

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

MAH-00378391 IP2-00056549
Master VARANASI VEHAN
15-12-2024 1 Y 5 M 29 D (M)
Dr. DR. LAKSHMI K VEDAPRAKASH



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/06/28	9.05am	ER.	ER-4	Sumita

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
13/06	10 cannulation	01	945585	Sumita
In ER cross check done by Vijay 13/6/26				
13/6	N.H.A	01	945630	[Signature]
In ER cross checked by Raju 16/6/26				

ANY OTHER INFORMATION

Op file given to parents.

* V. Teja

Date: 13/06/26 Time: 8:33 AM Prepared By: Sumita

<p>Staff Nurse</p> <p>Sumita</p>	<p>Shift / Ward</p> <p>ER to ER-4</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
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Ref.No. F/IN/PR/10



**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

MAH-00378391 IP2-00056549
Master VARANASI VEHAN
15-12-2024 1 Y 5 M 29 D (M)
Dr. DR.LAKSHMI K VEDAPRAKASH



Patient Name : Varanasi Vehan .

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 11.5kg (Centile _____)

On Examination :

Temperature : 101.2° F Pulse Rate: 142 bpm Description _____

B.P. 93/59 SPO2 98% at RA

Resp. rate and type of breathing : 26 /min

Rash _____

Lymphadenopathy _____

Oedema : _____

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.,) _____

Cardiovasclular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection (N)

Palpation : Soft

Auscultation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials :

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AGE (Probable viral)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

complications

Desired goals of the treatment :

H. stability

Planned Labs :

✓ ✓ ✓
CBP, CRP, SIE
BLOOD CTS ✓
B. urea ✓, S. creat ✓
GRAs ✓, LFT ✓
g6mg/dl ✓

Planned Management :

1) IVF
2) Inj. Pantoprazole
3) Fever management

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name Dr. Bhu Date 13/06/26 Time _____

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Master VARANASI VEHAN

15-12-2024 1 Y 5 M 30 D (M)

Dr. DR. LAKSHMI K VEDAPRAKASH



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26	S/B M Lami	
09:30 AM	History reviewed	
	PM	
	vomiting 2 days	
	fever " last night high grade	
	part- 170 fetal heart rate ⊕	
	sleepy but easily arousable	
	vitals stable	
	pulses @ home	
	chest clear	
	CvC 112W	
	Ahd 1.11	
	nutruder	Plan
		- cont IV fluids
		- Gammodier
		- Monitor vitals
		- Trace Bloods &
		intraum
		- Monitor I/O
	noted by	Anu
	Wjj	Annu
	13/6/26	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/12/26	4:57 AM reg.	
11:30 AM	fever spikes present.	<u>Advice</u>
	look - stools - 2 episodal. (greenish in color)	1) CST.
	O/E	2) Fever management
	PIA - RAJA, Nontode.	3) take resp panel, bloods
	CVS - S, S (H)	4) monitor vitals.
	RIS - BILAE (F)	
	vitals - stable.	Noted by <i>[Signature]</i>
	Peripheral pulse - well felt	13/12
	4:57 AM	No. VARISE
13/12	fever spikes present	<u>Advice</u>
9 AM	look - stools present. (greenish)	- Temp down
	O/E	- 76 RR, 100 BPM, 100
	CVS 100	- 76 Temp down
	RIS 100	
	end case.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/20 0800 AM	SIB, Down	
	Femur Spikes (+) Spawning out	
	ep loose stools	
	O/E sleeping but arousable	
	Rales @ lower	
	activity good	
	Chest clear CVS & HMO	
	Ahd soft non tender	Ma & cont EV fluids
		2/3 maintenance
		& Gastro diet
		Daw transm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/26	S/B. Registrar	
3pm	Acute gastroenteritis	
	fever spikes @ bed ↓	
	oral intake - better	
	loose - stools - 3 times from AM	
	clo - good	
	vital - stable	Adv
	CXR	- TC IV fluids
	R / (N)	(2 nd)
	P/A	- gastro diet
		- 1 st antibiotic
	Noted by Sis. Bikas	- Monitor vitals

