

KMV-00004305 IP-00060479  
Master NIHAL  
24-07-2020 5 Y 11 M 1 D (M)  
Dr. JYOTI BOTHRA



**ACTIVITY RECORD FOR BILLING**

Name: -----

UHID No : ----- IP No : ----- Consultant : ----- Dept : pediatrics

Date of Admission : 25/6/26 Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : ----- Ward : OT Suggested Billable bed type : -----

**WARD TRANSFERS**

| Date           | Time              | From      | To                   | Signature of Nurse |
|----------------|-------------------|-----------|----------------------|--------------------|
| <u>25/6/26</u> | <u>@ 12:25 PM</u> | <u>ER</u> | <u>OT</u>            | <u>[Signature]</u> |
| <u>25/6/26</u> | <u>8pm</u>        | <u>OT</u> | <u>Recovery Room</u> | <u>[Signature]</u> |
|                |                   |           |                      |                    |
|                |                   |           |                      |                    |

**Cross Consultation Visit**

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







|                        |   |                       |                   |
|------------------------|---|-----------------------|-------------------|
| <b>Name</b>            | Master NIHAL  | <b>UHID</b>           | KMV-00004305      |
| <b>Father/Guardian</b> | Mr CH RAVI KUMAR  | <b>Age/Gender</b>     | 5 Y 11 M 1 D/Male |
| <b>Address</b>         | JYOTHINAGAR ,JYOTHINAGAR , Marri Palem, Vishakhapatnam, Andhra Pradesh, INDIA, 530018 |                       |                   |
| <b>IP No</b>           | IP-00060479   | <b>Admission Date</b> | 25-06-2026        |
| <b>Ref Doctor</b>      | Self  | <b>Discharge Date</b> | 25-06-2026        |

## **DISCHARGE SUMMARY**

**Consultant : Dr. JYOTI BOTHRA**

DNB; MCh (Pediatric Surgery), FMAS  
SENIOR CONSULTANT PEDIATRIC SURGEON & UROLOGY  
TSMC/FMR/02962

**Diagnosis: Left Hydrocele**

**Surgical Procedure: Left high ligation of sac done under general anesthesia on 25.06.2026**

**History:** Master NIHAL, 5 Y 11 M 1 D male presented with complaint of swelling over the left testis. For the above complaints, he was admitted at Rainbow Children's Hospital for further management.

**Examination:** He was afebrile, maintaining saturations at room air. Heart rate was 100/min, Blood Pressure - 90/60 mmHg and RR - 22/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 17.8 kgs.

**Investigations:** Enclosed.

|      |              |      |              |
|------|--------------|------|--------------|
| Name | Master NIHAL | UHID | KMV-00004305 |
|------|--------------|------|--------------|

**Management:** Child was admitted in the ward and was started on IV fluids.

Hemogram showed Hb - 11.9 gm%, WBC - 11,790 cell/cmm, Platelets - 2.38 lakh/cmm.

**Procedure:** Left high ligation of sac done under general anesthesia on 25.06.2026

**Findings:** Left fluid filled processus vaginalis

**Procedure notes:**

- Left mid inguinal lower crease incision
- EOA opened
- Sac delineated from vas and vessels and divided
- Proximal end ligated and transfixed, Distal sac laid open
- Incision closed in layers

**Post-Operative Notes:** Post operative period was uneventful. After stabilization, child was started on oral feeds which he accepted and tolerated well. He remained hemodynamically stable during the hospital stay and operated site remained healthy. He is being discharged with the following advice.

**Advice:**

1. Diet as advised.
2. Remove dressing after 3 days and daily bath.
3. Syrup Paracetamol (5ml=240mg) 5ml, 8<sup>th</sup> hourly for 2 days and then (if required) for pain or fever more than 100°F.
4. Kindly consult Dr. Jyoti Bothra, Senior Consultant Pediatric Surgeon & Urologist, after 10 days in OPD with prior appointment (This consultation will be charged).

Name

Master NIHAL

UHID



To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

In Case of Emergency Contact 040-42462200, Extn: 2010 (or) 7337357870 for increasing breathing difficulty, dullness or high fever.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

Name : Yamini

Signature :

Relationship with patient : mother

This summary has been explained by : Ruby.

