ESTIMATION SLIP

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Date : 13/06/2026 UHID / IP No. : HNH-0001925 Sl No. 4146

Name of Patient : Master. Yashveen Ram Sidagam Age: 10M Gender: M

Father's / Husband's Name : Nagaraj G. Corporate / Occupation : _____

Address : 11 nagetnagar. Phone : 9949037490 Email : _____

Procedure / Plan : open orchidopexy Dos: _____

MODE OF PAYMENT : ☐ **SELF** ☑ **TPA :** GIPSA MD 2nd ☐ **GIPSA :** _____ **OTHER**

TARIFF INFORMATION :

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges				17000/day.						
	Doctor's Fee										
	L. Tax										

PARTICULARS	AMOUNT (₹)
Surgeon's / Anesthetists's Fee / O.T. Charges	Appx. 1,60,000 OT 1 hr.
O.T. Consumables	Subject to approval by TPA / Insurance Company
Instrument Charges ✓	Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations	extra As per actual - Not Included in Estimation

Equipment Charges				
	Monitor :	Oxygen :	Infusion pump / Syringe pump :	
	Ventilator :	*Conventional :*	*HFO-SLE 5000:*	*HFOSensormedix :*
	Photo therapy :	*Single Surface :*	*Double surface*	*Triple Surface*

Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc. extra	As per actual - Not Included in Estimation
Packages if N.C.	extra charges.
Others	
Initial Minimum Deposit	25,000 advance @ admission

REMARKS

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to Surgeon's decisions/Complications/Patient's requirements/Modes of Procedure (like Laparoscopie, Thoroscople, etc)/Unilateral to Bilateral Procedure,**
3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category
4. Room eligibility is purely subject to TPA approval and the Package/Room tariff starts from the time of admission.
5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA Insurance Company at later stage.
6. **For Non-Medicals, Disposables, Consumables, Infusion pump, Taxes, Implants, HIV/HbsAg, Medical Records, Insurance Processing Fee, Double occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.**
7. During Non-working hours of OT(8:00 PM to 6:00 AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this if not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9 am to 6pm. 8. Difference, if any between the final bill amount and amount permitted/approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICUS Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I Nagaraj G. Pitapam have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of the after discharge time I promise to settle the claim with the hospital

Signature of the Client | Father Signatory Relationship | Signature of the financial Counselor

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Yash Sidagam

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SURGERY DETAILS

Date : 20/6/26

Patient Name: Master yashvar Date of Birth: ~~10 months~~ 04-08-2025 Age: 10 months

Gender: Male Ward : OT-B UHID No.: HNH-00011925 IP26-00006615

Date of Surgery: 20/6/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (Rt) open orchidopexy

Time in : 11:45 Am Time Out : 12:45 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Swapna	
2.	Anaesthetist	: Dr. Samir Dr. Shenoy	
3.	Assistant Surgeon	:	
4.	OT Technician	: Br. Arvind Sr. Pallavi	
5.	Circulating Nurse	: Sr. Karuna Sr. Sushela	
6.	Assistant Nurse	: Sr. Archana Sr. Natasha	

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

Signature of the Surgeon

Karuna.
Signature of Circulating Nurse

Order No: 26-00020752 Order by: Archana 20/6/26 @ 1.31 PM

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Sm Sidagam.

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CONSUMABLES OF OT

Circulating staff : Karuna Technician : Dr Arindam Pallavi Date : 20/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack		01	Inj Vit.K		
LMA			Sutures 3/0 Rapid		01	Cord Clamp		
ECG leads : A / P / N		01	Vicryl 2803		01	Suction Catheter		
HME filter : A / P / N			2762, 2347	4+1	1	Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		03	Gloves SG 6.5		01+1	Surgical Gloves		
02 cc		02	Ealose 6.5		01	Gauze Pack		
01 cc			S.G (PF) 6.0		1	Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
~~RL~~ DNS		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Tranexa		01	Ointments					
Taxim 1g		01	Suction Catheter					
Fentanyl		01	Cap, Mask		10+10			
~~Morphine~~ DNS 10%		01	Gauze Pack 7.5x7.5		01			
Ketamine			Mop Pack		1			
Propofol		02	Steristrip Nelton cath		1			
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel 5					
Ondansetron		01	Foleys catheter					
~~Pencan 25g~~/ Spinal Needle 22 (P) (VYGon)		01	Urobag Tip cleaner		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics ~~DNS~~			Bandage					
~~CEFT~~			Tegaderm 8582		1			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet ~~Apron~~					
Tab. Misoprost : 200mg			Betadine Solution		01			
~~Cefoperazone~~			Microshield					
Nasal Oxy set (N)		01	Cotton Balls		01			
PCM		01	Latex Gloves		20			
Endle 7.5		2	Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002075 82 / 7581 Ordered by : Archana 20/6/26 @ 10.15 pm

