

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00204321 IP-00060370

Master CH MOURYA

09-05-2023 3 Y 1 M 12 D (M)

Dr. JYOTI BOTHRA



Patient Name

Ward:

IP.No:

DOA:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	-	-	
2	Discharge Summary	3	-	-	
3	Nursing Initial assessment form	2	-	-	
4	Patient Trasfer Forms	1	-	-	
5	In-patient Medical Record	3	-	-	
6	Doctors Progress Sheets	7	-	-	
7	Nurses Progress notes	5	-	-	
8	Consultation Sheets				
9	General Consent for Treatment	1	-	-	
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form	1	-	-	
20	Anaesthesia notes(Pre Anaesthesia & Post)	2	-	-	
21	Pre Operative checklist	1	-	-	
22	Surgical safety Checklist	1	-	-	
23	Operation Theatre notes	1	-	-	
24	Nurses Clinical Presentation				
25	TPR & BP chart	6	-	-	
26	Intake and Output chart (fluid Chart)	3	-	-	
	Drug Chart (Regular prescription)	4	-	-	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	1	-	-	
33	MLC form (in case of MLC)				
34	Patient Educatlon Form				
	Numpy - dumpy	3	-	-	
	Thrombophlebitis	2	-	-	
	Pain Assessment	2	-	-	
	Bearden Stone	1	-	-	
	Others	9	-	-	
	Total No. of Pages	61			

Noted by
Beevankar
20/6
@ 2pm

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060370

Admit Date : 17-Jun-2026

Admit Time : 08:03 AM UHID : VIH-00204321

Patient Details :

Patient Name : Master CH MOURYA

Age : 3 Y

Guardian : Mr CH SRINIVAS

DOB : 01-05-2023

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : jyothi nagar Karimnagar Hyderabad
Telangana INDIA 505001

Phone No : 9704776443/

E-mail : na@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr CH SRINIVAS

Relationship : S/O

Contact Address : jyothi nagar Karimnagar Hyderabad Telangana
INDIA 505001

Phone No : 9704776443 / 9100393085

Ch. Srinivas
Signature

Doctor Details :

Doctor Name : Dr. JYOTI BOTHRA

Specialisation : PEDIATRIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

PATIENT TRANSFER FORM



VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA



Date & Time of Admission 17/6/26 8:03 AM		Date & Time of Transfer Order 17/6/26 10:50 AM
Treating Consultant name	Transfer Ordered by Dr. Prashanti	Reason for Transfer Admission
From Unit ER	To Unit OP	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 21	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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring Dr. Prashanti	Name of Person Ordered Transfer Dr. Prashanti
---	--

Patient & Clinical Records Received by :

Date & Time of Patient Received : 17/6/26 @ 10:20 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

Patient Name : Mast. CH MOURYA UHID : VIH-00204321 IPD : IP-00060370 Gender : Male Age : 3 Y 1 M 8 D

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA

Rainbow Children's Hospital
 BirthRight BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery
 wt: -13.2kg
 Ht: -96cm

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. Mourya Age : 3y Gender : Male Female

Date : 17/6/26 Time of Arrival : 7:53AM

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: 97.3°F PR: 116b/m BP: 99/70 RR: 24b/m SpO₂: 98%

Chief Complaints: posted for laproscopic ses open @ wireless Rehabilitation

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <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		INITIAL PHYSIOLOGICAL STATUS <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.

M. Navga
 Signature of Parent / Guardian
 Triage Completion Time : 7:58AM

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 : Samuel

Signature of Triage Nurse : [Signature]

Date & Time : 17/6/26 @ 7:58AM

Patient Name : Mast. CH MOURYA UHID : VIH-00204321 IPD : IP-00060370 Gender : Male Age : 3 Y 1 M 8 D

VIH-00204321 IP-00060370
Master CH MOURYA
09-05-2023 3 Y 1 M 8 D (M)
Dr. JYOTI BOTHRA



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/6/26 Time of arrival : 7:58 AM
Chief Complaints: Posted for laproscopic sos open @ ureteric reimplantation RBS: _____
Height : 96cm Weight : 13.2kg BMI : _____ Head Circumference (<2 years) _____
Allergies: Yes No Medications Blood Transfusion Food Other: _____
If yes, identify _____
Pain Screening: Yes No If Yes, Pain Score: D 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 parents

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

Time of Initial assessment completed by ER Nurse : 8:02 AM

Patient Name : Mast. CH MOURYA UHID : VIH-00204321 IPD : IP-00060370 Gender : Male Age : 3 Y 1 M 8 D

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

Time	Nursing Notes
7.53 AM	Pt came to ER.
7.53 AM	Pt vitals checked and Record Done.
7.57 AM	Dr. Prabhanti seen the Pt Advice Admission.
8.10 AM	Pt admission process done.
8.20 AM	Pt IV placement Done and sample sent to Lab.
	Last food taken yesterday 9 PM
	Last water taken morning 6.30 AM
	Pt Shift ER TO OT

Samples collected by:

Sis. Royalaxmi

Time: 8-20 AM

Samples sent by:

Time: 8-25 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8.15 AM	PG Enema	PIR	100ml	[Signature]	SK

Condition of patient at time of shift - out :	Details of Shift - out
HR: 116 bpm BP: 99/70 CFT: 49cc	Shift - out from ER to: OT
RR: 24 bpm SPO ₂ : 98%	Time of Shift - out: 2:10:02 AM
GCS: 15/15 Temperature: 97.3 F	Handover given to: [Signature] - Anil
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable): —	Br - Sabin L

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): IV cannulization Done

Name of the Nurse : Sabin Signature of the Nurse : [Signature]

Date & Time : 12/6/20 @ 10:02 AM

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA



General Admission Assessment Form For Pediatrics

Diagnosis: Left open Ureteric Reimplantation
Arrival Time: 3:36 pm **Mode of Arrival:** by Stretcher **Admitting From:** ER OPD Direct OT
 Age: 13:2 Kn

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA



ACTIVITY RECORD FOR BILLING

Name: Mast. Ch. Mourya
UHID No.: 200321 **IP No.:** 60370 **Consultant:** Dr. Jyothi **Dept.:** 1st Floor
Date of Admission: 17/6/26 **Time:** 8:03 AM **Date of Discharge:** ----- **Time:** -----
Room / Bed No.: 130 **Ward:** MSW **Suggested Billable bed type:** -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6/26	10:02 AM	ER	OT	Sanjay
17/6/26	3:36 PM	OT	Room (130)	He

Cross Consultation Visit

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

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With parents

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

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No Waste Disposal Explained: Yes No

Infusion Pump : Yes No Hand hygiene Explained: Yes No Others

Patient Rights & Responsibilities: Yes No


Information given to parents

Nurse's Name: Sreekanth Date: 17/6/26 Time: 4.10pm

[Signature]
Signature

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	<u>[Signature]</u> <u>22/6</u>		

PATIENT TRANSFER FORM

Patient Name / I.P. No. VIH-00204321 IP-00060370 Master CH MOURYA 09-05-2023 3 Y 1 M 8 D (M) Dr. JYOTI BOTHRA 		Date & Time of Admission 17/6/26 @ 8:03 AM	Date & Time of Transfer Order 17/6/26 @ 3:36 PM
		Transfer ordered by Dr. Madhav	Reason for Transfer Post operative care
From Unit OT	To Unit (130) Room	Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in clinical file (34)	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.			
2.			
3.			
4.			
5.			
Shifting Summary / notes written by Doctor : Dr. Jyoti Bothra			
Name & Signature of Person who is Transferring S. Pradeep		Name of Person Ordered Transfer Dr. Madhav	
Patient & Clinical records received by : Sri. Sreekanth			
Date & Time of Patient Received @ 4 PM 17/6/26			

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

- Unavailable bed Nurse not available Available bed not ready



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00204321 IP-00060370
Master CH MOURYA
09-05-2023 3 Y 1 M 8 D (M)
Dr. JYOTI BOTHRA



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Ch. Mourya. Age/Sex _____
Information given by: mother. Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o (L) vesicoureteric Junction obstruction.
↓
posted for sx.

History of present illness :

child is a k/clo (L) VUTO.
↓
Now posted for sx
laproscopic (sos) open (L) ureteric
reimplantation.

NPO { 12Am - solids
6Am - liquids.

No H/o cold, cough, fever.



Pediatric Multiorgan History & Physical Examination

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

DSK



Normal right kidney.

Left kidney has severely pronounced hydronephrosis, normal cortical transit & moderately prolonged drainage via mildly dilated collecting system & dilated entire ureter - equivocal for obstruction at VUS.

Birth & Neonatal History:

Term / Bwt: 3.5 kgs / UUS / No NICU Admission.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

ly class II

Developmental History :

Development achieved as per Age - In all 4 domains.

Immunization History :

Immunized as per Age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13.745 (Centile _____)

On Examination :

Temperature : 97.3 F Pulse Rate : 116 b/m B.P. 99/70 SPO2 98%

Resp. rate and type of breathing : 24 b/m

Rash _____

Lymphadenopathy yo

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : ⊖

Air entry & breath sounds : B/LA ⊕

Any addes sounds : ⊖

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1 S2 ⊕

Any murmur : ⊖

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection (N)

Palpation : PA - soft

Ausculation : _____

Spine : yo External Genitelia : (N)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert 15/15

Cranial Nerves : (N)

Motor System:

Nutrition : _____

Tone : yo Power (R) (L)
4/5 4/5

Co-ordinator : (N)

Posture : _____

Involuntary Movements : (N)

Reflexes :

DTR +2 (Small 4 limbs) Superficials: tn t
flexors
Plantars _____

Sensory System :

_____ (N)

Bladder / Bowel : (N)

Clinical Summary & Diagnostic:

(L) VUJO
dr
Ported for sy → laproscopic (so) open (L)
Urethra reimplantation.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

✓
CBP ✓
RFT

✓
PAC - Done

Planned Management

- cannulate the child.

- shift to OT on call.

- monitor vitals

- Infor (01).

