011466 IP26-00006640
YUVANSH ASTHANA
2025 0 Y 9 M 24 D (M)
YOTI BOTHRA

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 25-06-2026

Patient Name: Master- yuvansh Date of Birth: 1-9-2025 Age: 9months

Gender: Male Ward : OT UHID No.: HNH-0001466

Date of Surgery: 25-06-26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : (L) Orchiopexy

Time in : 10 Am Time Out : 11 Am

		NAME	AMOUNT
1.	Surgeon	Dr. Jyothi	
2.	Anaesthetist	Dr. Samir	
3.	Assistant Surgeon		
4.	OT Technician	Sr. Pallavi	
5.	Circulating Nurse	Sr. Puja	
6.	Assistant Nurse	Sr. Archana	

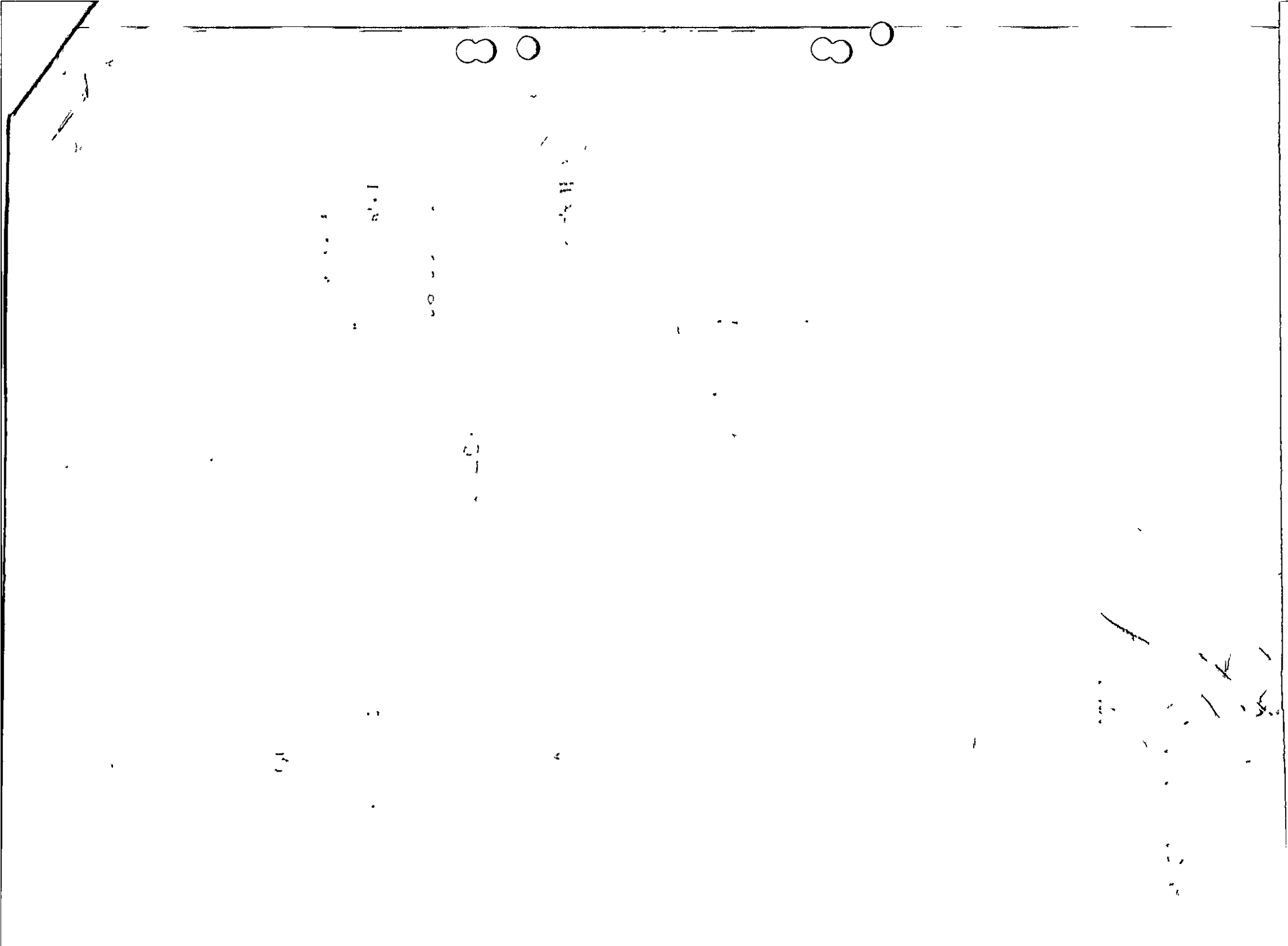
Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-0000208120 Order by: Archana 25/6/26 11:39 Am

