209 D.C

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Master ACHYUTHA RAM PEDDI	**UHID**	HNH-00015860
Father/Guardian	Mr jayaveer peddi	**Age/Gender**	4 Y 9 M 5 D/ Male
Address	Malakpet, Hyderabad Race Club, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006534	**Admission Date**	08-06-2026
Ref Doctor	SELF		
Discharge Date	09.06.2026		

Consultant:
Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
INFLUENZA A ILLNESS	

History: Master ACHYUTHA RAM PEDDI, 4 Y 9 M 5 D , old boy presented with history of fever, cough, dull activity since 2 days prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was febrile(102*F). His heart rate was 135/min, Blood pressure - 104/70 mmHg and Respiratory Rate - 30 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs

Name	Master ACHYUTHA RAM PEDDI	UHID	HNH-00015860
IP No	IP26-00006534	Admission Date	08-06-2026

of dehydration were present, strawberry tongue, tonsillar hypertrophy grade II with congestion were present . On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 15.8 kilo grams.

Investigations: Enclosed reports.

Adenovirus PCR was not detected.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was

SARS-CoV-2	NEGATIVE
Influenza A	**POSITIVE**
Influenza B	NEGATIVE
Respiratory Syncytial Virus (RSV)	NEGATIVE

Initial hemogram showed Hemoglobin of 11.4 gm%, White Blood Cell count of 4460 cells/cumm, platelet count of 1.83 lakhs/cumm and C-Reactive Protein of 5 mg/l. Complete urine examination shows 3-4 pus cells, 2-3 epithelial cells. Blood culture and sensitivity shows no growth after 24 hours of incubation. Dengue NS1was not detected.

Chest X-ray shows
There are mildly increased perihilar and peribronchial markings bilaterally, in keeping with lower respiratory

Name	Master ACHYUTHA RAM PEDDI	UHID	HNH-00015860
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tract inflammatory changes - ? Viral in etiology.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics.
Fever workup done reports showed Influenza A was positive, child was started on Oseltamivir.
He was regularly monitored for fever spikes, hemodynamic status, vital parameters, His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Medication during hospital stay:
Injection. Amoxiclav
Injection. Esomeprazole
Syp. Relent Plus
Injection. Ondansetron
Nasoclear nasal drops
Syrup. Fluvir

Advice:
* Diet as advised.

Name	Master ACHYUTHA RAM PEDDI	**UHID**	HNH-00015860
IP No	IP26-00006534	**Admission Date**	08-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. FLUVIR (OSELTAMIVIR – 5ml/60mg)	2.5 ml	9am-9pm (after food)	For 3 days. TILL 12/6/2026 NIGHT
2	Syrup. ONDEM (Ondansetron – 5ml/2mg)	5 ml	7am-7pm (30 minutes before food)	SOS
3	Syrup. RELENT PLUS (Cetrizine 5mg, Ambroxol 30mg/5ml)	2.5 ml	8am-8pm (1 hour before food)	For 3 days.
4	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. ANIKET ANIL PARASHAR on (12.06.2026) Friday at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* Food can decrease the absorption of **antihistamines.** Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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Name	Master ACHYUTHA RAM PEDDI	**UHID**	HNH-00015860
IP No	IP26-00006534	**Admission Date**	08-06-2026

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122.**
You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

R

MASTER ACHYUTHA RAM REDDY 4Y 9M 6D HN-0001586O CHEST PA 08 Jun 26 8:22 AM
RAINBOW CHILDREN'S HOSPITAL, HIMAYATH NAGAR

309
AE1 complex

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006534 **Admit Date** : 08-Jun-2026 **Admit Time** : 12:31 AM **UHID** : HNH-00015860

Patient Details :

Patient Name	: Master ACHYUTHA RAM PEDDI	**Age**	: 4 Y 9 M 5 D
Guardian	: Mr jayaveer peddi	**DOB**	: 03-09-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Malakpet Hyderabad Race Club Hyderabad Telangana INDIA 500036	**Phone No**	: 7093397172/ 7093397172
		E-mail	: jayaveerpeddi@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr jayaveer peddi **Relationship** : Father

Contact Address : Malakpet Hyderabad Race Club Hyderabad Telangana INDIA 500036 **Phone No** : 7093397172