Noted by
Dr. Sameer
17/6/26
@ 9:15 AM

Signature of the Doctor: _____

Signature of the Consultant: _____

Name of the Doctor: Dr. Pratik

Name of the Consultant: _____

Date & Time: 17/6/26

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/20 4PM	<p>S/P Resident</p> <p>Air - (It) vesico ureteric junction obstruction</p> <p>S/P - left open ureteric reimplantation.</p> <p>O/E</p> <p>child asleep</p> <p>Furtherme</p> <p>Vitals stable</p> <p>CVR - S102 (+)</p> <p>R/S - BAE (+)</p> <p>P/A - RFT</p>	<p>plan</p> <ol style="list-style-type: none"> 1) Pny peptaz 2) Pny Amoxicillin 3) Tab Tropaz 4) YD monitor
	<p>Wet by steel cath on 17/6/2016 @ 8PM</p>	
17/6/20	<p>C/S/Pny Anoro team.</p> <p>O'POD -</p> <p>S/P → (It) open Ureteric Reimplantation.</p> <p>Baby c/o pain (Mild discomfort).</p> <p>VITALS: Baby conscious, coherent</p> <p>PR - 105/min</p> <p>BPI - 87/48</p> <p>SpO2 - 100% (on Room air)</p> <p>CVR - S102 (+)</p> <p>R/S - BAE (+) clear</p>	<p>Re.</p> <ol style="list-style-type: none"> 1- Lig. O. X Bupivacaine + Imcglat fentanyl 2ml Botul given. 3- Continue Epidural 9/4min @ 2ml/hr.
		<p>Remaining drugs as per chart Dr. Jyoti Bothra (P.T.O)</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 10:45 AM	<u>S/S Resident</u>	
	<p>Am - (L) vesico ureteric Jctⁿ obstruction s/p: left open ureteric reimplantation POD-1</p>	
	O/E	
	Child alert	
	Eutermic	
	Weight stable	
	CVS - S1S2 (+)	
	R/S - BAE (+)	
	P/A - 80/60	
		Plan
		1) PnJ pпта3
		2) PnJ Amikacins
	0/0 - 1.5cc/kg/hr.	3) Tob Tropen
		4) Epidural empty for 3 days

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 Master CH MOURYA
 09-05-2023 3 Y 1 M 9 D (M)
 Dr. JYOTI BOTHRA



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6	SIB Dr Sunidhara (Aom)	
4pm	<p>POD₁ - Ureteric Reimplantation. On Epidural Infusion - 0.1% Bup + 1 ug/cc Fentanyl. @ 4 ml/hr. Comfortable. 137 to BP - 110/80, HR - 148, SpO₂ 98%. RA.</p>	
	<p>Otherwise not getting any other analgesic. Moving all 4 limbs actively. Adv- Cont same @ 4 ml/hr.</p>	
		Sunidhara
19/6	SIB Dr Sunidhara (Aom)	
7AM	<p>POD₂ - Comfortable. Able to sit and move BL LL. No Motor weakness. Hnd stable</p>	
	<p>Refilled @ 0.1% Bupivacaine + 1 ug/cc Fentanyl @ 4 ml/hr. Adv- Cst.</p>	
		Sunidhara

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/B Resident</u>	
<u>18/6/21</u> <u>5 PM</u>	<p>SMN - left Ulnar nerve Fractⁿ Obstruction S/p (L) open wound debridement</p>	
	<u>O/L</u>	
	child alert	
	febrile	
	vitals stable	
	Cv - S/S (P)	
	Rf - RAE (P)	
	P/A - soft	
		Plan
		1) CST
		2) Perform ops.
<u>Obv</u>		noted by manasa 18/6 (8 PM)

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 9 D (M)
 Dr. JYOTI BOTHRA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19.6.26 9.00 AM	<p>S/B Registrar</p> <p>Ⓢ VOT Obstruction</p> <p>S/P: Ⓢ Open Ureteric Re-implantation POD-2</p> <p>O/E child asleep</p> <p>CRT < 3 sec</p> <p>apical</p> <p>CUS - 9.5, 7</p> <p>RS - BAE Ⓢ, clear</p> <p>F/- soft</p>	
	<p>U/O : 2.2 cc/ml/hr</p>	<p>Plan</p> <ul style="list-style-type: none"> → Encourage suckling → Cont. rest → 300 ml NS over 4 hrs. → 1.5 litres / day.
19.6.26 4.00 PM	<p>S/B Registrar</p>	
	<p>U/O : 2.6 cc/kg/hr</p>	

VH-00204321

Master CH MOURYA

09-05-2023

Dr. JYOTI BOTHRA

IP-00060370

3 Y 1 M 10 D

(M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26	c/s/By Dr. Brunda (Axon Team)	
8pm	POD ₂ - Ureteric Reimplantation	
	On Epidural Infusion - 0.1% Bupivacaine + 1µg/cc Fentanyl	
	@ 4ml/hr	
	- Re-filled now	
	child - comfortable	
		Adv
		1) Continue Same Treatment
		2) Plan to Remove Epidural Tomorrow
		B do
20/6	Called for	
10am	→ c/o ? Displace Catheter	
	↓	
	repositioned by sister	
	QE. Catheter in position	
	no synphasic bludge	
	note small clot noted note reposition by	
	sister	
	adv	
	Catheter Care	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2:30 PM		
	- ? Obstruction of catheter	
	- catheter removed - Clots ++	
	Re-catheterization done	8hr
Dr. Jyoti Bathra		
20/6/2026 7:00 AM	Issue: Complaining of ? Abdominal distension	
	- U/O: 75ml over last 4 hrs @ 1.4 ml/kg/hr (Blood, clots, + Hematuria)	
	- Urine catheters in situ	
	↳ confirmed with USG pelvis	
	- Urinary catheters in situ (Bulb distended)	Bulb distended present in using Bulb
	- urinary bladder distension (absent)	
	Adv: ① Monitor U/O	
	② Fever spike present	
	③ Plan: for ? repeat CBP (? For persistent hematuria)	

20/6/2026
 (P.T.O.)

...GRESS NOTES AND DOCTOR'S ORDER

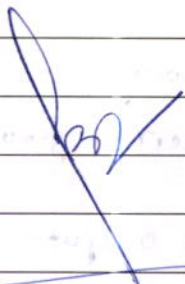
Date & Time	Progress Notes	Doctor's Order
	S/P Resident	
20/6 11AM	S/S - (L) Vesico-ureteric Junction Obstruction S/p - (L) open ureteric reimplantation.	(POD-3)
2 fever spikes T: 20 10AM	o/e Child unexp Further m/c Vitals stable Cvs - G2 (+) Rfx - RAE (+) P/A - Tachy/egid Ew - droopy/sleepy	o/e Abdomen Pch x distension
	U/O: 3.4cc/kg/hr.	plan 1) Pylor pylor 2 D3 2) Pyl Antecol D3 3) Tab - Tropam. - Remove catheter. (Hold). - Remove epidural
Mr. Lakshmi		noted by manata 20/6 @ 11AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		S/B Mr. Jyoti M...
	S/B Resident	
20/6 2pm	<p>Asis - (Lt) Vesicoureteric Junction Obstruction S/p - (Rt) open ureteric reimplantation</p> <p>(POB-S)</p> <p>fever spike - 100°F</p> <p>child Sleepy Anxious Urinary stch</p> <p>Cvs - S2 (+) R/S - RAE (+) P/A - S2 (+)</p>	
		Plan
		1) Cef
		2) Fey pem 8th hourly
		3) Proctodyns enem - given stat
		4) Monitor Urine output
		5) S2S → DNS (zoomed over 2hrs) ↳ if oral intake low.
	Dr. Vishwanath	noted by indy 20/6 2pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 2:00 PM	<p>Opd by <u>Dr. M. V. V. V. (Anesthesiologist)</u></p>	
	<p>D: (H) vesicovaginal junction obstruction s/p (L) open ureteric reimplantation.</p>	
	<p>✓ Patient - comfortable. * epidural catheter removed and tip is intact</p>	
	<p><u>Vitals:</u> O/E - pt is Active, clear. PR - 114/min BP - 112/74/44 SpO₂ - 100% O₂ RA. CVC - AB (+) AD - URIC (+) CAIS - Active, crying.</p>	
		<p><u>Dr. M. V. V. V. (DR. M. V. V. V.)</u></p>
		<p>Noted by <u>Indu</u> 20/6 02 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26 10:20 AM	S/B Resident.	
	Dx: (L) vesico ureteric Junction Obstruction S/p: (L) open ureteric reimplantation.	
	o/e	2 spikes of fever
	Child active	5 AM, 11 AM
	warm	
	vitals stable	
	CVC - f10 (f)	
	NFI - RAE (f)	
	PlA sxt	
	VO: 4cc/kg/hr.	Plan
		1) Duj pental Dy
		2) Duj Amikacel Dy
		3) Tab Tropen
		4) Duj pcm

Dr. Jyoti Bothra

Noted by

manasa

21/6
10:20 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/06/23		
8pm	<p><u>S/B Resident.</u></p> <p>Smu - (1) VUJ obstruction</p> <p>Sp: (2) open ureteric reimplantation</p>	
	<p>o/e</p> <p>Child alert</p> <p>Extremities</p> <p>USG stable</p> <p>CVC size (1)</p> <p>KPI - DRE (1)</p> <p>PIA soft</p>	<p>ifur spike = 11 AM 100F</p>
U/O: 24cc/kg/hr		<p>plan</p>
		<p>1) CSJ</p>
		<p>2) plan for catheter removal</p>
		<p>3) Performers</p>
		<p>Noted by Zndis 08pm 21/6/23</p>

Implementation

B

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/23	<p>MR. Benolant PDD-5</p>	
	<p>child active NO fever spike</p>	
	<p>eczema better marks</p>	
	<p>no sores</p>	<p>Plan</p>
	<p>U/O - 3.2cc/kg</p>	<p>1) Remove diaper 2) Remove dressing ↳ Bathing/Washing after d/s</p>
	<p>W/C today</p>	<p>3) Antibiotic - 2 weeks</p>
	<p>Boths</p>	<p>4) Strip after 3 months C UG</p>
<p>Noted by Benolant 22/6 @ 2pm</p>		



NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: _____		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known				
BACKGROUND		Surgery / Procedure: <u>Laparoscopic sigmoidectomy + ureteric stent placement</u>		Post OP Day: _____				
ASSESSMENT	Date	17/6/26	17/6/26	17/6/26	17/6/26	18/6/26	18/6/26	
	Shift	OT CMW	L	R	Night	M	E	
RECOMMENDATIONS	Medical Condition (Any special condition to be noted):	-	-	N/A	N/A	N/A	N/A	
	Diet:	NPO	-	Soft diet	S. diet	S. diet	S. diet	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	97.3 F	98.6 F	98.5 F	98.6 F	98.6 F	98.1 F
		Res:	24 blm	24.5 blm	24 blm	22 blm	26 blm	27 blm
		SpO ₂ :	98%	97%	98%	98%	98%	97%
		Pulse:	116 blm	112 blm	110 blm	92 blm	102 blm	115 blm
		BP:	99/70 (24)	90/60 (24)	96/60 (24)	98/57 (24)	-	110/60 (24)
LOC:		conscious	conscious	conscious	conscious	conscious	conscious	
Fall Risk Score:	10	10	10	10	10	10		
Pain Score:	0	2	0	0	0	0		
Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact		
Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Physiotherapy:	-	-	N/A	N/A	N/A	N/A		
Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Special Diet:	NPO	Oral	S. diet	S. diet	S. diet	S. diet		
Critical Lab Test / Values:	-	-	N/A	N/A	N/A	N/A		
Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	dependent	Dependent	Dependent	dependent	dependent	dependent		
Post Operative Procedure Special Orders:	-	-	epidural urinary catheter	epidural urinary catheter	epidural urinary catheter	epidural urinary catheter		
Handed Over By Name :	Sabin	Sreenivas	Soukanta	Subhram	Indra	Manasa		
Signature / ID :	Am	Am	Am	Am	Am	Am		
Date:	17/6/26	17/6/26	17/6/26	18/6/26	18/6/26	18/6/26		
Time:	@ 10:00 AM	@ 3:36 PM	@ 8 PM	@ 8 AM	@ 2 PM	@ 8 PM		
Taken Over By Name :	Sabin	Sreenivas	Subhram	Manasa	Manasa	Subhram		
Signature / ID :	Am	Am	Am	Am	Am	Am		
Date:	17/6/26	17/6/26	17/6/26	18/6/26	18/6/26	18/6/26		
Time:	10:20 AM	@ 4 PM	@ 8 PM	8 AM	@ 8 PM	@ 8 PM		

