

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



## SURGERY DETAILS

Date : 26/6/26

Patient Name: Master Raghoutampuram Date of Birth: 23-09-2021 Age: 4 yrs

Gender: Male Ward : OT UHID No: MNH-00005829

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

Name of the Surgery : COAGULATION ADENOTONSILLECTOMY & GA

Time in : 8 AM

Time Out : 9:20 AM

	NAME	AMOUNT
1. Surgeon	Dr. Allu Chandana	
2. Anaesthetist	Dr. Samir	
3. Assistant Surgeon		
4. OT Technician	Pr. Arvind	
5. Circulating Nurse	Sr. Sushreeka, Sr. Nitalu	
6. Assistant Nurse	Sr. Sangeetha, Sr. Archan, Sr. Pooja	

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

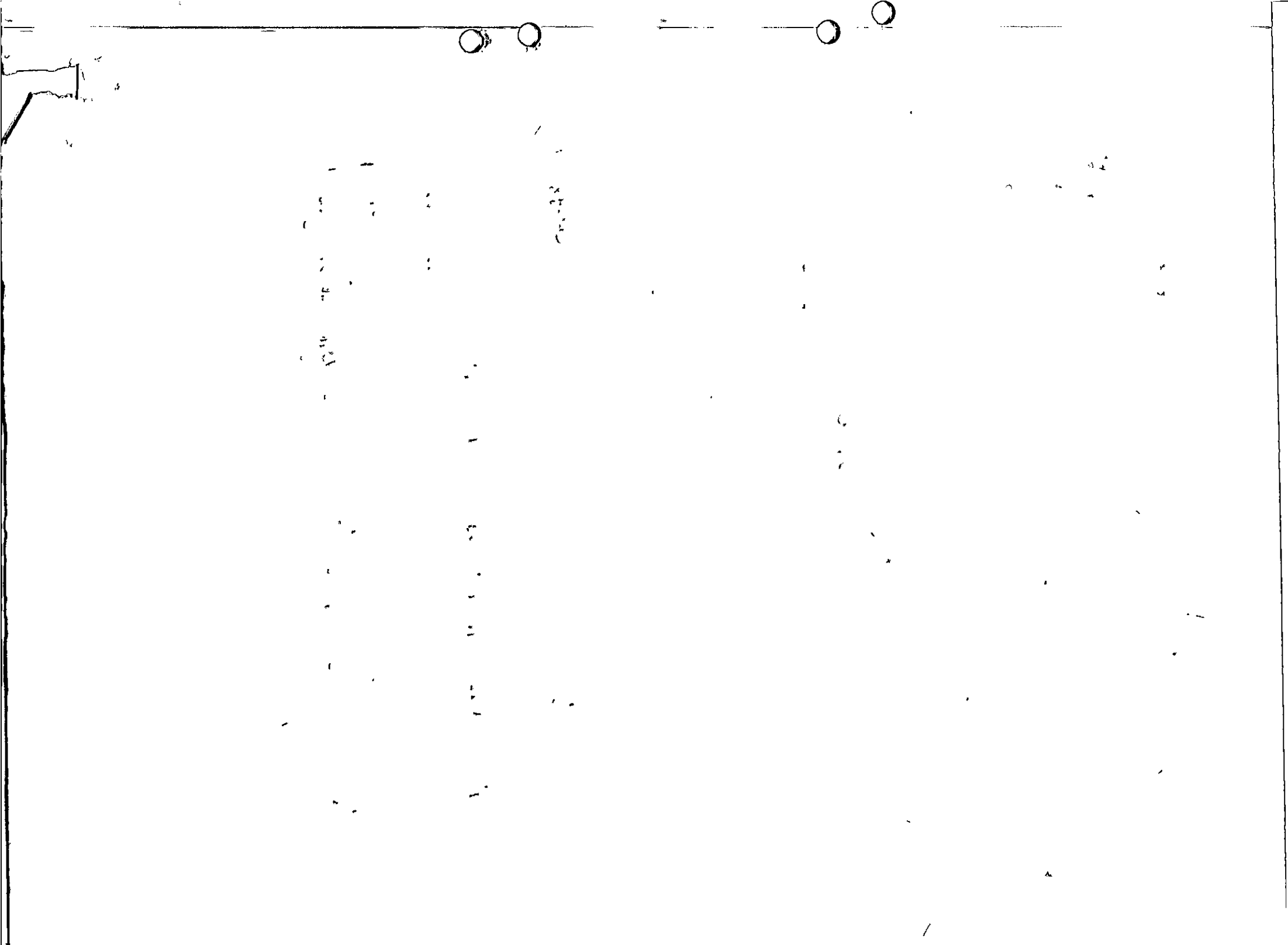
Coagulator charges (26-000208330)  
Nitalu

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000208330

Order by: Sushreeka 26/6/26





*Adenotonsillectomy*

**CONSUMABLES OF OT**

*Notana* Technician: *Arvind* Date: *26/6/26* Time: .....

