

BAH-00645090 IP5-00174706
Baby KHATIJAH ABDUL MAJEED
14-11-2024 1 Y 6 M 20 D (F)
Dr. VISHAKHA BASAVRAJ KARPE



SURGERY DETAILS

Date : 3/06/24

Patient Name: Baby KHATIJAH ABDUL MAJEED Date of Birth: 14-11-2024 Age: 1 Y 6 M

Gender: F Ward: P OT UHID No.: 0124906

Date of Surgery: 3/06/24 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery: Ommaya Reservoir removal

Time in : 3:15 PM

Time Out : 4:15 PM

	NAME	AMOUNT
1. Surgeon	Dr. Vishakha	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	VENICAT SAR	
5. Circulating Nurse	AKHIL	
6. Assistant Nurse	ROSI DAS	

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9641443

Order by: Bobi



Ommaya Reservoir Room
CONSUMABLES OF OT



Circulating staff : Technician : Date : Time : 2 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 3.5.4.0.45	1+1	0	Major Pack/drap	1	1	Inj Vit.K Monocly 40	2	2
LMA 11/2	1	—	Sutures 5003 5050	2+2	—	Cord Clamp		
ECG leads : A/P/N	5+1	03	2402, 2437	2+2	—	Suction Catheter		
HME filter : A/P/N	1	0	2303, 2304	2+2	—	Feeding Tube		
Syringes : 10 cc	10	4	prolin 3,4,5	2+2	—	Vaccum Suction Set		
05 cc	10	2	Gloves			Surgical Gloves		
02 cc	10	0	6 61 (2) 71	2+2	2	Gauze Pack		
01 cc	3	—	PF 6 (6) 71	2+2	1+1	Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	—	Surgical blade 11 (15)	2+2	1	Surgical Blade # 20		
IV set + Blood set	1+1	0	NG tube 6 NO	1	—	Koochies (S)		
RL	1	0	Cautery pencil	1	—	NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	3+1	0	Koochies (M)		0	1000, 500	2+2	1+1
0.2 mask CP	1	0	Ointments			Bone wax	1	—
Atracurium 0.1	1+1	—	Suction Catheter			Lox 7 Adrenaline	1	1
Fentanyl	1	0	Cap, Mask	5/5	5/5	8584	1	1
Morphine			Gauze Pack (N) 2	5/5	5	8582	1	1
Ketamine			Mop Pack	1	1	CC 64	1	1
Propofol	2	0	Steristrip			IV cannula 22, 24	1+1	—
Rocuronium	1	0	Underpad	1	1	Dexa	1	—
Glycopyrolate	1	0	Draw sheet	1	0	Tromexal	1	—
Myopyrolate + Neostigmine	2	0	Abgel	1	1	Mimiphe	1	0
Ondansetron	1	—	Foleys catheter			NG 5.6 7-8 9 10		—
Pencan 25g/ Spinal Needle 22		—	Urobag			Suction - 6.8 10		—
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Dextaramide 50	1	—
Bupivacaine 0.25% (Heavy)			Romodrain bag			clonidine	1	—
Antibiotics - Taxim 500	1	0	Bandage			50cc + pmaline	1+1	—
Amikacin 100	1	0	Regdorm	1	—	midez	1	0
Suppositories			loban	1	—	Nascul spray 18/14/16		—
Anamol : 80mg / 250mg / 170 mg	1+1	—	Double J Stent			Sob + Roll 6 + 4 line	2+1	—
Suprdol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	1+1	—	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Vaccum set	1	0	Microshield	1	0			
Gauze	3	0	Cotton Balls					
Gloves all	4	2	Latex Gloves	SP	SP			
IV p-cm	1	0	Ramdone Scrub	1	1			
3-way 100 + 10cm	1+1	—	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 964/228/229

Ordered by :

ACTIVITY RECORD FOR BILLING

Name : _____

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

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Date of Admission: _____ Discharge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	3pm	ER	OT	Anneub
3/6/26	7pm	OT	D/c	Dieg

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....
.....
.....
.....
.....
.....
.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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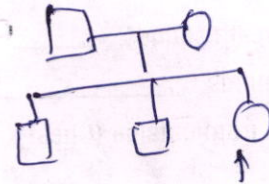
BAH-00845090 IPS-00174706
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Dr. VISHAKHA BASAVRAJ KARPE

Pediatric History & Physical Examination

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

~~None~~
No seizure
No Asthma.

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Adequately to age

Immunization History :

vaccinated till 9 months



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 9.2kg (Centile _____)

On Examination :

Temperature : 98.5°F Pulse Rate : 121/min B.P. 101/86/90 SPO2 100% on RA
Resp. rate and type of breathing : 26/min

Rash _____
Lymphadenopathy _____
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : BPEE
Any added sounds : clear
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : S2A1
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____
Palpation : ⓪
Auscultation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) _____

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Pediatric Multiorgan... & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Ache 10/15

Cranial Nerves : (N)

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : (N)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials:**
Plantars _____

Sensory System : (N)

Bladder / Bowel : _____

Clinical Summary & Diagnostic:
Case for ommye Resonator removal



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Completely

Desired goals of the treatment : _____

Remain new baby

Planned Labs:

CRP

Planned Management

- NPO from 8:10 pm

• (Powder milk)

- IVF 1/2 DNR @ 35 ml/hr

Signature of the Doctor: Ay

Signature of the Consultant: _____

Name of the Doctor: Dr. Arneekrishna

Name of the Consultant: _____

Date & Time: 3/6/26

Date & Time: _____

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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. Ommaya Resection removal
2. _____

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. 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>Removal of for implant</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. Risk of M. trap bleeding
Risk of stucked ventricular catheter

1. I authorize Dr. Vishakha and his / her team to perform the procedural sedation upon the patient / myself.
2. 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.
3. 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: Ajil
 Name: Ahmed Abdul Majeed
 Relationship with patient: Father
 Date & Time: 3/6/2026, 3:05pm

Witness:
 Signature: Hajera
 Name: Hajera Begum
 Date & Time: 3/6/2026, 1:3:05pm

Doctor (who is taking consent):
 Signature: [Signature] Name: Dr. Vishakha Date: 3/6/26 Time: 3:05 pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

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

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

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

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

a.	
b.	

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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Baby KHATIJAH ABDUL MAJEED

14-11-2024 1 Y 6 M 20 D (F)

Dr. VISHAKHA BASAVRAJ KARPE



KLIST

Surgeon : Dr. V. Nao

Asst. Surgeon :

Anaesthetist : Dr. Saxitha

Scrub Nurse : Bobi Jay

Patient Name : Baby. Khatija Abdul Majid Age : 1 Y Gender : F

UHID No. : 0180406 Surgery Name : Omphalocele repair

Date : 21/11/24 In-time : 2:20 PM Out-time : 4:20 PM



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN Time:.....

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 : *[Signature]*

Name : Dr. Jaya Chandra

TIME OUT Time: 2:45 PM

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? *dissection ommph* 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 : *[Signature]*

Name : Akhil

SIGN OUT Time: 4:20 PM

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded Yes No

That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) Yes No NA

The Specimen is Labelled (including patient name) Yes No NA

Whether there are any Equipment Problems to be addressed Yes No NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? Yes No

Signature : *[Signature]*

Name : Dr. Vishakha

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 3/06/26

To Be Filled In By Assigned Nurse :

Department : P.OF Duration of Procedure : 8

Name of Surgeon : Dr. Vishakha Date of Admission : 3/6/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic or <input type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic : <u>Surf. Tacrolim 40mg Surf. Amikacin</u>	
2.	Hair Removal <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes : <input type="checkbox"/> Surgical Clipper Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other : Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Patient's body temperature immediately post operation (Recovery Room) <u>37</u> °C <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : <u>Venkat sai 3/6/26</u> Date & Time of antibiotic administration : <u>Venkat sai 3/6/26</u> Date & Time procedure started : <u>3/6/26 : 8:50pm</u>	

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

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OPERATION THEATER NOTES

Patient's Name : Baby KHATIJAH ABDUL MAJEED Age : 1 Y Gender : Male Female

UHID No. : 0124006 Weight : 9.519 Height :

Surgeon : Dr. Vishakha Basavraj Asst. Surgeon :

Anesthetist : Dr. Sandhya OT Nurse : Sobhi Das Akhil OT Technician : Venkat Sai

Pre-Operative Diagnosis:

Surgical Procedure : Ommaya Reservoir removal

Indications for Surgery : part of Ommaya reservoir placement for post ventriculitis Hydrocephalus

Date : 3/6/24 Start Time : 3:50 PM End Time :

Pre Operative Preparations:

Position - supine & head resting on head ring
All pressure points padded
W warmer applied

Incision - Curvilinear incision along same mark

Post Operative Diagnosis: ✓

Peri-Operative Complications: ✓

Operation Notes: Painting & draping done
Incision made
Ommaya reservoir removed
Close done in layers with 4-0 ~~vicryl~~ nonabsorb
Dressing done.

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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

vitals
a/s

Wound Care:

Wf e/s leak

Drain /Special Lines/Catheters:

-

Special Patient Positioning and Requirements:

Head end elevation

Nutritional Instructions:

- Regular feeds once child is awake

When to Start Mobilization:

-

Special Referrals:

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

Yes No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 3/11/26 Time:

Note: Plan of care will be readjusted if necessary.