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

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00011925	Name	Master YASHVEER RAM SIDAGAM
Age / Sex	0 Y 10 M 16 D / Male	Doctor	SWAPNA PALAKURTHY
Adm/Reg Date/Time	20/06/2026 09:57	Payor	MDINDIA HEALTH INSURANCE TPA PVT LTD
Order Date	20/06/2026 15:52	Ordernumber	26-0000207582
Visit ID	IP26-00006615	Ward/Bed No	2F -PRIVATE ROOM / PVT-209
Patient Address	Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	ENCORE MICROPTIC GLOVES-7.5 PF		1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
3	TIP CLEANER ELECTRO BRASIVE(REF:E2401)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	MOPS 30X30 6PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	OXYGEN NASAL CANNULA (NEO)	OXYGEN NASAL CANULLA NEO	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	VICRYL PLUS 1 VP - (2347)	VICRYL PLUS 1 VP 2347	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
9	BIOXAMIC 500 MG INJ		1 Ampule	/ Once Daily	1 Days		1 Ampule	Dispensed
10	TEGADERM WITH PAD 5X7CMS (3582)(8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	DNS 500ML BOTTLE (EURO HEAD)- AQUA PULSE		1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
12	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
13	BUPICAIN HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	DEXTROSE IV 10% 500 BOTTLE		1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
15	MCT-ROF 100MG 10ML		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
16	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
17	SPINAL NEEDLE PED 22 G (VYGON-5183.57)	SPINAL NEEDLE 22G	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	SGLOVE # 6 (POWDER FREE)	SURGICAL GLOVES POWDER FREE 6.0	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
19	PREGELLED SURGICAL PLATES PEAD (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
21	E.C.G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
22	TAXIM INJ 1 GM		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
23	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
24	VICRYL RAPIDE 5-0 9915W	VICRYL RAPIDES-09915W	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
25	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
26	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
27	VICRYL 2-0 NW 2762	VICRYL 2-0 NW 2762	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

SWAPNA PALAKURTHY

* This document is just for reference purpose only. Not to be considered as primary report.

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00011925	**Name**	: Master YASHVEER RAM SIDAGAM
Age / Sex	: 0 Y 10 M 16 D / Male	**Doctor**	: SWAPNA PALAKURTHY
Adm/Reg Date/Time	: 20/06/2026 09:57	**Payor**	: MDINDIA HEALTH INSURANCE TPA PVT LTD
Order Date	: 20/06/2026 15:52	**Ordernumber**	: 26-0000207581
Visit ID	: IP26-00006615	**Ward/Bed No**	: 2F -PRIVATE ROOM / PVT-209
Patient Address	: Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
2	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Ordered
3	POVINANZ SOLUTION 10% 100 ML		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
4	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered

SWAPNA PALAKURTHY

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Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

DISCHARGE SUMMARY

Name	Master YASHVEER RAM SIDAGAM	**UHID**	HNH-00011925
Father/Guardian	Mr MEGHANADH	**Age/Gender**	0 Y 10 M 16 D/ Male
Address	Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006615	**Admission Date**	20-06-2026
Ref Doctor	Self.		
Discharge Date	21.06.2026		

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

DIAGNOSIS	ICD CODE
RIGHT UNDESCENDED TESTIS	

Procedure : Right open orchidopexy done on 20.06.2026.

History: Master YASHVEER RAM SIDAGAM, 0 Y 10 M 16 D child presented with history of right undescended testis noted at the time of birth. In view of no spontaneous descent child was admitted at Rainbow Children's Hospital for

Name	Master YASHVEER RAM SIDAGAM	UHID	HNH-00011925
IP No	IP26-00006615	Admission Date	20-06-2026

surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 103/min, and Respiratory rate - 24/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. Right undescended testis.

Weight on admission: 8.3 kilo grams.

Investigations: Enclosed reports.

Procedure : Right open orchidopexy done on 20.06.2026.

Intra-OP Findings:
- 1 x 0.5 cm right testis at mid inguinal region.
- Left testis normal.
- Right side scrotum mild hypoplastic.

Surgery Notes:
- Under ASP the above region cleared and draped.
- Inguinal crease incision given.
- Opened in layers.
- Above said findings noted.
- Testis separated from sac, adhesions released.
- Brought out into subdartos pouch and orchidopexy done.
- Inguinal crease incision closed.
- Haemostasis secured.
- Post procedure uneventful.

Name	Master YASHVEER RAM SIDAGAM	UHID	HNH-00011925
IP No	IP26-00006615	Admission Date	20-06-2026

surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 103/min, and Respiratory rate - 24/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. Right undescended testis.

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- Post procedure uneventful.

Name	Master YASHVEER RAM SIDAGAM	**UHID**	HNH-00011925
IP No	IP26-00006615	**Admission Date**	20-06-2026

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

Advice:
* Diet as advised.
* Syrup. P-250 (Paracetamol - 5ml/250mg) 2.5 ml thrice daily after food for 3 days.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5 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 on Tuesday (23.06.2026) in OPD between 5-6pm at Himayatnagar with prior appointment **(Review consultation will be charged)**.

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.

Name	Master YASHVEER RAM SIDAGAM	**UHID**	HNH-00011925
IP No	IP26-00006615	**Admission Date**	20-06-2026

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

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006615 **Admit Date** : 20-Jun-2026 **Admit Time** : 09:57 AM **UHID** : HNH-00011925

Patient Details :

Patient Name	: Master YASHVEER RAM SIDAGAM	**Age**	: 0 Y 10 M 16 D
Guardian	: Mr MEGHANADH	**DOB**	: 04-08-2025 06:30 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9100321789/ 9949037490
		E-mail	: MEGHA6589@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 MEGHANADH **Relationship** : Father

Contact Address : Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9100321789 / 9949037490

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 15000.00

Payor Name : MDINDIA HEALTH INSURANCE TPA PVT LTD

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Your Right to a Safe Delivery.

ACTIVITY RECORD FOR BILLING

HNH-00011925 IP26-00006615
Name: Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

UHID N ---------- Consultant : ---------- Dept : pediatric

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/06/26	11:27 AM	ER	OT	
20/6/26	12:50pm	OT	Pre-Post	
20/6/26	3pm	OT	3rd floor	

Cross Consultation Visit

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

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

INVESTIGATIONS

Date	Investigations	Order No.	Sign
20/6/26	CBP	0055	
		cross checked	done.

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
20/6/26	Infusion pump	10am	~~6pm~~ 3pm	7572	[signature]
			Cross	checked	done.
				by	Amruth.

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
20/6/26	IV placement	1	7539	Bhargavi
		Cross checked done.		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Patient ID# :

Consultant :

Final Diagnosis :

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Pediatric Multiorgan History & Physical Examination

Name : Yashveer Age

Informant Reliability

Chief Presenting Complaints & Duration (Chronologically):

c/o Right Undescend Testis

History of present illness :

child brought with
c/o Right sided undescended testis
Noted at birth
↓
In view of no spontaneous descend
↓
Plan for Right Open Orchidopexy

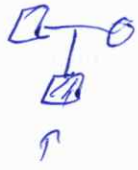
Currently No c/o Fever / Cold / Cough / Vo / La

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

FT / LSCS / 2.25 kg / CIAG



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Acte NIS, Upto date (Flu Not recen)

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 8.3kg (Centile _____)

On Examination :

Temperature : 97.2°F Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BL

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ (+)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : soft

Ausculation : _____

Spine: _____ External Genitelia : (R) Undescended Testis

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 : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

Right Undescended Testis

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP c̄ Canula

NIB Shirisha

Planned Management :

