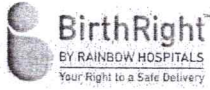


ANC-0000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF



DISCHARGE TRACKING SHEET

UHID :

FLOOR:


CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		10/6/26 @ 9:40pm	SS 01/07/21	
Activity Sheet updated by Pharmacy	6:50	6:51	Jaw	

ACTIVITY RECORD FOR BILLING



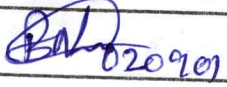

Name: **ANC-00000000** **IP28-00004543**
Baby ARYA **2 Y 1 M 16 D (M)**
24-04-2024
Dr. SELF

UHID No:  Consultant: _____ Dept: _____

Date of Admission: _____ Time: _____ Date of Discharge: _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/6/20	3.10 PM	BR	OT	
9/6/24	7.20 PM	OT-I	N-7/602	

CROSS CONSULTATION VISIT

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

ANC-00000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF



SURGERY DETAILS

Date : 9/6/26
Patient Name: BABY ARYA Date of Birth: 24/4/24 Age: 2y
Gender: MALE Ward: M-FLOOR UHID No: ANC-00000800
IP28-00004543
Date of Surgery: 9/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery: LEFT FEMUR CLOSED REDUCTION & HIP SPICA CASTING

Time in : 3:45 AM

Time Out : 5:00 PM

	NAME	AMOUNT
1. Surgeon	Dr. KARIN	
2. Anaesthetist	DR. NAHALAKSHMI	
3. Assistant Surgeon	Dr. CHARAN	
4. OT Technician	MR. RISHI	
5. Circulating Nurse	S.N. PUSHPAKATHI	
6. Assistant Nurse	S.N. LAKSHMI	

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

Signature of the Surgeon
[Signature]

Signature of Circulating Nurse
[Signature]

Order No:

Order by:



SURGERY DETAILS

Name of the Surgery: PLATE
 Date of Surgery: 1/6/90
 Surgeon: DR. [unclear]
 Assistant Surgeon: [unclear]
 OT Technician: [unclear]
 Circulating Nurse: [unclear]
 Assistant Nurse: [unclear]

Special Equipment: Endoscopy
 Microscope
 X-ray
 Other: [unclear]

Signature of Surgeon: [Signature]
 Order No: [unclear]



CONSUMABLES OF OT

Circulating staff : S/N Pushpa Technician : Rishi S Date : 09/06/26 Time : 3:40pm - 5pm

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack		-	Inj Vit.K		
LMA			Sutures		-	Cord Clamp		
ECG leads : A / P / N		03			-	Suction Catheter		
HME filter : A / P / N					-	Feeding Tube 9Fy		01
Syringes : 10 cc ✓		03			-	Vaccum Suction Set		
05 cc ✓		03	Gloves P.R 8		02	Surgical Gloves		
02 cc ✓		02			-	Gauze Pack		
01 cc ✓		01			-	Syringe 1ml/2ml 20ML		01
Cautery plate : A / P / N			Surgical blade		-	Surgical Blade # 20		
IV set <u>pedic drip set</u>		01	NG tube		-	Koochies (S)		
RL ✓		01	Cautery pencil		-	<u>10 Pcs</u>		01
NS : 10ml / 100ml / 500ml / 1000ml			Koochies		-	<u>Needle 18x1 1/2</u>		01
<u>Inj - Arsitei</u>		01	Ointments		-	<u>Dextrose 5%</u>		01
<u>Inj - Dextomid 50mg</u>		01	Suction Catheter		-			
Fentanyl			Cap, Mask		-			
Morphine			Gauze Pack <u>L</u>		02			
Ketamine			Mop Pack		-			
Propofol ✓		01	Steristrip		-			
Rocuronium			Underpad		02			
Glycopyrolate ✓		01	Draw sheet		-	<u>POP 10cm</u>		5
Myopyrolate			Abgel		-	<u>15cm</u>		2
Ondansetron ✓		01	Foleys catheter		-			
Pencan 25g/ Spinal Needle 22			Urobag		-	<u>Duco fibre 5</u>		01
Bupivacaine 0.25%			Chest Drainage Catheter		-	<u>stetifibre 10cm</u>		02
Bupivacaine 0.25%(Heavy)			Romodrain bag		-	<u>stetifibre 15cm</u>		01
Antibiotics			Bandage		-			
			Tegaderm		-			
Suppositories			Ioban		-			
Anamol : 80mg / 250mg / 170 mg			Double J Stent		-			
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet		-			
Tab. Misoprost : 200mg			Betadine Solution		-			
<u>Inj - Dexa</u>		01	Microshield		-			
<u>D/W</u>		03	Cotton Balls		-			
<u>Vain-o-line</u>		01	Latex Gloves		20 Pairs			
			Ramdione Scrub					
			Saral					