BAH-00645090 IP5-00174706
 Baby KHATIJAH ABDUL MAJEED
 14-11-2024 1 Y 6 M 20 D (F)
 Dr. VISHAKHA BASAVRAJ KARPE



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	Syrp LivPpi	1ml	PO	BD	14/11/24	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. S. K. Kamalakar

Date & Time : 3/6/24

Nurse Name & Signature: Annub

Date & Time : 3/6/24 2:10 pm



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
03/11/26	3:47 PM	Supp. PAXIM	400mg	W	[Signature]	Dr. Suma
03/11/26	3:48 PM	Supp. AMIKACIN	150mg	W	[Signature]	Dr. Suma
3/11/26	6:00 PM	Supp. PARACETAMOL	100mg	IV	[Signature]	Dr. Suma, Bodi

Signature VERIFIED BY: [Signature]

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00645090 IP5-00174706
 Baby KHATIJAH ABDUL MAJEED
 14-11-2024 1 Y 6 M 20 D (F)
 Dr. VISHAKHA BASAVRAJ KARPE



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Name: BABY KHATIJAH ABDUL MAJEED Age: 1Y 6M Sex: F UHID.No: BAH 00645090

Date: Time: Proposed Operation: OMAYA Reservoir
F/U of uterine meningocele meninges tubular

B.P / CRT: H.R: Weight: 9.5 ASA Physical Status: 1 2 3 4 5

Laboratory Data:

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

Allergies: No known allergy to any drugs.

Medical History: CVS: — Diabetes: —

RESP: no cough, cold, fever

CNS: —

Renal: — Physical Activity: —

Hepatic / GE: —

Others: —

Past Anaesthetic History: JAN 6: OMA YA RESERVOIR PLACEMENT 3 days
15 days later shunt placement RT MDP shunt

Physical Exam: Mouth Opening: cannot be assessed Mentohyoid Distance: — Neck: — Teeth: —

Airway: MP 1 2 3 4

Lungs: AEBE, clear

Heart: S1S2 NAD

CNS: —

Pregnant: Yes No NA Venous Access Site: — Spine Exam for regional: —

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

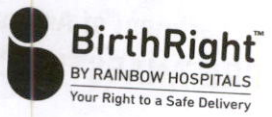
Solids / milk → 6 hrs.

→ CR, IV cannulation

Signature: [Signature] Name: Dr. Aditi M



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No

Physical Status: Patient Identified Consent Present Chart Reviewed

Fasting Status: Asymptomatic

H.R.: _____ B.P./CRT: _____ SpO₂: _____ R.R.: _____ Last Feed: _____

Pre-OP Diagnosis: OMMAYA INSITU Operation: OMMAYA RESERVOIR REMOVAL Date: 03/11/24

Surgeon: Dr. V. SHARMA Anaesthesiologist: Dr. S. R. J. / Dr. J. C. Technician: VENICAT

TIME	3:15	4:00	5:00																	
N ₂ O / AIR / O ₂ LPM	100 / 100 / 100	100 / 100 / 100	100 / 100 / 100																	
HALO / ISO / DEVO	0 / 0 / 0	0 / 0 / 0	0 / 0 / 0																	
Drugs:	<u>MIDAZOLAM 0.1mg</u> <u>FENTANYL 20ug</u> <u>ROCURONIUM 5mg</u> <u>NEOSTIGMINE 5mg</u> <u>Glycopyrronium 0.1mg</u>																			
Antibiotic																				
Suppository																				
Blood Loss																				
NOTES																				
Fluids																				
Blood																				
B.P.																				
V Systolic																				
Δ Diastolic																				
X Mean																				
• Heart Rate																				
Tourniquet on Time																				
Tourniquet off Time																				
Throat Pack In																				
Throat Pack Out																				

LAB Values

ABG: _____

GRBS: _____

Others: _____

- Equipment Checked and Functional
 - BP
 - Cuff Site: Hand
 - Art Site: _____
 - EKG Lead
 - Temp Site: chest
 - FIO₂ Monitor
 - Agent Monitor
 - Pulse Oximeter
 - Capnograph
 - Ventilator
 - Nerve Stimulator
- Position: Supine
- Pressure Points Checked
- Eye Care:**
- Oint
 - Tape
 - Padding
 - Awake

- Temp:**
- HME
 - Cling Film
 - Hugger's
 - Other
 - Fluid Warmer
 - OH Warmer
 - Cotton Wool
- Times:**
- Anaes Start: 3:15 PM
- OP Start: _____
- OP End: _____
- Leave OR: 4:15 PM
- Anaesthesia:**
- GA
 - Monitored Anaesthesia Care
 - Regional
- Line (Size & Location)**
- CVP: _____
 - ART: _____
 - IV: Hand
 - IV: _____
 - IV: _____

- Induction**
- IV
 - Inhal
 - Pre O₂
 - RSI
 - Others
- Mask
- Airway
- ETT # 3.5 at 11cm cm
- Oral
 - Nasal
 - Cuff
 - Tracheostomy
 - Topical
 - Drug: _____
- Awake
 - Direct Vision
 - Video Laryngoscopy
 - Stylette / Bougie
 - Fiberoptic
- Blade # 2 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: _____
- Signature of the Doctor: [Signature]

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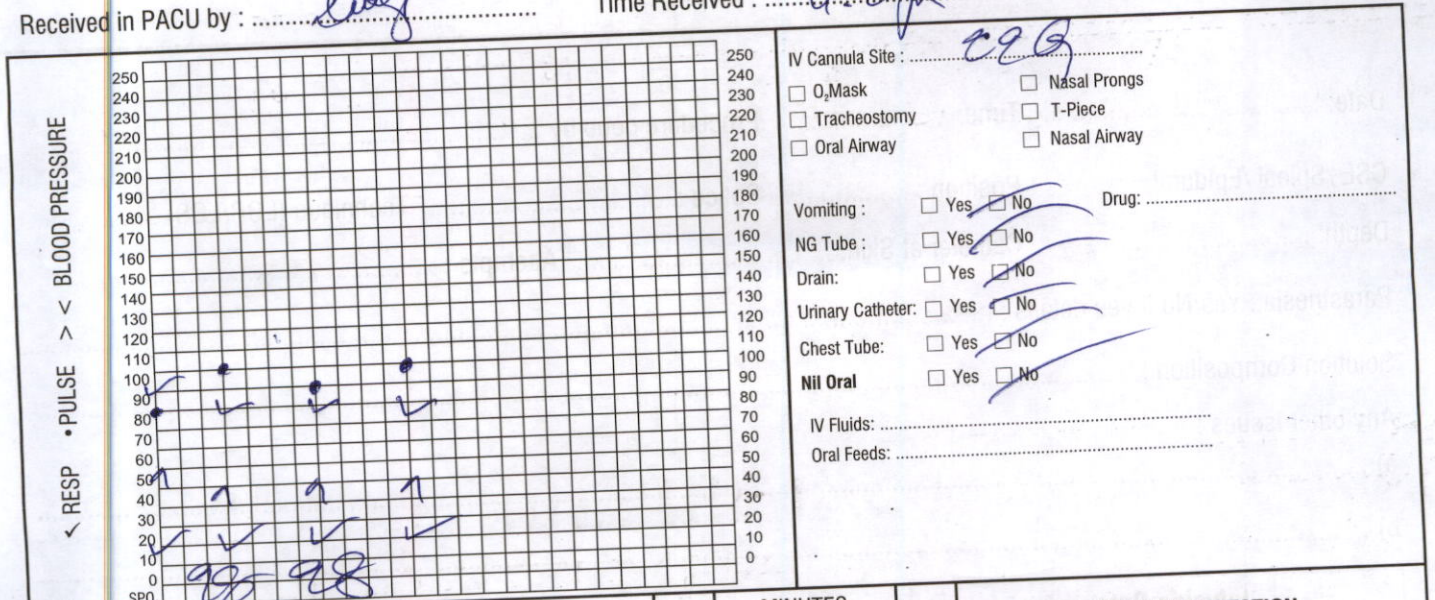


PI



UNIT RECORD

Received in PACU by: Drif Time Received: 4:10pm Time Discharged:



IV Cannula Site: 29G

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting: Yes No Drug:

NG Tube: Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Nil Oral Yes No

IV Fluids:

Oral Feeds:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6	4:10pm	1/10	—	<u>Drif</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name:

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name: Drif

PACU Nurse Signature: Drif

Date & Time: 3/6/2024

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):

Date & Time: 3/6/2024

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CONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: OMACA RESERVOIR REMOVAL

Anaesthesiologist: Dr. Aditi N Surgeon: Dr. Vishaka Basavraj KARPE

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: DESATURATION, BRADYCARDIA, LARYNGOSPASM

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: Hajera
Name: Hajera Begum
Relationship with patient: Mother
Date & Time: 18/5/21 4.45pm

Witness:

Signature: [Signature]
Name: [Name]
Date & Time: 18/5/21 4.45pm

Doctor (who is taking consent):

Signature: Aditi Name: Dr Aditi N Date: 18/5/21 Time: 4.40pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

హృదయ వ్యాధి రక్తపోటు మధుమేహం మూత్రపిండాల వైఫల్యం బహుళ అవయవ వైఫల్యం

కాలేయ సమస్యలు షాక్ ఊబకాయం దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
 లీజనల్ 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 సింట్రిల్ వెనస్ యాక్సెస్, ఆల్టిలియల్ లైన్, సపోజిటివ్ లిలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ 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: