ALL INDIA INSTITUTE OF MEDICAL SCIENCES, DEOGHAR
अखिल भारतीय आयुर्विज्ञान संस्थान, देवघर
INSTITUTE OF NATIONAL IMPORTANCE UNDER MINISTRY OF HEALTH AND FAMILY WELFARE
(स्वास्थ्य और परिवार कल्याण मंत्रालय के अंतर्गत राष्ट्रीय महत्व की संस्थान)
P.T.I., Daburgram, Jasidih, Deoghar, (Jharkhand) - 814142
पी.टी.आई., डाबरग्राम, जसीडीह, देवघर, (झारखंड) - ८१४११४२

Invitation of quotation
for
Printing of IPD Documents
for
AIIMS Deoghar

Reference No.: AIIMS/Deoghar/ IPD form/ 2023-24/01

Date of Issue: 13th March, 2023

Last Date of Submission: 21st March, 2023 at 05:00 PM.

All India Institute of Medical Sciences, Deoghar

P.T.I. campus, Daburgram, Jasidih, Deoghar: 814142, Jharkhand

Email: procurement@aiimsdeoghar.edu.in

Reference no: AIIMS/Deoghar/ IPD form/ 2023-24/01

Invitation of quotation for printing of IPD Documents for AIIMS Deoghar

Sealed Quotations are invited on behalf of AIIMS, Deoghar for **printing of IPD Documents (*Annexure-I)*** required for the Institute as per terms & conditions mentioned below. The filled quotations along with the entire required document must reach in the office of the undersigned on or before **21.03.2023 at 05:00 PM**. The **Envelope containing the quotation** must be sealed and **super scribed as under**:-

"QUOTATION FOR PRINTING OF IPD DOCUMENTS AT AIIMS DEOGHAR REFENRENCE NO.: DEOGHAR/ IPD FORM/ 2023-24/01, **DUE ON 21.03.2023 AT 05.00 PM"**

The Quotation should be send to the address:-

Assistant Procurement Officer
AIIMS Deoghar, PTI Campus,
Daburgram, Jasidih,
Deoghar, Jharkhand -814142.

1. Terms & Conditions:

a) The quotations received **after this deadline or unsealed shall not be entertained** under any circumstances whatsoever. In case of postal delay this Institute will not be responsible. The offer submitted by Fax / email shall not be considered and no correspondence will be entertained in this matter.
b) Quotations must be in the **enclosed prescribed Performa *(Annexure -2)* on the letter head of the firm duly signed** by the Proprietor/ Partner/ Director or their authorized representative, In case of signing of quotation by the authorized representative letter of authorization must be attached with the quotation.
c) The work should be executed as per direction of the nominated person.
d) The printing **should be done as per the Performa attached at the end of document.**
e) Final printing should be done after **proofreading and approval of the draft by the concerned department.**
f) The supplier should print and supply all the mentioned items.
g) Rates must be quoted in Indian rupees.
h) Rates must be inclusive of all charges (including Freight charges, Insurance, installation, taxes etc.).
i) **No overwriting or cutting** is permitted in the rate. If found, the quotation shall be summarily rejected.
j) The **rates quoted must be valid for 120 days minimum from the date of opening of the quotation** and silence of any tendered on this issue shall be treated as agreed with this condition.
k) **Total cost/amount will be taken in consideration for L1.** Becoming L1 will not be the criteria for awarding of purchase order unless the rates are reasonable & justified.
l) Quotations qualified by such vague and indefinite expressions such as "subject to prior confirmation", "subject to immediate acceptance" etc. will be treated as vague offers

and it will be rejected accordingly. Any conditional quotation shall be rejected summarily.

m) **Delivery Period** – within **20 days** from the issue of work order.

n) **Liquidated Damage**: - If the supplier fails to deliver the material on or before the stipulated date, then a penalty at the rate of 0.5 % per week of the total order value shall be levied subject to maximum of 10% of the total order value.

o) **Payment Terms**: Payment will be only after satisfactorily delivery / commissioning of material and after inspection by the AIIMS Deoghar.

p) The firm / agency may satisfy the following conditions and **attach self-attested copy of the same with the quotation:**

- The firm shall have valid GST / Other taxes and IT PAN.
- Registration of firm.
- The firm should not be black listed by any Government agency/Department.
- Similar work order of any government institute.

q) Quotations qualified by such vague and indefinite expressions such as "subject to prior confirmation", "subject to immediate acceptance" etc. will be treated as vague offers and It will be rejected accordingly. Any conditional quotation shall be rejected summarily.

r) **Disputes:** -In the event of any dispute or disagreement arising between the contractors and any other department of AIIMS Deoghar with regards to the interpretation of "Terms & Conditions" of this inquiry, the same shall be referred to arbitrator appointed by The Executive Director, AIIMS, Deoghar, whose decision will be final and binding upon the contractor.

s) AIIMS Deoghar reserve the right to accept or reject any or all quotations without assigning any reason there of and also does not bind itself to accepted the lowest quotation.

t) No quotation will be accepted if received after due date. The envelope containing quotation should be sealed with WAX/TAPE on both sides.

u) Procurement will be as per rule **GFR-155** of Government of India.

Encl.: Annexure 1 (Specification)

Annexure 2 (Format of price bid)

(***Annexure - 1)***

Reference no: AIIMS/Deoghar/ IPD form/ 2023-24/01

Sn. No.	Name of form	Specification	Qty. (copy)
1.	Doctor's Order sheet (Both side)	• A4 Paper • 70 GSM single side black print & 100 pages pad with pasting	10000
2.	Nurses Notes (Both side)		10000
3.	Investigation Record (single side)		3000
4.	In-take Output Records (single side)		10000
5.	ADL Chart (single side)		3000
6.	Admission Discharge Record (Both side)		3000
7.	Initial assessment (7 pages both side in 1 booklet)		3000
8.	Discharge summary (5 pages both side in 1 booklet)		3000
9.	Discharge order (single side)		3000
10.	Medication treatment record (Both side)		3000
11.	Graphic sheet (T. P. R) (single side)		3000
12.	Vital signs chart (single side)		10000
13.	Consent for surgery (English) (Both side)		3000
14.	General anesthesia consent (Both side)		3000
15.	Informed consent for Peripheral Nerve Block (Both side)		3000
16.	Informed consent for Spinal /Epidural Anesthesia (Both side)		3000
17.	Surgical safety checklist (single side)		3000
18.	Pre-Operative checklist (Both side)		3000
19.	Diet List (single side)		3000
20.	Referral Form (single side)		3000
21.	Census Index (single side)		3000
22.	Consent form for the Transfusion of blood/blood components (single side)		3000
23.	Case summary Record (single side)		3000
24.	Insulin Therapy & Blood Glucose Monitoring chart (single side)		3000
25.	Operation Notes (Both side)		3000
26.	Anesthesia Record (Preanaesthesia evaluation Intraoperative Notes, Post Operative Progress) (4 pages single side boolket)		3000