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Left vesico ureteric junction obstruction</i>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>nil</i>				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	<i>18/6</i>	<i>19/6</i>	<i>19/6/26</i>	<i>19/6/26</i>	<i>20/6</i>	
	Shift	<i>Night</i>	<i>m</i>	<i>e</i>	<i>Night</i>	<i>m</i>	
	Medical Condition (Any special condition to be noted):	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
ASSESSMENT	Diet:	<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.0°f</i>	<i>98.6°f</i>	<i>98.6°f</i>	<i>97.4°f</i>	<i>98.9°f</i>
		Res:	<i>28 b/m</i>	<i>26 b/m</i>	<i>20 b/m</i>	<i>24 b/m</i>	<i>25 b/m</i>
		SpO ₂ :	<i>100%</i>	<i>99%</i>	<i>100%</i>	<i>98.6%</i>	<i>98%</i>
		Pulse:	<i>85 b/m</i>	<i>86 b/m</i>	<i>103 b/m</i>	<i>112 b/m</i>	<i>115 b/m</i>
		BP:	<i>94/54/62</i>	<i>98/62(97)</i>	<i>98/61(75)</i>	<i>103/63(78)</i>	<i>112/70(80)</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
		Fall Risk Score:	<i>10</i>	<i>10</i>	<i>10</i>	<i>10</i>	<i>10</i>
	Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	
	Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	
	Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		Physiotherapy:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>
Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Special Diet:		<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	<i>s.diet</i>	
Critical Lab Test / Values:		<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):		<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>		
Handed Over By Name :	<i>Subham</i>	<i>Manasa</i>	<i>Sreeranjitha</i>	<i>Subham</i>	<i>Manasa</i>	<i>Rendu</i>	
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	<i>19/6/26</i>	<i>19/6/26</i>	<i>19/6/26</i>	<i>20/6</i>	<i>20/6</i>	<i>20/6/26</i>	
Time:	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</i>	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</i>	
Taken Over By Name :	<i>Manasa</i>	<i>Sreeranjitha</i>	<i>Subham</i>	<i>Manasa</i>	<i>Rendu</i>	<i>Manisha</i>	
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	<i>19/6/26</i>	<i>19/6/26</i>	<i>19/6/26</i>	<i>20/6</i>	<i>20/6/26</i>	<i>20/6/26</i>	
Time:	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</i>	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</i>	

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>1st vesico vesteric reimplantation</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>nil</i>					
	Surgery / Procedure: <i>nil</i>	Post OP Day:					
BACKGROUND	Date	<i>20/6/26</i>	<i>21/6</i>	<i>21/6</i>	<i>21/6</i>	<i>22/6</i>	
	Shift	<i>N</i>	<i>M</i>	<i>E</i>	<i>N</i>	<i>M</i>	
	Medical Condition (Any special condition to be noted):	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
	Diet:	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S diet</i>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.4°F</i>	<i>98.8°F</i>	<i>98.3°F</i>	<i>98.6°F</i>	<i>98.1°F</i>
		Res:	<i>26blm</i>	<i>27blm</i>	<i>26blm</i>	<i>27blm</i>	<i>20blm</i>
		SpO ₂ :	<i>99%</i>	<i>98%</i>	<i>98%</i>	<i>99%</i>	<i>99%</i>
		Pulse:	<i>110blm</i>	<i>117blm</i>	<i>110blm</i>	<i>103blm</i>	<i>114blm</i>
		BP:	<i>106/77(63)</i>	<i>109/80</i>	<i>101/68</i>	<i>105/78(60)</i>	<i>102/62(70)</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
	Fall Risk Score:	<i>10</i>	<i>10</i>	<i>10</i>	<i>10</i>	<i>10</i>	
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>		
Skin Integrity	<i>intact</i>	<i>intact</i>	<i>intact</i>	<i>intact</i>	<i>intact</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S diet</i>	
	Critical Lab Test / Values:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>		
Handed Over By Name :	<i>manisha</i>	<i>manasa</i>	<i>Indu</i>	<i>manisha</i>	<i>Anitha</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>21/6/26</i>	<i>21/6/26</i>	<i>21/6/26</i>	<i>22/6/26</i>	<i>22/6/26</i>		
Time:	<i>@8AM</i>	<i>@2pm</i>	<i>@2pm</i>	<i>@8AM</i>	<i>@2pm</i>		
Taken Over By Name :	<i>manasa</i>	<i>Indu</i>	<i>manisha</i>	<i>Anitha</i>	<i>[Signature]</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>21/6</i>	<i>21/6/26</i>	<i>21/6/26</i>	<i>22/6</i>	<i>[Signature]</i>		
Time:	<i>@8AM</i>	<i>@2pm</i>	<i>@8pm</i>	<i>@8AM</i>	<i>@2pm</i>		

*Noted by
 Benoni K
 @ 2pm*

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name:							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA



NURSING CARE RECORD



Date: 17/6/26

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify: Nil
- Maintain Fluid Balance
- Meet Elimination Needs
- Improve Activity Tolerance
- Ensure Safety
- Maintain Good Nutritional Status
- Early Ambulation Reduce Anxiety
- Maintain Skin Integrity
- Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	4pm	→ Relieve pain & Discomfort		→ Relieved pain & Discomfort	→ provided by Comfortable position	→ patient is Stable	Anthe 17/6 @ 8pm
	5pm	→ maintain Good Nutritional status		→ To oral intake is Good	→ provided by Soft diet		
Night	9pm	→ Ensure safety	9pm	→ Side rails kept up	→ Prevent from fall	→ patient is stable	Subhr 17/6 @ 8pm
	10pm	→ maintain good nutritional status	10pm	→ provided by Soft diet	→ oral intake is good		

0060370
3Y1M8D (M)
JYOTI BOTHRA

NURSING CARE RECORD



Date: 18/6/26

- Goals**
- Maintain Airway and Oxygenation
 - Maintain Personal Hygiene
 - Identify Potential Complications
 - Relieve Pain & Discomfort
 - Prevent Infection
 - Any Others. Specify.....
 - Maintain Fluid Balance
 - Meet Elimination Needs
 - Improve Activity Tolerance
 - Ensure Safety
 - Maintain Good Nutritional Status
 - Early Ambulation Reduce Anxiety
 - Maintain Skin Integrity
 - Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9:00	maintain aseptic techniques	9:30	maintained aseptic techniques	- prevent from Infection	- patient is stable	Indu @ 2pm 18/6/26
	1:10	ensure safety	1:20	side rails kept up	- prevent from falls risk	- no fresh complaints	
Afternoon	4 pm	→ Relieve pain and discomfort	4:30 pm	→ Administered medications as per order	→ To reduce pain	→ patient is stable	@ manasa
Night	9pm	→ I/O Chart	9pm	→ strict I/O chart	→ urin output is good	→ Patient is stable	Subham 19/6 @ 8AM
	10pm	→ Ensure safety	10pm	→ side rails kept up	→ prevent from fall risk		

NURSING CARE RECORD

Date: 19/6/26

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify.....
- Maintain Fluid Balance
- Meet Elimination Needs
- Improve Activity Tolerance
- Ensure Safety
- Maintain Good Nutritional Status
- Early Ambulation Reduce Anxiety
- Maintain Skin Integrity
- Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10am	→ Relieve pain & Discomfort		→ Relieved pain & Discomfort	→ To provide comfortable position	→ patient is stable	manasa 19/6 @ 2pm
Afternoon	5pm	→ Relieve pain & discomfort		→ Administered epidural medicine 4ml/hr	→ To relieve pain and discomfort	→ patient is stable	steekam 19/6/26 @ 8pm
Night	9pm	→ maintain good nutritional status		→ oral intake is good	→ maintain hydration	→ patient is stable	subhr 20/6 @ 8pm

NURSING CARE RECORD

Date: 20/6/2026

Goals

- Maintain Airway and Oxygenation
- Relieve Pain & Discomfort
- Maintain Fluid Balance
- Improve Activity Tolerance
- Maintain Good Nutritional Status
- Maintain Skin Integrity
- Maintain Personal Hygiene
- Prevent Infection
- Meet Elimination Needs
- Ensure Safety
- Early Ambulation Reduce Anxiety
- Patient & Family Education
- Identify Potential Complications
- Any Others. Specify: Nil

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10 AM	prevent infection		provided aseptic technique	→ To prevent infection	→ patient is stable	[Signature]
	11 AM	→ Hyperthermia	11:30 AM	→ patient have pyrexia 101.2°C	→ to reduce temperature		
Afternoon	3:00	maintain aseptic technique	3:30	maintained aseptic technique	- prevent from infection	- patient is stable	Indu [Signature]
	7:00	Ensure Safety	7:20	Side rails kept up	- prevent from falls risk	- no fresh complaints	
Night	9 PM	Ensure safety		- Side rail kept up	- prevent from fall risk	- patient is stable	Manisha 21/6/26 @ 8 PM

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 11 D (M)
 Dr. JYOTI BOTHRA



NURSING CARE RECORD

Date: 21/6/23

Goals

- Maintain Airway and Oxygenation
- Relieve Pain & Discomfort
- Maintain Fluid Balance
- Improve Activity Tolerance
- Maintain Good Nutritional Status
- Maintain Skin Integrity
- Maintain Personal Hygiene
- Prevent Infection
- Meet Elimination Needs
- Ensure Safety
- Early Ambulation Reduce Anxiety
- Patient & Family Education
- Identify Potential Complications
- Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	11:30 AM	→ Hypothermia	11:30 AM	→ patient have 99.9% temperature inj. Paracetamol given	→ To reduce temperature	→ patient is stable	manasa
Afternoon	3:00	maintain aseptic technique	3:30	maintained aseptic technique	- prevent from Infection	- patient is stable	Indu Sppr 21/6/23
	7:00	Ensure safety	7:30	side rails kept up	- prevent from Falls risk	- no fresh complaints	
Night	11:00	provide comfortable position	11:30	provided comfortable position	- To reduce discomfort	- patient is stable	manasha Q&A 22/6/23
	7:00	foley's care.	7:30	maintained foley's care	- To reduce Infection	- no fresh complaints	

VIH-00204321
 Master CH MOURYA
 09-05-2023 3 Y 1 M 11 D (M)
 Dr. JYOTI BOTHRA

IP-00060370

NURSING CARE RECORD



Date:

Goals

- Maintain Airway and Oxygenation
- Relieve Pain & Discomfort
- Maintain Fluid Balance
- Improve Activity Tolerance
- Maintain Good Nutritional Status
- Maintain Skin Integrity
- Maintain Personal Hygiene
- Prevent Infection
- Meet Elimination Needs
- Ensure Safety
- Early Ambulation Reduce Anxiety
- Patient & Family Education
- Identify Potential Complications
- Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10 AM	Maintain Fluid Balance - Ensure Safety	11 AM	- Maintained input/output chart - provided side rails	- To prevent dehydration - to prevent falls	Re-Assessment is done, vitals checked	Anilika 22/6/23 @ 2 pm
Afternoon				Discharge Note Doctor came for rounds and advice for discharge.			
Night					Noted by Benarika 22/6 @ 2 pm		



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
				18/6	18/6	18/6	19/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	③	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	②	2	2	2	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	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	①	1	1	1	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	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	①	1	1	1	1	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	1	1	1	1	
Total		10	10	10	10	10	10

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 sup.	✗	✗	✗	✗	✗	✗
Other Intervention(s) Specify	✓	✓	✓	✓	✓	✓
Nurse's Name:	Sulay Anitha	subh	Prab	nanoo	subh	
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	17/6	18/6	18/6	18/6	18/6	19/6
Time:	8-45 AM	@ 8 PM	4 AM	12 PM	4 PM	12 AM

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			19/6	19/6/2016	20/6	21/6/2016	22/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	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	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	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	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	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	1	1	1	1
Total			10	10	10	10	10

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:		Anil	Satish	Sush	Preethi	Ansh
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		19/6	19/6/2016	20/6	21/6/2016	22/6
Time:		11AM	5PM	10AM	10AM	6PM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			2016	21/6	21/6	21/6	22/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	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	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	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	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	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	1	1	1	1	
Total			10	10	10	10	10

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 up		✗	✗	✓	✗	✗
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		manisha	manisha	Broha	manisha	Anita
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		20/6	21/6	21/6	21/6	22/6
Time:		11pm	7:00	5:30	11pm	9AM



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/6/26	8.45 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	-	Sanjay
17/6/26	5pm	01	Surgical site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable position	Aneel
18/6	11AM	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	Oil	Indu
18/6	4pm	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	Nil	[Signature]
18/6	11pm	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	Nil	Subu
19/6	11AM	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	Nil	Aneel
19/6/26	5PM	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	-	Shekhar
19/6/26	11pm	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	Nil	Subu
20/6/26	10AM	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	-	Subu
20/6/26	11pm	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	Nil	vanisha

Re-assessment Frequency:

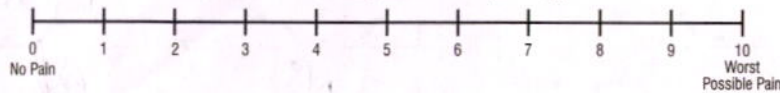
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/6	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	Nil	Zuber
21/6	4 PM	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	Nil	Zuber
21/6	11 PM	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	Nil	manesha
22/6	7 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	Nil	manesha
22/6	2 PM	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	Nil	Aartha
				<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:

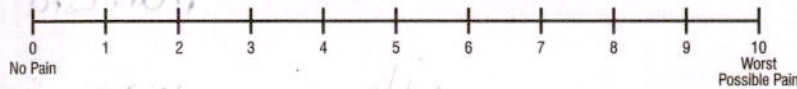
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

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
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/6 DAY-1			12/6 DAY-2			12/6 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	0	0	0	0	0	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	-	-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-		
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	-	-	-	-	-	-	-	-		
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	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse				SK	AK	SK	AK	SK	AK	SK	AK		

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 : Hema Name : PK

Signature of Ward In Charge :

Signature : AK Name : Elizabeth



CHECKLIST FOR THROMBOPHLEBITIS

20/6/2016

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 20/6			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	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	-	-	-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-				
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	-	-	-	-	-	-				
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	-	-	-	-	-	-				
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	-	-	-	-	-	-				
Signature of the Nurse				Sudha			Sudha			Sudha			

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 : Sudha Name : Sudha

Signature of Ward In Charge :
 Signature : Sudha Name : Sudha



BRADEN 'Q' SCALE

				Date :	17/6/24	18/6	18/6
				Time :	7:45 AM	5 PM	10:00 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
				TOTAL SCORE	28	19	19
				Evaluator's Name	Sainy	Shel	+

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

VIH-00204321
 Master CH MOURYA
 19-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA

IP-00060370



WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			17/6	18/6	19/6	20/6	21/6	
			Time:	Time:	Time:	Time:	Time:	Time:
			5pm	5pm	5pm	5pm	5pm	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0	0	
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0	0	
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0	0	
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0	0	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0	0	
Total Score			0	0	0	0	0	
Signature of the Nurse			<i>Anup</i>	<i>Arif</i>	<i>subhr</i>	<i>Indu</i>	<i>Indu</i>	

Intervention: No!

- High Risk = >2 Score
- Moderate Risk = 1-2 Score
- Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

SURGICAL SAFETY CHECKLIST

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA

Surgeon : Dr. Jyoti Bothra
 Asst. Surgeon :
 Anaesthetist : Dr. Medha
 Scrub Nurse : Pr. Ratan Bhasini



Age : 3Y Gender : M
 Patient Name : Open under Rump
 Date : 17/6/23 In-time : 10:30 AM Out-time : 1:30 PM



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>10:25 AM</u>
Patient Has Confirmed	
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
Site Marked	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
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
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. M. V. W. Bhasini</u>	

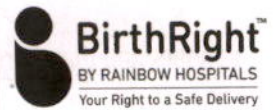
Before Skin Incision >>

TIME OUT	Time: <u>10:30 AM</u>
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site <u>Abdomen</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure <u>Open under Rump</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events <u>Rumprate</u>	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>None</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<u>None specific</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
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
Is Essential Imaging Displayed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>[Signature]</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>1:30 PM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
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. Jyoti Bothra</u>	

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Master CH Maurya Age : 2y Gender : Male Female

UHID NO: VH-00204321 Surgeon Name: Dr. Jyoti Bothra

Anaesthesiologist : Dr. Madhav

Operative procedure planned : Laparoscopic eos open left Ureteric Re implantation

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 : laryngospasm, Desaturation, Bleeding

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master CH Maurya the above mentioned operation / Diagnostic / Therapeutic procedures Laparoscopic eos open left Ureteric Re implantation

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 : *[Handwritten Signature]*

Name : *Ch. Srinivas*

Relationship with Patient:

Date & Time :

Witness :

Signature : *[Handwritten Signature]*

Name : *M. Anil*

Date & Time :

Doctor (who is taking the consent) :

Signature : *[Handwritten Signature]*

Name : *Dr. Brunda*

Date & Time : *16/6/26, 5:45pm*

VIH-00204321 IP-00060370
 Master CH MOURYA
 09-05-2023 3 Y 1 M 8 D (M)
 Dr. JYOTI BOTHRA



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 17/6/20

To Be Filled In By Assigned Nurse:

Department: ER Duration of Procedure:

Name of Surgeon: Dr. Jyoti Bothra Date of Admission: 17/6/20

Bundle Care Criteria: (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic Or <input checked="" type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic: <u>Trj. piperacillin 1.4gm.</u>	
2.	Hair Removal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes: <input type="checkbox"/> Surgical Clipper Department where Hair Removed: <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other: Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36</u> °C <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Tympanic (Goal: 36-37°C)	
4.	Name of doctor or staff administering the antibiotic: <u>Tab. Rakesh</u> Date & Time of antibiotic administration: <u>17/6/20 @ 10:00am.</u> Date & Time procedure started: <u>17/6/20 @ 10:30am.</u>	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Ch. Mowye Gender: Male Female Age : 3yrs
 UHID No : 60370 Date : 17/6/26

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)

(L) Open Ureteric Reimplantation
 upon Ch. Mowye
 (Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and/ or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Infection
 Name of the doctor performing surgery

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. Spohi Botley

Consentee :
 Signature : [Signature]
 Name : [Signature]
 Date & Time : [Signature]

Patient Attendant :
 Signature : [Signature]
 Name : Ch. Swines
 Relationship with Patient: Father
 Date & Time : 17/6/26 @ 10:30am

Witness :
 Signature : M. Nanya
 Name : M. Nanya
 Date & Time : 17/6/26 @ 10:30am

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : Dr. Spohi Botley
 Date & Time : 17/6/26 10:30AM

Rainbow Children's Medicare Ltd.

3-7-222 & 3-7-223, Sy. No. 51 & 54, Opp. New Karkhana Police Station

Karkhana Main Road, Kakaguda, Secunderabad - 500009.

Tel : +91-40-4246 2200, 2789 5050, 2789 6060.

GST: 36AABCR4014M1ZE email: vrchbilling@rainbowhospitals.in

CIN: L85110TG1998PLC029914 www.rainbowhospitals.in



OPERATION THEATER NOTES

Patient's Name : Master CH MOURYA	Age : 3 Y 1 M 8 D	Gender : Male
UHID : VIH-00204321	I.P. NO. 00060370	WEIGHT : 13.2kg
Surgeon : Dr. JYOTI BOTHRA	Asst surgeon : Dr -	
Anaesthetist : Dr MADHAV	OT Nurse : S/N Ratan/Abharani	
Surgical Procedure :. Left Open Ureteric Reimplantation		
Indications for Surgery : Left Vesico Ureteric junction obstruction		
Anaesthesia -GA		
PRE-OPERATIVE PREPARATION- Betadine skin preparation		
OPERATIVE NOTES: Findings: Non trabeculated bladder, obstructed left ureteric orifice Procedure notes: -Pfannestiel incision made - Bladder opened and retracted with ring retractor - Left ureteric orifice cannulated with ureteric catheter 3 Fr - Ureter mobilised adequately and reimplanted with Cohen's Cross triagonal method - Bladder closed in layers - Incision closed in layers Anaesthesia Uneventful recovery.		
POSTOPERATIVE ORDERS 1.Nil by mouth for 1 hour 2.Inj PIPTAZ 1.5gm 8hrly 3.Inj Amikacin 100mg 12hrly 4.Inj Paracetamol 150 mgs sos if pain(epidural monitoring) 5.Tab Tropan 5mg BD 6.Vitals chart		