Dr. Mani
 Surgeon

Dr. Subalokshmi
 Anaesthesiologist

Dr. Manjira
 Nurse

Rishi S
 OT Technician

Order No. : Ordered by :

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Anna Nagar



Old Survey No.230/7A part, Town Survey No.8, Pillaiyar Koil Street,
Thirmangalam Anna Nagar West Chennai Tamil Nadu INDIA 600040
Tel No : 044-69289928

VAT TIN :

CIN :

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS



IP No	IP28-00004543	Ward	5F-PRE/POST
Patient Name	Baby ARYA	Bed Name	PRE & POST OP 506
Age/Sex	2 Y 1 M 16 D / Male	Order No	28-0000149409
Date	09/06/2026 19:05	Prescription No	PRIP28-0070227
Payor	MEDI ASSIST INSURANCE TPA PVT LTD	Dispensed Date	09/06/2026 19:06
UHID	ANC-00000800		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
2	DEXARIL 4MG INJ		H	0DEX25008SR	06/27	1	10.88	10.88
3	DEXTOMID INJ 50 MCG 0.5 ML	Neon Laboratories Ltd		1257022	11/27	1	383.40	383.40
4	DEXTROSE IV 25 % 100 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	01B260748	01/27	1	22.03	22.03
5	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	026B24K67	01/31	3	21.83	65.49
6	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)		5344207	11/30	1	24.00	24.00
7	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	3	21.56	64.68
8	DSYRINGE DISCARDIT 20ML (BD)	BECTON DICKINSON (BD)	GENERAL	2403504	02/29	1	50.63	50.63
9	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	026A21K64	12/30	2	10.31	20.62
10	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	3	2.58	7.74
11	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0060425	03/27	3	34.65	103.95
12	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	0G25I010420	08/30	1	63.00	63.00
13	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353003	09/27	1	69.10	69.10
14	NEEDLE 18 * 1 1 2	Dispovan	GENERAL	49524C	11/30	1	3.38	3.38
15	ONDOKIND INJ 4 MG 2 ML	SWISS CRITICURE		BA26025	01/28	1	12.72	12.72
16	PEDIADRISET PLUS	ROMSONS		G26A020313	02/31	1	311.00	311.00
17	PYROLATE INJ AMP 0.2MG 1 ML	NEON LABORATORIES LTD	H	KP1254175	11/28	1	15.37	15.37
18	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D261807	03/29	2	60.74	121.48
19	VEIN-O-LINE 10CM ROMSONS		GENERAL	0G26A010486	12/30	1	386.00	386.00
Total :							1,548.48	1,780.77

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : RISHI S

RAINBOW CHILDREN'S MEDICARE LIMITED**Rainbow Children's Hospital - Anna Nagar**

Old Survey No.230/7A part, Town Survey No.8, Pillaiyar Koil Street,
Thirmangalam Anna Nagar West Chennai Tamil Nadu INDIA 600040
Tel No : 044-69289928



VAT TIN :

CIN :

