VIH-00167373 IP5-00174987
Master RISHI NITIN
03-02-2023 3 Y 4 M 7 D (M)
Dr. M N V POUSHYA SAI

Patient S

Sukhas 11/06/26.

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10-
8662

SURGERY DETAILS

Date : 10/06/26

Patient Name: Master. Rishi Date of Birth: 03/02/2023 Age: 3yrs

Gender: male Ward : Pre. OT UHID No.:

Date of Surgery: 10/06/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : upper GI endoscopy + foreign body removal.

Time in : 3:55 pm Time Out : 4:28pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Poushya	
2.	Anaesthetist	:	
3.	Assistant Surgeon	:	
4.	OT Technician	: Prashanth	
5.	Circulating Nurse	: Swapna	
6.	Assistant Nurse	: Benjamin	

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

Dr. Poushya. for

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9657669 Order by: Usmani

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F-B Removal

CONSUMABLES OF OT

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Circulating staff : ..... Technician : Prathusha Date : 10/6 Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 3.5 · 4.0 · 4.5	1+1+1	1	Major Pack			Inj Vit.K		
LMA 2	01	—	Sutures			Cord Clamp		
ECG leads : A / P / N	5+1	3				Suction Catheter		
HME filter : A / P / N	01	1				Feeding Tube		
Syringes : 10 cc	10	3				Vaccum Suction Set		
05 cc	10	3	Gloves			Surgical Gloves		
02 cc	10	3	6, 6½, 7, 7½	2+2+2	1+1	Gauze Pack		
01 cc	5	—	6½, 7, 7½	2+2+2		Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil			NS 500ml	1	—
NS : 10ml / 100ml / 500ml / 1000ml	2+1	1	Koochies			20cc, 50cc	1+1	—
Sunspirec	01	1	Ointments			Jelly	1	—
Vacuyset	01	1	Suction Catheter					
Fentanyl	01	1	Cap, Mask	5+5	—	20cc + 5cc	1+1	1+1
Morphine			Gauze Pack (N)	3	01	26 short needle	01	01
Ketamine			Mop Pack	1	—	Vacumset	1	—
Propofol	04	1	Steristrip			PF 7	1	—
Rocuronium	01	—	Underpad	1	01	NG - 6.	1	—
Glycopyrolate	01	—	Draw sheet	1	01	NS 500ml	1	—
Myopyrolate Pcco	01	—	Abgel			LOCLO A 0.1	1+1	—
Ondansetron	01	—	Foleys catheter			NA +820	1+1	—
Pencan 25g/ Spinal Needle 22	01	—	Urobag			O2 more (*)	01	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			Normal saline pulse	01	+
Bupivacaine 0.25%(Heavy)			Romodrain bag			80 Hand wash	1+1	—
Antibiotics			Bandage			Atracurium	1	1
IV PCM	01	—	Tegaderm			Sevoline	1	1
Suppositories			Ioban			Transfore	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	01	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution					
Zuplocm 4mg/2ml	1+1	—	Microshield	1	—			
Gauze roll 2cm	Half	—	Cotton Balls					
Dose 4 Tonsure	1+1	—	Latex Gloves	SP	—			
IV Cannula 22G	1+1	—	Ramdione Scrub					
Q. Sol. Spirit 1:3	Wet	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 96516728/96517071 Ordered by : .....

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

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ESTIMATION SLIP

Date : 10-June-26 UHID / IP No. : VIH-00167373 Sl No. 80662

Name of Patient : Mst. Rishi Nitin Age: 3yrs Gender: Male

Father's / Husband's Name : Mr. Nitin Corporate / Occupation : United States

Address : — Phone : 9967303721 Email: —pharmacopeia

Procedure / Plan : Upper GI Endoscopy + FB Removal

MODE OF PAYMENT : ☐ SELF ☑ TPA : THPL United India ☐ GIPSA: _____ OTHERS

TARIFF INFORMATION : Dr. Paushya (PTH-6)

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges										
	Doctor's Fee			14000/- per day		NA-					
	L. Tax										