- NPO ∴ 8 Am
- IVF - DNS
- ~~Rgt~~ Sx - Ⓡ Open Orchidopexy in OT

NIB Shirisha

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 Dr. Swapna on whose name the patient is being referred

Doctor's Signature Name [signature] Date 20/6/26 Time

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/25 3pm	S/B Dr Prabhath △ Post Orchidopexy (R) undescended testis Child awake. Stable. GC- fair Vitals stable P A Rt.	Adv — Stop IVF — Enlarge orally — CT BYPP-250 TID — D/S after Sx opinion & R/V after 2 days

(P.T.O)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Docu. No. : RCH /FRM / CLINICAL / 088

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MEDICATION RECONCILIATION FORM

Drug Allergies: N/A ☐ 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: ~~GR~~ 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: pranav

Date & Time : 20/06/26 @ 9:57 AM

Nurse Name & Signature: Shirisha

Date & Time : 20/06/26 @ 11:27 AM

HNH-00011925 IP26-00006615
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04-08-2025 0 Y 10 M 16 D (M)
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DRUG CHART

Date of Admission: 20/06/26 Drug Allergies: N/A ☐ 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 narnes, 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:				

VERIFIED BY Name

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

Weight. 8.3kg Ward. .....

DRUG : Inj AMOXICILLIN + CLAVULANATE

Dose	Route	Frequency	Start Date
250mg	IV	TID	20/6

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions: 90mg/kg/day

Date/Time: 20/6 — 10:50 AM — 7pm — 3pm

Daily Doctor's Endorsement by a Sign

DRUG : Syp. P-250

Dose	Route	Frequency	Start Date
2.5ml	PO	TID	20/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time: 6am — 2pm — 12pm inj — 10pm

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time:

Daily Doctor's Endorsement by a Sign

HNH-00011925 IP26-00006615
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04-08-2025 0 Y 10 M 16 D (M)
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
20/06/26	12:05pm	INJ PARACETAMOL	120 mg	IV		

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. ...8.3 kg... 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
20/6	10Am	IVF - DNS (2/3rd (M)	IV	20					
20/06/25	11:45Am	RINGER LACTATE	IV	32ml/hr		Kavya			
20/6	2:30PM	IVF 1/2DNS	IV	20ml					

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00011925 IP26-00006615 Master YASHVEER RAM SIDAGAM 04-08-2025 0 Y 10 M 16 D (M) Dr. SWAPNA PALAKURTHY	20/06/26 @10:02	20/06/26 @11:27 AM
	Transfer Ordered by Dr. pranav	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant ~~Yes~~ ☐ No ☐
Number of Sheets in Clinical File 15-1	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
Shirisha	Dr. pranav

Patient & Clinical Records Received by : Rajani 20/6/26 @ 11:25 AM

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

DUTY MOBILE
9246160961

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: MAST. YASHVEER RANA Age: 10M Sex: MALE UHID No: HNH-11925

Date: 18/6 Time: 5.40pm Proposed Operation: (R) ORCHIDOPEXY

Diagnosis: (R) UDT

B.P / CRT: H.R: Weight: 8.56 ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb:
TLC:
Plate:
PT:
PTT:
INR:

Glucose:
Urea:
Creat:
Na:
K:
Ca++:
Mg++:
Cl-:

Protein:
Alb:
Total Bill:
Dir. Bill:
LDH:
Alk phos:
Amylase:
SGOT/SGPT:

HIV:
HBS Ag:
HCV:
Blood group:
T3
T4
TSH

X-Ray:
ECG:
2D Echo:
Stress/Anglo:
Other:

Allergies: NKDA.

Medical History: CVS: -

RESP: Child healthy. Diabetes: -

CNS: No significant medical history.

Renal: Birth - 37 | EM IUGS (PROM) | NICU OBS | Shifted same day | Immunised

Hepatic / GE: No apparent dev. delays. Physical Activity: active

Others: -

Past Anaesthetic History: -

Physical Exam: alert & active

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

Lungs: BAE (+) clear clinically

Heart: S1+ S2+ No.

