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 : IP26-00006653 **Admit Date** : 26-Jun-2026 **Admit Time** : 06:49 AM **UHID** : HNH-00005829

Patient Details :

Patient Name	: Master MAYANK RAGHOTAMPURAM	**Age**	: 4 Y 9 M 3 D
Guardian	: Mr R. ABHISHEK	**DOB**	: 23-09-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 103,2-1-420, sreesha apartments, nallakunta Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9849532729/ 9908366636
		E-mail	: abhishek.ranghotam@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr R. ABHISHEK **Relationship** : Father

Contact Address : 103,2-1-420, sreesha apartments, nallakunta Nallakunta Hyderabad Telangana INDIA 500044 **Phone No** : 9849532729

R. Abhishek

Signature

Doctor Details :

Doctor Name : Dr. ALLU CHANDANA **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : DR. JAYASREE. C **Phone No** : 9963423073

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : SBI General Insurance Company Ltd

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ACTIVITY RECORD FOR BILLING

HNH-00005829 IP26-00006653
Name: ---- Master MAYANK RAGHOTAMPURAM ----------
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA
UHID No : -

--------- Consultant : ---------- Dept : ----------

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
26/6/26	7:30Am	ER	OT	A.R
26/6/26	10Am	OT	PICU	
26/6/26		PICU	Ward	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
26/6/20	CBP	10364	
	PAC ~~(GOD BLESS)~~		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
26/6/26	Invasive monitor	10 pm		} 8328	Sonam
26/6/26	Infusion pump	10 pm			

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
26/6/26	Iv canula	1	8294	AK

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-00005829 IP26-00006553
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Mouth breathing

History of present illness :

c/o Mouth breathing

c/o Recurrent URTI / chest ⊗

on Inhaler use

admitted for Adenotonsillectomy

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

FT / Twin 2 / LSCS / Uneventful

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Upto age.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 13.6 kg (Centile __________)

On Examination :

Temperature : 97.9F Pulse Rate: 123/min Description __________

B.P. 100/67 mmHg SPO2 97% @ RA at __________

Resp. rate and type of breathing : __________

Rash __________

Lymphadenopathy __________ NO

Oedema : __________

Respiratory system :

Inspection (any s/o distress) : __________

Air entry & breath sounds : TJCAHG (B). Clear

Any addes sounds : __________

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

Cardiovasclular System :

Inspection of procordium : __________

Heart Sounds : S1S2 (+)

Any murmur : __________

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

Per Abdomen :

Inspection __________

Palpation : Soft, NT

Ausculation : __________

Spine: __________ External Genitelia : __________

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____ Normal

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Adenodermillitis

_____

_____

_____

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP.

Planned Management :

Adenotonsillectomy

Nebulise

Levolin 0.63 mg

Budecort 1 mg

30 min prior to surgery

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 _____

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: MAYANK RAGHOTAMPURAM Age: 4y Sex: MALE UHID.No: HNH-5829

Date: 24/6 Time: 4pm. Proposed Operation: Adenotonsillectomy + Coablation

Diagnosis: Adenotonsilitis

B.P / CRT: ..... H.R: ..... Weight: 13.6 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: -

RESP: recurrent URTIs / wheeze (+) Diabetes: on routine inhaler use.

CNS: admitted in Oct-25', mouth breathing.

Renal: -

Hepatic / GE: Birth - FT/LSCS/Twin 2/uneventful Physical Activity: active

Others: No apparent dev. delays.

Past Anaesthetic History: nil -

Physical Exam: child alert, active

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

Lungs: BAE (+) clear clinically.

Heart: S1+S2+ M0.

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: peripheral Spine Exam for regional: -

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

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

CURRENT MEDICATIONS	DOSAGE
LEVOLIN Inhaler	1 puff tid.
BUDECORT	
Nasal spray.	

Pre-Operative Instructions:

1. DVT Prophylaxis: 12AM | FOOD MILK.
2. NIL ORAL → Water / ORS 2 Hours → 5AM - WATER; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - Clip to be done - cannulation.
   - NEBULISE - LEVOLIN 0.63mg + BUDECORT 1mg 20mins prior to Sx.

Signature: Name: Dr. Samir Nayak.

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

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

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: 106/Mt | B.P / CRT: 108/63 mmHg | SpO_2: 100%. | R.R: 22/br/min | Last Feed: >6hrs

Pre-OP Diagnosis: Adenoid Hypertrophy Operation: Coablation Adenotonsillectomy Date : ....