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
<del>ET tube</del> <i>RAE Tube 5.0</i>	✓	<i>2</i>	<i>Major Pack General</i>	✓		Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A (P) N	✓	<i>03</i>	<i>Infant feeding tube (7)</i>	<i>2</i>		Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		<i>05</i>	<i>Inj Adrenaline</i>	<i>2</i>		Vaccum Suction Set		
05 cc		<i>05</i>	<i>Gloves 6 1/2</i>	<i>1/1</i>		Surgical Gloves		
02 cc		<i>07</i>	<i>Endo 6 1/2</i>	<i>2</i>		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set		<i>01</i>	NG tube			Koochies (S)		
RL		<i>01</i>	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		<i>02</i>	Koochies					
<i>PCM</i>		<i>01</i>	Ointments					
<i>Agumentin 600 mg</i>		<i>01</i>	Suction Catheter					
Fentanyl		<i>01</i>	Cap, Mask	<i>10/10</i>				
<del>Morphine</del> <i>O2 mask (P)</i>		<i>01</i>	Gauze Pack <i>2.5x7.5, 10x10</i>	<i>1/2</i>				
Ketamine		<i>01</i>	Mop Pack	<i>+</i>				
Propofol		<i>0.2</i>	Steristrip					
<del>Roceuronium</del> <i>Dexamethasone</i>		<i>01</i>	Underpad	<i>+</i>				
Glycopyrolate		<i>01</i>	Draw sheet					
<del>Myopyrolate</del> <i>Tranexa</i>		<i>01</i>	Abgel <i>Savlon</i>	<i>+</i>				
<del>Ondansetron</del> <i>Neostigmine</i>		<i>01</i>	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			<del>loban</del> <i>Nasal pack</i>	<i>+</i>				
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	<i>2</i>				
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	<i>✓</i>				
<i>Midazolam</i>		<i>01</i>	Microshield	<i>1</i>				
<i>Adrenaline</i>		<i>01</i>	Cotton Balls					
<i>INT: Naloxone</i>		<i>01</i>	Latex Gloves	<i>10</i>				
<i>Case pack</i>		<i>01</i>	Ramdione Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. *26-0000208327/46*

Ordered by : *Arachana 26/6/26 @ 11:40 AM*

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



**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00005829      Name : Master MAYANK RAGHOTAMPURAM  
 Age / Sex : 4 Y 9 M 3 D / Male      Doctor : ALLU CHANDANA  
 Adm/Reg Date/Time : 26/06/2026 06:49      Payor : SBI General Insurance Company Ltd  
 Order Date : 26/06/2026 11:39      Ordernumber : 26-0000208347  
 Visit ID : IP26-00006653      Ward/Bed No : 2F -PICU / PICU-203  
 Patient Address : 103,2-1-420, sreasha apartments, nallakunta, Nallakunta, Hyderabad, Telangana, INDIA, 500044

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	AEQUIMENTIN INJ 600MG		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	RAE ORAL WITH CUFF TUBE-5.0	RAE ORAL CUFFED 5.0	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	INFANT FEEDING TUBE-7	INFANT FEEDING TUBE 7	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
4	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
5	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
6	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
7	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	NEX INJ AMP 400 MCG 1 ML		1 Ampule	Injection / Once Daily	1 Days		1 Ampule	Dispensed
9	Oxygen Mask With Tubing - PeadROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	BIOXAMIC 500 MG INJ		1 Ampule	/ Once Daily	1 Days		1 Ampule	Dispensed
11	F C G ELECTRODES (PAED)	ELECTRODES PED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
13	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
14	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
15	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
16	ADROGLARE(ADRENALINE) INJ 1MG 1ML		1 Vial	Injection / Once Daily	1 Days		3 Vial	Dispensed
17	MYOSTIGMIN INJ 1ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispensed
18	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	DEXAMETHASONE INJ 2 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
20	UNDER PAD 60X90 10's Pack -MEDICUBE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
21	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
22	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
23	MCT-ROF 100MG 10ML		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed

**ALLU CHANDANA**

**Reg No : 03408**

\* 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.



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 Patient Address : 103,2-1-420, sreesha apartments, nallakunta, Nallakunta, Hyderabad, Telangana, INDIA, 500044

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
2	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
4	POVINANZ SOLUTION 10% 100 ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
6	FACE MASK 3 LAYER ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
7	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
8	IVALON NASAL PACK WITH STRING (8CMX1.5CM)		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
9	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
10	SAVLON 100 ML		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
11	GENERAL SURGICAL KIT (MEDITAKE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed

**ALLU CHANDANA**

**Reg No : 03408**

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### DISCHARGE SUMMARY

<b>Name</b>	Master MAYANK RAGHOTAMPURAM	<b>UHID</b>	HNH-00005829
<b>Father/Guardian</b>	Mr R. ABHISHEK	<b>Age/Gender</b>	4 Y 9 M 3 D/ Male
<b>Address</b>	103,2-1-420, sreesha apartments, nallakunta, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
<b>IP No</b>	IP26-00006653	<b>Admission Date</b>	26-06-2026
<b>Ref Doctor</b>	DR. JAYASREE. C		
<b>Discharge Date</b>	27.06.2026		

**Consultant:**

**Dr. Allu Chandana**  
MBBS, MS (ENT), DNB,  
Fellowship in Pediatric ENT.

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
CHRONIC ADENOTONSILLITIS	

**Procedure :** Adenotonsillectomy with Coblation done on 26.06.2026.

**History:** Master MAYANK RAGHOTAMPURAM, 4 Y 9 M 3 D child presented with history of recurrent episodes of cold, cough associated with mouth breathing, snoring and sleep disturbances prior to admission. For the above complaints child was evaluated and found to have adenotonsillar hypertrophy, in view of

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<b>Name</b>	Master MAYANK RAGHOTAMPURAM	<b>UHID</b>	HNH-00005829
<b>IP No</b>	IP26-00006653	<b>Admission Date</b>	26-06-2026

which child was admitted at Rainbow Children's Hospital for surgical management.

**Examination:** Child was afebrile, maintaining saturations at room air. Heart rate was 123/min, Blood Pressure - 100/67mmHg and Respiratory rate - 30 /min. Bilateral hypertrophied inferior nasal turbinates present, grade 3 tonsillar hypertrophy. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 13.6 kilo grams.

**Investigations:** Enclosed reports.

**Indications for surgery:**

Coblation Adenotonsillectomy done on 26.06.2026.