Consultants Surgeon's Name

Dr. JYOTI BOTHRA

Date : 17/6/26

Consultant Surgeon's Signature

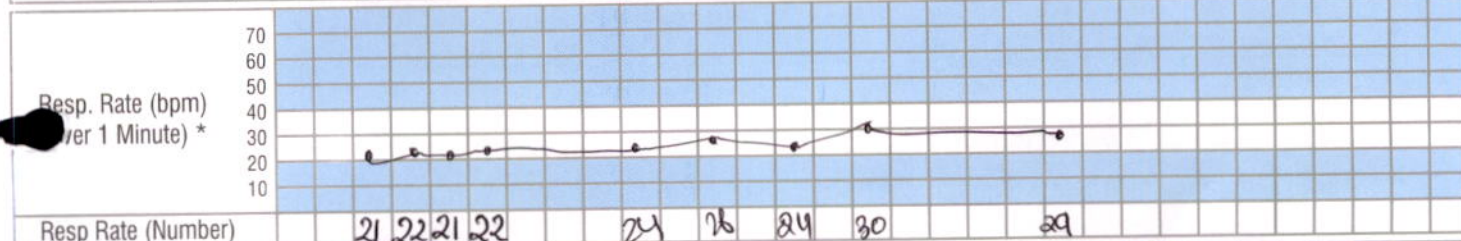
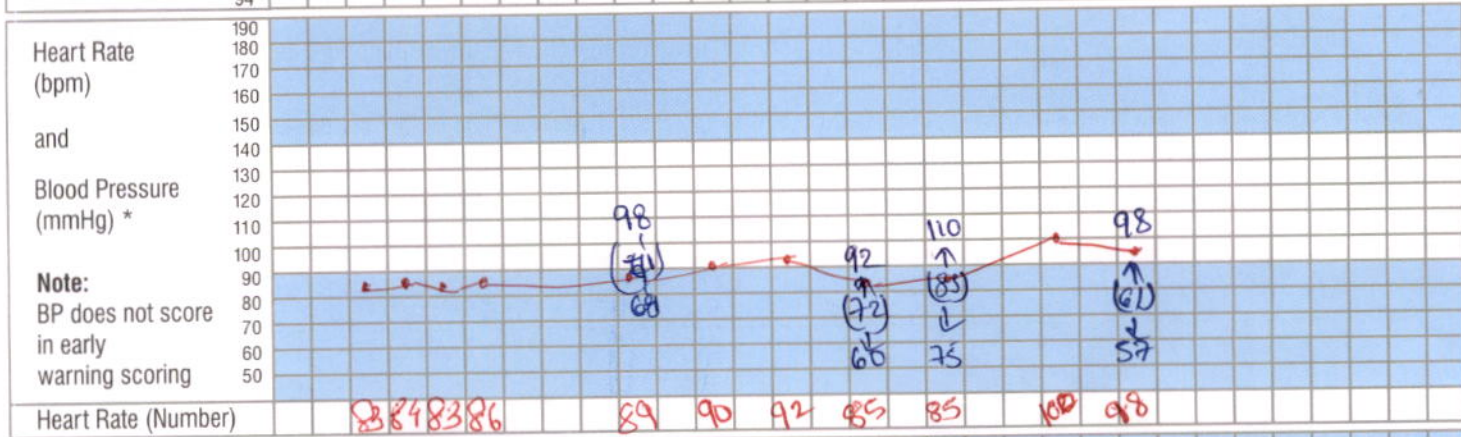
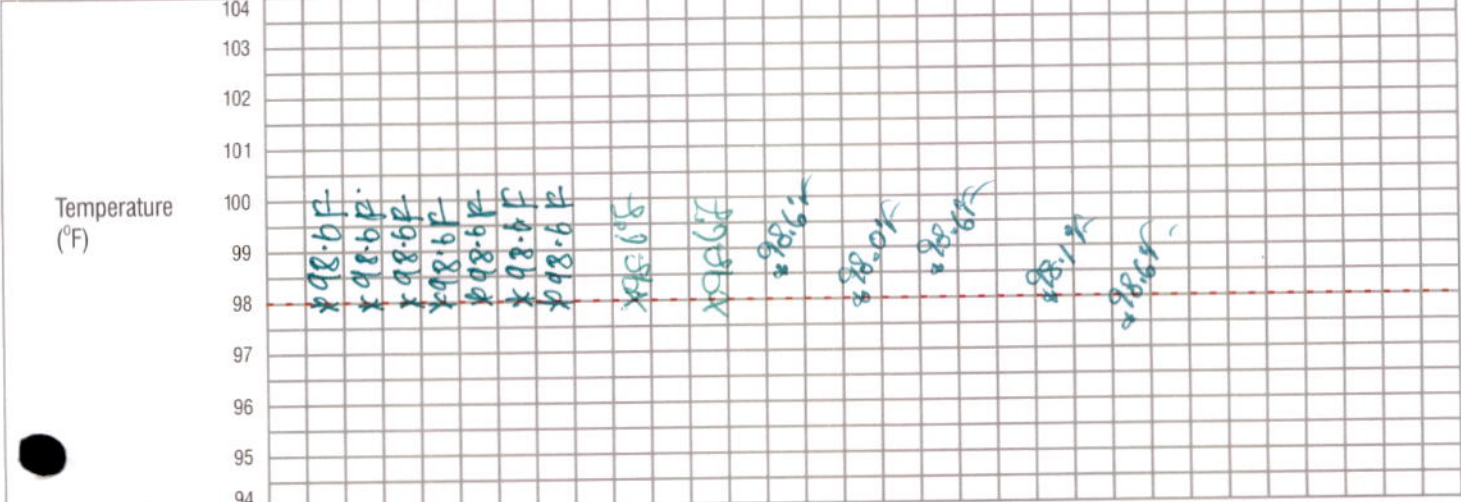
Time : 1:40 pm





EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:	9	10	11	12	1	2	3	5	7	10	12	2:50	5	7
Doctor / Nurse / Family Concern?	Am		Pm		Pm		Pm		Pm	Am		Am		Am



Resp Distress	Mod/ Severe None / Mild													
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	99	99	99	99	98	99	99	100	99	100	98	
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N	N	N	N	N	
GCS *		15	15	15	15	15	15	15	15	15	15	15		

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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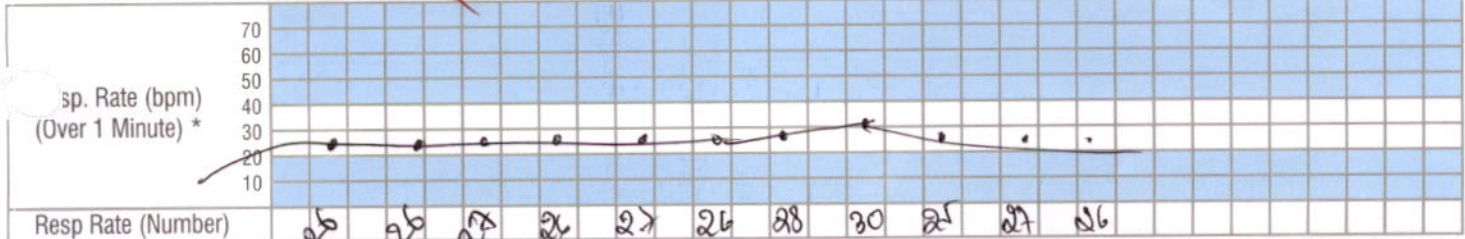
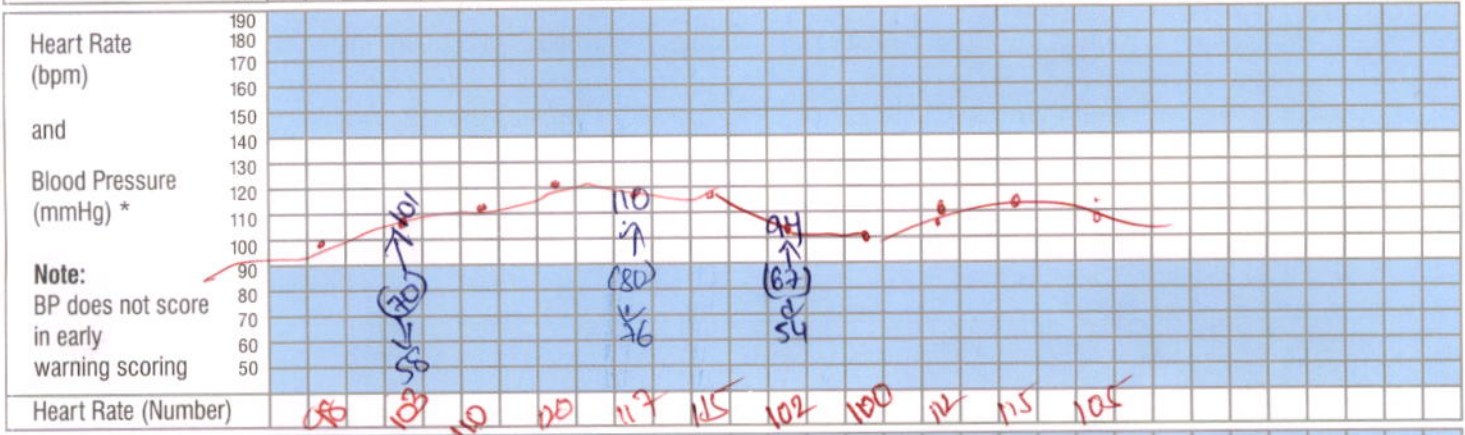
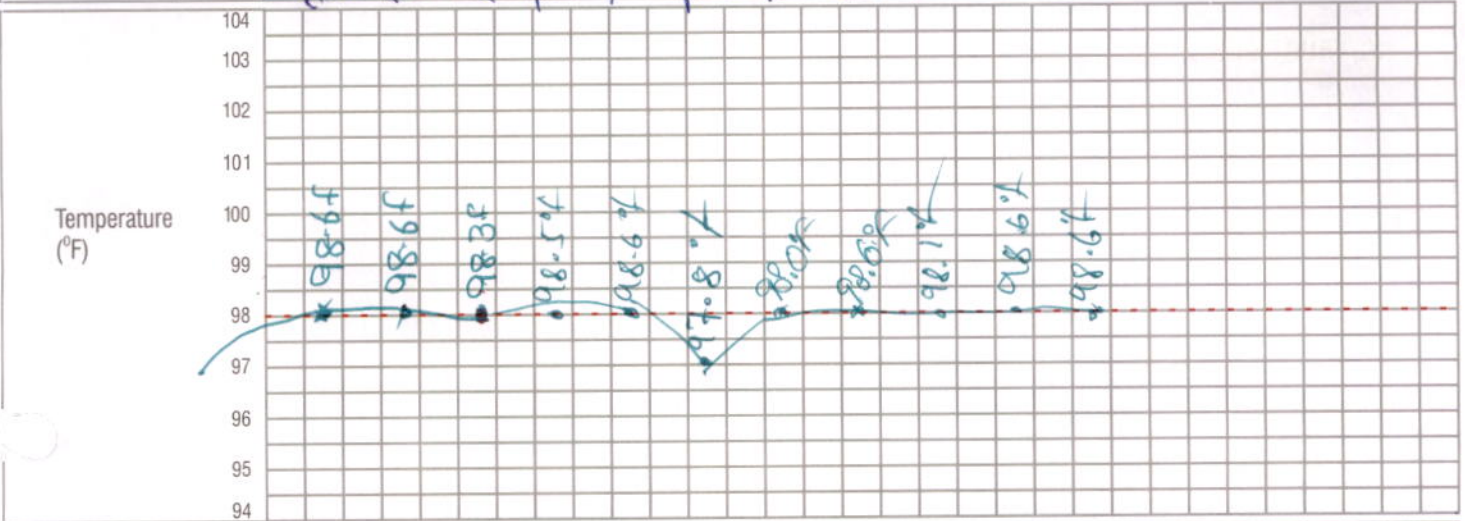
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/6/20 Time: 9 AM 11 AM 1 PM 3 PM 5 PM 7 PM 10 PM 1 AM 3 AM 5 AM 7 AM