Jayaveer P
Signature

Doctor Details :

Doctor Name : Dr. ANIKET ANIL PARASHAR **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. PRITESH NAGAR

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

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ACTIVI HNH-00015860 IP26-00006534 Master ACHYUTHA RAM PEDDI 03-09-2021 4 Y 9 M 6 D (M) Dr. ANIKET ANIL PARASHAR **IG**

Name: --

UHID No : ---------- IP No : ---------- Consultant : ---------- Dept : pediatrics

Date of Admission : 8/6/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	1;30am	ER	ward (209)	Bhargavi

Cross Consultation Visit

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

HNH-00015850 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

INVESTIGATIONS

Date	Investigations	Order No.	Sign
8/6/26	CBP, CRP		
	Dengue NS1		
	Blood C/S	9504	[signature]
	Respiratory panel		
	VBG	9505	
8/6/26	Chest x-ray	06867	[signature]
8/6/26	CUE	9511	[signature]

cross check done by sr. sandhya

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
8/6/26	Infusion pump	2:30 am.	9/6/26 10AM	05160	

cross check done by Sr. Sandhya

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
8/6/26	IV placement	01	5143	
			cross check done	
8/6/26	NHH	(1)	5882	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00015850 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- fever :: 2days
- do cough :: 2days
- do due evening :: 2days.

History of present illness :

child do fever :: 2days - high grade alw
chills - not relieving i medications

do cough :: dry cough
no nocturnal variations.

- Paring urine adequately.

- no do vomitings / Pain abdomen / loose stools / Sathypnea.

Pediatric Multiorgan History & Physical Examination

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

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

Birth & Neonatal History :

term / no NICU admission / CIAB / 2.8 kg

Birth & Socio Economic History :

About Father :

About Mother : mother - had fever 1 day ago.

Any additional Information :

Developmental History :

upto date

Immunization History :

upto date

Anthropometry

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

Weight (kgs) 15.83kg (Centile _____)

On Examination :

Temperature : 102°F Pulse Rate: 135bpm Description _____

B.P. 104/70 SPO2 98 at RA

Resp. rate and type of breathing : 30 cpm

Rash (-) signs of dehydration (+)

Lymphadenopathy (-)

Oedema : (-) oral cavity - strawberry tongue (+)

Respiratory system :

- tonsilar congestion

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE (+) more

Any addes sounds : _____ - hypertrophy (+) grade II.

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

Cardiovasclular System :

Inspection of procordium : S1 S2 (+)

Heart Sounds : no murmurs

Any murmur : _____

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

Per Abdomen :

Inspection soft

Palpation : no distension

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score :

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

AF 1 c dehydration

Pediatric Multiorgan History & Physical Examination

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP
CRP, VBG
Resp. panel
chest X Ray } Due
ECG (Due)
Blood cls.
dengue NS1

NB Sign
8/6/26

Planned Management :

1) IVF
2) IV amoxicillin
3)

NB Sign
8/6/26

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 D. Anitha on whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. Sneyha	
8/6/26		Plan
7:30 AM	D AFI E dehydration	
	Fever spikes (↑)	✓ C/F AMOXICLAV
	CVS - S1 S2 (+)	
	RS - B/L - AE (+)	✓ Trace Resp. panel Dengue NS1
	P/A - Soft	
	Conscious	✓ Encourage orally
	c/o vomiting	✓ C/F IV fluids
		✓ 13-Sugar Inj. ONDANSETRON 2mg IV TID
8/6/26 10 AM	S/B Dr. Aniketa	
	D AFI E dehydration	NB Sunanda
	? Viral pneumonia	Plan
	Fever spikes (+)	- C/F AMOXICLAV
	CVS - S1 S2 (+)	
	RS - B/L - AE (+)	- Trace Resp panel (5 viruses) Dengue NS 1
	P/A - Soft	
	Conscious	- C/F IV fluids
		Dr. Aniket