PARTICULARS			AMOUNT (₹) (GA+AAF) + (OT)
Surgeon's / Anesthetists's Fee / O.T. Charges			TSW → 55902 203098 11000/hr
O.T. Consumables			→ 7500 Subject to approval by TPA / Insurance Company
Instrument Charges			Endoscopy 2550/- → Not Covered by TPA / Insurance company
Pharmacy, Consumables & Investigations			Extra/- As per actual - Not Included in Estimation
Equipment Charges	Monitor :		Oxygen : Infusion pump / Syringe pump :
	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.			Extra/ As per actual - Not Included in Estimation
Package			
Others			Endology Basket → 25,000 Subject to coverage
Initial Minimum Deposit			→ 15,000/-

10-3K EB-Sp. Total

REMARKS:

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.**
3. 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.
4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission. Room at 12 STA @ 12 noon cycle
5. 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.
6. **For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.** IPH Diet / DAC / IDC / RRC.
7. During Non-working hours of O.T (8:00 PM ot 7:00AM), 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 9am to 6pm
8. 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.
9. 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 ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

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

Signature of the Client | Mother Signatory Relationship | Deepa Signature of the Financial Counselor

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ACTIVITY RECORD FOR BILLING

Name :_____ VIH-00167373 IP5-00174987 Master RISHI NITIN 03-02-2023 3 Y 4 M 7 D (M) Dr. M N V POUSHYA SAI _____

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ____ te of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/6/23	3:30 PM	GR	OT	
10/6/23	7:00 PM	OT	IOT	Patil

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/6/26	IV placement	1	514914	
10/6/26	PAC	1		

DC

ANY OTHER INFORMATION

DC

Date : 11/6/26 Time : 10Am Prepared By : Aruna

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Aruna	SPV 105		

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174987 **Admit Date** : 10-Jun-2026 **Admit Time** : 02:40 PM **UHID** : VIH-00167373

Patient Details :

Patient Name	: Master RISHI NITIN	**Age**	: 3 Y 4 M 7 D
Guardian	: Mr NITIN VIJAYAN	**DOB**	: 03-02-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 402, THOTA ARCADE, MANJEERA NAGAR COLONY, HI TENSION ROAD, Alwal Hyderabad Telangana INDIA 500010	**Phone No**	: 9967323721/ 9867426002
		E-mail	: rajitha.radhakrishnan@yahoo.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 405 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 405 **Admission Type** : First Visit

Contact Details :

Name : Mr NITIN VIJAYAN **Relationship** : Father

Contact Address : H NO 402, THOTA ARCADE, MANJEERA NAGAR COLONY, HI TENSION ROAD, Alwal Hyderabad Telangana INDIA 500010 **Phone No** : 9967323721 / 9867426002

Signature

Doctor Details :

Doctor Name : Dr. M N V POUSHYA SAI **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : FAMILY HEALTH PLAN INSURANCE TPA LTD

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Master RISHI NITIN
03-02-2023 3 Y 4 M 7 D (M)
Dr. M N V POUSHYA SAI

Pediatric Multiorgan History & Physical Examination

Name : Rishi Nitin Age/Sex 2½/M

Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

a/k/c/o child accidentally ingested a coin ~~on Sa~~ 2 days ago.

History of present illness :

↓

evaluated

→ coin FB visualised in stomach after 1 hour on abdominal xray.

↓

→ advised to watch for passage in stools

→ no c/o abdominal pain / constipation bleeding / melena.

~~tid~~

→ ~~adeq~~ repeat xray after 2 days. s/o coin in UGI tract.

→ adequately NPO.

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Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

(N) perinatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information : (N)

Developmental History : appropriate for age.

Immunization History : immunised for age.

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms)_____ (Centile _____) Height (cms): 98cms (Centile_____)

Weight (kgs)) ~~13.8~~ 15.14 kg. (Centile _____)

On Examination :

Temperature : 98 °F Pulse Rate : 108/min B.P. 104/72 SPO2 98%.

Resp.rate and type of breathing : 20/min

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BAE (+)

Any addes sounds : clear.

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : (N)

Any murmur : none.

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

Per Abdomen :

Inspection

Palpation : Soft / NT / no HSM.

Ausculation :

Spine : External Genitelia :

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

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : alert

Cranial Nerves :

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

FB in ~~stomach~~ UGI tract

now for UGIE & FB removal

(P.T.O.)

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03-02-2023 3 Y 4 M 7 D (M)
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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: perforation of ~~stomach~~ small intestine

Desired goals of the treatment : surgical management

Planned Labs:

Collect 1 plain/EDTA & PT/INR sample.