Doctor / Nurse / Family Concern? Am Am Am M PM PM PM AM AM AM AM



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)	O ₂ Saturations (%)	
		98 97 98 97 98 97 99 100 97 98 98
Conscious Level	Normal / Altered	
		N N N N N N H H N N N
GCS *		15 15 16 15 15 15 15 15 15 15 15

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

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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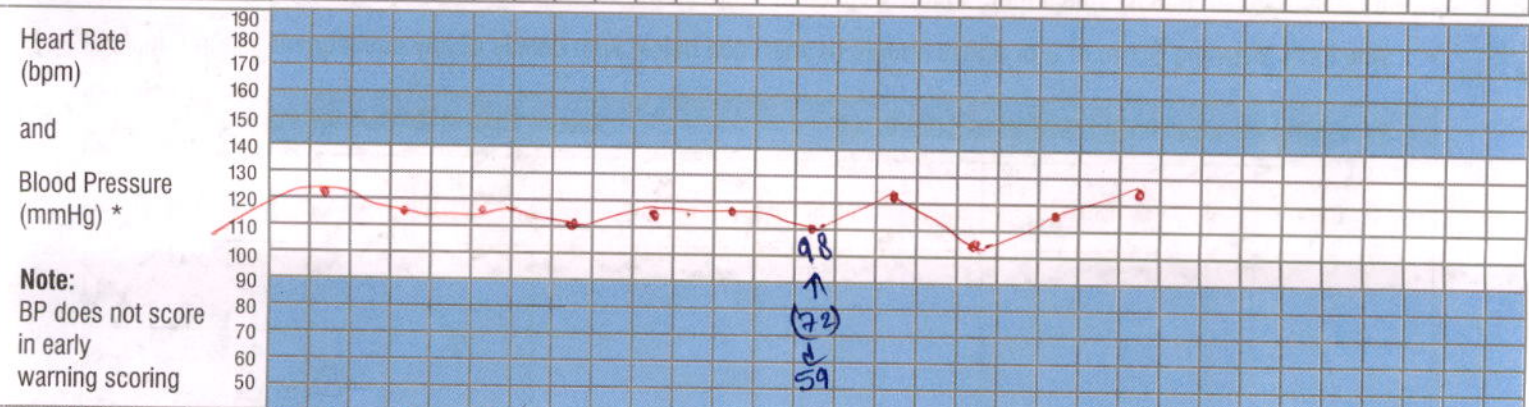
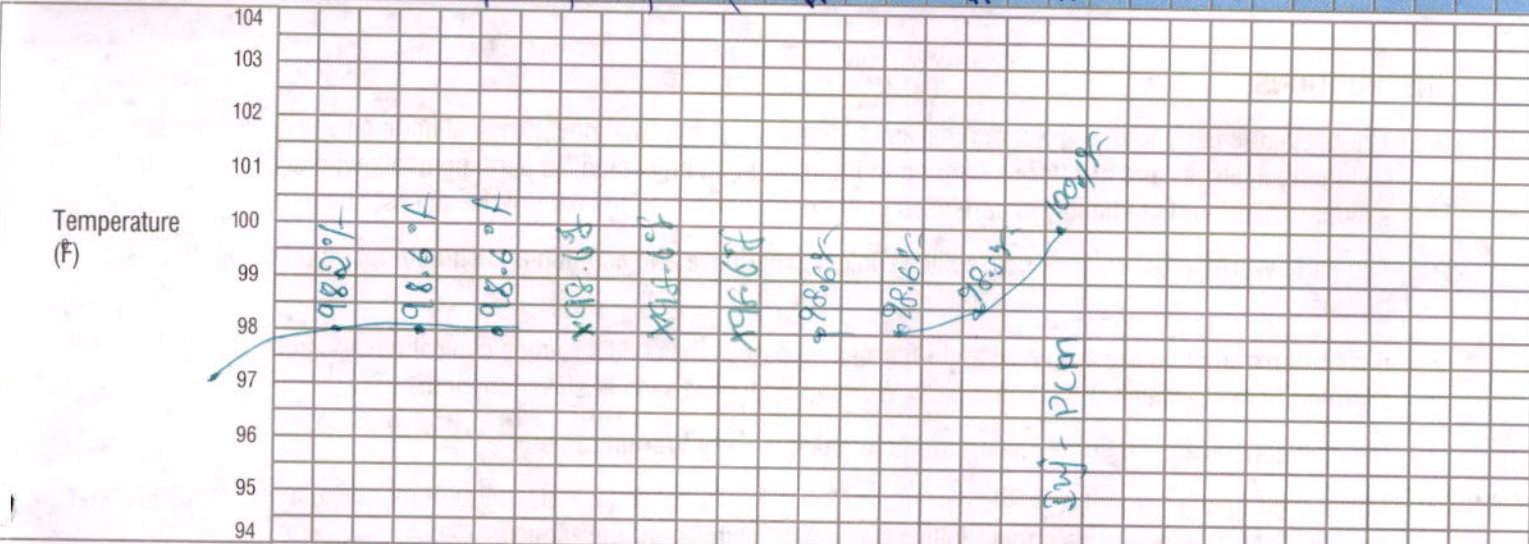
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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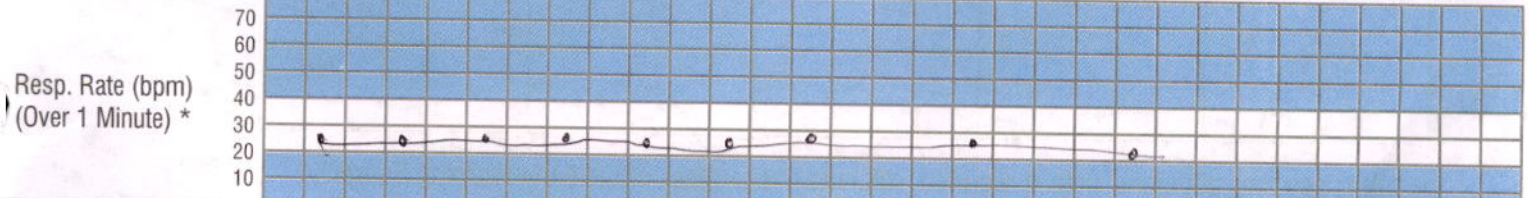
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/6/26 Time: 9 11 1 2 5 7 10 1 4 7:30

Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM AM AM AM AM



Heart Rate (Number) 120 117 117 110 115 117 110 121 108 116 124



Resp Rate (Number) 26 25 26 28 25 26 29 27 22

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 97 98 98 99 98 99 97 98 99 100 99

Conscious Level Normal / Altered N N N N N N N N N N N

GCS * 15 15 15 15 15 15 15 15 15 15 15

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

ACTIONS
 NB: Scores 3 should be recorded overleaf
 Score 1 : Continue normal observation by staff nurse
 Score 2 : Shift in charge nurse to be informed and continue hourly observations
 Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

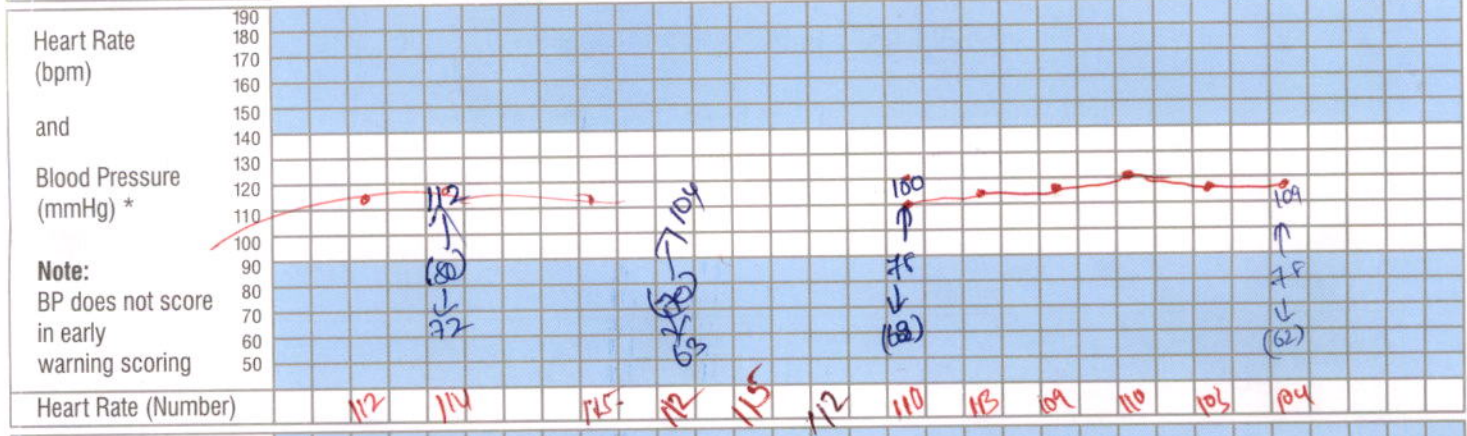
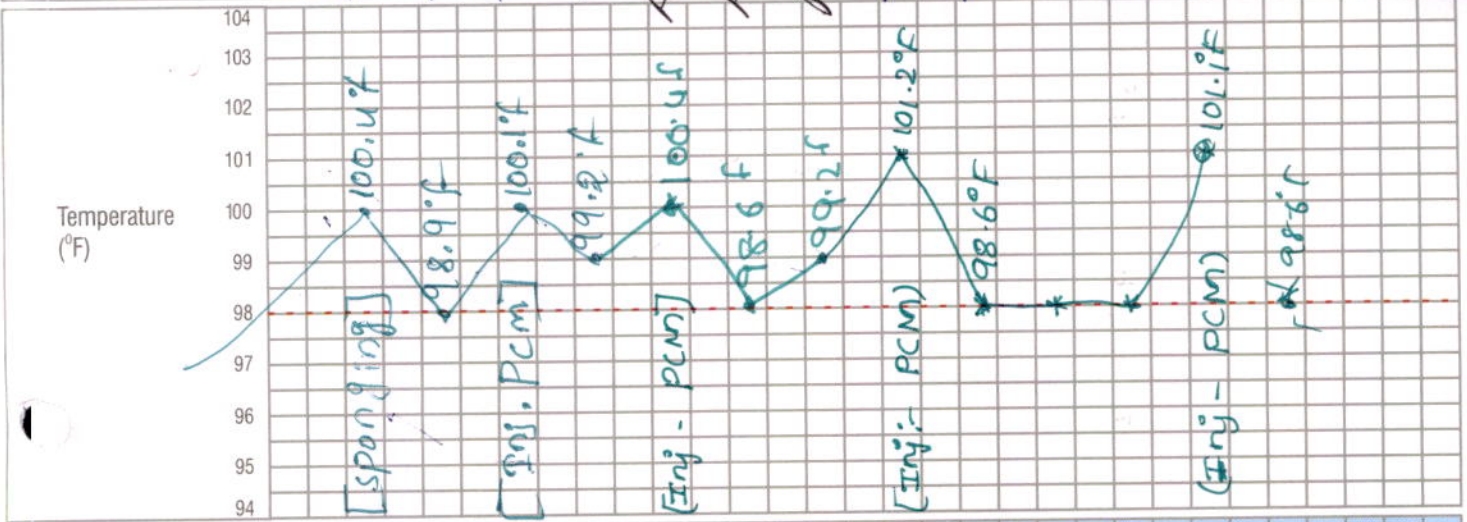
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6 Time: 9:50
 Doctor / Nurse / Family Concern? AM AM AM AM AM AM AM PM PM AM AM AM AM



