

ADMISSION SHEET



Registration Details :

Admission No : IP22-00023359 Admit Date : 23-Jun-2026 Admit Time : 01:26 PM UHID : HCV-00036561

Patient Details :

Patient Name : Master VEDANT VARMA DANTULURI Age : 2 Y 5 M 5 D
Guardian : Mr SANDEEP VARMA DOB : 18-01-2024
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : Marri Palem Vishakhapatnam Andhra Pradesh INDIA 530018 Phone No : 9000252599/ 9000252599
E-mail : No@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PRI 305 Ward Name : 3F-THIRD FLOOR
Room No : PRI 305 Admission Type : First Visit

Contact Details :

Name : Mr SANDEEP VARMA Relationship : S/O
Contact Address : Marri Palem Vishakhapatnam Andhra Pradesh INDIA 530018 Phone No :

Sandeep Varma
Signature


Doctor Details :

Doctor Name : Dr. Kandula RadhaKrishna / Dr. Raju Kakarlapudi Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : GENERALI CENTRAL INSURANCE COMPANY LIMITED

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/6/20	Infusion pump	2pm	24/6/20 2pm	90631	
Chairs owned by Sandhya					



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : _____ HCV-00036561 IP22-00023350 _____
Master VEDANT VARMA DANTULURI
UHID ID : _____ 18-01-2024 2 Y 5 M 5 D (M) _____
Dr. Kandula RadhaKrishna / Dr. Raju
Department : _____
Consultant : _____



HCV-00036561 IP22-00023359
Master VEDANT VARMA DANTULURI
19-01-2024 2 Y 5 M 5 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju



Padiatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

History of present illness:

clapper - at Midnight
of paroxysmal event in the form
of SOB lasting for 5 min 1 hour back.
↓
Postictally, child is lethargic
↓
Brought to ER

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Master VEDANT VARMA DANTULURI
18-01-2024 2 Y 5 M 5 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju



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

nil

Birth & Neonatal History:

7 lbs wt 3.5 kg / well baby

Family Chart



Birth & Socio Economic History:

About Father: _____

About Mother: _____

Any additional Information: _____

Developmental History:

Ⓜ

Immunization History:

upto date

Anthropometry:

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

Weight (kgs) 17.1 kg (Centile _____)

On Examination:

Temperature: 102 F Pulse Rate : _____ B.P. _____ SPO2 _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema: _____

Allergies (if any): _____

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Master VEDANT VARMA DANTULURI

18-01-2024 2 Y 6 M 6 D (M)

Dr. Kandula RadhaKrishna / Dr. Raju



Respiratory System:

BLAE (+) clear

Inspection (any s/o distress):

Air entry & breath sound :

Any Addes sounds :

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

Cardiovascular System:

S1 S2 (+)

Inspection of procordium :

Heart Sounds :

Any murmur:

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

Per Abdomen:

Abt Soft, Non tender

Inspection :

Palpation :

Ausculation :

Spine : External Genitelia :

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

Central Nervous System:

Level of Consciousness : AVPU / GCS Score: Conscious, Irritable

Cranial Nerves :

Motor System:

Nutrition :

Tone: Power

Co-ordinator :

Posture:

Involuntary Movements :

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Master VEDANT VARMA DANTULURI
16-01-2024 2 Y 5 M 5 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju



Reflexes:

DTR _____

Superficials: _____

Plantars _____

Bladder / Bowel: _____

Clinical Summary & Diagnostic: _____

Febriile Seizures

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the of the treatment: _____

Planned Labs:

CBC
CRP
Sr ch
CVE → due
N.B
Aruna
23/06/26

Planned Management:

IVR - DNS
Syr ONDGM - 4ed
Syr ESTERNA
Tab Clabazam
NIB Aruna
23/06/2026

Signature of the Doctor: _____

Aruna

Signature of the Consultant: _____

Name of the Doctor: _____

Aruna

Name of the Consultant: _____

Date & Time: _____

23/06/2026

Date & Time: _____



DISCHARGE PLANNING FORM

Note: * To be completed by 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

<input type="checkbox"/> 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 : _____

clsr Dr. RK / Dr. Raju / Dr. Balaji

24/6/26
8 AM

Hx: simple febrile seizures

- clo 2 fever spikes in last 24hr
- No clo seizures
- oral intake - good

OE:

- active, alert
- R/L - BLAEE (A), clear
- C/L - S11 (A)
- P/A - soft, non-tender

Adm:

- Encourage orally
- cont. IV fluid
- cont. clonazepam
- syp. cetirizine

Balaji

Discharge

Rx:

- Give clonazepam for 1 more day

- Syp. CETIRIZINE disal OD (3) capz

N.B. Sankar
24/6/26

24/6/26
8 AM



Patient Name : Age :
 Gender M F - Hospital No. :
 Consultant :
 Date of Admission :

HCV-00036561 IP22-00023359
 Master VEDANT VARMA DANTULURI
 18-01-2024 2 Y 5 M 5 D (M)
 Dr. Kandula RadhaKrishna / Dr. Raju



DRUG ALLERGIES :



FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : Syn. P 250				Date															
				Time	23/6	24/6													
Dose	Route	Frequency	Start Dt.																
5ml	P/O	SOS	23/6	Syn 4hr															
Doctor's Signature		Valid Period	Pharm.	[Signatures]															
Additional Instructions				Syn 1250mg Temp > 100°F Paracetamol															
DRUG : Syn. ZBUCESZC				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
8ml	P/O	SOS	23/6																
Doctor's Signature		Valid Period	Pharm.	[Signatures]															
Additional Instructions				Syn 100mg Temp > 102°F															
DRUG :				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions																			

PATIENT TRANSFER FORM

Patient Name / I.P. No HCV-00036561 IP22-00023359 Master VEDANT VARMA DANTULURI 18-01-2024 2 Y 5 M 5 D (M) Dr. Kandula RadhaKrishna / Dr. Raju		Date & Time of Admission 23/06/2026 @ 11:26pm	Date & Time of Transfer Order 23/06/2026 @
		Transfer ordered by Dr. haritha	Reason for Transfer Admission
From Bed / Ward / Hospital ER	To Bed / Ward / Hospital 3 rd floor (305)	Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in clinical file 12	Number of Imaging films	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.	DOLC	1	
2.	2U set	1	
3.			
4.			
5.			
Shifting Summary / Notes written by Doctor: Dr. haritha			
Name and Signature of Person filling this part Arune	Name of person ordering transfer Dr. haritha	Name & Signature of Nurse Supervisor Dhanalakshmi	Referral note & referral Doctor Name:
Patient & Clinical records received by: 			
Signature with Date & Time 23/06/26 2:32 PM			

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