

KUH-00078398 IP5-00175033  
Baby Of G VERONICA TWIN - I  
16-09-2019 6 Y 8 M 26 D (F)  
Dr. NAMRATA



# SURGERY DETAILS

Date : 11/6/28

Patient Name: D/O Veronica Twin - I Date of Birth: Age:

Gender: female Ward: P-UT UHID No.:

Date of Surgery: 11/6/28  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : DENTAL EXTRACTION

Time in : 2 PM

Time Out : 2:30 PM

|                      | NAME       | AMOUNT   |
|----------------------|------------|----------|
| 1. Surgeon           | DR NAMRATA | NPR00097 |
| 2. Anaesthetist      |            |          |
| 3. Assistant Surgeon |            |          |
| 4. OT Technician     | Roshan     |          |
| 5. Circulating Nurse | Rabi       |          |
| 6. Assistant Nurse   | Pravabhati |          |

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

*Namrata*  
Signature of the Surgeon

*[Signature]*  
Signature of Circulating Nurse

Order No: 9653150

Order by: *Rabi*



*Dental*

**CONSUMABLES OF OT**

Circulating staff : ..... Technician : ..... Date : ..... Time : *2 PM*

| Anesthesia Disposables              | Qty    |      | Surgical Disposables      | Qty    |      | Disposables (Baby Side)    | Qty    |      |
|-------------------------------------|--------|------|---------------------------|--------|------|----------------------------|--------|------|
|                                     | Issued | Used |                           | Issued | Used |                            | Issued | Used |
| <i>Not</i> ET tube <i>9, 5.5, 6</i> | 14     | 1    | Major Pack <i>drop</i>    | 1      | 1    | Inj Vit.K                  |        |      |
| LMA <i>2, 2.5</i>                   | 1      | 1    | Sutures                   |        |      | Cord Clamp                 |        |      |
| ECG leads : A (P) N                 | 5      | 1    |                           |        |      | Suction Catheter           |        |      |
| HME filter : A (P) N                | 1      | 1    |                           |        |      | Feeding Tube               |        |      |
| Syringes : 10 cc                    | 10     | 5    |                           |        |      | Vaccum Suction Set         |        |      |
| 05 cc                               | 10     | 3    | Gloves                    |        |      | Surgical Gloves            |        |      |
| 02 cc                               | 10     | 0    | <i>6, 6, 7, 7</i>         |        |      | Gauze Pack                 |        |      |
| 01 cc                               | 1      | 1    | <i>PP (6, 0, 2, 7, 7)</i> | 1      | 1    | Syringe 1ml / 2ml          |        |      |
| Cautery plate : A (P) N             | 1      | 1    | Surgical blade            |        |      | Surgical Blade # 20        |        |      |
| IV set                              | 1      | 1    | NG tube                   |        |      | Koochies (S)               |        |      |
| RL                                  |        |      | Cautery pencil            |        |      | <i>NS 500ml</i>            | 1      | 1    |
| NS: 10ml / 100ml / 500ml / 1000ml   | 5      | 1    | Koochies                  |        |      | <i>(see, see 24, 24)</i>   | 1      | 1    |
| <i>minispre</i>                     | 1      | 1    | Ointments                 |        |      | <i>Lox e Adrenaline</i>    | 1      | 1    |
| <i>O2 mask (P)</i>                  | 1      | 1    | Suction Catheter          |        |      | <i>26 needle</i>           | 1      | 1    |
| Fentanyl                            | 1      | 1    | Cap, Mask                 |        |      | <i>Ribbon gauze</i>        | 1      | 1    |
| Morphine                            |        |      | Gauze Pack <i>N</i>       | 3      | 0    |                            |        |      |
| Ketamine                            |        |      | Mop Pack                  | 1      | 1    |                            |        |      |
| Propofol                            | 3      | 2    | Steristrip                |        |      |                            |        |      |
| Rocuronium                          | 1      | 1    | Underpad                  | 1      | 1    |                            |        |      |
| Glycopyrolate                       | 1      | 0    | Draw sheet                | 1      | 1    |                            |        |      |
| Myopyrolate + NEO                   | 2      | 1    | Abgel                     |        |      |                            |        |      |
| Ondansetron                         | 1      | 1    | Foleys catheter           |        |      |                            |        |      |
| Pencan 25g/ Spinal Needle (22)      | 1      | 1    | Urobag                    |        |      |                            |        |      |
| Bupivacaine 0.25%                   | 1      | 1    | Chest Drainage Catheter   |        |      | <i>oral Air way</i>        |        |      |
| Bupivacaine 0.25%(Heavy)            |        |      | Romodrain bag             |        |      | <i>1, 2</i>                | 1      | 1    |
| Antibiotics                         |        |      | Bandage                   |        |      | <i>Nasal Air way</i>       |        |      |
| <i>IV pen + Damed</i>               | 1      | 1    | Tegaderm                  |        |      | <i>22, 24</i>              | 1      | 1    |
| Suppositories                       |        |      | Ioban                     |        |      | <i>50 cc + pm line</i>     | 1      | 1    |
| Anamol : 80mg / 250mg / 170 mg      |        |      | Double J Stent            |        |      |                            |        |      |
| Supridol : 100mg                    |        |      | Vaccum Suction set        | 1      | 1    | <i>STCOL + Nasal spray</i> | 1      | 1    |
| Justin : 12.5 mg (25mg) / 100mg     | 1      | 1    | Plastic Bed Sheet         | 1      | 1    | <i>(P)</i>                 |        |      |
| Tab. Misoprost : 200mg              |        |      | Betadine Solution         |        |      |                            |        |      |
| <i>3way 10 + 100cm</i>              | 1      | 1    | Microshield               | 1      | 1    |                            |        |      |
| <i>vaccum set</i>                   | 1      | 1    | Cotton Balls              | 1      | 1    |                            |        |      |
| <i>Tobanexa + DEXA</i>              | 1      | 1    | Latex Gloves              | 8      | 8    |                            |        |      |
| <i>WCannula 22, 24</i>              | 1      | 1    | Ramdione Scrub            |        |      |                            |        |      |
| <i>Coler + GATE</i>                 | 1      | 1    | Saral                     |        |      |                            |        |      |

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175033 Admit Date : 11-Jun-2026 Admit Time : 01:08 PM UHID : KUH-00078398

Patient Details :

Patient Name : Baby Of G VERONICA TWIN - I Age : 6 Y 8 M 26 D  
Guardian : Mr K VINAY KUMAR DOB : 16-09-2019  
Gender : Female Religion :  
Occupation : Martial Status : Single  
Address (H) : H.NO-5-1-87/5/2 , SIDDHARTH NAGAR, Phone No : 9177978227/ 7995684341  
Sangareddy Medak Telangana INDIA 502001 E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 403 Ward Name : 4F-OT COMPLEX  
Room No : PRE OP 403 Admission Type : First Visit

Contact Details :

Name : Mr K VINAY KUMAR Relationship : Father  
Contact Address : H.NO-5-1-87/5/2 , SIDDHARTH NAGAR, Phone No : 9177978227 / 7995684341  
Sangareddy Medak Telangana INDIA 502001

  
Signature

Doctor Details :

Doctor Name : Dr. NAMRATA Specialisation : DENTAL  
Referral Doctor : SELF Phone No :  
Co-Consultant :

Payment Details :

Deposit Amount : 0.00  
Payment Mode : Cash Payor Name : SELFPAY

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NPO 10:00am solid  
 12:00pm liquid



# EMERGENCY ROOM TRIAGE FORM

Patient's Name: B/O Veronica Twin-I. Age: 6yr Gender:  Male  Female  
 Date: 11/06/26 Time of Arrival: 12:00pm Triage Completion Time: 12:42pm  
 Allergies:  No  Yes  Food  Medications  Other (Specify):  Not known any drug Allergies  
 Source of Information:  Parents  Others (Specify):  
 Mode of Arrival:  Ambulatory  Wheelchair  Stretcher  Ambulance

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

Initial Vital Signs: Temp: 98.0f PR: 103bpm BP: 96/53 RR: 22b/m SpO<sub>2</sub>: 100%  
 Chief Complaints: came for dental extraction

| 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 type="checkbox"/> 60 min             |
| <input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient   | <input checked="" 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]

## 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 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: Keuthare

Signature of Triage Nurse: [Signature]

Date & Time: 11/06/26 @ 12:42pm

## ERROR LOG

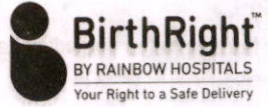
LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /  
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/6/20 Time of arrival : 12:44pm  
 Chief Complaints: came for dental extraction RBS: NA  
 Height : 114cms Weight : 17.2kg BMI : NA Head Circumference (<2 years) : NA  
**Allergies:**  Yes  No  Medications  Blood Transfusion  Food  Other: NA  
 If yes, identify NA  
**Pain Screening:**  Yes  No If Yes, Pain Score: 0/10 Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character NA  Location NA  Frequency NA  Duration NA

**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:** NA (Date/Time): NA

**Social History:** Lives With Family

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

Cultural & Spiritual Needs:  Yes  No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 12:46pm

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

| Time | Nursing Notes          |
|------|------------------------|
|      | Assessing pt condition |
|      | monitored vitals       |
|      | Placental sample       |
|      | sample send to lab     |
|      | shipped to OT.         |
|      |                        |
|      |                        |
|      |                        |

