HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

Rainbow® Children's Hospital
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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
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2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
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13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
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43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Essays	6			
	Total No. of Pages	24			

Signature and Date : 12/06/20 20

(P.T.O)

DISCHARGE SUMMARY

Name	Master CHETAN REDDY VELUTHURLA	**UHID**	HNH-00004021
Father/Guardian	Mr NARSIMHA V	**Age/Gender**	3 Y 2 M 19 D/ Male
Address	h no 201 uday aditya apts kavadiguda gandhinagar, Kavadi Guda, Hyderabad, Telangana, INDIA, 500080		
IP No	IP26-00006565	**Admission Date**	12-06-2026
Ref Doctor	Self.		
Discharge Date	12.06.2026		

Consultant:
Dr. SWAPNA PALAKURTHY
MBBS, MS, MCH
CONSULTANT PEDIATRIC SURGEON
69373

Co-Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
RIGHT CONGENITAL HYDROCELE	

Procedure : RIGHT OPEN HIGH LIGATION OF SAC DONE ON 12.06.2026

History: Master CHETAN REDDY VELUTHURLA, 3 Y 2 M 19 D child presented with history of right scrotal swelling, posted for right high ligation of sac prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for surgical management.

Name	Master CHETAN REDDY VELUTHURLA	**UHID**	HNH-00004021
IP No	IP26-00006565	**Admission Date**	12-06-2026

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 100/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. Genitals: Right hydrocele of 5 x 7cm size. Examination of other systems was normal.

Weight on admission: 11.8 kilo grams.

Investigations: Enclosed reports.

Procedure : RIGHT OPEN HIGH LIGATION OF SAC DONE ON 12.06.2026

Surgery Notes:
Intra OP Findings: Right hydrocele of 5 x 7cm size with clear fluid as content.
* Inguinal crease incision given.
* Opened inlayer
* Cord structures identified and sac dissected transfixed cut, distal sac lay opened.
* Haemostasis secured.
* Incision closed in layers.
* Post procedure uneventful.

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

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. Taxim-O (Cefixime - 5ml/100mg)	3ml	8am - 8pm (after food)	For 5 days.
2	Syrup. Crocin DS(240mg/5ml)	3.5ml	8am-8pm (after food)	for 3 days

Name	Master CHETAN REDDY VELUTHURLA	UHID	HNH-00004021
IP No	IP26-00006565	Admission Date	12-06-2026

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3.5 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 after 2 weeks in OPD 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, 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**

Registrar/Resident/C.M.O

Dr. SWAPNA PALAKURTHY
MBBS, MS, MCH
CONSULTANT PEDIATRIC SURGEON
69373

PATIENT TRANSFER FORM

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HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

	Date & Time of Admission	Date & Time of Transfer Order
	12/6/26 @ 00:00Am	12/6/26 @ 11:35Am
Treating Consultant Name	Transfer Ordered by: Dr- Ayesha	Reason for Transfer: observation
From Unit: OT	To Unit: 2nd floor	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File	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.	0	—
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. Ayesha

Patient & Clinical Records Received by : 12/6/26 @ 11:35

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

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 : IP26-00006565 **Admit Date** : 12-Jun-2026 **Admit Time** : 06:18 AM **UHID** : HNH-00004021

Patient Details :

Patient Name	: Master CHETAN REDDY VELUTHURLA	**Age**	: 3 Y 2 M 19 D
Guardian	: Mr NARSIMHA V	**DOB**	: 24-03-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: h no 201 uday aditya apts kavadiguda gandhinagar Kavadi Guda Hyderabad Telangana INDIA 500080	**Phone No**	: 9885165676/ 9963992550
		E-mail	: narsimhav11@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 NARSIMHA V **Relationship** : Father

Contact Address : h no 201 uday aditya apts kavadiguda gandhinagar Kavadi Guda Hyderabad Telangana INDIA 500080 **Phone No** : 9885165676

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA PALAKURTHY **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : Self. **Phone No** :

Co-Consultant : Dr. SINDHURA MUNUKUNTLA

Payment Details :

Deposit Amount : 5000.00

Payment Mode : DC/CC Card **Payor Name** : MEDI ASSIST INSURANCE TPA PVT LTD

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

wt - 11.85 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Chetan ..... Age : 3 ..... **Gender:** ☑ Male ☐ Female

Date : 12/6/26 ..... Time of Arrival : 6: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 ..... PR: 90 ... BP: 98/63 RR: ..... SpO_2: 98 %

Chief Complaints: c/o coming for ot hydrocele.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ 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.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 6:2Am

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 : Anupam .....