Summary prepared by: Dr. B. Prashanthi  
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

**Dr. JYOTI BOTHRA**

DNB; MCh (Pediatric Surgery), FMAS  
SENIOR CONSULTANT PEDIATRIC SURGEON & UROLOGY  
TSMC/FMR/02962

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KMV-00004305 IP-00060479

DICAL CASE SHEET



Patient Name

Master NIHAL  
24-07-2020 5 Y 11 M 1 D (M)  
Dr. JYOTI BOTHRA

IP. No :

Ward :



DOD :

| Sl.No. | List of Records                           | No. of Pages | Legibility | Completeness | Remarks |
|--------|---|--------------|------------|--------------|---------|
| 1      | Admission sheet                           | 1            | ✓          | ✓            |         |
| 2      | Discharge Summary                         | 2            | ✓          | ✓            |         |
| 3      | Nursing Initial assessment.               | 1            | ✓          | ✓            |         |
| 4      | Patient Transfer form                     | 2            | ✓          | ✓            |         |
| 5      | In-patient Medical record                 | 1            | ✓          | ✓            |         |
| 6      | Doctors progress sheets                   | 1            | ✓          | ✓            |         |
| 7      | Nursing plan of care and handover sheets  | 1            | ✓          | ✓            |         |
| 8      | Consultation sheet                        | 1            | ✓          | ✓            |         |
| 9      | General consent for treatment             | 1            | ✓          | ✓            |         |
| 10     | Consent for Surgery                       | 1            | ✓          | ✓            |         |
| 11     | Consent for blood transfusion             | 1            | ✓          | ✓            |         |
| 12     | Consent for chemotherapy                  | 1            | ✓          | ✓            |         |
| 13     | Consent for high risk                     | 1            | ✓          | ✓            |         |
| 14     | Consent for Restraint                     | 1            | ✓          | ✓            |         |
| 15     | LAMA consent                              | 1            | ✓          | ✓            |         |
| 16     | Consent for special procedure/Sedation    | 1            | ✓          | ✓            |         |
| 17     | Consent for Formula feed                  | 1            | ✓          | ✓            |         |
| 18     | Consent for MTP                           | 1            | ✓          | ✓            |         |
| 19     | Consent for Radiological Investigations   | 1            | ✓          | ✓            |         |
| 20     | Consent for HIV test                      | 1            | ✓          | ✓            |         |
| 21     | Anaesthesia notes (Pre Anaesthesia& post) | 1            | ✓          | ✓            |         |
| 22     | Neonatal Admission/Delivery/Physical Exam | 1            | ✓          | ✓            |         |
| 23     | Medication Reconciliation                 | 1            | ✓          | ✓            |         |
| 24     | Emergency Triage record                   | 1            | ✓          | ✓            |         |
| 25     | Pre operative check list                  | 1            | ✓          | ✓            |         |
| 26     | Surgical safety checklist                 | 1            | ✓          | ✓            |         |
| 27     | Operation Theatre notes                   | 1            | ✓          | ✓            |         |
| 28     | Nurses clinical Presentation              | 1            | ✓          | ✓            |         |
| 29     | TPR & BP chart                            | 1            | ✓          | ✓            |         |
| 30     | Intake and Out take chart (fluid chart)   | 1            | ✓          | ✓            |         |
| 31     | Drug chart (Regular Prescription)         | 1            | ✓          | ✓            |         |
| 32     | Investigation Values (result sheet)       | 1            | ✓          | ✓            |         |
| 33     | Nebulization chart                        | 1            | ✓          | ✓            |         |
| 34     | Nutritional review chart                  | 1            | ✓          | ✓            |         |
| 35     | Intensive care unit (ICU Charts)          | 1            | ✓          | ✓            |         |
| 36     | Consent for Admission in PICU/NICU        | 1            | ✓          | ✓            |         |
| 37     | The Humpty dumpty scale                   | 1            | ✓          | ✓            |         |
| 38     | Braden Q Scale                            | 1            | ✓          | ✓            |         |
| 39     | Bed side check list                       | 1            | ✓          | ✓            |         |
| 40     | PICU bed formula Dilution feeds           | 1            | ✓          | ✓            |         |
| 41     | Gastro monitoring chart                   | 1            | ✓          | ✓            |         |
| 42     | Rch ED doctors note                       | 1            | ✓          | ✓            |         |
| 43     | BP Monitoring chart                       | 1            | ✓          | ✓            |         |
| 44     | RBS monitoring chart                      | 1            | ✓          | ✓            |         |
|        | Arshat Peery                              | 1            | ✓          | ✓            |         |

Total No. of Pages 31

Signature and Date : 27/6/24

# ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /  
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

*Handwritten signature and illegible text*

## ADMISSION SHEET

### Registration Details :



Admission No : IP-00060479

Admit Date : 25-Jun-2026

Admit Time : 11:39 AM UHID : KMV-00004305

### Patient Details :

Patient Name : Master NIHAL

Age : 5 Y 11 M 1 D

Guardian : Mr CH RAVI KUMAR

DOB : 24-07-2020

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : JYOTHINAGAR ,JYOTHINAGAR Marri Palem  
Vishakhapatnam Andhra Pradesh INDIA  
530018

Phone No : 7989295025

E-mail : na123@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

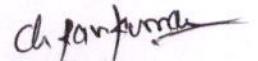
### Contact Details :

Name : Mr CH RAVI KUMAR

Relationship : Father

Contact Address : JYOTHINAGAR ,JYOTHINAGAR Marri Palem  
Vishakhapatnam Andhra Pradesh INDIA 530018

Phone No : 7989295025

  
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

KMV-00004305 IP-00060479  
 Master NIHAL  
 24-07-2020 5 Y 11 M 1 D (M)  
 Dr. JYOTI BOTHRA



### NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/20 Time of arrival : 11:22 AM  
 Chief Complaints : Ch. Came from Surgery (Left High Ligation of Sac) RBS: ( )  
 Height : 112 cms Weight : 17.80 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 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?) 1 (sister)

Time of Initial assessment completed by ER Nurse : 11:26 AM

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

| Time     | Nursing Notes  |
|----------|--|
| 11:17 AM | Patient came to ER                                   |
| 11:20 AM | Vitals checked & recorded.                           |
| 11:25 AM | Doctor seen the patient & Advice for admission.      |
| 11:29 AM | Admission done.                                      |
| 12:00 PM | IV placement done, Sample collected and send to Lab. |
| 11:45 AM | NIPO - 2:00 AM (Solid) - Disposed - 11:30 AM.        |
| 12:25 PM | Patient shifted to OT                                |

Samples collected by: } Dr. Rajgouram  
 Samples sent by: }  
 Time: @ 12:02 PM  
 Time: @ 12:05 PM

Medication given in ER:

| Date / Time | Medication | Route | Dosage & Instructions | Doctor Sign | Nurse Sign 1 |
|-------------|------------|-------|-----------------------|-------------|--------------|
| /           |            |       |                       |             |              |

|   |  |  |
|---|--|--|
| Condition of patient at time of shift - out :<br>HR: 128b/min, BP: 106/182 (89) CFT: Kasec, RR: 24 b/min SPO2: 99%, GCS: 4, 5, 6, Temperature: 98.7°F, Pain Score: 0, Repeat RBS (if applicable): - |  | Details of Shift - out :<br>Shift - out from ER to: OT<br>Time of Shift - out: @ 12:25 PM<br>Handover given to: Dr. Parosona<br>(Nurse's Name) by Architha |
|---|--|--|

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any):

IV placement done.


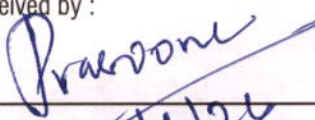
Name of the Nurse: Architha.  
 Date & Time: 25/01/20 @ 12:25 PM

Signature of the Nurse:



# PATIENT TRANSFER FORM


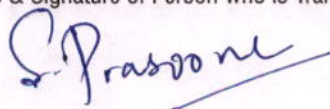
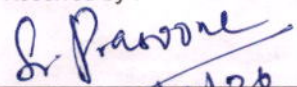


|   |                              |  |  |
|---|------------------------------|--|--|
| KMV-00004305      IP-00060479<br>Master NIHAL<br>24-07-2020      5 Y 11 M 1 D      (M)<br>Dr. JYOTI BOTHRA<br> |                              | Date & Time of Admission<br>25/6/26 @ 11.39AM  | Date & Time of Transfer Order<br>25/6/26 @ 12:25PM |
| Transfer Ordered by<br>Dr. prashanthi   |                              | Reason for Transfer<br>Admission   |  |
| From Unit<br>ER   | To Unit<br>OT                | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| Number of Sheets in Clinical File<br>21   | Number of Imaging Films<br>— | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |  |
| Medications / Consumables / Surgicals / Hand over   |                              |  |  |
| Sl.No.  | Item Name                    | Quantity   |  |
| 1.  |                              |  |  |
| 2.  |                              |  |  |
| 3.  |                              |  |  |
| 4.  |                              |  |  |
| 5.  |                              |  |  |
| Shifting Summary / Notes Written by Doctor :      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                              |  |  |
| Name & Signature of Person who is Transferring<br>Architha / As   |                              | Name of Person Ordered Transfer<br>Dr. prashanthi  |  |
| Patient & Clinical Records Received by :<br>   |                              |  |  |
| Date & Time of Patient Received :<br>25/6/26  |                              |  |  |

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

# PATIENT TRANSFER FORM

|   |                                    |   |  |
|---|------------------------------------|---|--|
| Patient Name & UHID No.<br><br>KMV-00004305      IP-00060479<br>Master NIHAL<br>24-07-2020      5 Y 11 M 1 D (M)<br>Dr. JYOTI BOTHRA<br> |                                    | Date & Time of Admission<br><br>25/6/26, 11:39 am   | Date & Time of Transfer Order<br><br>25/6/26 @ 3pm |
|   |                                    | Transfer Ordered by<br><br>Dr. M. Selvar  | Reason for Transfer<br><br>Post of Care            |
| From Unit<br><br>OT   | To Unit<br><br>Recovery Room       | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| Number of Sheets in Clinical File<br><br>(26)   | Number of Imaging Films<br><br>nil | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what <input checked="" type="checkbox"/> |  |
| Medications / Consumables / Surgicals / Hand over   |                                    |   |  |
| Sl.No.  | Item Name                          | Quantity  |  |
| 1.  |                                    |   |  |
| 2.  |                                    |   |  |
| 3.  |                                    |   |  |
| 4.  |                                    |   |  |
| 5.  |                                    |   |  |
| Shifting Summary / Notes Written by Doctor :      Yes <input type="checkbox"/> No <input type="checkbox"/>  |                                    |   |  |
| Name & Signature of Person who is Transferring<br><br>   |                                    | Name of Person Ordered Transfer<br><br>Dr. M. Selvar  |  |
| Patient & Clinical Records Received by :<br><br>   |                                    |   |  |
| Date & Time of Patient Received :      25/6/26 @ 3pm  |                                    |   |  |

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



### PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time    | Progress Notes  | Doctor's Order |
|----------------|---|----------------|
| <u>25/6/26</u> | S/B or <u>spoke</u><br><br>of do High ligation of sac<br><br>stable |                |
|                | Adv<br><u>R/w</u> 20 S  |                |
|                | f<br>B  |                |
|                |   |                |
|                |   |                |





## NURSING SHIFT HAND OVER FORM

|                        |  |   |  |  |  |  |  |
|------------------------|--|---|--|--|--|--|--|
| <b>SITUATION</b>       | Diagnosis:   | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |  |  |  |  |  |
|                        | Surgery / Procedure:                                   | Post OP Day:  |  |  |  |  |  |
| <b>BACKGROUND</b>      | Date   |   |  |  |  |  |  |
|                        | Shift  |   |  |  |  |  |  |
|                        | Medical Condition (Any special condition to be noted): |   |  |  |  |  |  |
|                        | Diet:  |   |  |  |  |  |  |
| <b>ASSESSMENT</b>      | 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 <sub>2</sub> :  |  |  |  |  |  |
|                        |  | Pulse:  |  |  |  |  |  |
|                        |  | BP:   |  |  |  |  |  |
|                        |  | LOC:  |  |  |  |  |  |
|                        |  | Fall Risk Score:  |  |  |  |  |  |
|                        | Pain Score:  |   |  |  |  |  |  |
|                        | Skin Integrity   |   |  |  |  |  |  |
| <b>Recommendations</b> | 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 |
|                        | ADL (Dependent / Non Dependent):                       |   |  |  |  |  |  |
|                        | 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 |
|                        | Post Operative Procedure Special Orders:               |   |  |  |  |  |  |
|                        | Handed Over By Name :                                  |   |  |  |  |  |  |
|                        | Signature / ID :                                       |   |  |  |  |  |  |
|                        | Date:  |   |  |  |  |  |  |
|                        | Time:  |   |  |  |  |  |  |
|                        | Taken Over By Name :                                   |   |  |  |  |  |  |
|                        | Signature / ID :                                       |   |  |  |  |  |  |
|                        | Date:  |   |  |  |  |  |  |
|                        | Time:  |   |  |  |  |  |  |



# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Master Nihal Age : 5 yr Gender : Male  Female

UHID NO: ..... Surgeon Name: Dr. Jyoti

Anaesthesiologist : Dr. Vineeta

Operative procedure planned : ① High ligation of sac

## 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 : Desaturation, Bronchospasm, Laryngospasm

Comments : .....

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

## DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Master Nihal the above mentioned operation / Diagnostic / Therapeutic procedures ① High ligation of sac.

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 anaesthesiologist 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 : [Signature]  
Name : N. Yaman  
Relationship with Patient: Mother  
Date & Time : 24/06/2026

**Witness :**

Signature : [Signature]  
Name : GIORDANO PERAZZINI  
Date & Time : 24/06/2026

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

Signature : [Signature]  
Name : DR. M. VIARETTA  
Date & Time : 24/06/2026

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mast. Nihal Gender:  Male  Female Age : 54r  
 UHID No : 04305 Date : 25/6/26

**Instruction:**

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avpid technical terms)

(2) high ligation of sac  
 upon Nihal  
 (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

**My signature on this form indicates that**

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Jyoti Botla

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

**Patient Attendant :**  
 Signature : [Signature]  
 Name : Ranjana Chappal  
 Relationship with Patient: father  
 Date & Time : 25/6/26, 1pm

**Witness :**  
 Signature : [Signature]  
 Name : [Name]  
 Date & Time : 25/06/26, 1pm

**Doctor (who is taking the consent) :**  
 Signature : [Signature]  
 Name : Dr. Jyoti Botla  
 Date & Time : 25/6/26, 1pm



