

ADMISSION SHEET



Registran Details :

Admission ID : IP22-00023331

Admit Date : 20-Jun-2026

Admit Time : 02:12 PM UHID : HCV-00039624

Patient Details :

Patient Name : Baby Of YOGITHA

Age : 4 M

Guardian : Mr P V L GANESH

DOB : 13-02-2026 05:00 PM

Gender : Male

Religion :

Occupation :

Marital Status :

Address (H) : Vepagunta Visakhapatnam Andhra Pradesh
INDIA 530047

Phone No : 9880522003/

E-mail : 9880522003@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 307

Ward Name : 3F-THIRD FLOOR

Room No : SPVT 307

Admission Type : First Visit

Contact Details :

Name : Mr P V L GANESH

Relationship : S/O

Contact Address : Vepagunta Visakhapatnam Andhra Pradesh
INDIA 530047

Phone No :

A. Yogitha
Signature

Doctor Details :

Doctor Name : Dr. TIRUMALASETTY PARAMESH

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

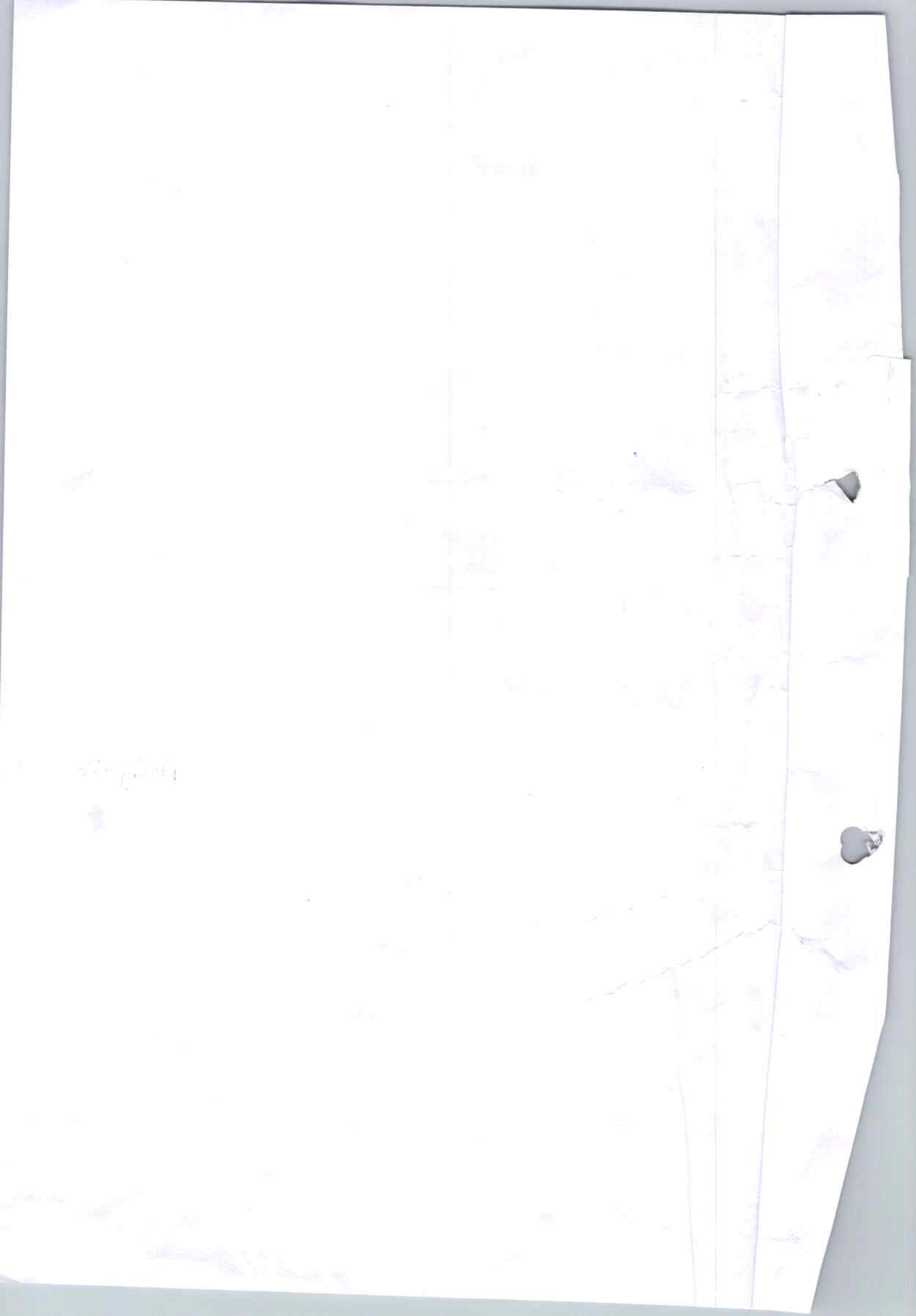
Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD



ACTIVITY RECORD FOR BILLING

Name: _____
 UHID No : HCV-00039624 IP22-00023331
 Date of Admission : Baby Of YOGITHA 13-02-2026 4 M (M) sultant : Dept.:
 Room / Bed No : Dr. TIRUMALABETTY PARAMESH
 Date of Discharge: Time:
 Suggested Billable bed type:



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/05/26	3:50pm	ER	3 rd floor (301)	Akhil

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. himajamadam	20/06/2027	690018	Akhil
2.	Dr. Anirudh	23/6/26	90662	De
3.	Dr. Y. Sushma praja (neonatologist)	25/6/26	91149	Durga
4.				cross consult by way
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
20/5/26	CRP, CRP, Electrolytes	13330 ✓	Akhil
	PBS - 75ng/dl	13331 ✓	Akhil
20/6	Blood C/S	3347 ✓	Nile
21/6	Complete stool Exam	3356 ✓	Nile
21/6	CUE	13369 ✓	Dipa
21/6	CRP, CRP, Electrolytes	3347	Nile
24/6	CRP, RFT (Urea, Creatinine, uric acid, electrolytes)	13501 ✓	Durga
24/6	Stool C/S	13522 ✓	Bandhya
24/6	Stool CALPROTECTIN	13520 ✓	Bandhya
24/6	USG Abdomen	6996 ✓	Sandhya
24/6	X-ray Erect Abdomen	007002 ✓	24/6
CRP data by 24/6			



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : _____ HCV-00039624 IP22-00023331 _____
Baby Of YOGITHA
13-02-2026 4 M (M)
UHID ID : _____ Dr. TIRUMALASSETTY PARAMESH _____
Department : _____
Consultant : _____

Padiatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- watery loose stools - 10-11 episodes

History of present illness:

→ 4 months old male with h/o loose stools, 10-11 episodes/day, not associated with blood in stools, since 2 days. H/o 20mg wt loss in 3 days

→ H/o. Reduced urine output. ~ 2 times/day & 20g

→ No H/o fever, cough, cold

→ No H/o reduced feed intake.

H/o. Jejunal atresia. S/p laparotomy ileo-jejunal anastomosis - Feb/26.

15/6/26

Stool microscopy - Normal.

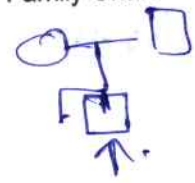
HCV-00039624 IP22-00023331
 Baby Of YOGITHA (M)
 13-02-2026 4 M
 Dr. TIRUMALASSETTY PARAMESH


Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History:

Term / NVD / LBW (2.17 kg)
 Nice admission 140 genital abuse

Family Chart



Birth & Socio Economic History:

About Father: _____
 About Mother: _____
 Any additional Information: _____

Developmental History:

(N) as per age

Immunization History:

Immunized

Anthropometry:

Head Circum (cms) _____ (Centile _____) Height (cms) _____ (Centile _____)
 Weight (kgs) 4.1 kg (Centile _____)

On Examination:

Temperature: (N) Pulse Rate: 90/min B.P. _____ SPO2 99% @ R.O.
 Resp. rate and type of breathing: RR ⊕ AE-
 MWS

Rash _____
 Lymphadenopathy _____
 Oedema: _____
 Allergies (if any): _____

HCV-00039824 IP22-00023331
Baby Of YOGITHA
13-02-2026 4 M (M)
Dr. TIRUMALABETTY PARAMESH



Respiratory System:

Inspection (any s/o distress): (N)

Air entry & breath sound : B/L ALC ⊕

Any Addees sounds : -

Relevant data from outside (Chest X-Ray, ABG, etc.,)

Cardiovascular System:

Inspection of procordium : (N)

Heart Sounds : S1 S2 ⊕

Any murmur: -

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,)

Per Abdomen:

Inspection : (N)

Palpation : act

Ausculation : BS ⊕

Spine : (N) External Genitelia : (N)

Relevant data from outside (CT.USE.etc.,)

Central Nervous System:

Level of Consciousness : AVPU / GCS Score: / (N)

Cranial Nerves : / (N)

Motor System:

Nutrition : good.

Tone: / Power 8/5

Co-ordinator : / (N)

Posture: -

Involuntary Movements : -

HCV-00039624 IP22-00023331
Baby Of YOGITHA
13-02-2026 4 M (M)
Dr. TIRUMALASSETTY PARAMESH



Reflexes:

DTR

(N)

Superficials:

(N)

Plantars

(N)

Bladder / Bowel:

(N)

Clinical Summary & Diagnostic:

Acute gastroenteritis.
slp + H/O jejunal atresia

Pediatric Multiorgan History & Physical Examination

slp → ileojejunal
anastomosis

Preventive aspects of the treatment:

Desired goals of the of the treatment:

Planned Labs:

- CBC
- Clp
- S. electrolyte

Planned Management:

- Diffusion man concentration
- Monitor urine output & stool frequency
- Continue max feed

Signature of the Doctor:

Signature of the Consultant:

Name of the Doctor: Paramesh

Name of the Consultant: Paramesh

Date & Time: 20/6/26 1pm

Date & Time: 20/6/26



DISCHARGE PLAINING FORM

Note: * To be completed by a Doctor within (24) hours of admission

1. Anticipated Date of Discharge : _____

2. Destnation Post Discharge : Home

Family Members Notified (Person Contacted _____)

Transfer

Hospital Facility Notified (Person Contacted _____)

3. Discharge Status: Self Care Family Home Care Home Professional Assistance

Needs Assistance In:

Remarks

- | | | |
|-------------------------------------|--|-------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

4. Nutritional Plan:

Ditary Instruction Discussed with the:

Patient Family Member Other:.....

5. Discharge Planning Discussed with the:

Patient Family Member Other:.....

6. Patient / Family Education Plan:

Education Topic /s :.....

Patient's Educational Topic/s discussed with the:

Patient Family Member Other:.....


Doctor Signature: _____

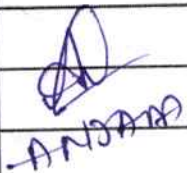
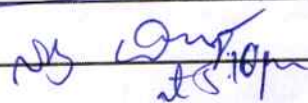
Name of the Doctor : _____

Date & Time : _____

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Ref. No. : F / HW / PGN / INPR / 15

HCV-00039824 IP22-00023331
 Patient: Baby Of YOGITHA
 13-02-2026 4 M (M)
 Age: Dr. TIRUMALABETTY PARAMESH
 I.P. N 

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
20/06/26	5pm	S/B Dr. PV / Dr. AJ AGE i some dehydration
		Afebrile
		No further loose stools
		Urine → decreased
		<u>plan</u>
		1) cont IVF-DNS @ 10ml/hr
		2) w/f urine output
		3) vitals monitoring
		4) Trace electrolytes report
		 ANJANA
20/06/26	10pm	 ANJANA

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

20/6/22
10pm

CLB Dr. Aditya / Dr. Anjana / Dr. Sumina

Ans - AGE \bar{c} some dehydration

Baby reviewed

4 episodes of loose stools

no c/o fever

no c/o dull activity (reduced) food intake

OLE

child is irritable

Adv


1. Plan to start antibiotics
2. Send Wc, Blood cl, CSE ~~urine~~ stool culture
3. cont IV fluids

h
Sumina

N.B. male

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Ref. No. : F / HW / PGN / INPR / 15

HCV-00039624 IP22-00023331
Pat Baby Of YOGITHA ...
13-02-2026 4 M (M) IF
Ag Dr. TIRUMALASETTY PARAMESH
I.P. 

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
21/6/26	8AM	<p>cl/b (Dr. Paramesh) Dr. Balaji</p> <p>Dis: AGE & some dehydrated</p> <p>cl/b jejunal atresia</p> <p>slp + ileojejunal anastomosis</p> <ul style="list-style-type: none"> • 2 episodes of loose stools. • NO clo feces. • oral intake - poor. <p><u>PIE:</u></p> <p>dull, irritabile</p> <p>• Pst BU AE(+) , cl/b</p> <p>• CUE + S11S2(+)</p> <p>• P/A + soft, non-tender</p> <p><u>Adm:</u></p> <ul style="list-style-type: none"> • cont - sup. ceftriaxone • cont. s.v fluids • trace blood cl <p>CUE, urine, Stool culture. send.</p> <p>complete stool examinal.</p> <p style="text-align: right;">Dr. BALAJI</p> <p style="text-align: right;">N.R</p> <p style="text-align: right;">R</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

21/6/26

6pm

clsb Dr. Venu / Dr. Balaji

ORIS: AGE \bar{c} some dehydrated

kleto jejunal atresia slp. Pleojejunal

• clo 8 episodes of loose stools

anastomosis

• no clo fever

• No clo vomiting

• urine \rightarrow good

OLA:

child is sleeping

• P/A: soft, non-tender

• CUS \rightarrow S1, S2 \oplus

CVE \rightarrow normal

Stool examination \rightarrow normal

Advice:

• cont. sup. ceftriaxone

• cont. sup fluids

• trace blood cl,
stool cl

Q

BALAJI

21/6/26

10pm

clsb Dr. Hanika / Dr. Balaji

child reviewed,

• clo loose stools (2 episodes)

Advice:

• ORS sachets
• Ryt cont. the same

Q BALAJI

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Ref. No. : F / HW / PGN / INPR / 15

HCV-00039824 IP22-00023331

Patient: Baby Of YOGITHA

13-02-2026

4 M

(M)

Age :

Dr. TIRUMALABETTY PARAMESH

I.P. #



DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
22/6/26	8 AM	<p>cls/B Dr. paramesh / Dr. Balaji</p> <p>DSS: AGE E Some dehydration</p> <p>klclo jejunal atresia</p> <p>slp ileojejunal anastom</p> <ul style="list-style-type: none"> • cbc 10 episodes of loose stool overnight • No cbc fever • No cbc vomiting • urine → good. <p>OLE:</p> <p>active, alert.</p> <ul style="list-style-type: none"> • cve + 31.5 (P) • PLA + Soft, non-tender <p>Admed:</p> <ul style="list-style-type: none"> • cont. sup. Ceftriaxone • D.V. DNS 15ml/hr • trace blood cl, Stool yellow cl • RFT → normal @ 6 AM. cep on 24/6/26 BALAJI • plan to discuss c paediatric gastroenterologist <p>Noted by <i>[Signature]</i></p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

22/6/26

SIB Dr. VU / Dr. Yash

5 PM

AGE with some dehydration

KIC/O - Jejunal atresia

SIP Ileojejunal anastomosis

- 5 episode of loose stool today

- No fever

- No vomit

- U/O - good

O/E - Active

RIS - clear

PIA - soft

Adm

- (+) Blood C/S

- (+) Stool C/S

- RFT, CRP on
6 AM 24/6/26

- Gastroenterology opinion

pln op
owd
22/6/26



Dr. VU

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Ref. No. : F / HW / PGN / INPR / 15

HCV-00039824 IP22-00023331

Baby Of YOGITHA

13-02-2026

4 M

(M)

Dr. TIRUMALASETTY PARAMESH

F



DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
2/6/26	10pm	cls/B Dr Anuja / Dr Sree
		Case Reviewed,
		11 episodes of loose stools since morning
		<u>o/c</u>
		sleeping
		pulsu - good
		CRP < 25
		vitals - stable
		PA: sgt BS ⊕
		u.v - good.
		<u>Plan</u>
		1) ⊕ stool c/s f blood c/s
		2) RFT, CRP on 24/6/26
		6am
		3) pediatric Ceftioz option
		for review
		→ NB Discharge at 10:30pm

[Signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

23/6/26
8am

C/S/B Dr paramush / Dr Free

D = AGE with some Dehydration
K/C/O equal at base
S/P Stereotypical Anasarca

- (small amount)
- 13 episodes of loose stools in past 24 hours
 - feed - taking well.

O/E

Alert
 pulse - good
 CRT < 3s
 P/A - soft, BS (+)
 J/O - good.

Blood cts - stool

Plan

- Gastroenterology opinion body
- RFT, CRP on 24/6/26
6am
- trace stool cts

Free
 Dr Free

N. B Sandhya
 O A 222
 23/6/26
 9AM

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Def No.: F / HW / PGN / INPR / 15

HCV-00038624

Baby Of YOGITHA

13-02-2026

4 M

Dr. TIRUMALASETTY PARAMESH (M)

IP22-00023331



F

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
	23/6/26	cls/b Dr. paramesh / Dr. Balaji
	5pm	
		<p><u>dxs:</u> AGE c some dehydration.</p> <p>kleb jejunal atresia</p> <p>slp ileojejunal anastomosis</p>
		<p>3 episodes of loose stools (semi solid)</p> <p>• NO cl. Vomiting</p> <p>• NO cl. fever</p>
		<p><u>OLE:</u></p> <p>• active, alert</p> <p>PLA + soft, non-tenes</p> <p>RI + BILAE@, clear.</p>
		<p><u>Advice:</u></p> <p>• cont sup. rehydration</p> <p>• cont Z&D drops</p> <p>• Econorm sachet</p> <p>• RFT, CRP + U/m@</p> <p>6 AM</p> <p>• Trace stool cl</p>
		<p>→ Decide on USG, Stool calprotectin TIM after lunch</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

24/6/26

SAM

cls(B Dr. paramesh) Dr. Balaj

DSS: AGE \bar{c} some dehydrator

kleb jejunal atresia

slp ileojejunal anastomosis

- clo & epithel of loose stools (semi solid + watery)
- NO clo fever
- NO clo vomiting
- Feeding \rightarrow well

OLE:

active, alert

PLA+ soft, non-tender

Bowel sound \oplus

CLL+ \bullet S1, S2 \oplus

\bullet Pulses \rightarrow present

\bullet RHT \bullet BIL AFA \oplus , clear

creatinine \rightarrow 0.2

urea \rightarrow 10.4

CRP \rightarrow 9

Advice:

- cont. sup. ceftazoxime
- cont Z&D dropl. ^{COU}
- Econorm sachet
- TO decide on USG abdomen & stool _{cl}, stool cal-protein after rounds, ^{today}

R. Balaj

N-B Sanding

04/2/26
24/6/26

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

HCV-00038624 IP22-00023331

Baby Of YOGITHA

13-02-2026 4 M (M)

Pa Dr. TIRUMALASETTY PARAMESH



Ag I.P. No. :

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
24/6/26	5pm	<p>cls/B Dr. Hanika / Dr. Balaji</p> <p><u>PHYS:</u> AGA - some dehydration Kilo jejunal atresia. slp. ileojejunal anastomosis</p> <ul style="list-style-type: none"> • clo 3 episodes of loose stool • NO clo fever • NO clo vomiting • Feeding + well <p><u>OLE:</u> active, alert. PLAY - soft, nondescript</p> <p><u>Adm:</u> • cont inj. ceftriaxone Dy / Dz</p> <p>• cont Z&D drops Econorm sachet.</p> <p><u>USG Abdomen:</u> Sub acute Bowel obstruction</p> <p><u>Signature:</u> BALAJI N/B you 24/6</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

25/6/26
8am

C/O/B Dr Paramesh/Dr Strawens

Δ = k/c/o Jeyral Ahrens

s/p Laprotomy

AGE with some Dehydration

- passed 10 episodes of loose stools - small amount.
- feed - on ~~2~~ formula feeds
- multiple whitish spots ⊕ over body

O/E

Alert.

pulse - good

Hemodynamically - stable

P/A - soft, BS ⊕

urine output - good.

Plan

4) Derm. consultation today.

1) low Δ of electrolytes
D/S/O 7

2) wft signs of dehydration

3) PO start

Neocate feeds

(1 scoop = 30ml water)

(N.B. Bland diet)

0A222

25/6/26

9AM.

Dr Straws

Fecal alproctolin
non specific

Paramesh

26/6/26
BAM

CLLB Dr. Paramesh (Dr. Balaji)

PMH: Acute gastroenteritis & some
dehydrated
ileo jejunal atresia
slp ileojejunal anastomosis

- clo 3 episodes of loose stool (semi solid)
- NO colic
- NO clo vomiting

OLE:

active alert

- PE - BIL AB⁺, alert
- PLA - soft, non-tender
- CUS - S1, S2⁺

Advice:

- Discharge + today
- cont. mediate feeds
- review on ~~next~~ Tuesday


Balaji



CONSULTATION FORM

Doctor Name : Y. Swapna Priya
Date : 25/6/26 Hour : 9:15pm

Hospital : RCM - VIZAG

Referred for : Opinion Co-Management
 Transfer of care

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
Date : Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____ M.D.

Report of Findings and Recommendations :

Thanks for Referral,
On examination Multiple papules (+) on
forehead, upper limbs and chest.
? Miliaria Rubra

Rx
1) MOMET Lotion / OINTMENT
✓—————✓ x 5-6 days
↓ After 5-6 days
twice weekly on Rash
x 3 wks

Consultant :
Name : Y. Swapna Priya Signature : Y. Swapna Date & Time : 25/6/26 9:30pm

NOTE : If more space is required use another consultation sheet as continuation

CONSULTATION FORM

Doctor Name : Dr. Himaja
Date : 20/06/2026 Hour :

Hospital : <u>Rainbow Children's</u>	Type of Referral : <input type="checkbox"/> Emergency (within one hr.)
Referred for : <input type="checkbox"/> Opinion <input type="checkbox"/> Co-Management	<input checked="" type="checkbox"/> Urgent (within 6 hrs.) <input type="checkbox"/> Non Urgent (within 24 hrs.)
<input type="checkbox"/> Transfer of care	Date : <u>20/6/26</u> Time : <u>5pm</u> By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____ M.D.

Report of Findings and Recommendations :

K/C/o jejunal atresia operated in newborn period.
now c/o loose stools & ↑ frequency : 5 days
no vomiting, no blood in stools
n/o fever ⊕.

P/A - soft
scar healthy

Δ : Viral GE

No surgical intervention needed now

Consultant :

Name : Signature : Himaja Date & Time : 20/6/26

NOTE : If more space is required use another consultation sheet as continuation

CONSULTATION FORM



Doctor Name : Dr. Anindya

Date : 23/6/26 Hour :

Hospital : RCH

Type of Referral : Emergency (within one hr.)

Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

Referred for : Opinion Co-Management

Transfer of care

Date : Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____ M.D.

Report of Findings and Recommendations :

cs/b Dr. Anindya (our care)

no ce seen @ present
 well defined Anorectal PV so c
 no ce pain ad
 Anorectal anatomy

no stool - ce

o/c : Care & Collect

PIA ——— south
 5/10

- i) use Abd
- ii) stool - Calprotectin

part of rectum
 in the lumen

- i) stool - rectum : (2)
- ii) TC : 18,000

(Plz mention reaction of
 stool - Acidic /
 Alkaline)

Signature

Consultant :

Name : Dr. Anindya

Signature : [Signature]

Date & Time : 23/6/26
5:00 p.m.

NOTE : If more space is required use another consultation sheet as continuation

RESULT SHEET

Patient Name :

Age : Ger

I.D. No. :

HCV-00030624 IP22-00023331 / 17
Baby Of YOGITHA
13-02-2026 4 M (M)
Dr. TIRUMALABETTY PARAMESH


Date	90/6/96	24/6/20			
Time					
Hb	10.1				
PCV	30.0				
RBC	3.79				
WBC	18.31				
N/L	38.5/50.9				
Platelets	2.27				
CRP	140	9			
ESR					
PCT					
RBS					
Na	134	135			
K	4.66	5.28			
Cl	102	109			
Ca/Mg					
Phosphate					
Urea		10.4			
Creatinine		0.2			
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid		5.3			
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					
Doctor's Signature					

Date	21/6/26					
Time						
CUE - Alb / <i>Protein</i>	<i>NI</i>					
CUE - Sugar	<i>NI</i>					
CUE - Ketones	<i>negative</i>					
CUE - PUS Cells	<i>1-2</i>					
CUE - RBC Cells	<i>NI</i>					
CUE / <i>epithelial cell</i>	<i>1-2</i>					
<i>C. stool Examination</i>	<i>21/6/26</i>					
Stool Pus Cell	<i>2-3</i>					
OVA / Cyst / <i>mucus</i>	<i>Absent</i>					
Occult Blood	<i>Absent</i>					
Doctor's Signature						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :


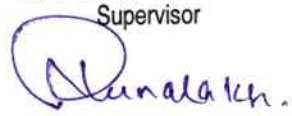
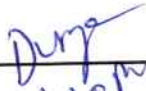
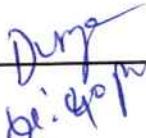
 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

PATIENT TRANSFER FORM

Patient Name / I.P. No HCV-00039624 IP22-00023331 Baby Of YOGITHA 13-02-2026 4 M (M) Dr. TIRUMALABETTY PARAMESH 	Date & Time of Admission 20/06/2026 @ 2:12pm	Date & Time of Transfer Order 20/06/2026 @ 3:50pm	
	Transfer ordered by Dr. Sreevali	Reason for Transfer Admission	
From Bed / Ward / Hospital ER	To Bed / Ward / Hospital 3 rd floor (301)	Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in clinical file 18	Number of Imaging films 10	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, What ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	DNS	2	
2.	DuSet	1	
3.			
4.			
5.			
Shifting Summary / Notes written by Doctor: Dr. Sreevali			
Name and Signature of Person filling this part Arhil.	Name of person ordering transfer Dr. Sreevali	Name & Signature of Nurse Supervisor 	Referral note & referral Doctor Name:
Patient & Clinical records received by: 			
Signature with Date & Time 			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below:

Unavailable bed

Nurse not available

Available bed not ready

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 20/06/2026 Time of arrival: @ 2:00pm
 Chief Complaints: clo loose stools RBS:
 Height: 54.5cm Weight: 4.25 BMI: Head Circumference (<2 years)
 Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify
 Pain Screening: Yes No If Yes, Pain Score: Pain Tool Used: N Pass FLACC Wong Baker
 Character Location Frequency Duration

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse : 05 min

