

Patient Sticker

BAH-00613398 IP5-00175021
Master GOLLA SIVA KRISHNA
17-08-2019 8 Y 9 M 25 D (M)
Dr. HARISH JAYARAM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 11/6/2019

Patient Name: Mast. Golla Siva Krishna Date of Birth: 17/8/2019 Age: 6.4

Gender: Male Ward: P.OT UHID No.: BAH-00613398

Date of Surgery: 11/6/2019 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Left opn Orchiopexy

Time in : 12:30 pm

Time Out : 1:30 pm

	NAME	AMOUNT
1. Surgeon	Dr. Harish	
2. Anaesthetist	Dr. Subram	
3. Assistant Surgeon		
4. OT Technician	venkata. sai	
5. Circulating Nurse	Benjamin	
6. Assistant Nurse	Suman	

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: 9653134

Order by: Benjamin

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Orchiopexy

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CONSUMABLES OF OT

Circulating Staff Technician : Date : *7/15* Time : *11 Am*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 5, 5.5, 6	14	1	Major Pack <i>drap</i>	1	1	Inj Vit.K		
LMA 2, 2 1/2	14	1	Sutures <i>9915</i>	2	1	Cord Clamp		
ECG leads : A (P) N	5	03	<i>2303 2437</i>	2+2	1	Suction Catheter		
HME filter : A (P) N	1	1	<i>2304, 2304</i>	2+2	1	Feeding Tube		
Syringes : 10 cc	10	5	<i>Coomic 40, 5-0</i>	2+2	1	Vaccum Suction Set		
05 cc	10	4	Gloves			Surgical Gloves		
02 cc	10	2	<i>6, 6 1/2 (7, 7 1/2)</i>	2+2+2	2	Gauze Pack		
01 cc	2	1	<i>PF 6, 6 1/2 7 (7 1/2)</i>	2+2+2	1	Syringe 1ml / 2ml		
Cautery plate : A (P) N	1	0	Surgical blade <i>11 #15</i>	1+1	1	Surgical Blade # 20		
IV set	1	0	NG tube			Koochies (S)		
RL		0	Cautery pencil			<i>NS Coomic</i>	1	1
NS <i>10ml / 100ml / 500ml / 1000ml</i>	5+1	3+1	Koochies <i>X 2</i>	1	1	<i>10cc see</i>	2+2	1
<i>minispine</i>	1	0	Ointments			<i>July</i>	1	1
<i>O2 mask (P)</i>	1	1	Suction Catheter					
Fentanyl	1	0	Cap, Mask	5	5			
Morphine			Gauze Pack <i>(N+A)</i>	3	2			
Ketamine			Mop Pack	1	0			
Propofol	3	02	Steristrip					
Rocuronium	1	1	Underpad	1	1			
Glycopyrolate	1	1	Draw sheet	1	1			
Myopyrolate + NCO	2	1	Abgel					
Ondansetron	1	1	Foleys catheter					
Pencan 25g/ Spinal Needle <i>22</i>	1	0	Urobag			<i>oral air way</i>		
Bupivacaine 0.25%	1	0	Chest Drainage Catheter			<i>01, 2</i>	1+1	1
Bupivacaine 0.25%(Heavy)	1	0	Romodrain bag			<i>Nasal air way</i>		
Antibiotics			Bandage			<i>18 22, 24</i>	1+1	0
<i>WPCM</i>	1	0	Tegaderm			<i>50cc + proline</i>	1+1	1
Suppositories			Ioban			<i>Dexmed</i>	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent			<i>ET. pack (Burd)</i>	0	0
Supridol : 100mg			Vaccum Suction set					
Justin : <i>12.5 mg / 25mg / 100mg</i>	1+1	0	Plastic Bed Sheet	1	1			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
<i>3 ways 10 + 100cm</i>	1+1	1	Microshield	1	1			
<i>iv cannula (22, 24)</i>	1+1	1	Cotton Balls	1	1			
<i>Gloves all + Gauze</i>	4+4	0	Latex Gloves	5	10			
<i>Dexa + Tranex</i>	1+1	1	Ramdione Scrub					
<i>Vaccum set</i>	1	1	Saral					

Surgeon Anaesthesiologist Nurse OT Technician
 Order No. : *97653284* Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125



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. Left open Orchiopexy
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)
① To bring left testis to its normal anatomical site	N/A

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. Bleeding, infection, recurrence

1. I authorize Dr. Harish Jayaram 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: Rajesh Guler
 Relationship with patient: Father
 Date & Time: 11/6/20
11:20 am

Witness:
 Signature: _____
 Name: Lakshmi Suthi
 Date & Time: 11/6/20
11:20 am

Doctor (who is taking consent):
 Signature: _____ Name: Dr. Niteetha Date: 11/6/20 Time: 11:30 pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్ఫో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రా అంగీకరిస్తున్నాను. (టెక్నికల్ చదాలు వాడవద్దు మరియు ఖాళీ 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 సాధ్యమైనవి నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్టీషియా వల్ల అలెర్జిక్ పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ 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:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Harish
 Asst. Surgeon : Dr. Malu
 Anaesthetist : Dr. Shek
 Scrub Nurse : Suman

Patient Name : Age : Gender :
 UHID No. : Surgery Name : Open orchidop.
 Date : 11/6/20 In-time : Out-time :

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Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

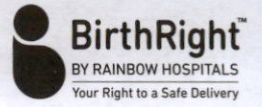
SIGN IN		Time: <u>12pm</u>
Patient Has Confirmed		
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site Marked		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Safety Check Completed		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Does Patient have a:		
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <u>[Signature]</u>		
Name : <u>DR. SIVAKRISHNA</u>		

TIME OUT		Time: <u>12:27pm</u>
Confirm all team members have introduced themselves by Name and Role		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>157</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Is Essential Imaging Displayed?		
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature : <u>[Signature]</u>		
Name : <u>Benjamin</u>		

SIGN OUT		Time: <u>1:27pm</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Whether there are any Equipment Problems to be addressed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Malu</u>		

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/6/24

Department : P.O.T. Duration of Procedure : 1 hr

Name of Surgeon : Dr. Harish Jayaram Date of Admission : 11/6/24

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic or <input type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Name of the Antibiotic : _____	<i>[Signature]</i>
2.	Hair Removal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No if Yes : Surgical Clipper Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other : _____ Skin preparation done (cleansing surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<i>[Signature]</i>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>37</u> °C <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	<i>[Signature]</i>
4.	Name of doctor or staff administering the antibiotic : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 11/6/24 @ 12-27 pm	<i>[Signature]</i>

- 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

Patient Sticker



OPERATION THEATER NOTES

Patient's Name : Master Golla Siva Krishna Age : 6 year Gender : Male Female

UHID No. 50400613398 Weight : 16 Kg Height :

Surgeon : Dr. Harish Asst. Surgeon : Dr. Malika

Anesthetist : Dr. Shekhar OT Nurse : Suman. Banjan OT Technician : Venkat

Pre-Operative Diagnosis: Left palpable undescended testis

Surgical Procedure :
Left Open Orchiopexy

Indications for Surgery :
Left palpable undescended testis

Date : 11/6/26 Start Time : 12:27 pm End Time : 1:27 pm

Pre Operative Preparations:

5% betadine

Post Operative Diagnosis:

Left palpable undescended testis

Peri-Operative Complications:

nil

Operation Notes:

findy
- Left testis found in (L) inguinal canal
- Left testis - healthy - smaller than (R) testis
- Left vas & vessels - normal

Procedure

- ① Left lower groin incision taken
- ② Incision deepened to open subcutaneous tissue
- ③ ^{External} ~~Ext.~~ oblique identified & opened.
- ④ Testis & vas identified in inguinal canal
- ⑤ Patent processus vaginalis separated from vas & vessels
- ⑥ Gubernacular attachment to testis cut
- ⑦ High ligation of sac dome
- ⑧ Fibrous bands around the vas & vessels released to add length to vas.

Amount of Blood Loss: $\approx 1\text{ml}$

Blood Transfused (in ML) - Nil

Name and Number of Surgical Specimen sent for examination:

- Nil

Peri-Operative Complications: - Nil

- ⑧ Testis & vas mobilised & brought into scrotum
- ⑨ Supra-dartos pouch created & testis anchored in the pouch
- ⑩ wound closed in layers
- ⑪ Hemostasis secured

DAY CARE

① Syp CROCIN 5ml P/O Thrice daily for 3 days
(5ml = 240mg) Ab sos. for pain

Review after 3 days on Monday in OPD
Dr. Anish Sr

Name of the Surgeon: Dr. Anish Sr

Signature of the Surgeon: 

Date & Time: 11/6/20 1:25 PM

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Hospital
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POST-SURGICAL CARE PLAN FORM

Procedure Done: *Left open Orchiopexy*

Post-Surgical Diagnosis: *Left palpable undescended testis*

Post-Operative Monitoring Parameters /Frequency:

TPR monitor every 15 min for 1st hr

Wound Care:

Dressing

Drain /Special Lines/Catheters:

- Nil -

Special Patient Positioning and Requirements:

- Nil -

Nutritional Instructions:

*AS soon as child is fully awake
Full feeds*

When to Start Mobilization:

As soon as possible

Special Referrals:

- Nil -

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

Yes No

Any Other Post-Operative Care Needed including Required Follow Up

- Nil -


Treating Surgeon
(Signature & Stamp) *[Signature]*

Date: *11/6/24* Time: *12:25 PM*

Note: Plan of care will be readjusted if necessary.

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

4626

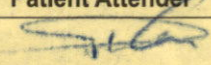
Patient Name: MASTER GOLLA SIVA KRISHNA	Age: 6y4m20d	Gender: MALE	
UHID No: BAH-00613398	IP No: 00175021	Date: 11/06/26 Time: 11:56AM	
Diagnosis: ORCHIDOPEXY OPEN U/L			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Inj. Fentanyl Citrate 100 mcg / 2 ml	100mcg	SOS
2.	Fentanyl Citrate 25 mcg patch	-	-
3.	Inj. Morphine 15 mg / ml	-	-
Doctor Name: M. SINDHU		Doctor Registration No: 3795	
Signature: 			


NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E


(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP5-00175021 Date: 11/06/26

Aadhaar No. of the Patient (Optional):

1.	Name : MASTER GOLLA SIVA KRISHNA	Remarks		
2.	Complete postal address (with contact number, if any)	2ND FLOOR OPPOSITE MY SQUARE USHAS STREET SUREDRAM, MAHARAJA NAGAR HYD 500005		
3.	Brief description of the illness	ORCHIDOPEXY OPEN U/L		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	-		
5.	Details of essential Narcotic drug dispensed	FENTANYL		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
11/06/26	INT-FENTANYL	ONE AMPHOLE		

Dispensed by (Name & ID No.): Sangeetha 015095 Signature: 

Received by (Name & ID No.): S.P. 607811 Signature: 

Time : 12 PM

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175021 Admit Date : 11-Jun-2026 Admit Time : 10:37 AM UHID : BAH-00613398

Patient Details :

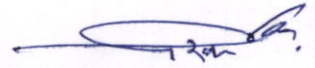
Patient Name : Master GOLLA SIVA KRISHNA Age : 6 Y 9 M 25 D
Guardian : MR GOLLA RAJESH BABU DOB : 17-08-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : 2ND FLOOR, OPPOSITE MY SQUARE VILLAS Phone No : 9177824510/ 9912578528
STREET , SURARAM Shahpur Nagar E-mail : RAJESHBABU47@GMAIL.COM
Hyderabad Telangana INDIA 500055

Admission Details :

Bed Type : DAY CARE Bed No : POST OP 411 Ward Name : 4F-OT COMPLEX
Room No : POST OP 411 Admission Type : First Visit

Contact Details :

Name : MR GOLLA RAJESH BABU Relationship : Father
Contact Address : 2ND FLOOR, OPPOSITE MY SQUARE Phone No : 9177824510
VILLAS STREET , SURARAM Shahpur Nagar
Hyderabad Telangana INDIA 500055



Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM Specialisation : PEDIATRIC SURGERY
Referral Doctor : self Phone No :
Co-Consultant :

Payment Details :

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

BAH-00613398 IP5-00175021
Master GOLLA SIVA KRISHNA
17-08-2019 6 Y 9 M 26 D (M)
Dr. HARISH JAYARAM

CONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: Left hip arthroscopy

Anaesthesiologist: Dr. Shabna Surgeon: Dr. Harish

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

Heart Disease Hypertension Diabetes Renal Failure Multi Organ Failure Hepatic Disorders

Shock Obesity Chronic Obstructive Pulmonary Disease

Others: Desaturation, 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. Sri Lakshmi Devi

Name: G. Sri Lakshmi Devi

Relationship with patient: Mother

Date & Time: 9/6/2020 5:30 pm

Witness:

Signature: [Signature]

Name: G. Rajan Babu

Date & Time: 11/6/2020 11:00 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Shabna Date: 9/6/2020 Time: 5:30 pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్:

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

హృదయ వ్యాధి రక్తపోటు మధుమేహం మూత్రపిండాల వైఫల్యం బహుళ అవయవ వైఫల్యం

కాలేయ సమస్యలు షాక్ ఊబకాయం దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
 లీజనల్ అనస్థీషియా జనరల్ అనస్థీషియా మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. దీటిలో 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 వెనెస్ యాక్సెస్, ఆర్థీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



BAH-00613398 IPS-00175021
 Master GOLLA SIVA KRISHNA
 17-08-2019 8 Y 9 M 25 D (M)
 Dr. HARISH JAYARAM



Name: Golla Siva Krishna Age: 9y Sex: male UHID.No: BAH 00613348
 Date: 9/6/2026 Time: 5:20pm Proposed Operation: Left open orchiopexy
 Diagnosis: Left undescended testis
 B.P / CRT: <3sec H.R: Weight: 15.1kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

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

Allergies:

N

Medical History: CVS: (-) NVD / 2-5kg / CIAB / No MCV action

RESP: (+) sneezing Diabetes:

CNS: (-)

Renal: (-)

Hepatic / GE: (-) Physical Activity: active

Others: (-)

Past Anaesthetic History: h/o accidental GA → U/L

Physical Exam: Anteroposterior elongation of face.

Airway: M1 2 3 4 Mouth Opening: w Mentohyoid Distance: Neck: w Teeth: nt loose

Lungs: chest clear

Heart: S1S2

CNS: Gcs-Pil

Pregnant: Yes No NA Venous Access Site: Spine Exam for regional: normal

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: (G) CRP on connected

Signature: [Signature] Name: Dr. SHOBNA

ANAESTHESIA CHART



Change in Patient Condition: Yes No Fasting Status: adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 94 B.P / CRT: 86/50 SpO₂: 100 R.R: 92 Last Feed: >6h

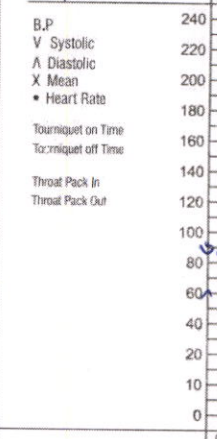
Pre-OP Diagnosis: (G) UOI Operation: (G) open low occlusion Date: 11/5/20

Surgeon: Dr. Harish Anaesthesiologist: Dr. SHARAD Technician: Venkatesh

TIME	12:45	X	1:15																	
N ₂ O /AIR /O ₂ LPM																				
HALO /SO /SEVO																				
Drugs:																				
	<u>DYMOIDAZ 0.16</u>																			
	<u>FINIDAM 2.5mg</u>																			
	<u>PROPOFOL 30+10+10</u>																			
FiO ₂ / SaO ₂	<u>100</u>	<u>100</u>																		
ETCO ₂																				
ECG	<u>60</u>	<u>58</u>																		
Temperature																				
Urine Output																				
Fluids	<u>RINGER</u>	<u>150ml/h</u>																		
Blood	<u>LACTATE</u>																			

Antibiotic
 Suppository
DICLOF
NAC
12-5
 Blood Loss

NOTES



LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP

Cuff Site: lum

Art Site:

EKG Lead

Temp Site scm

FiO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: supin

Pressure Points Checked

Eye Care:

Oint

Tape

Padding

Awake

Temp:

HME Fluid Warmer

Cling Film GH Warmer

Huggers Cotton Wool

Other

Times:

Anaes Start: 12:15pm

OP Start:

OP End:

Leave OR:

Anaesthesia: 1:30pm

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP:

ART:

IV: 22G @ hand

IV:

IV:

Induction

IV Inhal

Pre O₂ RSI

Others

Mask SGA O₂ via nasal

Airway Oral Nasal mong

ETT# at cm e3/6

Oral Nasal Cuff

Tracheostomy Topical

Drug:

Awake Direct Vision

Video Laryngoscopy Stylette / Bougie

Fiberoptic

Blade# Attempts:

Difficulty Why?

Bilat = BS

Semi-Closed Circle

Closed Circle

Other

Regional:

Extremity Specify:

Spinal Epidural Caudal

Others:

Position:

Site: caudal -> sacral level

Needle Size: 22G Depth:

Parasthesia Yes No

Catheter at skin cm

Drug Name & Conc:

Bolus: 0.25% Bupivacaine

Infusion: 1.0+2.0

Block Level:

Comments:

Transportation to

PACU ICU Other

Relaxant Reversed Yes No NA

Name of the Doctor: Dr. SHARAD

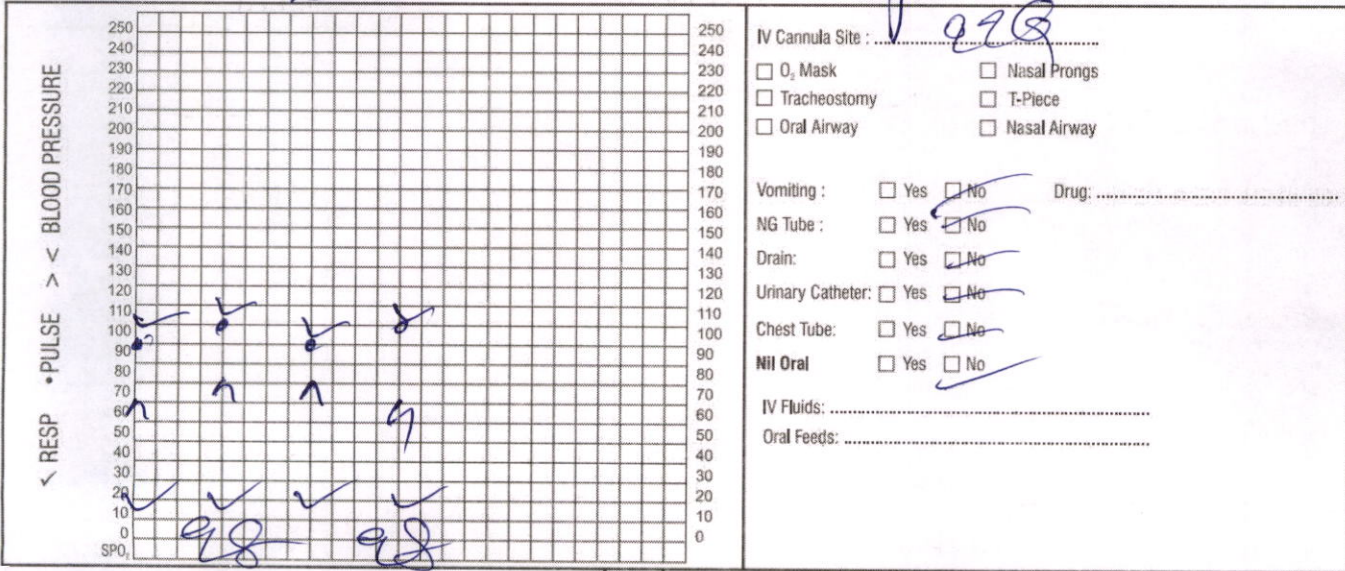
Signature of the Doctor: [Signature]

BAH-00613398
 Master GOLLA SIVA KRISHNA
 17-08-2019 6 Y 9 M 25 D (M)
 Dr. HARISH JAYARAM



POST-ANESTHESIA CARE UNIT RECORD

Received in PACU by : [Signature] Time Received : 1:35pm 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	1	1	1		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	1	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		8	8	9		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/6	1:35pm	7/10	—	[Signature]

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name : Dr. SIVA KRISHNA

Anaesthesiologist Signature: [Signature]

Date & Time: 11/6/2019 1:35pm

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 11/6/2019 1:35pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): [Signature]

Date & Time: 11/6/2019 1:35pm

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

BAH-00613398 IPS-00175021
Master GOLLA SIVA KRISHNA (M)
17-08-2019 8 Y 9 M 25 D
Dr. HARISH JAYARAM



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/20	11:15 AM	ER	OT	pooja
11/6	9:30 AM	OT	billing	Devi

Cross Consultation Visit

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



Golla siva krishna

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Harish Jayaram Date : 11/06/26

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

Start Time of Assessment: Weight: 14.75 kg

Allergic History:

Chief Complaints: Follow up case of undescended testis
day care admission
(testopen & orchiopexy)

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: UVN / 2.5 kg / C150 / NO NICU stay

Medication History:

Relevant Investigations:

Primary Assessment

Airway Open Maintainable Not Maintainable

Any urgent interventions needed: Yes No
 If Yes

Breathing Rate: 22/min SpO₂ on FIO₂ 100% R/A

Rhythm:

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: 96/min. CFT Central Peripheral 2 sec

Any urgent interventions needed: Yes No

If Yes:

BP: 101/70 (79) mmHg

Murmurs: Yes No

Pulse Volume: Central Peripheral

Liver Span:

If in Shock: Compensated Hypotensive

ECG:

Muffled Heart Sound: Yes No

Any Signs of Heart Failure: Yes No

Engorged Neck Veins: Yes No

Disability

GCS: 15/15 AVPU:

Any urgent interventions needed: Yes No

If Yes:

Pupils: Responsive Non-Responsive

Size: Right Left

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Exposure

Temp.: 98.8 f

Any Rash: Yes No,

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes:

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

Secondary Assessment: Head to toe examination with positive findings:

left ankle tenderness @

Palpable a aneurysmal region.

Labs Planned: CBP 2 IV cannuli. (PA done)

Treatment Planned: Left Open Orthopedy

subpoin

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

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by Name of the Doctor: N. Peatw...

Signature: N. Peatw...

Date & Time: 11/06/26, 10:35 am.

Sr. Doctor on Duty (If necessary) Name of the Sr. Doctor:

Signature:

Date & Time:

BAH-00813398 IP5-00175021
 Master GOLLA SIVA KRISHNA
 17-08-2019 6 Y 9 M 25 D (M)
 Dr. HARISH JAYARAM



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<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. Prathap Kumar N. Prathap

Date & Time : 17/08/20, 10:35 AM

Nurse Name & Signature: Poorna

Date & Time : 11/6/20 @ 10:45 AM



Golla Siva Krishna

DRUG CHART

Date of Admission: 11/6/20 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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 Signature



REGULAR PRESCRIPTIONS

Weight. ...14.5kg Ward. ...OT.....

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			



I.V. FLUIDS CHART

Weight. 15kg : Ward. 05

Signature
 VERIFIED BY : Name

Date	Time	Composition of I.V. Fluid (if infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
11/6/26		DNS	IV	50	N.P.D				

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 17-08-2019 6 Y 9 M 26 D (M)
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RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
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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 17-08-2019 8 Y 9 M 25 D (M)
 Dr. HARISH JAYARAM



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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						