 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: 9
OP Start: 16
OP End:
Leave OR: 9.30

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV:
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA 1½
☐ Airway ☐ Oral ☐ Nasal
ETT# ...—... at ...—... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: —

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# — Attempts: 1
Difficulty Why? —

☐ **Bilat = BS**
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: .... Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dr Atul R

Signature of the Doctor: [signature]

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sandhya Time Received : 9:30Am Time Discharged : ....

✓ RESP •PULSE > < BLOOD PRESSURE (chart, 0–250; SPO₂)

IV Cannula Site : R 49 Lt

- [x] O₂ Mask
- [ ] Nasal Prongs
- [ ] Tracheostomy
- [ ] T-Piece
- [ ] Oral Airway
- [ ] Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: ....

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☐ Yes ☑ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☑ Yes ☐ No

IV Fluids: ½ Day

Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	2	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2	2	
		TOTAL	9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/5/26	9:30	0	NA	[signature]
21/5/26	11:30	0	NA	[signature]
				[signature]

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

Anaesthesiologist Name : Dr Aditi N

Anaesthesiologist Signature: [signature]

Date & Time: 21/5/26 11:20 AM

PACU Nurse Name : Sangeetha

PACU Nurse Signature: [signature]

Date & Time: 21/5/26

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): ....

Date & Time: ....

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: .... Time: .... Procedure done by ....

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

Depth: .... Catheter at Skin: .... Attempts : ....

Parasthesia : Yes/No if yes details : ....

Solution Composition : ....

Any other issues :

a) ....

b) ....

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

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

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

OPERATION THEATER NOTES

HNH-00015531
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY
IP26-00006394

Patient's Name : ....Age : 1Y/17 Gender : Female

UHID.: .... IP.No. :..Weight : ....

Surgeon : Dr. Swapna. P	Asst. Surgeon :
Anesthetist : Dr. Samir	OT Nurse : Sandhya
Surgical Procedure : Primary Suturing	
Indications for Surgery : (Lt) Outer canthus laceration (eye)	

Date : 21/5/26	Start Time : 9.00Am	End Time : 9.30AM.

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

- Z-shaped (Lt) eye outer canthus laceration of 3×0.5×0.5cm size with inferior flap dermal laceration
- primary suturing done with 6-0 vicryl
- Haemostasis secured
- post procedure uneventful

(P.T.O)

POST - OPERATIVE ORDERS :

Wt: 8.2kg.

- NPO till 3hrs.
- IVF → 1/2 DNS 32ml/hr
- Syp. Augmentin | PO | BD
  (5ml/457mg)
  3ml ———————— 3ml
  × 5days
- R/A 2days to OPD (5-6pm)
- Syp. Ibugesic | PO | TID
  2ml —— 2ml —— 2ml × 3days
- Avoid head down position
- Regen-D ointment for L/A
  wq ———————— Evy → After primary dress.

....

Consultant Surgeon's Name

....

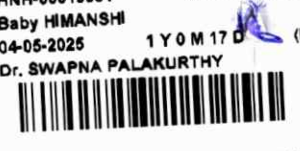
Consultant Surgeon's Signature

Date : ....Time : ....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
Asst. Surgeon : ....
Anaesthetist : Dr. Samir
Scrub Nurse : Sandhya

Patient Name : ....
UHID No. : ....
Date : 2/3/26



Gender : Female

In time : 9:00Am   Out time : 9:30Am

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: ....

Patient Has Confirmed

Item			
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 : ....

Name : ....

TIME OUT — Time: 8:50Am

Item			
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 — Lt eyeside	☑ Yes	☐ No	
Correct Procedure — Suturing	☑ Yes	☐ No	
Anticipated Critical Events			
Surgeon Reviews:			
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? — Nil, 30 mints, minimal	☑ 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

Signature : Sushuls

Name : Sushuls 8:50Am

SIGN OUT — Time: ....

Nurse Verbally Confirms with the Team:

Item			
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	

Inj. Augmentine 400mg @ 9Am

Signature : [signature]

Name : ....

Doc. No. : RCH / FRM / CLINICAL / 111

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015531 IP26-00006394 Baby HIMANSHI 04-05-2025 1 Y 0 M 17 D (F) Dr. SWAPNA PALAKURTHY	21/5/26' @ 7.33Am	21/5/26' @ 9.45Am.
	Transfer Ordered by Dr. Samir.	**Reason for Transfer** Post-op.
From Unit OT	**To Unit** Post-op	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 28	**Number of Imaging Films** Nil	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Dr. Samir.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sandhya	Dr. Swapna P.

Patient & Clinical Records Received by :

Sandhya.

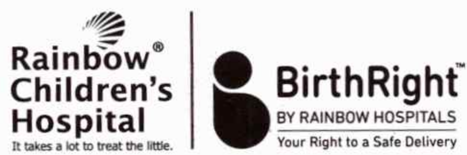
Date & Time of Patient Received : 21/5/26' @ 9.45Am.