(Annexure - 2)

Reference no: AIIMS/Deoghar/ IPD form/ 2023-24/01 **Date:**

[Letter head of firm]

PRICE BID FORM

To,
Assistant Procurement Officer,
AIIMS, Deoghar.
Jharkhand

Dear Sir,

I/We ..... am/are submitting the quotation for reference "QUOTATION FOR PRINTING OF IPD DOCUMENTS AT AIIMS DEOGHAR REFENRENCE NO.: AIIMS/Deoghar/ IPD FORM/ 2023-24/01, **DUE ON 21.03.2023 AT 05.00 PM"** at AIIMS Deoghar.

1. I/We have thoroughly examined, understood and accepted terms & conditions given in the enquiry document, failing which my quotation will be rejected out rightly.
2. I/We hereby offer to supply at the following rates:

S. no.	Name of Item with specification	Unit Price	GST %	Unit price With GST	Total Qty	Total cost
1						
		Total cost/ amount				
	Total cost/amount (in words)					

Note:-

- The bidder must quoted their quotation only in above said format on the letter of firm otherwise quotation will be REJECTED.
- Attached all the relevant documents asked.
- Should attach samples.

Date:

(Name):

Place:

Name of Firm/Company/Agency:

GSTIN No.:

Phone No:

Email:

(Signature of Authorized Person) _____

Seal: _____

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भारतसरकार/ Government of India

आरोग्यम् परमं सुखम्

Doctor Order Sheet

Date:.....

Pt.'s Name.....Age/Sex.....Ward/Bed No.....

IP No.....CR No.....

Doctor's Name.....

Date & Time	Progress Notes	Name & Signature

Progress

Date & Time	Progress Notes	Name & Signature

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Investigation Record

Patient Name: Age/Sex : UHID Number:	HBV:_____ HCV:_____ HIV:_____	Diagnosis: Tumor Markers:

Investigations	Date								
FBS/RBS									
Hb									
TLC									
DLC									
Platelets									
ESR									
MCV									
MCHC									
Urea									
Creatinine									
Na^+									
K^+									
Serum Uric Acid									
Bilirubin(T)									
Bilirubin(C)									
SGOT									
SGPT									
ALP									
Protein									
Albumin									
Globulin									

C/S:	Sign Name:
Radiology:	Sign Name:

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Patient's Name..... Age/Sex..... Ward/Bed No.....

IPD No..... CR No.....

Doctor's Name.....Diagnosis.....

Date & Time	NURSES NOTE	Signature

Patient's Name..... Age/Sex..... Ward/Bed No.....

IPD No..... CR No.....

Doctor's Name.....Diagnosis.....

Date & Time	NURSES NOTE	Signature

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Intake-Output Record

All I.V Fluid orders to be written Daily, Dated , Timed and Signed by Doctor

Patient Name:	Date:
Age/Sex:	Central Line DOI:
CR No:	Previous Day Intake:
Urinary cath. DOI:	Previous Day Output:
IV Cannula DOI:	Previous Day Balance:
I.V Fluid Orders:	N.O/S.N.O Signature
	M / E / N
(Doctor's Signature)	

Time	Intake			Output			
	Oral	Enteral	Parentral/ Intravenous	Urine	Gastric Losses	Bowels	Drains
Total Intake:			Total Output:		Balance:		

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Checklist of Activities of Daily Living (ADL)

NAME.....AGE/SEX.....

CR NO.....Ward.....Bed No.....

Doctor's name..... Service/Unit.....

FUNCTION	INDEPENDENT	NEEDS HELP	DEPENDENT	DOES NOT DO
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				

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ADMISSION AND DISCHARGE RECORD (AT ADMISSION)

C.R NO. | ADMISSION NO./IP No.

NAME:
AGE/SEX:
SON/DAUGHTER/WIFE OF:
MARTIAL STATUS:
ADDRESS:
STATE:
NATIONALITY: TEL/MOB NO.:
INCOME DECLARED
Rs..... .....(in words only)
NAME: Signature:
Thumb Impression:
WARD: Unit: GEN/PVT.BED NO: Name of HOD/Consultant:

(At Admission)

Adv. Sec. Deposit Rs: Receipt No: Dated: Sig. Of MRC

Date of Admission | Time | AM/PM | Date of Discharge/Death | Time | AM/PM

FINAL DIAGNOSIS: COMPULSORY BEFORE DISPATCHING RECORD TO MRD
(Please don't use Abbreviation's and Mention in capital letters)

ICD CODE NUMBER

COMPLICATION IF ANY:
SURGICAL PROCEDURES:

Name of the Surgeon Date of Operation
What was the outcome of Admission? (Please Encircle)
RECOVERED, IMPROVED, UNCHANGED, LAMA, ABSCOND, WORSE, DIED :(< 48Hrs > 48Hrs)
CAUSE OF DEATH Direct..... Autopsy No.
Underlying..... Partial/Complete
Junior Sign..... Senior Sign.....
Resident Name..... Resident Name.....
CONSULTANT Name: HOD Name:

(At Discharge)

FOR OFFICE USE (MRD)
DATE:..... SIGNATURE OF RECEIPT MRT/CLERK:.....
RECORD: (MLC/DEATH) (Tick Mark)

GENERAL CONSENT FORM

Consent is hereby given for the performance of any diagnostic Examination, treatment recommended, biopsy, transfusion operation/procedure under anaesthesia, local or general that may be deemed necessary in the proper medical/surgical care of my patient. However, I understand that before doing any unconventional treatment, specific informed consent would be taken from me.

(Name of the Patient) _____
While the patient is in Hospital.

Signature of Patient/Relative _____
Name (Capital Letters) With Address _____
_____
_____

Relationship _____

Witness Signature _____
Name (Capital Letters) With Address _____
_____

LAMA CONSENT

This is to certify that I, _____ am getting discharge against the advice of the attending physician/acknowledge that I have been informed of the risks involved and hereby release the attending physician and the hospital from all responsibility for any consequences which may result from such discharge.