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP28-00004543	Ward	5F-PRE/POST
Patient Name	Baby ARYA	Bed Name	PRE & POST OP 506
Age/Sex	2 Y 1 M 16 D / Male	Order No	28-0000149408
Date	09/06/2026 19:05	Prescription No	PRIP28-0070226
Payor	MEDI ASSIST INSURANCE TPA PVT LTD	Dispensed Date	09/06/2026 19:05
UHID	ANC-00000800		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	3M CAST POP 10CMS	3M HEALTHCARE	GENERAL	ND2605006	12/28	3	201.00	603.00
2	3M CAST POP 15CMS	3M HEALTHCARE		ND2505066	05/28	2	239.06	478.125
3	ARTIFLEX 10 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	024MA035	11/28	1	198.75	198.75
4	ARTIFLEX 10 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	025MA029	07/29	1	232.00	232.00
5	ARTIFLEX 15 CM X 3M (SOFTROLL)	BSN MEDICAL	GENERAL	23MA0280	12/28	1	290.62	290.625
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	20260416	03/29	1	105.00	105.00
7	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS		ENPF030020	11/28	40	25.00	1,000.00
8	RAPIDUR 10 CMS	BSN MEDICAL		23H084	11/28	2	194.00	388.00
9	SGLOVE # 8.0(POWDER FREE)	ANSEL	GENERAL	260300741T	04/29	2	128.00	256.00
10	TRICOFIX STOCKINETTE 5CM X 1M	BSN MEDICAL	GENERAL	243608460	08/29	1	120.94	120.938
Total :							1,734.38	3,672.44

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : RISHI S



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Arya Gender: Male Female Age : 2 years
UHID No : 000 00 800 / 0000 4543 Date : 9/6/2026

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)

CLOSED REDUCTION and HIP SPICA APPLICATION

upon

(Name of the Patient)

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

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

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

NEUROVASCULAR DAMAGE, COMPARTMENT SYNDROME; RISK OF LOSS OF REDUCTION, PRESSURE SORES; NEED FOR RE-PROCEDURE

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. HARIN

Consentee :
Signature : C. Soundarya
Name : C. Soundarya
Date & Time : 9/6/2026

Patient Attendant :
Signature : [Signature]
Name : T. RAJAKKAND
Relationship with Patient : FATHER
Date & Time : 09/06/2026 03:40 PM

Witness :
Signature : _____
Name : _____
Date & Time : _____

Doctor (who is taking the consent) :
Signature : Dr HARIN
Name : [Signature]
Date & Time : 09/06/2026 3:40 PM

CONSENT FORM FOR ANAESTHESIA

ANC-0000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF



Patient Name : BABY - ARYA Age : 2Y Gender : Male Female
UHID NO: 0800 / 4543 Surgeon Name: DR. HARIN
Anaesthesiologist : DR. KARTHIKA Operative procedure planned : CLOSED REDUCTION & POP

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 anaesthetics 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 :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthesia 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 anaesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury of the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia 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 anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : C. Soundarya
Name : C. Soundarya
Relationship with Patient : Mother
Date & Time : 9/6/2026

Witness :

Signature : [Signature]
Name : RAJAKKANI
Date & Time : 09/06/2026 / 15:10 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : DR. E. KARTHIKA Date & Time : 9/6/26



OPERATION NOTES

Surgeon : Dr HARIN		Asst. Surgeon : Dr. CHIRAN	
Anesthetist : DR. NATHANARAYAN		OT Nurse : Sri Lakshmi	
Pre-Operative Diagnosis: LEFT SHAFT OF FEMUR FRACTURE			
Surgical Procedure : Left femur closed reduction + hip spica casting			
Weight : 11 kg	Date : 9/6/26	Start Time : 3:45 PM	End Time : 5 PM
Post Operative Diagnosis:			
Peri-Operative Complications: nil			
Operation Notes:			
Findings: -			
Procedure Notes: ↓ GA, child supine on hip spica board. &			
- Gentle in-line traction & ER given.			
- Hip maintained in 60° flexion, 30° abduction & knee in 70° flexion			
- Casting done from trunk at level of nipple downwards to thigh & leg			
- Gentle valgus given at fracture site.			
- Reduction satisfactory ↓ c-arm			
- Spica casting completed. DP felt over DPA. Child withstood procedure well			
Amount of Blood Loss: -		Blood Transfused (in ML) -	
Name and Number of Surgical Specimen sent for examination: -			

ANC-00000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF



POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

- Monitor vital
- Monitor left foot for capillary refill

Wound Care:

INS-PARA 110mg IV 10-1

Drain /Special Lines/Catheters:

post procedure xray
xray left femur - as/act

Special Patient Positioning and Requirements:

- supine / sitting

Nutritional Instructions:

- as per anaesthesia order / pediatrician order

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

Yes No

Any Other Post-Operative Care Needed including Required Follow Up

NI

Name of the Surgeon: Dr. Havin

Signature of the Surgeon: [Signature]

Date & Time: 9/6/26 at 5PM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

ANC-00000800
Baby ARYA
24-04-2024
Dr. SELF

IP28-00004543
2 Y 1 M 16 D (M)



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Age: Sex: UHID.No:

Date: 9/6/26 Time: Proposed Operation: CLOSED REDUCTION + POP

Diagnosis: (L) FEMUR #

B.P / CRT: 90/60mm H.R: 140/min Weight: 10.5 Kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 10.5 Glucose: Protein: HIV: X-Ray:
 PCV: 30 Urea: Alb: HBS Ag: ECG:
 WBC: 11,760 Creat: Total Bill: HCV: 2D Echo:
 Plate: 4,87,000 Na: Dir. Bill: Blood group: O+ve Stress/Angio:
 PT: 16.8 K: LDH: T3 Other:
 PTT: 36.5 Ca++: Alk phos: T4
 INR: 1.16 Mg++: Amylase: TSH
 Cl -: SGOT/SGPT:

Allergies: Not Known

Medical History: CVS:
 RESP:
 CNS:
 Renal:
 Hepatic / GE:
 Others:
 Diabetes: LSCS - Term
Birth wt - 3kg.
No NICU stay.
Milestones (N)
 Physical Activity: Vaccination upto date

NORMAL

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:
 Lungs: B/L AE(+)
 Heart: S,S(+)
 CNS: NAND

Pregnant: Yes No N/A Venous Access Site: (+) - Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

- Pre-Operative Instructions:**
- DVT Prophylaxis :
 - Water / ORS 2 Hours
 - Others 6 Hours
 - NIL ORAL
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: Karthiga Name: DR. E. KARTHIGA



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Pankaj Pawar Time Received: 5 PM Time Discharged: 7:30 PM

RESP • PULSE > BLOOD PRESSURE	250		250
	240		240
	230		230
	220		220
	210		210
	200		200
	190		190
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
50		50	
40		40	
30		30	
20		20	
10		10	
0		0	
SPO ₂		0	

IV Cannula Site :

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting : Yes No Drug:

NG Tube : Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Nil Oral Yes No

IV Fluids:

Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY					A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION					
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION					
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS					
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR					
TOTAL <u>9/10</u>						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			<u>NPO - 3hrs</u>	

Pain Tool Used: N PASS FLACC Wong Baker NPS

- Reassessment Frequency:
- Every eight hours for all hospitalized patients.
 - For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr. Mahalaksan

Anaesthesiologist Signature: Maha

Date & Time: 96373

PACU Nurse Name : Dr. Pankaj Pawar

PACU Nurse Signature: Pankaj

Date & Time: 9/6/26 at 5 PM

Transferred to Unit by (PACU): [Signature]

Date & Time: 9/6/26 at 7:30 PM



Wsky

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby Arya Age: 2y Gender: Male Female

Date: 9/16/26 Time of Arrival: 11:00 AM Not known

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: 98.6 F PR: 110/60 BP: _____ RR: 36/min SpO₂: 100%

Chief Complaints: Atx fall on the Rest Room (fracture on the @ femur)

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

Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input checked="" type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input checked="" type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input 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.

