

Patient Stic

VIH-00129184 IP-00060246
Master VIHAAN MADDURI
14-11-2020 5 Y 6 M 23 D (A)
Dr. MADHAVI PARISA



SURGERY DETAILS

Date : 06/06/20

Patient Name: Mast. vihaan madduri Date of Birth: 14/11/2020 Age: 5y

Gender: male Ward: OT UHID No: 129184

Date of Surgery: 06/06/20 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : COBALATION ASSISTED ABDOMINO IDECTOMY
+ BLEED TURBINOPLASTY

Time in : 9:40 AM Time Out : 10:20 AM

	NAME	AMOUNT
1. Surgeon	Dr. madhavi parisa	OT charges
2. Anaesthetist	Dr. Madhav / Dr. Hima Bindhu	Cobulator charge
3. Assistant Surgeon	-	Start time: 9:50 AM
4. OT Technician	Br. Rakesh / sr. vaishnavi	End time: 10:15 AM
5. Circulating Nurse	sr. Meghana / sr. vanitha	order no: 3087402
6. Assistant Nurse	sr. Ruby.p	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 3087400 / 3087401

Order by: Manimala

CONSUMABLES

OF OT Adenoidectomy + Turbinoplasty

Patient Name :

Gender M F UHI:

Date : 06/06/26



Circulating Staff : S.S. Manitha

Technician : Br. Raksh / Sr. Vaishnavi

Anaesthesia Disposables	Issued	Qty		Surgical disposables	Issued	Qty		Disposables (Baby side)	Issued	Qty	
		Used	Used			Used	Used				
ET tube - Pac SO cuffed		1	1	Major Pack				Inj. Vit. K			
LMA				Sutures				Cord Clamp			
ECG leads : A/P/N								Suction Catheter			
HME filter : A/P/N								Feeding Tube			
Syringe 10 cc		5	5					Vaccum Suction Set			
05 cc		6	6	Gloves (200)				Surgical Gloves			
02 cc - 20cc		1	1	6 (PP) + 1 (250) → 1+1				Gauze Pack			
01 cc				7 (PP) + 7 (50) → 1+1				Syringe 1 ml / 2 ml			
Cautery Plate : A/P/N				Surgical blade				Surgical Blade # 20			
IV set		1	1	NG tube 8NO+G NO → 1+1				Koochies (S)			
RL		1	1	Cautery Pencil							
NS : 10ml/100 ml/ 500ml/1000ml		1	1	Koochies				Savlon		1	
Retractor Oxametwasore		1	1	Ointments Nelon (12NO) → 1				Protogona		2	
O ₂ mask (P)		1	1	Suction Catheter				[Edema Probe]			
Fentanyl - Atacurium		1	1	Cap. Mask			8	Reflex ultra → 1			
Morphine vein-o-line (1000)		2	2	Gauze Pack			2				
Ketamine midazolam		1	1	Mop Pack							
Propofol		2	2	Steristrip							
Rocuronium metalar		1	1	Underpad							
Glycopyrolate pyralate		1	1	Draw Sheet							
Myopyrolate myostigmine		3	3	Abgel Allegorb → 2			2				
Ondansetron				Foleys Catheter							
Pencan 25g/Spinal Needle 22				Urobag							
Bupivacine 0.25%				Chest Drainage Catheter							
Bupivacine 0.25%(Heavy)				Romodrain bag							
Antibiotics				Bandage 6 inch → 1			1				
				Tegaderm							
Suppositories				Ioban							
Anamol : 80mg/250mg/170 mg				Double J Stent							
Supridol 100 mg				Vaccum Suction set			2				
Justin : 12.5 mg/25 mg/ 100 mg		1	1	Plastic Bed Sheet							
Tab. Misoprost : 200 mg				Betadine Solution							
Nasopharyngeal (20)		1	1	Microshield							
				Cotton Balls							
				Latex Gloves							
				Ramdione Scrub							
				Saral							

Surgeon Dr. Madhavi P Anaesthesiologist Dr. S. S. Manitha Nurse Sri. Ruby P OT Technician Br. Raksh
 Order No. : 3087408/3087408 Ordered by : Br. Manimala (Raksh)



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,
Kakaguda, Karkhana Hyderabad Telangana INDIA 500009
Tel No : 040-42462200, Ext 2000,2001,2002

VAT TIN : 36920283145

CIN : L85110TG1998PLC029914

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS



IP No IP-00060246 Ward N 0 GF-EMERGENCY
Patient Name Master VIHAAN MADDURI Bed Name ER 102
Age/Sex 5 Y 6 M 23 D / Male Order No 0003087408
Date 06/06/2026 10:58 Prescription No PRIP-1290090
Payor MEDI ASSIST INSURANCE TPA PVT LTD Dispensed Date 06/06/2026 10:59
UHID VIH-00129184