Resp Distress	Mod/ Severe None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal Altered	99 98 97 98 99 98 99 98 98 99 98 99
GCS *		15 15 15 15 15 15 15 15 15 15 15 15

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

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
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Date	Time	Early Warning Score	Date	Time	Name

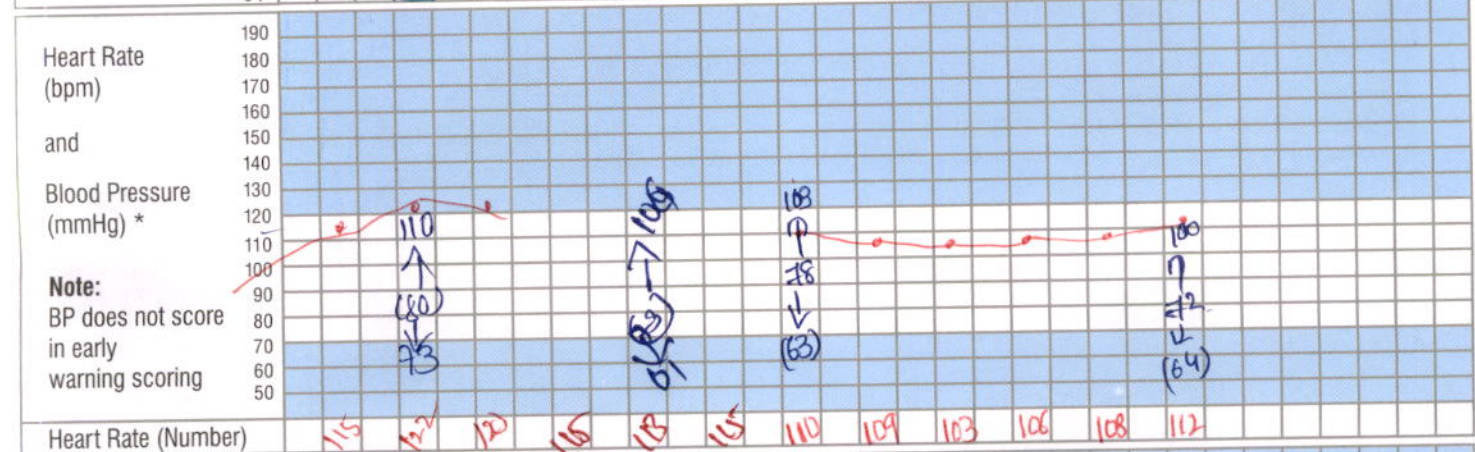
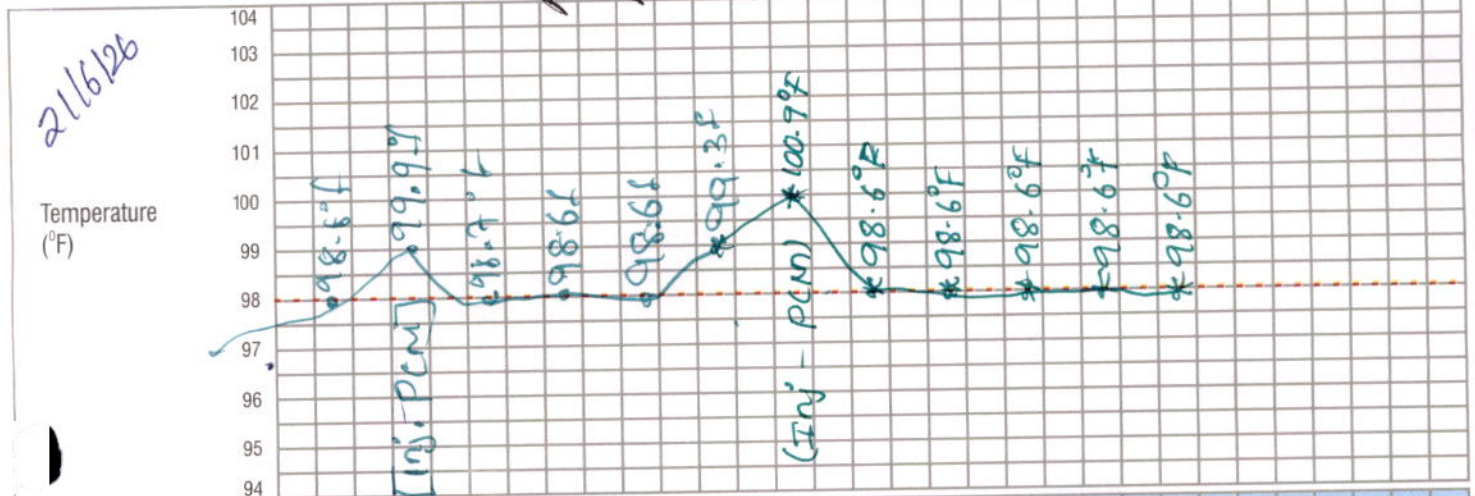
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 9 AM	11 AM	1 PM	3 PM	5 PM	7 PM	9:15 PM	11 PM	1 AM	3 AM	5 AM	7 AM
Doctor / Nurse / Family Concern?	M	M	PN	PN	PN	PN	PN	PN	AM	PN	AM	AM



Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	98 97 98 98 98 98 98 97 99 98 97 98
Conscious Level	Normal Altered
GCS *	15 15 15 15 15 15 15 15 15 15 15 15

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

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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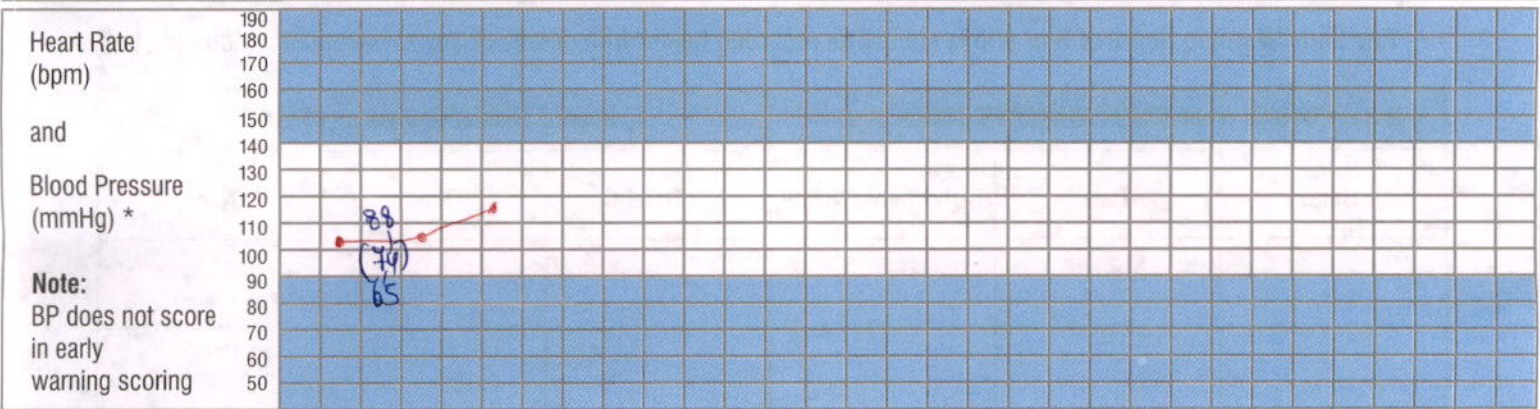
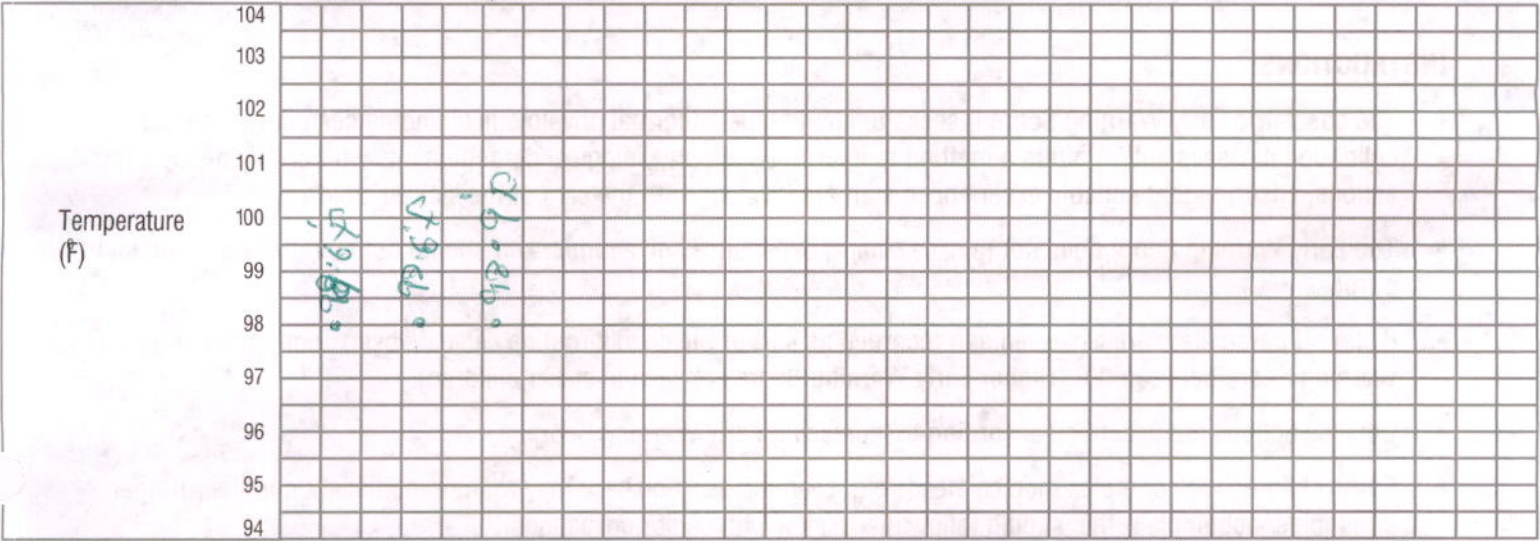
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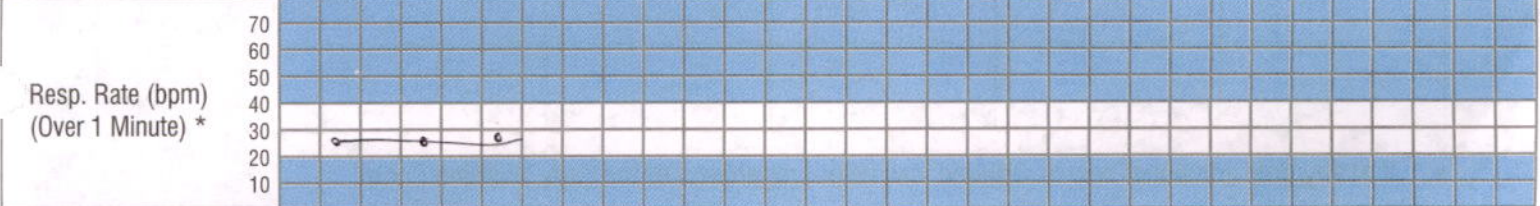
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 22/6/20 Time: 9 4 1