Signature of Triage Nurse : A.P .....

Date & Time : 12/6/26 .....

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/6/26 Time of arrival : 6Am

Chief Complaints: c/o coming fever of 1 day headache RBS: .....

Height : ..... Weight : ..... 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 : ..... 6Am .....

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

Time	Nursing Notes
	Assessed the patient condition vital checked. IV canula done.

Samples collected by:

Samples sent by : vidya.

Time:

Time: 6:30 AM

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: 97 BP: 98/63 CFT: –	Shift - out from ER to: OT
RR: 23 SPO_2: 99%	Time of Shift - out: 7:00 AM
GCS: – Temperature : 98.3	Handover given to: SN
Pain Score: .	(Nurse's Name)
Repeat RBS (if applicable): –	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anupam Signature of the Nurse : A.R

Date & Time : 12/6/26 @ 6:5AM

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : RIGHT CONGENITAL HYDROCOELE.

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Pediatric Multiorga **ion**

Name : CHETAN REDDY Age/Sex 3yrs

Informant PARENTS Reliability Good.

Chief Presenting Complaints & Duration (Chronologically):

Rt. hydrocele x birth.

History of present illness :

- Child has complaints c/o right hydrocele; posted for rt. ligation of sac.

Pediatric Multiorgan History & Physical Examination

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

Nil premorbid.

Birth & Neonatal History :

Fullterm | NVD | CIAB | Mcle.

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally (N).

Immunization History :

As per NIS.

Anthropometry

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

Weight (kgs) 11.8 Kgs. (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: 100/min. Description _____

B.P. _____ SPO2 100% RA at _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy Absent

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : BAE (+).

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : S_1, S_2 (+).

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection SNT, NT.

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel : N

Clinical Summary & Diagnostic :

RIGHT CONGENITAL HYDROCOELE.

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP
BT, CT.

PAC done.

Planned Management :

IVF fall maint.

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 _____

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CIS/B Dr. Sindhura	
12/6 9:00 AM	(Rt) Congenital Hydrocele S/P - (Rt) high ligation of SAC. Plan	
	Awake	- ~~NF Dextrose~~
	vitals - stable	- NF plasmalyte.
		- Syp. Cefcin DS. 8 6H.
		- Encourage orally.
		NB Sent on 9/12

Dr. Sindhura

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DRUG CHART

Date of Admission: 12/6/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Signature

VERIFIED BY : Name

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Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

Weight. 11.8 kg Ward. .....

DRUG :				Date / Time													
Dose	Route	Frequency	Start Date														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	

DRUG : Inj. TAXIM				Date / Time	12/6												
Dose	Route	Frequency	Start Date		8.30 AM ✓												
600mg	IV	BD	12/6														
Name & Signature of the Doctor Starting the Drugs: Dr. Dhakshayani																	
Additional Instructions:					8 PM												
Daily Doctor's Endorsement by a Sign					✓												

DRUG : Syp. Crocin DS.				Date / Time	12/6												
Dose	Route	Frequency	Start Date		8 AM Tab												
3.5ml	PO	BD H	12/6		2 PM Syp												
Name & Signature of the Doctor Starting the Drugs: Dr. Dhakshayani					8 PM												
Additional Instructions: (240/5ml)					2 AM ✓												
Daily Doctor's Endorsement by a Sign																	

DRUG :				Date / Time													
Dose	Route	Frequency	Start Date														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	

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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
12/6/2026	8.30am	Inj PARACETAMOL	150mg	IV		
12/6/2026	8.40am	DICLOFENAC suppository	12.5mg	IV		
12/6/2026	9.30am	Inj TRANEXAMIC ACID	150mg	IV		
12/6/2026	8.30am	Inj TAXIM	600mg	IV		

Verified by Dr. Dhakshayani

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

HNH-00004021 IP26-00006565
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24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. 11.8 Kgs. Ward. .....

Date	Time	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
12/6/26	9 PM	PLASMALYTE 400ml + 100ml 25% DX	IV	45	VZ	A.F / PNF	12/1	B.	

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

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

CHBH / FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/6/26 Time: 2

Doctor / Nurse / Family Concern? P

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

102 (80) 67

Heart Rate (Number) 92 bb

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 28 bb

Resp Distress	Mod/ Severe
	None / Mild

Receiving O_2 (l/min)

O_2 Saturations (%) 100%

Conscious Level	Normal
	Altered

GCS *

TOTAL SCORE
Number of shaded boxes 0
Pain Score 0
Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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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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ACTIVITY RECORD FOR BILLING

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

Name: ----------

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

Date of Admission : ---------- ....e : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/6/26	7:00 Am	ER	OT	A.P / Sangeetha
12/6/26	9:25 AM	OT	Per-Post	Anitha.

Cross Consultation Visit

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

HNH-00004021 IP26-0000...
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

INVESTIGATIONS

Date	Investigations	Order No.	Sign
12/6/26	CRP	9683	[illegible]
	[illegible]	9683	[illegible]
		Cross	Checked done by [illegible]

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
12/6	Infusion pump	9 Am	STOP 12pm	6221	

Cross checked done by Gs

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
12/6/26	w placement	1	6131	
[	PAC done op Basic.]			
12/6	N.H.A	1	6227	

Cross checked by

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

OT.

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00004021 IP26-00006565 Master CHETAN REDDY 24-03-2023 3 Y 2 M 19 D (M) Dr. SWAPNA PALAKURTHY	12/6/26 / 6:00 Am	12/6/26 / 8:00 Am.
	Transfer Ordered by Dr. Shabana	Reason for Transfer Observation
From Unit OT	To Unit Pre-Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	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.	RL	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. Swapna P	Dr. Shabana

Patient & Clinical Records Received by :
Sr. Natalia.

Date & Time of Patient Received : 12/6/26 @ 9.40 Am.

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

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

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/6/26 Time: 2pm

Weight: 11-8/9 Centile: <10th

Height: ..... Centile: .....

Inference: underweight child

RDA: ..... Calories: 1300 kcal/d Protein: 22gms/d

Diet Recommendations: liquid diet

Re-Assesment: Avoid Spicy, Chilled & outside foods.

