RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

S.No.	CASE SHEET	YES	NO	N/A
1	Admission Record			
2	General Consent			
3	Requestion Slip for HIV Screening Test			
4	Covid Consent			
5	Consent For Vulnerable Patients			
6	Trauma Evaluation Sheet / ASSESMENT FORM			
7	Doctor's Inital Asessement			
8	SOS/ STAT Medication Chart			
9	Plan of Primary Consultant			
10	Nurse's Initial Asessement			
11	Doctor's Notes			
12	Nursing Care Plan			
13	Medication Chart			
14	Nursing Assesment Chart			
15	Investigation - Result Chart			
16	Sub Cutaneous Insulin Chart			
17	Investigation - Critical Result Verbal Communication			
18	Doctor's Verbal Orders			
19	NON DRUG ORDERS			
20	ICU CHART			
21	TPR & BP Graphic Chart			
22	Intake Output Chart			
23	Patient and Family Education and Nutrition Plan			
24	Nutrition Assessment Form			
25	Doctor's Visit Sheet			
26	Activity Card			

S.No.	OT - CONSENT FORM	YES	NO	N/A
1	Consent for Invasive Procedure			
2	Anaesthetic Consent for Diagnostic / Therapeutic			
3	Procedure / surgery / treatment / high risk consent			
4	Authorization of Patient			
5	High Risk Consent - ENGLISH / Telugu			
6	Consent for Anaesthesia			
7	Pre Anaesthetic Evaluation			
8	Preoperative Check List			
9	Jewellery Consent Form			
10	Surgical Safty Check List			
11	Anaesthesia Chart			
12	Post Anaesthesia Care Unit Record			
13	Operation Notes			
14	Post - Operative Doctors Notes			
S.No.	**OTHER FORMS**	**YES**	**NO**	**N/A**
1	CONSENT FORM FOR BLOOD TRANSFUSION			
2	PRE TRANSFUSION CHECK LIST			
3	ALPHA BED			
4	VENTILATOR CONSENT			
5	PHYSICAL RESTRAINT FORM			
6	ADVERSE DRUG REACTION (ADR) SHEET			
7	PHYSIOTHERAPY CONSENT FROM			
8	LEFT AGAINST MEDICAL ADVICE			
9	DISCHARGE SUMMARY			
10				
11				
12				
13				
14				
15				
16				

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

WARD / ICU ..... BED NO..... IP NO.....

ADMISSION RECORD

NAME OF PATIENT		UHID / PMRN:	
Age:	Sex:	Date of Admission:	Time:
Qualification:		WAP No:	
Depart:	Ward:	Claim No:	
Father's / Husband's Name:		Occupation:	Annual Income:

Address:

House No: Street: Village/Town: Mandal:

District: Pincode: Mobile No:

Email id:

Medico legal case: Yes / No Details of Police information:

Name of the informant: Police Station:

PC Name & No:

Identification marks: 1.

2. ICD Code:

Provisional Diagnosis on Admission:

Final Diagnosis:

Secondary Diagnosis:

Complications:

Operative Procedure | Date of Surgery :

Consultants:

Date & Time of Discharge: Hospital Stay:

Discharge Status: Cured / Relived / Improved / Not Relived / Referred to higher Center

LAMA : Signature of the Patient / Thumb impression :

Expired (Case): Date & Time

AUTOPSY Yes / No

(Stamp & Signature of Treating Doctor): Date & Time:

Date of discharge / Death / LAMA / Absconded. **Final Diagnosis** 1. 2. Signature of the Patient: Signature if the Attendent :	**No. of Hospital days** **ICD Code No.** 1. 2. Histopathology Code - Signature with name :

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PATIENT MOVEMENT (SHIFTING) INFORMATION

EMD./AMC/SP/ROOM/SD/GW/RICU/SICU/NICU

Sl No.	Shifted from	Patient Handed over by (sign with name)	Date & Time	Shifted to	Patient taken over by (sign with name)	Date	Time	Remarks (if any)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

IN PATIENT BLOOD INVESTIGATIONS RECORD

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

LABORATORY INVESTIGATIONS

Sl No.	Ward / Bed no.	Name of the Investigation	Investigation advised Date / Time	Sample sent by the Name Date / Time	Sample received by the Name Date / Time	Reports received by the Name Date / Time	Remarks

RADIOLOGY DEPARTMENT

Sl. No.	Ward/ Bed No.	Name of the Investigation	Investigation advised Date/Time	Test Done Date/Time	Reports received by the name Date/Time	Remarks

COMPUTERISED E.C.G & 2D ECHO & TMT

Sl. No.	Ward/ Bed No.	Name of the Investigation	Investigation advised Date/Time	Test Done Date/Time	Reports received by the name Date/Time	Remarks

OTHERS

Sl. No.	Ward/ Bed No.	Name of the Investigation	Investigation advised Date/Time	Test Done Date/Time	Reports received by the name Date/Time	Remarks

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

సాధారణ అంగీకార పత్రము

నేను.....(రోగి పేరు), వయస్సు.....లింగం.....

కుమారుడు/కుమార్తె/భార్య.....

నేను.....(అంగీకారమిచ్చు వారి పేరు), వయస్సు.....లింగం.....

కుమారుడు/కుమార్తె/భార్య.....(రోగికి గల సంబంధం).....

.....

ఫోన్ నెం.....(దయచేసి తప్పులు లేకుండా పూర్తి వివరాలు ఇవ్వగలరు. తప్పులను సరిచేయడం తర్వాత వీలుపడదు) నాకోసం /రోగి కోసం క్రింద సూచించిన అన్ని విషయాలకు పూర్ణ అంగీకారము తెలుపుచున్నాను).

అ) అవసరమైన స్త్రచికిత్స దాని కోసం అవసరమైన మత్తు మందు కోసం

ఆ) ఏ విధమైన చికిత్పాదలు కూడా కీమోలెరపి ఔషధాలు, రేడియో తెరపే అవి వాటి ద్వారా గావి ఇంకే ఇతర విధంగా (పేరెంటల్) గా ఇవ్వడం కోసం

ఇ) అవసరమైతే రక్తం, లేదా రక్తా సంబంధిత భాగాలు (కంపోనెంట్లు) శరీరంలోకి పంపించడం కోసం.

ఈ) రోగి, ఐడెంటిటీ కాపాడుతూ వైద్య విజ్ఞాన విచారణ కొరకై ఫోటోలు, టీవి రికార్డులు మరియు వైద్య విజ్ఞావ విచారణ కొరకు, చిదిత్స జరిగేటప్పుడు అనుమతించబడ్డ వ్యక్తులు హాజరు కోసం పూర్తి ఆరగీకారము తెలుపుచున్నాను.

2) నేను, నా/రోగి సంబంధీకులు మరియు మిత్రులు ఆసుపత్రి యొక్క పూర్తి విధి, విధానములు, రోగి పందర్శవ సమయములు మరిము ఇతర నిర్దేశములు పాటించి సహకరించగలమని అంగీకారము తెలుపుచున్నాము.

3) పైన సూచించిన విషయాలను డా|| శ్రీ.....గారు నాకు చదివి వివరించి, నాకు తెలిపిన భాషలో అర్థం అయ్యోటట్లు వివరించారని ధృవీకరించుచునాను.

4) పైవ సూచించిన విషయాలన్నిటిని నేను పూర్తి స్పృహలో ఉండి మనస్పూర్తిగా ఇచ్చిన అంగీకార పత్రము ఇది అని ధృవీకరించుచున్నాను.

డాక్టరు సంతకం :.....

డాక్టరు పేరు :.....

స్థలము.....

తేది.....

సమయం : .....

రోగి / రోగి సంబంధికుని సంతకము/వేలిముద్ర

రోగి / రోగి సంబంధికుని పేరు :.

రోగితో గల సంబంధము :.

చదివి వినిపించి, వివరించిన డాక్టరు / అడ్మిషన్ అధికారి గారి సంతకము.....

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

GENERAL CONSENT

I (Patient Name), _____Age_____Sex_____

S/o,W/o,D/o _____

I((Patient's Representative's Name) _____

(Relation to Patient) _____Age_____Sex_____S/o,W/o,D/o_____

Address of _____

Consenter _____

_____

Phone No._____(Please give full and correct particulars of the patient Subsequent alteration in Name & age etc will not be possible) do hereby consent self / above mentioned patient for the following.

(a) For any operation performed under any anaesthesia as deemed necessary.

(b) For any procedure, including therapeutic and / or investigation, by medical nursing and technical, sta ffor RVM CHARITABLE TRUST Hospital as deemed necessary for the diagnosis and treatment.

(c) For administration of any medication both oral & parental and medical and nursing of RVM CHARITABLE TRUST Hospital as deemed necessary for the treatment.

(d) For transfusion of blood and components as deemed necessary for the treatment.

(e) For still photography / TV recording, telecasting and publication of same in medical journals of procedure(s), which would be performed, for the purpose of advancing medical education with provision of safeguarding my / patient's identity.

2) I agree and I will make all others related to me / patient to agree to abide by the regulations of the hospital including visiting hours, which are conveyed to us by the hospital staff.

3) I undertake full responsibility to clear all dues to the hospital and promise to deposit insufficient advance amounts to meet emergency treatment also as and when payment requisition slip are issued.

4) I also certify that all the above have been read over and explained to me in the language I understand by Dr. / Sri._____RVM CHARITABLE TRUST HOSPITAL

5) I certify that this consent is given by me in my full senses and on my own free will.

