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ACTIVITY RECORD FOR BILLING

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Name: ---------- ----------

UHID No : ---------- IP No : ---------- --------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/6/26	10:50pm.	ER	309	Bikan 10:50pm.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
4/6/26	CBP, CRP, S/E, Blood c/s	26007731	Bikam.
	LFT, PT/APTT	"	"
5/06/26	stool c/s	26007736	
5/6/26	CSE	26007766	poonam
7/06/26	CBP, CRP	26007852	
	cross checked		by Rajkumar 6/06/26 6Am

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/6/26	Infusion pump	11.20pm	5/6/26 6AM	943059	
4/6/26	USG Abdomen	(out side door) ①			Bikani

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
4/6/26	IV Canaulation	1	943027	Bikan
5/6/26	NHA	1	943258	[illegible]
	cross Checked by			Rajlaxmi 6/06/26 6AM

ANY OTHER INFORMATION of file given to the Parent's Ishwarya

Date : 4/6/26 Time : 10PM Prepared By : Bikan

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Cross checked done by Bikan 4/6/26	10.50PM		

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PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Patient Name: JOSHNITHA

UHID ID:

Department:

Consultant: Dr. Varun.

Docu. No. : RCH/FRM / GENERAL / 065

(P.T.O.)

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

→ c/o fever since yesterday
c/o loose stools since today
blood in stools evening.

History of present illness :

c/o fever since yesterday.

cm - 1 day
watery to semi solid
blood in stools
tenesmus (+).

- No vomiting

No H/o traveling / No H/o
outside food intake.

outside USG c/o colitis

KOH-00304143 IP2-00056462
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04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

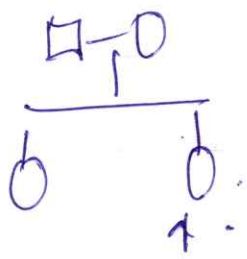
Pediatric Multiorgan History & Physical Examination

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

–

Birth & Neonatal History:

T/CHAB / NO NICU stay



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

as per age

Immunization History :

as per schedule

(P.T.O.)

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 9.3kg (Centile _____)

On Examination :

Temperature : 100°F Pulse Rate : 108/min B.P. _____ SPO2 98% on RA.

Resp.rate and type of breathing : 28/min.

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): —

Respiratory System :

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

Air entry & breath sounds : BAE (+).

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur :

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

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation :

Spine : External Genitelia :

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

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Dr. KADIRI BHANU VARUN KUMAR

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves :

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR (N) **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

conti.

(P.T.O.)

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2Y2M0D (F)
Dr. KADIRI BHANU VARUN KUMAR

→ Intake
→ Blood in nutrien
↓
inv. → Wises

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: complications.

Desired goals of the treatment : 4. Stability

Planned Labs:

CBP, CRP, S/E
CSE
Stool c/s
Blood c/s
LFT
PT/APTT/INR.

Noted by Riken

Planned Management

1) IVF
2) Inj. Ceftriaxone
3) Inj. Metronidazole.
4) Economy.

Signature of the Doctor: Dr. Bhy
Name of the Doctor: Dr Bhavani
Date & Time:

Signature of the Consultant:
Name of the Consultant:
Date & Time:

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2Y2M0D (F)
Dr. KADIRI BHANU VARUN KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. Varun :	
4/6/26 11:30pm .		
	No fresh complaints	
	O/E:	Rx
	GC-Stable	T/c Same treatment
	noted by Reylin 11.30pm. 4/06/26.	

(P.T.O)

KOH-00304143 IP2-00056462
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04-04-2024 2 Y 2 M 1 D (F)
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DGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/06/26	S/B Dr. Varun:	
	Not	
	1 episode of fever (+)	Rx
	1 episode of loose stool	T/c same treatment
	O/E:	
	GC - Stable	
	noted my Rajku 5/06/26	

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04-04-2024 2 Y 2 M 1 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	S/B. Registrar	
3:40pm		
	Complaints	
	No fever spikes	
	oral intake ⊕	
	U/O - good	
	stool - once in MM	
	vital - stable	Sd
	CVS - S1S2 ⊕	— T/c iv fluid, antibiot
	RS - clear	
	P/A soft	
		- Monitor vital
	Noted by	
	Sandhya 5/6/26	
	@ 3:40pm	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6 7PM	RD Dr David	
	Review ↓	
	1 loose stools (+)	↑ feeds
	Intake - ok	
	(+) Chydrocele - bdg	
	Plan	
		Continue same
	Noted by Dr Sandhya 5/6/26 @ 7PM	Nursing / PSVRD