**Surgery :**

- Under GA patient in Rose's position.
- Boyle davis mouth gag applied.
- Bilateral tonsillectomy done with coblation.
- Under endoscopic guidance adenoidectomy done.
- Hemostasis secured, procedure uneventful.

**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:**



<b>Name</b>	Master MAYANK RAGHOTAMPURAM	<b>UHID</b>	HNH-00005829
<b>IP No</b>	IP26-00006653	<b>Admission Date</b>	26-06-2026

\* Diet as advised.

\*Syrup. Augmentin DDS (Amoxicillin - 400mg + Potassium clavulanate - 57mg/5ml) 2.5 ml twice daily for 7 days.

\* Syrup. Relent plus 3 ml twice daily after food for 7 days.

\*Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4ml 6th hourly(6am,12pm,6pm,12am) daily after food for 7 days.

\* Otrivin-P nasal drops, 2 drops in each nostril thrice daily for 5 days.

\* Gargle with Betadine thrice daily for 7 days.

\* Tablet. Ibugesic 5 ml 12th hourly (9am,9pm) daily after food for 5 days.

\* Solspre nasal spray twice daily for 3 weeks.

### **Fever Management**

\* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4ml 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. ALLU CHANDANA after 1 week in OPD at Himayatnagar with prior appointment (**Review consultation will be charged**).

### **Food instructions while taking medications:**

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

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

1000

1000

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<b>Name</b>	Master MAYANK RAGHOTAMPURAM	<b>UHID</b>	HNH-00005829
<b>IP No</b>	IP26-00006653	<b>Admission Date</b>	26-06-2026

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

You can also take appointments at any time by going **online** to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**

  
Registrar/Resident/C.M.O




**Consultant:**

**Dr. Allu Chandana**  
MBBS, MS (ENT), DNB,  
Fellowship in Pediatric ENT.

### ACTIVITY RECORD FOR BILLING

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

UHID No: -  Consultant: \_\_\_\_\_ Dept: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No: \_\_\_\_\_ Ward: \_\_\_\_\_ Suggested Billable bed type: \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/6/26	7:30 AM	ER	OT	A.R. / [Signature]
26/6/26	10 AM	OT	PICU	[Signature]
26/6/26	12 PM	PICU	Ward (300 floor)	Seena / Seena

### Cross Consultation Visit

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







Ref.No. F/IN/PR/10




# Rainbow<sup>®</sup> Children's Hospital

## PEDIATRIC IN-PATIENT MEDICAL RECORD

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

Patient Name : \_\_\_\_\_

Patient ID# : \_\_\_\_\_  \_\_\_\_\_

Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

also mouth breathing

History of present illness :

also Mouth breathing

also Recurrent ORTI / pharyngitis

On Inhaler use

admitted for Adenotonsillectomy



**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 13.6 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 97.9 F Pulse Rate: 123/min Description \_\_\_\_\_

B.P. 100/67 mmHg SPO2 99% @ RA at \_\_\_\_\_

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_

Lymphadenopathy no

Oedema : \_\_\_\_\_

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : TSCAB @, clear

Any addes sounds : \_\_\_\_\_

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

**Cardiovascular System :**

Inspection of procordium : \_\_\_\_\_

Heart Sounds : S<sub>1</sub>S<sub>2</sub> @

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : soft NI

Ausculation : \_\_\_\_\_

Spine: \_\_\_\_\_ External Genitalia : photo

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

**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 :**

*Adenovirus infection*

**Pediatric Multiorgan History & Physical Examination**

Preventive aspects of the treatment :

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Desired goals of the treatment :

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**Planned Labs :**

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*CBP.*

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**Planned Management :**

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*Admission to ICU*

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*Nebulise*

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*Levalin 0.83mg*

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*TBudesonid 1mg* } →

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*30 min prior to*

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*surgery*

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**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 : \_\_\_\_\_  
(Referring 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**



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

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

Diagnosis: Adenotomillectomy

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/Angio: .....  
 PT: ..... K: ..... LDH: ..... T3 ..... Other: .....  
 PTT: ..... Ca++: ..... Alk phos: ..... T4 .....  
 INR: ..... Mg++: ..... Amylase: ..... TSH .....  
 Cl -: ..... SGOT/SGPT: .....

Allergies: NKA

Medical History: CVS: -

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

CNS: admitting in Oct-25, mouth breathing.

Renal: -

Hepatic / GE: Birth - FT / USC / 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: 3PR Neck: (N) Teeth: intact

Lungs: RAE (+) clear clinically.

Heart: S1S2 + no.

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
<u>LEVOLIN</u>	<u>Jinanda tid.</u>
<u>BUDECORT</u>	
<u>Nasal spray.</u>	

**Pre-Operative Instructions:**

- DVT Prophylaxis: Water / ORS 2 Hours 5AM - WATER
- NIL ORAL Others 6 Hours
- Informed Consent:  Standard  High Risk
- Post Operative Pain Management:  Discussed with Patient
- Other Instructions: Chp. to be done - cannulation.  
NEBU USE [ LEVOLIN 0.62mg ] 20mins prior to sx.  
[ BUDECORT 1mg ]

Signature: [Signature] Name: Dr. Samir Unayath



# ANAESTHESIA CHART



## 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 my SpO<sub>2</sub>: 100% R.R: 22/mt/mt Last Feed: >6hr

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

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

TIME	8:00	8:30	9:00	9:30	9:45	9:50														
N <sub>2</sub> O (AIR / O <sub>2</sub> ) LPM	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///	///
HALO / SO / SEVO	MAC																			
Drugs:																				
1. MIDAZOLAM	0.6mg																			
2. FENTANYL	25 mcg iv																			
3. PROPOL	20 + 20 mg																			
4. KETAMINE	25mg iv																			
5. ROXAPROFEN	7mg iv																			
6. PARALUMOL	200mg																			
7. DEXAMETHASONE	2mg																			
8. TRANEXEMILAC	200mg																			
9. NALOXONE	120mcg																			
10. NEOSTIGMINE + 11. GLYCOPYRROLATE	0.8mg iv + 0.2mg iv																			
FIO <sub>2</sub> / SaO <sub>2</sub>	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
ETCO <sub>2</sub>	40	38	38	38	36	44	48	52	42											
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature	34.5	34.5	34.5	34.5	34.5	35.3	35.6	35.6	35.6											
Urine Output																				
Fluids	Ringer Lactate @ 130ml/hr →																			