Patient or Guardian's Signature _____

Thumb Impression

Witness _____

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Initial Assessment

Chief Complaints:

History of Present Illness:

Initial Assessment

Past History (DM, HTN, TB, Allergy, Drug Reactions, Surgery or any other):

Family history:

Personal history:

Sleep: Appetite:

Bowel & Bladder habits:

Diet/Nutritional Screening:

Addiction with Duration:

Drug Allergies:

Treatment History:

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General Physical Examination

Consciousness:

Built: Weight: Height:

Temperature: Pulse: Respiration: B.P:

Eyes (pallor/Icterus):

Lips:

Oral cavity:

Neck:

Nails:

Lymph nodes:

Systemic Examination

Abdomen

Inspection

Palpation:

Percussion:

Auscultation:

Cardio Vascular System

- Inspection of Pericordium:
- Palpation:
- Percussion:
- Auscultation:

Respiratory System:

- Inspection of Precordium:
- Palpation:
- Percussion:
- Auscultation:

Nervous System:

- Higher Mental functions:
- Meningeal Signs:
- Fundus:
- Cranial Nerves:
- Motor Examination:
- Sensory System:
- Reflex (Deep/Superficial):
- GCS: (E:_____V:_____M:_____=_____

Musculo Skeletal System:

Endocrine System:

Local/Other System Examination:

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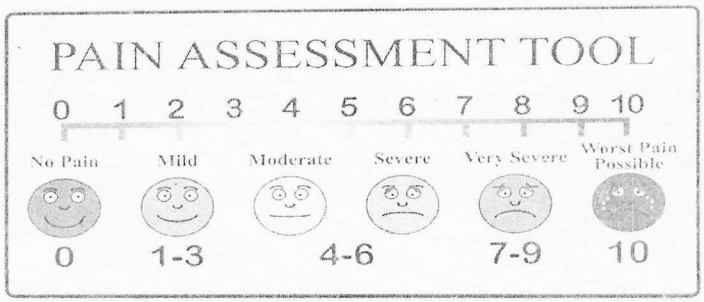
Pain Assessment:



VAS Score:

Pain Relieving Measures:

Clinical Impression/Diagnosis:

Clinical Care Plan:

J.R/S.R Signature:

Name:

Date & Time:

Consultant In-charge/HOD Signature:

Name:

Date & Time:

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DISCHARGE SUMMARY

Name _____ Age _____ Sex _____

CR No _____ IPD No. _____ Doctor's Name _____

Diagnosis _____

DOA _____ DOD _____

Associated Diseases _____

Allergic to: _____

Case Summary:

INVESTIGATIONS

Investigation	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Hb %										
TLC										
DLC										
Platelet										
ESR/CRP										
Blood Sugar										
Urea										
Creatinine										
Serum Uric Acid										
Sodium										
Potassium										
Calcium										
Phosphate										
Total Protein										
Albumin										
Total Bilirubin										
Direct Bilirubin										
Indirect Bilirubin										
SGOT/AST										
SGPT/ALT										
SAP										
PT/INR										
APTT										
BT/CT										
HIV Serology										
HCV										
HbsAg										

Others

Microbiology:

Pathology:

Radiology:

- X-ray:-
- USG:-
- CT Scan:-
- MRI:-
- Others:-

Treatment Given

Medicine	Dosage	No. Of Days

Advice on Discharge

Rx:-

Follow-up:

Note:
Please do not wait for appointment date and time during Emergency. You are requested to report to AIIMS at room no_____ During OPD hours.
In Emergency contact phone no_____

Name & Sign of Resident

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DISCHARGE ORDER

Date.....

Pt.'s Name.....Age/Sex.....Ward/Bed No.....

IP No.....CR No .....

Doctor's Name.....

Name _____

Address _____

From Room or Ward _____ Bed _____ Service _____

Attending Doctor _____

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Medication Treatment Record

Patient Name: Age/Sex: CR Number:	Height: Weight: BMI:	Diagnosis: Drug Allergies:

List of drugs prescribed		Time	Date										
			NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug.												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												
Dr's Sign	Drug:												
	Date: (Dose/Route/Frequency)												

Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												
Dr's Sign	Drug: Date: (Dose/Route/Frequency)												

Once Only Medicine (Stat Orders)

Date	Time	Medication	Dose	Route	Dr's Signature	Time Given	N.O/S.N.O Sign

Note: All the Medication Orders to be written in "Capital Letters" & to be signed by the concerned Doctor. The administration day details of all Antibiotics and High-alert drugs need to be marked with Red Pen. The Not Available (N/A); Not Given (N/G) and Withhold (W/H) Medication Details need to be informed to the respective Doctors immediately. All telephonic orders to be documented at the earliest by the concerned Doctors.

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GRAPHIC SHEET(T.P.R)

Name.. Age/Sex........... C.R No..

Doctor's Name.. Ward/Bed No..................................

DATE									
DAYS IN HOSP									
DAYS P.O.									
TIME									

C°	F°	PULSE
41.1	106°	160
40.6	105°	150
40.0	104°	140
39.4	103°	130
38.9	102°	120
38.3	101°	110
37.8	100°	100
37.2	99°	90
36.7	98°	80
36.1	97°	70
35.6	96°	60
35.0	95°	50

Respiration								
Stool								
Intake/Output								
Weight								

Nirja Xalxo

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आरोग्यम परम सुखम

Vital Signs Chart

Patient Name: CR Number:

Age/Sex: Ward/Bed No:

Diagnosis: Date of Surgery

Date	Time	Temp(F°)	Pulse (bpm)	Respiration (bpm)	B.P (mm of hg)	SPO2%	O2 Flow(Lt/min)	Pain Rating	N.O/S.N.O Sign

Note: Any **deviation in Vital Signs** needs to be documented by using Red Pen.

Neija Xalxo

ALL INDIA INSTITUTE OF MEDICAL SCIENCES DEOGHAR
अखिल भारतीय आयुर्विज्ञान संस्थान देवघर
(स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार केअधीन राष्ट्रीय महत्व का संस्थान)
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CONSENT FOR SURGERY/OPERATION PROCEDURE(S)

Patient Name: Date:

Department: Doctor's name:

CR No: Age/Sex:

Address:

1. I_____ authorize the performance of (Name of Operation)_____

_____By or under the direction of Dr._____

2. My Doctor has fully explained to me the condition requiring treatment and the nature, purpose, risk and benefits of the Operation(s)/ procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications in my own language. I was given the opportunity to ask questions and any such questions were answered to my satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science.

3. My consent is given with the understanding that any operation or procedure, including anesthesia, involves risks and hazards. The more common risks include; but are not limited to: infection, bleeding requiring blood transfusion(s), nerve injury, blood clots, heart attack, stroke, allergic reaction(s), damage to teeth and pneumonia. These risks can be serious and possibly fatal & in post-operative period, I may require re look operation & prolonged hospitalization.

4. I give my consent to the performance of operations or other procedures in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, including the implantation of medical devices, which the above named Doctor or his/her associate(s) or assistant(s) may consider necessary or advisable in the course of the operation.

5. I understand the risks, benefits, and alternatives to the type and method of anesthesia or sedation recommended, and I consent to the administration of such anesthesia as may be considered necessary or advisable by the Doctor for this surgery/procedure.

6. I give my consent to the photo graphing or video taping of the surgery or procedure(s) to be performed, including appropriate portions of my body for medical, scientific, or educational or research purposes, provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.

7. I give my consent to the presence of observer sing the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my Doctor.

8. I give my consent to the disposal of any human tissue or body part which may here move during the surgery/procedure(s).

9. I have been advised that there is a possibility of damage to teeth during surgery and administration of anesthesia, particularly if the teeth are weak, loose, decayed or artificial, and I waive any claim for damage to teeth as a result thereof.

10. I understand that if I am pregnant or if there is the possibility that I maybe pregnant, I must inform the doctor immediately since the scheduled surgery/procedure(s) could cause harm to my (unborn) child or me.

11. High Risk if any:

Signature of Patient:

Signature of witness:

Thumb Impression:

Thumb Impression:

Signature of Operating Doctor

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Department of Anaesthesiology

निश्चेतना (GENERAL ANAESTHESIA) के लिए सूचित सहमति

मैं GENERAL ANAESTHESIA के लिए मेरी सहमति देता/देती हूं, जिसके संकेत, लाभ और हानि मुझे अच्छी तरह से समझाए गए है। मैं ऊपर की गई प्रक्रिया से जुड़े संभावित परिणामों और जोखिम को समझता हूं जो कि नीचे दी गई सूची तक सीमित नही है।

पोस्टऑपरेटिव मतली और उल्टी	दर्द (जैसे सिरदर्द, पीठ दर्द)
गले में खरास	क्षणिक भ्रम या स्मृति हानि
चक्कर आना और बेहोश महसूस करना	मूत्र का पार करने में कठिनाई सॉस लेने में कठिनाइ, सीने में संक्रमण
कंपकपि	दात, होठ और जीभ को नुकसान
खुजली	अवेयरनैस
आँखों को नुकसान	नस की क्षति
मौजूदा चिकित्सा की स्थिति बदतर हो सकती है।	यांत्रिक वेंटिलेशन की आवश्यकता को सकती है।
कार्डियक की जटिलताए जैसे मायोकार्डियल इसकिमिया/इन्फार्क्शन, आरिथमियास	दवाओं से गंभीर एलर्जी से (एनाफिलेक्सिस)
रीढ की हड्डी में नसों को सथायी क्षति	उपकरण की असफलता
मृत्यु (<1 प्रति 10000)	

मैं किसी अन्य प्रक्रिया/पक्रिया में बदलाव /आइसीयू भर्ती की आवश्यकता के लिए भी मेरी सहमति देता हूँ, जैसा कि उपचार के दौरान आवश्यक समझा जाता है।

मैं आवश्यक दवाएँ देने, आवश्यकता पडने पर रक्त/ रक्त उत्पादों को चढाने के लिए अपनी सहमति देता हू।

मैं किसी भी ज्ञात एलर्जी या नशीली दवाओं की प्रतिकियाओं से पीडित नहीं हूं/हू _____ (दवा का नाम/एलर्जी)

मैं उच्च रक्तचाप/मधुमेह/थायरॉयड रोग/सांस की बीमारी/हृदय रोग या_____ किसी भी अन्य प्रमुख बीमारी से पीडित हूं/पीडित नही हूं/इलाज कर रहा हूं/इलाज पर नही हूं_____ (उपचार का विवरण)
मैं_____ के लिए मेरी सहमति नही देता। ((प्रक्रिया का नाम)/ लागू नही

मरीज/रिश्तदोर द्वारा किसी भी प्रश्न पर चर्चा

गवाह 1 हस्ताक्षर (नाम)

रोगी/ रिश्तेदार के हस्ताक्षर (नाम)

गवाह 2 हस्ताक्षर (नाम)

दिनांक और समय:

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Department of Anaesthesiology

Informed Consent for GENERAL ANAESTHESIA

I give my consent for General Anaesthesia, the indications, benefits and risk of which have been well explained to me.

I understand the possible consequences and risks associated with above said procedure which include but are not limited to the list given below:

Postoperative nausea and vomiting	Transient Confusion or memory loss
Sore throat	Difficulty passing urine
Dizziness and feeling faint	Breathing difficulty, chest infection
Shivering	Damage to teeth, lips and tongue
Itching	Awareness
Aches (like headache, backache) and pain when drugs are injected	Damage to the eyes
Equipment failure	Nerve damage
Cardiac complications like myocardiac ischaemia/infarction, arrythmias	Existing medical conditions getting worse
Permanent Damage to nerves in the spine	Respiratory failure requiring mechanical ventilation
Death(<1%)	Serious allergy to drugs (Anaphylaxis)

I also give my consent for any other procedure/ change of plan / requirement of ICU care post operatively as deemed necessary during the course of treatment.

I further give my consent for the administration of required drugs, infusions, blood/blood products, any other treatment/procedure deemed necessary.

I state that I am suffering/ not suffering from any known allergy or drug reactions..... (Name of drug / allergen applicable)

I also state that I am suffering/ Not suffering from hypertension/ diabetes/ thyroid disease/ respiratory illness/ heart disease or ..... (any other major illness) and I am on treatment / not on treatment .....(Details of treatment) I do not give my consent for ..... (Name of procedure)/ Not applicable.

Discussion on any query by patient/relative:

Witness 1: Signature/Name

Signature /Name of patient/relative

Witness 2: Signature/Name

Date & Time:

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Department of Anaesthesiology

Informed Consent for PERIPHERAL NERVE BLOCK

I give my consent for Peripheral Nerve Block, the indications, benefits and risk of which have been well explained to me.

I understand the possible consequences and risks associated with above said procedure which include but are not limited to the list given below:

Inadequate effect leading to switch to another modality of anaesthesia	Nerve injury temporary or very rarely permanent (ranging from 0.03% for supraclavicular blocks to 0.3% for femoral blocks to up to 3% for interscalene blocks)
Local anaesthetic toxicity	

I also give my consent for any other procedure/ change of plan / requirement of ICU care post operatively as deemed necessary during the course of treatment

I further give my consent for the administration of required drugs, infusions, blood/blood products, any other treatment/procedure deemed necessary.

I state that I am suffering/ not suffering from any known allergy or drug reactions..... (Name of drug / allergen applicable)

I also state that I am suffering/ Not suffering from hypertension/ diabetes/ thyroid disease/ respiratory illness/ heart disease or ..... (any other major illness) and I am on treatment / not on treatment ..... (Details of treatment)

I do not give my consent for ..... (Name of procedure)/ Not applicable.

Discussion on any query by patient/relative:

Witness 1: Signature/Name

Signature/Name of patient/relative

Witness 2: Signature/Name

Date & Time:

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आरोग्यम् परमं सुखम्

Department of Anaesthesiology

Peripheral Nerve Block के लिए सूचित सहमति

मैं **Peripheral Nerve Block** के मेरी सहमति देता हू जिसके संकेत, लाभ और हानि और लाभ मुझे अच्छी तरह से समझाए गए है। मैं ऊपर की गई प्रक्रिया से जुड़े संभावित परिणामों और जोखिम को समझता हूं जो कि नीचे दी गई सूची तक सीमित नहीं है।

अपर्याप्त प्रभाव, संज्ञाहरण के अन्य साधन पर स्विच करने के लिए अक्षमता	स्थानीय संवेदनाहारी विशाक्तता
तंत्रिका चोट अस्थायी या बहुत कम ही स्थायी (0.03: से सुप्राक्ले क्लियर ब्लॉक के लिए 0.03% फिमोरल ब्लॉक के लिए इन्टर स्किलीन ब्लॉक के लिए 3: तक)	

मैं, किसी अन्य प्रक्रिया/प्रक्रिया में बदलाव /आइसीयू भर्ती की आवश्यकता के लिए भी मेरी सहमति देता हूँ, जैसा कि उपचार के दौरान आवश्यक समझा जाता है।

मैं आवश्यक दवाएँ देने, आवश्यकता पड़ने पर रक्त/रक्त उत्पादों को चढाने के लिए अपनी सहमति देता हूँ।

मैं किसी भी ज्ञात एलर्जी या नशीली दवाओं की प्रतिक्रियाओं से पीड़ित नहीं हूं /हूं _____(दवा का नाम/एलर्जी)

मैं उच्च रक्तचाप/मधुमेह/थायरॉयड रोग/सांस की बीमारी/हृदय रोग या _____ किसी भी अन्य प्रमुख बीमारी से पीड़ित हूं/पीड़ित नहीं हूं/इलाज कर रहा हं/, इलाज पर नहीं हूं _____ (उपचार का विवरण)

मैं _____ के लिए मेरी सहमति नहीं देता। (प्रक्रिया का नाम)/लागू नहीं

मरीज/रिश्तेदार द्वारा किसी भी प्रश्न पर चर्चा:

गवाह 1 हस्ताक्षर (नाम)

रोगी/ रिश्तेदार के हस्ताक्षर (नाम)

गवाह 2 हस्ताक्षर (नाम)

दिनांक और समय:

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Department of Anaesthesiology

Informed Consent for SPINAL/ EPIDURAL ANAESTHESIA

I give my consent for Spinal/ Epidural Anaesthesia, the indications, benefits and risk of which have been well explained to me.

I understand the possible consequences and risks associated with above said procedure which include but are not limited to the list given below:

Difficulty in passing urine(urinary retention)	Itching
Shivering and/or Hypothermia	Nausea and vomiting
Headache	Low blood pressure
Existing medical conditions getting worse	Soreness at injection sites
Nerve Injury (0.1 per 10000)	LA toxicity
Abscess/Meningitis (0.3-0.6 per 10000)	Haematoma (0.06 to 01 per 10000)
Death	Serious allergy to drugs (Anaphylaxis)

I also give my consent for any other procedure/ change of plan / requirement of ICU care post operatively as deemed necessary during the course of treatment

I further give my consent for the administration of required drugs, infusions, blood/blood products, any other treatment/procedure deemed necessary.

I state that I am suffering/ not suffering from any known allergy or drug reactions.....(Name of drug/allergen applicable)

I also state that I am suffering/ Not suffering from hypertension/ diabetes/ thyroid disease/ respiratory illness/ heart disease or ..... (any other major illness) and I am on treatment / not on treatment ..... (Details of treatment)

I do not give my consent for ..... (Name of procedure)/ Not applicable.

Discussion on any query by patient/relative:

Witness 1: Signature/Name

Signature/Name of patient/relative

Witness 2: Signature/Name

Date & Time:

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Department of Anaesthesiology

Spinal and Epidural Anaesthesia/Analgesia के लिए सूचित सहमति

मैं Spinal or Epidural Anaesthesia/Analgesia के मेरी सहमति देता हू जिसके संकेत, हानि और लाभ मुझे अच्छी तरह से समझाए गए है। मैं ऊपर की गई प्रकिया से जुड़े संभावित परिणामों और जोखिम को समझता हू जो कि नीचे दी गई सूची तक सीमित नहीं है।

कम रक्त दबाव	इंजेक्शन साइटों पर दद
खुजली	मौजूदा चिकित्सा की स्थिति बदतर हो सकती है।
शब में कठिनाई (मूत्र प्रतिधारण)	एलए विशक्तता
सरदद	तंत्रिका चाटे (0.1 प्रति 10000)
मतली और उल्टी	एब्सेस/मेनिनजाइटिस (03-0.6 प्रति 10000)
कपकपी और/ या हाइपोथर्मिया	हेमेटोमा (0.06 0.1 प्रति 10000)
दवाओं से गभीर एलर्जी (एनाफिलेक्सिस)	मृत्यु (<1 प्रति 10000)

मैं, किसी अन्य प्रक्रिया/प्रक्रिया में बदलाव /आइसीयू भर्ती की आवश्यकता के लिए भी मेरी सहमति देता हूँ, जैसा कि उपचार के दौरान आवश्यक समझा जाता है।

मैं आवश्यक दवाएँ देने आवश्यकता पड़ने पर रक्त/रक्त उत्पादों को चढाने के लिए अपनी सहमति देता हूँ।

मैं किसी भी ज्ञात एलर्जी या नशीली दवाओं की प्रतिक्रियाओं से पीड़ित नहीं हूं /हू _____(दवा का नाम/एलर्जी)

मैं उच्च रक्तचाप/मधुमेह/थायरॉयड रोग/सांस की बीमारी/हृदय रोग या _____ किसी भी अन्य प्रमुख बीमारी से पीड़ित हू/पीड़ित नही हू/इलाज कर रहा ह/ू इलाज पर नहीं हू _____ (उपचार का विवरण)

मैं _____ के लिए मेरी सहमति नही देता। (प्रक्रिया का नाम)/लागू नहीं

मरीज/रिश्तेदार द्वारा किसी भी प्रश्न पर टिप्पणी:

गवाह 1 हस्ताक्षर (नाम) रोगी/ रिश्तेदार के हस्ताक्षर (नाम)

गवाह 2 हस्ताक्षर (नाम)

दिनांक और समय:

ALL INDIA INSTITUTE OF MEDICAL SCIENCES DEOGHAR
अखिल भारतीय आयुर्विज्ञान संस्थान देवघर
(स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार केअधीन राष्ट्रीय महत्व का संस्थान)
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SURGICAL SAFETY CHECKLIST

Date: _____

Before induction of anaesthesia>>>>>>	Before skin incision>>>>>>>>>>>>>>>>>>>>>>>>>	Before patient leaves operating room
SIGN IN	TIME OUT	SIGN OUT
☐ PATIENT HAS CONFIRMED • IDENTITY • SITE • PROCEDURE • CONSENT	☐ CONFIRM TEAM MEMBERS HAVE INTRODUCED INTRODUCED THEMSELEVES BY NAME AND ROLE ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM PATIENT SITE PROCEDURE	☐ NURSE VERBALLY CONFIRMS WITH THE TEAM: ☐ THE NAME OF THE PROCEDURE RECORDED ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE) ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME) ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
☐ SITE MARKED/NOT APPLICABLE		
☐ ANAESTHESIA SAFETY CHECK COMPLETED		
☐ PULSE OXIMETER ON PATIENT AND FUCNTIONING	ANTICIPATED CRITICAL EVENTS	
DOES PATIENT HAVE A: KNOWN ALLERGY? ☐ NO ☐ YES	☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTI- CIPATED BLOOD LOSS?	☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT
DIFFICULT AIRWAY/ASPIRATION RISK? ☐ NO ☐ YES, AND EQUIPMENT/ASSSISTANCE AVAILABLE	☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIPIC CONCERNS?	
RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)? ☐ NO ☐ YES AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED	NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?	
	HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES? ☐ YES ☐ NOT APPLICABLE	
	IS ESSENTIAL IMAGING DISPLAYED? ☐ YES ☐ NOT APPLICABLE	

Patients name:_____ Age/Sex:_____ C.R No._____ Ward/Bed No._____

Doctor's Name:_____ Name of the procedure:_____ Name of the Circulatory Nurse with Sign_____

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PRE-OPERATIVE CHECKLIST

Patient's Name: Date:

CR Number: Height/Weight:

Age/Gender: Ward/Unit: Doctor's name:

Procedure Name:

Sr. No	Item	Yes/No	Remarks
1	Identification Tag	Y/N	
2	Vital assessment	Y/N	Temp.....Pulse..... Respiration.....BP.....SPO_2.....
3	PAC done	Y/N	
4	Consent taken		
	1) Surgery	Y/N	
	2) Anesthesia	Y/N	
5	Nil per Oral	Y/N	From.....
6	Skin/Part Preparation	Y/N	Specify area.....
7	Bowel wash/enema given	Y/N	
8	Nail polish removed	Y/N	
9	Jewellery & belongings removed and handed over to relatives	Y/N	Specify .....
10	Dentures/ contact lens removed	Y/N	Specify .....

11	Any Medical Implant	Y/N	Specify.....
12	Bladder emptied	Y/N	
13	Iv cannula, Urinary Catheter, Ryles Tube inserted as per order	Y/N	Specify.....
14	OT gown Given	Y/N	
15	Significant past history of illness	Y/N	Specify.....
16	Any Allergy	Y/N	Specify.....
17	Blood Grouping/ cross matching	Y/N	Specify.....
18	Blood arranged	Y/N	No. of Unit.....
19	Any infection (HIV, HCV, HBsAg)	Y/N	Specify.....
20	Pre- Operative Medication	Y/N	
	.....		.....
	.....		.....
	.....		.....
	.....		.....
21	Number of Investigation Film	Y/N	MRI..... CT.....XRAY.....
			ECG.....Any Other.....

Any other

Handed Over By: Nursing Officer's Name.....Sign with date.....

Taken Over By: Nursing Officer's Name.....Sign with date.....

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अखिल भारतीय आयुर्विज्ञान संस्थान देवघर

(स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार केअधीन राष्ट्रीय महत्व का संस्थान)

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आरोग्यम् परमं सुखम्

DIET LIST

Ward Name..Date....................................

Bed No.	Patient Name	Normal Diet		Soft Diet		Liquid Diet		Optional	Sign. of Dietician
		Veg	Non-Veg	Veg	Non-Veg	Veg	Non Veg		

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Referral Form

Patient Name:	**UHID:**
Age/Sex:	**Department:**
Consultant Incharge:	
Provisional Diagnosis:	
Referred to:	
Department:	
Type of Reference: Emergency/Urgent/Routine	
Referred For: Opinion/Co- management/Transfer	
Cause of reference:	

Signature of Junior / Senior

Resident

Name of JR/SR:

Date & time:

Note: Response time for reference completion: Emergency referrals need to be addressed Immediately; Urgent referrals to be completed Within 4-6 hrs; Routine referrals to be done within 12 hrs.

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CENSUS INDEX

WARD-

DATE-

New Admission					Transfer in					
Sl. No.	Time	Name	IP No.	Bed No.	Sl. No.	Time	Name	IP No.	From	Bed No.

Discharge/Death/LAMA/Absconded					Transfer out					
Sl. No.	Time	Name	IP No.	Bed No.	Sl. No.	Time	Name	IP No.	To	Bed No.

MIDNIGHT CENSUS

	Previous Patient	New Admission	Transfer In	Transfer Out	Discharge	Death	Abscond	LAMA	Total Patient	Total Bed-	
										Occupied	Vacant
Adult											
Child											

Total No. of Patients-

Name & Sign. Of NO-

Note: - Kindly maintain index in every shift and census at midnight. (12 AM)

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Consent Form for the Transfusion of Blood/ Blood Components

Patient Name.....CR Number.....Ward No.....

Blood transfusion is a life saving medical procedure. Blood can be given as 'whole blood' or as components such as red cells, Platelets, Plasma and Cryoprecipitate.

1. I/My patient have been informed of the transfusion options available and expected benefits of transfusion of blood and/ or components.
2. I/My patient agree to the administration of blood and/or components in the interest of proper medical care.
3. I/My patient understand that blood, blood component to be administrated have been prepared and tested in accordance with rules established by national regulation. However, there is still a very small chance that in adverse reaction can occur such as fever with or without chills and rigor, itching and hives which are treatable. Rarely an unpredictable life threatening event can also occur.
4. I/My patient have been informed that despite mandatory screening for blood born infections such as HIV, Hepatitis B, Hepatitis C, Syphilis and Malaria, the risk of acquiring this infection is not totally eliminated.
5. I/My patient have had the opportunity to ask questions about transfusion, alternative to transfusion, risk of not transfusing, the procedure to the be used and relative risks and hazards involved.
6. I/My patient believe that I have been sufficiently informed to make a decision to give consent for transfusion of blood/blood components.
7. I/My patient have been informed and explained the above in language that I/My patient understand.

Authorization BY PATIENT
Signature/ Thumb impassion.....
Name of the patient.....
Date.....

Signature/.....

Signature of Doctor.....
Designation.....

AUTHORIZATION BY PATIENTS ATTENDANT/NEXT OF KIN

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

Signature/Thumb impression.....
Name.....
Relation with Patient.....
Date.....

Signature/Thumb impression.....
Name of Witness.....

Signature of Doctor.....
Designation.....

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Case Summary Records

Department.....

Date of Admission: ..... Time of Admission: .....

CR No:.....Admission No:.....	WARD.....
NAME:.....AGE/SEX.....Weight.....	UNIT.....
FATHER'S NAME.....	BED NO.....
MOTHER'S NAME.....	AYUSHMAAN BHARAT CARD NO.....
ADDRESS:.....	.....
.....	Others.....
PHONE NO.....	

Time of Discharge/Death: ..... Date of Discharge/ Death: .....

FINAL DIAGNOSIS	ICD CODE:
COMPLICATIONS IF ANY.	

SURGICAL PROCEDURES: YES/NO

Name of Surgeon: Date of Operation.

OUTCOME OF ADMISSION: (Encircle) Recovered/ Improved/ Unchanged/ Worse/ Died (<48 Hrs. />48 Hrs.)
MODE OF DISCHARGE: Discharge/ Discharge on Request/ Leaving Against Medical Advice/ Abscond

CAUSE OF DEATH:

Primary/Immediate _____

Antecedent/Underlying _____

Doctor's Name & Signature

FOR OFFICE USE MRD
Date:
Discuss with MRD
Signature of MRD/ Clerk:
Record: MLC/Death

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Insulin Therapy & Blood Glucose Monitoring Chart

Insulin Sliding Scale	Insulin (R) Dose
< 100 Mg/dl	
100 to 150 Mg/dl	
151 to 200 Mg/dl	
201 to 250 Mg/dl	
251 to 300 Mg/dl	
251 to 300 Mg/dl	
300 to 350 Mg/dl	
> 351 Mg/dl	

Patient Name :
Age/Sex :
UHID Number :
ABG :
HbA1C :
Urine Ketones :
In case of Blood sugar less than 100mg/dl (or) more than 250 mg/dl (or) any other issue, please inform to Dr.____

S.No	Insulins Prescribed	Date				
01						
02						
03						
04						
Doctor's Daily Signature						

Date	Time	Blood Sugar (mg/dl)	Insulin Dose	Signature

All India Institute of Medical Sciences, Deoghar
ANAESTHESIA RECORD

PREANAESTHESIA EVALUATION

Name:	Age / Sex:	Date:	**Diagnosis:**
Registration no.:	Ward/ Bed no.:	Dept:	

MEDICAL HISTORY

CNS:	**Procedure**:
Cardiovascular:	**ASA Status**: 1 2 3 4 5 E
Respiratory:	METS: <4 / > 4 — Preg:
	BHT: — Drugs:
Endocrine:	Tobacco: Y / N — Alcohol: Y / N
Renal/ GI/ Hepatic / MSK/ Hemat.:	Smoking: Y / N — Allergies:
Previous Surgeries:	Anaesthesia Complications: Yes/No Patient / Family _____
Medicines	Indices: (RCRI, APFEL, STOPBANG)
Others (Obs.(LMP), Paedia., etc) :	General physical exam: P/ Ict/ Cy/ Cl/ Oed Gait: Nutrition:

GPE

Physical: Wt.:_____ kg Ht: _____BMI:_____SPO_2:_____%
Vitals: BP:_____/____ PR:_____ T:_____ RR: _____

CNS:
Spine:
Neck movement: Adeq / Inadeq

EXAM

Mouth opening: Adeq./ Inadeq. MPG : 1 2 3 4 Teeth: TM distance:	**Lungs**	**Heart**

INVESTIGATIONS

Date:	Date:	Date:
Hb/ Hct: TLC: DLC: PLTs: PT/aPTT: INR:	Bld sugar (F/ PP): BUN /Cr.: S. Electro.(Na^+/ K^+): LFT: CXR: ECG:	**Other Investigations :**

Preanaesthesia Instructions
(निर्देश) –

- ऑपरेशन से 2 घंटे पहले तक, सादा पानी या निम्बू की शिकंजी पी सकते हैं।
- ऑपरेशन से 8 घंटे पहले तक, हल्का आहार ले सकते हैं।
- छोटे बच्चों को, माँ का दूध ऑपरेशन से 4 घंटे पहले तक व अन्य किसी भी प्रकार का दूध ऑपरेशन से 6 घंटे पहले तक दे सकते हैं।
- ऑपरेशन से पहले नकली दाँत, कान की मशीन, ऑखों के कोन्टेक्ट लेंस, गहने व नेल पॉलिश निकालना अनिवार्य हैं।
- ऑपरेशन के दिन प्रातः दातुन/मंजन करना अनिवार्य हैं।
- ऑपरेशन की सहमति पर मरीज / रिश्तेदार के हस्ताक्षर अनिवार्य हैं।

(Get written informed consent signed)
dications_____

Remark / References / Review PAC / Premedications –

Date:_____Name:_____Signature:_____

ANAESTHESIA RECORD
INTRAOPERATIVE NOTES

Date:		Diagnosis:	**PAC (Day of surgery)**
OT No:		Procedure:	ASA : 1 2 3 4 5 E
	Time	Anaesthetist(s):	NPO Status: Y / N
Enter OT		Surgeon(s):	Informed Consent : Y / N
Leave OT		Anaesthesia Technique : GA - Regional - IV Sedation - L/ MAC	Review History/drug: Y/N
Duration		**Vitals**: BP: ____ / ____mm Hg PR:_____/min SpO_2 :____ T: ____	Heart & Lungs:
Drugs within last 24 hrs:			Post op ICU care: Y / N If yes, _____

Preoperative Remarks: **Handover time:** **Incision time:**

Premedications: Glycopyrolate _____Midazolam_____Dexamethasone_____Lignocaine _____

Body position: Supine / Prone / Lateral (R/L) / Lithotomy / Sitting / Knee Elbow / Trendelenburg / Other _____

TIME		30 min	60 min	90 min	2 hr	2.5 hr	3 hr	3.5 hr	4 hr	4.5 hr	5 hr	5.5 hr
MONITORS	ECG											
	SpO_2											
	$EtCO_2$											
	CVP											
	TEMP											
VITAL SIGNS	BP SYST. v MEAN x DIAST ^ PULSE + SpO_2 o	260 240 220 200 180 160 140 120 100 80 60 40 20 0										
FLD												
	Urine (ml)											
VENT	Tidal Volume (ml)											
	Resp. Rate (/min)											
	Peak Pr.(cm H_2O)											
	PEEP (cm H_2O)											

Intraop. Remark

ANAESTHESIA RECORD
INTRAOPERATIVE NOTES

INDUCTION AND INTRAOPERATIVE DRUGS (DOSAGES AND TIME)											Total Dose
Oxygen (L/min)											
N_2O /Air (L/min)											
Sevo/Iso/Des/Hal											
Induction Agent											
Opioids											
NMBD (mg)											

MONITORS & EQUIPMENT

- ☐ Continuous ECG
- ☐ Pulse Oximeter
- ☐ Noninvasive BP: Left / Right
- ☐ Intraarterial B.P (Art Line____)
- ☐ Stethoscope: Precord. /Esoph.
- ☐ End Tidal CO_2
- ☐ Gas Analyzer
- ☐ Temp_____
- ☐ NMT
- ☐ BIS
- ☐ Airway Humidifier
- ☐ Fluid warmer
- ☐ NG/OG Tube
- ☐ Foley Catheter
- ☐ IV(s)_____
- ☐ CVC_____

GENERAL ANAESTHESIA

- Elective/ Rapid sequence induction
- Pre-Oxygenation
- Induction - IV / Inhalation / IM / Rectal
- Intubation / LMA / Mask

AIRWAY MANAGEMENT

- INTUBATION
  - Oral / Nasal
  - PVC / Armoured / DLT / RAE
  - Cuffed / Uncuffed
  - Under Vision/ Intubation Aids_____
  - Tube Size_____Secured at ____cm
  - Blade_____ Attempts_____
  - Breath Sounds_____
- AIRWAY: Oral / Nasal
- CIRCUIT: Closed/ Coaxial/ Non Rebreathing
- DIFFICULTY: Mask Ventilation/ Intubation/None
- CL Grade:_____
- VENTILATION: Spont./ Manual/ Mech.

REGIONAL ANAESTHESIA

- Spinal / Epidural / Block
- Block Type_____
- Position _____
- Site _____
- Technique_____
- Needle_____Attempts _____
- Drug(s) with dose_____
- Catheter: Y/N_____
- Onset of Analgesia _____
- Complications and Remarks :

FLUID CHARTING			
FLUID/BLOOD INFUSED		**FLUID LOSS**	
Name of Fluid	Amount (ml)	Type of Fluid	Amount (ml)
		Blood suction	
		Drapes	
		Total	
		GIT- Bowel/NEG	
		Urine	
		Insensible	
Total			

Ondansetron	
Time/Dose	

Reversal	
Time	
Neostigmine	
Glycopyrolate	
Extubation	
Time	

ANAESTHESIA RECOVERY

- Consciousness : Fully awake / sleepy / drowsy
- Response to pain : Adequate / Poor / Under systemic analgesia (VAS Score - _____
- Airway Reflexes : Adequate / Inadequate
- NM Recovery : Head lift_____ Tongue Protrusion _____ Power Grade _____
- Vitals : PR - _____ BP - _____ SpO_2 - _____ RR-_____ CVP - _____
- Respiration :
  - Spontaneous/ Assit. / IPPV
  - Pattern - Regular / Irregular TV – Adequate / Satisfactory / Inadequate

ANAESTHESIA RECORD
POST OPERATIVE PROGRESS

NOTES IN RECOVERY ROOM

Arrival Time :

Condition:

- Mental Status :
- Vitals: PR - _____ BP -_____ RR - _____ TEMP - _____ SpO_2 - _____
- Oxygen : ☐ Not required ☐ Nasal ☐ Mask ☐ T piece ☐ CPAP ☐ Vent Setting

General instructions:

- Position:
- Airway:
- Suction every ..... Oropharyangeal /Endotracheal
- Vital charting every ..... for .....
- Intake output charting every ..... for .....
- Oxygen Therapy :
- Investigations required :
- Treatment:
- I.V. Fluids:
- Analgesics (Systemic/ Epidural) :
- Special Measures :

Pain control acceptable	Yes / No
Agitation	Yes / No
Nausea & Vomiting	Yes / No
Shivering	Yes / No
Hypothermia	Yes / No
Respiratory complications (Airway Obstruction, Hypoventilation, Hypoxemia)	Yes / No
Circulatory Complications (Hypotension, Hypertension Arrhythmias)	Yes / No

SURGEONS TO NOTE

Following to be included in Discharge summary

Name:_____Signature: _____

Shifting Notes:

- Discharge Score: (Modified Aldrette):-
- Condition –
- Vitals - PR - _____ BP -_____ RR - _____ TEMP -_____ SpO_2 - _____
- Shifted to _____

Signature: Date & Time:

NOTES IN WARD/ ICU (By receiving nursing staff)

- Arrival Time :
- Condition:
- Vitals: PR -_____ BP -_____ RR - _____ TEMP -_____ SpO_2 - _____
- Oxygen : ☐ Not required ☐ Nasal ☐ Mask ☐ T piece ☐ CPAP ☐ Vent Setting
- Name & Signature: Date & Time:

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OPERATION NOTES

Patient Name: **Age:** **Gender: M/F**

Department: **UHID:**

Diagnosis:

Pre-operative:

Post-operative:

Surgery: **Anaesthesia: GA/Local /Spinal**

Surgeon: **Anaesthetist:**

Assistant: **Assistant:**

Assisting Nursing officer:

Operative Notes:

J.R/S.R Signature:	**Consultant Incharge:**
Name:	**Name:**
Date & Time:	**Date & Time:**

OPERATION NOTES

Post-operative Orders:

Material for warded to laboratory (If any)**:**

J.R/S.R Signature: **Name:** **Date & Time:**	**Consultant Incharge:** **Name:** **Date & Time:**