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ALLESORB CORE TURNAROUND COVER 40x60IN		General	250922J	12/30	2	425.00	850.00
2	BANDAGE # 6 INCH	Muttu	GENERAL	BH55	01/28	1	20.60	20.60
3	ENCORE MICROPTIC GLOVES-6 PF	ELITE MEDICALS	GENERAL	260300751T	03/29	1	128.00	128.00
4	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		260301121T	03/29	1	128.00	128.00
5	FACE MASK-3LAYER THREADED	Sunrise		VI02012026	12/99	8	10.00	80.00
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	17O724	06/27	2	100.00	200.00
7	INFANT FEEDING TUBE-6	ROMSONS	GENERAL	G26A010116	12/30	1	63.00	63.00
8	INFANT FEEDING TUBE-8	ROMSONS		G26A01056O	12/30	1	63.00	63.00
9	NELTON CATHETER 12FR	Polymed	GENERAL	251497BH	07/30	1	78.00	78.00
10	PROTO GOWN (ADULT) (PROTECTCARE)		General	VI20052026	12/30	2	450.00	900.00
11	REFLEX ULTRA 45 WITH IC (EIC4845-01)	ARTHOCARE	C1	2197660	11/28	1	4,258.12	4,258.12
12	SAVLON 100 ML	ITC LTD		SAL25185	07/28	1	62.00	62.00
13	SGLOVE # 6.5 (SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26D2005	03/31	1	91.00	91.00
14	SGLOVE # 7.0(SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26D2005	03/31	1	91.00	91.00
15	VACCUME SUCTION SET	ROMSONS		K26B010713	01/31	2	739.00	1,478.00
Total :							6,706.72	8,490.72

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : RUBY FLORENCE VELPULA

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Secunderabad



H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,
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VAT TIN : 36920283145

CIN : L85110TG1998PLC029914

DL NO :

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Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No	IP-00060246	Ward	N 0 GF-EMERGENCY
Patient Name	Master VIHAAN MADDURI	Bed Name	ER 102
Age/Sex	5 Y 6 M 23 D / Male	Order No	0003087437
Date	06/06/2026 12:00	Prescription No	PRIP-1290095
Payor	MEDI ASSIST INSURANCE TPA PVT LTD	Dispensed Date	06/06/2026 12:01
UHID	VIH-00129184		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ATACURIUM 2.5ML INJ	ZYDUS HEALTHCARE		TAE25015	10/27	1	45.30	45.30
2	DEXAMETHASONE INJ 2 ML	PENTA PHARMA	H	NA00395A	04/27	1	10.87	10.87
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26CO3K92	01/31	5	28.13	140.65
4	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26CO3K96	02/31	6	21.56	129.36
5	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26A06K07	12/30	1	11.25	11.25
6	INTRAFIX(TRANSFLO)	Bbraun Medical PvtLtd		25L13K8961	10/30	1	333.09	333.09
7	JUSTIN SUPPOSITORIES 12.5 MG 5 S	Neon Laboratories Ltd	H	BLNP278009	02/28	1	12.14	12.14
8	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353002	07/27	2	69.10	138.20
9	METOLAR INJ 5 MG 5 ML	CIPLA LIMITED	H	5L60237	08/28	1	18.15	18.15
10	MIDAZOX INJ 5MG 5ML		H	KAS26001	01/28	1	30.90	30.90
11	MYOSTIGMIN INJ 1ML	NEON LABORATORIES LTD	H	KP017027	08/28	3	5.33	15.99
12	NASOPHARYNGEAL TUBES 20	RUSCH	GENERAL	KME23CZ537	02/28	1	232.50	232.50
13	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirilif	H	1C261641	02/29	1	44.93	44.93
14	OXYGEN NASEL CANNULA (PEAD)	Polymed		K25L040093	11/30	1	255.00	255.00
15	PYROLATE INJ AMP 0.2MG 1 ML	NEON LABORATORIES LTD	H	KP1254176	12/28	1	15.37	15.37
16	RAE ORAL WITH CUFF TUBE-5.0	RUSCH		40E25M1338	11/30	1	1,525.00	1,525.00
17	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1C261729	02/29	1	69.39	69.39
18	VEIN-O-LINE 100CM ROMSONS	ROMSONS		K26D010315	03/31	2	464.00	928.00
Total :							3,192.01	3,956.09