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RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	S/B Dr. Varun:	
9:45 am	No fresh episodes of fever	
	O/E:	
	Child active	Rx T/c same treatment.
		CBP } TM:
		CRP }
		Trace Culture
	Noted by poonam 6/6/26 9 Am	

KOH-00304143 IP2-00056462
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Dr. KADIRI BHANU VARUN KUMAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B · Registrar	
6/6/26		
3:15 pm	Colitis	
	· stool (+) only once	
	tenesmus (+)	
	No fever spikes	
	vital stable	
	Chest clear	Adv
	P/A soft	- CBP, CRP T/M
		- Trace culture
		· Tk IV antibiotic
		- Enteroegy orally
	Noted by pediatrician 6/6/26 3:15 pm	

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D
Dr. KADIRI BHANU VARUN KUMAR (F)

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OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6 9pm	S/b Dr Anand	
	[illegible] ↓	
	[illegible] ↓	
	[illegible]	
	S(W)	NAD
	[illegible]	Continue same
		HBP CAG | [illegible]
		Monitor [illegible]
	Noted by	Poonam 6/6/2[illegible]

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

KOH-00304143 IP2-00056462
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/24		

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RESULT SHEET

Date	4/06/26	7/06/26				
Time	10.16pm	7.19am				
Hb	12.2	11.5				
PCV	37.0	34.8				
RBC	4.50	4.26				
WBC	14.38	7.95				
N/L						
Platelets	354	316				
CRP	48	11				
ESR						
PCT						
RBS						
Na	137					
K	5.0					
Cl	104					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	282					
SGPT	17					
SGOT	34					
T.Bill/Conj	0.3 / 0.1	0.2 / 0.2				
T.Protein	6.8					
S.Albumin	4.3					
S.Globulin	2.5					
A/G Ratio	1.7					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	17/1.2					
APTT	32					
CSF Protein / Sugar						
Cells						
N/L						

Date	5/06/26				
Time	12pm				
CUE - Alb					
CUE - Sugar					
CUE - Ketones					
CUE - PUS Cells					
CUE - RBC Cells					
CUE					
stool examination					
Stool Pus Cell	5-6				
~~OVA / Cyst~~ fat Globules	present (+)				
~~Occult~~ Blood	present				
mucus	present				
Undigested food	present (+)				
RBC (stool)	3-4.				

Culture and Sensitivities : Blood c/s 4/6/26 @ 4/06/26 10:16pm → 24 hrs NO Growth → 48 hrs NO Growth
5/06/26 stool c/s -f
12pm

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: 309

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 4/6/26 @ 10PM

Nurse Name & Signature: Bikani

Date & Time : 4/6/26 @ 10:10 P.M

Docu. No. : RCH / FRM / GENERAL / 090

Drug

$$\frac{\text{Doctor order} \times \text{Total ml}}{\text{Total mg}}$$

Inj; ceftriaxone 450 mg = $\frac{\text{Doctor order } 450\text{ mg} \times 5\text{ ml}}{\text{Total mg } 500\text{ mg}}$ = 4.5 ml

Inj: ~~Metrozyle~~
Metronidazole = $\frac{\text{Doctor order } 70\text{ mg} \times 100\text{ ml}}{\text{Total } 500\text{ mg}}$ = 14 ml

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DRUG CHART

Date of Admission: 4/06/26 Drug Allergies: – ☐ Not known any 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: SYP. CROCIN - DS				Date/Time
Dose	Route	Frequency	Start Date	
3ml	oral	SOS	4/06	
Doctor's Signature		Valid Period	Pharm.	
Bhu				
Additional Instructions: max 5-6 hrs T > 100°F				

DRUG: SYP. IBUGESIC				Date/Time
Dose	Route	Frequency	Start Date	5/6/26
4ml	oral	SOS	4/06	6:20 AM
Doctor's Signature		Valid Period	Pharm.	Rajini
Bhu				
Additional Instructions: max 8th hrly T > 102°F				