Docu. No. : RCH /FRM / GENERAL / 114



HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

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CONSUMABLES OF OT

Circulating staff : Puja Technician : A. Saraswathi Date : 25-06-2026 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack General		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03	9915, 2437	4	4	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		01				Vaccum Suction Set		
05 cc			Gloves Encore 6½ 6	4	02	Surgical Gloves		
02 cc		01				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 15no		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
Dextrose 5%		01	Ointments					
O2 mask [P]		01	Suction Catheter					
Fentanyl		01	Cap, Mask	50	50			
Morphine			Gauze Pack ~~05~~		02			
Ketamine			Mop Pack		01			
Propofol		02	Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron vgen			Foleys catheter					
Pencan 25g/ ~~Spinal~~ Needle 22		01	Urobag					
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm 8582		1			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield		01			
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002081 04 Ordered by : Sudha G 25/6/26 @ 10:50 Am.

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

RAINBOW CHILDREN'S MEDICARE LIMITED

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

VAT TIN : CIN :

DL NO :

Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP26-00006640	**Ward**	4F -OT
Patient Name	Master YUVANSH ASTHANA	**Bed Name**	PDA-412
Age/Sex	0 Y 9 M 24 D / Male	**Order No**	26-0000208104
Date	25/06/2026 10:49	**Prescription No**	PRIP26-0090173
Payor	BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.	**Dispensed Date**	25/06/2026 10:51
UHID	HNH-00011466		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DEXTROSE IV 5% 500 ML BOTTLE	OTSUKA PHARMACEUTICAL INDIA PVT LT	H	1A250171	12/27	1	86.38	86.381
2	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26B20K65	01/31	1	28.13	28 13
3	DSYRINGS 2 5ML(NIPRO)	NIPRO	GENERAL	26A05K04	12/30	2	11.25	22.50
4	E C G ELECTRODES (PAED)	Adilase	GENERAL	71603Z6	02/28	3	34.64	103.92
5	Encore Microptic gloves-6 5		H	2510073405	10/28	2	117 00	234 00
6	ENCORE MICROPTIC GLOVES-6 PF	ELITE MEDICALS	GENERAL	260300911T	03/29	1	128.00	128.00
7	GENERAL SURGICAL KIT (MEDITAKE)		H	0705026	05/29	1	1,950.00	1,950.00
8	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353002	07/27	2	69.10	138.20
9	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1L255946	11/28	1	93.94	93.94
10	Oxygen Mask With Tubing - PeadROMSONS-FC		GENERAL	G26B040154	01/31	1	460.00	460.00
11	PREGELLED SURGICAL PLATES PEAD (ADVANCE)	The Advanced cadiomed	GENERAL	2502272401	02/28	1	1,050.00	1,050.00
12	SPINAL NEEDLE PED 22 G (VYGON-5183 57)	VYGON		1O0424AG	04/29	1	275 62	275 625
13	SURGICAL BLADE 15	Surgeon	GENERAL	090823	07/28	1	6.66	6.656
14	TEGADERM WITH PAD 5X7CMS (3582)(8582)	3M HEALTHCARE	GENERAL	R3260919	02/29	1	192.00	192.00
15	UNDER PAD 60X90 10's Pack - MEDICUBE		GENERAL	06260501	04/29	1	146.20	146.20
16	VICRYL 3-0 VP 2437	ETHICON SUTURES-J&J	C1	T502I	02/30	1	708.00	708.00
17	VICRYL RAPIDE 5-0 9915W	ETHICON SUTURES-J&J	C1	AW6249	04/30	1	885.00	885.00
						Total :	**6,241.92**	**6,508.55**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GUVVALA VIJAYA SUSHEELA

209
FC

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DISCHARGE SUMMARY

Name	Master YUVANSH ASTHANA	**UHID**	HNH-00011466
Father/Guardian	Mr AKASH ASTHANA	**Age/Gender**	0 Y 9 M 24 D/ Male
Address	Manikonda, Hyderabad, Telangana, INDIA, 500089		
IP No	IP26-00006640	**Admission Date**	25-06-2026
Ref Doctor	Self.		
Discharge Date	26.06.2026		

Consultant:
Dr. JYOTI BOTHRA
DNB, MCh (Pediatric Surgery), FMAS
SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY
TSMC/FMR/02962

DIAGNOSIS	ICD CODE
LEFT PALPABLE UNDESCENDED TESTES	

Procedure : LEFT ORCHIOPEXY DONE ON 25.06.2026

History: Master YUVANSH ASTHANA, 0 Y 9 M 24 D child presented with history of left undescended testes came for surgical conclusion prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for

Name	Master YUVANSH ASTHANA	UHID	HNH-00011466
IP No	IP26-00006640	Admission Date	25-06-2026

surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 120/min and Respiratory rate - 28 /min. On examination full felt in mid inguinal region. 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: 8.3 kilo grams.

Investigations: Enclosed reports.

Procedure : LEFT ORCHIOPEXY DONE ON 25.06.2026

Surgery Notes:
* Left mid-inguinal lower crease incision
* EOA opened
* Testes found and dissected for adequate length.
* A Tunnel created into left hemiscrotum with subdartos pouch.
* Testes fixed in left hemiscrotum.
* Incision closed in layers.

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

Advice:
* Diet as advised.
* Remove dressing at home on Monday

Name	Master YUVANSH ASTHANA	**UHID**	HNH-00011466
IP No	IP26-00006640	**Admission Date**	25-06-2026

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2 ml, twice a day for 2 days and SOS.

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. JYOTI BOTHRA after 2 weeks in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:

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

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

Name	Master YUVANSH ASTHANA	**UHID**	HNH-00011466
IP No	IP26-00006640	**Admission Date**	25-06-2026

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

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Dr. JYOTI BOTHRA
DNB, MCh (Pediatric Surgery), FMAS
SENIOR CONSULTANT PEDIATRIC SURGERY & UROLOGY
TSMC/FMR/02962

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ACTIVITY RECORD FOR BILLING

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

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

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
25/6/26	8:40 Am	ER	OT	A.P / Pujea.
25/6/26	1 Pm	OT	ward 2nd floor.	Puja / Durga

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
25/6/26	CBP	0312	
	PAC (OP Basic done.)		
		cross checked done by Amruta	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/6/26	IV cannula.	1	8065	
		cross checked done by Anjuthi.		
25/6/26 (2:23pm)	NTA	(1)	8165	
		Cross checked done by Sruthi		

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-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o (lt) undescended testis.
came for surgical correction.

History of present illness :

- Child. presented with h/o left undescended testis which is palpable came for surgery.
- No h/o fever, cough, cold.
- No h/o loosestools, vomitings.
- No h/o. Bowel Bladder abnormalities.

Pediatric Multiorgan History & Physical Examination

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

Not significant

Birth & Neonatal History :

NVD / Term / 3.1kg (B. wt) / CIAB

No NICU admission.

Birth & Socio Economic History :

About Father :

About Mother : Not significant.

Any additional Information :

Developmental History :

Appropriate.

Immunization History :

Upto date.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 8.3 kg. (Centile _____)

On Examination :

Temperature : Afebrile. Pulse Rate: 120 Description _____

B.P. 91/62 mm Hg. SPO2 98% RA at _____

Resp. rate and type of breathing : (N).

Rash – C/E Tubis- left in Mid Inguinal region.

Lymphadenopathy –

Oedema : –

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+) NVBS (+).

Any addes sounds : No.

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : No murmur.

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

Per Abdomen :

Inspection _____

Palpation : Soft, Not distended

Ausculation : No organomyaly.

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : N Power N

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars N

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic :

(Rt) palpable undescended testis.

cam for (B) open Orchiodopexy.

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

- CBP

PAC consent } done.

Planned Management :

Plan

- (L) open orchiopexy.
- IV cannulation.
- Inj Iside 2u m/th (SOS) (2/5)
- NPO from 6AM (No milk). 8AM (water)
- Inj om (SOS).

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 Dr Jyoti Bothra Date 26/6/26 Time 3 pm

Dr. JYOTI BOTHRA Reg. No: 0_762

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 2pm	S/B Dr. Archana . Case of S/P left orchiopexy . on Room Air Dressing on left side (P) vitally stable SE P/A - soft .	Adv . - NBM broken - Crocin drops 1.2 ml (100 mg/ml) TDS for the next 2 days ↓ SOS thereafter . - Watch for dressing soakage - Discharge.

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
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DRUG CHART

Date of Admission: 25/4/26 Drug Allergies: Nill ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : SUROCIN (100 mg/ml)				Date → Time
Dose: 1.2ml	Route: oral	Frequency: SOS	Start Date: 25/6/26	
Doctor's Signature: Dr. Mehar	Valid Period	Pharm.		
Additional Instructions:				

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

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

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

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

REGULAR PRESCRIPTIONS

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

DRUG : CROCIN drops

Dose	Route	Frequency	Start Date
1.2 ml	oral	TID	25/6/26

Name & Signature of the Doctor Starting the Drugs:
Dr. Archana

Additional Instructions:
(100 mg/ml)

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient ' ticker

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

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

I.V. FLUIDS CHART

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

Date	Time	tion 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
25/6/26	10.00	RINGER LACTATE	IV	50 ml/hr					
25/6/26	1 pm	"	IV	↓ Stop			25/6/26		

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MEDICATION RECONCILIATION FORM

Drug Allergies: NO ☐ 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. Anushka.

Date & Time : 25/6/26 @ 8:20 Am

Nurse Name & Signature: Anupam

Date & Time : 25/6/26 @ @ 8:20 Am.

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

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OPERATION THEATER NOTES

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

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

UHID.: ..... o. :.....Weight : .....

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure :
(1) Orchiopexy

Indications for Surgery :
(1) palpable UDT

Date : 25/6/26	Start Time : 10Am	End Time : 11Am

PRE-OPERATIVE PREPARATION :
- NBM

OPERATION NOTES:
- left mid-inguinal lower crease incision
- EOA opened
- Testes found & dissected for adequate length
- & funnel created into left hemiscrotum with subdartos pouch
- Testes fixed in left hemiscrotum
- Incision closed in layers.

POST - OPERATIVE ORDERS :

- NO N/BM

- TPR

I/o chart.

On RLC.

- Tab CROCIN OS ~~3rd~~ 2nd twice a day x 2 days then SOS

- Remove dressing @ home on Monday

- FU after 2 weeks

Dr Jyoti Bothra

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 25/6/26 Time : 11 AM

SURGICAL SAFETY CHECKLIST

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

Patient Name : HNH-00011466 IP2 006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA
UHID No. :
Date : 25/6/26

... Gender : Male
:
11Am
10Am

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 1000Am

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

L. side

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 : Dr Samir
Name : Dr Samir

Before Skin Incision ➤ ➤

TIME OUT Time: 10:18am

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, 20 min Anticipated Blood Loss? 5 ml NO ☑ 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 : Natasha @ 10:18am
Name : Natasha.

Before Patient Leaves Operating Room

SIGN OUT Time: 11Am

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 :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00011466 IP26-00006640 Master YUVANSH ASTHANA 01-09-2025 0 Y 9 M 24 D (M) Dr. JYOTI BOTHRA	25/6/26 @ 8:03Am	25/6/26 @ 11Am
	Transfer Ordered by Dr. samir	Reason for Transfer Observation
From Unit OT	To Unit pre-post	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.	Rh	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
Sis. puja	Dr. samir.

Patient & Clinical Records Received by : Divya 25/6/26

Date & Time of Patient Received :

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

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Yuvansh Asthana Gender: ☑ Male ☐ Female Age : 9 1/2 mth

UHID No : 6640 Date : 25/6/26

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)

Left Open Orchiopexy

upon (Name of the Patient) Yuvansh

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.

Infection

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: Dr Jyoti Bothra

Consentee :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature :

Name : AAKASH ASTHANA

Relationship with Patient: FATHER

Date & Time :

Witness :

Signature :

Name : Asmita Srivastava

Date & Time : 25/6/26

Doctor (who is taking the consent) :

Signature :

Name : Dr Jyoti Bothra

Date & Time : 25/6/26, 10AM

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Yuvansh Asthana Age : 8 M Gender : Male ☑ Female ☐

UHID NO: KR HNH-0001146 6 Surgeon Name: Dr. Jyothi

Anaesthesiologist : Dr. Samir.

Operative procedure planned : (R) (L) open orchiopexy.

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 : laryngospasm, bronchospasm

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 Yuvansh Asthana the above mentioned operation / Diagnostic / Therapeutic procedures (L) open orchiopexy.

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 : Smitha

Name : Asmitha Srivastava

Relationship with Patient: Mother

Date & Time : 22/6/26 12:20 pm

Witness :

Signature : Akash

Name : Akash Asthana

Date & Time : 22/6/26 12:21 pm

Doctor (who is taking the consent) :

Signature : Dr Akhila K

Name : Dr. Akhila. K.

Date & Time : 22/6/26 12:01 pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Yuvansh Abhang Age: 8m. Sex: M UHID.No : HNH-0001114666.

Date: 22/6/26 Time: 12:00pm. Proposed Operation: (L) open orchiopexy.

Diagnosis: (R) palpable UDT.

B.P / CRT: <3sec H.R: 122 Weight: 8.3kgs 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: - Nil -

Medical History: CVS : Nil - NVD | 3.1kgs | CIAB | No NICU admission

RESP : H/O cold 1wk back. Diabetes : Developmental appropriate

CNS : Immunised till date.

Renal :

Hepatic / GE : Nil - Physical Activity: active

Others :

Past Anaesthetic History: Nil -

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : BAE (+) Clr.

Heart: S1S2 (+)

CNS: alert.

Pregnant: ☐ Yes ☐ No ☑ NA | Venous Access Site : accessible | Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis : ✓
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   → CBC on cannulation -

4:00AM.
↑
* 6:00AM → Breast feed
↑
8:00AM → water
↑
25/6/26 10:00AM - 5%

Signature: Name: Dr. Akhil

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

Patient Sticker

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: 126	B.P / CRT: <3sec	SpO_2: 100	R.R: 28	Last Feed: >6h

Pre-OP Diagnosis: UDT Operation: open (L) orchiopexy Date: 25/6/25

Surgeon: Dr. Jyothi Anaesthesiologist: Dr. Sanil / Dr. Shalu Technician: Soranam Pallavi

TIME 10 11

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

Inj. MIDAZ 0.8 mg

Inj. FENTANYL 15+5 mcg

Inj PROPOFOL 20+10+10+10

Antibiotic

Suppository

Blood Loss

FIO_2 / SaO_2 100 100 100

$ETCO_2$

ECG SR SR SR

Temperature

Urine Output

NOTES

Fluids

Blood

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional
☒ BP
☐ Cuff Site: .....
☐ Art Site: .....
☒ EKG Lead
☒ Temp Site skin
☐ FIO_2 Monitor
☐ Agent Monitor
☒ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: supine
☐ Pressure Points Checked

Eye Care:
☐ Oint
☒ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 10 am
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia: 11 am
☐ GA
☒ Monitored Anaesthesia Care
☒ Regional

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

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

☐ Mask ☐ SGA O_2 via mask @ 4L/h
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

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

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

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

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

Name of the Doctor : Dr. Shalu
Signature of the Doctor : .....

Patient Sticker

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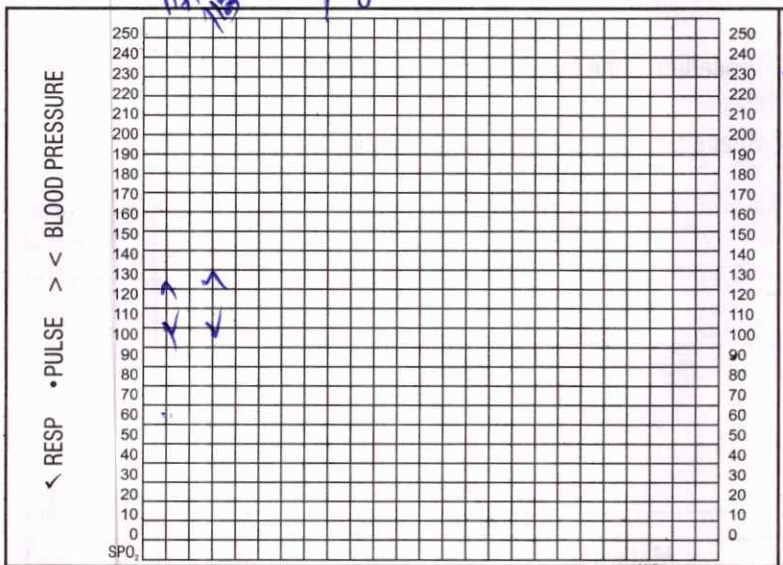
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : 11Am 1130am Priya. Time Received : 11Am. Time Discharged : .....



IV Cannula Site : Right

- ☑ 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: RL
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		0	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		8	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/6/21		0.	no pain.	

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: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00011466 IP26-00006640 Master YUVANSH ASTHANA 01-09-2025 0 Y 9 M 24 D (M) Dr. JYOTI BOTHRA	25/6/26 @ 8:13 Am	25/6/26 @ 8:30 am
	Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 21	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
Bhanvi	Dr. Anusha.

Patient & Clinical Records Received by : Puja

Date & Time of Patient Received : 25/6/26 @ 9:10am.

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-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

wt - 8.33 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Yuvansh Asthana. Age : 9m. **Gender:** ☑ Male ☐ Female

Date : 25/6/26 Time of Arrival : 7:55 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: 97.7 PR: 120 BP: 91/62 RR: ..... SpO_2: 99%

Chief Complaints: came for OT undescended Suganis

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 : 7:57 Am

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Anupam

Signature of Triage Nurse : A.P

Date & Time : 25/6/26

HNH-00011466 IP26-00006640
Master YUVANSH ASTHANA
01-09-2025 0 Y 9 M 24 D (M)
Dr. JYOTI BOTHRA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/26 Time of arrival : 7:59 Am

Chief Complaints: C/O came down ~~on~~ ot undescended Scrotum RBS: .....

Height : ..... Weight : 8.33 Kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: ..... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☐ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 8:00 Am

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

Time	Nursing Notes
	Assessed The paliend condition
	vital checked.
	IV canula done.

Samples collected by: / Time:

Samples sent by : / visaya. Time: / 8:10 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: 92 ~~88~~/62 CFT:	Shift - out from ER to: OT
RR: ..... SPO_2 : 99	Time of Shift - out: .....
GCS: ..... Temperature : 98.2	Handover given to: .....
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement Done

Name of the Nurse : Amy Ann Signature of the Nurse : A.P

Date & Time : ~~25/6/26~~ 25/6/26 @ 8:00 Am

HNH-00011466
Master YUVANSH ASTHANA
01-09-2025 IP26-00006640
Dr. JYOTI BOTHRA 0 Y 9 M 24 D (M)

209

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 25/6/26 Time: 2:23pm

Weight: 8.3 Kg Centile: 10th

Height: — Centile: —

Inference: Underweight child.

RDA: — Calories: 98 kcal/kg/d Protein: 1.6 gms/kg/d

Diet Recommendations: DBM foods

Re-Assesment: Stage (2) weaning foods & HEE advised

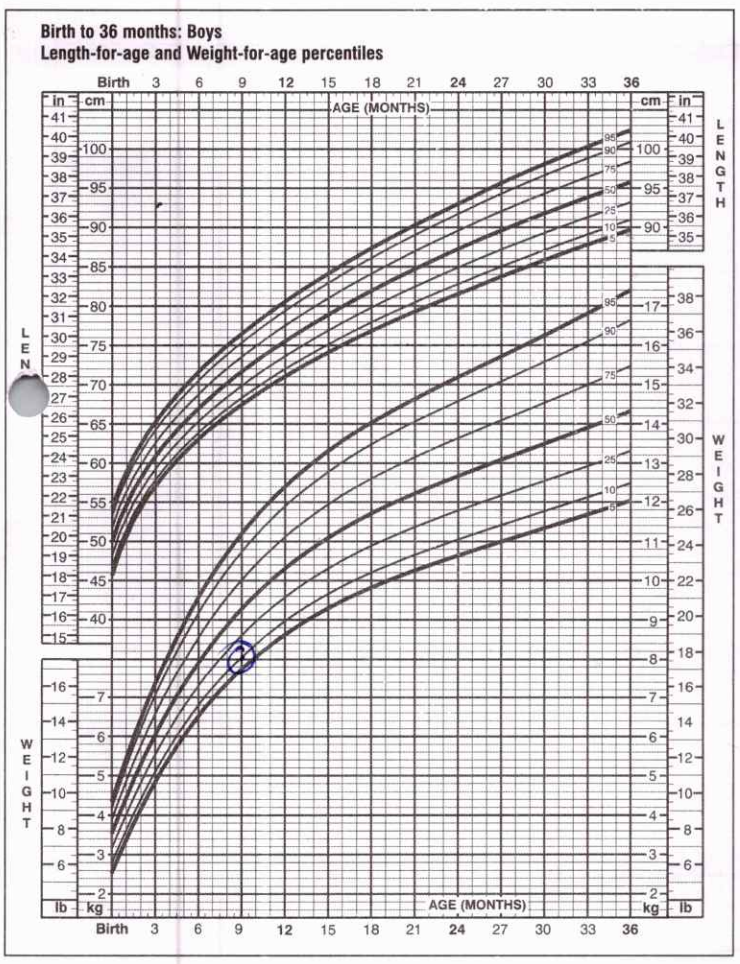
Food Allergies: NO Veg/Non-veg Veg.