## MEDICATION RECONCILIATION FORM

Drug Allergies: NO  Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---|-------------------|---------------------------|-----------|--------------------------|--|
| 1    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 5    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 6    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 7    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 8    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 10   |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Prashanthi

Date & Time: 25/6/26 @ 11:25 AM

Nurse Name & Signature: Dr. Chitra

Date & Time: 25/6/26 @ 11:25 AM

Patient Name : Mast. NIHAL UHID : KMV-00004305 IPD : IP-00060479 Gender : Male Age : 5 Y 11 M 1 D

KMV-00004305 IP-00060479  
 Master NIHAL  
 24-07-2020 5 Y 11 M 1 D (M)  
 Dr. JYOTI BOTHRA



wt - 17.80 kgs.  
 Ht - 112 cms.



### EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. Nihal Age : 5 years Gender :  Male  Female

Date : 25/6/20 Time of Arrival : @ 11:17 hr.

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: 98.5° F PR: 127bpm BP: 109/84 (90) RR: 24b/min SpO<sub>2</sub>: 99%

Chief Complaints: cto. Came for Surgery (left High Ligation of Sac)

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

| Triage Classification  | CTAS                                       |
|--|--|
| <input type="checkbox"/> Level 1 : Resuscitation   | <input type="checkbox"/> Immediate         |
| <input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening   | <input type="checkbox"/> < 15 min          |
| <input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening | <input type="checkbox"/> 30 min            |
| <input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening                              | <input checked="" type="checkbox"/> 60 min |
| <input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient   | <input type="checkbox"/> 120 min           |

**NOTE :** All immunocompromised children and preterm babies to be considered Level 2.  
 All Children less than 2 years age with high fever to be considered Level 3.

\* CTAS - Canadian Triage and Acuity Scale

Ch. Ravikumar  
 Signature of Parent / Guardian

Triage Completion Time : @ 11:20 hr.

### 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.

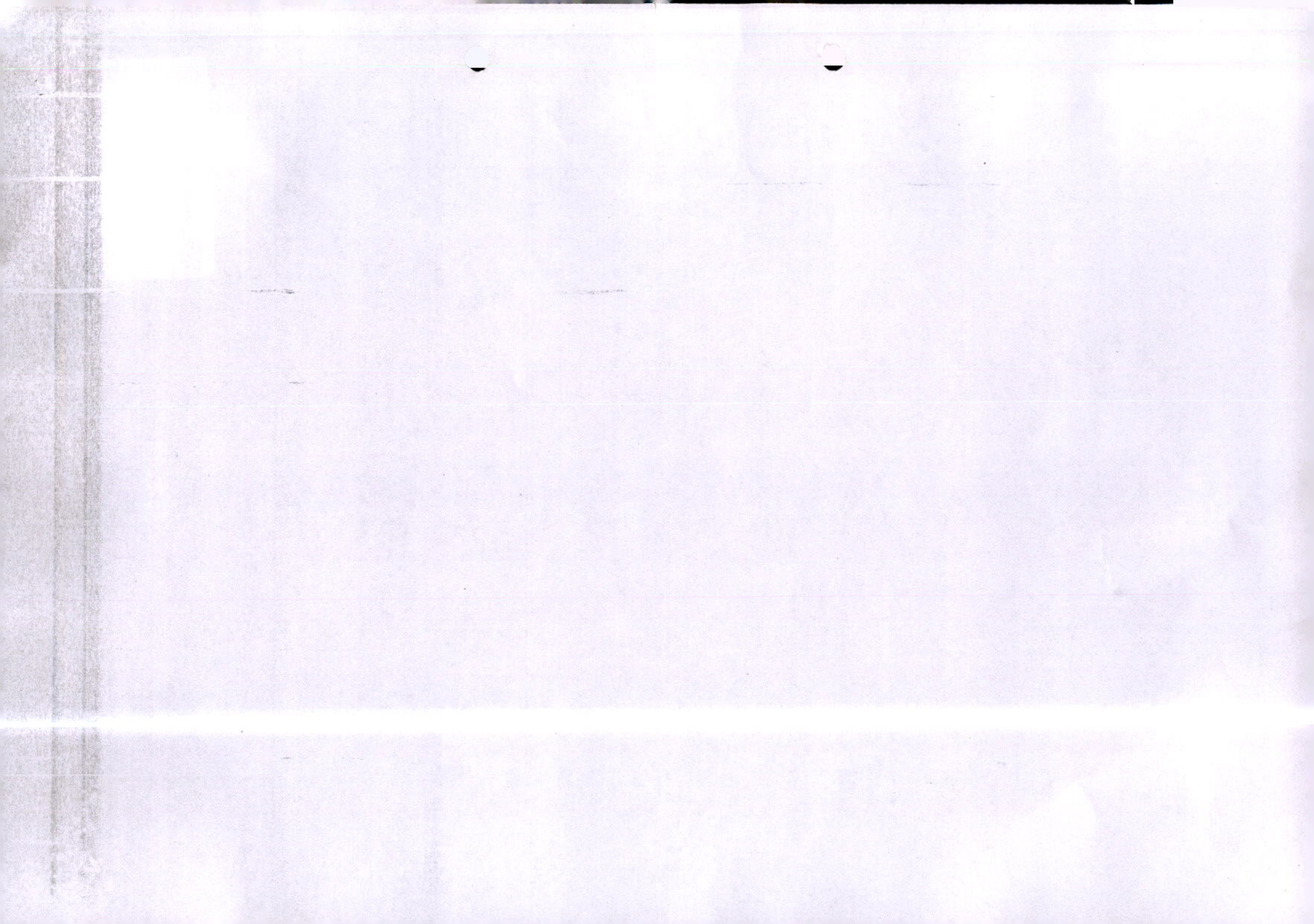
**PART D. ACTION / INTERVENTION:** (for positive suspected communicable disease triage screening)

- 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 : Suragatha

Signature of Triage Nurse : [Signature]

Date & Time : 25/6/20 @ 11:20 pm.



# SURGICAL SAFETY CHECKLIST

KMV-00004305 IP-00060479  
 Master NIHAL  
 24-07-2020 5 Y 11 M 1 D (M)  
 Dr. JYOTI BOTHRA

Surgeon: Dr. Jyoti Bothra  
 Asst. Surgeon: Dr. Anshu De Brauda  
 Anaesthetist: Dr. Anshu De Brauda  
 Scrub Nurse: Dr. Anshu De Brauda



Age: 54 Gender: M  
 Primary Name: High ligation of sac  
 Date: 25/6/20 In-time: 1:30 pm Out-time: 2 pm



Dr. Anshu De Brauda

## Before Induction of Anaesthesia >>

## Before Skin Incision >>

## Before Patient Leaves Operating Room

| SIGN IN  | Time: <u>1:10 pm</u>  |
|--|---|
| <b>Patient Has Confirmed</b>   |   |
| Identity   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Site   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Procedure  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Consent  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 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                             |
| <b>Does Patient have a:</b>  |   |
| Known Allergy?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |
| <b>Difficult Airway / Aspiration Risk?</b>                               |   |
| Yes, & Equipment / Assistance Available                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |   |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |
| Blood Units Reserved   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |   |
|  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |
| Signature: <u>B. de Brauda</u>   |   |
| Name: <u>Dr. Brauda</u>  |   |
|  | <u>25/6/20</u>  |

| TIME OUT  | Time: <u>1:30 pm</u>  |
|---|---|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b> <u>Master Nihal</u>   |   |
| Correct Patient (Check ID Band)   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| Correct Site  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| Correct Procedure   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>High ligation of sac</u>                             |
| <b>Anticipated Critical Events</b> <u>at Sac</u>  |   |
| <b>Surgeon Reviews:</b>   |   |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?  | <u>20 ml</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA<br><u>5 ml</u> |
| <b>Anaesthesia Team Reviews:</b>  |   |
| Are There Any Patient-specific Concerns?  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <u>Sensors</u>              |
| <b>Nursing Team Reviews:</b>  |   |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                             |
| <b>Is Essential Imaging Displayed?</b> <input type="checkbox"/> Yes <input checked="" 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>Ahmed Hussain</u>   |   |
| Name: <u>Ahmed Hussain</u>  |   |

| SIGN OUT  | Time: <u>2 pm</u>   |
|---|---|
| <b>Nurse Verbally Confirms with the Team:</b>                             |   |
| The Name of the Procedure Recorded  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| The Specimen is Labelled (including patient name)                         | <input checked="" 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 |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                |   |
| What are the key concerns for recovery and management of this patient?    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Signature: <u>Dr. Jyoti Bothra</u>  |   |
| Name: <u>Dr. Jyoti Bothra</u>   |   |