Antibiotic  
**AUGMENTIN 390mg iv**  
 Suppository

Blood Loss

NOTES

LAB Values

ABG

GRBS

Others

<p><input checked="" type="checkbox"/> Equipment Checked and Functional</p> <p><input checked="" type="checkbox"/> BP</p> <p><input checked="" type="checkbox"/> Cuff Site: <u>leg</u></p> <p><input type="checkbox"/> Art Site: .....</p> <p><input checked="" type="checkbox"/> EKG Lead <u>selected</u></p> <p><input checked="" type="checkbox"/> Temp Site: <u>chest</u></p> <p><input checked="" type="checkbox"/> FIO<sub>2</sub> Monitor</p> <p><input checked="" type="checkbox"/> Agent Monitor</p> <p><input checked="" type="checkbox"/> Pulse Oximeter</p> <p><input type="checkbox"/> Capnograph</p> <p><input checked="" type="checkbox"/> Ventilator</p> <p><input type="checkbox"/> Nerve Stimulator</p> <p>Position: <u>supine</u></p> <p><input type="checkbox"/> Pressure Points Checked</p> <p>Eye Care:</p> <p><input type="checkbox"/> Oint</p> <p><input checked="" type="checkbox"/> Tape</p> <p><input type="checkbox"/> Padding</p> <p><input type="checkbox"/> Awake</p>	<p>Temp:</p> <p><input checked="" type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer</p> <p><input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer</p> <p><input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool</p> <p><input checked="" type="checkbox"/> Other</p> <p>Times:</p> <p>Anaes Start: <u>8:00 AM</u></p> <p>OP Start: <u>8:15 AM</u></p> <p>OP End: <u>9:20 AM</u></p> <p>Leave OR: <u>9:45 AM</u></p> <p>Anaesthesia:</p> <p><input checked="" type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care</p> <p><input type="checkbox"/> Regional</p> <p>Line (Size &amp; Location)</p> <p><input type="checkbox"/> CVP: .....</p> <p><input type="checkbox"/> ART: .....</p> <p><input checked="" type="checkbox"/> IV: <u>22g DOV</u></p> <p><input type="checkbox"/> IV: .....</p> <p><input type="checkbox"/> IV: .....</p>	<p>Induction</p> <p><input checked="" type="checkbox"/> IV <input checked="" type="checkbox"/> Inhal</p> <p><input checked="" type="checkbox"/> Pre O<sub>2</sub> <input type="checkbox"/> RSI</p> <p><input type="checkbox"/> Others</p> <p><input type="checkbox"/> Mask <input type="checkbox"/> SGA</p> <p><input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal</p> <p>ETT# <u>5.0</u> at <u>bank pole</u></p> <p><input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff</p> <p><input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical</p> <p><input type="checkbox"/> Drug: .....</p> <p><input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision</p> <p><input checked="" type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie</p> <p><input type="checkbox"/> Fiberoptic</p> <p>Blade# <u>2</u> Attempts: <u>01</u></p> <p>Difficulty Why? .....</p> <p><input type="checkbox"/> Bilat = BS</p> <p><input type="checkbox"/> Semi-Closed Circle</p> <p><input checked="" type="checkbox"/> Closed Circle</p> <p><input type="checkbox"/> Other</p>	<p>Regional:</p> <p>Extremity Specify: .....</p> <p><input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal</p> <p>Others: .....</p> <p>Position: .....</p> <p>Site: .....</p> <p>Needle Size: ..... Depth: .....</p> <p>Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Catheter at skin ..... cm</p> <p>Drug Name &amp; Conc: .....</p> <p>Bolus: .....</p> <p>Infusion: .....</p> <p>Block Level: .....</p> <p>Comments: .....</p> <p>Transportation to</p> <p><input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input checked="" type="checkbox"/> Other</p> <p>Relaxant Reversed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>Name of the Doctor: <u>Dr.</u></p> <p>Signature of the Doctor: .....</p>
--	--	--	--






**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
26/6 11:00 Am.	<p><u>clsis for Naipaya</u></p> <p>Chronic Adenotonsillitis</p> <p>S/p - Coblation Adenotonsillectomy</p>	
	Awake.	<u>Plan</u>
	<p>Vitals -</p> <ul style="list-style-type: none"> <li>HR. - 92.</li> <li>RR - 20.</li> <li>SpO<sub>2</sub> - 98%.</li> </ul>	- Allow orally (liquids)
	R/S - B/L ACP	- Cont IVF 1/2 M
	PIA - soft, NT	- cont. Acyclovir. PCM.
		- Inj DEXA stat dose at 7pm today & 7am tomorrow
		- Cont Relat plug Solspore N/S Otrivin-P
		- Monitor vitals
		<p style="text-align: right;">@deep</p> <p>Noted by Suman @ 11 AM</p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 5:30 pm	C/S/B - Dr. Prashanti	
	<del>sp</del> - chronic Adenotonsillectomy <sup>Adeno</sup> tonsillectomy Coagulation	
	- A/GK	Plan
	- intermittent irritability	
	- o/e	- Discharge
	vitals stable	- Give stat
	oa, pink	Dexamethasone
	sp. ant.	before discharge
		





REGULAR PRESCRIPTIONS

Weight. 13kg Ward. ....

<b>DRUG:</b> 2mj. AUGMENTIN.				Date Time	26/6
Dose	Route	Frequency	Start Date		
350mg	IV	Q8H	26/6	6AM	5PM ✓
Name & Signature of the Doctor Starting the Drugs:					
					2PM
Additional Instructions:					10PM
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG:</b> 2mj. PCM.				Date Time	26/6
Dose	Route	Frequency	Start Date		
200mg	IV	Q6H	26/6	6AM	
Name & Signature of the Doctor Starting the Drugs:					
					12PM 8:00AM ✓
Additional Instructions:					6PM 12AM
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG:</b> 2mj. PAN.				Date Time	26/6
Dose	Route	Frequency	Start Date		
20mg	IV	OD	26/6		
Name & Signature of the Doctor Starting the Drugs:					
					6PM
Additional Instructions:					
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG:</b> SyP. RELENT PLUS				Date Time	26/6
Dose	Route	Frequency	Start Date		
3ml	PO	BD	26/6	10AM	2PM ✓
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					10PM
<b>Daily Doctor's Endorsement by a Sign</b>					



Sheet No: ..... R PRESCRIPTIONS Weight ..... Ward .....

<b>DRUG :</b> OTRIVIN - P. Nasal Drops				Date/Time	26/6
Dose	Route	Frequency	Start Dt.		
2/2	Nasal	BD	26/6	10AM	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:				10PM	
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG :</b> SOLSPRE Nasal spray				Date/Time	26/6
Dose	Route	Frequency	Start Dt.		
1 Puff	Nasal	BD	26/6	10AM	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:				10PM	
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG :</b> BETADINE GARGLE				Date/Time	26/6
Dose	Route	Frequency	Start Dt.		
	PO	Q6H	26/6	6AM	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:				12PM 6PM 12AM	
<b>Daily Doctor's Endorsement by a Sign</b>					
<b>DRUG :</b>				Date/Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
<b>Daily Doctor's Endorsement by a Sign</b>					

Signature  
VERIFIED BY : Name

Patient Sticker



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight .....

Ward .....

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

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

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

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

Signature  
VERIFIED BY : Name



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

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

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
26/06	7AM	NEBI 0 LEVOLISA	0.63mg	NEBI	[Signature]	[Signature]
26/06	7:10AM	NEBI 0 TSOBICART	1mg	NEBI	[Signature]	[Signature]
26/6	8am	AUGMENTIN	390 mg	IV	[Signature]	A Arche
26/6	8:15am	DEXAMETHASONE	2mg	IV	[Signature]	A Archa
26/6	8:15am	TRANEXAMIC ACID	200 mg	IV	[Signature]	A Arche
26/6	8:15am	PARACETAMOL	200 mg	IV	[Signature]	A Arche
26/6	9:30am	inj. NALOXONE	120mcg	IV	[Signature]	A Arj
26/6	7:00pm	inj. DEXAMETHASONE	2mg	IV	[Signature]	
		before discharge				

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



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



## CHECKLIST FOR THROMBOPHLEBITIS



S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <sup>26/6</sup>			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 cord pyrexia	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 of Ward In Charge :

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

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



## PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	10 AM	0		<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

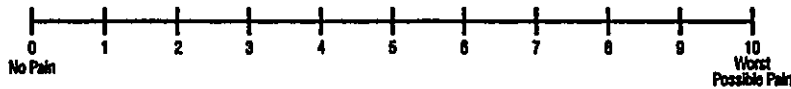
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 - 60 minutes after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

# PAIN ASSESSMENT TOOLS

## 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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> , 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> , less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0

No Hurt

2

Hurts Little Bit

4

Hurts Little More

6

Even More

8

Hurts Whole Lot

10

Hurts Worst



## THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	26/6				
	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					
<b>Total</b>							


**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:							

# PATIENT TRANSFER FORM

HNH-00005829      IP26-00006653 Master MAYANK RAGHOTAMPURAM 23-09-2021      4 Y 9 M 3 D      (M) Dr. ALLU CHANDANA 		Date & Time of Admission <i>25/6/26</i>	Date & Time of Transfer Order <i>26/6/26 @ 11:30 AM</i>
Treating Consultant Name <i>DR. Allu Chandana</i>		Transfer Ordered by <i>Sunam</i>	Reason for Transfer <i>Baby stable</i>
From Unit <i>PICU</i>		To Unit <i>3<sup>rd</sup> Floor (310)</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>-</i>		Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	<i>Sodium Csolspre</i>	<i>1</i>	
2.	<i>syrup Relent</i>	<i>1</i>	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :    Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Sunam</i>		Name of Person Ordered Transfer	
Patient & Clinical Records Received by :			
Date & Time of Patient Received : <i>26/6/26 @ 1:15 PM</i>			

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

96-0000



### NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mastu Mayank Raghotsampurnam Age: 4Y Gender: Male  
 UHID No: H/11-00005829 IP No: \_\_\_\_\_ Date: 26/6/26 Time: \_\_\_\_\_  
 Diagnosis: Adenotonsilidomy (Ward-OT)

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100 mcg</u>	<u>01 Amp</u>
2.	Morphine Sulphate Inj. 15mg/ML	_____	_____
3.	Remifentanyl Hydrochloride Inj. 2MG	_____	_____
4.	Remifentanyl Hydrochloride inj. 1MG	_____	_____

Doctor Name: Dramir 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 : <u>Mastu Mayank Raghotsampurnam</u>	Remarks
2.	Complete postal address (with contact number, if any)	<u>Adenotonsilidomy</u>
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded)	<u>No</u>
5.	Details of essential Narcotic drug dispensed	<u>Fentanyl</u>

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

Dispensed by (Name & ID No.): Sania (019442) Signature: [Signature]  
M Arvind Kumar (021357)  
 Received by (Name & ID No.): \_\_\_\_\_ Signature: [Signature]

Time: .....



NARCOTIC PRESCRIPTION FORM

(PATIENT COPY)

Patient Name: Michael James Smith  
 Date: 11/14/11  
 Doctor: Dr. [Signature]  
 Prescription Details:

Drug Name	Dosage	Quantity	Refills
<u>Hydrocodone</u>	<u>5mg/5ml</u>	<u>30</u>	<u>0</u>

Doctor Signature: [Signature]  
 Date: 11/14/11

NARCOTIC DISPENSING FORM

APPENDIX A - FORM NO. 3E

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

Registration No.: 11111  
 Patient Name: Michael James Smith  
 Date: 11/14/11  
 Doctor: Dr. [Signature]  
 Dispensing Details:

Name of the Essential Narcotic Drug	Quantity	Signature of the Patient	Signature of the Parent/Guardian
<u>Hydrocodone</u>	<u>30</u>	<u>[Signature]</u>	<u>[Signature]</u>

Date: 11/14/11  
 Doctor Signature: [Signature]

26-0000

**NARCOTIC PRESCRIPTION FORM  
(MEDICAL RECORD)**

Patient Name: <u>Master Mayank Rajhotaipur</u>	Age: <u>4y</u>	Gender: <u>Male</u>	
UHID No: <u>UHID-00005829</u>	IP No:	Date: <u>26/6/26</u> Time:	
Diagnosis: <u>Adenotonsillectomy (Word-OT)</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100 mcg</u>	<u>01 Amp</u>
2.	Morphine Sulphate Inj. 15mg/ML	<u>—</u>	<u>—</u>
3.	Remifentanyl Hydrochloride Inj. 2MG	<u>—</u>	<u>—</u>
4.	Remifentanyl Hydrochloride inj. 1MG	<u>—</u>	<u>—</u>
Doctor Name: <u>Dr. Arvind</u>		Doctor Registration No: <u>67929</u>	
Signature: <u>[Signature]</u>			

**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: <u>Master Mayank Rajhotaipur</u>	Remarks		
2.	Complete postal address (with contact number, if any)			
3.	Brief description of the illness	<u>Adenotonsillectomy</u>		
4.	Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded)	<u>No</u>		
5.	Details of essential Narcotic drug dispensed	<u>Fentanyl</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>26/6</u>	<u>INJ: Fentanyl</u>	<u>01</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): Sana (019442) Signature: [Signature]  
Received by (Name & ID No.): M Arvind Kumar (021257) Signature: [Signature]  
Time: .....



# PATIENT TRANSFER FORM



Patient Name & UHID No.  HNH-00005829      IP26-00006653 Master MAYANK RAGHOTAMPURAM 23-09-2021      4 Y 9 M 3 D      (M) Dr. ALLU CHANDANA 		Date & Time of Admission  26/6/26	Date & Time of Transfer Order  26/6/26 @ 7:30am
		Transfer Ordered by  Dr. Susant.	Reason for Transfer  Admission
From Unit  ER	To Unit  OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File  18	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring  Ampan.		Name of Person Ordered Transfer  Dr. Susant.	
Patient & Clinical Records Received by :  Sangeeta.			
Date & Time of Patient Received : 26/6/26 @ 7:30 Am			

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

- Unavailable Bed                     
  Nurse not Available                     
  Available Bed not ready



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : ..... Age : ..... Gender:  Male  Female  
 Date : 26/ Time of Arrival : 6:45 AM  
 Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify): .....  Not known  
 Source of Information :  Parents  Others (Specify) .....  
 Mode of Arrival :  Ambulatory  Wheelchair  Ambulance  
 Initial Vital Signs: Temp: 97.9 PR: 123 BP: 100/67 RR: ..... SpO<sub>2</sub>: 99  
 Chief Complaints: No came from of tonic remedy

<b>INITIAL PHYSIOLOGICAL CATEGORIZATION</b> Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<b>INITIAL PHYSIOLOGICAL STATUS</b> <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening
--	--	---	--

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 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:**

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- 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

- 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: .....
- 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 : Amupam Signature of Triage Nurse : A.R  
 Date & Time : 26/6/26 @ 6:45 AM  
 Docu. No. : RCH / FRM / CLINICAL / 085

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



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 26/6/26 Time of arrival: 6:45 AM

Chief Complaints: CB came for st. toni calomy. 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 forearm  Frequency \_\_\_\_\_  Duration \_\_\_\_\_

<p><b>RISK FOR FALL:</b></p> <p><input type="checkbox"/> If patient is &lt; 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is &gt; 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>• Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>• Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Escort while ambulating</li> <li><input type="checkbox"/> Assist Patient</li> <li><input type="checkbox"/> Educate patient and family on fall precautions/prevention</li> </ul>	<p><b>Functional Screening:</b> <input type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mobility Problem <input checked="" type="checkbox"/></li> <li><input type="checkbox"/> Walking Problem</li> <li><input type="checkbox"/> Developmental Delay</li> <li><input type="checkbox"/> Musculoskeletal Congenital Abnormality</li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p>.....</p> <p>.....</p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Underweight</li> <li><input type="checkbox"/> Overweight</li> <li><input type="checkbox"/> Feeding Problem</li> <li><input type="checkbox"/> Special diet</li> <li><input type="checkbox"/> Special feeding method</li> </ul> <p><b>Inform consultant for positive criteria</b></p>
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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: 6:45 AM

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

Time	Nursing Notes
	Assessed the patient condition vitals checked.

Samples collected by:

Samples sent by:

*malayer*

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: <i>123</i> ..... BP: <i>100/60</i> ..... CFT: ..... RR: <i>20</i> ..... SPO <sub>2</sub> : <i>99</i> ..... GCS: <i>-</i> ..... Temperature: <i>98</i> ..... Pain Score: <i>0.2</i> ..... Repeat RBS (if applicable): .....	Shift - out from ER to: <i>OT</i> ..... Time of Shift - out: ..... Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

Name of the Nurse : *AmfAm* .....

Signature of the Nurse : *AD* .....

Date & Time : *26/6/20 @ 5:45 AM* .....

### POST OPERATIVE - DOCTORS HANDOVER FORM

OT to  PICU  NICU  MICU  WARD

Date: 26/6/26 Time: 9:52am

Name of the Surgery: DDENOTONSILECTOMY & 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 @ 130ml/h

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 & Adrenaline 1ml + 4ml (NS) given (1:100)

On arrival to PICU / NICU / MICU / WARD:

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

Peripheries: Warm SpO<sub>2</sub>: 100% & 4L O<sub>2</sub>/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: 9:52am

Handover given by:

Handover taken by:

Anesthesiologist's Name: Dr. Ayesha

Doctor's Name: .....

Signature: [Signature]

Signature: .....

Date & Time: 26/6/26, 10:05am

Date & Time: .....

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Your Right to a Safe Delivery

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

## OPERATION THEATER NOTES

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

Patient's

UHID.: ...



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

Surgeon : <u>Dr Chandana</u>	Asst. Surgeon :
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Anesthetist :	OT Nurse :
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Surgical Procedure :	<u>COBLATION ADENOTONSILLECTOMY</u>
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Indications for Surgery :	<u>Chronic Adenotonsillitis</u>
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Date : <u>26/6/26</u>	Start Time : <u>8Am</u>	End Time : <u>9:20Am</u>
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PRE-OPERATIVE PREPARATION :

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OPERATION NOTES:

LGA pt in Rosie's position  
Boyle Davis mouth gag applied.  
B/L Tonsillectomy done with coblation.  
Endoscopic guidance adenoidectomy done  
hemostasis secured. procedure  
uneventful.

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POST - OPERATIVE ORDERS :

- NPO until fully awake
- Inj. AUGMENTIN - 340mg /iv/ Q8H
- Inj. PCM - 200mg /iv/ Q6H
- Inj. PAN 20mg /iv/ qm/od
- Inj. DEXA - 1.5mg /iv/ 7pm/ 7am (2 doses)

- Syp. RELENT - plus  
3ml \_\_\_\_\_ 3ml

D/S med

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

OTRIVIN - p N/D  
2° \_\_\_\_\_ 2°  
SOLSPRE N/S  
↑↑ | ↑↑  
- BETADINE gargles Q6H

Dr. Chandana

Consultant Surgeon's Name

Consultant Surgeon's Signature

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

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Allu Chandana  
 Asst. Surgeon : .....  
 Anaesthetist : Dr. Samir  
 Scrub Nurse : Sr. Sangeetha

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



Age : 4yrs Gender : Male  
 Primary Name : .....  
 Date : 26/6/26 In-time : 8am Out-time : 9:20am



Sr. Archana  
Sr. puja

## Before Induction of Anaesthesia >>

SIGN IN	Time: <u>8:00am</u>
<b>Patient Has Confirmed</b>	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Site Marked</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
<b>Anaesthesia Safety Check Completed</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pulse Oximeter on Patient &amp; Functioning</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Patient have a:</b>	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Difficult Airway / Aspiration Risk?</b>	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b>	
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Anjee</u>	

## Before Skin Incision >>



TIME OUT	Time: <u>7:55am</u>
<b>Confirm all team members have introduced themselves by Name and Role</b>	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anticipated Critical Events</b>	
<b>Surgeon Reviews:</b>	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Anaesthesia Team Reviews:</b>	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>Nursing Team Reviews:</b>	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Is Essential Imaging Displayed?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Puja</u>	

## Before Patient Leaves Operating Room

SIGN OUT	Time: <u>9:20am</u>
<b>Nurse Verbally Confirms with the Team:</b>	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
<b>To Surgeon, Anaesthetist and Nurse:</b>	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Chandana</u>	

# PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00005829 IP26-00006653 Master MAYANK RAGHOTAMPURAM 23-09-2021 4 Y 9 M 3 D (M) Dr. ALLU CHANDANA 		Date & Time of Admission 26/6/20 @ 6:49 AM	Date & Time of Transfer Order 26/6/20 @ 9:45 AM
		Transfer Ordered by Dr. Samir	Reason for Transfer observation
From Unit OT	To Unit PICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	PI	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Samir	
Patient & Clinical Records Received by : Junam			
Date & Time of Patient Received : 26/6/20 @			

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



Patient Name: Mast Mayank Raghulapuram Age: 4y Gender: Male  Female

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

Anaesthesiologist: Dr. Samir / 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 and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

**Specific High Risk (s) :** The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease
- Hypertension
- Diabetes mellitus
- Renal failure
- Hepatic disorders
- Shock
- Multiple organ failure
- Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others: Dr 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 : R. Abhishek

Name : R. ABHISHEK

Relationship with Patient : FATHER

Date & Time : 26/06/26

**Witness :** Madhura

Signature : .....

Name : MADHURA PATIL

Date & Time : 26/06/26

**Doctor (who is taking the consent) :**

Signature : Dr. Sanjay Chavhan

Name : Dr. Sanjay Chavhan

Date & Time : 26/6 at 7:30am.