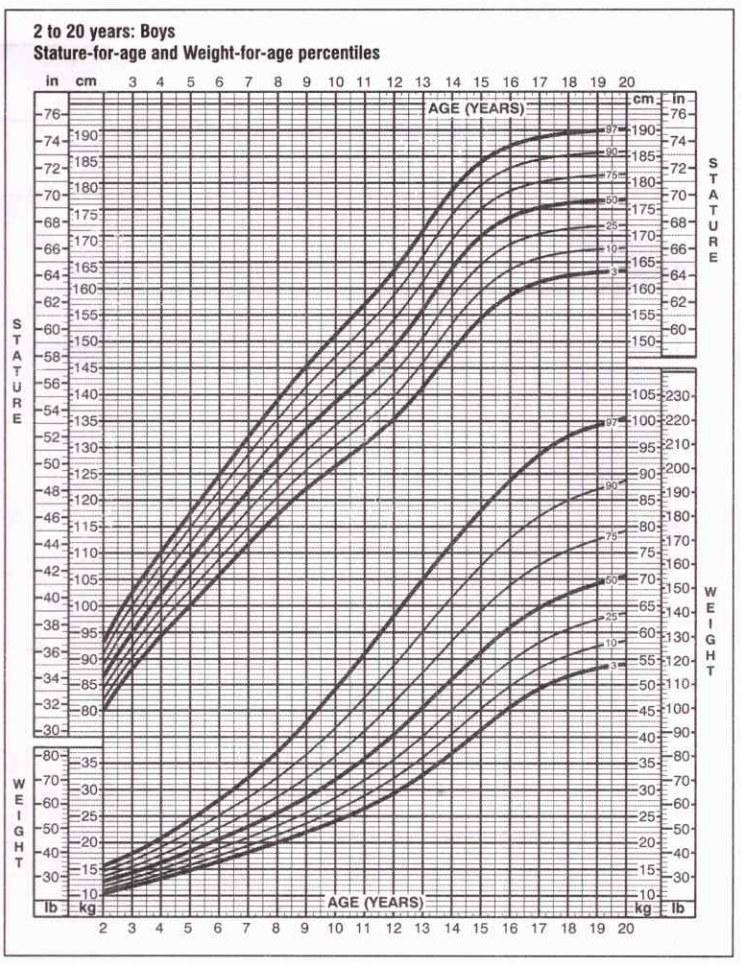
Diagnosis: Left open orchidopexy

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Sathwika-G Dietician's Signature

Docu. No. : RCH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes:

#26-0000208077

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	Master Yuvansh Asthana	Age:	0Y9M24D	Gender:	Male
UHID No:	HIDH-0001146	IP No:	26-0000664	Date:	25/6/26 Time: 8.51AM
Diagnosis:	Orchiopexy open Bilateral				OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Aamir

Doctor Registration No: 67729.

Signature:

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

IP Registration No: 26-00006640 Date: 25/6/26

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

1.	Name : Master Yuvansh Asthana	Remarks
2.	Complete postal address (with contact number, if any) Manikonda Hyderabad.	
3.	Brief description of the illness	
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
25/6/26	Fentanyl	01		

Dispensed by (Name & ID No.): Same (011442) Signature: Same

Received by (Name & ID No.): U Pallavi 017921 Signature: U. Pallavi

Time: .....