CNS:

Pregnant: ☐ Yes ☐ No ☐ ~~NA~~ Venous Access Site: peripheral Spine Exam for regional: Caudal space prominent & fel

Anaesthetic Plan: ☐ ~~MAC~~ ☐ ~~REGIONAL~~ ☐ GA-ETT ☐ LMA * (CAUDAL ANESTHESIA)*

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

CURRENT MEDICATIONS	DOSAGE
D3.	

Pre-Operative Instructions:

1. DVT Prophylaxis: FORMULA FOOD 6AM ← 8AM ← MOTHER MILK 12pm
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — 10AM - WATER ORS
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
- CBP on Cannulation.

Signature: Name: Dr. Sanur Chaujalk

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
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ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 103 bpm | B.P /~~CRT~~: | SpO_2: 98% | R.R: | Last Fed: > 6hrs

Pre-OP Diagnosis: (R) UDT | Operation: Right Orchidopexy | Date: 20/06/26

Surgeon: DR. SW. A.PNA | Anaesthesiologist: DR SAMIR / DR SHIV | Technician: Arvind / Ravi

TIME	11:45			12:45pm
N_2O /AIR O_2 LPM	O_2 @ 2 4/min Nasal prongs			
HALO /SO 7SEVO				
Drugs:				
INJ MIDAZOLAM	0.5mg IV			
INJ FENTANYL	20mcg IV			
INJ PROPOFOL	20+20mg IV			
INJ PARACETAMOL	120mg IV			
FIO_2 / SaO_2	98	97	97	98
ETCO$_2$	20	18	14	16
ECG	SR	SR	SR	SR
Temperature				
Urine Output				
Fluids / Blood	RL 32ml/hr →			

Supposi...

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: (L) LL
☐ Art Site:
☑ EKG Lead
☑ Temp Site Nas
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: SUPINE
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding

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

Times:
Anaes Start: 11:45 AM
OP Start:
OP End:
Leave OR: 12:45 pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☑ Regional

Line (Site & Location)
☐ CVP:
☐ ART:
☑ IV: (L) UL 24
☐ IV:
☐ IV:

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

☐ Mask ☐ SGA
☐ 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: (L) lateral
Site:
Needle Size: 22G Quincke Depth:
Parasthesia ☐ Yes ☑ No
Catheter at skin ... cm
Drug Name & Conc: 0.25% Bupivacaine 8ml
Bolus:
Infusion:
Block Level:
Comments:

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

Name of the Doctor: DR SHIVA
Signature of the Doctor:

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
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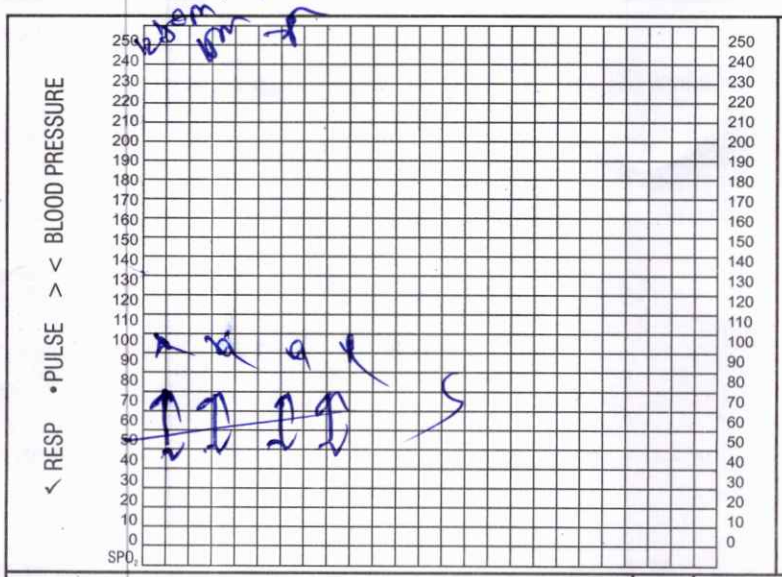
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Natasha Time Received : 12.50 pm Time Discharged : .....



IV Cannula Site : Left hand

- ☐ O_2 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: DNS.
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	1	2			A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	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			
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	2	2	2			
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2			
	TOTAL	9	9	10			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/6/26	12.50pm	0/10	Normal (Reassessed after 1 hour)	
20/6/26	1.50pm	0/10	Normal	

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

Anaesthesiologist Name : DR SHINY
Anaesthesiologist Signature: [signature]
Date & Time: 20/06/26 2:25 pm

PACU Nurse Name : Natasha
PACU Nurse Signature: Natasha
Date & Time: 20/6/26 2:25 pm

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): 2nd floor Room No: 209
Date & Time: .....

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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		Maternal		FHR	Comments
			Left	Right	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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : MASTER YASHVEER RAM Age : 10M Gender : Male ☑ Female ☐

UHID NO: HNH-11925 Surgeon Name: DR SWAPNA

Anaesthesiologist : DR SHINY / DR. SAMIR

Operative procedure planned : RIGHT ORCHIDOPEXY

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 : BRONCHOSPASM, LARYNGOSPASM

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 MASTER YASHVEER the above mentioned operation / Diagnostic / Therapeutic procedures RIGHT ORCHIDOPEXY

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 : .....

Name : Meghanath

Relationship with Patient: Father

Date & Time : 20/06/26, 11:20 Am

Witness :

Signature : .....

Name : S. Vijayalakshmi

Date & Time : 20/06/26, 11:21 Am

Doctor (who is taking the consent) :

Signature : .....

Name : DR SHINY

Date & Time : 20/06/26, 11:20 Am

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : .... Gender: ☐ Male ☐ Female Age : .....

UHID No : .... Date : .....

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 Open Orchidopexy .....

..... 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.

- Testis Retraction, Atrophy Testis
- Wound dehiscence
- Bleeding

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 : Meghanath

Relationship with Patient: father

Date & Time : .....

Witness :

Signature : .....

Name : S. Vijayalakshmi

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Swapna Palakurthy

Date & Time : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Rainbow Children's Hospital | BirthRight

Patient Name .... Gender: Male Female Age ....

UHID No .... Date ....

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)

....

....

.... upon ....

....

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.

....

....

....

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 ....

Relationship with Patient ....

Date & Time ....

Witness :

Signature ....

Name ....

Date & Time : ....

Doctor (who is taking the consent) :

Signature ....

Name : ....

Date & Time ....

Docu. No. RCH FRM / CLINICAL / 027

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OPERATION THEATER NOTES

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Patient's Name : .....Age : .....Gender : .....

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : (RT) open Orchidopexy

Indications for Surgery : (RT) UDT (palpable).

Date : 20/6/26	Start Time : 11:45 Am	End Time : 12:45 pm

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings:

- 1 x 0.5 cm (RT) testis @ mid inguinal region
- (LT) testis - (N).
- (RT) side scrotum → mild hypoplastic.

⇒ Asp the above region cleaned & draped

- Inguinal crease incision given
- opened in layers.
- Above said findings noted
- Testis separated from Sac, Adhesions released
- Brought out into Subdartos pouch
- & orchidopexy done.
- Inguinal crease incision closed
- Hemostasis secured, post procedure Overall

POST - OPERATIVE ORDERS :

* Npo till 3 hrs

* IVF - 1/2 DNS @ 2ml/hr Wt: 12.28 kg

* Inj. pcm 1gm | iv | sos

* Sy. p-250mg | po | TID

2.5ml — 2.5ml — 2.5ml

x 3 days.

* R/A 2 days (5-6 pm on Tuesday)

* Maintain vitals / Inform SS.

....

Consultant Surgeon's Name Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

Surgeon : Dr. Swapna
Asst. Surgeon :
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Archana

..... Age : ..... Gender : .....
Name : .....

Date : 20/8/26 In-time : 11:45 Out-time : 12:45 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:45am

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 : Swapna

Name : .....

Before Skin Incision ➤➤

TIME OUT Time: 11:51 AM

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? Non / 1 hour / soon ☑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 : Kaveri

Name : Kaveri @ 11:51 AM

Before Patient Leaves Operating Room

SIGN OUT Time: 12:45 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 : .....

Name : .....