NB Fentanyl

Planned Management

1.) PAC due
2.) Continue NPO
3.) Shift to OT.
4.) IVF/DNS.
5.) Upper GI endoscopy ~~&~~ FB removal today.

NB Fentanyl

Signature of the Doctor: Dr. Athile
Name of the Doctor: Dr. Athile
Date & Time: 10/6/26

Signature of the Consultant: .....
Name of the Consultant: .....
Date & Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 4.50pm	S/B Gastro team Accidental coin ingestion ↓ Removed upper GI endoscopy + F.B removal done.	Plan: ① Sucral 3ml TID. ② Once awake, give liquids followed by soft diet. Dr. Hema
11/06/26 9AM	C/S/B - Gastro Team. Accidental coin ingestion No fever No vomiting O/E - Hemodynamically stable Chest - clear.	Plan 1) Allow orally - Soft diet 2) Sucral syrup to continue 3) Stop IV fluids 4) Add mucont.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Docu. No. : RCHBH /FRM / CLINICAL / 088

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea		DIC				
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						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anjila

Date & Time : 10/6/26

Nurse Name & Signature: T. Jyothsna, RN

Date & Time : 10/6/26 @ 3p

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DRUG CHART

Date of Admission: 10/6/26 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)

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

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

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

VERIFIED BY : Name Signatu

Master RISHI NITIN
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REGULAR PRESCRIPTIONS

Weight. 15.1 kg Ward. .....

DRUG : Syp. SUCRAL

Dose	Route	Frequency	Start Date
3ml	PO	TID	10/6

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

Additional Instructions:

Date / Time	10/6	11/6
		6 AM X ~~grand sister~~
		2pm X
		10pm ~~grand sister~~

Daily Doctor's Endorsement by a Sign

DRUG : Mu-ont powder.

Dose	Route	Frequency	Start Date
3spoons	PO	OD (HS)	11/06

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
+ 150ml of water
+ 2spoons + 120ml.

Daily Doctor's Endorsement by a Sign

DRUG : SYP SMUTH -

Dose	Route	Frequency	Start Date
12ml	PO	OD (HS)	11/06

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
8ml — 4ml — Stop.

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Weight. 15.1Kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

03-02-2023 3 Y 4 M 7 D (M)
Dr. M N V POUSHYA SAI

I.V. FLUIDS CHART

Weight. 15 kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
10/6		IVF DNS	IV	50		Not to be continued			
		DLC							

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

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No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..10/06.. Time:	10 pm	2 am	6 am
Doctor / Nurse / Family Concern?			
Temperature (F)	(98.0°F)	(97.9°F)	(96.3°F)
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	106 / (82) / 54	98 / (61) / 50	82 / (54) / 50
Heart Rate (Number)	115bpm	112bpm	101bpm
Resp. Rate (bpm) (Over 1 Minute) *			
Resp Rate (Number)	26b/m	26b/m	24b/m
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	100%	97%	98%
Conscious Level: Normal / Altered			
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	1	1
Pain Score	0	0	0
Observer's Initials			

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

Patient Sticker

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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.

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

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Dr. M N V POUSHYA SAI

FLUID CHART

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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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
10/6	02:00 pm											
	03:00 pm											
	04:00 pm		water								0	
	05:00 pm		Juice								0	
	06:00 pm											
	07:00 pm					07	to	ward				
Total Intake :						**Total Output :**						
10/6	08:00 pm	↑									0	
	09:00 pm		milk							✓	0	
	10:00 pm	NIO									0	
	11:00 pm	IVF				✓		NP		✓	0	
	12:00 am	↓									0	
	01:00 am									✓	0	
Total Intake :						**Total Output :**						
11/6	02:00 am	↑									0	
	03:00 am									✓	0	
	04:00 am	NIO									0	
	05:00 am	IVF					NP			✓	0	
	06:00 am										0	
	07:00 am	↓								✓	0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Total Intake :						**Total Output :**						
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	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: ..... Age: ..... Sex: ..... UHID.No : .....

Date: .... Proposed Operation: .....

Diagnosis: .....