Samples collected by: *Mr. Prancy*  
 Samples sent by: *Mr. Sanku*

Time: *11:30pm*  
 Time: *11:30pm*

**Medication given in ER:**

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

| Condition of patient at time of shift - out :            | Details of Shift - out             |
|--|------------------------------------|
| HR: <i>117b/m</i> BP: <i>102/70</i> CFT: <i>&lt;2sec</i> | Shift - out from ER to: <i>OT</i>  |
| RR: <i>24b/m</i> SPO <sub>2</sub> : <i>98%</i>           | Time of Shift - out: <i>1:50pm</i> |
| GCS: <i>15/15</i> Temperature: <i>98.6</i>               | Handover given to: <i>Prancer</i>  |
| Pain Score: <i>0/10</i>                                  | (Nurse's Name)                     |
| Repeat RBS (if applicable): <i>NA</i>                    |                                    |

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): .....

*Replacement*

Name of the Nurse: *Jelaye* Signature of the Nurse: *[Signature]*

Date & Time: *11/6/26 @ 1:50pm*

**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_

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Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_



Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

**WARD TRANSFERS**

| Date  | Time   | From | To      | Signature of Nurse |
|-------|--------|------|---------|--------------------|
| 11/16 | 1:50pm | OT   | OT      | Jagan              |
| 11/16 |        | OT   | billing | Deep               |
|       |        |      |         |                    |
|       |        |      |         |                    |
|       |        |      |         |                    |

**Cross Consultation Visit**

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



## PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Veronica twin-I Date: 11/6/26  
Dr. Namrata

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

Start Time of Assessment: \_\_\_\_\_ Weight: 17-28 kg

Allergic History: \_\_\_\_\_

Chief Complaints: Dental caries

Pediatric Assessment Triangle

A Appearance - TICLS \_\_\_\_\_

B \_\_\_\_\_ C Circulation  Normal  Abnormal

Breathing  ↑ WOB  ↓ WOB  Normal  Gasping / Apnea

Pallor  Cyanosis  Mottling  Bleeding

Initial Physiological Status:  Stable  Unstable  
 Life Threatening  Non Life Threatening

Any urgent interventions needed:  Yes  No  
 If Yes \_\_\_\_\_

Significant Past History: Tern / LUS / 2.2kg / No New Stay

Medication History: \_\_\_\_\_

Relevant Investigations: \_\_\_\_\_

**Primary Assessment**

**Airway**  Open  Maintainable  Not Maintainable

**Breathing** Rate: 22/min SpO<sub>2</sub> on FiO<sub>2</sub>: 98% ER/A


Retractions:  Suprasternal  ICR  SCR  
 Sternal  Supraclavicular  Nasal Flaring

Respiratory Noises:  Stridor  Wheezing  Grunting

Air Entry: \_\_\_\_\_

Palpation Findings (if necessary): \_\_\_\_\_

Any urgent interventions needed:  Yes  No  
 If Yes \_\_\_\_\_

**Circulation**  HR: 103/min CFT  Central .....  Peripheral ..... Any urgent interventions needed:  Yes  No

BP: 96/53 mmHg

Pulse Volume:  Central .....  Peripheral .....

If in Shock:  Compensated .....  Hypotensive .....

Murmurs:  Yes  No


Liver Span: .....

ECG: .....

Any Signs of Heart Failure:  Yes  No

Muffled Heart Sound:  Yes  No

Engorged Neck Veins:  Yes  No


**Disability**  GCS: 15/15 AVPU: ..... Any urgent interventions needed:  Yes  No

Pupils:  Responsive  Non-Responsive

Size:  Right .....  Left .....

Active Seizures:  Yes  No Sugars: .....

Signs of Neurological compromise .....

**Exposure**  Temp.: 98°F Any rash:  Yes  No, Any urgent interventions needed:  Yes  No

If yes describe the rash .....

Active bleed .....

Lacerations  Abrasions  bruises

Describe: .....

- Final Physiological Status:**  Respiratory Distress  Respiratory Failure  Respiratory Arrest
- Shock - Compensated  Hypotensive
- Cardiopulmonary Arrest  Hemodynamically Stable

**Secondary Assessment:** Head to toe examination with positive findings: Dental Caries, Right lower incisor.

**Labs Planned:** CBC

**Treatment Planned:** NPO 12pm - liquids. Dental Extraction. NB [unclear] 11/6/26

Need for Oxygen:  Yes  No if yes Low Flow  High Flow  PPV

Final Diagnosis with possible Differential Diagnosis (if necessary): Dental caries, plan of dental extraction

Assessment done by Name of the Doctor: N. Penton  
Signature: [Signature]  
Date & Time: 11/04/26

Sr. Doctor on Duty (if necessary) Name of the Sr. Doctor: .....  
Signature: .....  
Date & Time: .....

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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: ..... ICU .....

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 : ..... N. Praveen N.P.S .....

Date & Time : ..... 11/08/20, 2:20 PM .....

Nurse Name & Signature: ..... [Signature] .....

Date & Time : ..... 11/08/20 @ 1:50 PM .....



# DRUG CHART

Date of Admission: ..... 11/6 ..... 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                          |       |              |            | Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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

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

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







KUH-00078398 IP5-00175033  
 Baby Of G VERONICA TWIN - I  
 16-09-2019 8 Y 8 M 26 D (F)  
 Dr. NAMRATA



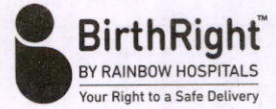
## RESULT SHEET

|                     |  |  |  |  |  |
|---------------------|--|--|--|--|--|
| Date                |  |  |  |  |  |
| Time                |  |  |  |  |  |
| Hb                  |  |  |  |  |  |
| PCV                 |  |  |  |  |  |
| RBC                 |  |  |  |  |  |
| WBC                 |  |  |  |  |  |
| N/L                 |  |  |  |  |  |
| Platelets           |  |  |  |  |  |
| CRP                 |  |  |  |  |  |
| ESR                 |  |  |  |  |  |
| PCT                 |  |  |  |  |  |
| RBS                 |  |  |  |  |  |
| Na                  |  |  |  |  |  |
| K                   |  |  |  |  |  |
| Cl                  |  |  |  |  |  |
| Ca/Mg               |  |  |  |  |  |
| Phosphate           |  |  |  |  |  |
| Urea                |  |  |  |  |  |
| Creatinine          |  |  |  |  |  |
| ALP                 |  |  |  |  |  |
| SGPT                |  |  |  |  |  |
| SGOT                |  |  |  |  |  |
| T.Bill/Conj         |  |  |  |  |  |
| T.Protein           |  |  |  |  |  |
| S.Albumin           |  |  |  |  |  |
| S.Globulin          |  |  |  |  |  |
| A/G Ratio           |  |  |  |  |  |
| Uric Acid           |  |  |  |  |  |
| S.Amylase           |  |  |  |  |  |
| Sr.Lipase           |  |  |  |  |  |
| Blood Lactate       |  |  |  |  |  |
| S.Cholesterol       |  |  |  |  |  |
| PT/INR              |  |  |  |  |  |
| APTT                |  |  |  |  |  |
| CSF Protein / Sugar |  |  |  |  |  |
| Cells               |  |  |  |  |  |
| N/L                 |  |  |  |  |  |



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 Dr. NAMRATA

11/6



# FLUID CHART

Sheet No. :                     

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

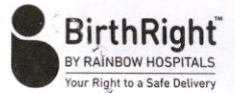
| Date                  | Time     | Intake          |       |     | Output                |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------|----------|-----------------|-------|-----|-----------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                       |          | Nature of Fluid | Route |     | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
|                       |          |                 | Mouth | I.V | N.G                   |           |       |          |       |                                 |             |  |
|                       | 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> |           |       |          |       |                                 |             |  |

**Total 24 hrs. Intake**                          

**Total 24 hrs. Output**

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

|                       |          | Intake          |       |     |     | Output                |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------|----------|-----------------|-------|-----|-----|-----------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
| Date                  | Time     | Nature of Fluid | Route |     |     | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
|                       |          |                 | Mouth | I.V | N.G |                       |           |       |          |       |                                 |             |  |
|                       | 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> |           |       |          |       |                                 |             |  |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

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 Baby Of G VERONICA TWIN - I  
 16-09-2019 8 Y 8 M 26 D (F)  
 Dr. NAMRATA



### THE HUMPTY DUMPTY SCALE

116

| PARAMETER                                 | CRITERIA  | SCORE | DATE | DATE | DATE | DATE | DATE |
|---|---|-------|------|------|------|------|------|
| Age                                       | Less than 3 years old   | 4     |      |      |      |      |      |
|   | 3 to less than 7 years old  | 3     | 3    |      |      |      |      |
|   | 7 to less than 13 years old   | 2     |      |      |      |      |      |
|   | 13 years old and above  | 1     |      |      |      |      |      |
| Gender                                    | Male  | 2     |      |      |      |      |      |
|   | Female  | 1     | 1    |      |      |      |      |
| Diagnosis                                 | Neurological Diagnosis  | 4     |      |      |      |      |      |
|   | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.) | 3     |      |      |      |      |      |
|   | Psych / Behavioral Disorders  | 2     |      |      |      |      |      |
|   | Other Diagnosis   | 1     | 1    |      |      |      |      |
| Cognitive Impairments                     | Not Aware of Limitations  | 3     |      |      |      |      |      |
|   | Forget Limitations  | 2     |      |      |      |      |      |
|   | Oriented to own Ability   | 1     | 1    |      |      |      |      |
|   | History of Falls or Infant - Toddler Placed in Bed  | 4     |      |      |      |      |      |
| Environmental Factors                     | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)             | 3     |      |      |      |      |      |
|   | Patient Placed in Bed   | 2     | 2    |      |      |      |      |
|   | Outpatient Area   | 1     |      |      |      |      |      |
| Response to Surgery / Sedation Anesthesia | Within 24 hours   | 3     |      |      |      |      |      |
|   | Within 48 hours   | 2     |      |      |      |      |      |
|   | More than 48 hours / None   | 1     | 1    |      |      |      |      |
| Medication Usage                          | Sedatives (excluding ICU patients sedated and paralyzed)  | 3     |      |      |      |      |      |
|   | Hypnotics   | 3     |      |      |      |      |      |
|   | Barbiturates  | 3     |      |      |      |      |      |
|   | Phenothiazines  | 3     |      |      |      |      |      |
|   | Antidepressants   | 3     |      |      |      |      |      |
|   | Laxatives / Diuretics   | 3     |      |      |      |      |      |
|   | Narcotics   | 3     |      |      |      |      |      |
|   | One of the Meds listed above  | 2     |      |      |      |      |      |
|   | Other Medications / None  | 1     |      |      |      |      |      |
| <b>TOTAL</b>                              |   |       | 5    |      |      |      |      |

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

|                               |  |     |  |  |  |  |
|-------------------------------|--|-----|--|--|--|--|
| Bed in low position           |  | yes |  |  |  |  |
| Call device within reach      |  | yes |  |  |  |  |
| Wheels Locked                 |  | yes |  |  |  |  |
| Room free of clutter          |  | yes |  |  |  |  |
| Adequate Lighting             |  | yes |  |  |  |  |
| Wheel Chair Support           |  | no  |  |  |  |  |
| Other Intervention(s) Specify |  | no  |  |  |  |  |
| Nurse's Name :                |  |     |  |  |  |  |
| Signature :                   |  |     |  |  |  |  |
| Date :                        |  |     |  |  |  |  |
| Time :                        |  |     |  |  |  |  |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Namrata Department: paed Date of Admission: 11/6

|                        |   |  |
|------------------------|---|--|
| <b>SITUATION</b>       | Diagnosis: <u>Dental Extraction</u>   | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |
| <b>BACKGROUND</b>      | Area: <u>ICU</u><br>Shift Time: <u>2pm</u>  |  |
| <b>ASSESSMENT</b>      | Medical Condition (Any special condition to be noted): <u>NA</u>  |  |
| <b>ASSESSMENT</b>      | Allergy: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Tubes/Drains/Catheter: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Vital Signs:<br>Temp: <u>98.6</u><br>Res: <u>24</u><br>SpO <sub>2</sub> : <u>98</u><br>Pulse: <u>100</u><br>BP: <u>100/70</u><br>Fall Risk Score: <u>10</u><br>Pain Score: <u>0</u> |  |
| <b>Recommendations</b> | Safety Needs: <u>Yes</u><br>Physiotherapy: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Others Specify: <u>NA</u><br>Special Diet: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                        | Other Special Orders / Medications: <u>NA</u>   |  |
|                        | Post Operative Procedure Special Orders: <u>NA</u>  |  |
|                        | Handed Over By Name: <u>Jarany</u>  |  |
|                        | Signature: <u>[Signature]</u>   |  |
|                        | Date: <u>11/6</u>   |  |
|                        | Time: <u>2pm</u>  |  |
|                        | Taken Over By Name: <u>Preema</u>   |  |
|                        | Signature: <u>[Signature]</u>   |  |
|                        | Date: <u>11/6</u>   |  |
|                        | Time: <u>2pm</u>  |  |

Patient Sticker

## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| <b>SITUATION</b>                         | Diagnosis: .....                                       | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |  |  |  |  |  |  |
| <b>BACKGROUND</b>                        | Area   |   |  |  |  |  |  |  |
|  | Shift Time   |   |  |  |  |  |  |  |
|  | Medical Condition (Any special condition to be noted): |   |  |  |  |  |  |  |
| <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 |  |
|  | 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:   |  |  |  |  |  |  |
| Fall Risk Score:                         |  |   |  |  |  |  |  |  |
| Pain Score:                              |  |   |  |  |  |  |  |  |
| <b>Recommendations</b>                   | Safety Needs:  |   |  |  |  |  |  |  |
|  | Physiotherapy  | <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 |  |
|  | Others Specify:  |   |  |  |  |  |  |  |
|  | Special Diet:  | <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 |  |
|  | Other Special Orders / Medications:                    |   |  |  |  |  |  |  |
| Post Operative Procedure Special Orders: |  |   |  |  |  |  |  |  |
| Handed Over By Name :                    |  |   |  |  |  |  |  |  |
| Signature :                              |  |   |  |  |  |  |  |  |
| Date:                                    |  |   |  |  |  |  |  |  |
| Time:                                    |  |   |  |  |  |  |  |  |
| Taken Over By Name :                     |  |   |  |  |  |  |  |  |
| Signature :                              |  |   |  |  |  |  |  |  |
| Date:                                    |  |   |  |  |  |  |  |  |
| Time:                                    |  |   |  |  |  |  |  |  |



# 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. DENTAL EXTRACTION (D) IV SEDATION
- 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) |
|---|---|
| RELIEF OF PAIN AND INFECTION              |   |

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. NO COMPLICATIONS

1. I authorize Dr. \_\_\_\_\_ 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: KAVINAY KUMAR  
Relationship with patient: Daughter  
Date & Time: 11/6/26 @ 2pm Rather

**Witness:**

Signature: \_\_\_\_\_  
Name: G. Rachel  
Date & Time: 11/06/26 @ 2pm

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

Signature: \_\_\_\_\_ Name: DR. NAMRATAK Date: 11/06/26 Time: 1:57 PM

## శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు:  రోగి  రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన ద్వ్యక్తి, రోగి/నా పైన రైన్ఫో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు భాష స్థలం వదిలివేయకండి)

1 .....

2 .....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

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

| శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు: | శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు |
|---------------------------------------|---|
|                                       |   |

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మానరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, 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. |  |

4. డాక్టర్ \_\_\_\_\_ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- 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: .....



IST

Surgeon : Dr. Swathi  
 Asst. Surgeon : .....  
 Anaesthetist : Dr. Savana  
 Scrub Nurse : Pravathi

Patient Name : B/D Veronica Age : 6Y Gender : F  
 UHID No. : 78938 Surgery Name : Dental extraction  
 Date : 11/6/26 In-time : 2pm Out-time : 2:30pm



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

**SIGN IN** Time:.....

**Patient Has Confirmed**

Identity  Yes  No  
 Site  Yes  No  
 Procedure  Yes  No  
 Consent  Yes  No

**Site Marked**  Yes  No  NA

**Anaesthesia Safety Check Completed**  Yes  No

**Pulse Oximeter on Patient & Functioning**  Yes  No

**Does Patient have a:**

Known Allergy?  Yes  No

**Difficult Airway / Aspiration Risk?**

Yes, & Equipment / Assistance Available  Yes  No

**Risk of > 500ml Blood Loss (7ml/kg In Children)?**

Yes, and Adequate Intravenous Access and Fluids Planned  Yes  No  NA

Blood Units Reserved  Yes  No  NA

**Has Antibiotic Prophylaxis been given within the last 60 minutes?**  Yes  No  NA

Signature : .....  
 Name : Dr. Swathi

**TIME OUT** Time: 2:06 pm

**Confirm all team members have introduced themselves by Name and Role**  Yes  No

**Surgeon, Anaesthesia Professional and Nurse Verbally Confirm**

Correct Patient (Check ID Band)  Yes  No  
 Correct Site  Yes  No  
 Correct Procedure  Yes  No

**Anticipated Critical Events**

**Surgeon Reviews:**

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?  Yes  No  NA  
*Nil to report*

**Anaesthesia Team Reviews:**

Are There Any Patient-specific Concerns?  Yes  No  NA

**Nursing Team Reviews:**

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?  Yes  No  NA

**Is Essential Imaging Displayed?**  Yes  No  NA

Power Supply, Earthing, Power Backup and functioning of equipment checked.  Yes  No

Signature : .....  
 Name : Dr. Swathi

**SIGN OUT** Time: 2:28 pm

**Nurse Verbally Confirms with the Team:**

The Name of the Procedure Recorded  Yes  No  
 That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)  Yes  No  NA  
 The Specimen is Labelled (including patient name)  Yes  No  NA  
 Whether there are any Equipment Problems to be addressed  Yes  No  NA

**To Surgeon, Anaesthetist and Nurse:**

What are the key concerns for recovery and management of this patient?  Yes  No

Signature : Namrata  
 Name : DR NAMRATA K

KUM-00078398 IP5-00175033  
 Baby Of G VERONICA TWIN - I  
 16-09-2019 6 Y 8 M 26 D (F)

Patient Sticker

Dr. NAMRATA



## BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/6/20

Department : P-5T Duration of Procedure : 10 mls.

Name of Surgeon : Dr. Namrata Date of Admission : 11/6/20

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

|    |  | Staff Signature |
|----|--|-----------------|
| 1. | Antibiotic given prior to surgery ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Single Dose Antibiotic or <input checked="" type="checkbox"/> Long Antibiotic Regime<br>Antibiotic administered within 60 minutes prior to incision ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Name of the Antibiotic : .....                      |                 |
| 2. | Hair Removal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No if Yes : Surgical Clipper<br>Department where Hair Removed : <input type="checkbox"/> Ward <input checked="" type="checkbox"/> Operating Room<br><input type="checkbox"/> Other : .....<br>Skin preparation done (cleanse surgical area with antiseptic agent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                 |
|    | Patient's body temperature immediately post operation (Recovery Room) 36.1 °C<br><input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)   |                 |
| 4. | Name of doctor or staff administering the antibiotic : .....<br>Date & Time of antibiotic administration : .....<br>Date & Time procedure started : @ 2:6 pm 11/6/20   |                 |

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

KUH-00078398 IP5-00175033  
Baby Of G VERONICA TWIN - I  
16-09-2019 6 Y 8 M 26 D (F)  
Dr. NAMRATA



Patient

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender :  Male  Female

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

Surgeon : ..... Asst. Surgeon : .....

Anesthetist : ..... OT Nurse: ..... OT Technician: .....

Pre-Operative Diagnosis: .....

Surgical Procedure :  
DENTAL EXTRACTION (1) IV SEDATION.

Indications for Surgery :  
DENTAL CARRIES

Date : ..... Start Time : ..... End Time : .....

Pre Operative Preparations:  
.....  
.....  
.....

Post Operative Diagnosis: .....

Peri-Operative Complications:  
.....  
.....

Operation Notes: (1) IV SEDATION .

1. EXTRACTION DONE OF 82, 85 .

SOFT FOOD FOR 3 DAYS

GENTLE BRUSHING FOR 3 DAYS .

REVIEW AFTER 3 DAYS .

R Syrup. IBUGESIC (5ml) x 3 days  
(1 — 1 — 1)



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Baby Of G VERONICA TWIN - I  
16-09-2019 8 Y 8 M 26 D (F)  
Dr. NAMRATA



Patient Sticker

# POST-SURGICAL CARE PLAN FORM

Procedure Done: EXTRACTION

Post-Surgical Diagnosis: \_\_\_\_\_

Post-Operative Monitoring Parameters / Frequency: \_\_\_\_\_

Wound Care: BLEEDING EVERY 15 MIN S

Drain / Special Lines / Catheters: \_\_\_\_\_

Special Patient Positioning and Requirements: \_\_\_\_\_

Nutritional Instructions: \_\_\_\_\_

When to Start Mobilization: \_\_\_\_\_

Special Referrals: \_\_\_\_\_

The new order for all required medications documented in doctor order/medication sheet  
 Yes  No

Any Other Post-Operative Care Needed including Recovery Room Follow Up

Namrata  
Treating Surgeon  
(Signature & Stamp)

Date: 11/06/26 Time: \_\_\_\_\_

Note: Plan of care will be readjusted if necessary.





# CONSENT FOR ANAESTHESIA

Authorization By:  Patient  Patient Attendant

Operative Procedure: B/L veronica twin I

Anaesthesiologist: Dr. Shabana Surgeon: Dr. Namrata

### 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 Desaturatin, Bronchospasm, 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: G. Veronica

Name: G. Veronica

Relationship with patient: Mother

Date & Time: 09/06/2019, 5:24 PM

### Witness:

Signature: [Signature]

Name: Peena

Date & Time: 9/6/2019 @ 5:30 PM

Name: Dr. Shabana Date 9/6/2019 Time: 5:23 PM

# అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు:  రోగి  రోగి అటెండెంట్

శస్త్రచికిత్స: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా వైద్యుడు: .....  
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 శిరస్థాపన 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 సార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:  
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  బహుశ 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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
  - శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థోలియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్స్ 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 స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:  
సంతకం: .....  
పేరు: .....  
రోగితో సంబంధం: .....  
తేదీ & సమయం: .....

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

డాక్టర్ :  
సంతకం: ..... పేరు: .....

Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**

KUH-00078398 IP5-00175033  
 Baby Of G VERONICA TWIN - I  
 16-09-2019 8 Y 8 M 26 D (F)  
 Dr. NAMRATA



Name: B/o veronica twin Age: 6 Sex: Female UHID.No: KUH 00078398  
 Date: 9/6/2026 Time: 5:20pm Proposed Operation: Dental Extraction  
 Diagnosis: Dental Caries  
 B.P/CRT: 120/80 H.R: ..... Weight: 16.5kg 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/Angio: ..... |
| PT: .....    | K: .....       | LDH: .....        | T3: .....          | Other: .....        |
| PTT: .....   | Ca++: .....    | Alk phos: .....   | T4: .....          |                     |
| INR: .....   | Mg++: .....    | Amylase: .....    | TSH: .....         |                     |
|              | Cl-: .....     | SGOT/SGPT: .....  |                    |                     |

Allergies: nil.

Medical History: CVS:  Tamilselvi / 2.2kg / CIAB / No NICU admission  
 RESP:  Diabetes: - normal milestones  
 CNS:   
 Renal:   
 Hepatic / GE:  Physical Activity: active, Beach  
 Others:

Past Anaesthetic History:   
 Physical Exam: No obvious facial anomaly  
 Airway: MP 1  2  3  4 Mouth Opening: N Mentohyoid Distance: N Neck: N Teeth: not loose tooth  
 Lungs: clear (R) lower incisor  
 Heart: S.S.2d  
 CNS: Good

Pregnant:  Yes  No  N/A Venous Access Site: ..... Spine Exam for regional: not done

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
|                     |        |
|                     |        |
|                     |        |
|                     |        |

- Pre-Operative Instructions:**
- DVT Prophylaxis :
  - NIL ORAL  $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions: (S) CBL

Signature: [Signature] Name: Dr. Shalm

Patient Sticker

# ANAESTHESIA CHART



## Pre Induction Assessment:

**Change in Patient Condition:**  Yes  No

**Physical Status:**  Patient Identified  Consent Present  Chart Reviewed

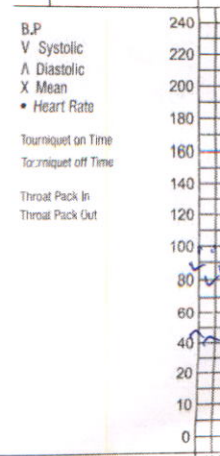
**Fasting Status:** *adequate*

H.R: *113* B.P/CRT: *90/65* SpO<sub>2</sub>: *100* R.R: *20* Last Feed: *2L*

Pre-OP Diagnosis: *Dental Caries* Operation: *Dental Extractions* Date: *11/6/2026*

Surgeon: *Dr Namrata* Anaesthesiologist: *Dr Swathi / Dr Shalu* Technician:

| TIME  | 2          |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|------------|------------|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| N <sub>2</sub> O / AIR / O <sub>2</sub> LPM |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HALO / SO / SEVO                            |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drugs:                                      |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <i>Tu MIDAZ 1mg</i>                         |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <i>J EGMANY 30mg</i>                        |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <i>PROPOFOL 30 4 20 4 20 110</i>            |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FiO <sub>2</sub> / SaO <sub>2</sub>         | <i>100</i> | <i>100</i> | <i>100</i> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ETCO <sub>2</sub>                           |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ECG   | <i>SR</i>  | <i>SL</i>  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Temperature                                 |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urine Output                                |            |            |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



LAB Values

ABG

CPBS

Others

- Equipment Checked and Functional
- BP
- Cuff Site: *(R) ul*
- Art Site: .....
- EKG Lead
- Temp Site *sku*
- FIO<sub>2</sub> Monitor
- Agent Monitor
- Pulse Oximeter
- Capnograph
- Ventilator
- Nerve Stimulator
- Pressure Pulse Clinician

**Temp:**

- HME
- Cling Film
- Hugger's
- Other
- Fluid Warmer
- OH Warmer
- Cotton Wool

**Times:**

Anaes Start: *2:00 PM*

OP Start: *1*

OP End: *1*

Leave OR: *2:30 PM*

**Anaesthesia:**

- GA
- Monitored Anaesthesia Care
- Regional

**Line (Site & Location)**

- CVP
- ART
- IV: *(D) ul 22g*
- IV
- IV

**Induction**

- IV
- Pre O<sub>2</sub>
- Others
- Inhal
- RSI

*O<sub>2</sub> via nasal very.*

- Mask
- Airway
- Oral
- Tracheostomy
- Drug:
- SGAs
- Oral
- Nasal
- Cuff
- Topical
- Awake
- Video Laryngoscopy
- Fiberoptic
- Direct Vision
- Stylette / Bougie

Blade # ..... Attempts: .....

Difficulty Why? .....

- Bilal = BS
- Semi-Closed Circle
- Closed Circle
- Other

**Regional:**

Extremity: .....

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  SNA

Name of the Doctor: *Dr Shalu*

Signature of the Doctor: *[Signature]*