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26	S/B on dahi	
0930am	No firm patches	ATI ? Viral 1 Enteric
	Gc fair	
	mid rubeosis of Eys	
	Vitals stable	
	Cvs & thro	Pla
	Amd r/r	Stop IV fluids
	non tender	Gastro diet
		Trace cultures
15/6/26	S/B on dahi	+ CUS abdomen
0400pm		- CUE
	Gc fair	Am
	No fever or rashes	Maurty
	active	
	Cmt uen	
	Cvs & thro	Pla
	Amd r/r	
	non tender	- cont same
	started by Bikar	7. Dic Hm
	15/6/26 @ 3:30 PM	Am
		Maurty

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26	S/B on Lamin	
0915 AM	AFI / ? Viral ? Enteric	AGE = Some dehydr
	No fever spikes GC for acute cont clear	
	CVS S/T to And soft No tendu	<u>Plan</u> - Diclofenac
		- byc Ziprova x 5 days
		- Enteroquin x 5 days
		- ZCD drops 1 ml orally x 2 weeks
		FU on Sat day
		<u>Plan</u> Mucuna

Noted by
 [Signature]
 @ 16/6/26



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: ER - 4

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]

Date & Time: 13/06/2026, 8:30 AM

Nurse Name & Signature: Sunite Mura

Date & Time: 13/06/2026, 8:32 AM

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



REGULAR PRESCRIPTIONS

Weight. 11.5kg Ward.



DRUG : <u>INJ. PANTOPRAZOLE</u>				Date	<u>13/6</u>	<u>14/6</u>	<u>15/6</u>	<u>16/6</u>											
Dose	Route	Frequency	Start Date	Time	<u>9:30 am</u>	<u>6:00 am</u>	<u>8:30 am</u>	<u>6:00 am</u>											
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>13/06</u>		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>											
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>ENTEROGERMINA</u>				Date	<u>13/6</u>	<u>14/6</u>	<u>15/6</u>												
Dose	Route	Frequency	Start Date	Time	<u>9:25 am</u>	<u>6:15 am</u>	<u>10 am</u>												
<u>1vial</u>	<u>oral</u>	<u>BD</u>	<u>13/06</u>		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>												
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:				<u>9am</u> <u>6pm</u> <u>[Signature]</u>															
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>Z & D DROPS</u>				Date	<u>13/6</u>	<u>14/6</u>	<u>15/6</u>												
Dose	Route	Frequency	Start Date	Time	<u>9:40 am</u>	<u>10 am</u>	<u>10 am</u>												
<u>1ml</u>	<u>oral</u>	<u>DD</u>	<u>13/06</u>		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>												
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>TAB. FRISIUM</u>				Date	<u>13/06</u>	<u>14/6</u>	<u>15/6</u>												
Dose	Route	Frequency	Start Date	Time	<u>7:00 pm</u>	<u>10:00 am</u>	<u>12:00 pm</u>												
<u>1/2 tab</u>	<u>oral</u>	<u>BD</u>	<u>13/06</u>		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>												
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:				<u>start from evening</u> <u>9:30</u> <u>[Signature]</u>															
Daily Doctor's Endorsement by a Sign																			

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Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg) 11.6kg
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REGULAR PRESCRIPTIONS

DRUG : CEFTRIAXONE				Date	Time
Dose	Route	Frequency	Start Dt.		
500mg	IV	twice	13/6/26	13/6	14/6
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.					

MAH-00378391 IP2-00056549

Master VARANASI VEHAN

15-12-2024 1 Y 5 M 30 D (M)

Dr. DR. LAKSHMI K VEDAPRAKASH

Patient Name :

I.P. No.

Sheet No.

Wards

Weight (kg)



CLAR 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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..... IONAL HEALTH ASSESSMENT - BOYS

Date: 13/6/26 Time: 10:20am

Weight: 11.5kg Centile: 5th Centile

Height: - Centile: -

Inference: starved

RDA: - Calories: 1000 cal/day Protein: 15gm/day

Diet Recommendations: soft diet

Re-Assessment: -

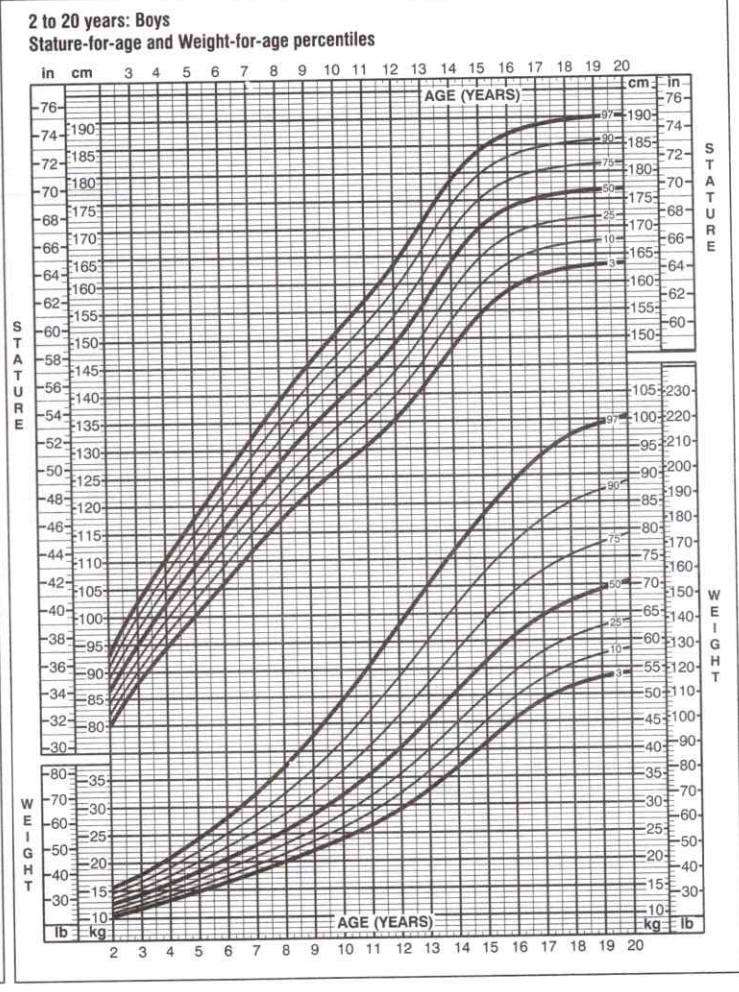
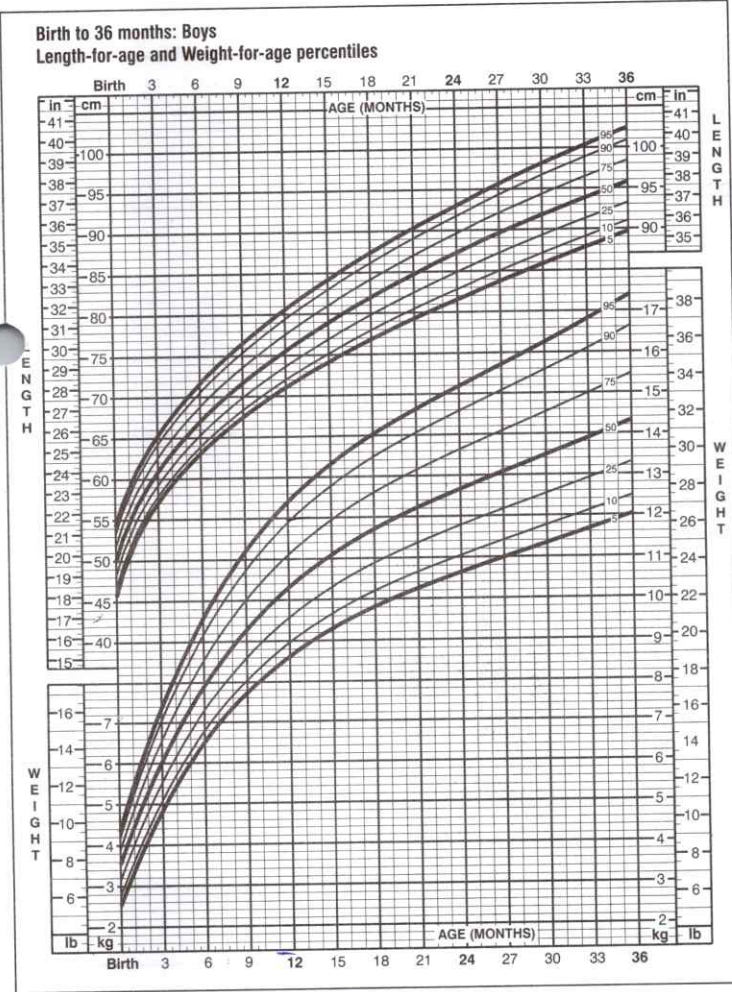
Food Allergies: no allergies Veg/Non-veg: Veg Non-veg

Diagnosis: AGE (probable viral)

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: -

GROWTH CHART (BOYS)



Dietician's Name: Lakshmi

Dietician's Signature: [Signature]



NURSING ASSESSMENT SHEET IN EMERGENCY ROOM

Ref No. : F/ ER / NUR /

Name :

Age :

IP No. : ..