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/06/26 2:40PM	C/b/b - Dr. Sumanth / Dr. Anusha	
	Influenza A illness	
	(fever ⊕ 2:20 AM / c/o mouth breathing)	
	O/E: A.C - fair Hemodynamically stable (Hydration - good)	
	S/E - RS: BLAE ⊕	
		Adv - IV fluids (2/3 M) - Inj ~~[illegible]~~ Amoxiclav - Syp. Fluvir - Supportive care - Monitor vitals and inform SOS - ENT Opinion Sumanth
		B Sneha

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

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/c/s. D. Paeds	
08/06/26 5PM	Influenza A Illness pneumonia	
	fever (+)	
	poor oral intake	
	O/E. GC-fair	
	vitals: stable	
	Hydration - good	
		Adv
		- Stop. Inj Amoxiclav
		- Syp. Fluvir. x 5 days
		- Supportive care
		- Monitor vitals and
		Inform SOS
	IV fluid stop	[signature]
	If poor oral intake	
	↳ Restart after 4 hours	
		N/B Sn

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4Y9M5D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 8AM	c/s/B- Dr. Prashanti Influenz A Pneumonia. last fever spike at 3pm. poor oral intake. O/E vitals stable S/E RS - B/LAE +, N/o Added sounds	Rl aw - stop IV fluids - Stop IV Amoxyclav - c f fluvir (oseltamivir) - Nasoclear - ondaw - Esomeprazole - Relent plus - Antipyretic - Monitor vitals 6 hrly NBM after tea

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI (M)
03-09-2021 4 Y 9 M 5 D
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Pavitesh	
9/6		
9.00Am	Influenza A illness.	
	No fever.	Plan
	oral intake - poor.	
		- cont fluvir.
	Vitals - stable.	
		- Encourage orally
	R/S - B/L AE@P	
	P/A - Soft, NT	- Monitor vitals
		- Discharge today
		NB Smoke cessation

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

NH-00015860 IP26-00006534
laster ACHYUTHA RAM PEDDI
3-09-2021 4 Y 9 M 5 D (M)
r. ANIKET ANIL PARASHAR

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RESULT SHEET

Date	8/6/26					
Time						
Hb	11.4					
PCV	32.0					
RBC	4.32					
WBC	4.46					
N/L	66.3/17.9					
Platelets	183					
CRP	5.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	8/6					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	Present ++					
CUE - PUS Cells	3-4					
CUE - RBC Cells	2-4					
CUE - Nitrite	Negative					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue NS1 :— -ve						
Respiratory panel :— A +ve						
Flu — ⊕ ve						
Adeno — (-ve)						

Culture and Sensitivities : Blood c/s :—

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

NH-00015860 IP26-00006534
aster ACHYUTHA RAM PEDDI
3-09-2021 4 Y 9 M 5 D (M)
r. ANIKET ANIL PARASHAR

Doc. 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

	11AM	6AM	7:20 PM
Date : 12/6/26			
Doctor / Nurse / Family Concern?			

Temperature (F) — 104 103 102 101 100 99 98 97 96 95 94

99°F · 99.6°F · 101.4°F · Given Syp crocin

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

104 / 70

Heart Rate (Number)	138 bpm	102 bpm

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

Resp Rate (Number)	34 bpm	32 bpm
Resp Distress: Mod/ Severe / None / Mild		
Receiving O_2 (l/min)		
O_2 Saturations (%)	99%	100%
Conscious Level: Normal / Altered		
GCS *	–	–
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	R	R

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.

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

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)