Signature :

Place :

Date :

Time :

_____

Thumb impression/Signature of the Patient /Representative

:

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

హెచ్ఐవి స్క్రీనింగ్ అభ్యర్థన పత్రం

పేరు :..... వయస్సు: ..... స్త్రీ/పు: .....

చిరునామా:.....

మొబైల్/ఫోన్ నెం: .....

శాంపుల్ తీసుకున్న తేది: .....సమయం.....

నిర్ధారణకు కారణాలు:.....

నష్టం కలిగే అలవాట్లు : బ్లడ్ / ట్రాన్స్ ఫ్యూషన్ /హోమో సెక్సువల్ / డ్రగ్ అబ్యూస్ / ట్రాన్స్ ప్లాంట్// ప్రోమిస్యూటీ / ఇతరములు

వివాహ వివరములు : వివాహితులు/ అవివాహితులు / విడాకులు / వేరుగా ఉండడం/ వితంతువు

స్త్రీలు : గర్భిణి / గర్భిణి కాదు.

వృత్తి : ట్రక్ డ్రైవర్ / లేబర్ / రైతు / గృహిణి / ఇతరులు.....

సంబంధిత ఇతర వివరాలు :

సమ్మతి

ఇందుమూలముగా నేను తెలియపరిచేది ఏమనగా, హెచ్ఐవి పరీక్ష గురించి, తసంబంధిత పరిణామాలు, పరీక్ష ఫలితాలు, తాత్కాలికంగా వెలువడిన పాజిటివ్, నెగిటివ్ మరియు మధ్యంతర ఫలితాల గురించి పూర్తిగా వివరించడమైనది. హెచ్ఐవికి సంబంధించిన పూర్తి వివరాలు, వాటి వ్యాప్తి, పరీక్షా విధానం, వాటి హద్దులు మరియు పరీక్ష వివరాలు గురించి నాకు అర్థమయ్యేలా వివరించారు. నేను ఈ రోటిన్ స్క్రీనింగ్ కు సమ్మతిని నిరాకరించే అవకాశం ఉందన్న విషయం నాకు తెలుసు.

డాక్టరు సంతకం :.....

డాక్టరు పేరు :.....

తేది.....

సమయం :.....

రోగి సంతకము/వేలిముద్ర

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO..... Ward / ICU.....Bed No.....

REQUISITION FOR HIV SCREENING

Name:..... Age:..... Sex:.....IP/OP No.:.....

Residential Address :.....

..... Mobile No:.....

Sampling Date & Time:.....

Reason for screening:.....

Concerned Risk : Blood Transfusion/Homosexual/Drug abuse/Transplant/Promiscuity/Others

Marital Status : Married / Unmarried / Divorced / Separated / Widow

Females : Pregnant / Not applicable

Occupation : Truck Driver / Labour / Farmer / Housewife / Others.....

RELEVANT CLINICAL DETAILS / OTHERS :

Consent :

This is to state that I have been counselled about the HIV test to be conducted on me and have been explained about the implications of the test results-positive, provisionally positive, negative or indeterminate all the details pertaining to HIV, its transmission testing procedure, its limitations and interpertations of results have been explained to me in a manner that I can understand.
I know that I can deny consent and OPT out from this routine screening.

Signature :

Thumb impression / Signature of patient

Date :

Time :

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

INITIAL ASSESSMENT

Date:

Time:

1. Chief Complaints:

2. History of Present Illness

3. History of Past Illness

- ☐ Hypertention.....
- ☐ Diabetes:.....
- ☐ Heart disease:.....
- ☐ Lung disease:.....
- ☐ Liver disease:.....
- ☐ Kidney disease:.....
- ☐ Thyroid:.....
- ☐ Surgeries:.....
- ☐ Steroid Medication

Any other - specify:.....

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

4. TREATMENT HISTORY :

4.1 Diabeties - No/Yes, Details : _____

4.2 Hypertension - No / Yes, Details : _____

4.3 CAD - No / Yes, Details : _____

4.4 Asthma - No / Yes, Details : _____

4.5 Tuberculosis - No / Yes, Details : _____

4.6 Antibiotics - No / Yes, Details : _____

4.7 Hormones - No / Yes, Details : _____

4.8 Chemo / Radiation - No / Yes, Details : _____

4.9 Blood Transfusion - No / Yes, Details: : _____

4.10 Surgeries- No/Yes, Details : _____

4.11 Other - No / Yes, Details : _____

5. PERSONAL HISTORY:

Marital status: ☐ Single ☐ Married Habits : Tobacco use ☐ Yes ☐ No

Diet: ☐ Veg ☐ Non Veg Alcohol Use ☐ Yes ☐ No

Any other - specify:.....

.....

6. FAMILY HISTORY

☐ Diabetics (DM) ☐ Hypertension (HTN) ☐ Asthama/COPD ☐ TB ☐ Drug Allergy

☐ Heart Disease ☐ Kidney Disease ☐ Liver Disease ☐ Cancer ☐ Stroke ☐ Seizures

Any other - specify:.....

.....

7. ALLERGIES :(if yes specify)

☐ Medication Allergy 1. ..... ☐ Foods: ..... ☐ Pollens: .....

☐ Any other - specify:.....

.....

8. OLD MEDICATION RECONCILIATION :

Source of Previous Medication List

(Check all that apply)

☐ Patient Old Prescription

☐ Family Recall

☐ Previous Discharge papers

☐ Others

☐ This patient is mot on any Prescription, over the counter medication or herbal remedies

☐ Included inthe Treatment Chart

Previous Prescribed Drug Name	To be continued In the hospital		Dose	Route	Fre-quency	Last dose taken (Date & time)
	Yes	No				
	Yes	No				
	Yes	No				
	Yes	No				
	Yes	No				
	Yes	No				
	Yes	No				
	Yes	No				

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

9. MENSTRUAL HISTORY

9.1 Age of Menarche

9.2 Menstrual Cycle = Duration of Cycle / No of days of Bleeding (Past) (Present)

9.3 LMP _____

9.4 Any Gynecological problems: No / Yes, Details _____

10. OBSTETRIC HISTORY.

10.1 Age at marriage_____

10.2 Age at first child birth_____

10.3 Gravida_____

10.4 Para_____

10.5 Still Birth_____

10.6 No. of living Children_____

10.7 Family planning methods used

Oralpills/IUD/IVD permanent Sterilization

10.8 No. of Abortions_____

10.9 Others_____

11.1 BIRTH HISTORY

a) FTND / Caesarean Delivery / Delivery By Vacuum Suction / Forceps Delivery

b) History of Birth Asphyxia - No / Yes

11.2. DEVELOPMENT HISTORY (As per IP Guidelines)

Normal / Abnormal, Details - _____

_____

11.3 IMMUNIZATION STATUS (As per IP Guidlines)

Up to Mark / Not upto mark

12. PHYSICAL EXAMINATION

A. GENERAL

1. Height
2. Weight
3. BMI
4. Body Surface area _____m2
5. Pallor - No/Yes
6. Icterus - No / Yes
7. Cyanosis - No/Yes
8. Clubbing of fingers/toes - No / Yes
9. Lymphadenopathy - No/Yes
10. Oedema of feet - No / Yes
11. Malnutrition - No/Yes
12. Dehydration - No/Yes - Mild / Moderate / Servere
13. Temparature_____ -^{0}C/F
14. Pluse rate : _____bpm
15. Respiration (count for a full min.) Rate_____ / min
16. BP Lt.Arm _____mm / Hg; Rt. Arm_____ mm / Hg
17. SPO_2 at Room air _____% / at_____ liters of O_2
18. GRBS _____ mg / dl

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

SYSTEMIC EXAMINATION:

B. CARDIO VASCULAR SYSTEM

1. Thrills No / Yes
2. Cardiac Sounds — Heart Sounds
3. Cardiac murmurs No / Yes

C. RESPIRATORY SYSTEM

1. Dyspnoea - No / Yes
2. Wheeze - No / Yes
3. Position of Trachea - Central / Shifted to Right / Left
4. Breath Sounds - Rhonchi / Rales (Crepts) Pleural rub / Vesicular

D. ABDOMEN

1. Shape of abdomen - Scaphoid / Obese / Distended
2. Tenderness - Not /Yes, Details
3. Palpable mass - Not /Yes, Details
4. Hernial Orifices - Normal / Hernia, Details
5. Free Fluid - No / Yes
6. Bruits - No / Yes
7. Liver - Not palpable / Palpable, Details.
8. Spleen - Not palpable / Papable Details.
9. Bowel sounds - No / Yes
10. Genitals
11. Speculum Examination
12. PV Examination
13. P/R Examination

CENTRAL NERVOUS SYSTEM

1. Level of Consciousness
   a. Conscious / Alert
   b. Drowsy Arousable
   c. Stuporous
   d. Coma
2. Speech - Normal / No Response / Slurred Incoherent / Aphasic
3. Signs of Meningeal Irritation
   a. Neck Stiffness - No/ Yes
   b. Kerning's Sign - No/ Yes
4. Cranial Nerves
5. Motor System
6. Sensory System
7. Glasgow Scale = E_4 V_5 M_6= E +V +M = /15

9. REFLEXES

	Biceps	Triceps	Supinator	Knee	Ankie
LEFT					
RIGHT					

Plantars - Flexor / Extensor / Equivocal / Unelicitable

Cerebella Signs

9.1. Finger - Nose In-coordination - No/Yes

9.2. Knee - Heel In-coordination - No/Yes

10. Gait - Hemiplegic / Slow, Shuffling / Ataxic / High / Stepping

F. MUSCULO SKELETAL SYSTEM

G. SKIN

H. EXAMINATION OF HEAD & NECK

I. EXAMINATION OF BREAST

J. EXAMINATION OF ENT

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

K. EXAMINATION OF TEETH AND ORAL CAVITY

11. PROVISIONAL DIAGNOSIS / DIAGNOSIS

12. NUTRITIONAL NEEDS

13. VULNERABILITY : YES / NO

14. INVISTIGATIONS ADVISED.

15.

15.1 Brief History

15.2. Diagnosis:

15.3 Reason for Referral :

Informant-patient's/guardian's Name_____

Name of Patient's Attendant_____Relation_____

Initial Assessment Performed by Doctor_____

(write Name In CAPS)

Name of the Doctor:

(Signature)

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PLAN OF PRIMARY CONSULTANT

PROVISIONAL DIAGNOSIS / DIAGNOSIS :

PLAN OF CARE:

PREVENTIVE **PROMOTIVE** **CURATIVE** **REHABILITATIVE**

EXPECTED OUTCOME (PROGNOSIS): (GOOD, GUARDED, POOR)

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PREVENTIVE ASPECTS OF CARE :

SIGNATURE WITH NAME OF CONSULTANT DOCTOR

TIME:

DATE:

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PAIN ASSESSMENT SHEET

PAIN SCALE:- 0-5 YEARS

CATEGORY	SCORING			
	0	1		2
Face	No Particular expression of amile	Occasional grimace or frown, withdraw Disinterested		Erquent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, ness		Kickin or legs drawn up
Activity	Lying quietly normal position moves easily	Squiming shifting back and forth tense		Arched, rigid or jerking
City	No Cry (awake or sleep)	Moans or whimpers occasional complaint		Crying steadily, screams of sobs, Frequent complaints
Consolability	Content, relaxed	Reassured by iccasuitching hugging or beigouonal talked to distractible		Difficult to console ofcomfort

The Behavioural Pain Score

Item	*Description*	*Score*
FACIAL EXPRESSION	*Relaxed*	*1*
	Partially Tightened (brow Lowering)	*2*
	Fully Tightened (eyelid Closing)	*3*
	Grimacing	*4*
UPPER LIMB	*No Movement*	*1*
	Partially bent	*2*
	Fully bent with finger flexion	*3*
	Permanently retracted	*4*
COMPLIANCE WITH VENTILATION	*Toleration movement*	*1*
	Coughing but tolerating ventilation for most of the time	*2*
	Fighting ventilator	*3*
	Unable to control ventilation	*4*
	Total Score	

Intervention:

Doctor Name:

Date:

Time :

Doctor Signature:

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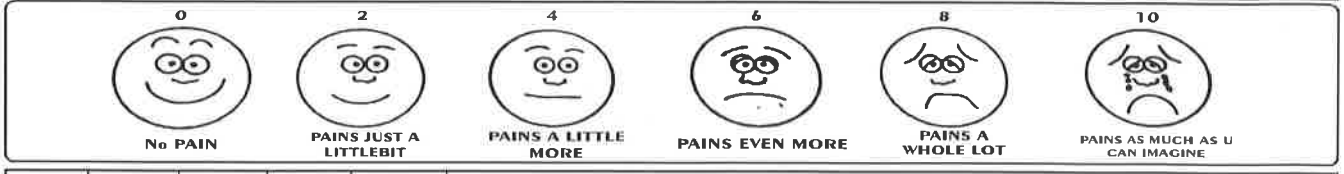
PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PAIN REASSESSMENT SHEET



Date	Time	Pain Score	Sign	Assessed by	If Pain Score >= 4					
					Character	Acuity	Modifying factors	Location	Patient / Family Educated	Intervention
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	
				☐ Doctor ☐ Nurse	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Acute (<6 weeks) ☐ Chronic (>6 weeks)	☐ Increasing ☐ Decreasing		☐ Yes ☐ No	

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

NURSES INITIAL ASSESSMENT FORM

Bed No.:	**Room No:**	**Floor:**	**Date:**

Admission Date		Time of Admission	

Patient Arrival:	Walking/Wheelchair/Stretcher:
Condition of the Patient at the Time of Admission:	Conscious/Semiconscious/ Un-conscious/Dyspnoea/Comatose

ID Band Type: General/Vulnerable	Consultant Doctor	Dr.

Languages Known Speak:	Understand	Write

Persons to contact in emergency:

Vital Signs

Temp F	Pulse: B P M	Resp: RPM	BP: mm of Hg	SPO2 %

Height cms	Weight Kg	Built of Patient	Moderate/Obese/Thin

Artificial Dentures	Yes / No	Oral Hygiene	

Nutritional Needs	

Past History Yes / No	Asthama	Other Resp.	HTN	CAD	Cancer	Hepatitis
	Glaucoma	Storke	GI	Musculo Skeletal		Others
Allergies	Drug	Blood Transfusion		Food	Others	
Brief History						

MEDICATION HISTORY PRIOR TO ADMISSION

S. No.	Medication	Dose	Route	Freq.	Date & Time of last dose	Others Remark

Assessment of Activities of Daily Life :

Activity	Independent	Assist.	Dependent	Activity	Independent	Assist.	Dependent
Bathing				Mobilization			
Dressing				Stair Climbing			
Eating				Toilet Use			

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

NURSES INITIAL ASSESSMENT FORM

Current Sensory Impairment Levels:

Hearing Impairment: ☐ Yes ☐ No ☐ unable to assess

Visual Impairment ☐ Yes ☐ No ☐ unable to assess

If Yes: Hearing Aid ☐ B/L ☐ Lt ☐ Rt ☐ Glasses ☐ Contact lenses

Current Cardiovascular Ststus:

Pulse Rate:_____/min ☐ Regular ☐ Irregular Pulse ☐ Others:_____

Peripheral Circulation:

☐ Pink ☐ Cyanotic ☐ Warm ☐ Cold

☐ Edema ☐ Pale ☐ Numbness ☐ Others :_____

Current Respiratory Status:

☐ Cough ☐ Productive ☐ Non-Productive

☐ Sputum ☐ Color :_____ ☐ Consistency:_____ ☐ Amount:_____

☐ Oxygen Therapy: ☐ Yes ☐ No

☐ Lungs Sounds : ☐ Normal ☐ Abnormal If abnormal Explain:_____

Current Gastro Intestinal Status:

Abdomen: ☐ Soft ☐ Non-Tender ☐ Tender ☐ Firm ☐ Distended

Bowel Sounds ☐ Present (every 5-10 Seconds) ☐ Absent ☐ Others:_____

Flatus: ☐ Yes ☐ No

Bowel Elimination: ☐ Continent ☐ Incontinent ☐ Constipations ☐ Diarrhoea

☐ Regular ☐ Irregular ☐ Color of stool:_____

Current Genitourinary System:

Urine: ☐ Continent ☐ Incontinent ☐ Catheter ☐ Date inserted:_____

Urine Appearance : ☐ Clear ☐ Yellow ☐ Hematuria ☐ Cloudy

☐ Others:_____

Menstrual Cycle: ☐ Regular ☐ Irregular ☐ NA ☐ Other:_____

Nutritional Assessment

Height:_____Cms Weight:_____Kgs BMI: $\frac{\text{Wt. in Kg}}{\text{Ht. in (M)}}$

Appetite : Good / Moderate / Poor Any Special Dite:_____

☐ Vegetarian ☐ Non-Vegetarian ☐ Mixed

Form Completed By:

Name:_____Sign:_____Date:___/___/___Time___:____AM/PM

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

Date & Time	Doctor's Notes	Signature with Name

Note : Pain Score to be filled for applicable Patients only otherwise put"_____"

"CONFIDENTIAL "

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

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UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date & Time	Doctor's Notes	Signature with Name

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Date & Time	Doctor's Notes	Signature with Name

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date & Time	Doctor's Notes	Signature with Name

Note : Pain Score to be filled for applicable Patients only otherwise put"_____"

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RVM CHARITABLE TRUST HOSPITAL

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NURSE'S RECORD

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date	Time	Nurses Notes	Signature

RVM CHARITABLE TRUST HOSPITAL

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NURSE'S RECORD

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date	Time	Nurses Notes	Signature

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Date	Time	Nurses Notes	Signature

RVM CHARITABLE TRUST HOSPITAL

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DRUG ORDER SHEET

History of Allergy : Yes / No / Not Know	
Medication	Type of Allergy

Name:_____ Sex:_____ Age:_____

UHID / PMRN._____IP No._____D.O.A:_____

Ward / ICU:_____ Consultant:_____

Height_____Body Weight (if<14years old)_____

Six rights of medication administration	
1.	Right patient
2.	Right dose
3.	Right method
4.	Right frequency
5.	Right medication
6.	Right documentation

ONE TIME DRUGS (STAT) & PRE-MEDICATION DRUGS

Date	Medication	Dose	Route	Prescriber Signature	Time given	Given by. / Checked by.

All Medical, Nursing and pharmacy Staff are expected to comply with the requriements of RVM Hospital Policy

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

ONLY GENERIC NAMES TO BE USED

REGULAR PRESCRIPTIONS

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

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ONLY GENERIC NAMES TO BE USED

REGULAR PRESCRIPTIONS

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

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UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

ONLY GENERIC NAMES TO BE USED

REGULAR PRESCRIPTIONS

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

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PATIENT'S NAME..... **AGE**..... **SEX**.....

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ONLY GENERIC NAMES TO BE USED

REGULAR PRESCRIPTIONS

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
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Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

			Regular Time						
Approved drug name	Dose	Route							
Signature	Date	Frequency							
Special directions									

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

PRN (AS REQUIRED) (SOS)

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PRN (AS REQUIRED) (SOS)

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

Approved drug name	Dose	Route	Date						
Signature	Date		Time						
			Dose						
Special directions			Sign						
			Check						

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

SUB CUTANEOUS INSULIN CHART

DATE	PLASMA BLOOD GLUCOSE			INSULIN DOSE			Signature		
	BBF 7-00 AM	BL 1-00 PM	BD 7-00 PM	BBF 7-00 AM	BL 1-00 PM	BD 7-00 PM	Sign Check	Sign Check	Sign Check

RVM CHARITABLE TRUST HOSPITAL

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UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

NURSE ASSESSMENT CHART (TO BE FILLED BY NURSE)

Date									
	Morning shift	Noon shift	Night shift	Morning shift	Noon shift	Night shift	Morning shift	Noon shift	Night shift
Handing over	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Talking over	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Airway	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam
Emergency Drugs									
Supervision of Sanitation									
Wound Dressing									
Monitoring Vital Data									
Patient Conselling									
Following Doctor's Rounds									
Medicine Distribution									
Bed making									
Diet	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify
Others Nursing Procedures									
Signature with name of nurse									

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

NURSE ASSESSMENT CHART (TO BE FILLED BY NURSE)

Date									
	Morning shift	Noon shift	Night shift	Morning shift	Noon shift	Night shift	Morning shift	Noon shift	Night shift
Handing over	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Talking over	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Airway	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam	Clear / Suction Nebulize Steam
Emergency Drugs									
Supervision of Sanitation									
Wound Dressing									
Monitoring Vital Data									
Patient Conselling									
Following Doctor's Rounds									
Medicine Distribution									
Bed making									
Diet	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify	NBM/Soft/ Diabetic/ Regular/ Other/ Pls.Specify
Others Nursing Procedures									
Signature with name of nurse									

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

DAILY CLINICAL HANDOVER SHEET

Patient Name:_____ Sex : Female ☐ Male ☐

Consultant :_____ Age :_____

D.O.A :_____ UHID /PMRN._____ IP No._____

Current update & active problem list

(List all active problems and issues of the patient. This will include diagnosis)

Current clinical findings

(Document +ve & -ve relevent clinical findings)

Clinical change over shift

(Please document change / No changes of vitals / Changes of vital, any important sign e.g. abdominal distension; also document intake / output)

Plan of care

(Document summary of care given in past shift and plan to be carried out in the next shift)

Handingover Doctor	Takingover Doctor
Name :_____	Name :_____
Signature :_____	Signature :_____
Date :_____ Time:_____	Date :_____ Time:_____

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

DAILY CLINICAL HANDOVER SHEET

Patient Name:_____ Sex : Female ☐ Male ☐

Consultant :_____ Age : _____

D.O.A :_____ UHID /PMRN._____ IP No. _____

Current update & active problem list

(List all active problems and issues of the patient. This will include diagnosis)

Current clinical findings

(Document +ve & -ve relevent clinical findings)

Clinical change over shift

(Please document change / No changes of vitals / Changes of vital, any important sign e.g. abdominal distension; also document intake / output)

Plan of care

(Document summary of care given in past shift and plan to be carried out in the next shift)

Handingover Doctor	Takingover Doctor
Name :_____	Name :_____
Signature :_____	Signature :_____
Date :_____ Time:_____	Date :_____ Time:_____

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT & FAMILY COUNSELLING RECORD

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date & Time	Information Provided	To Whom	Name & Signature	Name & Signature

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT & FAMILY COUNSELLING RECORD

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Date & Time	Information Provided	To Whom	Name & Signature	Name & Signature

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

ACTIVITY CARD

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

VENTILATOR

S.No	Date & Time	Start Time	Mode, Type of	Sign with Name	Date	Stop End Time & Weaning	Sign with Name

BIP AP

S.No	Date & Time	Start Time	Mode, Type of	Sign with Name	Date	Stop End Time & Weaning	Sign with Name

BEDSIDE PROCEDURES

ECG / URINE SUGAR / GRBS / ALPHA BED / SYRINGE PUMP / OTHERS

(if other please spcify)

S.No	Procedure	Date	Start Time	Sign With Name	Date	End Time	Sign With Name

DRESSING

S.No	Date	Item & Quantity	Done by Sign	Date	Item & Quantity	Done by Sign

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

OXYGEN

S.No	Date	Start Time	Sign with Name	Date	Start Time	Sign with Name

MONITOR / PULSE OXIMETER

S.No	Date & Time	Start Time	Mode, Type of	Sign with Name	Date	Stop End Time & Weaning	Sign with Name

NEBULISATION

S.No	Date & Time	Start Time	Mode, Type of	Sign with Name	Date	Stop End Time & Weaning	Sign with Name

PRP. PLATELE + BLOOD TRANSFUSION

S.No	Date	Start Time	Sign with Name	Date	Start Time	Sign with Name

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

BLOOD GROUP: **:HIV** **HBSAG:** **HCV**

Date						
Hb%						
PCV						
TLC						
RBC						
Platelet count						
ESR						
FBS/PLBS/GRBS						
Blood Urea						
S. Creatinine						
S. Nat						
S.K+						
S.Cl-						
PTT						
APTT						
INR						
BT						
CT						
T. Bilirubin						
D. Bilirubin						
I. Bilirubin						
SGPT						
SGOT						
Alk. Phosphate						
T. Proteins						
Albumin						
Globulin						
A/G Ratio						
CUE / Ketones						
Pus Cells						
S. Calcium						
S Magnesium						
FDP						
CT SCAN						
MRI Scan						
Chest X-Ray						
LDH						
TROPT						
2D ECHO						
OTHERS						
Sign. with Name						

Confidential

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

BLOOD GROUP: **:HIV** **HBSAG:** **HCV**

Date						
Hb%						
PCV						
TLC						
RBC						
Platelet count						
ESR						
FBS/PLBS/GRBS						
Blood Urea						
S. Creatinine						
S. Nat						
S.K+						
S.Cl-						
PTT						
APTT						
INR						
BT						
CT						
T. Bilirubin						
D. Bilirubin						
I. Bilirubin						
SGPT						
SGOT						
Alk. Phosphate						
T. Proteins						
Albumin						
Globulin						
A/G Ratio						
CUE / Ketones						
Pus Cells						
S. Calcium						
S Magnesium						
FDP						
CT SCAN						
MRI Scan						
Chest X-Ray						
LDH						
TROPT						
2D ECHO						
OTHERS						
Sign. with Name						

Confidential

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

INVESTIGATION - CRITICAL RESULTS / VERBAL COMMUNICATIONS

(TO BE FILLED BY NURSES)

DATE & TIME	INVESTIGATION	VERBAL COMMUNICATION (PLEASE READ BACK)		ABNORMAL RESULTS INFORMED TO DOCTOR		
		REPORT	RECEIVED BY	TO	BY	SIGN WITH NAME

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

DOCTOR'S VERBAL ORDER

Diagnosis :

Consultant Name :

S. No	Date / Time Order Given	Details of Verbal Order	Order Taken & Followed by	Order Given by
1			Name	Name
			Sign Dt & Time	Sign Dt & Time
2			Name	Name
			Sign Dt & Time	Sign Dt & Time
3			Name	Name
			Sign Dt & Time	Sign Dt & Time
4			Name	Name
			Sign Dt & Time	Sign Dt & Time

NON - DRUG ORDERS

Date	Time	Diet Order	Other Orders	Signature

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**..... **Ward / ICU**.....**Bed No**.....

TPR & BP GRAPHIC SHEET

DATE																																										
POST OP. Day																																										
			AM			PM			AM			PM			AM			PM			AM			PM			AM			PM			AM			PM		
			4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
TEMPERATURE	44.8	105																																								
	43	104																																								
	42	103																																								
	41	102																																								
	40	101																																								
	39	100																																								
	38	99																																								
	37.6	98.6																																								
	37	98																																								
	36	97																																								
PULSE		140																																								
		130																																								
		120																																								
		110																																								
		100																																								
		90																																								
		80																																								
		70																																								
		60																																								
RESP		40																																								
		30																																								
		20																																								
		10																																								
Blood Pressure		Diastolic																																								
		Systolic																																								
IV Fluids																																										
output																																										

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**..... **Ward / ICU**.....**Bed No**.....

TPR & BP GRAPHIC SHEET

DATE																																			
POST OP. Day																																			
		AM			PM			AM			PM			AM			PM			AM			PM			AM			PM			AM			PM		
		4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
TEMPERATURE	44.8	105																																	
	43	104																																	
	42	103																																	
	41	102																																	
	40	101																																	
	39	100																																	
	38	99																																	
	37.6	98.6																																	
	37	98																																	
	36	97																																	
PULSE		140																																	
		130																																	
		120																																	
		110																																	
		100																																	
		90																																	
		80																																	
		70																																	
		60																																	
RESP		40																																	
		30																																	
		20																																	
		10																																	
Blood Pressure	Diastolic																																		
	Systolic																																		
IV Fluids																																			
output																																			

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**..... **Ward / ICU**.....**Bed No**.....

INTAKE AND OUTPUT CHART

Hosp. No:
Date :

Past 24 Hrs. Intake

ORAL
I.V
other

Total

Past 24 Hrs. Output

Urine
NASOGASTRIC ASPRATION
Drainage
Other
Total

Hours	(Medication, IV Nutrition, Fluids, Blood)			Oral (Medication Food)		Urine	N.G.Asp	Drainage	Other	Signature
	Fluids	Hrly	Total	Fluids	Amount					
8-00 AM										
9-00 AM										
10-00 AM										
11-00 AM										
12-00 Noon										
1-00 PM										
2-00 PM										
3-00 PM										
4-00 PM										
5-00 PM										
6-00 PM										
7-00 PM										
8-00 PM										
9-00 PM										
10-00 PM										
11-00 PM										
12-00 Mid Night										
1-00 AM										
2-00 AM										
3-00 AM										
4-00 AM										
5-00 AM										
6-00 AM										
7-00 AM										

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO..... Ward / ICU.....Bed No.....

INTAKE AND OUTPUT CHART

Hosp. No:
Date :

Past 24 Hrs. Intake

ORAL
I.V
other

Total

Past 24 Hrs. Output

Urine
NASOGASTRIC ASPRATION
Drainage
Other
Total

Hours	(Medication, IV Nutrition, Fluids, Blood)			Oral (Medication Food)		Urine	N.G.Asp	Drainage	Other	Signature
	Fluids	Hrly	Total	Fluids	Amount					
8-00 AM										
9-00 AM										
10-00 AM										
11-00 AM										
12-00 Noon										
1-00 PM										
2-00 PM										
3-00 PM										
4-00 PM										
5-00 PM										
6-00 PM										
7-00 PM										
8-00 PM										
9-00 PM										
10-00 PM										
11-00 PM										
12-00 Mid Night										
1-00 AM										
2-00 AM										
3-00 AM										
4-00 AM										
5-00 AM										
6-00 AM										
7-00 AM										

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

DISCHARGE SUMMARY

Patient's Name : Mr / Mrs / Miss Age: Sex : M/F

Father's / Husband's Name

Address :

IP No:

Room / Ward & Bed No.

Ph No.:

D.O.A.: D.O.S.: D.O.D:

Cured / Relieved / Referred To Higher Centre / LAMA

MLC Case Yes / No, If Yes MLC No.

Details of Police Information :

Name of The Informant

Police Station :

PC who Brought / To whom Informed : P.C. No.

CONSULTANTS:

Primary 1.

2.

3.

4.

DIAGNOSIS:

NAME OF SURGERY:

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

REASONS FOR ADMISSION :

SIGNIFICANT FINDINGS:

CLINICAL SUMMARY:

PATIENT'S CONDITION AT THE TIME OF DISCHARGE:

NAME OF SURGERY PERFORMED IN DETAILS :

ANY OTHER PROCEDURES PERFORMED:

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

INVESTIGATIONS DONE & SPECIAL INVESTIGATION (MRI/CT/DOPPLERS)

COURSE OF THE TREATMENT IN THE HOSPITAL:

MEDICATION ADMINISTERED:

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**..... **Ward / ICU**.....**Bed No**.....

DISCHARGE TREATMENT ADVISED

FOLLOW-UP MEDICATION :

FOLLOW-UP ADVICE :

DIET :

OTHERS INSTRUCTIONS :

CAUSE OF DEATH (IF THE PATIENT EXPIRED) :

WHEN AND HOW TO OBTAIN URGENT CARE :

IN CASE OF EMERGENCY PLEASE CONTACT :

Date and Time :

Consultant Name :

Department:

REGISTRAR / RESIDENT

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PLANNED SURGERY.....**SURGEON** .....

PRE ANAESTHESIA CHECK UP

PRE ANAESTHETIC ASSESSMENT

Past Medical History	Details	Functional Status
Diabetes mellitus		
Hypertension		
Asthma		
Coronary artery disease		
Myocardial infarction		
CVA		
Thyroid disease		
Renal disease		
Smoking / Alcohol		

Previous surgery / anaesthesia exposure

Any known allergies.

EXAMINATION

Pulse		CVS	Mouth opening	Airway
BP			TMJ	
SpO_2		RS	Mallampati	
Weight			Neck Movement	
Height		P/A	Lumbar spine	
BMI			Teeth / Dentures	
		CNS		

INVESTIGATION

Hb%		HIV		RBS		**Drugs used**	ECG
WBC		HCV		FBS			
Platelets		HbSAg		PLBS			
Blood Group		BT		HbA_1C			2D Echo
Na^+		CT		PFT			
K^+		T3		Others			Stress Test
B. Urea		T4					
S. Cr		TSH					CAG
INR		C Xray					
CUE		CT					
		MRI					

ASA Grade I / II / III / IV / V / VI E

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

Problems : Identified at PAC	Pre - Operative instructions
1.	1. NBM from
2.	2. Informed Consent: Standard / High Risk for Anaesthesia
3.	3. Shift to OT at
4.	4. Premedication
5.	5. Cross Consultations
6.	6. Reserve Blood

PLAN OF ANAESTHESIA [TICK APPLICABLE]

General Anaesthesia / Regional Anaesthesia _____ Signature:_____

Special equipment to be kept ready_____ Signature:_____

SPECIALIST OPINION

[Eg. Cardiology / Nephrology / Pulmonology]

_____

_____

_____

_____

Name:_____ Date:_____

Signature of Specialist:_____ Time:_____

_____

REVIEW PRE-ANAESTHETIC EVALUATION (ON DAY OF SURGERY) Date:_____

1. Vitals Signs: PR BP RR Temp

2 Fasting Status

3. Consent

4. Medication Status

Signature:

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

ANAESTHESIA CHART

Date :			Anaesthesiologist		
Monitoring	IV access		Surgeons		
ECG NBP / IBP Pulse Oxy ETCO2	Cannula		Cir nurse		
	Side		Scrub nurse		
	Art line		Technician		
Temp	CVP		Theatre		

Anaesthesia - G.A/ S.A./ E.A./ I.V. Sedation / MAC / Nerve block

REGIONAL ANAESTHESIA

Technique.....

Approach.....

Position.....

Preparation: Bet / Chlorhex /

Gloves / Gown / Depth.....

Needle: Gauge / Length / Depth.....

Space.....

Catheter@skin.....

Complicatons / Incidents.....

.....

Drug

LA

Additives

Epidural

USG.....

Nerve Stimulator.....

Onset of Action.....

Sensory Level.....

Motor Level.....

GENERAL ANAESTHESIA

Pre oxygenation.....

Induction [IV / Inhalational / TIVA] .....

Intubation - Nasal / Oral, Size .....

Cuff..... Length.....

LMA.....

Ventilation - Controlled / Spontaneous

Circuit.....

Ventilation : MV.....

TV.....

RR.....

I:E.....

- C/L Grading I / II / III I IV :
- Type of Laryngoscope used :
- Easy / difficult:
- Position

Safety

Eyes

Pressure areas

Warmer

TOURNIQUET - Applied at.....Removed at.....

Space for additional notes during induction / intra-op and immediate post-op period

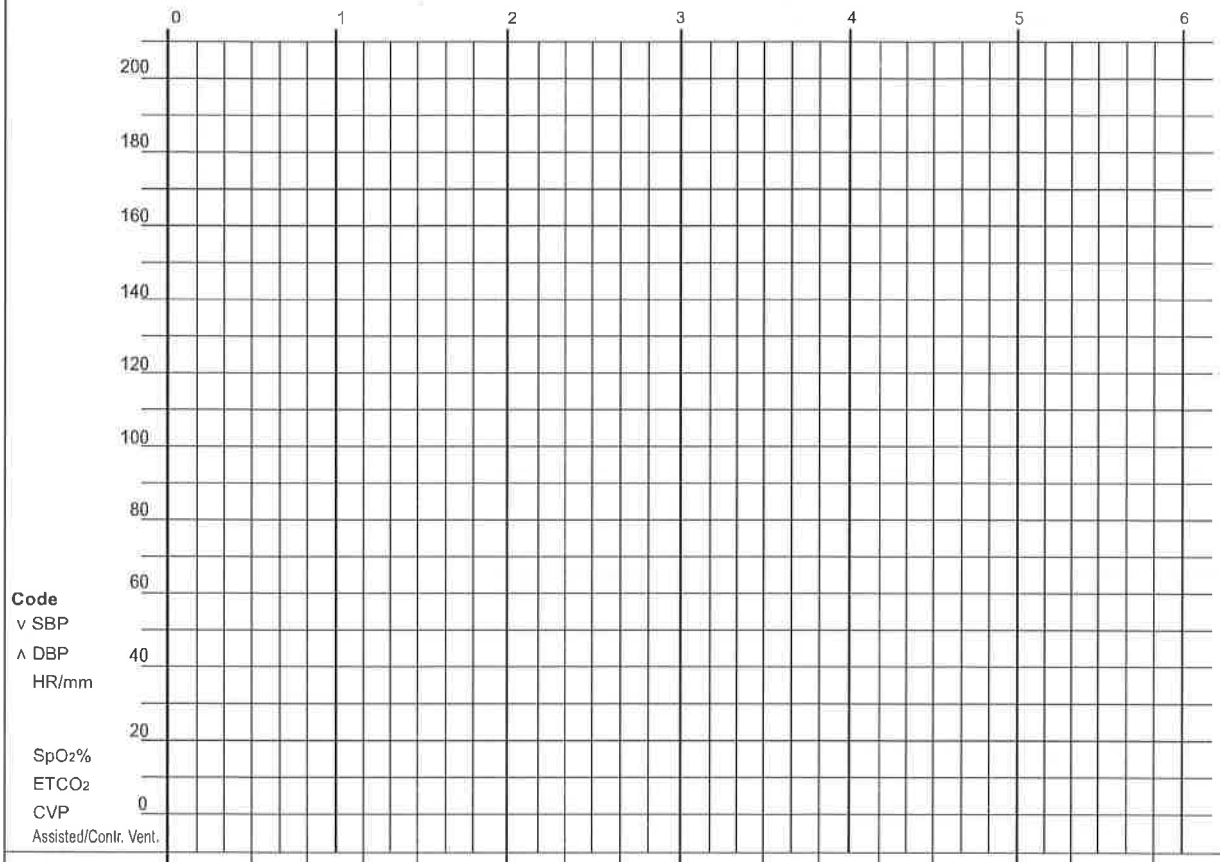
.....

Anaesthesiologist **Start:** **End:**

Surgery: **Start:** **End:**

Time of Induction **Total Dose**

Time														
Oxygen														
Nitrogen oxide														
Iso/Sevo/Des														
Anaesthesia Drugs														
1.														
2.														
3.														
4.														
Antibiotics	1.													Remarks
	2.													



IV Fluids - 1															Total ml
IV Fluids - 2															
Blood															
Bl. Loss															
Ur. Output															
Temp															

Time of Completion of Surgery

Time of Extubation

Post Operative Instructions: **Date:**

Anaesthesiologist Name / Signature

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

CONSENT FOR ANAESTHESIA

PROCEDURE TO BE PERFORMED :_____

_____

I confirm that I have explained the type of Anaesthetic (General / Regional / Sedation) Proposed to the patient in terms which, in my judgement, are suited to the understanding of the patient and/or one of the parents or guardians of the patient.

Signature : **Date :**

Name of Anaesthesiologist / Consultant :

Counselling has been done to explain the high risk involved in administering anaesthesia for the proposed surgery because of the following medical problems

1. _____
2. _____
3. _____
4. _____

Patients receiving general anaesthesia may require tube in the windpipe (Endotracheal Intubation): the intubation could cause a sore throat and hoarseness. Also teeth or dental prosthesis could become loose. If they develop respiratory complications, they may be put on ventilators to support their lungs. Accidental death is extremely rare; however, a very remote possibility of this always exists in any surgery or anaesthesia.

The operation may be performed under general anaesthesia / spinal / epidural / field / local anaesthesia as per the decision of the surgeon and the Anaesthesiologist concerned.

Allergic reactions do occur. You need to inform us of any allergy you have. If you had any problems in previous surgery or anaesthesia, the same should be communicated to the doctor.

I Agree	• to what is proposed which has been explained to me by the doctor named on the form.
I Understand	• that the procedure may not be done by the doctor who has assessed me.
	• that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
I Agree	• to the use of the type of anaesthetic that I have been told about.

Signature of Patient / *Guardian : **Name:**

***Relationship with patient:** **Date:** **Time:**

PS: You are welcome to discuss any of the points mentioned above with the doctors attending on you before signing on the informed consent

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO..... Ward / ICU.....Bed No.....

అనస్థీషియా కొరకు తెలియజేయు అంగీకారము

నిర్వహించవలసిన చికిత్సా విధానం _____

నేను పేషంట్ కు ఇవ్వవలసిన అనస్థటిక్ రకము(లోకల్ /జనరల్ /సేడేషన్) గురించి నాకు తెలిసినంతమేరకు పేషంటు మరియు / లేదా తల్లిదండ్రులలో ఒకరికి లేదా పేషంటు యొక్క సంరక్షకులకు అర్థమయ్యే విధంగా వివరించడం జరిగిందని ధృవీకరిస్తున్నాను.

సంతకం:_____ పెరు: _____

అనస్థటిస్ట్/డాక్టర్ పేరు _____

ఈ క్రింది వ్రాయబడిన ఆరోగ్య సమస్యల వలన మీకు ఆపరేషన్ చేసే ముందు ఇచ్చే అనస్థీషియా / మత్తు మందు వలన కొన్ని ప్రమాదములు, ఎదురు కావచ్చు

1._____

2._____

3._____

4._____

సాధారణ అనస్థీషియా ఇచ్చేందుకు శ్వాసనాళంలోకి ఒక ట్యూబును (ఎండోట్రాకియల్ ఇన్ ట్యుబేషన్) పంపించవలసి రావచ్చు. ఈ ఇన్ ట్యూబేషన్ వల్ల గొంతు మంట మరియు గొంతుకు అడ్డం పడినట్లు అనిపించవచ్చు మరియు దీనివల్ల దంతములు లేదా దంతముల అనురిక వదులు కావచ్చు. ఒకవేళ శ్వాసతీసుకోవడంలో ఇబ్బందులు ఎదురైతే వారికి వెంటిలేటర్ సహాయంతో శ్వాసను అందించవలసి రావచ్చు. ప్రమాదవశాత్తు మరణించడం అనేది అత్యంత అరుదుగా జరుగుతుంది.

శస్త్రచికిత్స జరిపేందుకు ఏ రకమైన అనస్థీషియా, ఎక్కడ ఇవ్వాలి (సాధారణ అనస్థీషియా/వెన్ను నడుముకు క్రింది భాగంలో ఇచ్చే మత్తుమందు) అన్న విషయాలను సంబంధిత సర్జన్ మరియు అనస్థిటిస్ట్ లు నిర్ణయిస్తారు

మత్తుమందు వల్ల అలర్జీలు వంటివి కలుగవచ్చు. అలాంటివి ఏమైనా కలిగితే వెంటనే వైద్యసిబ్బందికి తెలియజేయాలి. ఇదివరకు మీకు || నిర్వహించిన శస్త్రచికిత్త లేదా అనస్థీషియాల వల్ల సమస్యలేమైనా కలిగితే వాటి వివరాలు డాక్టరుకు తప్పనిసరిగా తెలియజేయాలి.

ఈ ఫారంలో పేర్కొన్న పేరు గల డాక్టరు నాకు వివరించినటువంటి చికిత్సా విధానానికి నేను అనుమతిస్తున్నాను.

ఈ శస్త్రచికిత్సను నన్ను పరీక్షించిన డాక్టరు మాత్రమే నిర్వహించక పోవచ్చని నేను అర్థం చేసుకున్నాను.

ఈ ఫారంలో వివరించబడిన శస్త్రచికిత్సకు అదనంగా ఎటువంటి చికిత్సనైనను అవసరం మేరకు మరియు వైద్యపరంగా నిర్ణయించిన మేరకు నిర్వహించబడతాయి.

నాకు చెప్పబడినటువంటి అనస్థిటిక్ విధానం ఉపయోగించేందుకు నేను అనుమతిస్తున్నాను.

*పేషంటు / *సంరక్షకుని సంతకం:_____ పేరు:_____

*పేషంటుతో గల సంబంధం: _____ తేది: _____ సమయం _____

గమనిక: ఈ ఫారముపై సంతకము చేయుటకు ముందు మీరు ఇందులో పేర్కొనబడిన ఏ అంశము గురించైనా సంబంధిత డాక్టరుతో చర్చించవచ్చును.

RVM CHARITABLE TRUST HOSPITAL

Laxmakkapally (Vill), Mulugu(M), Siddipet(D), Telangana 502279

PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

CONSENT FORM FOR PROCEDURE / SURGERY TREATMENT, HIGH RISK CONSENT

(The contents of this form have been explained to me in my spoken language)

INSTRUCTIONS: This consent form should be signed by patient (If an adult 18 years older): by a parent / guardian if the patient is a minor: by the spouse or adult children or parents or adult brothers or sisters or other family member or significant other (in this order of priority) if the patient lacks the ability to make an informed decision. The physician or his authorised doctors are responsible for obtaining informed consent.

I hereby authorize the performance of the following operation(s), procedure(s) or treatment(s) (hereafter referred to as procedures) (Use no abbreviation / Avoid technical terms).

_____ up on

(Name of patient)_____

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observation and / or diagnostics performed. 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 or success or outcomes.

The benefit and risks of this surgery/ procedure have been explained to me. I have also been told about the alternatives available for this procedure/surgery including the advantages and disadvantages of the alternatives.

I authorize Dr._____ and such assistants and associates as may be selected by him/her to perform any part the above procedure(s) upon myself/the patient. I have been advised and agree that any member of this team may perform any part of my procedures(s) according to his/her stage of training and ability, if in the opinion of the named physician the experience and capability of the assistant surgeon justifies such a decision.

As with any procedure, I am aware that risks such as blood loss, hematoma, infection (early or delayed), deep vein thrombosis, embolism, heart failure, cardiac arrest, change in blood pressure, allergic reactions, paralysis etc., may arise necessitating attention. I have also been explained risks of neurovascular complications, restriction / stiffness of joints, periprosthetic fractures and that the original shape and function may not be regained. Therefore, in addition to consenting to the performance of the particular procedure(s), I also consent and authorize the rendering of such other care and treatment as my physician or his assignee reasonably believes necessary should one or more of these and or there unforeseeable events occur.

Blood product transfusions: This consent includes the administration of blood or product transfusion during this procedure and immediate post-operative period. I also understand that unpredictable reactions may occur which include but are not limited to fever, rash and shortness of breath, shock and in rare occasions death.

Expected benefits of the transfusion many include minimizing shock, brain and other organ damage, hastening recovery and limiting blood loss, however, I understand that there are no guarantees offered as to the expected benefits of the transfusion.

సర్జరీచికిత్స, ప్రమాదకర చికిత్స కొరకు అంగీకార పత్రము

ఈ పత్రం నందు గల అంశాలు నేను మాట్లాడే భాషలో నాకు వివరించబడినవి)

సూచనలు : ఈ అంగీకార పత్రముపై పేషెంటు (18 సం||లు అంతకు మించిన వయస్సు కలిగిన వారు): పేషెంటు మైనరు అయిన పక్షంలో పేషెంటు యొక్క తల్లిదండ్రులు/సంరక్షకులు : పేషెంటు నిర్ణయం తీసుకోలేని స్థితిలో ఉన్నప్పుడు పేషెంటు యొక్క భాగస్వామి లేదా 18 సం||లు పైబడిన సంతానం లేదా తల్లిదండ్రులు లేదా మేజరైన సోదరుడు లేదా సోదరి లేదా ఇతర కుటుంబ సభ్యులు లేదా గుర్తించదగిన ఇతర వ్యక్తి (ఇక్కడ ఇచ్చిన ప్రాధాన్యతా క్రమం ప్రకారం) తప్పనిసరిగా సంతకం చేయాలి. ఈ అంగీకారమును చికిత్సను నిర్వహిస్తోన్న డాక్టరు లేదా తత్సమానమైన హోదా కలిగిన వైద్యులు పేషంటు నుండి తప్పనిసరిగా స్వీకరించాలి.

నేను ఈ క్రింది పేర్కొనబడిన శస్త్ర చికిత్స (లు) చికిత్స (లు) ట ఇక మీదట చికిత్సగా పేర్కొనబడుతుంది ఈ సంక్షిప్త అక్షరాలు/సాంకేతిక పదాలను ఉపయోగించవద్దు _____

_____ను/లను

_____ అనబడు పేషెంటుకు నిర్వహించుటకు అధికారికంగా అనుమతించబడ్డాను.

నాకు జరిపిన వైద్య పరీక్షల ద్వారా మరియు వైద్య పర్యవేక్షణ ద్వారా సూచించబడిన ఈ చికిత్స(లు) ను నిర్వహించుటకు గల కారణాలు, ఈ చికిత్స(లు) ను అందించటం వల్ల కలుగు ప్రయోజనాలను నాకు తెలపడమైనది. ఇది శాస్త్రపరంగా నిర్వహించు వైద్య ప్రక్రియ అయినప్పటికీ కలగబోవు ఫలితాల పట్ల ఎటువంటి హామీలను ఇవ్వడం ఉండదని నేను గుర్తించాను.

ఈ సర్జర్/చికిత్స వల్ల కలిగే లాభాలు మరియు ప్రమాదాల గురించి నాకు వివరించటం జరిగింది. అంతేకాకుండా ఈ సర్జరీ/చికిత్సకు ప్రత్యామ్నాయ సర్జరీ/చికిత్సల గురించి, వాటి వల్ల కలిగే లాభనష్టాల గురించి కూడా వివరించడం జరిగింది.

నేను డా".....గారిని మరియు ఆయన/ఆమెచే ఎంపిక చేసుకోబడిన వారి సహాయకులను మరియు సహచర వైద్యులను, పై చికిత్స (లు) లో ఏ విభాగానైనా నాపై/పేషెంటుపై జరుపుటకు అనుమతిస్తున్నాను. పైన పేర్కొనబడిన డాక్టరుగారి అనుభవము మరియు సామర్థ్యము మేరకు, ఆయన/ఆమె అవసరమని నిర్ణయించిన ఈ వైద్యసిబ్బందిలో ఏ సభ్యులైననూ, చికిత్సలోని ఏ విభాగానైననూ, అతడు/ఆమె అందుకున్న శిక్షణ మరియు సామర్థ్యము మేరకు నిర్వహించుటకు నేను అనుమతిస్తున్నాను.

పై చికిత్సను నిర్వహించునపుడు రక్తమును కోల్పోవుట, హెమటోమా, ఇన్ఫెక్షన్ (వెంటనే లేదా కొన్ని రోజుల తరువాత), సిరలలో రక్తము గడ్డకట్టుట, రక్తనాళాల మార్గములో అవరోధాలు ఏర్పడటం, గుండెపోటు, రక్తపోటులో మార్పులు, అనస్థీషియా వల్ల కలుగు ఎలర్జీలు, పక్షవాతము మొదలగు ప్రమాదకర పరిస్థితులు ఏర్పడేందుకు అవకాశం ఉందని నాకు తెలుసు. వీటితోపాటు న్యూరోవస్క్యూ లర్ కాంప్లికేషన్స్, కీళ్ళసమస్యలు, పెరిప్రొస్థటిక్ ఫ్రాక్చర్స్ మరియు తిరిగి సరిచిద్దలేని విధంగా ఎముకల సహజ రూపము మరియు పనితీరు దెబ్బతినటం వంటి సమస్యలు ఏర్పడే అవకాశం, ఉందని నాకు వివరించడం జరిగింది. అందువల్ల పై చికిత్సతో పాటు అందులో ఏర్పడిన ఇతర సమస్యలను సరిచిద్దేందుకు అవసరమైన అదనపు చికిత్స(ల) ను చేయుటకు నా/ పేషెంటు యొక్క డాక్టరుకు లేదా తత్సమాన అర్హతగల వైద్యులకు అనుమతినిస్తూ నేను అంగీకారము తెలుపుతున్నాను.

రక్తము మరియు దాని యొక్క ఇతర ఉత్పాదకాల మార్పిడి: పై చికిత్సను నిర్వహించేటప్పుడు లేదా నిర్వహించిన వెంటనే రక్తము లేదా దాని యొక్క ఇతర ఉత్పాదకాలను మార్పిడి చేయవలసిన అవసరం ఏర్పడవచ్చు. దీని వల్ల జ్వరము, దద్దుర్లు, శ్వాస అందకపోవడం, షాక్కు గురికావడం మరియు అరుదైన సందర్భాలలో మరణం సంభవించటం వంటివి జరిగే అవకాశం వున్నదని నాకు తెలుసు. అయినను పై చికిత్స కొరకు నేను అంగీకరిస్తున్నాను.

పై ఉత్పాదరాల మార్పిడివల్ల ఆశించిన ఫలితాలు. అనగా మెదడు మరియు ఇతర అవయనాలకు జరుగు నష్టాన్ని తగ్గించడం, రక్తస్రావన్ని ఆపడం, త్వరగా కోలుకోవడానికి సహకరించడం వంటి ఫలితాలకు ఎటువంటి హామీలు ఇవ్వబడలేదు మరియు ఇచ్చేందుకు అవకాశం లేదని నాకు తెలుసు.

RVM CHARITABLE TRUST HOSPITAL

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

AUTHORIZATION OF PATIENT

I acknowledge that I have had an opportunity to discuss and understand this procedure, as started above, with my physician or physician designate, and hereby consent to this procedure and collection of biological sample (Blood or Tissue)

Patient :..... Date:.....

Witness:..... Date:.....

Doctor:..... Date:.....

PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____ and I _____ _____ (name / relationship to the patient), therefore consent for the patient I acknowledge that I have had an opportunity to discuss and understand this procedure, as stated above with my physician or physician designate, and hereby consent to this procedure.

Patient :..... Date:.....

Witness:..... Date:.....

Doctor:..... Date:.....

HIGH RISK CONSENT - INDEMNITY STATEMENT

I.....have been explained about the surgery, I have been explained by the doctors that the causes of my / my patient being at high risk due to following.

1.
2.
3.

I have also been explained that the possible complications of surgery / anaesthesia are as follows

1.
2.
3.

I also state that I or my family shall not hold **RVM Charitable Trust Hospital** or its doctors for any consequences Whatsoever

Patient / Patient representative:.....

Patient :..... Date:.....

Witness:..... Date:.....

Doctor:..... Date:.....

Interpreter used, Name.....

The biological sample (blood or tissue) collected from your body for diagnostic tests or surgical resection may be given without disclosing your identity by **RVM Charitable Trust Hospital** doctor to research scientists with affiliated institutions for diagnostic or therapeutic research purpose. This will happen only if there is any sample left-over after its intended medical use. There will be no additional sample collected.

This research use may not benefit you but will help in better understanding of disease and better treatment for other patients in future.

You have the option to disallow us from such research use of the left-over sample.

if you do not agree to allow research use of the left-over samples, please fill in the checked box else we will consider it as a positive decision.

☐ I do not agree to allow research use of the left-over samples.

_____

Authorization of Patient / Patient representative / Surrogate

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

PRE OPERATIVE CHECKLIST

	Yes	No	Checked at OT Reception
1. Patient UHID / IP number & identification band Checked			
2. Marking of site :			
3. Consent for surgery			
4. High risk consent			
5. Investigations in case sheet: CT EXAM			
6. Blood requirement:.....Type & cross match units			
7. Allergies:			
8. Preoperative preparation documented / Skin preparation			
9. Vital signs recorded Weight:			
10. Enema.....Bowel wash.....Laxatives.....			
11. Pre-op medication given (if yes, time.....AM / PM) / PAC Done			
12. NBM from			
13. Drug chart present			
14. Dentures removed / In situ			
15. Contact lenses / glasses / removed and in safe keeping			
16. Prosthesis / Hearing aid removed / in situ			
17. Jewellery / other metal removed			
Ward nurse Signature Date & Time			
OT Reception Signature Date & Time			

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

TIME OUT **Date:**.....**OT:**.....

BEFORE INDUCTION OF ANAESTHESIA

STEP 1	TECHNICIAN TO DO	Anaesthesiologist / Surgeon / Nurse

☐ **Confirmed with patient** Ask Patient

- Identity ☐ Yes ☐ No
- Site ☐ Yes ☐ No
- Procedure ☐ Yes ☐ No
- Consent ☐ Yes ☐ No

☐ Site marked/not spplicable ☐ Yes ☐ No

☐ Anaesthesia Safety Check Completed ☐ Yes ☐ No

☐ Pulse Oximeter on Patient and Functioning ☐ Yes ☐ No

Technician to Check

Does patient have

1) Known Allergy ? Ask Patient

☐ Yes ☐ No

2) Difficult Airway / Aspiration Risk Ask Anaesthetist

☐ No ☐ Yes, and Equipment/ Assistance Available

3) Risk of >500ml Blood Loss (7ml/kg in Children) ? Ask Surgeon

☐ No ☐ Yes, and Equipment/ Assistance Available

BEFORE SKIN INCISION

STEP 2	CIRCULATING NURSE TO DO	Anaesthesiologist / Surgeon / Nurse

☐ Confirm all team members have introduced themselves by name and role Ask Each of Team

☐ Surgeon, Anaesthetist and nurse verbally confirm Ask Each of Team

- Patient Name
- Site
- Procedure

Anticipated Critical Events

Nursing team reviews: Has sterility (including indicator results) been confirmed? ☐ Yes ☐ No Ask Scrub Nurse

are there equipment issues or any concerns? ☐ Yes ☐ No

1) Has antibiotic prophylaxis been given within the last 60 minutes ? Ask Technician

☐ Yes ☐ Not applicable

2) Is essential imaging displayed? Ask Technician

☐ Yes ☐ Not applicable

BEFORE PATIENT LEAVES OPERATING ROOM

STEP 3	CIRCULATING NURSE TO DO	Anaesthesiologist / Surgeon / Nurse

Nurse verbally conforms with the team

☐ Instrument, sponge and needle counts are correct Ask Scrub Nurse ☐ Yes ☐ No

☐ The specimen is labelled (including patient name) Ask Scrub Nurse ☐ Yes ☐ No

☐ Whether there are any equipment problems to be addressed Ask Scrub Nurse ☐ Yes ☐ No

☐ Case sheet check completed, all investigations collected ☐ Yes ☐ No

Signature of Anaesthesiologist	Signature of Surgeon	Signature of Nurse

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PATIENT'S NAME..... AGE..... SEX.....

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

INTRAOPERATIVE NURSING / SURGEON RECORD

Specimen _____ ☐ Pathology ☐ Microbiology ☐ Frozen section

Time sent _____ Time of report _____ (for frozen section)

PACKING / DRAINS / CATHETERS

Type	Size	Site	Amount	Sign

Count	Sponges	Gauze	Roller gauze	Instruments count	Needle	Circ nurse
Pre-op						
At Closure						
Final						

Count correct : ☐ yes ☐ no if no, time when surgeon informed : ☐ yes ☐ no

Signature of Surgeon / Scrub nurse_____

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

IMPLANT STICKERS

OT TIME AND EQUIPMENT USED FORM

Theater Name:_____

Procedure start time _____ Procedure end time _____

C-Arm	:	☐ Major	☐ Major	☐ Single Shot
Microscope	:	☐ Major	☐ Major	
Arthroscopy Equip	:	☐ Major	☐ Major	
Endoscopy Equip	:	☐ Major	☐ Major	
Harmonic	:	☐ Major	☐ Major	
Co-Ablator	:	☐ A	☐ B	
Ligasure	:	☐ Major	☐ Major	
ENT Shaver	:	☐ Major	☐ Major	
LMA	:	☐ Yes	☐ No	
CD / DVD	:	☐ Yes	☐ No	
Ultrasound	:	☐	☐	
Fibreoptic Intubation	:	☐	☐	
Neuromonitor	:	☐	☐	
Laser	:	☐	☐	
Body Warmer	:	☐	☐	
Fluid Warmer	:	☐	☐	

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SURGEON'S NOTES

IMMEDIATE PRE - OP SURGICAL ASSESSMENT

_____

_____

_____

Surgery _____

Surgeon _____ **Assistants** _____

Anaesthesiologist _____ **Scrub nurse** _____

Type of anaesthesia : GA/SA/CSEA/Block& Other _____

Diagnosis _____

Incision _____

Findings _____

_____

_____

_____

Procedure _____

_____

_____

_____

_____

_____

_____

Post-Op surgical orders _____

_____

_____

_____

X-rays/Histopathology/ C-S/ Others _____

_____

_____

Signature **Date** **Time**

Note: Please enter all drug orders in drug order form

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PATIENT'S NAME..... AGE..... SEX.....,

UHID / PMRN.....IPNO.....Ward / ICU.....Bed No.....

THE TIME OF DISCHARGE from SICU / RECOVERY :.....AM / PM

ALDRETE SCORE

At time of discharge from to SICU / Recovery

Variable Evaluated	
Activity	
Able to move four extremities on command	2
Able to move two extremities on command	1
Able to move no extremities on command	0
Breathing	
Able to breathe deeply and cough freely	2
Dyspnea	1
Apnea	0
Circulation	
Systemic blood pressure = 20% of the preanesthetic level	2
Systemic blood pressure is 20% to 40% of the preanesthetic level	1
Systemic blood pressure = 50% of the preanesthetic level	0
Consciousness	
Fully awake	2
Arousable	1
Not responding	0
Pulse Oximetry	
>92% while breathing room air	2
Need supplemental oxygen to maintain saturation >90%	1
<90% even with supplement oxygen	0
TOTAL SCORE	

Score 9 or 10 is needed to discharge a patient

Total Score _____/10

(Patient must score above 10 to be transferred safely from the SICU)

Surgeon Signature Nurse Signature: Date: Time:

Pain Assessment Scale										
0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain		Severe pain		Very Severe		Worst pain

Pain score :

SPACE FOR ADDITIONAL NOTES:

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PATIENT'S NAME..... **AGE**..... **SEX**.....

UHID / PMRN.....**IPNO**.....**Ward / ICU**.....**Bed No**.....

POST OPERATIVE INSTRUCTIONS

DRUG ORDERS

- ☐ • IV Fluids ml per hour RL / DNS / NS / 5D
- ☐ • Antibiotic
- ☐ • Antacids
- ☐ • Epidural
- ☐ • Analgesics
- ☐ • Oxygen
- ☐ • DVT Prophylaxis
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
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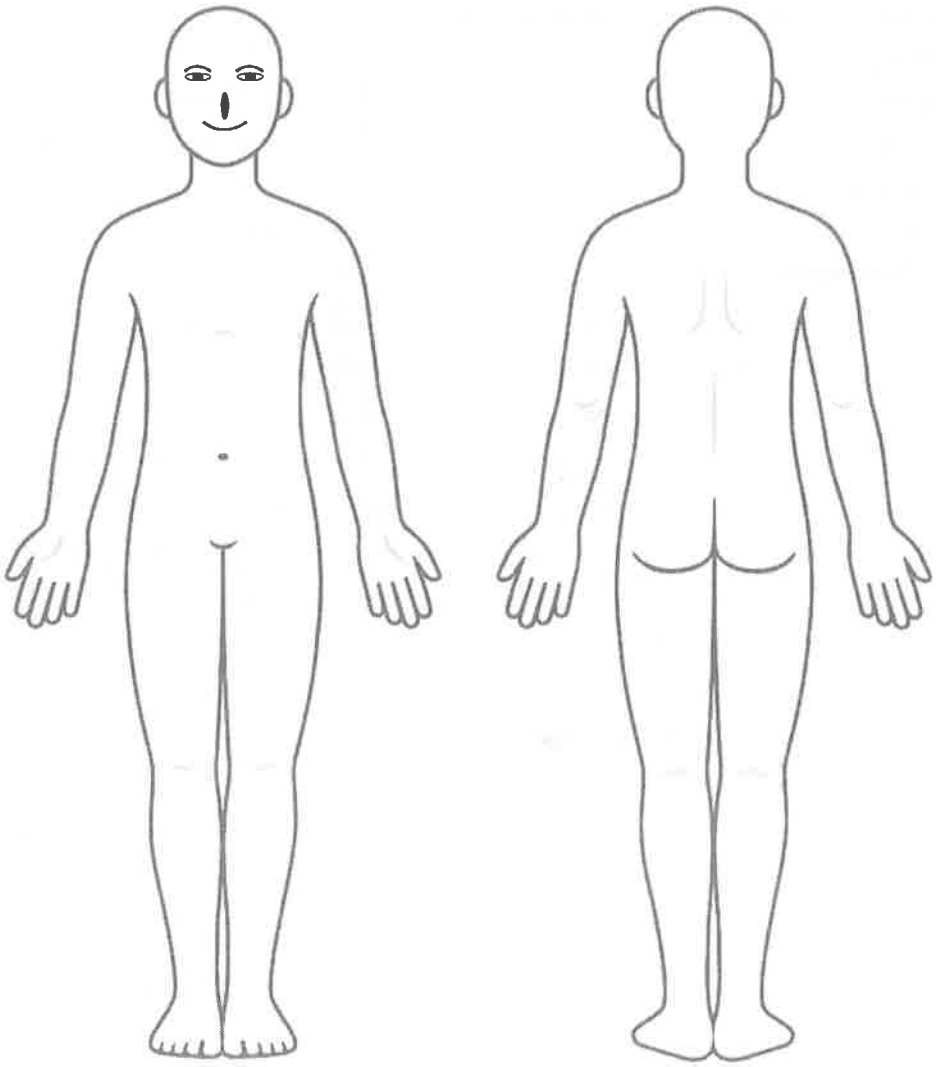
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Non drug orders

- ☐ Nil by mouth (NBM) till ☐
- ☐ Continuous ECG / SpO_2 / NIBP ☐
- ☐ Input - Output Monitoring ☐
- ☐ Oxygen with Nasal cannula / Face mask 2 - 4 L ☐
- ☐ Encourage oral feeds after 4 hours ☐
- ☐ Shift to ward at
- ☐ Stay in SICU overnight

Surgeon Name & Signature:

Date: Time:

SURGICAL SITE MARKING