DRUG:				Date/Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Signature

VERIFIED BY : Name

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

REGULAR PRESCRIPTIONS

Weight. 9.3kg Ward. SNCU/PICU

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
450mg	IV	BD	4/06

Name & Signature of the Doctor Starting the Drugs: Bhy

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	4/06	5/06	6/06	7/06
6am		7:30 pm Rajitha Laxmi	Rajitha Laxmi	Rajitha Laxmi
6pm	11:30pm Rajitha	Bindhu Sunita	Poonam Laxmi	

DRUG : INJ. METRONIDAZOLE

Dose	Route	Frequency	Start Date
70mg	IV	8th	4/06

Name & Signature of the Doctor Starting the Drugs: Bhy

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	4/06	5/06	6/06	7/06
8am		Rajitha Laxmi	Rajitha Laxmi	Rajitha Laxmi
8pm	7:30 pm Rajitha Laxmi Geethika Poonam	Poonam Laxmi		
10pm	11 Bindhu Sunita	Rajitha Laxmi		

DRUG : ECONORM SACHET

Dose	Route	Frequency	Start Date
1sachet	Ora	BD	4/06

Name & Signature of the Doctor Starting the Drugs: Bhy

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	4/06	5/6	6/6
9am		11 Aziz Poonam	10:40am Poonam
9pm	11.40pm Rajitha Laxmi	11PM Rajitha Laxmi	Rajitha Laxmi

DRUG : SYP. ZINCONIA

Dose	Route	Frequency	Start Date
5ml	Oral	OD	4/06

Name & Signature of the Doctor Starting the Drugs: Bhy

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	4/06	5/06	6/06
10pm	11.30pm Rajitha Laxmi	11PM Rajitha Laxmi	Rajitha Laxmi

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KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D
Dr. KADIRI BHANU VARUN KUMAR (F)

Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG :				Date ➤ Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.																		

DRUG :				Date ➤ Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.																		

DRUG :				Date ➤ Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.																		

DRUG :				Date ➤ Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.																		

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Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤

Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤

Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤

Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤

Time ▼

Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Weight. ..... Ward. .....

VARIABLE DOSE		Date ➤ / Time								
				Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE		Date ➤ / Time								
				Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

I.V. FLUIDS CHART

Weight. 1.3 Ward. 3rd

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/06	11:20 pm	IVF - DNS (1/5th)	IV	18	[illegible]	[illegible]	5/6	Blue	[illegible]

VERIFIED BY : Name ..... Signature .....

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Patient Sticker

Joshnitha
2y2m

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 5/6/26 Time: 10.30am

Weight: 9.3kg Centile: <3rd Centile

Height: – Centile: –

Inference: Nourished.

RDA: Calories: 1000cals/day Protein: 20gm/day

Diet Recommendations: soft diet

Re-Assesment:

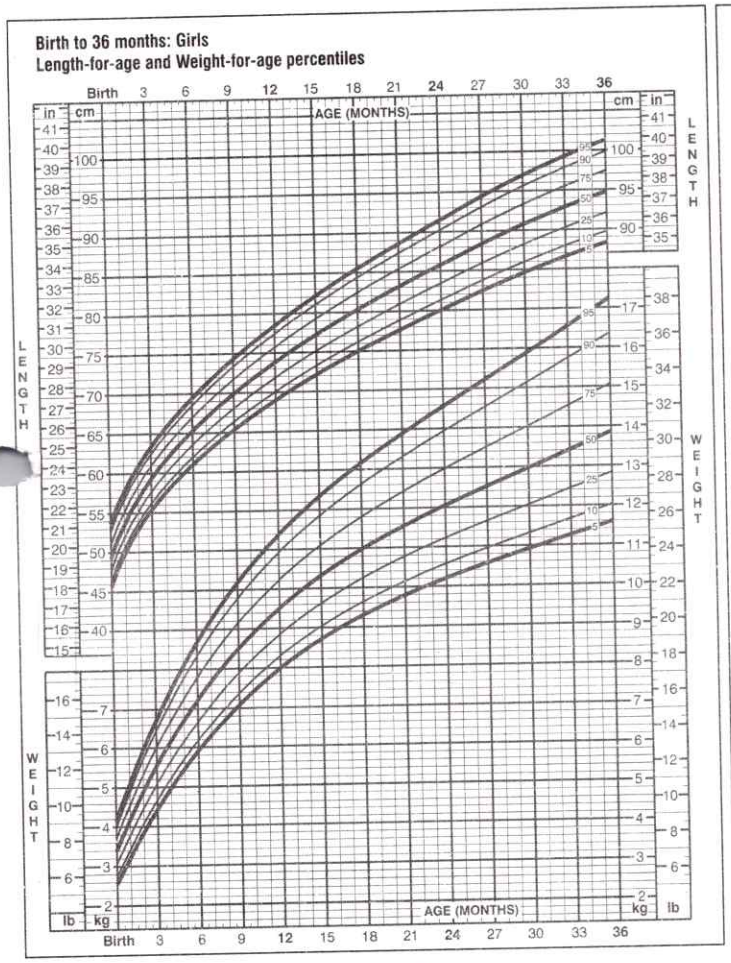
Food Allergies: NO allergies ✓Veg/Non-veg