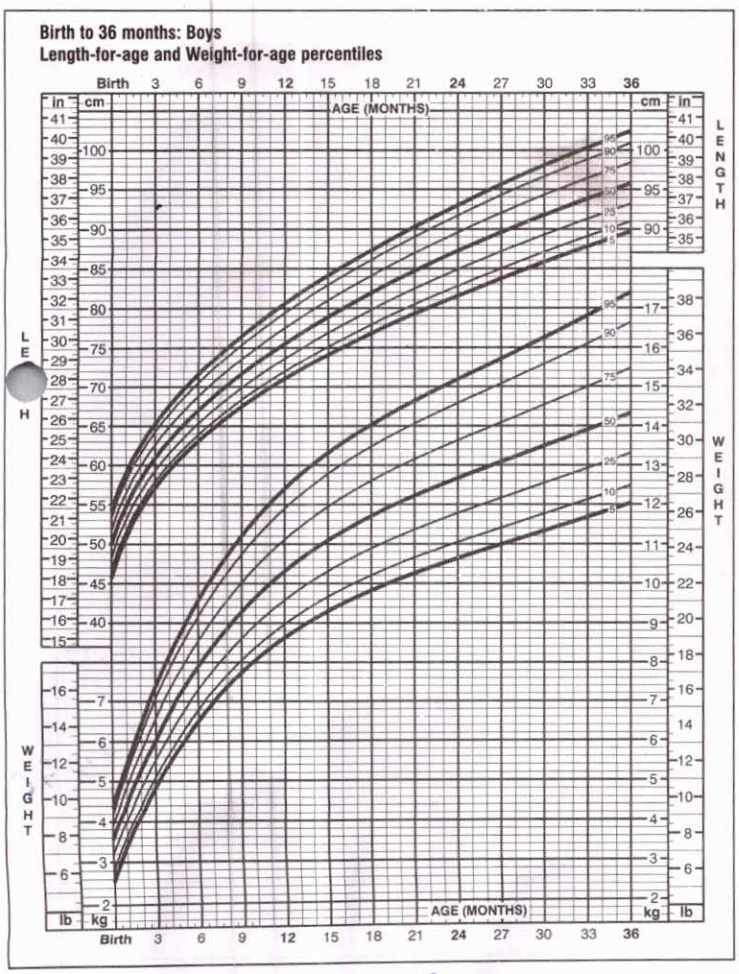
Food Allergies: NO Veg/Non-veg NON-veg

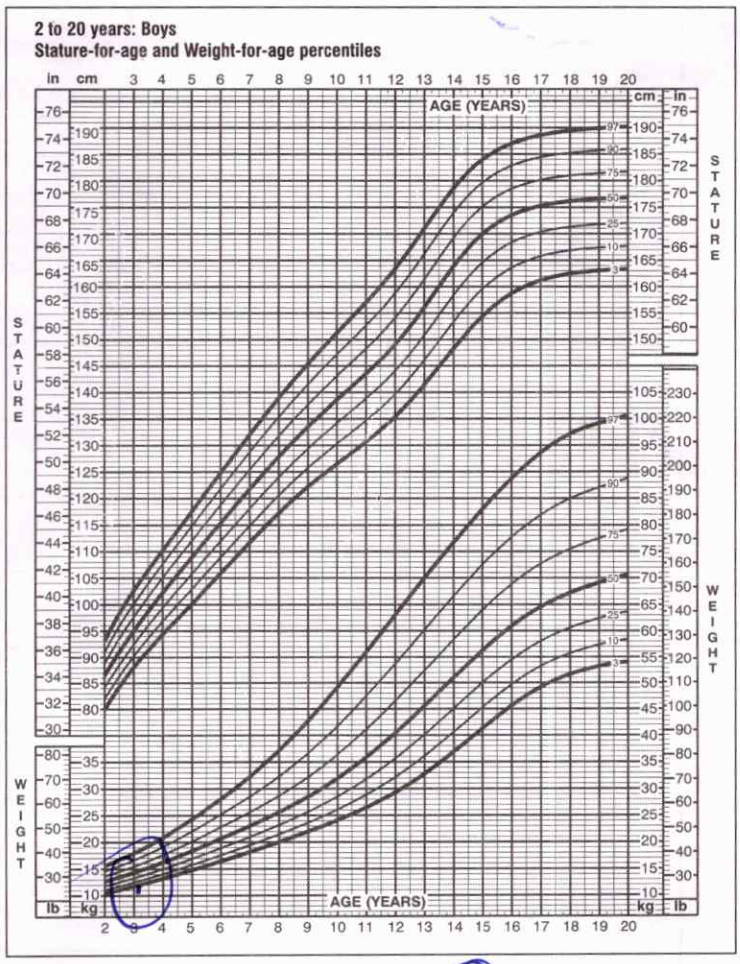
Diagnosis: Right congenital hydrocele

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sravanj

GROWTH CHART (BOYS)





Dietician's Name Sathwika Dietician's Signature

Docu. No. : RCH /FRM / CLINICAL / 160

(P.T.O.)

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00004021 IP26-00006565 Master CHETAN REDDY 24-03-2023 3 Y 2 M 19 D (M) Dr. SWAPNA PALAKURTHY	12/6/26 @ 6:18 Am	12/6/26 @ 6:20 Am
	Transfer Ordered by Dr. Susant	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	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
Anupam	Dr. Susant

Patient & Clinical Records Received by :

Swapna

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

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NIL ..... ☐ 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 : ..... Dr. Varun .....

Date & Time : ..... 12/6/26 @ 6:20 AM .....

Nurse Name & Signature: ..... Anupam .....

Date & Time : ..... 12/6/26 @ 6:22 AM .....

Docu. No. : RCH /FRM / GENERAL / 090

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OPERATION THEATER NOTES

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

F ..... Age : 34 ..... Gender : male

L ..... I.P.No. : ..... Weight : .....

Surgeon : Dr. Swapna. P	Asst. Surgeon :
Anesthetist : Dr. Shalini	OT Nurse : Ardhanari/Natasha

Surgical Procedure : (Rt) open High ligation of Sac

Indications for Surgery : (Rt) Hydrocele.

Date : 12/06/2026	Start Time : 8:35 Am	End Time : 9:35 Am.

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings: (Rt) Hydrocele of 5x7 cm size with clear fluid as content.

- Inguinal Crease incision given
- opened in layers
- Cord structures identified & Sac dissected transfixed cut, distal Sac lay opened
- Haemostasis secured
- Incision closed in layers.
- post procedure uneventful

(Cp: 7.0)

POST - OPERATIVE ORDERS :

Npo till 3 hrs wt: 12 kg.

IVF - ½ DNS @ 12 ml/hr

Inj. ~~Aug~~ Cefotaxime 1gm | iv | BD

Inj pcm 12 ml | iv | TID

Inj pan 12 mg | iv | od

Monitor vitals / Inform SOS.

....

Consultant Surgeon's Name Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

Surgeon : Dr. Swapna P.
Asst. Surgeon :
Anaesthetist : Dr. Shakuna
Scrub Nurse : Archana, Natasha

Age : 3y Gender : male
ery Name :
Date : 12/6/24 In-time : 8:35Am Out-time : 9:35Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:25am

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 Shakuna

Before Skin Incision ➤➤

TIME OUT Time: 8:45am

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 (R-t) high digital ☑ 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

Signature : Swapna

Name : Swapna 12/6/24 @ 8:45Am

Before Patient Leaves Operating Room

SIGN OUT Time: 9:35Am

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. Swapna P.

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mast. CHETAN REDDY Age: 3Y Sex: MALE UHID No: HNH-4021

Date: 8/6 Time: 1130 am Proposed Operation: (R) high ligation

Diagnosis: (R) HYDROCELE

B.P / CRT: ..... H.R: ..... Weight: 12kg. 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/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS: No H/o CHD°.

RESP: H/o RSV Bronchiolitis 2024 - req. admission Diabetes: discharged healthy.

CNS: -

Renal: -

Hepatic / GE: - Physical Activity: active.

Others: - Birth → FT/NVD/CAB/MNJ / Immunised.

Past Anaesthetic History: nil.

Physical Exam: child alert / active.

Airway: MP (1) 2 3 4 Mouth Opening: adq Mentohyoid Distance: 3FB Neck: (N) Teeth: intact

Lungs: BAE ⊕ Clinically clear.

Heart: S1+S2+ No

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA | Venous Access Site: peripheral Spine Exam for regional: midline.

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

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No SAUDAL ANESTHESIA

CURRENT MEDICATIONS	DOSAGE
-nil-	

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — FOOD/JUICE/MILK 6HOURS.
3. Informed Consent: ☑ Standard ☐ High Risk WATER/ORS
4. Post Operative Pain Management: ☐ Discussed with Patient 24HRS.
5. Other Instructions:
   - CBP on cannulation

Signature: ..... Name: Dr. Sapna Prayath

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

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ ~~No~~			Fasting Status: adequate
Physical Status:	☑ ~~Patient Identified~~	☑ ~~Consent Present~~	☑ ~~Chart Reviewed~~

H.R: 94	B.P / CRT: 104/60	SpO_2: 100	R.R: 21	Last Feed: 6hr

Pre-OP Diagnosis: (R) Hydrocele Operation: High ligation of Sac Date: 12/6/2023

Surgeon: Dr. Swapna Anaesthesiologist: Dr. Shalini Technician: Sai

TIME	8.35	×	9.30
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:	Inj. MIDAZ 0.6mg Inj. FENTANYL 2 50 mcg Inj. PARACETAMOL 150 mg Inj. PROPOFOL 30+10+10 Inj. TRANEXA 150 mg		
FIO_2 / SaO_2	100	100	100
$ETCO_2$			
ECG	SR	SR	SR
Temperature			
Urine Output			
Fluids / Blood			

Antibiotic

Suppository: DICLOFENAC 12.5mg

Blood Loss

NOTES

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

LAB Values: ABG / GRBS / Others

☑ ~~Equipment Checked and Functional~~
☑ ~~BP~~
☑ ~~Cuff Site:~~ (R) leg
☐ Art Site: .....
☑ ~~EKG Lead~~
☐ Temp Site skin
☐ FIO_2 Monitor
☐ Agent Monitor
☑ ~~Pulse Oximeter~~
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: supine
☑ ~~Pressure Points Checked~~