UHID : ...

MAH-00378391

IP2-00056549

Master VARANASI VEHAN

15-12-2024

1 Y 5 M 29 D (M)

Dr. DR. LAKSHMI K VEDAPRAKASH



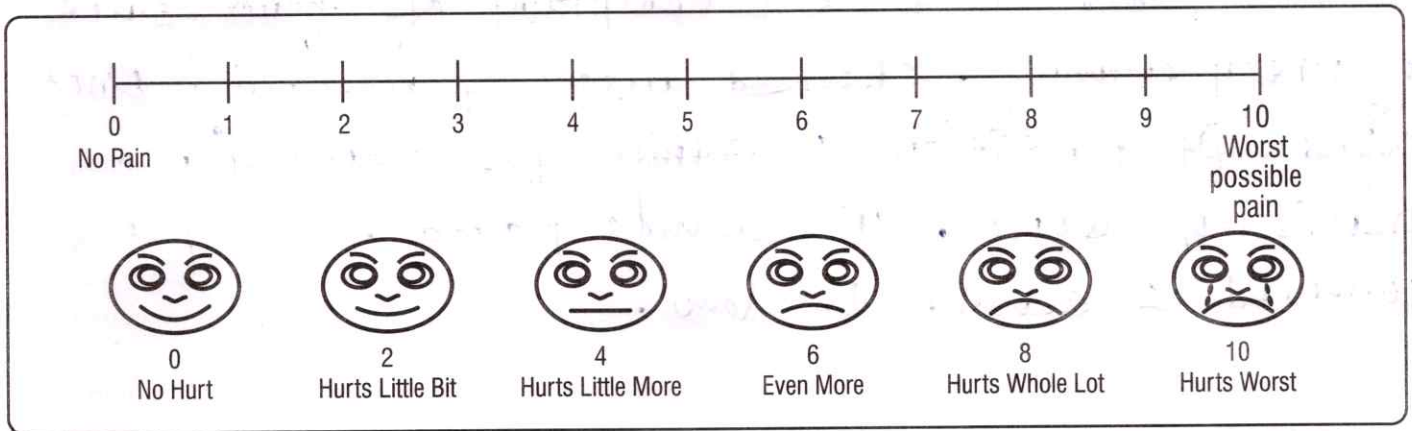
F

Date : 13/06/26 Time of arrival : 7:47 AM

VITALS : Temperature : 101.20 F HR : 142 SP02 : 98%

BP : 93/59 RR : 31 Height : Weight : 11.5 kg

PAIN ASSESSMENT - ABOVE 5 YEARS
Wong - Baker Pain Rating Scale



Do you have pain now : Yes No, If yes location of pain :

Pain Score :

Plan of action if score > 5 :

PAIN ASSESSMENT FOR CHILDREN < 5 YEARS AGE

CATEGORY	SCORING		
	0	1	2
Face	<u>No</u> particular expression or smile	Occasional grimace or frown withdraw disinterested	Frequent to constant quivering chin, clenched jaw
Legs	<u>Normal</u> position or relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	<u>Laying</u> quietly normal position, moves easily	Squirming shifting back and forth tense	Arched, right or jerking
Cry	No cry (awake or asleep)	<u>Moans</u> or whimpers Occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	<u>Content</u> , relaxed	Reassured by occasional touching hugging or being talked to, distractible	Difficult to console or comfort

Investigation sent	Time	Result Collected	Result to be collected
CBP, CRP,			
S. creat, LFT	9.30 am	ND	ND
B. Urea, Blood clt			
SRBS - 20 mgly			

Nursing Notes: Patient came to ER a complaint of fever since yesterday evening, checked vitals & recorded. Doctor assess pt condition & advice for admission. Admission done, IV cannula placed, sample collected & send to lab.

DISCHARGED FROM EMERGENCY ROOM TO :

- Ward
 OT
 HOME
 DAMA
 Died
 PICU
 NICU
 MICU
 Labour Room

Nurse Signature: Sm

Nurse Name: Sm. To Mura

Date: 13/06/26 Time: 8:25 AM