Signature of Parent / Guardian: C. Wsky
 Triage Completion Time: 11:02 AM

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: Nil
- 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: B. Normal Rajan
 Date & Time: 9/16/26 @ 11:02 AM
 Docu. No.: RCH / FRM / CLINICAL / 085

Signature of Triage Nurse: B. Normal Rajan
020901



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 9/6/26 Time of arrival: 11:00 AM RBS: Factor on the [unclear]

Chief Complaints: Hb fall for on the Post Room

Height: — Weight: 10.5 kg BMI: — Head Circumference (<2 years) —

Allergies: Yes No Medications Blood Transfusion Food Other: —

If yes, identify —

Pain Screening: Yes No If Yes, Pain Score: 0/10 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
- Uses furniture for support

Yes No
 Yes No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

Yes No
 Yes No
 Yes No
 Yes No

Mental Status: Forgets limitations

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse: 11:15 AM

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

Time	Nursing Notes
11:45	<p>came to ER. clo fall from toilet. femur fracture on. Malini may seen the CWIC. later 4 to Mrs. Subbawa. 70 placed no done blood tests. CBC, blood glucose, PT/APTT sent to lab. Dr. Pulama did on. fracture. Dr. Ad Vireh plan for closed reduction in OT of legs. - Post op consultant done in terms to Anesthetist</p>

Samples collected by: *D/C Siva*

Time: *11:20 AM*

Samples sent by: *Shr. Normal Rajan*

Time: *11:30 AM*

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
<i>9/6/26</i> <i>11 AM</i>	<i>Syp. P250</i>	<i>P/O</i>	<i>5ml.</i>	<i>Anest</i>	<i>V/S</i>
<i>12 PM</i>	<i>Tab. PARACETAMOL</i>	<i>IV</i>	<i>110mg.</i>	<i>163765</i>	<i>V/S</i> <i>RECU</i>

Condition of patient at time of shift - out :	Details of Shift - out
<p>HR: <i>113b/min</i> BP: <i>100/60</i> CFT: <i>2cm</i></p> <p>RR: <i>32b/min</i> SPO₂: <i>100%</i></p> <p>GCS: <i>15/15</i> Temperature: <i>98.2F</i></p> <p>Pain Score: <i>4/10</i></p> <p>Repeat RBS (if applicable): <i>-</i></p>	<p>Shift - out from ER to: <i>OT</i></p> <p>Time of Shift - out:</p> <p>Handover given to: <i>SN</i></p> <p>(Nurse's Name)</p>

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): *11 placement Done by Dr Siva Kumar*
226 at (R) Motable

Name of the Nurse: *B. Normal Rajan*

Signature of the Nurse: *B. Normal Rajan*
020201

Date & Time: *9/6/26 @ 11 AM*



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Date: 9/6/2026

Admitting Doctor: Dr. Harin

Type of Admission: OPD ER Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: _____ Weight: 10.5 kg

Allergic History: _____

Chief Complaints: _____
Shaft of Femur Fracture
(Displaced Fracture)
 ↓
So cloud reduction
+ hip spica cast
 ↓
G.A

Pediatric Assessment Triangle

A Appearance - TICLS Alert, active
(Irritable but consolable)

B Breathing

- ↑ WOB
- ↓ WOB
- Normal
- Gasping / Apnea

C Circulation

- Normal
- Abnormal
 - Pallor
 - Cyanosis
 - Mottling
 - Bleeding

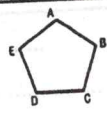
Initial Physiological Status: Stable Unstable

- Life Threatening
- Non Life Threatening

Any urgent interventions needed: Yes No
 If Yes _____


Significant Past History: _____
 Medication History: _____
 Relevant Investigations: _____