# 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

|   |   |                       |
|---|---|-----------------------|
| <b>Patient's Name : Master NIHAL</b>  | <b>Age : 5 Y 11 M 1 D</b>                   | <b>Gender : Male</b>  |
| <b>UHID : KMV-00004305</b>  | <b>I.P. NO. 00060479</b>                    | <b>WEIGHT :17.8kg</b> |
| <b>Surgeon : Dr.. JYOTI BOTHRA</b>  | <b>Asst surgeon : Dr. _____</b>             |                       |
| <b>Anaesthetist : Dr Madhav</b>   | <b>OT Nurse : S/N <i>Rafan/Prassana</i></b> |                       |
| <b>Surgical Procedure :. Left High ligation of sac</b>  |   |                       |
| <b>Indications for Surgery : Left Hydrocele</b>   |   |                       |
| <b>Anaesthesia - GA</b>   |   |                       |
| <b>PRE-OPERATIVE PREPARATION-</b><br>Betadine skin preparation  |   |                       |
| <b>OPERATIVE NOTES:</b><br><b>Findings:</b> Left fluid filled processus vaginalis<br><b>Procedure notes:</b><br>- Left mid inguinal lower crease incision<br>- EOA opened<br>- Sac delineated from vas and vessels and divided<br>- Proximal end ligated and transfixed, Distal sac laid open<br>- Incision closed in layers  |   |                       |
| <b>DISCHARGE ORDERS:</b><br>1. Diet as advised.<br>2. Remove dressing after 3 days and daily bath<br>3. Syp. Crocin-DS (5ml/240mg) 5ml twice a day for 2 days & SOS for pain/fever > 100°F (maximum 6th hourly).<br>4. Kindly consult Dr. Jyoti Bothra, Consultant Pediatric Surgeon & Urologist, after 10 days week in OPD with prior appointment (This consultation will be charged). |   |                       |

**Consultants Surgeon's Name**

Dr. JYOTI BOTHRA

**Date :** *25/6/26*

**Consultant Surgeon's Signature**

**Time :**

*2pm*





**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 28/6/20 Time: 12 1 2 3 4

Doctor / Nurse / Family Concern? PN

|                 |     |              |              |              |              |              |
|-----------------|-----|--------------|--------------|--------------|--------------|--------------|
| Temperature (F) | 104 |              |              |              |              |              |
|                 | 103 |              |              |              |              |              |
|                 | 102 |              |              |              |              |              |
|                 | 101 |              |              |              |              |              |
|                 | 100 | <u>99.6F</u> | <u>99.6F</u> | <u>99.6F</u> | <u>99.6F</u> | <u>99.6F</u> |
|                 | 98  | <u>98.8F</u> | <u>98.8F</u> | <u>98.8F</u> | <u>98.8F</u> | <u>98.8F</u> |

|  |     |            |            |            |            |            |
|--|-----|------------|------------|------------|------------|------------|
| Heart Rate (bpm)                                 | 190 |            |            |            |            |            |
|  | 180 |            |            |            |            |            |
| and Blood Pressure (mmHg) *                      | 130 |            |            |            |            |            |
|  | 120 | <u>105</u> | <u>100</u> | <u>104</u> | <u>112</u> | <u>100</u> |
| Note: BP does not score in early warning scoring | 90  |            |            |            |            |            |
|  | 80  | <u>67</u>  | <u>60</u>  | <u>69</u>  | <u>59</u>  | <u>61</u>  |
| Heart Rate (Number)                              |     | <u>114</u> | <u>98</u>  | <u>104</u> | <u>112</u> | <u>111</u> |

|                                    |    |           |           |           |           |           |
|------------------------------------|----|-----------|-----------|-----------|-----------|-----------|
| Resp. Rate (bpm) (Over 1 Minute) * | 70 |           |           |           |           |           |
|                                    | 60 |           |           |           |           |           |
| Resp Rate (Number)                 |    | <u>24</u> | <u>20</u> | <u>24</u> | <u>24</u> | <u>20</u> |

|                                  |                                |           |           |            |           |           |
|----------------------------------|--------------------------------|-----------|-----------|------------|-----------|-----------|
| Resp Distress                    | Mod/ Severe None / Mild        |           |           |            |           |           |
| Receiving O <sub>2</sub> (l/min) | O <sub>2</sub> Saturations (%) | <u>98</u> | <u>97</u> | <u>100</u> | <u>99</u> | <u>98</u> |
| Conscious Level                  | Normal Altered                 | <u>NA</u> | <u>NA</u> | <u>NA</u>  | <u>NA</u> | <u>NA</u> |
| GCS *                            |                                | <u>6</u>  | <u>15</u> | <u>15</u>  | <u>15</u> | <u>15</u> |

|                        |           |           |           |           |           |
|------------------------|-----------|-----------|-----------|-----------|-----------|
| <b>TOTAL SCORE</b>     |           |           |           |           |           |
| Number of shaded boxes | <u>2</u>  | <u>0</u>  | <u>0</u>  | <u>0</u>  | <u>0</u>  |
| Pain Score             | <u>0</u>  | <u>0</u>  | <u>0</u>  | <u>0</u>  | <u>0</u>  |
| Observer's Initials    | <u>PN</u> | <u>PN</u> | <u>PN</u> | <u>PN</u> | <u>PN</u> |

**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:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- 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

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

|          |   |
|----------|---|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)   |
| <b>S</b> | <b>SITUATION:</b> 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>B</b> | <b>BACK GROUND:</b> 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) |
| <b>A</b> | <b>ASSESSMENT:</b> 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.   |
| <b>R</b> | <b>RECOMMENDATION:</b> 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. 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 |                                |             |  |
| 5/5                         | 08:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 09:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 10:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 11:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 12:00 pm |                 | N.B.M  |     |     |                       |           |       |          |       | 0                              | guy         |  |
|                             | 01:00 pm |                 | N.B.M  |     |     |                       |           |       |          |       | 0                              |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
| 2/5                         | 02:00 pm |                 | N.B.M  |     |     |                       |           |       |          |       | 0                              | dy          |  |
|                             | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 04:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 05:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 06:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                             | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                             | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                             | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
| <b>Total 24 hrs. Intake</b> |          |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total 24 hrs. Output</b> |          |                 |        |     |     |                       |           |       |          |       |                                |             |  |

Patient Sticker

# 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     | Nature of Fluid | Intake |     |     | Output                |           |       |          |       | IV Site Thrombophlebitis 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 |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 02:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 05:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 06:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Intake</b> |  |
|-----------------------------|--|

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Output</b> |  |
|-----------------------------|--|



# DRUG CHART

Date of Admission: 25/6/20 Drug Allergies:  Not known any Drug Allergies

## FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
  - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
  - Discontinue a drug by drawing a line **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)

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Signature  
VERIFIED BY : Name



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

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

**STAT / ONCE ONLY DRUGS**

| Date    | Time    | Medication       | Dosage & Other Instructions | Route | Signature | Nurses           |
|---------|---------|------------------|-----------------------------|-------|-----------|------------------|
| 25/6/26 | 1:40pm  | INT. PARACETAMOL | 255MG                       | IV    | B de      | Aris<br>Varshnav |
| 25/6/26 | 11:30pm | SUPP-DICLOFENAC  | 12.5MG                      | PIR   | B de      | Aris<br>Varshnav |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |
|         |         |                  |                             |       |           |                  |

Signature  
Name



**REGULAR PRESCRIPTIONS**

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

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



# ESTIMATION SLIP



Date: 25/06/20 UHID/IP No.: VAD-KMV-00004305 Sl. No.: 29108

Name of Patient: Mast Nihal Age: M Gender: 54

Father's / Husband's Name: Mr. CH Ravi Kumar Corporate/Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: 7989295025 Email: \_\_\_\_\_

Procedure/Plan: (L) High ligation of sac DOS: \_\_\_\_\_

MODE OF PAYMENT:  SELF  TPA: CASH  GIPSA: \_\_\_\_\_  OTHER

TARIFF INFORMATION: Dr. Jyoti bothra

| ROOM CATEGORY   | GW                            | SW | TSW             | PR | DLX  | NICU    | PICU | MICU | DAY CARE |
|---|-------------------------------|----|-----------------|----|--|---------|------|------|----------|
| Room Rent & Nursing Charges   |                               |    |                 |    |  | 8 hrs d |      |      |          |
| Doctor's Fee  |                               |    |                 |    |  | stay    |      |      |          |
| L. Tax  |                               |    |                 |    |  |         |      |      | 480      |
| PARTICULARS   |                               |    |                 |    | AMOUNT ( ₹ )                                 |         |      |      |          |
| Surgeon's / Anesthetist's Fee / O.T Charges   |                               |    |                 |    | 46,000/-                                     |         |      |      |          |
| O.T Consumables   |                               |    |                 |    | 3,000/-                                      |         |      |      |          |
| Instrument Charges  |                               |    |                 |    | Subject to approval by TPA/Insurance Company |         |      |      |          |
| Pharmacy, Consumables & Investigations  |                               |    |                 |    | Not Covered by TPA/Insurance Company         |         |      |      |          |
|   |                               |    |                 |    | As per actual - Not Included In Estimation   |         |      |      |          |
| Equipment Charges   | Monitor: 1,500/-              |    | Oxygen:         |    | Infusion Pump/Syringe Pump: 900/-            |         |      |      |          |
|   | Ventilator: Conventional:     |    | HFO-SLE 5000:   |    | HFO-Sensormedix:                             |         |      |      |          |
|   | Phototherapy: Single Surface: |    | Double Surface: |    | Triple Surface:                              |         |      |      |          |
| Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc. |                               |    |                 |    | As per actual - Not Included In Estimation   |         |      |      |          |
| Package   |                               |    |                 |    | Rec - 2,000/-                                |         |      |      |          |
| Initial Minimum Deposit   |                               |    |                 |    | 60,000/-                                     |         |      |      |          |

**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, Thoroscopic, 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

Ravi Kumar Chappala 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.

Chappala  
Signature of the Client

\_\_\_\_\_  
Signatory Relationship

154  
Signature of the Financial Counselor