NH-00015860 IP26-00006534
aster ACHYUTHA RAM PEDDI
3-09-2021 4 Y 9 M 5 D (M)
r. ANIKET ANIL PARASHAR

H / FRM / CLINICAL / 125

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

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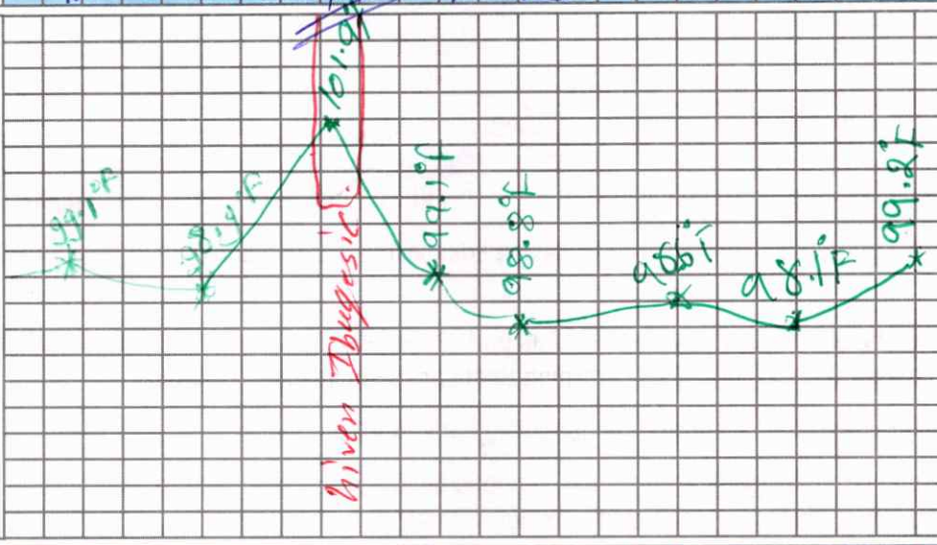
EARLY WARNING SCORE: CHILDREN'S UNIT

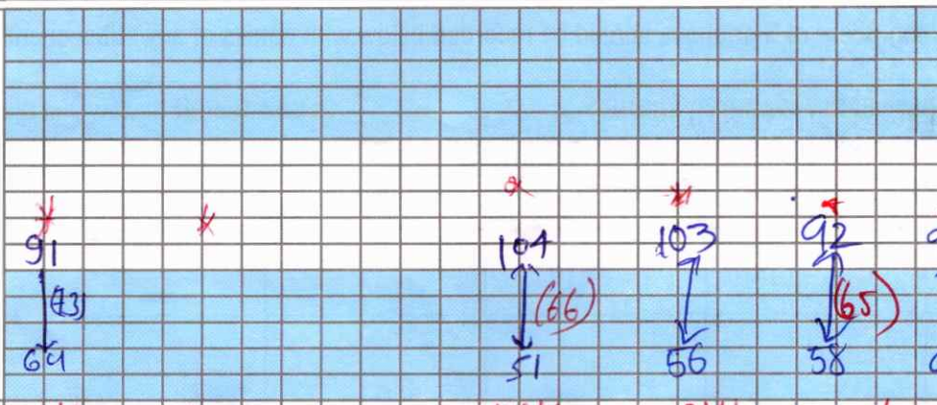
Date : 31/5 ..... Time:	10 AM	2 PM	3:12 PM	3:45 PM	6 PM	10pm	2am	6Am
Doctor / Nurse / Family Concern?								

Temperature (F)



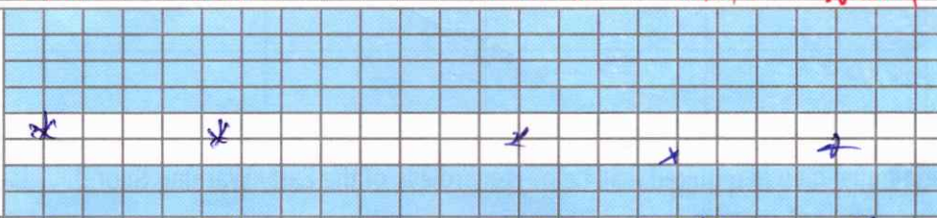
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)	107bm	110bm	116bpm	101bm	146bm	103bm

Resp. Rate (bpm) (Over 1 Minute) *



Resp Rate (Number)	30bm	30bm	30bpm	28bm	25bm	23bm

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

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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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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FLUID CHART

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											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
8/6/26	02:00 am	Plumbyl		30ml		NA		NA			0	
	03:00 am			30ml								
	04:00 am			30ml								
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			30m								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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.