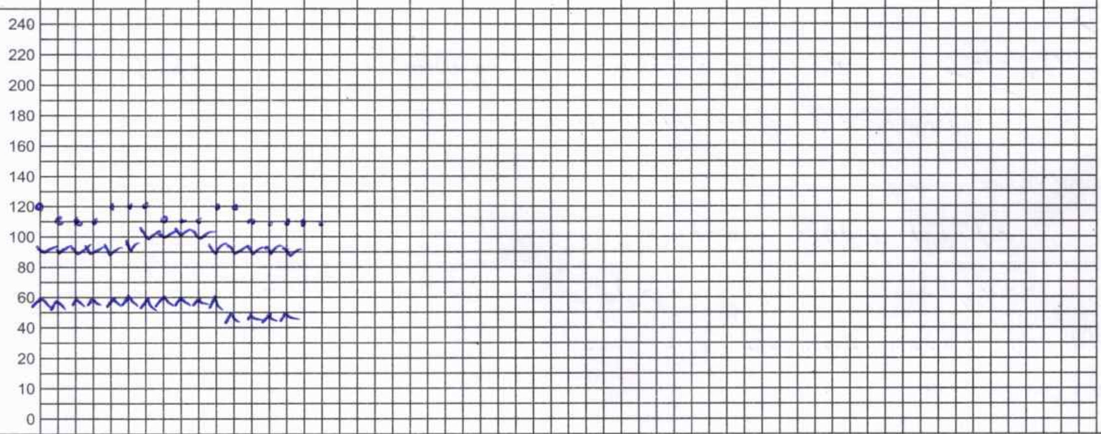
Surgeon: Dr. ALLU CHANDANA Anaesthesiologist: Dr. SAMIR Technician: Aravind.

TIME	8:00		8:30		9:00		9:30		9:45	9:50
N_2O /AIR /O_2 LPM	/ /	/ / /	/ / /	/ / /	/ / / /	← O_2		→		
HALO /SO /SEVO	MAC-1 →									
Drugs:										
Inj. MIDAZOLAM	0.6mg									
Inj. FENTANYL	25 mcg iv									
Inj. PROPOFOL	20 + 20 mg									
Inj. KETAMINE	25mg iv									
Inj. ROCURONIUM	7mg iv									
Inj. PARACETAMOL	200mg									
Inj. DEXAMETHASONE	2mg						Inj. NEOSTIGMINE 0.8mg IV + Inj. GLYCOPYRROLATE 0.2 mg IV			
Inj. TRANEXEMIC ACID	200mg									
Inj. NALAXONE	120mcg									
FIO_2 / SaO_2	100	100	100	100	100	100	100	100	100	
$ETCO_2$	40	38	38	38	36	44	48	52	42	
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Temperature	34.5	34.5	34.5	34.5	34.4	35.3	35.6	35.6	35.6	
Urine Output										

Fluids / Blood: RINGER LACTATE @130mL/hr → →

Antibiotic: AUGMENTIN 390mg iv
Suppository
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



LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (L) leg.
☐ Art Site: ....
☑ EKG Lead - 3 electrode
☑ Temp Site (L) chest
☑ 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: 8:00 AM
OP Start: 8:15 Am
OP End: 9:20 Am
Leave OR: 9:45 Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: 22G (L) DV
☐ IV: ....
☐ IV: ....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 5.0 at South pole
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ....

☐ Awake ☐ Direct Vision
☑ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 01
Difficulty Why? -

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

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: ....
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: ....
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....
Transportation to
☑ PACU ☐ ICU ☑ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor : Dr.
Signature of the Doctor : ....

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

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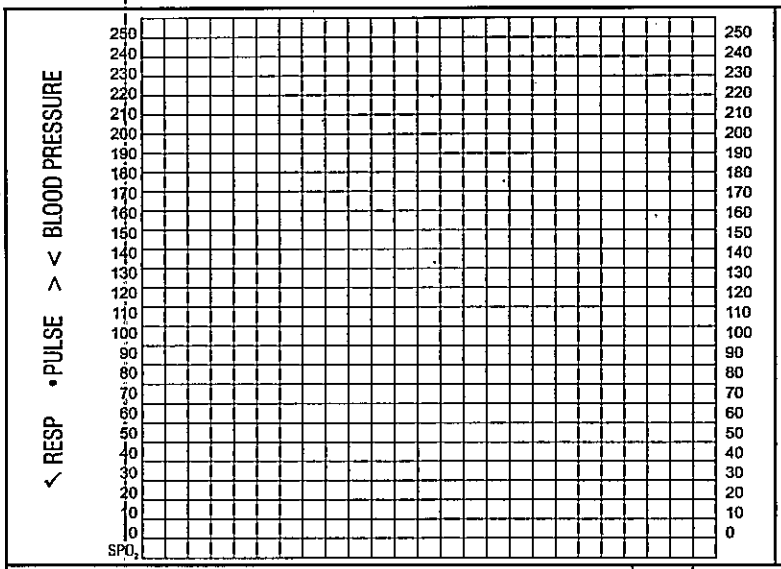
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