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : RUBY FLORENCE VELPULA

ACTIVITY LOG

VIH-00129184 IP-00060246
Master VIHAAN MADDURI
14-11-2020 5 Y 6 M 23 D (M)
Dr. MADHAVI PARISA

Name: _____

UHID # _____



Consultant : _____ Dept : _____

Date of Admission : 6/6/26 Time : _____ Date of Discharge : _____ Time : _____

Room / Bed No : 0.T Ward : 0.T Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/6/26	9:10 AM	ER	0.T	
6/6/26	12:05 AM	OT	Room (114)	

Cross Consultation Visit

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



ADMISSION SHEET



Registration Details :

Admission No : IP-00060246

Admit Date : 06-Jun-2026

Admit Time : 08:08 AM UHID : VIH-00129184

Patient Details :

Patient Name : Master VIHAAN MADDURI
Guardian : Mr M VINOD SHIVA PRASAD
Gender : Male
Occupation :
Address (H) : H NO: 2-11-127/B,,SRINAGAR COLONY, UPPAL
Uppal Hyderabad Telangana INDIA 500039

Age : 5 Y 6 M 23 D
DOB : 14-11-2020
Religion :
Marital Status : Single
Phone No : 8019424847
E-mail : prasadmadduri54@gmail.com

Admission Details :

Bed Type : SHARED WARD
Room No : ER 102

Bed No : ER 102
Admission Type : First Visit

Ward Name : N 0 GF-EMERGENCY

Contact Details :

Name : Mr M VINOD SHIVA PRASAD
Contact Address : H NO: 2-11-127/B,,SRINAGAR COLONY,
UPPAL , Uppal Hyderabad Telangana INDIA
500039

Relationship
Phone No 424847

Signature

Doctor Details :

Doctor Name : Dr. MADHAVI PARISA
Referral Doctor :
Co-Consultant :

Specialisation : NOSE AND THROAT
Phone No

Payment Details :

Payment Mode : Cash

Deposit Amount : 00

Payor Name

VEDI ASSIST INSURANCE TPA PVT
L7



ADMISSION SHEET

Registration Details :



Admission No : IP-00060246 Admit Date : 06-Jun-2026 Admit Time : 08:08 AM UHID : VIH-00129184

Patient Details :

Patient Name : Master VIHAAN MADDURI Age : 5 Y 6 M 23 D
Guardian : Mr M VINOD SHIVA PRASAD DOB : 14-11-2020
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO: 2-11-127/B,,SRINAGAR COLONY, UPPAL Phone No : 8019424847
, Uppal Hyderabad Telangana INDIA 500039 E-mail : prasadmadduri54@gmail.com

Admission Details :

Bed Type : SHARED WARD Bed No : ER 102 Ward Name : N 0 GF-EMERGENCY
Room No : ER 102 Admission Type : First Visit

Contact Details :

Name : Mr M VINOD SHIVA PRASAD Relationship : S/O
Contact Address : H NO: 2-11-127/B,,SRINAGAR COLONY, Phone No : 8019424847
UPPAL , Uppal Hyderabad Telangana INDIA
500039


Signature

Doctor Details :

Doctor Name : Dr. MADHAVI PARISA Specialisation : EAR NOSE AND THROAT
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Adenotonsillectomy
Arrival Time: 12:15pm **Mode of Arrival:** Stroke **Admitting From:** ER OPD Direct OT

Allergy / Adverse Reaction: nil **Body Weight:** Kg
Height: cm

Past Medical History: Obtained From Patient Family Member Medical Record Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Family History: nil

Has the child or close family member had recent contact with a communicable disease? Yes No

If yes please list,

Was the child's birth normal? Yes No If No, please describe problems:

Are the child's immunization up to date? Yes No

Current Medication: None Yes, If Yes, fill reconciliation form

Observations: Weight: Length: Head Circumference (< 2 years):

Temp.: 98.6 F HR: 110 RR: 25 bpm BP: 106/80mm

Pain Score: 0 **Specify Site:** nil (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: Yes No **Score:** 1 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score) 28 (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, **Pain Score:** 0 **Pain Tool Used:** N Pass FLACC Wong Baker

Character of Pain: 0 **Location:** **Frequency:** **Duration:**

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 Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?) 0

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No

Waste Disposal Explained: Yes No

Infusion Pump : Yes No

Hand hygiene Explained: Yes No Others

Patient Rights & Responsibilities: Yes No

Information given to Mother

Nurse's Name: Sandu Date: 6/6/26 Time: 12:30pm Signature 

D

VIH-00129184 IP-00060246
 Master VIHAAN MADDURI
 14-11-2020 5 Y 6 M 23 D (M)
 Dr. MADHAVI PARISA



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/6/26 Time of arrival : 8:01 AM coblation
 Chief Complaints: patient came to surgery Adenoidectomy OBSS
 Height : 112cm Weight : 20.4kg BMI : - Head Circumference (<2 years) : -
 Allergies: Yes No Medications Blood Transfusion Food Other: -
 If yes, identify -
 Pain Screening: Yes No If Yes, Pain Score: "2" Pain Tool Used: N Pass FLACC Wong Baker
 Character - Location - Frequency - Duration -

<p>RISK FOR FALL:</p> <p><input checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <ul style="list-style-type: none"> Escort while ambulating <input type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention <input checked="" type="checkbox"/> 	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality <input type="checkbox"/> <p>Inform consultant for positive criteria</p> <hr/> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method <input type="checkbox"/> <p>Inform consultant for positive criteria</p>
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Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

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


Social History: Lives With family

Siblings in household Yes No (if yes How Many?) 1 (sister)

Time of Initial assessment completed by ER Nurse : 8:5 AM

PATIENT TRANSFER FORM




Patient Name & UHID No. VIH-00129184 IP-00060246 Master VIHAAN MADDURI 14-11-2020 5 Y 6 M 23 D (M) Dr. MADHAVI PARISA 		Date & Time of Admission 6/6/26 @ 8:08 AM	Date & Time of Transfer Order 6/6/26 @ 9:10 AM
From Unit ER		To Unit O.T	Reason for Transfer Admission
Number of Sheets in Clinical File 23	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over <i>OP file given</i>			
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 <i>Dr. Parvaneh</i>		Name of Person Ordered Transfer <i>Dr. Vishwaja</i>	
Patient & Clinical Records Received by : <i>Parvaneh</i>			
Date & Time of Patient Received : <i>6/6/26 @ 9:15 am</i>			

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.		Date & Time of Admission	Date & Time of Transfer Order
VIH-00129184 IP-00060246 Master VIHAAN MADDURI 14-11-2020 5 Y 6 M 23 D Dr. MADHAVI PARISA 		06/06/26 @ 8:08 am	06/6/26 @ 12:05 am
Transfer Ordered by		Reason for Transfer	
Dr. Himabindu Dr. Madhav		post operative care	
From Unit	To Unit	Information to Attendant	
OT	114	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
26	nil	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Oxygen Mask	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		Name of Person Ordered Transfer	
Dr. Prasanna		Dr. Himabindu	
Patient & Clinical Records Received by : Indu			
Date & Time of Patient Received : 06/10/26			

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

10:02
am

John C. Smith
John C. Smith
John C. Smith

10:11

(3)

John C. Smith

John C. Smith

John C. Smith

John C. Smith



CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name : Mastes M. Vihann Age : 5yr.
 Gender: M F - IP No: Consultant : Dr. P. Madhavi
 Ward / Bed No. : Anaesthesiologist : Dr. M. Vineetara
 Operative procedure planned : Adenoidectomy & Tonsillectomy

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 / RTA
- Incapacitating COPD Others : Bronchospasm, cyanosis, desaturation.

Comments : Desaturation.

- 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 Mastes M. Vihann the above mentioned operation / Diagnostic / Therapeutic procedures Adenoidectomy & Tonsillectomy

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored anaesthesia care (MAC)) as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anaesthesia.

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

I authorize the anaesthetic team to perform any additional procedures (for example, CVP line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / MAC 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 : Vinod Shiva Desai

Relationship with Patient: Father

Date & Time : 4/06/26

Witness :

Signature : [Signature]

Name : M. Swathi (Mother)

Date & Time : 4/06/2026

Doctor (who is taking the consent) :

Signature : [Signature]

Name : DR. M. VINAYAKA

Date & Time : 04/06/26

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

VIH-00128184 IP-00060246
Master VIHAAN MADDURI
14-11-2020 5 Y 6 M 23 D (M)
Dr. MADHAVI PARISA



Name: Master M. Vihaan Age: 5y Sex: Male UHID.No:

Date: 04/06/20 Time: Proposed Operation: Adenoidectomy - Tonsillectomy

Diagnosis: Adenoid Hypertrophy

B.P / CRT: H.R: Weight: 20.3kg ASA Physical Status: 1 2 3 4 5
(20th May)

Laboratory Data:

Hgb: <u>12.6</u>	Glucose: <u>91</u>	Protein:	HIV: <u>NR</u>	X-Ray: <u>CXR - (W)</u>
PCV:	Urea:	Alb:	HBS Ag: <u>NR</u>	EKG: <u>WNL</u>
WBC: <u>6000</u>	Creat: <u>0.4</u>	Total Bill:	HCV: <u>NR</u>	2D Echo:
Plate: <u>3.54</u>	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT: <u>16.5</u>	K:	LDH:	T3:	Other:
PTT: <u>33.7</u>	Ca++:	Alk phos:	T4:	<u>pry NP: c/o adenoid hypertrophy & moderate airway obstruction</u>
INR: <u>1.1</u>	Mg++:	Amylase:	TSH:	
BS: <u>1.20</u>	Cl-:	SGOT/SGPT:		
CF: <u>5.30</u>				

Allergies: NEDA

Medical History: CVS:

RESP: mouth breathing & smoking

Diabetes:

CNS:

LSCFAT/BWT: 2.7kg/ NO NICU admission

Renal:

CIAB / no developmental delay

Hepatic/GE: ⊖

Physical Activity: Immunized till date. Active.

Others:

Past Anaesthetic History: ⊖

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 2f Mentohyoid Distance: (W) Neck: (W) Teeth: Intact no loose teeth

Lungs: clear

Heart: 65 (+)

CNS: conscious, alert

Pregnant: Yes No NA Venous Access Site: acclav Spine Exam for regional: (W)

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No
Parents

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature] Name: DR. M. VINETHA



ANAESTHESIA CHART



Change in Patient Condition: Yes No **Fasting Status:** Adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 105/min B.P/CRT: 99/59 SpO₂: 100% R.R: 22/min Last Feed: > 6hr

Pre-OP Diagnosis: Adenoid hypertrophy Operation: Adenoidectomy Date: 6/6/26

Surgeon: Dr. Madhav P Anaesthesiologist: Dr. Rima Bhatnagar Technician: Rakesh

TIME	SpO ₂	HR	BP	Temp	ETCO ₂	Urine Output	Notes
9:40 AM	100	100	100/60	36.7	40		PL @ 20ml/hr
9:45 AM	100	100	100/60	36.7	40		
9:50 AM	100	100	100/60	36.7	40		
10:00 AM	100	100	100/60	36.7	40		

LAB Values

ABG

GPBB

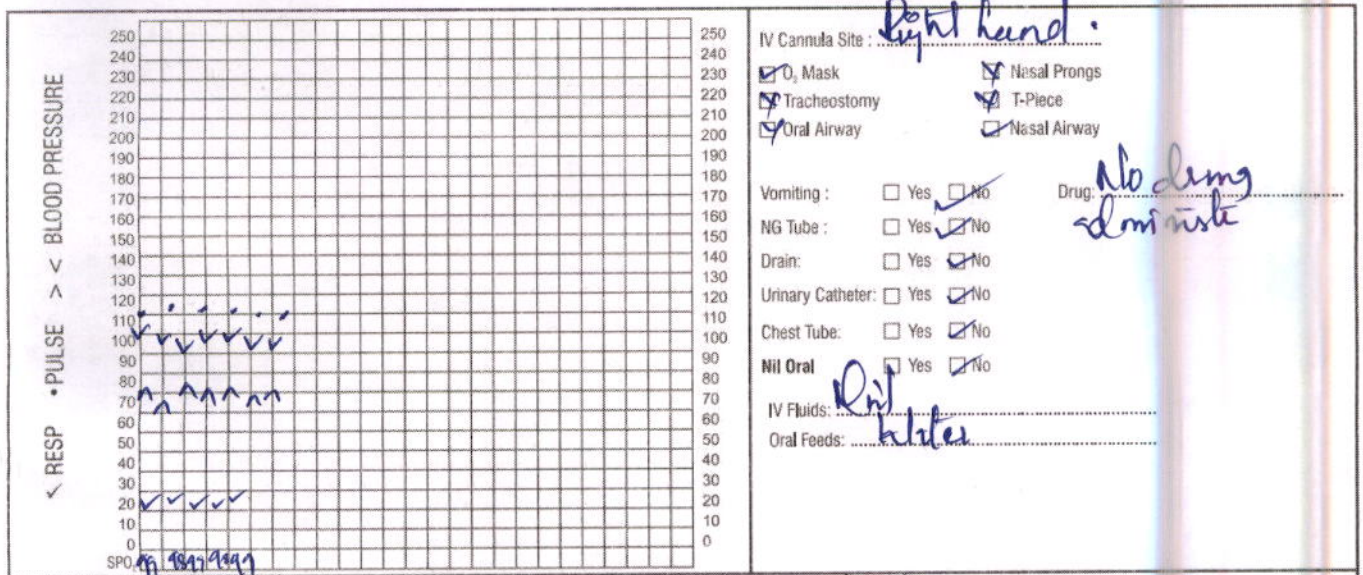
Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input checked="" type="checkbox"/> Cuff Site: <u>Right</u> <input checked="" type="checkbox"/> Art Site: <input checked="" type="checkbox"/> EKG Lead: <u>3 leads</u> <input checked="" type="checkbox"/> Temp Site: <u>skin</u> <input checked="" type="checkbox"/> FIO ₂ Monitor <input checked="" type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input checked="" type="checkbox"/> Capnograph <input checked="" type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: <u>Supine</u> <input checked="" type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Goggles <input checked="" type="checkbox"/> Tape <input type="checkbox"/> Padding <input type="checkbox"/> Awake	Temp: <input checked="" type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input checked="" type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other Times: Anaes Start: <u>9:40 AM</u> OP Start: <u>9:50 AM</u> OP End: <u>10:20 AM</u> Leave OR: Anaesthesia: <input checked="" type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional Line (Size & Location) <input type="checkbox"/> CVP: <input type="checkbox"/> ART: <input checked="" type="checkbox"/> IV: <u>2x9 RUL</u> <input type="checkbox"/> IV: <input type="checkbox"/> IV:	Induction: <input checked="" type="checkbox"/> IV <input checked="" type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ET# <u>5.0</u> at <u>15.5</u> cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input checked="" type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input checked="" type="checkbox"/> Drug: <u>ADACURILUM</u> <input type="checkbox"/> Awake <input checked="" type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade # <u>2</u> Attempts: <u>1</u> Difficulty Why?	Regional: Extremity <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: Position: Site: Needle Size: Depth: Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin: cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Name of the Doctor: <u>Dr. Rima Bhatnagar</u> Signature of the Doctor:
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sr. Prasad Time Received: 10:30am Time Discharged:



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
<u>6/6/20</u>	<u>10:30 am</u>	<u>0 Score</u>	<u>-</u>	<u>[Signature]</u>

Pain Tool Used: N PASS FLACC Wong Baker MPS
 Anaesthesiologist Name: Dr. Himabindu / Dr. Madhav
 Anaesthesiologist Signature: [Signature]
 Date & Time: 6/6/20 @ 11am
 PACU Nurse Name: Sr. Prasad
 PACU Nurse Signature: [Signature]
 Date & Time: 6/6/20

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 relieving intervention
 d. With in 30-60 minutes after pain relief intervention
 Transferred to Unit by (PACU): Sr. Prasad
 Date & Time: 6/6/20

Pain-relief: good,

Ry

w/F bleed

Nil oral till 120PH

Start with i/c cold fluids

↳ i/c cramps

Soft diet

SyP. CLAMP bid

SyP. ASLENT bid

SyP. IBUBESIC e bid

ORINASE - P.M. drops 000-000-000

,

↓

Name of the Surgeon: Dr. P. Madhau

Signature of the Surgeon: Madhau

Date & Time: 6/6/26 @ 10:30am

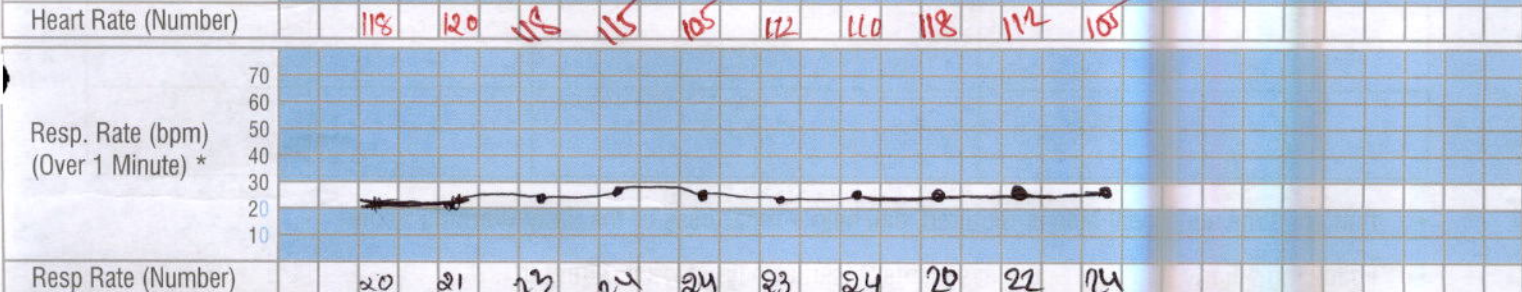
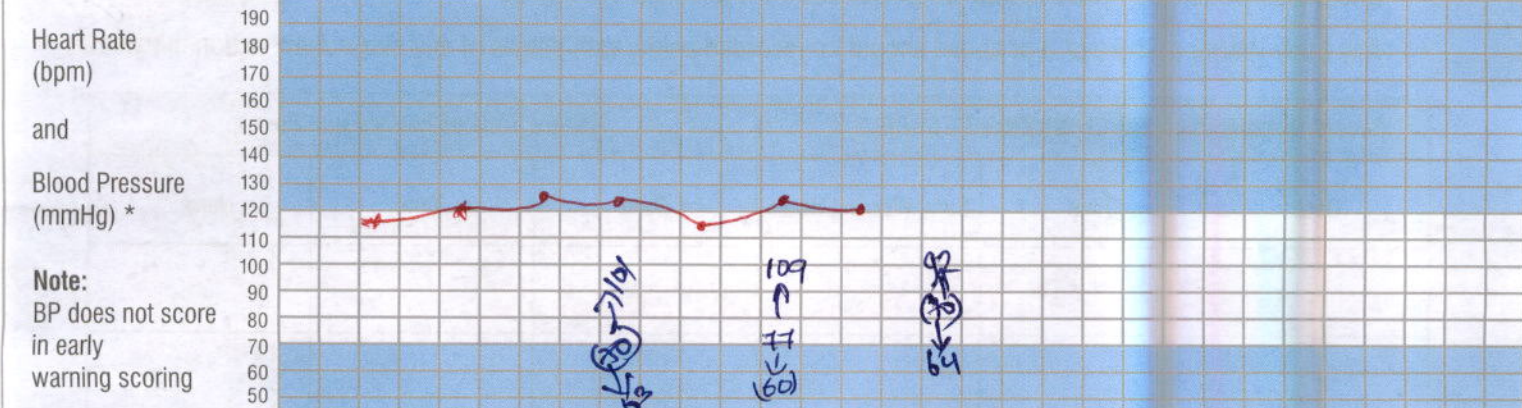
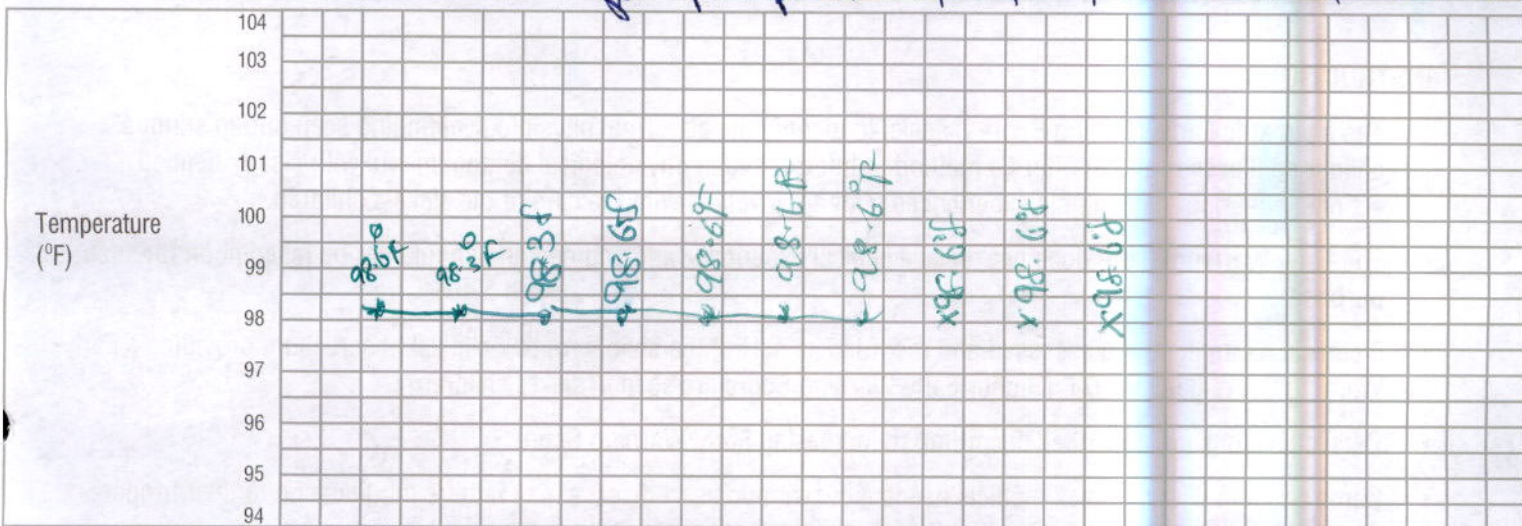


SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/6/20 Time: 9 Am 10 Am 11 Am 1 Pm 3 Pm 5 Pm 7 Pm 9 Pm 11 Pm 1 Am 3 Am 5 Am 7 Am
 Doctor / Nurse / Family Concern?



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

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

- 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.

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)

VIH-00129184 IP-00060246
 Master VIHAAN MADDURI
 14-11-2020 5 Y 6 M 23 D (M)
 Dr. MADHAVI PARISA

FLUID CHART

Sheet No. : (1)

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 Thrombo-phlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
6/6/20	08:00 am	NBM								✓	[Handwritten notes and signatures]	@ 2pm 6/6/20		
	09:00 am	NBM	RC + 200ml/hr											
	10:00 am	NBM												
	11:00 am													
	12:00 pm	Ice								✓				
	01:00 pm													
Total Intake :						Total Output :						2 times		
6/6/20	02:00 pm	Ice Cream									[Handwritten notes and signatures]	@ 8pm 6/6/20		
	03:00 pm									✓				
	04:00 pm													
	05:00 pm	Juice												
	06:00 pm									✓				
	07:00 pm													
Total Intake :						Total Output :						2 times		
7/6/20	08:00 pm										[Handwritten notes and signatures]	@ 8pm 7/6/20		
	09:00 pm	Ice Cream								✓				
	10:00 pm													
	11:00 pm													
	12:00 am									✓				
	01:00 am													
Total Intake :						Total Output :						2 times		
	02:00 am										[Handwritten notes and signatures]			
	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		



DRUG CHART

Date of Admission: 6/6/26 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



REGULAR PRESCRIPTIONS

Weight. 20.4kg Ward. O.T

Dr. Parashankar

Dr. Parashankar

Dr. Parashankar

Dr. Parashankar

DRUG : Symp. CLAMP				Date Time	6/6/20
Dose	Route	Frequency	Start Date		
1ml	P/O	12 th hourly	6/6/20	10 AM	/
Name & Signature of the Doctor Starting the Drugs:				Dr. Parashankar	
Additional Instructions:				10 ESU PM	
Daily Doctor's Endorsement by a Sign					

DRUG : Symp. PLENTIPUR				Date Time	6/6/20
Dose	Route	Frequency	Start Date		
2-5ml	P/O	12 th hourly	6/6/20	6 AM	/
Name & Signature of the Doctor Starting the Drugs:				Dr. Parashankar	
Additional Instructions:				6 2PM PM	
Daily Doctor's Endorsement by a Sign					

DRUG : Symp. IBUGESIC plus				Date Time	6/6/20
Dose	Route	Frequency	Start Date		
10ml	P/O	12 th hourly	6/6/20	10 AM	/
Name & Signature of the Doctor Starting the Drugs:				Dr. Parashankar	
Additional Instructions:				10 ESU PM	
Daily Doctor's Endorsement by a Sign					

DRUG : NAROVION PPRAL				Date Time	6/6/20
Dose	Route	Frequency	Start Date		
2 DROPS	P/O	8 th hourly	6/6/20	2 PM	/
Name & Signature of the Doctor Starting the Drugs:				Dr. Parashankar	
Additional Instructions:				10 ESU PM	
Daily Doctor's Endorsement by a Sign					



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
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.	

Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
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
6/6/20	9:40 AM	INJ. AUGMENTIN	600mg	IV	[Signature]	[Signatures]
6/6/20	9:45 AM	INJ. PARACETAMOL	300mg	IV	[Signature]	[Signatures]
6/6	9:46 AM	INJ. DEXAMETHASONE	2mg	IV	[Signature]	[Signatures]
6/6	9:48 AM	DICLOFENACOPP.	25mg	PR	[Signature]	[Signatures]

VERIFIED BY : Name Signature

Dr. Parisa

Patient Name : VIHAAN MADDURI UHID : VIH-00129184 IPD : IP-00060246 Gender : Male Age : 5 Y 6 M 23

VIH-00129184 IP-00060246
 Master VIHAAN MADDURI
 14-11-2020 5 Y 6 M 23 D (M)
 Dr. MADHAVI PARISA




wt: - 20.4kg
 Ht: - 112cm
 Gender: Male Female

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master. vihaan Age : 5Y
 Date : 6/6/26 Time of Arrival : 7:56 AM

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of information: Parents Others (Specify):

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 98.6°F PR: 82b/M BP: 102/56 RR: 20b/M SpO₂: 100%

Chief Complaints: patient came to (Adenoidectomy coblation)

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

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input checked="" 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
 Signature of Parent / Guardian: [Signature]
 Triage Completion Time : 8:00 AM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? Yes No

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
- 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

Name of Triage Nurse : Swathi

Date & Time : 6/6/26 @ 8:00 AM

Docu. No. : RCH/FRM / CLINICAL / 085

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).

Signature of Triage Nurse : [Signature]