




ACTIVITY RECORD FOR BILLING

Name:----- HCV-00037258 IP22-00023368
 UHID No :... Master SUNDAR GOPAL BEHERA
 07-11-2019 8 Y 7 M 17 D (M) Consultant : *Dr. Shashwat* Dept.: *PICU*
 Date of Adm  Date of Discharge: *21/6/26* Time: *3p.m.*
 Room / Bed No : Ward : *PICU* Suggested Billable bed type:.....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>24/6/26</i>	<i>10:30A</i>	<i>ER</i>	<i>PICU</i>	<i>Aguna</i>

Cross Consultation Visit

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



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name

:

HCV-00037256 IP22-00023368
Master SUNDAR GOPAL BEHERA
07-11-2019 6 Y 7 M 17 D (M)
Dr. SHASHWAT MOHANTY

Sundar Gopal Behera

UHID ID

:



Department

:

Consultant

:

HCV-00037256 IP22-00023368
Master SUNDAR GOPAL BEHERA
07-11-2019 6 Y 7 M 17 D (M)



Padiatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

KILLO Thalassaemia Major
↓
Came for Blood Transfusion

History of present illness:

- No Fresh Issues

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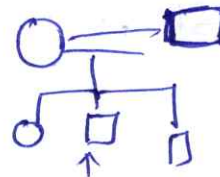
Past History : (Including details of any previous investigation or treatment)

K1110 - Thalassemia Major

Birth & Neonatal History:

Term / NVD / Well Boy

Family Chart



Birth & Socio Economic History:

About Father: _____

About Mother: _____

Any additional Information: _____

Developmental History:

Normal

Immunization History:

Done acc. to VZP

Anthropometry:

Head Circum (cms) _____ (Centile _____) Height (cms) _____ (Centile _____)

Weight (kgs) ^{13.4 kg} _____ (Centile _____)

On Examination:

Temperature: (N) Pulse Rate: 100 bpm B.P. _____ SPO2 98% RA

Resp. rate and type of breathing : _____

RR - 30/min

Rash _____

Lymphadenopathy _____

Oedema: _____

Allergies (if any): _____

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Respiratory System:

Inspection (any s/o distress): _____

Air entry & breath sound : Clear

Any Addes sounds : _____

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

Cardiovascular System:

Inspection of procordium : _____

Heart Sounds : IS1D L+

Any murmur: _____

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

Per Abdomen:

Inspection : _____

Palpation : Soft

Ausculation : _____

Spine : _____ External Genitelia : _____

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

Central Nervous System:

Level of Consciousness : AVPU / GCS Score: Active

Cranial Nerves : _____

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture: _____

Involuntary Movements : _____

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 Dr. BHASHWAT MOHANTY

DISCHARGE PLANNING FORM

Note: * 10 ... y a Doctor within (24) hours of admission

1. Anticipated Date of Discharge : _____

2. Destination 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:

Dietary 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 : _____



CONSENT FOR BLOOD TRANSFUSION

Patient Name: 1st Gopal Behera Age: 6y 7m 17d
 Gender: M F - IP No. : 23268
 Ward / Bed NO. : Plan Date : 24/6/26

Type of Blood Product: LD PRBC

I, Bhanu Charan Behera hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for HIV antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections can very rarely occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood component transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about he alternative for this procedure that.....

LD PRBC

All the above-mentioned risks have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood /or blood components (PRBC, Platelets, FFP, Cryoprecipitate etc) to me /my Patient during he present hospital stay and treatment.

Patient(Or Patient relative./ Guardian):

Signature : Bhanu Charan Behera
 Name : BHANU CHARAN BEHERA
 Date & Time : 24-06-2026, 11.00 AM

Witness:

Signature : (M)
 Name : Murali
 Address : Relt (V.B.24)

second attendant not available

Doctor(Who is taking the consent):

Signature :
 Name :
 Date & Time : 24/06/26 11AM

Contact No. :
 Date & Time : 24/06/26 11AM

రోగి పేరు వయస్సు.....పు స్త్రీ

ఐ.పి. నెంబరు వార్డు/ బెడ్ నెం
రక్త మార్పిడి రకం

నేను ఇండు మూలముగా రెయిన్ బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా (నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త భాగాల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటెటిస్ బి సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడీస్, మలేరియా మరియు సిఫిస్ లక్షణాలు లేవని పరీక్షించబడినదనియు వివరించడమైనది. రక్త పరీక్ష విండో పీరియడ్ లో జరిగినప్పటికీ మరియు పరీక్షలో కనబడని అనేక ఇతర ఇన్ ఫెక్షన్ ద్వారా అతి అరుదుగా రక్తమాలిపడి చేసినప్పుడు మార్పిడి ఇన్ ఫెక్షన్లు సోకి వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త భాగ మార్పిడికి సంబంధించిన రియాక్షన్లు సోకే ప్రమాదం వుందని, ద్రవం ఓవర్ లోడ్ మొదలగు సాధారణంగా అరుదైనది అని నేను అర్థం చేసుకున్నాను.

డాక్టర్లు ఈ ప్రక్రియలో ప్రత్యామ్నాయం గురించి నాకు/ నా రోగికి ఏమని వివరించారనగా పైన పేర్కొన్న అన్ని రకాల సమస్యలను నా రోగికి చికిత్స చేసే డాక్టరు నాకు / మాకు పూర్తిగా అర్థమయ్యే జాషలో వివరించినారు, దానికి నేను అంగీకరింస్తూ, నా రోగికి పూర్తి రక్తమార్పిడికి (మొత్తం రక్తం) / రక్త భాగాల మార్పిడికి (పి.ఆర్.బి.సి., ప్లేట్ లెట్స్, ఎఫ్.ఎఫ్.పి.) క్రయోప్రెసిపిటెట్ మొదలగునవి. మా సమ్మాతిని ఇస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు.....

పేరు.....

తేది మరియు సమయము

తేది మరియు సమయము

డాక్టర్

సంతకము

పేరు.....

తేది మరియు సమయము



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

UDPRBC

Name of the patient : Master Sunder Gopal Behera UHID : 37256 I.P. No. : 23368

Age : 6y 7m 12d Gender : M Department : paed Ward : paed

Blood group of the patient : 'B' positive Blood group on the Blood bag : 'B' positive

Blood bank issue no : 2356 Date of collection : 17/6/26 Date of expiry : 28/7/26

Date & Time of starting transfusion : 24/6/26 @ 10:30 AM Planned duration of transfusion : 6 Hours

PLEASE MONITOR THE FOLLOWING EVERY 30 MINUTES

Time	HR	Temperature	Blood pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
10:30 AM	102	97.2°f	100/45 (62)	100%	-	-	-	-
11 AM	99	96.0°f	111/43 (60)	100%	-	-	-	-
11:30 AM	109	96.1°f	111/43 (60)	96%	-	-	-	-
12 PM	105	96.5°f	111/67 (80)	98%	-	-	-	-
1 PM	113	97.3°f		99%	-	-	-	-

Comments :

Nurse Name : Nurse Signature :



PATIENT TRANSFER FORM

Patient Name / I.P. No HCV-00037258 IP22-00023368 Master SUNDAR GOPAL BEHERA 07-11-2019 8 Y 7 M 17 D (M) Dr. SHASHWAT MOHANTY 	Date & Time of Admission 24/6/26 at 9:28 AM	Date & Time of Transfer Order 24/6/26 at 10:30 AM																		
From Bed / Ward / Hospital FR	Transfer ordered by Dr.	Reason for Transfer Admission																		
To Bed / Ward / Hospital PICU	Information to attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, What ?																		
Number of Sheets in clinical file (12)	Number of Imaging films	Medications / Consumables / Surgicals / Hand over																		
<table border="1"> <thead> <tr> <th>Sl.No.</th> <th>Item Name</th> <th>Quantity</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td></tr> </tbody> </table>			Sl.No.	Item Name	Quantity	1.			2.			3.			4.			5.		
Sl.No.	Item Name	Quantity																		
1.																				
2.																				
3.																				
4.																				
5.																				
Shifting Summary / Notes written by Doctor:																				
Name and Signature of Person filling this part Aguna	Name of person ordering transfer Dr. yesh.	Name & Signature of Nurse Supervisor Dhanduini	Referral note & referral Doctor Name:																	
Patient & Clinical records received by: 24/6/26 at 10:34 AM																				
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