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
8/6/26	08:00 am	Plasmolyte	sups	30ml		NA	0	NA		✓	0	[illegible signature]
	09:00 am			30ml								
	10:00 am			30 ml								
	11:00 am			30 ml						✓		
	12:00 pm			30ml								
	01:00 pm			30ml								
Total Intake :								**Total Output :**		U-2		M-0
8/6/26	02:00 pm	Plasmolyte	Curd Rice, Chapati	30ml		NA	0	NA			0	[illegible signature]
	03:00 pm			30ml						✓	0	
	04:00 pm			30ml							0	
	05:00 pm			~~30ml~~							0	
	06:00 pm			~~30ml~~						✓	0	
	07:00 pm										0	
Total Intake :								**Total Output :**		U-2	M1	-x
8/6/26	08:00 pm	Plasmolyte	chapathi, H2O	0		NA	0	NA			0	[illegible signature]
	09:00 pm											
	10:00 pm									✓		
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :								**Total Output :**				
9/6/26	02:00 am	0	H2O	0		NA	0	NA			0	[illegible signature]
	03:00 am											
	04:00 am									✓		
	05:00 am											
	06:00 am									✓		
	07:00 am											
Total Intake :								**Total Output :**		U-3	M-0	

Total 24 hrs. Intake	

Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 7/6/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				N/A			
Afternoon							
Night	2pm 8pm	→ Assess the patient general condition → monitor vitals → Administer medications as per doctor's orders	2pm 8pm	→ Assessed the patient general condition → IV fluids to continue. → Administer medications as per orders.	Patient is stable	Rechecked vitals	

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NURSING CARE RECORD

Date: 8/6/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify............
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM to 2pm	Assess the Pt. condition. Monitor vitals. Maintain I/O chart. Drug give as per drug chart.	8 AM to 2 PM	Assessed the Pt. condition. Monitored vitals. Maintained I/O chart. Drug given as per drug chart.	Patient is stable now	Re checked vitals	Khushboo (signature)
Afternoon	2pm to 8pm	- Assess the pt condition - Monitor vitals - Maintain I/O Chart - Medication Given as per drug chart	2pm to 8pm	- Assessed the pt condition - Monitor vitals - Maintain I/O Chart - Medication Given as per drug chart	Pt is stable	Re checked vitals	mainsha (signature)
Night	8pm to 8AM	→ Assess the Pt condition → monitor the vitals → maintain I/O chart → Administer medication as per drug chart	8pm to 8am	Assessed the pati [illegible] V/S Administer medicine Maintain I/O chart	administer medicine	Re-assessed the pt	(signature)

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI c̄ dehydration			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	7/6/26 N1	8/6/26 E2	9/6 8am			
	Medical Condition (Any special condition to be noted):	–	–	–			
	Diet:	–	–	–			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–			
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.8 F	98.6 °F	98.3 F			
	Res:	30 b/m	30 b/m	28 b/m			
	SpO_2:	99%	99%	100%			
	Pulse:	140 b/m	128 b/m	116 b/m			
	BP:	104/75	102/70	100/62			
	LOC:	–	–	–			
	Fall Risk Score:	–	–	–			
	Pain Score:	–	"0"	–			
	Skin Integrity	–	Good	–			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–	–			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–	–			
	Critical Lab Test / Values:	–	–	–			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–	–	–			
Post Operative Procedure Special Orders:		–	–	–			
Handed Over By Name :		priyanka	Siri	Vasanth			
Signature / ID :		[signature]	[signature]	[signature]			
Date:		8/6/26	8/6	9/6			
Time:		8Am	8pm	8am			
Taken Over By Name :		Sneha	[illegible]				
Signature / ID :		[signature]	[signature]				
Date:		8/6/26	8/6				
Time:		2pm	8pm				

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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BRADEN 'Q' SCALE

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					Date : 8/6/26	8/6/26	9/6	
					Time : 2am	Eg		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
					TOTAL SCORE	28	28	25	
					Evaluator's Name			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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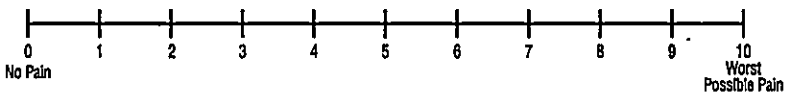
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6/26	2:am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
8/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
8/6/26	6pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
8/6	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
9/6	8am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

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CHECKLIST FOR THROMBOPHLEBITIS

7/6/26 8/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	0				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	0				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	0				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	0				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	0				
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : Balarani Name : Balarani

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nill ..... ☑ 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: ..... E.R ..... Shifted to: ..... ward (209) .....

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 : ..... Dr. Tanvi .....

Date & Time : ..... 8/6/26 @ 12:40 Am .....

Nurse Name & Signature: ..... Bhargavi .....

Date & Time : ..... 8/6/26 @ 12:45 Am .....

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DRUG CHART

Date of Admission: 8/6/26 Drug Allergies: NIL ☐ 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 narnes, 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 UROCIN-DS

Dose	Route	Frequency	Start Date
5ml	PO	8.6h SOS	7/6

Doctor's Signature | Valid Period | Pharm.

Additional Instructions: if temp > 100'4

Date/Time: 8/6 7.20 n

DRUG : SYP IBUGESIC

Dose	Route	Frequency	Start Date
6ml	PO	SOS	7/6

Doctor's Signature | Valid Period | Pharm.

Additional Instructions: if temp > 102'F

Date/Time: 8/6 3.12P

DRUG :

Dose	Route	Frequency	Start Date

Doctor's Signature | Valid Period | Pharm.

Additional Instructions:

Date/Time

Sign

VERIFIED BY : Name

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Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS Weight. 15.8/09 Ward. .....

Verified by Dr. Dhakshayani

DRUG : INJ AMOXICLAV

Dose	Route	Frequency	Start Date
500mg	IV	TID	7/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	8/6
6Am	2:30 Am
2pm	
10pm	

Verified by Dr. Dhakshayani

DRUG : INJ ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
15mg	IV	OD	7/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	8/6	9/6
6Am	2Am	

Verified by Dr. Dhakshayani

DRUG : SYP RELENT PLUS

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	7/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	8/6	8/6	9/6
10Am			
10pm	2Am		

Verified by Dr. Dhakshayani

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date
2mg	IV	TID	8/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	8/6	9/6
6am	8am	
2pm		
10pm		

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 15.8kg Ward ....

DRUG : Nasoclear Nasal drops (struck through)

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : NASOCLEAR NASAL DROP

Dose	Route	Frequency	Start Dt.
2°	Nasal	Q4hly	8/6

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 8/6 — 10AM, 2PM, 6PM, 10PM, 2AM, 6AM, 2A; 9/6

DRUG : FLUVIR SYP

Dose	Route	Frequency	Start Dt.
4 ml	PO	BD	8/6

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions: OSELTAMIVIR

Daily Doctor's Endorsement by a Sign

Date/Time: 8/6 — 11AM, 11PM; 9/6

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Pa[illegible]nt Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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																		

Signature

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																		

03-09-2021 4Y9M5D (M)
Dr. ANIKET ANIL PARASHAR

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.	

Signature .....

VERIFIED BY , Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Master ACHYUTHA RAM PEDDI

I.V. FLUIDS CHART

Weight. 15.8kg Ward. .....

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
8/6/26	1am	IVF-PLASMALYTE (2/3) main	IV	30 ml/hr			9/6.		

PATIENT TRANSFER FORM

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HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Date & Time of Admission	Date & Time of Transfer Order
8/6/26 @ 12:30am	8/6/26 @ 1:30am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
	Dr. Tanvi	Admission

From Unit	To Unit	Information to Attendant
ER	ward (209)	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
25/-		Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Bhargavi	Dr. Tanvi.

Patient & Clinical Records Received by : priyanka

Date & Time of Patient Received : 8/6/26 @ 2Am

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

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

wt - 15.83kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Achyutha Ram Peddi Age : 4y 8 month **Gender:** ☑ Male ☐ Female

Date : 8/6/26 Time of Arrival : 12:10 Am

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ..... ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 100.6°F PR: 135b/m BP: 104/70 mmHg RR: ..... SpO_2: 99%

Chief Complaints: c/o. fever since yesterday, cough, mild

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal
☐ Abnormal
☐ Bleeding

Work of Breathing
☑ Normal
☐ Decreased
☐ Increased
☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 12:12 PM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : .....

Signature of Triage Nurse : .....

Date & Time : 8/6/26 @ 12:15 Am

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 12:17 Am

Chief Complaints: c/o - fever since yesterday, cough mild

Height : ..... Weight : 15.83 Kg 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 ☐ Yes ☑ No
If **'Yes'** tick below fall risk intervention directly
If Patient is > 6 years
If **'Yes'** 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 .....