Primary Assessment

Airway 

- Open
- Maintainable
- Not Maintainable

Any urgent interventions needed: Yes No
 If Yes _____

Breathing 

Rate: 28/min SpO₂ on FIO₂: 99-100

Rhythm: Regular

Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: clear

Palpation Findings (if necessary): _____

Any urgent interventions needed: Yes No
 If Yes _____



Circulation

HR: 140/min

CFT Central
Peripheral < 3mm

Any urgent interventions needed: Yes No

BP: 93/62 (71) mmHg

Pulse Volume: Central
 Peripheral low flow

If in Shock: Compensated
 Hypotensive

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

Murmurs: Yes No

Liver Span: (2)

ECG:

Any Signs of Heart Failure: Yes No

If Yes



Disability

GCS: 5/15 AVPU: (A)

Pupils: Responsive Non-Responsive

Size: Right
 Left 2mm

Active Seizures: Yes No Sugars:

Signs of Neurological compromise: Tent (2)
NO FND

Any urgent interventions needed: Yes No

If Yes

Exposure



Temp.: (N)

Any Rash: Yes No

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes

Final Physiological Status: Respiratory Distress Respiratory Failure Respiratory Arrest
 Shock - Compensated Hypotensive

Cardiopulmonary Arrest Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

(2) Thigh - swelling -> firm to hard
Tender (2) Warm (2)

Labs Planned:

as per chart

Treatment Planned:

as per chart

Need for Oxygen: Yes No if yes Low Flow

High Flow PPV

Final Diagnosis with possible Differential Diagnosis (If necessary): blast of femur # -> for 5x

Assessment done by Name of the Doctor: Purnima

Sr. Doctor on Duty (If necessary)

Signature: Purnima

Name of the Sr. Doctor:

Date & Time: 9/6/26 e 11:30am

Signature:

Date & Time:

Physical Examination



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

ANC-00000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF

UHID ID:

Department:

Consultant:





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

_____ *- no previous admission.* _____

Birth & Neonatal History:

Term (38+4w) / LSCS / 3kg

Family Chart

CLAB

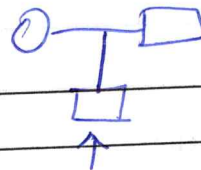
no NICU stay

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____



Developmental History :

Ⓜ for age

Immunization History :

full date see to IAP.

Anthropometry :

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

Weight (kgs) *10.5 kg* (Centile _____)

On Examination :

Temperature : *Ⓜ* Pulse Rate : *140/min* B.P. *93/62 (71)* SPO2 *99 / rra*

Resp.rate and type of breathing : _____

RR = 28/min

PPWF

Rash _____ *⊖*

Lymphadenopathy _____ *⊖*

Oedema : _____ *⊖*

Allergies (if any): _____

Patient Sticker



Respiratory System :

Inspection (any s/o distress) : _____

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

Any added sounds : No added sounds

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

Cardiovascular System :

Inspection of precordium : SR (+)

Heart Sounds : M (-)

Any murmur : _____

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

Per Abdomen :

Inspection : soft; non-tender

Palpation : No organomegaly

Auscultation : _____

Spine : _____ External Genitalia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : ACS-15/15

Motor System : Tone - @
NO FND

Nutrition : _____

Tone : _____ Power : _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

ANC-0000800

IP28-00004543

Baby ARYA

24-04-2024

2 Y 1 M 16 D (M)

Dr. SELF

Pati



Reflexes :

DTR

Superficials:

Plantars

Sensory System :

4/e. ② Thigh = swelling (+); warmth (+)
mid 1/3 Tenderness (+)

Bladder / Bowel :

ROM - Restricted
DP (+) over PAs PTA

Clinical Summary & Diagnostic:

Shaft of Femur fracture → closed Reduction
+ hip spica cast JGA.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
PT/APTT/INR
blood grouping

Planned Management

→ closed Reduction +
hip spica cast JGA

Signature of the Doctor: *Juanita*

Name of the Doctor: Dr. Juanita

Date & Time: 9/6/26 e 11am

Signature of the Consultant: *[Signature]*

Name of the Consultant: Dr. HARN

Date & Time: (P.T.O.)

ANC-0000800 IP28-00004543
Baby ARYA
24-04-2024 2 Y 1 M 16 D (M)
Dr. SELF



DISCHARGE PLANNING FORM

NOTE: * To be completed by a Doctor within (24) hours of admission.

1. Anticipated Date of Discharge:

2. Destination Post Discharge: Home
Family Members Notified (Person Contacted)

Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: Self Care Family Home Care Home Professional Assistance

Needs Assistance In:

- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Remarks
.....
.....
.....
.....
.....
.....

4. Nutritional Plan:
 Dietary Instruction Discussed with the:
 Patient Family Member Others:

5. Discharge Planning Discussed with the:
 Patient Family Member Others:

6. Patient/Family Educational Plan:
 Educational Topic/s:

Patient's Educational Topic/s discussed with the:
 Patient Family Member Others:

Doctor Signature:

Doctor Name:

Date and Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 2:10 PM	SIR Dr. Mittal	
	(L) Femur closed shaft fracture Sx: (L) Femur closed reduction +	
	Child awake.	
	NO issues	
	Tolerating liquids well up: not found little surgery	
	O/E: Alert Afebrile PWF	
	S/E: cvs: 91.2 (+) PS: B/LA (+) PLA: soft	L/E: Drug intact.
	Plan: To encourage soft solid diet to do X-RAY (L) Femur shaft.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/05/26	<p>sls Dr. HARIN (ORTH)</p>	
6 am	<p>Day 1, closed reduction + hip spica casting @ femur</p>	
	<p>child is comfortable, awake encourages alert & active no cl. irritability</p>	
	<p>sls - vitals - stable</p>	
	<p>Hx of spica cast - no elbow swell - intact cast - foot Rom @ - CRT - good issues - PP @ over DPA</p>	
	<p>- Spica cast care, diaper care, pressure sore check Advice: explained</p>	
	<p>- To start on normal diet as tolerated - Plan for discharge today</p>	
	<p><u>Discharge advice</u></p>	
	<p>- To change of position frequently - to avoid pressure sore</p>	
	<p>- Can be made to sit/lie down as per comfort</p>	
	<p>- To wlk @ foot perfusion / pulses continuously</p>	
	<p>- Diaper care & to avoid soiling of spica cast</p>	

ANC-00000800
Baby ARYA
24-04-2024
Dr. SELF

IP28-00004543
2 Y 1 M 16 D (M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Rx	
	SYP - P ₂₅₀ (PARACETAMOL) 5ml 5ml P _{ho} 1-1-1	x 4 days ↓ 505.
	- To use pillow support underneath left lower limb	
	- In case of inconsolable cry/painful foot movement/ pale foot to consult in ER immediately	
	- To review after one week	
	10/6/26 10/6/26 8:50AM	S/B Dr. Aneshu
	FRACTURE (L) FEMUR CLOSED REDUCTION & HIP SPICA CASTING. Child well. No fever. Started oral feeds → No vomiting child alert Distal to cast - finger movement (+). Colour pink. Dorsalis pedis (+).	Aneshu 163765

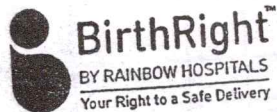
ANC-00000800 IP28-00004543
 Baby ARYA
 24-04-2024 2 Y 1 M 16 D (M)
 Dr. SELF



RESULT SHEET

Date	9/6/26				
Time					
Hb	10.5				
PCV	30				
RBC	4.14				
WBC	11.76				
N/L	46/50				
Platelets	4.87				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	16.3/1.16				
APTT	36.5				
CSF Protein / Sugar					
Cells					
N/L					

Ref. No. : F / HW / DC / INPR / 05



Patient Name : ANC-00000800 IP28-00004543
 Baby ARYA
 24-04-2024 2 Y 1 M 16 D (M)
 Gender M Dr. SELF

Age :

Consultant :

Date of Admission :

DRUG ALLERGIES : *Nil*

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. **ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.**
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, **BLOCK LETTERS**, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a **NEW PRESCRIPTION**. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the **FIVE RIGHTS** before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES
 (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

Patient Name :



I.P. No. Sheet No. Wards Weight (kg)
 2 1 Mr. Jee 11kg

REGULAR PRESCRIPTIONS

DRUG : IVZ PANTOP

Dose	Route	Frequency	Start Dt.	Date Time
<u>1mg IV</u>	<u>IV</u>	<u>OD</u>	<u>9/6/24</u>	<u>9/6/24</u>

Name & Signature of the Doctor starting the Drugs:
P. Selva
 114301

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.	Date Time

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.	Date Time

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.	Date Time

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

ANC-00000800 IP28-00004543
 Baby ARYA 2 Y 1 M 16 D (M)
 24-04-2024
 Dr. SELF



NURSING CARE RECORD

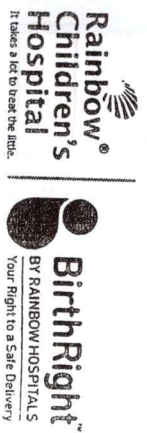
Date: 9/6/24

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning						
Afternoon	<p>8pm</p> <p>Assess the baby general condition provide comfortable position</p>		<p>Assessed the baby general condition provided comfortable position.</p>	<p>Baby vitals stable.</p>	<p>Baby in line patterned no redness & swelling.</p>	<p>[Signature]</p>
Night	<p>10pm</p> <p>Assess the baby condition encourage over fluid</p>	10pm	<p>Assessed the baby condition encourage over fluid</p>	<p>Improves over fluid</p>	<p>IV lines present</p>	<p>[Signature]</p>

Patient Sticker

NURSING CARE RECORD



- 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:

Date:

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature

ANC-00000800

IP28-00004543

Baby ARYA

2 Y 1 M 16 D (M)

24-04-2024

Dr. SELF



NURSES NOTES

oil

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9/6/26	3pm.	Patient Received from PR. to preop patient consent done. Baby vitals checked & recorded.	
	3:45pm	Baby shifted to OT-1 Baby sign in done. As vitals monitors are connected. Anaesthesia given by anesthetic man. position the	
		Baby procedure start at 3:58pm Baby vitals monitored during procedure. Left femur closed Deduction + hip epica casting done by Dr. Harin. Reposition	
	7pm.	The Baby Review the baby from Anaesthesia and shift the baby from OT-1 to post op ward. Baby vitals are monitored. Baby had sip of water There is no complaints of Nausea &	
	7:30pm	vomiting. Baby shifted to N-floor	
		Relieving notes:	
9/6/26	7:30pm	Baby received from OT staff Lakshmi	
		→ baby is active and alert	
		→ baby IV line present and pattern IV pend stop.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



No Known Drug Allergies

Drug Allergies

NP1

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9/6/26		→ baby had liquid diet	
		→ today plan array of lateral	
		baby vitals stable.	
	8pm →	baby handovers given to night	→ ps
		duty staff Kayal	(ps)
		9/6/26 - Night duty	→ ps
	8pm	child is handing	
		over taken from Kreening	
		she is alert conscious	
		and oriented. IV line kept	
		in position.	
	4pm	child location informed	
		to Dr. Harin Sir	
		she	
	10pm	while working, child	
		had to drink.	
	12 AM	vital monitoring	
		and recording	
		child is sleeping	
		well.	6 0935
	4pm	vital monitoring	
		and recording.	
	6pm	medication given	
		as per drug chart	
		Dr. Harin Sir seen	
		the patient today	
		Discharge	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