☐ 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: .....
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						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						
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION						
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS						
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR						
		TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

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

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

Transferred to Unit by (PACU): .....
Date & Time: .....

HNH-00005629 IP26-00006653
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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 : .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6 11:00 Am.	c/s/o Dr. Naipuya Chronic Adenotonsillitis S/p - Coblation Adenotonsillectomy	
	Awake.	Plan
	Vitals - HR. - 92. RR - 20. SpO2 - 98%	- Allow orally (liquids)
	R/S - B/L AE(+)	- Cont IVF 1/2 M
	P/A - soft, NT	- Cont. Acyclovir. PCM. - Inj DexA stat dose at 7pm today & 7am tomorrow - Cont Relcet plus Solspire N/S Otrivin-P - Monitor vitals

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: .... Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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:																		

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

REGULAR PRESCRIPTIONS

Weight. 13kg Ward. .....

DRUG : Inj. AUGMENTIN.

Dose	Route	Frequency	Start Date
350mg	IV	8H	26/6.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	26/6														
Time	6AM														
	2PM														

DRUG : Inj. PCM.

Dose	Route	Frequency	Start Date
200mg	IV	6H	26/6.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date															
Time															

DRUG : Inj. PAN

Dose	Route	Frequency	Start Date
20mg.	IV.	OD	26/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date															
Time															

DRUG : Syp. RELENT PLUS

Dose	Route	Frequency	Start Date
3ml.	PO	BD	26/6.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date															
Time															

Patient Sticker

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

					Date / Time
DRUG : OTRIVIN – P. Nasal drops					
Dose: 2 / 2	Route: Nasal	Frequency: BD	Start Dt.: 26/6.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

					Date / Time
DRUG : SOLSPRE Nasal spray					
Dose: 1 Puff	Route: Nasal	Frequency: BD	Start Dt.: 26/6.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

					Date / Time
DRUG : BETADINE GARGLE					
Dose	Route: PO.	Frequency: QGH	Start Dt.: 26/6.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

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

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

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

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.	

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.	

Signature .....

VERIFIED BY Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
26/06	7AM	NGB & LEVOCIN	0.63 g	NGB	Sig	
26/06	7:10AM	NEB & TOBECORT	1 mg	NGB	Sig	A.K
26/6	8am	AUGMENTIN	390 mg	IV	Chi	A Archa
26/6	815am	DEXAMETHASONE	2mg	IV	Chi	A Archa
26/6	815am	TRANEXAMIC ACID	200 mg	IV	Chi	A Archa
26/6	815am	PARACETAMOL	200 mg	IV	Chi	A Archa
26/6	9:30Am	Inj. NALAXONE	120mcg	IV	Sig	A Arj
26/6.	7:00PM	Inj. DEXAMETHASONE	2mg	IV.	Sig	

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

I.V. FLUIDS CHART

Weight. ..... 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
26/6	8AM	RINGER LACTATE	IV	130 + 50					
26/6.		IVF PLASMALYTE. (1/2 M)	IV.	25ml					

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

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature							
Date:							
Time:							
Taken Over By Name :							
Signature							
Date:							
Time:							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 26/6			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA									
			Signature of the Nurse										

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Patient ID

BRADEN 'Q' SCALE

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				Date : 26/6			
				Time :			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.			
				TOTAL SCORE			
				Evaluator's Name			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

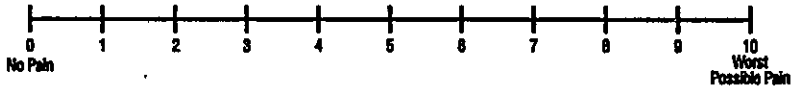
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	10 AM	0		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 26/6	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1				
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3				
	Within 48 hours	2					
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
	Total						

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position						
	Call device within reach						
	Wheels Locked						
	Room free of clutter						
	Adequate lighting						
	Wheel chair support						
	Other Intervention(s) Specify						
	Nurse's Name:						
	Signature:						
	Date:						
	Time:						

96-0000

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mastu Mayank Raghotampuram	Age: 4Y	Gender: Male	
UHID No: HNH-00005829	IP No:	Date: 26/6/26	Time:
Diagnosis: Adenotonsillectomy (Ward - 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 Amir

Doctor Registration No: 67929

Signature: [signature]

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

IP Registration No: .... **Date:** 26/6/26

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

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

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
26/6	INJ: Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): Sania (018442) M Arvind Kumar (02795?) Signature: Sania [signature]

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

Time: ....