IN



# FOR SURGERY OR

# SPECIAL PROCEDURE



Patient Name : MAYANK RAGHOTAMPURAM Gender:  Male  Female Age : 4 yrs 9 months  
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 LGA  
.....  
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 : [Signature]  
Name : L. ABHISHEK  
Relationship with Patient: FATHER  
Date & Time : 26/06/26

**Witness :**

Signature : [Signature]  
Name : Madhura Patel  
Date & Time : 26/06/2026 7:30

**Doctor (who is taking the consent) :**

Signature : [Signature]  
Name : Dr. CHANDANA  
Date & Time : 26/6/26 7:45am

Patient Sticker



# 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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

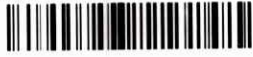
Doctor Name & Signature : Dr. Susant .....

Date & Time : 26/6/26 @ 6:00 AM .....

Nurse Name & Signature : Amfarn .....

Date & Time : 26/6/26 @ 7:00 AM .....

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



310 → 305

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 26/6/26 Time: 2:30 pm

Weight: 13.46 Kg Centile: 43

Height: Centile:

Inference: Underweight child

RDA: Calories: 1350 Kcal/day Protein: 23 g/day

Diet Recommendations: Soft diet with liquids

Re-Assessment: NO Junk, Oily food

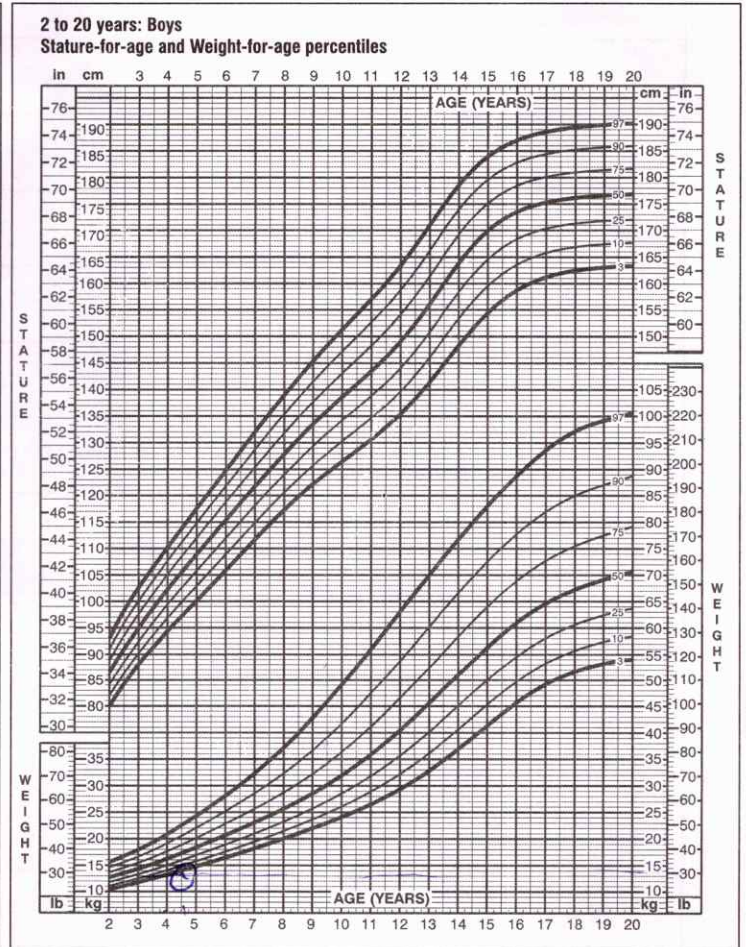
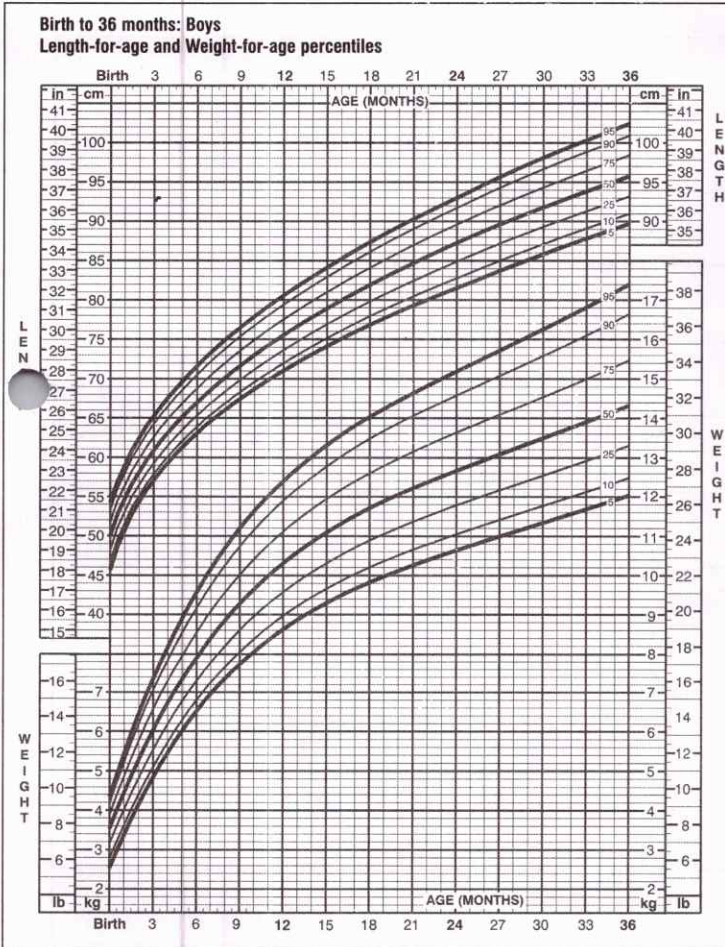
Food Allergies: NO Veg/Non-veg Veg

Diagnosis: Adenofenitis

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Malhas

## GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya