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PATIENT TRANSFER FORM

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

	Date & Time of Admission	Date & Time of Transfer Order
	26/6/26 @ 9:57 AM	20/6/26 @ 12:15 PM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr Swapna	Dr. Samir.	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	2nd Floor. Room no 209	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
19	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS	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
Karuna	Dr. Samir.

Patient & Clinical Records Received by : Anusha

Date & Time of Patient Received : 20/6/26 CRM.

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-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

wt 8.28kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : yashveer Ram Sidagam Age : 10months **Gender:** ☑ Male ☐ Female

Date : 20/06/26 Time of Arrival : 9:58AM

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: 97.2F PR: 120/M BP: ..... RR: 28/M SpO_2: 98%

Chief Complaints: c/o come for surgery R/sut undescended tgs H's

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 : 10:10AM

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 : shyrising

Signature of Triage Nurse : .....

Date & Time : 20/06/26 @ 9:59AM

HNH-00011925 IP26-00006615
Master YASHVEER RAM SIDAGAM
04-08-2025 0 Y 10 M 16 D (M)
Dr. SWAPNA PALAKURTHY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/06/24 Time of arrival : 10:02 AM

Chief Complaints: c/o come for surgery Rt undescended testis

Height : ..... Weight : 8.28 kgs 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 ☐ Yes ☑ No

If **'Yes'** tick below fall risk intervention directly

If Patient is > 6 years

If **'Yes'** 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 : @ 10:04 AM

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

Time	Nursing Notes
10:05 AM	Assess the patient condition monitor the vital sign

Samples collected by: / Suganda Time:

Samples sent by : / Time: 10:20 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: 120 b/m BP: ..... CFT:	Shift - out from ER to: OT
RR: 36 b/m SPO2 at FiO2: 98 l	Time of Shift - out: 11:27 AM
GCS: 15/ Temperature : 98 F	Handover given to: .....
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable): N/A	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement done

Name of the Nurse : Shiviraj Signature of the Nurse : Sd

Date & Time : 20/06/26 @ 10:05 AM

26-0000207532

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Master Yashveer Ram Sidagam	Age: 10M	Gender: Male.	
UHID No: HINH-000111925	IP No: 26-0000066615	Date: 20/6/26	Time: 10.00 Am
Diagnosis: Right Open Orchiopexy		(Wed. OT)	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr Samir

Doctor Registration No: 67029

Signature:

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

IP Registration No: IP26-0000066615 Date: 20/6/2026

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

1.	Name : Master Yashveer Ram Sidagam	Remarks
2.	Complete postal address (with contact number, if any)	Himayat Nagar Hyderabad
3.	Brief description of the illness	Right open Orchiopexy.
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	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
20/6	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Sania (018662. M Arvind Kumar (021257) Signature:

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

Time: .....

26-00002075 32

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:	Master Yashveer Ram Sidagam	Age:	10M	Gender:	Male.
UHID No:	HNH - 0001119 25	IP No:	26-00006615	Date:	20/6/26 Time: 10:00 AM
Diagnosis:	Right open Orchiopexy (Under. OT)				

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr Sammy

Doctor Registration No: 67929

Signature:

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

IP Registration No: IP26-00006615 **Date:** 20/6/2026

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

1.	**Name :** Master Yashveer Ram Sidagam	**Remarks**
2.	Complete postal address (with contact number, if any)	Himayat Nagar Hyderabad
3.	Brief description of the illness	Right open Orchiopexy
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	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
20/6	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Sonia (018662. Signature: .....

Received by (Name & ID No.): M Arvind Kumar (03257) Signature: .....

Time: .....

Rainbow Children's Hospital

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NARCOTIC PRESCRIPTION FORM

(MEDICAL RECORD)

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

PRESCRIPTION DETAILS (Tick only one of the two)

S.No	Drug Name	Dosage	Remarks
1	Tapentadol Orally Tab 50mg/SR		
2	Morphine Sulphate Inj 15mg/ml		
3	Pentazocine Hydrochloride Inj 30mg		
4	Ephedrine Hydrochloride Inj 15mg		

Doctor Name: Doctor Registration No:

Signature:

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO: 32

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: Date:

Address 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 same)					
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 No):

Received by (Name & ID No):

Signature

Signature

Time

Doctor Seal with Name / Medical Reg. No