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

Docu. No. : RCH /FRM / CLINICAL / 102

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

Patient Name : .... Gender: ☐ Male ☑ Female Age : 1y/17m

UHID No : .... Date : 21/5/26

Instruction:
This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

Primary Suturing

upon

(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized 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. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

- Infection
- Bleeding
- Keloid formation

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: ....

Consentee :

Signature : ....

Name : ....

Date & Time : ....

Patient Attendant :

Signature : [signature]

Name : Deepthi

Relationship with Patient: Aunty.

Date & Time : ....

Witness :

Signature : [signature]

Name : Sandhya

Date & Time : 21/5/26 @ 8:20am

Doctor (who is taking the consent) :

Signature : [signature]

Name : ....

Date & Time : ....

Docu. No. : RCH /FRM / CLINICAL / 027

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

Patient Name : Ba .... Age : 10m Gender : Male ☐ Female ☑

UHID NO: .... Surgeon Name: Dr Swapna.

Anaesthesiologist : Dr Samir Mayatla.

Operative procedure planned : Suturing

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Laryngospasm, O_2 support.

Comments : ....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient .... the above mentioned operation / Diagnostic / Therapeutic procedures Suturing

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

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : M. [signature]

Name : M. PREETHI

Relationship with Patient: MOTHER

Date & Time : 21/5/26

Witness :

Signature : [signature]

Name : Dr. Deepthi M

Date & Time : 21/5/26

Doctor (who is taking the consent) :

Signature : Aditi

Name : Dr Aditi N

Date & Time : 21/5/26

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name :

Patient ID# : HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2026 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Informant ______ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

c/o Fall from height yesterday
evening ..
Causing injury to (L) Lower eyelid

History of present illness :

Baby was apparently alright till yesterday
then had. fall from height causing Laceration to
left Lower eyelid

O/E - Eyelid Laceration 2cm x 1cm
on Lt Lower eye.
eye - spared.

Pediatric Multiorgan History & Physical Examination

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

—

Birth & Neonatal History :

FTLSCS | C.IAB | NO NICU admission | 3.94 kg.

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Up to date

Immunization History :

Up to date.

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) ________ (Centile ________) Height (cm) : ________ (Centile ________)

Weight (kgs) 8.2 kg. (Centile ________)

On Examination :

Temperature : ________ Pulse Rate: 123/min Description ________

B.P. ________ SPO2 98 % at RA

Resp. rate and type of breathing : ________

Laceration 2cm x 1cm on (L) Lower eyelid

Rash ________

Lymphadenopathy ________

Oedema : ________

Respiratory system : BAE-equal.

Inspection (any s/o distress) : ________

Air entry & breath sounds : ________

Any addes sounds : ________

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

Cardiovasclular System : S_1 S_2 +

Inspection of procordium : ________

Heart Sounds : ________

Any murmur : ________

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) ________

Per Abdomen : Soft

Inspection ________

Palpation : ________

Ausculation : ________

Spine: ________ External Genitelia : ________

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Laceration to Lt lower eyelid

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Prevent local site infection.

Desired goals of the treatment :

Planned Labs :

CBP.

Planned Management :

PAC.

Suturing under GA.

Inj Augmentin 300mg IV TID

IVF. DNS. 2/3 Maintenance.

Please fill up the following details

1. Name of the Referring Doctor : ____________
2. Name of the Referring Hospital : ____________
   (Including the name of City)
3. Contact number of the Referring Doctor : ____________
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team ____________ on whose name the patient is being referred

Doctor's Signature Name ____________ Date ____________ Time ____________

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015531 IP26-00006394 Baby HIMANSHI 04-05-2025 1 Y 0 M 17 D (F) Dr. SWAPNA PALAKURTHY	21/5/26 @	21/5/26 @
	Transfer Ordered by: Dr. Prabhat	Reason for Transfer: Admission
From Unit: ER	To Unit: OT	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 25	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.		
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. Prabhat

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

Docu. No. : RCH /FRM / CLINICAL / 102

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2026 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

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: Ward

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Prabhat

Date & Time : 21/5/26 @ 7:30 AM

Nurse Name & Signature: Jyoti / Jyoti

Date & Time : 21/5/26 7:32 A

ACTIVITY RECORD FOR BILLING

Name: ------- HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

UHID No : --- ------- Consultant : ------------------------ Dept : ----------------

Date of Adm -------------- Date of Discharge : ---------------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/5/26	8:10 Am	ER	~~ward~~ OT	~~[illegible]~~ Sudha

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
21/5/26	CBP	8582	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
21/3/26	IV canula	1	1053	AR

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

DRUG CHART

Date of Admission: .... 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name .... Signature ....