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

Time of Initial assessment completed by ER Nurse : .....

Nursing Care Plan (Including Labs / Medications / Other Care):

Time	Nursing Notes
	Assessed the patient condition vital checked.

Samples collected by: Jyothi Time:

Samples sent by : Time: 12:50 Am

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8/6/26 12:30 am	Ibugesic Syp	oral	7 ml.	Dr. Tanvi	

Condition of patient at time of shift - out :	Details of Shift - out
HR: 135 b/m BP: 104/70 mm Hg CFT:	Shift - out from ER to: ward (209)
RR: SPO2 at FiO2: 99%	Time of Shift - out: 1:30 am
GCS: Temperature : 100.6°F	Handover given to: (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse : Anu Sam Signature of the Nurse : AF

Date & Time : 8/6/26 9

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aster ACHYUTHA RAM PEDDI
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r. ANIKET ANIL PARASHAR

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/6/26 Time: 10:00 am

Weight: 15.83kg Centile: 50th

Height: — Centile: —

Inference: Well nourished child

RDA: — Calories: 1350 Kcal/day Protein: 23 gms/day

Diet Recommendations: Balanced diet with liquids

Re-Assesment: N/D Junk, spicy Oily food

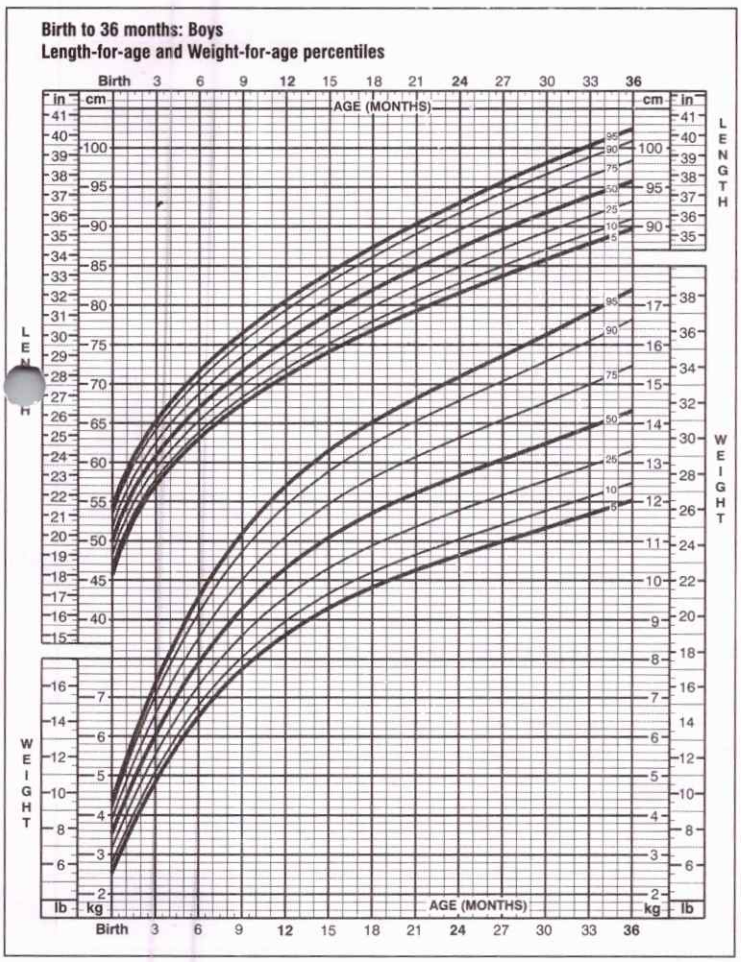
Food Allergies: N/D Veg/~~Non-veg~~ Veg

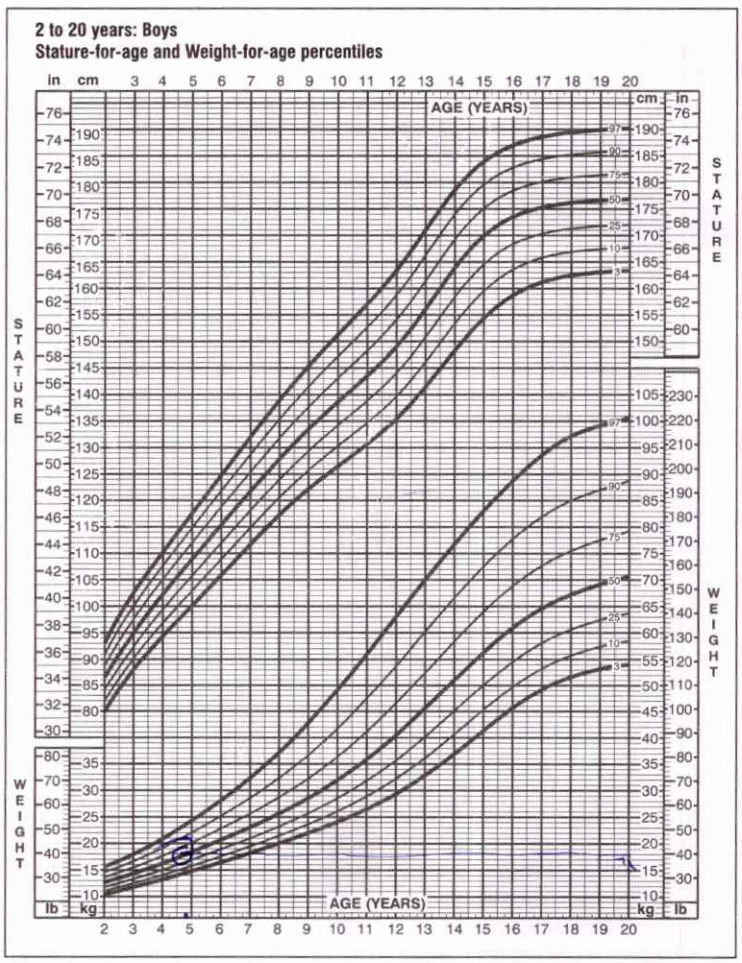
Diagnosis: AFIC dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Daily Notes:

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master ACHYUTHA RAM PEDDI**	**Age :**	**4 Y 9 M 5 D**
IP No:	**IP26-00006534**	**Sex:**	**Male**
Consultant:	**Dr. ANIKET ANIL PARASHAR**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....) Jayaraj P

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:
Jayaraj P

Name: JAYAVEER PEDDI

Relationship: FATHER

Date: 08/06/2026 Time: 00:46 AM

Witness Name:

Witness Signature:

Patient Address:

Malakpet Hyderabad Race Club
Hyderabad Telangana INDIA 500036

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4Y9M5D (M)
Dr. ANIKET ANIL PARASHAR

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

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Your Right to a Safe Delivery

25 yrs

BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaln the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

HNH-00015860 IP26-00006534
Master ACHYUTHA RAM PEDDI
03-09-2021 4 Y 9 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

DECLARATION BY PATIENT / ATTENDANT (TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)

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Date: 08-06-26

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate /Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: ACHYUTHA RAM PEDDI Date & Time of Admission: 08/06/2026 12:46.

Name of the Parent / Guardian: JAYAVEER PEDDI Mobile Number: 7093397172

Parent Aadhaar Card Number: .....

Jayaveer. P

Signature & Relation

Docu. No. : RCHBH /FRM / GENERAL / 476

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UNDERTAKING OF INSURANCE PATIENT/ CREDIT PATIENT FOR ADVANCE PAYMENT

To

The Management,

Rainbow Children's Hospital, Himayat Nagar,

Hyderabad - 500029.

Sub:- **Undertaking of Insurance Patient for Advance Payment.**

I Mr./Mrs./Ms. JAYAVEER PEDDI (Father/ Mother/ Other_____) of Master/ Baby/ Baby of/ Mrs. / Ms. ACHYUTHA RAM PEDDI was bought to your hospital on Emergency basis on 08-06-26 at 12:31 AM approximate charges deposit details were explained by the front office executive on duty.

As I have cashless insurance so I have to pay 10 K as a caution deposit at the time of admission. If there will be any difference amount after getting the approval I'll pay that amount at the time discharge.

Thanking You

Jayaveer P

Signature

Name:- JAYAVEER PEDDI

Ph. No.:- 7093397192