Doctor / Nurse / Family Concern? AM AM PM



Heart Rate (Number) 102 106 148



Resp Rate (Number) 29 26 28

Resp Distress	Mod/ Severe			
	None / Mild	<u>N</u>	<u>N</u>	<u>N</u>

Receiving O ₂ (l/min)			
O ₂ Saturations (%)	<u>98</u>	<u>99</u>	<u>99</u>

Conscious Level	Normal / Altered			
		<u>N</u>	<u>N</u>	<u>N</u>

GCS * 15 15 15

TOTAL SCORE			
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>A</u>	<u>A</u>	<u>A</u>

*Noted by
 Bewarika
 22/6
 @ 9pm*

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

FLUID CHART

Sheet No. : ①

17/6/26

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
17/6/26	08:00 am											
	09:00 am											
	10:00 am		NBM + RL + 150 ml/h									
	11:00 am		NBM									
	12:00 pm		NBM									
	01:00 pm		NBM									
	Total Intake :						Total Output :					
17/6/26	02:00 pm		NBM									
	03:00 pm		Epidural									
	04:00 pm	water	2.5 ml									
	05:00 pm	Polly water	2.5 ml									
	06:00 pm		2.5 ml									
	07:00 pm		2.5 ml									
Total Intake :			10 ml			Total Output :						
17/6/26	08:00 pm		3 ml									
	09:00 pm	Rice water	3 ml									
	10:00 pm		3 ml						350ml			
	11:00 pm		4 ml									
	12:00 am		4 ml									
	01:00 am		4 ml									
Total Intake :			21 ml			Total Output :						
18/6/26	02:00 am		4 ml									
	03:00 am		4 ml									
	04:00 am		4 ml									
	05:00 am		4 ml									
	06:00 am		4 ml						150ml			
	07:00 am		4 ml									
	Total Intake :			24 ml			Total Output :					
Total 24 hrs. Intake		Epidural 55 ml			Total 24 hrs. Output		500 ml (1.5 cc/kg over 24 hours)					



FLUID CHART

Sheet No. : 2

18/6/26

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake		NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	epidural							
18/6	08:00 am		4ml								Indo 22pm 18/6/26
	09:00 am		4ml								
	10:00 am		4ml								
	11:00 am		4ml								
	12:00 pm		4ml					10ml			
	01:00 pm		4ml								
Total Intake :			24ml		Total Output :						
20/6	02:00 pm		4ml								manasa 18/6 27am
	03:00 pm		4ml								
	04:00 pm		4ml								
	05:00 pm		4ml								
	06:00 pm		4ml								
	07:00 pm		4ml					300ml			
Total Intake :			24ml		Total Output :						
18/6	08:00 pm		4ml								Subham 19/6 @ 8am
	09:00 pm		4ml								
	10:00 pm		4ml								
	11:00 pm		4ml								
	12:00 am		4ml								
	01:00 am		4ml								
Total Intake :			24ml		Total Output :						
19/6	02:00 am		4ml								300ml
	03:00 am		4ml								
	04:00 am										
	05:00 am										
	06:00 am										
	07:00 am										
Total Intake :			8ml		Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output 710ml (2.2 cc/kg over 24 hours)

FLUID CHART

Sheet No. : 3

19/6/26

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	NG	Diarrhoea	Vomit	Drainage	Urine				
19/6	08:00 am				epistaxial N.G								
	09:00 am	Edly water		4ml									
	10:00 am		NS	4ml									
	11:00 am			4ml									
	12:00 pm			75ml	4ml								
	01:00 pm			75ml	4ml					100ml			
Total Intake :			24ml			Total Output :							
19/6	02:00 pm			75ml	4ml								
	03:00 pm			75ml	4ml								
	04:00 pm				4ml					780ml			
	05:00 pm				4ml								
	06:00 pm				4ml								
	07:00 pm												
Total Intake :			20ml			Total Output :							
19/6	08:00 pm			4ml									
	09:00 pm	Rice		4ml									
	10:00 pm	water		4ml									
	11:00 pm			4ml						700ml			
	12:00 am			4ml									
	01:00 am			4ml									
Total Intake :			24ml			Total Output :							
20/6	02:00 am			4ml						100ml			
	03:00 am			4ml									
	04:00 am			4ml									
	05:00 am			4ml									
	06:00 am			4ml									
	07:00 am			4ml									
Total Intake :			24ml			Total Output :							

Total 24 hrs. Intake 92ml

Total 24 hrs. Output 1080ml (3.4 cc/kg/hr)

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FLUID CHART

Sheet No. : (4)

21/6/2026

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/6	08:00 am			4ml								} Manisha 20/6	
	09:00 am	water		4ml									
	10:00 am			4ml									
	11:00 am	water		4ml									
	12:00 pm	water		4ml					170ml				
	01:00 pm			4ml									
Total Intake : 16ml			Total Output : 170ml										
20/6	02:00 pm	lechi		40ml							} Indu 20/6 @ 8pm 20/6/26		
	03:00 pm			40ml									
	04:00 pm	water		40ml									
	05:00 pm			40ml									
	06:00 pm			40ml					150ml				
	07:00 pm			40ml									
Total Intake : 240ml			Total Output : 150ml										
20/6	08:00 pm	lechi		40ml					400ml		} Manisha		
	09:00 pm	water		40ml									
	10:00 pm			40ml									
	11:00 pm			40ml									
	12:00 am			40ml									
	01:00 am			40ml									
Total Intake : 240ml			Total Output : 400ml										
21/6/26	02:00 am			40ml							} Manisha 21/6/26 @ 8am		
	03:00 am			40ml									
	04:00 am			40ml					350ml				
	05:00 am			40ml									
	06:00 am												
	07:00 am								200ml				
Total Intake : 160ml			Total Output : 550ml										
Total 24 hrs. Intake			640ml										
Total 24 hrs. Output			1270ml										



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
21/6	08:00 am		mlk									Manisha 21/6
	09:00 am											
	10:00 am		2dl									
	11:00 am											
	12:30 pm								130ml			
	01:00 pm		water									
Total Intake :					Total Output :					130ml		
21/6	02:00 pm								100ml		Manisha 21/6	
	03:00 pm		mlk									
	04:00 pm		water									
	05:00 pm											
	06:00 pm											
	07:00 pm								200ml			
Total Intake :					Total Output :					300ml		
21/6	08:00 pm										Manisha 21/6	
	09:00 pm		Rice									
	10:00 pm											
	11:00 pm		water						200ml			
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
22/6	02:00 am								100ml		Manisha 22/6	
	03:00 am		water									
	04:00 am											
	05:00 am											
	06:00 am								300ml			
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output 1030ml



FLUID CHART

Sheet No. :

22/6/26

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
22/6/26	08:00 am		Milk									Amita 22/6/26 @ 2pm
	09:00 am		Dosa									
	10:00 am		Water						100ml			
	11:00 am											
	12:00 pm											
	01:00 pm											

Total Intake :

Total Output :

	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											

Total Intake :

Total Output :

	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											

Total Intake :

Total Output :

	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											

Total Intake :

Total Output :

Noted by
 Benavika
 22/6
 @ 2pm

Total 24 hrs. Intake

Total 24 hrs. Output

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FLUID CHART

Sheet No. :

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--



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 :

Date & Time :

Nurse Name & Signature: B.P.A. Sanjay

Date & Time : 17/6/23 @ 8.45 AM



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

Dr. Jyoti Bothra

DRUG : INJ. PARACETAMOL				Date Time	20/6/2018																	
Dose	Route	Frequency	Start Dt.	6	am																	
200mg	IV	8th hourly	20/6																			
Name & Signature of the Doctor Starting the Drugs: Dr. Ushwaja				2	Pm																	
Additional Instructions: 10-15mg/kg/dose				10	Pm																	
Daily Doctor's Endorsement by a Sign																						

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

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

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

Signature
Name

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 Dr. JYOTI BOTHRA



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

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

VERIFIED BY : Name Signature



ESTIMATION SLIP



Date: 04/06/26 UHID/IP No.: VIIH-204321 Sl. No.: 28864

Name of Patient: Mast CH. Mouzha Age: 24 Gender: M

Father's / Husband's Name: Mr. Srinivasa Corporate/Occupation: PUT

Address: KarimNagar Phone: 9704776443 Email: _____

Procedure/Plan: Ureteric Reimplantation DOS: _____

MODE OF PAYMENT: SELF TPA: CASIT GIPSA: _____ OTHER

REFERRAL INFORMATION: Dr. Jothi bathary

ROOM CATEGORY	GW	SW	TSW	PR	DLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges			12 Noon		to				
Attendant's Fee			12 Noon		Billing.				
L. Tax	<u>790</u>								

PARTICULARS		AMOUNT (₹)	
Surgeon's / Anesthetist's Fee / O.T Charges		<u>2,05,000/-</u>	
O.T Consumables		<u>10,000/-</u>	Subject to approval by TPA/Insurance Company
Instrument Charges		<u>8,000/-</u>	Not Covered by TPA/Insurance Company
Pharmacy, Consumables & Investigations		* As per actual - Not Included In Estimation	
Equipment Charges	Monitor: <u>1,500/-</u>	Oxygen: <u>4,800/-</u>	Infusion Pump/Syringe Pump: <u>900/-</u>
	Ventilator	Conventional:	HFO-SLE 5000:
	Phototherapy	Single Surface:	Double Surface:
Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc.		* As per actual - Not Included In Estimation	
Package	<u>NHA-1,000/-</u>	<u>MRD-2,500/-</u>	<u>Consultant-2,500/day</u>
Others	<u>5-D.A</u>	<u>5-D.A</u>	<u>Rec-2,000/-</u>
Initial Minimum Deposit		<u>2,80,000/-</u>	

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

DECLARATION

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

Signature of the Client: Chandrasekar Signatory Relationship: _____ Signature of the Financial Counselor: [Signature]