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☑ ~~Hugger's~~ ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 8:35am
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia: 9.35am
☐ GA
☑ ~~Monitored Anaesthesia Care~~
☐ ~~Regional~~

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ ~~IV:~~ (R) hand 22G
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA O_2 via nasal prong
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

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

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

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☑ ~~Caudal~~
Others: .....
Position: Lateral
Site: Sacral hiatus
Needle Size: 22G Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: 0.25% bupivacaine
Bolus: 11ml
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☑ ~~PACU~~ ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ ~~NA~~
Name of the Doctor: Dr Shalini
Signature of the Doctor: .....

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 19 D (M)
Dr. SWAPNA PALAKURTHY

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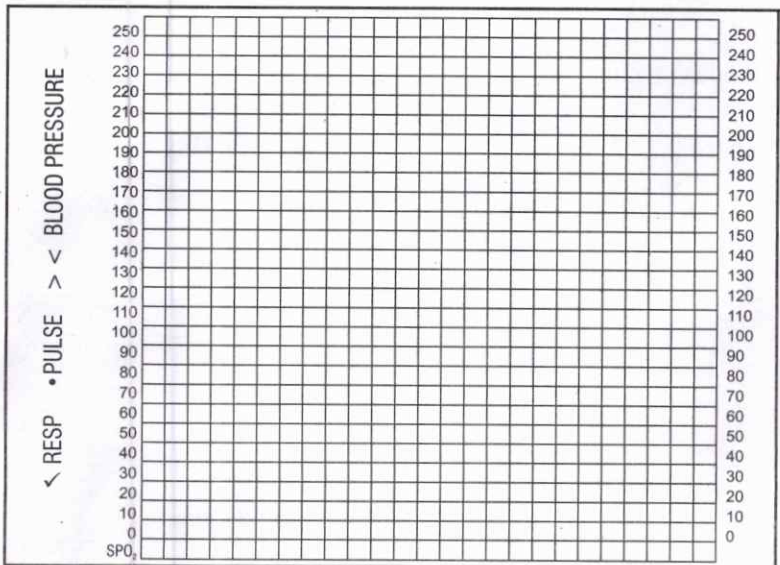
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 12/6/26 @ 09.40 Am Time Discharged : .....



IV Cannula Site : Right

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ 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: plasmalyte 400ml
Oral Feeds: .....

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
12/6/26.		0	N/o pain.	

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

Anaesthesiologist Name : Dr. SK Ayesha
Anaesthesiologist Signature:
Date & Time: .....

PACU Nurse Name : Archana
PACU Nurse Signature: Archana
Date & Time: 12/6/26 @ -

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: .....

HNH-00004021 IP26-00006565
Master CHETAN REDDY
24-03-2023 3 Y 2 M 18 D (M)
Dr. SWAPNA PALAKURTHY

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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 BP	Maternal Pulse	FHR	Comments

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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mast. Chelan Reddy Age : 3y Gender : Male ☒ Female ☐

UHID NO: HNH-4021 Surgeon Name: Dr. Swapna Palakurthy

Anaesthesiologist : Dr. Sanni Gayatri

Operative procedure planned : (R) HIGH HCATION OF SAC

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 : Dr Supplementation

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 .....

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 : Narsimha

Name : NARSIMHA-V

Relationship with Patient: FATHER

Date & Time : 12/06/2026 07:30AM

Witness :

Signature : Sravani

Name : Sravani

Date & Time : 12/6/26 7:30 Am

Doctor (who is taking the consent) :

Signature : Dr Ramu Narayana

Name : Dr Ramu Narayana

Date & Time : 12/6 at 745am

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Master. Chetan Reddy Gender: ☑ Male ☐ Female Age : 3Yr.

UHID No : HNH00004021 Date : 12/06/26

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)

(Rt) High ligation of Sac

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.

- Bleeding
- Infection
- Recurrence.

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 : .....

Name : NARSIMHA . V

Relationship with Patient: FATHER

Date & Time : 12/06/2026 07:00 AM

Witness :

Signature : .....

Name : Sravani

Date & Time : 12/6/26 7:50 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Swapna Palaniyandy

Date & Time : .....