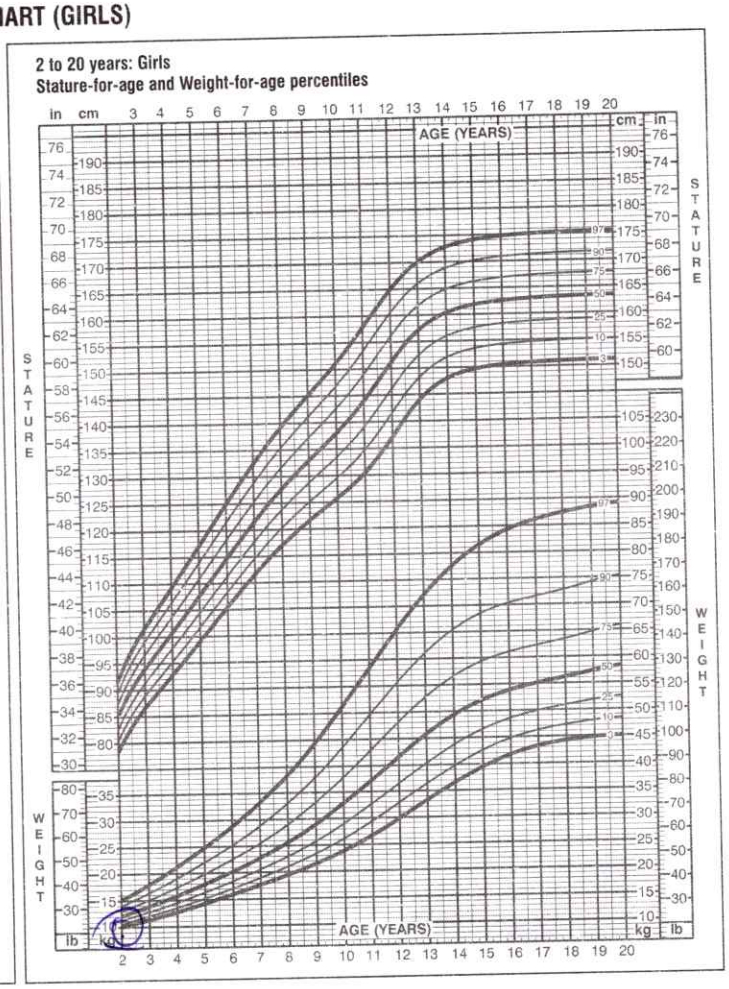
Diagnosis: Colitis

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Ishwarya

GROWTH CHART (GIRLS)





Dietician's Name: Lakshmi

Dietician's Signature:

Docu. No. : RCH /FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

No. : RCHBH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/06 .... Time:	7	8	9	10	11			12	1	2	3	4	5	6	7	8	9	10	11			12	1	2	3	4	5	6	7
Doctor / Nurse / Family Concern?																	9:30 pm					30						20	50

Temperature (°F): 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Syp Crocin DI given @ 10.0 °F; 98.5°F; 97.5°F; 97.8°F; 102.5°F; Syp. Ibugesic 4ml given; 99.2°F

Heart Rate (bpm) and Blood Pressure (mmHg) *: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

99 / 60 ; 100 / 60

Heart Rate (Number)																	140					128						121	

Resp. Rate (bpm) (Over 1 Minute) *: 70, 60, 50, 40, 30, 20, 10

Resp Rate (Number)																	36					36						34	
Resp Distress: Mod/ Severe																													
Resp Distress: None / Mild																													
Receiving O_2(l/min)																													
O_2Saturations (%)																	100%					99%						100%	
Conscious Level: Normal																													
Conscious Level: Altered																													
GCS *																	15/15					15/15						15/15	
TOTAL SCORE Number of shaded boxes																													
Pain Score																	0					0						0	
Observer's Initials																	Smith					[illegible]						[illegible]	

ACTIONS NB: Scores 3 should be recorded overleaf	
Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

7502

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

Patient N 02

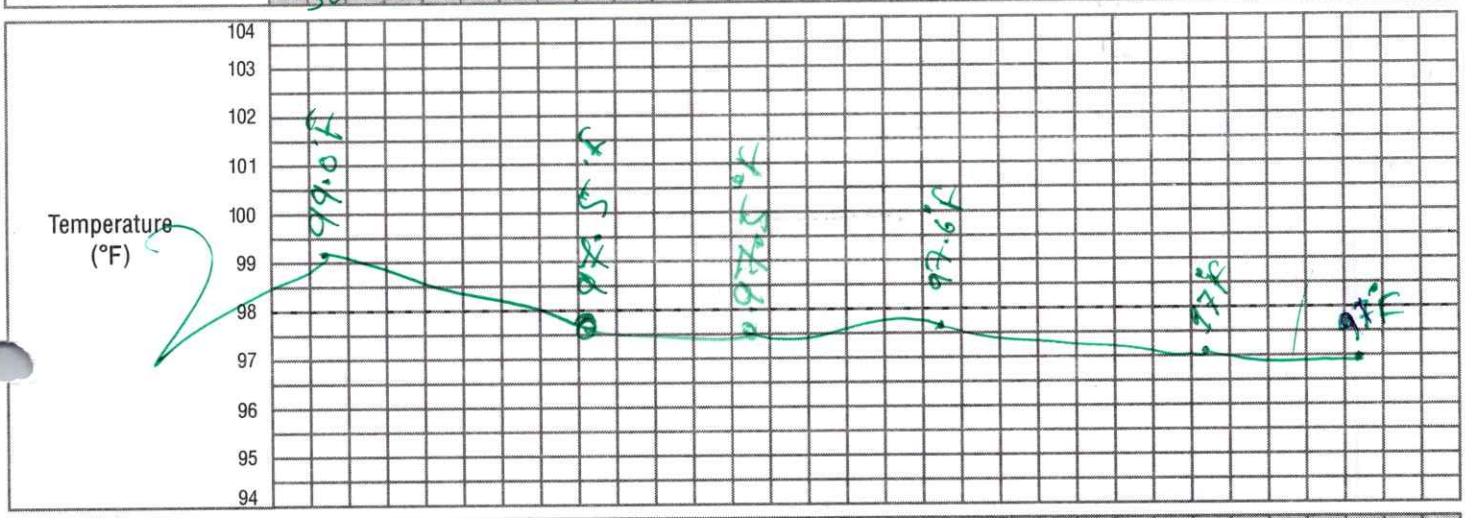
Date of .....

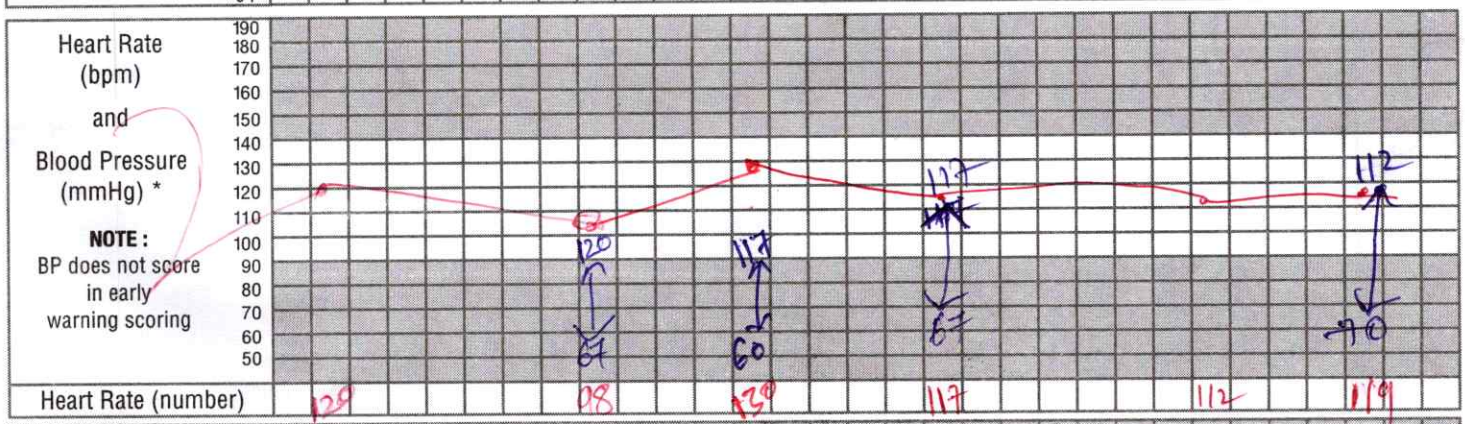
KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D (F)
Dr. KADIRI BHANU VARUN KUMAR

EARLY WARNING SCORE: CHILDREN'S

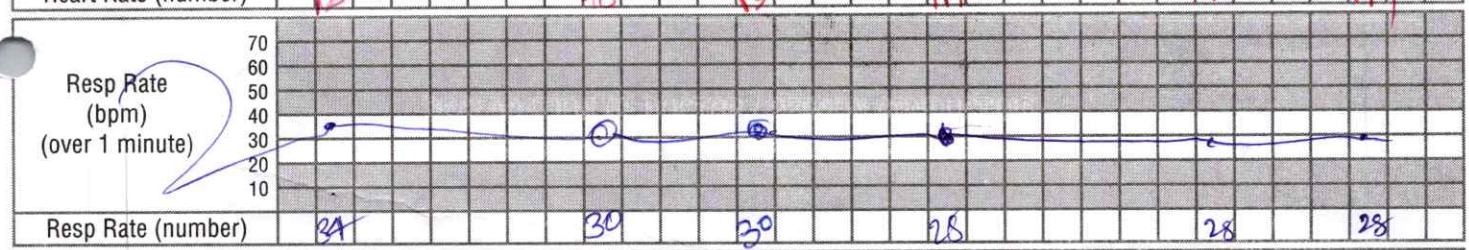
Date : 5/6 Time: 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8

Doctor / Nurse / Family Concern? 30





Heart Rate (number)	129	98	130	117	112	119



Resp Rate (number)	34	30	30	28	28	28
Resp. Mod/Severe Distress None/Mild						
Receiving O2 (L/min) O2 saturations (%)	98%	98%	98%	99%	98%	99%
Conscious Normal Level Decreased						
GCS *	15	15	15	15	0	0
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Observer's initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS	
NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

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PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

KOH-00304143 IP2-00056462 EWS / 02
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D (F)
Dr. KADIRI BHANU VARUN KUMAR

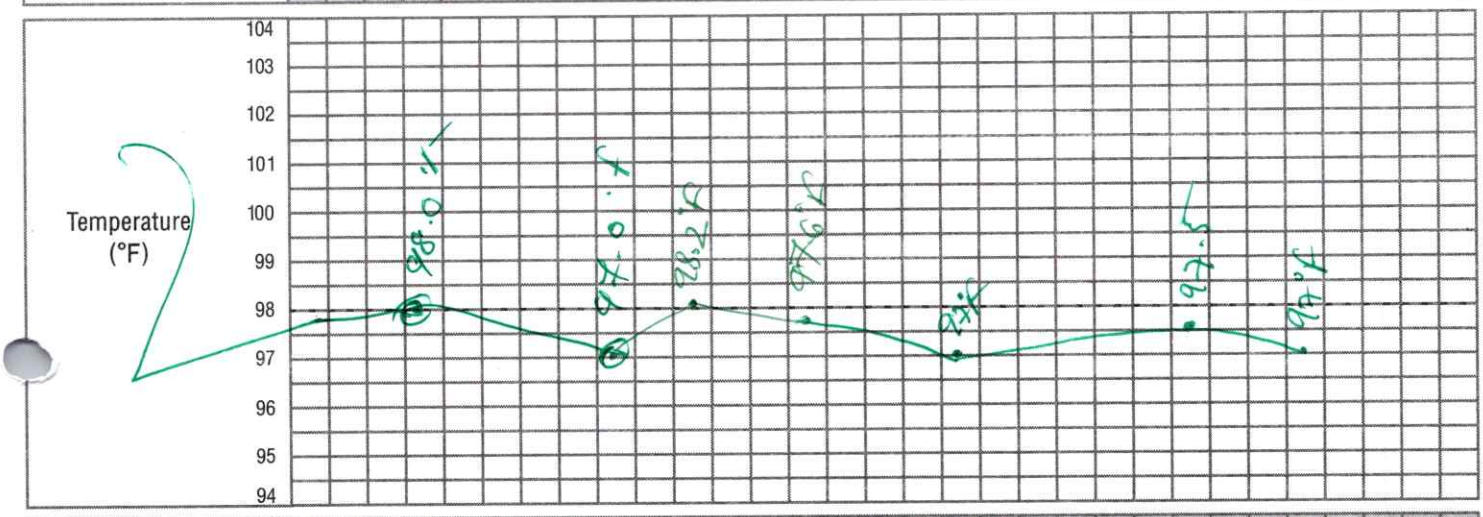
Patient .....