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS Weight. 8.2kg Ward. ....

DRUG : INJ AUGMENTIN.

Dose	Route	Frequency	Start Date
300mg	IV	TID	21/5/26

Name & Signature of the Doctor Starting the Drugs: Dr Prabhakar

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : IV

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

Weight. .... Ward. ....

	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.	

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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/5/26	9.30	Suppository PARACETAMOL	170 mg	PR	Sdih	[signature]
21/5/21	9.00	INJ AUGMENTIN	250 mg	IV	Sdih	[signature]

VERIFIED BY : Name .... Signature ....

Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. 8.2kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/5/25	7:30AM	IVF DNS (2/3 Maintenance).	IV.	20	[signature]	[signature]			[signature]

VERIFIED BY : Name .... Signature ....

HNH-00015531 IP26-00006394
Baby HIMANSHI
04-05-2025 1 Y 0 M 17 D (F)
Dr. SWAPNA PALAKURTHY

Wt 8.2 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Himanshi Age : .... **Gender:** ☐ Male ☑ Female

Date : 21/5/26 Time of Arrival : 7:30 Am

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): .... ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) ....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.6F PR: 149b/m BP: .... RR: .... SpO_2: 97%

Chief Complaints: c/o came for Surgery

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

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : ....

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

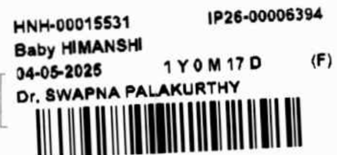
☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Jyoti

Signature of Triage Nurse : Jyoti

Date & Time : 21/5/26 @ 7:32Am



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/5/26 Time of arrival : 7:30 Am

Chief Complaints: come for suturing RBS: ....

Height : .... Weight : 8.2 kg BMI : .... Head Circumference (<2 years) ....

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: ....

If yes , identify ....

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

☐ Character .... ☐ Location .... ☐ Frequency .... ☐ Duration ....

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

....

....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With family.

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

Time of Initial assessment completed by ER Nurse : 7:33 Am

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

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

Time	Nursing Notes
	Assessed The patient condition
	vital checked.
	cannula done.

Samples collected by: Jyothi

Samples sent by :

Time:

Time: 8:00AM

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: .... BP: .... CFT:	Shift - out from ER to: ....
RR: .... SPO_2 :	Time of Shift - out: ....
GCS:.......... Temperature :	Handover given to: .... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): ....

....

Name of the Nurse : Amrutam .... Signature of the Nurse : AT ....

Date & Time : 21/5/26 @ 7:35AM

26-0000201061

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Baby Himanshi		Age: 1y	Gender: Female
UHID No: HNH-0005531	IP No: IP26-00006394	Date: 21/5/26	Time:
Diagnosis: Suturing		ward - 07	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	1Amp
2.	Morphine Sulphate Inj. 15mg/Ml	/	/
3.	Remifentanil Hydrochloride Inj. 2MG	/	/
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Heena

Doctor Registration No: 2038

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006394 **Date:** 21/5/26

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	**Name :** Baby Himanshi	
2.	Complete postal address (with contact number, if any)	6-1-585/B-2 Plot 8 Maruti nagar Khairatabad hyderabad telangana 500004
3.	Brief description of the illness	Suturing
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/5/26	Fentanyl	1 Amp	M.	

Dispensed by (Name & ID No.): Saroj (014882) .... Signature: ....

Received by (Name & ID No.): Saraswathi (021006) .... Signature: ....

Time: ....

FRM/CLINICAL/133

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Baby Himansh		Age: 1y	Gender: Female
UHID No:	IP No:	Date:	Time:
Diagnosis: Seizure			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG	/	/
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. H [illegible] Doctor Registration No: 2038

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: .... **Date:** ..../..../26...............

Aadhaar No. of the Patient (Optional): ....

1.	Name : Baby Himansh	Remarks
2.	Complete postal address (with contact number, if any)	[illegible]
3.	Brief description of the illness	Seizure
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

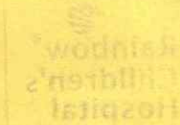
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
[illegible]	Fentanyl	1 Amp	M. [illegible]	

Dispensed by (Name & ID No.): .... Signature: ....

Received by (Name & ID No.): .... Signature: ....

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133



NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:	Age:	Gender:
UHID No:	IP No: Date:	Time:
Diagnosis:		

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj. 50mcg/Ml		
2	Morphine Sulphate Inj. 15mg/Ml		
3	Remifentanil Hydrochloride Inj. 2MG		
4	Remifentanil Hydrochloride Inj. 1MG		

Doctor Name: Doctor Registration No:

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: Date: ....

Aadhaar No. of the Patient (Optional):

		Remarks
1.	Name:	
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the practitioner)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID): Signature:

Received by (Name & ID): Signature:

Time:

Doc No: RCH-