26-0000

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Master Mayank Raghotampuram		Age: 4Y	Gender: Male
UHID No: HNH-00005829	IP No:	Date: 26/6/26	Time:
Diagnosis: Adenotonsillectomy (Ward - 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 Amir   Doctor Registration No: 67929

Signature: [signature]

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

IP Registration No: ....   **Date:** 26/6/26

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

1.	**Name :** Master Mayank Raghotampuram	**Remarks**
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	Adenotonsillectomy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
26/6	INJ: Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): Sana (018442) .... Signature: Sana

Received by (Name & ID No.): M Arvind Kumar (021957) .... Signature: AW

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00005829 IP26-00006653 Master MAYANK RAGHOTAMPURAM 23-09-2021 4 Y 9 M 3 D (M) Dr. ALLU CHANDANA	26/6/26	26/6/26 @ 7:30am
	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 18	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 : Sangeeta.

Date & Time of Patient Received : 26/6/26 @ 7:30Am

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-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

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EMERGENCY ROOM TRIAGE FORM

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

Date : 26/ ..... Time of Arrival : 6:45AM .....

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: 97.9 PR: 123 BP: 100/67 RR: ..... SpO_2: 99 .....

Chief Complaints: C/O came for T/T tonsillectomy .....

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 : .....

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.R .....

Date & Time : 26/6/26 @ 6:45 A.m

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM (M)
23-09-2021 4 Y 9 M 3 D
Dr. ALLU CHANDANA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 26/6/26 Time of arrival : 6:45 A.m

Chief Complaints: c/o came for c/o fomicilloms RBS: ...

Height : ... Weight : 13.6 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 foncin ☐ 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

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

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 Fammy

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

Time of Initial assessment completed by ER Nurse : 6:450 Am

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

Time	Nursing Notes
	Assessed the patient condition
	vital checked.

Samples collected by:

Samples sent by : Malayee

Time:

Time: 1:30 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: 123 BP: 100/60 CFT:	Shift - out from ER to: OT
RR: 30 SPO_2 : 99	Time of Shift - out: .....
GCS: — Temperature : 98	Handover given to: .....
Pain Score: 02	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Ampam

Signature of the Nurse : AP

Date & Time : 24/6/22 @ 5:45 Am

Patient Sticker

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POST OPERATIVE - DOCTORS HANDOVER FORM

OT to ☑ PICU ☐ NICU ☐ MICU ☐ WARD

Date: 26/6/26 Time: 9:57Am

Name of the Surgery: ADENOTONSILECTOMY C COBLATION

Drugs used for sedation during surgical procedure: Inj: PROPOFOL 20+20+10+10mg IV, Inj. FENTANYL 25mcg
Inj. MIDAZOLAM 0.6mg IV

IV Fluids type / amount used using surgical procedure: RL @ 130 ml/hr

Input 250 ml Output ..... ml Blood Loss 25 ml

Blood Transfusion if any ←

Any intra operative event: Delayed Recovery, Inj. NALOXONE 120mcg IV
post extubation: Nebulisation C Adrenaline 1ml+4ml(NS) (1:100) given

On arrival to PICU / NICU / MICU / WARD:

Temp: ..... HR: 132/min RR: 18/min BP: 113/61 mmHg CRT: < 3sec

Peripheries: Warm SpO_2: 100% C 4Lit O_2/min

Drains: NIL

ET Tube: ☐ Cuffed ☐ Uncuffed

Size of ETT: ..... Length of Fixation of ETT: .....

Surgeon's Notes: ☐ Yes ☐ No

Time of Arrival to Unit: 9:57Am

Handover given by:	Handover taken by:
Anesthesiologist's Name Dr. Ayesha	Doctor's Name .....
Signature: Ayesha	Signature: .....
Date & Time: 26/6/26, 10:05Am	Date & Time: .....

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OPERATION THEATER NOTES

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M
Dr. ALLU CHANDANA

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

UHID.: ... .I.P.No. :.....Weight : .....

Surgeon : Dr Chandana	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : COBLATION ADENOTONSILLECTOMY

Indications for Surgery : Chronic Adenotonsillitis

Date : 26/6/26	Start Time : 8 Am	End Time : 9:20 Am

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: I/GA · pt in Rosés position
Boyle Davis mouth gag applied.
B/L Tonsillectomy done with coblation.
Endoscopic guidance adenoidectomy done
Hemostasis secured. procedure
uneventful.

POST - OPERATIVE ORDERS :

- NPO until fully awake.
- Inj. AUGMENTIN - 540mg / IV / Q8H
- Inj. PCM - 200mg / IV / Q6H
- Inj. PAN 20mg / IV / 8am OD
- Inj. DEXA - 1.5mg / IV / 7pm / 7am (2 doses)
- Syp. RELENT - plus
  3ml ——— 3ml
  OTRIVIN - P N/D
  2° ——— 2°
  SOLSPRE N/S
  ↑↑ | ↑↑
- BETADINE gargles Q6H

D/S med

1 week
- Syp. Amoxclav (6am, 12pm, 6pm, 12am)
- Syp. PCM - 15mg/kg/6th hourly
- Syp. TRUGESIC - 5ml/12th hourly (9am/9pm)
- Syp. RELENT x 1 week
- SOLSPRE - 3 weeks
- OTRIVIN - 5 days

Dr. Chandana

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 26/6/26 Time : 9:00am

SURGICAL SAFETY CHECKLIST

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D M
Dr. ALLU CHANDANA

Surgeon : Dr. Allu Chandana
Asst. Surgeon :
Anaesthetist : Dr. SAMIR
Scrub Nurse : ST. Sangeetha / Sr. Archana / Sr. puja.

..... Age : 4Y 9M Gender : Male
...ery Name :
Date 26/6/26 In-time : 8Am Out-time : 9.20Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:00Am

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 : Anm
Name : Dr. Ameer

Before Skin Incision ➤➤

TIME OUT Time: 7:55am

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA

Signature : Puja @7:55am
Name : Puja.

Before Patient Leaves Operating Room

SIGN OUT Time: 9:20Am

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 : Dr. Chandana

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00005829 IP26-00006653 Master MAYANK RAGHOTAMPURAM 23-09-2021 4 Y 9 M 3 D (M Dr. ALLU CHANDANA	26/6/26 @ 6:49 Am	26/6/26 @ 9:45 Am
	Transfer Ordered by Dr. Samir.	Reason for Transfer observation
From Unit OT	To Unit PICU	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.	RI	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. Samir

Patient & Clinical Records Received by : Sunam

Date & Time of Patient Received : 26/6/26 @

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mast Mayank Raghulampuram Age : 4y Gender : Male ☑ Female ☐

UHID NO: HNH-5829 Surgeon Name: Dr. Allu Chandana

Anaesthesiologist : Dr Sanvi / Dr Ayesha

Operative procedure planned : Adenotonsillectomy coablation

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 : O2 supplementation / 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 ..... 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 : .....

Name : R. ABHISHEK

Relationship with Patient: FATHER

Date & Time : 26/06/26

Witness :

Signature : .....

Name : MADHURA PATIL

Date & Time : 26/06/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Laxmi Nayak

Date & Time : 26/6 at 7.30 am.

HNH-00005829 IP26-00006653
Master MAYANK RAGHOTAMPURAM
23-09-2021 4 Y 9 M 3 D (M)
Dr. ALLU CHANDANA

IN FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MAYANK RAGHUTAMPURAM Gender: ☑ Male ☐ Female Age : 4yrs 9months

UHID No : ..... Date : 26/6/26

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)

..... COBLATION ADENOTONSILLECTOMY UGA

..... upon .....

(Name of the Patient) MAYANK RAGHOTAMPURAM

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 .....
..... Laryngospasm .....
.....

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 : L. ABHISHEK

Relationship with Patient: FATHER

Date & Time : 26/06/26

Witness :

Signature : .....

Name : Madhura Patil

Date & Time : 26/06/2026 7:30

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. CHANDANA

Date & Time : 26/6/26 7:45am

Patient Sticker

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: OT

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Susant

Date & Time : 26/6/26 @ 6:30 Am

Nurse Name & Signature: Anupam

Date & Time : 26/6/26 @ 7:00 Am