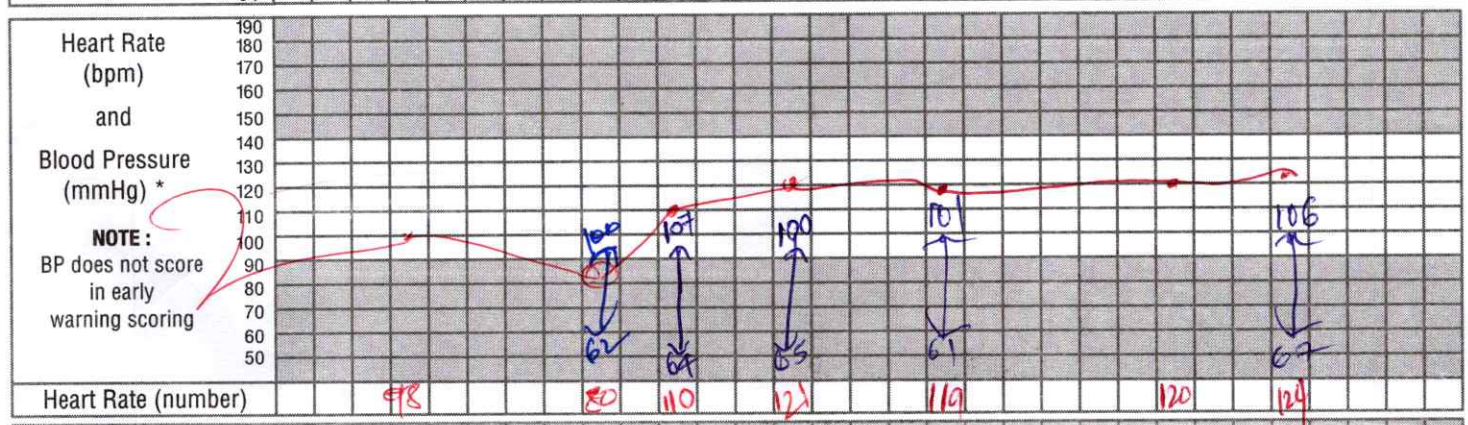
Date of .....

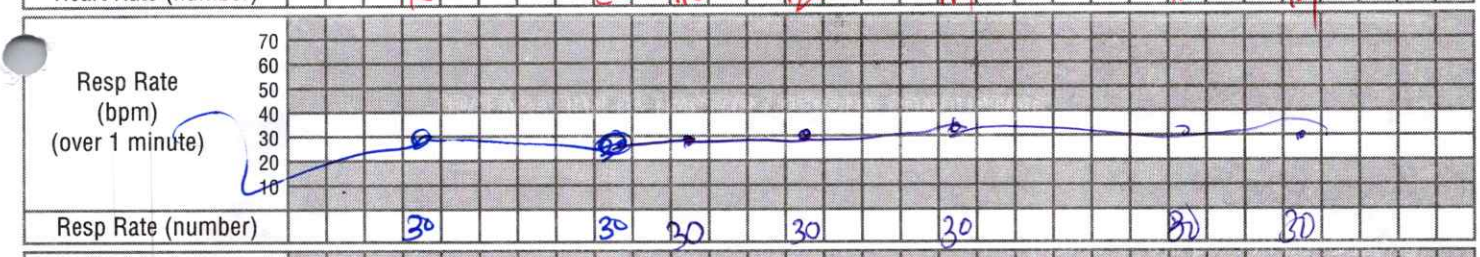
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/6/26 Time: 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8

Doctor / Nurse / Family Concern?







Resp. Mod/Severe Distress None/Mild										RA		RA			RA			RA			RA			RA						
Receiving O2 (L/min) O2 saturations (%)				98%				97%		99%		100%			99%			99%			100%									
Conscious Normal Level Decreased																														
GCS *				15/15				15/15		15/15		15/15			15/15			15/15			15/15									
TOTAL SCORE Number of shaded boxes				0				0		0		0			0			0			0									
Observer's initials				[illegible]				[illegible]		[illegible]		[illegible]			[illegible]			[illegible]			[illegible]									

ACTIONS	
NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 0 D (F)
Dr. KADIRI BHANU VARUN KUMAR

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FLUID CHART

4/06/26

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	D	~~18ml~~	18ml							0	
	12:00 am	N	small quantity	–							0	
	01:00 am	S	-Idly	18ml							0	
Total Intake : DNS 36ml, Idly						**Total Output :** U – 0 m 0						
	02:00 am			18ml								
	03:00 am	D		18ml								
	04:00 am	N	1/2 O	18ml							0	
	05:00 am	S		18ml								
	06:00 am			–							0	
	07:00 am			–								
Total Intake : DNS 72ml						**Total Output :** U – 1 m – 1						

Total 24 hrs. Intake	DNS 108ml, Idly	**Total 24 hrs. Output**	U-1 m-1

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D (F)
Dr. KADIRI BHANU VARUN KUMAR

05/06/26

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FLUID CHART

Sheet No. : 2

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	D		—							0	
	09:00 am			—								
	10:00 am	N	Semiya	18ml							0	
	11:00 am		H2O	18ml			✓			✓		Peace
	12:00 pm	S	Rice	18ml						✓	0	
	01:00 pm			18ml						✓	0	
Total Intake : Semiya Rice + H2O						Total Output : U – 2 m – 1						
	02:00 pm	D		—								
	03:00 pm		Curd	18ml							0	
	04:00 pm	N	Rice	18ml			Loose			✓	0	Smile
	05:00 pm		H2O	—							0	
	06:00 pm	S		—							0	
	07:00 pm			—								
Total Intake : DNS – 36ml + curd Rice						Total Output : U – 1 m – 01						
	08:00 pm			—								
	09:00 pm		Apple	—							0	
	10:00 pm		+	—								
	11:00 pm		H2O	—							0	H
	12:00 am	D		18ml								
	01:00 am	N S		18ml			✓			✓	0	
Total Intake : Apple + H2O 36ml						Total Output : U – 1 m – 1						
	02:00 am			18ml								
	03:00 am	D	H2O	18ml							0	
	04:00 am	N		18ml								
	05:00 am			18ml							0	H
	06:00 am	S		18ml							0	
	07:00 am											
Total Intake : DNS 90ml						Total Output : U – 0 m – 0						

Total 24 hrs. Intake	Semiya, Curd rice, Apple, Coconut water H2O, DNS 234	Total 24 hrs. Output	U – 4 m – 3

Docu. No. : RCH /FRM / CLINICAL / 092

KOH-00304143 IP2-00056462
Baby JOSHNITHA RAYAPATI
04-04-2024 2 Y 2 M 1 D (F)
Dr. KADIRI BHANU VARUN KUMAR

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FLUID CHART

Sheet No. : 3

616

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am										0	
	09:00 am		Chapati								0	
	10:00 am		egg									
	11:00 am		Panner				✓			✓	0	Pooja
	12:00 pm		H2O								0	
	01:00 pm									✓	0	
Total Intake :		Chapati egg + Panner + H2O				Total Output :				U-2		M-1
	02:00 pm											
	03:00 pm		Curd				✓					
	04:00 pm		Rice							✓	0	
	05:00 pm		H2O									
	06:00 pm		+				✓				0	
	07:00 pm		Soup Chapati							✓	0	
Total Intake :		Curd Rice + H2O + Soup + Chapati				Total Output				U-02		M-02
	08:00 pm		Apple									
	09:00 pm		fruit									
	10:00 pm		Soups								0	
	11:00 pm		H2O							✓	0	
	12:00 am										0	
	01:00 am											
Total Intake :		Apple + Soups, H2O				Total Output :				U-1		M-0
	02:00 am											
	03:00 am											
	04:00 am		H2O								0	
	05:00 am											
	06:00 am									✓	0	
	07:00 am											
Total Intake :		H2O				Total Output :				U-1		M-0

Total 24 hrs. Intake	Chapati, egg, H2O Curd rice, fruit, soups	Total 24 hrs. Output	U-6 M-3

Docu. No. : RCH /FRM / CLINICAL / 092