B.P / CRT: ..... H.R: ..... Weight: 15Kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray: .....
PCV:	Urea:	Alb:	HBS Ag:	ECG: .....
WBC:	Creat:	Total Bill:	HCV:	2D Echo: .....
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo: .....
PT:	K:	LDH:	T3	Other: .....
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies:

Medical History: CVS :

RESP : NO h/o cough, cold, fever. Diabetes :

CNS :

Renal :

Hepatic / GE : Physical Activity:

Others :

FT | NICU for Aspiration & Asphyxiation

Past Anaesthetic History: nil.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: >3F Mentohyoid Distance: (N) Neck: (N) Teeth: intact.

Lungs :

Heart: WNL.

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA | 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:

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

.....

.....

Signature: ..... Name: Dr. AISHWARYA .....

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Adequate	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 120/mn	B.P / CRT: 90/47	SpO_2: 100%	R.R:	Last Feed:	
Pre-OP Diagnosis: FB Stomach	Operation: Endoscopy FB removal			Date: 10/1/24	
Surgeon: Dr. Pankaj	Anaesthesiologist: Shilpa			Technician: Venkat	

TIME 4/10 4/40

N_2O /AIR /O_2 LPM
HALO /SO /SEVO mac 1—
Drugs:
PROPOFOL 40mg
FENTANYL 20µg
MEPAZ 0.6mg
SCOLINE

Antibiotic
Suppository
Blood Loss
NOTES

FIO_2 / SaO_2 100 100
$ETCO_2$ 30 45
ECG SR SR
Temperature
Urine Output

Fluids
Blood

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

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values
ABG
GRBS
Others

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

Position: Lateral.
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 4/10
OP Start: .....
OP End: .....
Leave OR: 4/40 PM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 24G
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☑ Oral ☐ Nasal
ETT# 4.5 at 14 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 2 Attempts: 1
Difficulty Why? .....

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

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor: Dr Shilpa
Signature of the Doctor: .....

Dr. M N V POUSHYA SAI (M)

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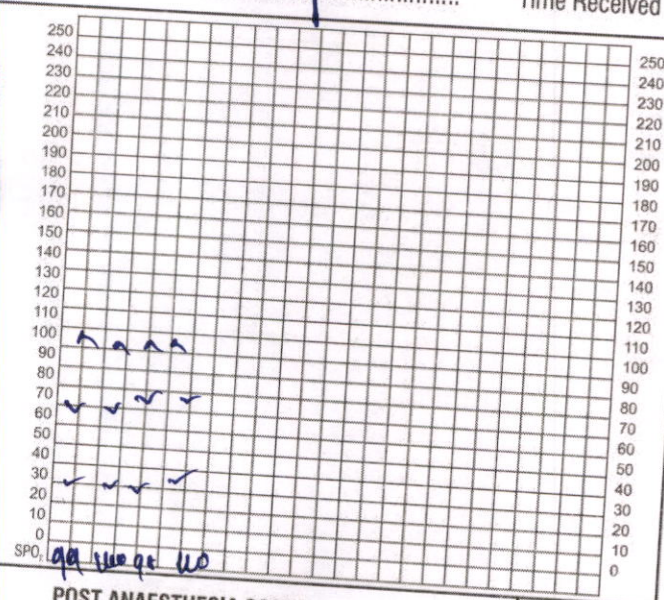
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 11:40pm ..... Time Discharged : 6.55pm .....



IV Cannula Site : .....

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ 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: Orally

POST ANAESTHESIA SCORE
(Modified Aldrete Score)

		IN	MINUTES 30	60	90	OUT
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	1	1	2	2	
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
	TOTAL	8	9	10	10	

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/6	6.pm	0/10	—	

Pain Tool Used: ☐ N PASS ☑ FLACC ☐ Wong Baker ☐ NPS

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

Anaesthesiologist Name : Dr. [illegible]
Anaesthesiologist Signature: .....
Date & Time: 10/9/26 5pm

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 10/9/26. @ 5.30pm

Transferred to Unit by (PACU): 105
Date & Time: 10/.

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EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: FOREIGN BODY

Anaesthesiologist: Dr. AISHWARYA Surgeon: Dr. POUSHYA

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 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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others desaturation, laryngospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☐ General Anaesthesia ☑ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [signature]
Name: Rajitha Radhakrishnan
Relationship with patient: Mother
Date & Time: 10/06/26 3:56pm

Witness:

Signature: [signature]
Name: Preetha Radhakrishnan
Date & Time: 10/06/26 03:56pm

Doctor (who is taking consent):

Signature: [signature] Name: Dr. AISHWARYA Date 10/6/26 Time: 4 pm

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ లీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

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03-02-2023 3 Y 4 M 7 D (M)
Dr. M N V POUSHYA SAI

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 upper GI endoscopy + FB removal (coin).

2 .....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
–	–

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a. Infection
Bleeding Perforation

1. I authorize Dr. Dr. M N V Poushya Sai and his / her team to perform the procedural sedation upon the patient / myself.
2. I recognize 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.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:
Signature: .....
Name: RAJITHA. R
Relationship with patient: MOTHER
Date & Time: 10/06/26 3⁴⁰ PM

Witness:
Signature: .....
Name: Prithvi
Date & Time: 10/6/26 3⁴⁰ PM

Doctor (who is taking consent):
Signature: ..... Name: Dr. M N V Poushya Sai Date 11/6/26 Time: 3⁴⁰ PM

Patient Sticker

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శస్త్రచికిత్స / ప్రాసీజర్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైనో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీ ...కి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రాసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
   అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.
b.

1. 4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
   ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

VIH-00167373 IP5-00174987
Master RISHI NITIN
03-02-2023 3 Y 4 M 7 D (M)
Dr. M N V POUSHYA SAI

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OPERATION THEATER NOTES

Patient's Name : Rishi Nitin ..... Age : ..... Gender : ☐ Male ☐ Female

UHID No.: ..... Weight : ..... Height : .....

Surgeon : Dr. Poushya	Asst. Surgeon :	
Anesthetist :	OT Nurse: Benjamin	OT Technician: prashanth

Pre-Operative Diagnosis: foreign body ingestion

Surgical Procedure : upper GI endoscopy + foreign body removal

Indications for Surgery : foreign body ingestion

Date : 10/06/26	Start Time : 4:10 pm	End Time : 4:30 pm.

Pre Operative Preparations: -

Post Operative Diagnosis: accidental coin ingestion

Peri-Operative Complications: -

Operation Notes: under strict aseptic precautions.
an endoscope was passed from the mouth into the esophagus and advanced into the stomach.
A coin was visualized in the stomach. It was removed using basket forceps.

Amount of Blood Loss: 1 ml	Blood Transfused (in ML) —
Name and Number of Surgical Specimen sent for examination:	
Peri-Operative Complications: —	

Name of the Surgeon: Dr. Poushya

Signature of the Surgeon:

Date & Time: 15/6/26 4:40 pm

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Procedure Done: upper GI endoscopy + foreign body removal

Post-Surgical Diagnosis: Accidental coin ingestion

Post-Operative Monitoring Parameters /Frequency: Monitor for 1 hour.

Wound Care: —

Drain /Special Lines/Catheters: —

Special Patient Positioning and Requirements: —

Nutritional Instructions: —

When to Start Mobilization: Immediately

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

Treating Surgeon (Signature & Stamp) Dr. Hema

Date: 10/6/26 Time: 4:40 pm

Note: Plan of care will be readjusted if necessary.

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/6/26 Time: 8 am

Weight: 15.14 kgs Centile: >50th

Height: 98 cms Centile: 50th

Inference: well child

RDA: – Calories: 1300 kcal/d Protein: 22 g/d

Diet Recommendations: soft diet

Re-Assesment: Avoid spicy, chilled & outside foods

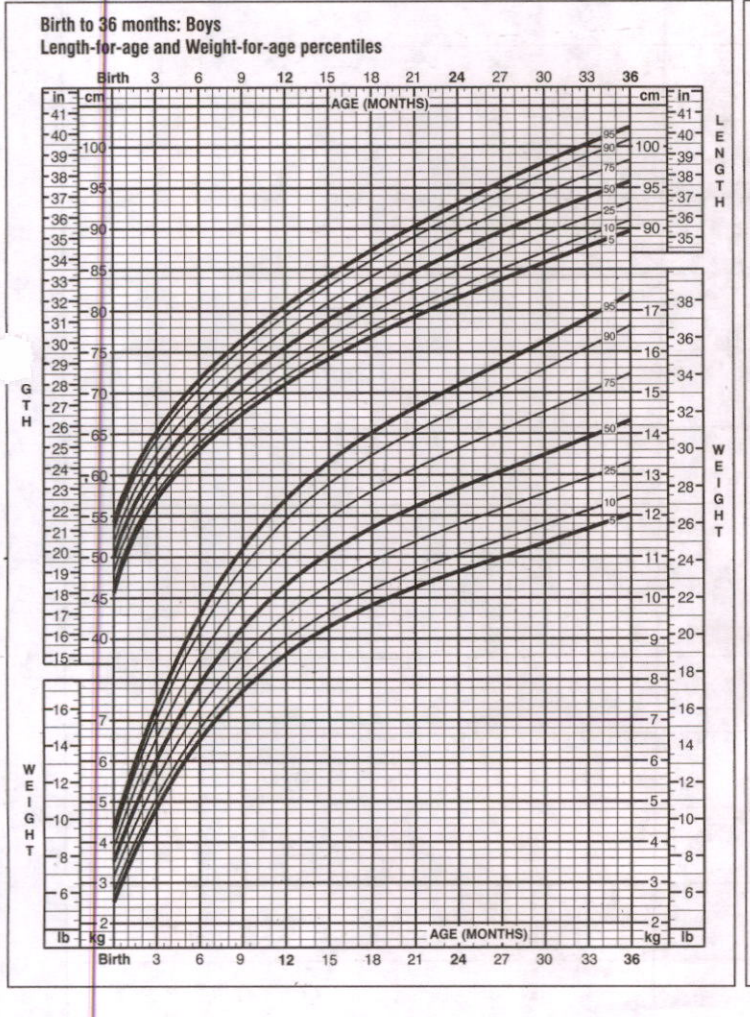
Food Allergies: No Veg/Non-veg Non-veg

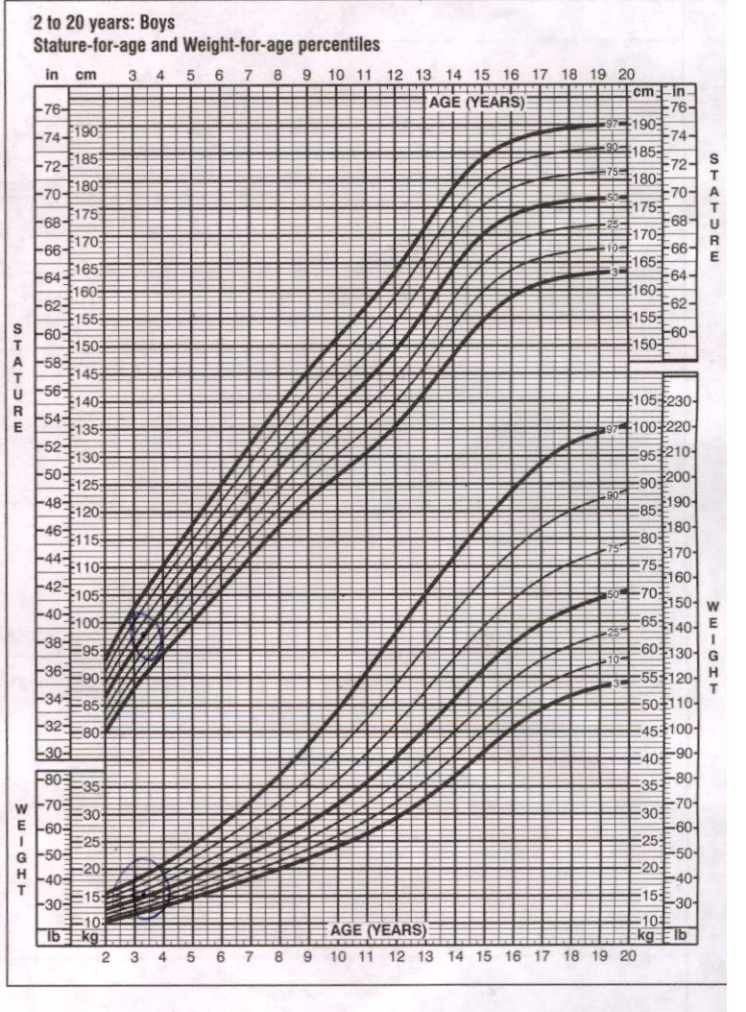
Diagnosis: FB in UGI tract

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Monica Dietician's Signature Monica

Daily Notes: