



## DEFICIENCY CHECK LIST OF CASE SHEET

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<b>Name</b>	Mrs POOJA SANGHI	<b>UHID</b>	HNH-00011469
<b>Father/Guardian</b>	Mr NAVEEN GANDU	<b>Age/Gender</b>	26 Y 0 M 4 D/ Female
<b>Address</b>	Himaytnagar, Himayatnagar, Hyderabad, Telangana, INDIA, 500029		
<b>IP No</b>	IP26-00006514	<b>Admission Date</b>	05-06-2026
<b>Ref Doctor</b>	Self.		
<b>Discharge Date</b>	07.06.2026		

**DISCHARGE SUMMARY**

**Consultant:**

Dr. Kadiyala Ramya Theja  
MBBS, DNB  
TSMC/FMR/01458

**Diagnosis: G2A1 WITH 39 WEEKS FOR INDUCTION OF LABOUR**

**SPONTANEOUS VAGINAL DELIVERY DONE ON 06.06.2026**

**History:**

LMP: 05.09.2026  
EDD:12.06.2026

Obstetric formula: G2A1  
Gestation at admission: 39 weeks

**Obstetric History:**

G1 - MTP at 6 weeks  
G2 - Present pregnancy, Spontaneous conception.

Medical History : Nil

Surgical History: Nil

Allergies : Nil

Family History : Nil

**Antenatal Details:**

Mrs POOJA SANGHI was booked to Rainbow hospital at 6 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal with uterine artery showing PI 2.52 with unilateral notch. FTS was low risk. TIFFA was normal. Fetal growth monitoring was done by serial growth scan. Growth Scan done on 22.05.2026 showed SLIUP at 37 weeks with cephalic presentation with EFW: 2.5kg (14%) with AC 1% with AFI 16.2cm with

**DISCHARGE SUMMARY**

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>Father/Guardian</b>	Mr P CHANDU	<b>Age/Gender</b>	0 Y 8 M 0 D/ Female
<b>Address</b>	1-7-1002/43/A, Ram Nagar, Hyderabad, Telangana, INDIA, 500020		
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026
<b>Ref Doctor</b>	SELF		
<b>Discharge Date</b>	27.06.2026		

**Consultant:**

**Dr. ABHISHEK RAVINDRA JAIN**

MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN PEDIATRIC NEUROLOGY

CONSULTANT PEDIATRIC NEUROLOGIST

TSMC/FMR/02757

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
UNPROVOKED SEIZURE	

**History:** Baby YASHNA ISHANVI CHANDRA, 0 Y 8 M 0 D , old girl presented

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026

with the history of fever since 3 days, cough and cold since 6 days, abnormal movements 2-3 episodes of seizure in the form of uprolling of eyeballs generalised tonic clonic movements lasting for 10 seconds, prior to admission. For the above complaints, she was investigated and treated at near by hospital. In view of persistence of symptoms, she was referred to admitted at Rainbow Children's Hospital - Himayatnagar for further management.

**Examination:** She was afebrile, maintaining saturations at room air. Her heart rate was 138/min and Respiratory Rate - 30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were signs of raised intracranial pressure.

Weight on admission : 5.7 kilograms.

**Investigations:** Enclosed reports.

VBG showed pH of 7.31, pCO<sub>2</sub> of 39.6 mmHg, pO<sub>2</sub> of 52 mmHg, HCO<sub>3</sub> of 20.1 mmol/L and BE of -6.1mmol/L.

Initial hemogram showed Hemoglobin of 7.2gm%, White Blood Cell count of 7760cells/cumm, platelet count of 3.04lakhs/cumm

**CSF Analysis**

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026

COLOUR	COLOURLESS			
APPEARANCE	CLEAR			
PH	8.0	7.35 - 7.45	unit	H
CLOT FORMATION	NO CLOT	-		-
CSF PROTEIN	24	15 - 45	mg/dl	-
CSF GLUCOSE	53	60 - 90	mg/dl	L
CELL COUNT	NO CELLS			

Blood culture shows : No growth after 24 hrs of incubation

**Management:** She was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. She was treated symptomatically with antacids and antipyretics. In view of chest signs, she was nebulised with 3% NS.

She was regularly monitored for fever spikes, hemodynamic & neurological status. She had no further episodes of seizure after admission. Lumbar puncture was performed, which showed no cells, but the culture and sensitivity report is awaited.

As child also showed delay in achieving milestones , Tandem mass spectrometry was sent.

She remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026

Parents were counselled regarding the nature of seizures and measures to reduce future episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

**Advice:**

\* Diet as advised.

<b>S.No</b>	<b>MEDICATION</b>	<b>DOSE</b>	<b>TIMINGS</b>	<b>DURATION</b>
1	INJ CEFTRIAXONE(250MG)	250 mg IV	12th hourly	Till follow up
2	Syp LEVIPIL (levetiracetam) 100mg/ml	1ml per oral	12th hourly	Till further advice
3	NEBULISATION with 3% NS	1 respule	6th hourly	Till follow up
4	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

**Plan: To collect CSF culture report and TMS report on followup.**

Review consultation with Dr. ABHISHEK RAVINDRA JAIN on Monday (29.06.2026) at RCH Banjara hills Rainbow Childrens hospital in OPD with prior appointment (**Review consultation will be charged**).

**Food instructions while taking medications:**

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026

\* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure 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 **Himayatnagar / 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](http://www.rainbowhospitals.in)**

*Dr. Archana*  
**Registrar/Resident/C.M.O**

<b>Name</b>	Baby YASHNA ISHANVI CHANDRA	<b>UHID</b>	HNH-00016171
<b>IP No</b>	IP26-00006648	<b>Admission Date</b>	25-06-2026

**Dr. ABHISHEK RAVINDRA JAIN**  
MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN PEDIATRIC  
NEUROLOGY  
CONSULTANT PEDIATRIC NEUROLOGIST  
TSMC/FMR/02757

**ADMISSION SHEET**



**Registration Details :**

Admission No : IP26-00006648      Admit Date : 25-Jun-2026      Admit Time : 09:15 PM      UHID : HNH-00016171

**Patient Details :**

Patient Name : Baby YASHNA ISHANVI CHANDRA      Age : 0 Y 7 M 29 D  
Guardian : Mr P CHANDU      DOB : 27-10-2025 01:00 AM  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : 1-7-1002/43/A Ram Nagar Hyderabad      Phone No : 7032548875  
Telangana INDIA 500020      E-mail : PONNAMCHAU6410@GMAIL.COM

**Admission Details :**

Bed Type : DAY CARE      Bed No : ER02      Ward Name : GF -EMERGENCY  
Room No : ER02      Admission Type : First Visit

**Contact Details :**

Name : Mr P CHANDU      Relationship : Father  
Contact Address : 1-7-1002/43/A Ram Nagar Hyderabad      Phone No : 7032548875  
Telangana INDIA 500020

  
Signature

**Doctor Details :**

Doctor Name : Dr. ABHISHEK RAVINDRA JAIN      Specialisation : PEDIATRIC NEUROLOGY  
Referral Doctor : SELF      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : Cash      Deposit Amount : 20000.00  
Payor Name : SELFPAY



**ACTIV** HNH-00018171 IP26-00006648 **NG**

Baby YASHNA ISHANVI CHAUDRA  
27-10-2025 0 Y 7 M 29 D (F)  
Dr. ABHISHEK RAVINDRA JAIN

Name: -----



UHID No ----- Consultant: ----- Dept: pediatric

Date of Admission: 25/6/26 Time: ----- Date of Discharge: ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<u>25/6/26</u>	<del>ER</del>	<u>ER</u>	<u>218</u>	<u>Kunjoy</u>
<u>25/6/26</u>	<u>12pm</u>	<u>ward</u>	<u>PICU</u>	<u>Sen</u>
<u>26/6/26</u>	<u>5pm.</u>	<u>PICU</u>	<u>218</u>	<u>Kunjoy</u>

**Cross Consultation Visit**

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











## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : \_\_\_\_\_

Patient ID# : \_\_\_\_\_

Consultant : Dr. ABHISHEK.

Final Diagnosis : \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

Name: 1 Age/Sex 8 months

Informant: Parents Reliability: Good

Chief Presenting Complaints & Duration (Chronologically):

c/o - Fever for 3 days (6 days back), cold cough x 6 days  
c/o - Abnormal movements 2-3 episodes (yesterday)  
c/o -

History of present illness:

mild cold, cough x 6 days, not also fast breathing  
also noisy breathing

do Abnormal movements yesterday 3PM  
(2-3 episodes) in the form of stiffness of  
all 4 limbs, also uprolling of eyes and  
sweating from mouth each episode lasting for 10-15 minutes

taken to outside hospital (Tij Lorazepam 1/6  
Tij Lorazepam)  
LIV fluid, IV Antibiotics, Nebulization

3% NS. Tij Acyclovir

CRP 1.6, TLC - 12.23k (22.7/67.9)

SGOT/PT - 118/51

EGU - normal, MRI Brain - Benign enlargement  
of subarachnoid spaces in bilateral frontal convexities  
No fever (week back) (for 3 days)



Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 5.7 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 98.6 F Pulse Rate: 138/min Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 95-97% @ RA at \_\_\_\_\_

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_ No

Lymphadenopathy \_\_\_\_\_ No

Oedema : \_\_\_\_\_ No

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : TBAC ⊕, (occasional crackles ⊕)

Any added sounds : Conducting sounds ⊕

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

**Cardiovascular System :**

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S2 ⊕

Any murmur : \_\_\_\_\_

Relevant data from outside (Chest X-Ray, ECG, ECHO, Etc..) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft Non-tender

Auscultation : \_\_\_\_\_

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Alert

Cranial Nerves : pupils Normal size, reactive to light

Motor System :

Nutrition : \_\_\_\_\_

Tone : hypotonia Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : No

Reflexes :

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

withdrawing to pain

Bladder / Bowel : \_\_\_\_\_

Clinical Summary & Diagnostic :

Cryptosporidiosis under evaluation with LRTI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Desired goals of the treatment :

\_\_\_\_\_

\_\_\_\_\_

**Planned Labs :**

\_\_\_\_\_

\_\_\_\_\_

- CRP, VISA, PIRS.

\_\_\_\_\_

- T Blood C/S

\_\_\_\_\_

- Extra plain sample

\_\_\_\_\_

\_\_\_\_\_

**Planned Management :**

\_\_\_\_\_

- NPO till T/M

\_\_\_\_\_

- IV fluids

\_\_\_\_\_

- IV Levipid

\_\_\_\_\_

(Maintenance)

\_\_\_\_\_

- Zoj Ceftriaxone

\_\_\_\_\_

(LP to be decided

\_\_\_\_\_

T/M)

\_\_\_\_\_

(O<sub>2</sub> @ NPO @ 1 lit/min)

\_\_\_\_\_

**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 \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Dr. ABHIR K. RABINDRA JAIN  
Reg. No. 50275710

Abhishek



PROGRESS NOTES AND DOCTOR'S ORDER

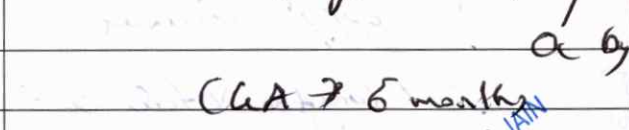
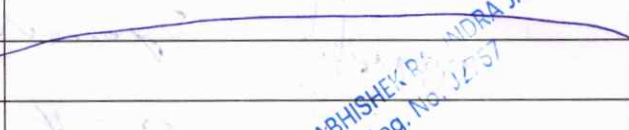
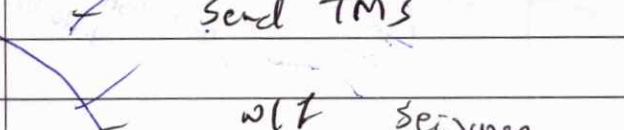
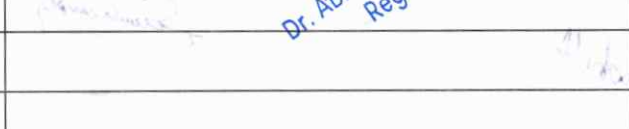



Date & Time	Progress Notes	Doctor's Order
26/06/26 7 AM	c/s/s. Dr. Sankarsh/ Dr. Shreyan	
	Di: Unprovoked seizure ± LRTI	
	Afebrile	
	No further seizure activity	
	cold ⊕	
	O/E: Irritable	
	vitality Temp: 97.5F	
	HR: 130/min	
	SpO <sub>2</sub> : 99% @ NP @ 1lit/min	
	S/E: PA: Soft Non-tender	
	RS: J3C+E ⊕, crackling	TS/C crackle ⊕
		Sounds ⊕
	- O <sub>2</sub> ± NP @ 1lit/min	Adv
		- IV fluids (1/2 m)
		- IV Levipil (non-venous)
		- 2x Ceftriaxone
		- w/f. seizure
		- Monitor vitals and
		Inform
		NB-Mantech
		Sankarsh

Dr. ABHISHEK RAVINDRA JAIN  
 Reg. No: 02757

Abhishek



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/10/25 9 AM	S/B Dr. Abhishek Jain Δ Unprovoked seizures = LRTI 2-3 episodes - 2 days back No further seizures	Plg
	No further seizures	cf LEVITIC
	WS - S <sub>1</sub> , S <sub>2</sub> ⊕	
	RS - BIC - AIC ⊕	cf LEFTRIAXONE
	DII - conducted sound ⊕ coarse crepts ⊕	Neb = 3% NS 6 <sup>th</sup> ly
	⊕ P/A - soft hepatomegaly ⊕ splenomegaly ⊕	Monitor R/S Sp O <sub>2</sub>
	Hypotonia ⊕	Lumbar puncture today
	Roll over ⊕	cf IV fluids
	Birth history - late preterm (34 weeks) 1.936 / 74NB / NICU stay α by NT - today	Chest & limb physiotherapy
	CGA → 6 months	Send TMS
		w/lt seizures
		
		
		

Dr. ABHISHEK RAVINDRA JAIN  
 Reg. No. J2-57

Abhishek  
 Dr. Abhishek Ravindra Jain



AB  
 LPR  
 CSF

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 1 pm	<p><u>c/s/by. Dr. Anush</u></p> <p><u>Lumbar puncture notes</u></p> <p>Under strict aseptic precautions, lumbar puncture performed @ L3-L4 interspace using 22G spinal needle. Clear CSF was obtained &amp; collected in 4 containers.</p> <p>↓</p> <p>- Needle removed &amp; sterile dressing.</p>	<p><u>Plan</u></p> <p>- CSF/c/s</p> <p>- CSF Analysis - Prot Gloc cell count cell type</p>
	<p>HR - 111/min</p> <p>RR = 38/min.</p> <p>SpO<sub>2</sub> = 98% on 1lit/lc</p> <p><u>GRRS = 6/7 (all)</u></p> <p><u>BP =</u></p>	<p>- Plan CSF PCR a/c to CSF analysis report.</p> <p>- Monitor vitals.</p>
	<p><u>AF</u></p>	<p>- Once child gets active ↓ start DBF. &amp; taper IV fluids.</p> <p>Recheck GRRS @ 3pm.</p>

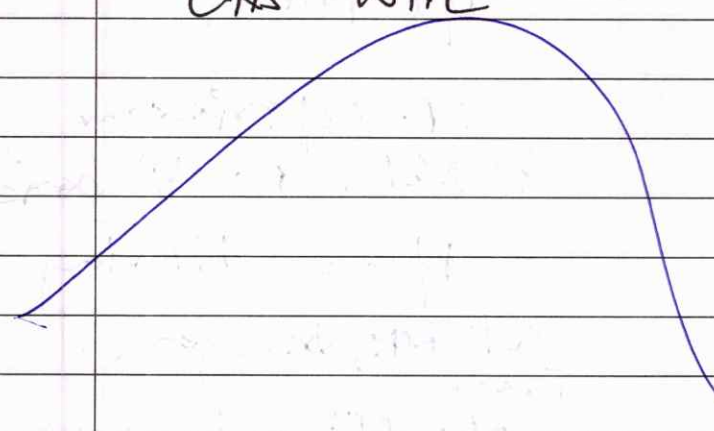


## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/25 7:10pm	s/b Dr. Abhishek - CSF counts → protein (24) CSF sugar (53) ; No cells Δ <sup>sub</sup> - Unprovoked seizures - LPRT ↓ evaluation	
	No fever spikes No seizure episodes post admission on Room Air	Adv • (T) CSF culture • (T) TMS • Ct ceftriaxone + levizacetam
	vitally stable HR - 132 bpm RR - 38/min PP - wf SpO <sub>2</sub> - 97% @RA	
	sle NAD RL - AEB E PLA - soft, HS <sup>sub</sup> megaly ⊕ non-tender	
	Dr. ABHISHEK RAVINDRA JAIN Reg. No. 02757	Abhishek -

HNM-00016171 IP26-00006648  
 Baby YASHNA ISHANVI CHANDRA  
 27-10-2025 0 Y 8 M 0 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN

SS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/25	C/I/b Dr. Venmu/Dr. Pranav.	
8 AM	Δ - unprovoked seizures ± LFTI.	
	- <del>As</del> - fever spikes → 8:00 AM (100.0°F).	
	- cough ⊕	
	- NO - further e/o seizures.	
	Q/E - vitals stable.	
	Q/E - P/A - SRT, NT.	
	CNS - WNL.	Plan
		- Chase CF cultures.
		- Chase TMS.
		- Ct. Leftrixone
		2 covers.
		- Ct. Hyper-meb. PGM.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/10/25	C/S/b Dr. Abhishek	
9:15 AM	Δ - Unprovoked seizure.	
	five spikes (+)	
	- long (+)	
	Q/E - vitals stable.	
	Q/E - WNL.	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Plan</div>
		- D/S today.
		- Cf. Ceftriaxone & Neb. on OP basis.
		- R/V on Monday at RCH, Bengaluru.
	- Of persistent fever, CBP, CRP & chest X ray to repeat.	- <del>cf.</del> esp culture, TMS.
	- R/V with Dr. Abhishek & Dr. Rama devi on Monday	- Cf. Ceftriaxone & neb. till report comes.
	- change to oral Zovipil 1ml BID	Abhishek

Dr. ABHISHEK RAVINDRA JAIN  
 Reg. No: 02757



# CROSS CONSULTATION FORM

Doctor Name : D. Padma (PT) Date : 26/6/26 Time : 3.30 PM

Diagnosis : unprovoked seizures + LRTI

Hospital : RCH,

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Physiotherapy.

Signature: \_\_\_\_\_

Findings and Recommendations :

S/B Physiotherapist

do. unprovoked seizures  
+ LRTI

- Re:-
- chest physiotherapy given
  - limb physiotherapy
  - Joint compressions
  - AROM ex's
  - Pelvic bridging.

Consultant :

Name : Dr. Padma (PT) Signature : [Signature] Date & Time : 26/6/26  
3.30 PM



# CONSENT FOR SPECIAL PROCEDURES

Patient Name : MNH-00018171 IP26-00006648  
Baby YASHNA ISHANVI CHANDRA  
27-10-2025 0 Y 7 M 30 D (F)  
Dr. ABHISHEK RAVINDRA JAIN

Gender:  Male  Female

UHID No :

Department : 3<sup>rd</sup> Floor

Date : 26/6/26



I ..... S/D/W/O .....

Here by give consent for procedure of : Lumbar Puncture

For my patient, Named : YASHNA ISHANVI CHAUDRA

The doctors have clearly explained to me that the procedure has following possible complications:

(rarely)  
bleeding, herniation, headache, pain at puncture site  
rarely nerve injury

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

The need for lumbar puncture for CSF analysis has been explained; complications have also been explained.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Prashanti / Dr Anusha

**Patient Attendant :**

Signature : *Chauhan*

Name : Chauhan P

Relationship with Patient: Father

Date & Time : 26/6/26 11AM

**Witness :**

Signature : *A*

Name : Anusha

Date & Time : 26/6/26 12pm

**Doctor (who is taking the consent) :**

Signature : *Prashanti*

Name : Dr. Prashanti

Date & Time : 11:40 am

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HNH-00016171 IP26-00006648  
 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... all .....  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: ..... ICU ..... Shifted to: ..... Ward .....

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

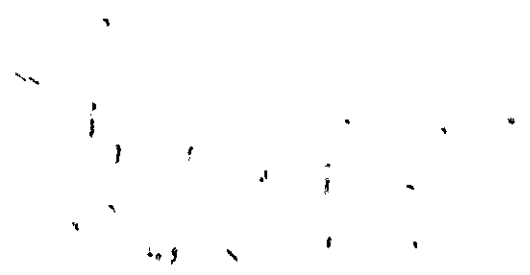
Doctor Name & Signature: ..... Dr. Abhishek Jain .....

Date & Time: ..... 25/6/26 @ 9:10 PM .....

Nurse Name & Signature: ..... [Signature] .....

Date & Time: ..... 25/6/26 @ 9:01 PM .....

T R





## DRUG CHART

Date of Admission: 25/6/26 Drug Allergies: None  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 Hospital's Verbal Order Policy.

### SOS / PRN (As Required Medication)

DRUG : <u>IMS. MIDAZOLAM</u>				Date Time
Dose <u>1mg</u>	Route <u>IV</u>	Frequency <u>SOS</u>	Start Date <u>25/06</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	
Additional Instructions: <u>In case of (1ml/1mg) seizures</u>				

DRUG : <u>CROSIN DROPS</u>				Date Time
Dose <u>0.9ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>26/6</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions:				

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

Verified by  
Dr. Dhakshayani

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



REGULAR PRESCRIPTIONS

Weight. 5.5 kg Ward. ....

Verified by  
Dr. Dhakshayani

DRUG : <u>INT. CERTIAXONE</u>				Date Time	<u>25/6</u> <u>10/6</u>
Dose	Route	Frequency	Start Date		
<u>250mg</u>	<u>IV</u>	<u>12H</u>	<u>25/06</u>	<u>10AM</u>	<u>10/6</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Sankh</u>					
Additional Instructions:					
<u>give over 1 hour</u>				<u>10PM</u>	<u>12AM</u>
Daily Doctor's Endorsement by a Sign					

DRUG : <del>SEP</del>				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>INT. LEVIPIL</u>				Date Time	
Dose	Route	Frequency	Start Date		
<u>100mg</u>	<u>IV</u>	<u>12H</u>	<u>25/06</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Sankh</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>NEB 2 HYPERNEB</u> <sup>(3% NS)</sup>				Date Time	<u>25/6</u>
Dose	Route	Frequency	Start Date		
<u>ml</u>	<u>NEB</u>	<u>6H</u>	<u>25/06</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Sankh</u>					
Additional Instructions:					
<u>See the chart</u>					
Daily Doctor's Endorsement by a Sign					

Verified by  
Dr. Dhakshayani









I.V. FLUIDS CHART

Weight. .... 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
25/06	11 AM	IVE - 1/2 DNS	IV	20	<i>[Signature]</i>	<i>[Signature]</i>			<i>[Signature]</i>
				↓		<i>[Signature]</i>			<i>[Signature]</i>
		IVE - 1/2 DNP	Iv	10		<i>[Signature]</i>			<i>[Signature]</i>
				↓		<i>[Signature]</i>			<i>[Signature]</i>
25/6	12pm	IVF @ DNS .	iv	20ml	<i>[Signature]</i>	<i>[Signature]</i>			<i>[Signature]</i>

Signature  
VERIFIED BY: Name



6th half

## NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
27/6	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00	Nebulization (3hrs)		
	06.00			
	07.00			
	08.00			
	09.00			
10.00				
11.00				
12.00				
13.00				
14.00				
15.00				
16.00				
17.00				
18.00				
19.00				
20.00				
21.00				
22.00				
23.00				

Dr. Ahluwalia  
 208539 Chaur

Handwritten scribbles and a horizontal line.

Handwritten scribbles.

Handwritten scribbles and lines.

Handwritten scribbles and a horizontal line.



HNH-00016171 IP26-00006648  
 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



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 Children's  
 Hospital  
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BirthRight<sup>™</sup>  
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 Your Right to a Safe Delivery

## NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00	B-1-NS (2)	Arshi	Chauhan
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00	B-1-NS (3)	Arshi	Chauhan
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00	Hyper neb. (208466)		
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00	Hyper neb (nebulization)	Arshi	Chauhan

216

Do

1

Do

2

Handwritten signature or text at the bottom of the page.

HNH-00016171 IP26-00006648  
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## NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
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	10.00			
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	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00	3-1. NS. (1)	(MSJ)	dhars

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## RESULT SHEET

Date	25/6/26				
Time					
Hb	7.2				
PCV	22.1				
RBC	3.44				
WBC	7.76				
N/L	36.6/57.0				
Platelets	304				
CRP					
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	24/53				
Cells					
N/L					



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: RCH / FRM / CLINICAL / 124

**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**

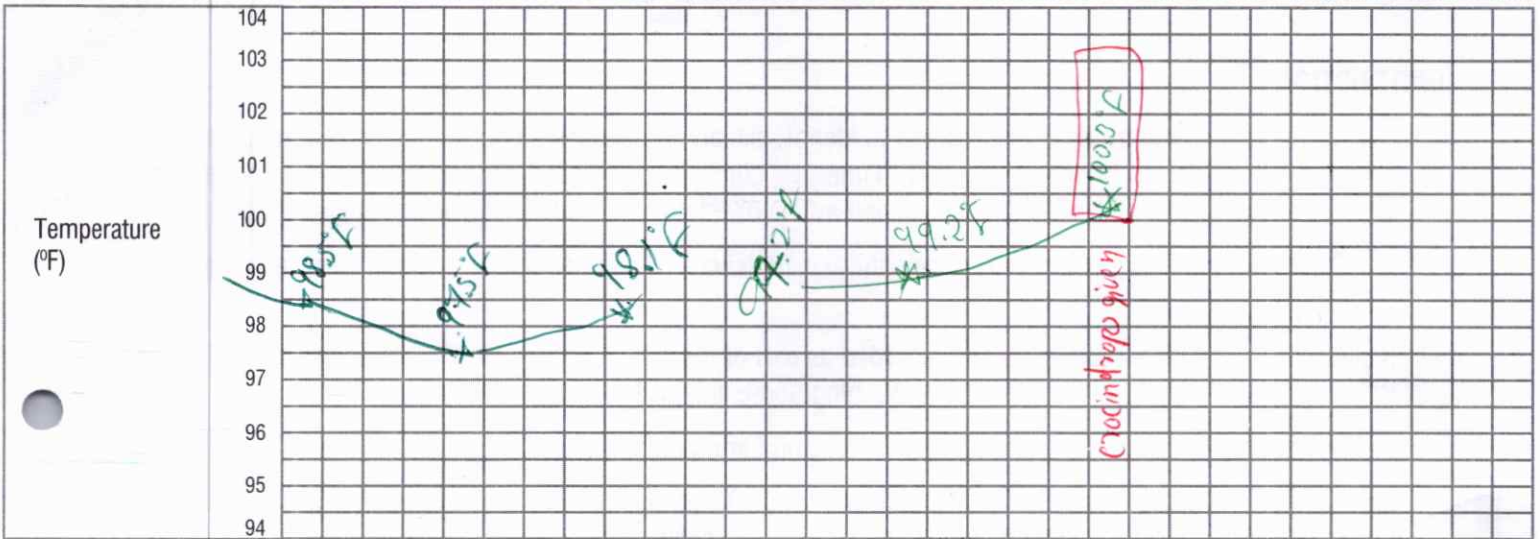
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**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 25/11/25 Time: 11pm 2Am 6Am 10pm 2Am 6:30Am

Doctor/Nurse/Family Concern?



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

Note: BP does not score in early warning scoring

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
11pm	148	135
2Am	140	135
6Am	135	135
10pm	140	135
2Am	140	135

Heart Rate (Number)

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

Time	Resp. Rate (bpm)
11pm	38
2Am	40
6Am	40
10pm	40
2Am	40

Resp Rate (Number)

Time	Resp Rate (Number)
11pm	38
2Am	40
6Am	40
10pm	40
2Am	40

Time	Resp Mod/ Severe Distress	None / Mild
11pm	Cal	100%
2Am	Cal	100%
6Am	Cal	100%
10pm	Cal	100%
2Am	Cal	99.1

Time	Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)
11pm	2	100%
2Am	2	100%
6Am	2	100%
10pm	2	100%
2Am	2	99.1

Time	Conscious Level	Normal / Altered
11pm	Normal	
2Am	Normal	
6Am	Normal	
10pm	Normal	
2Am	Normal	

Time	GCS *
11pm	15
2Am	15
6Am	15
10pm	15
2Am	15

**ACTIONS**

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 incharge and PICU /NICU fellow or PICU/NICU 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.

# 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)

HNH-00018171 IP26-00006648  
 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
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RCH / FRM / CLINICAL / 124

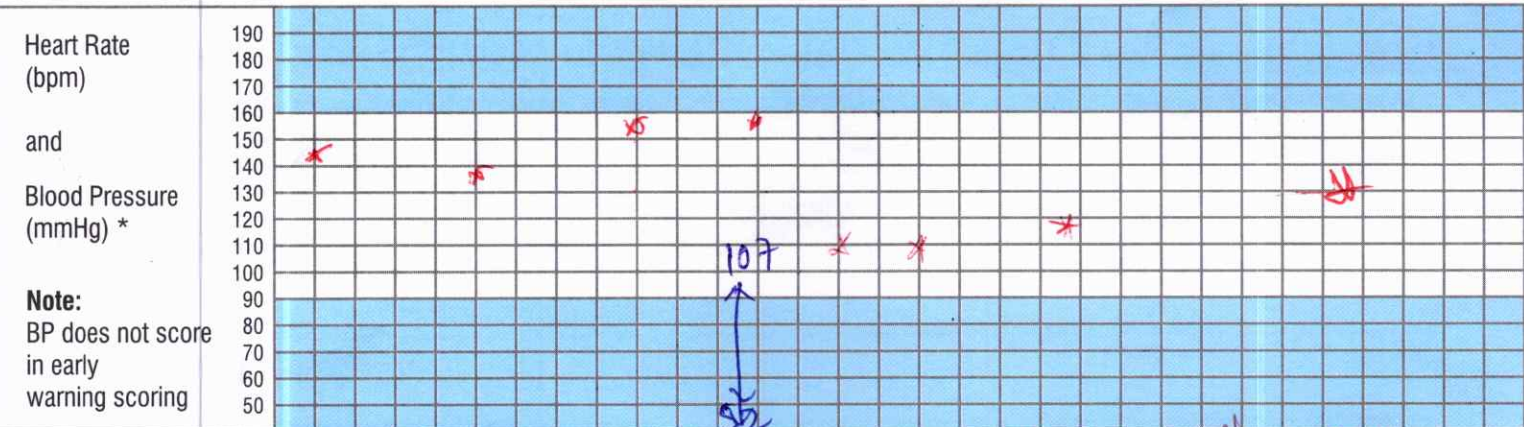
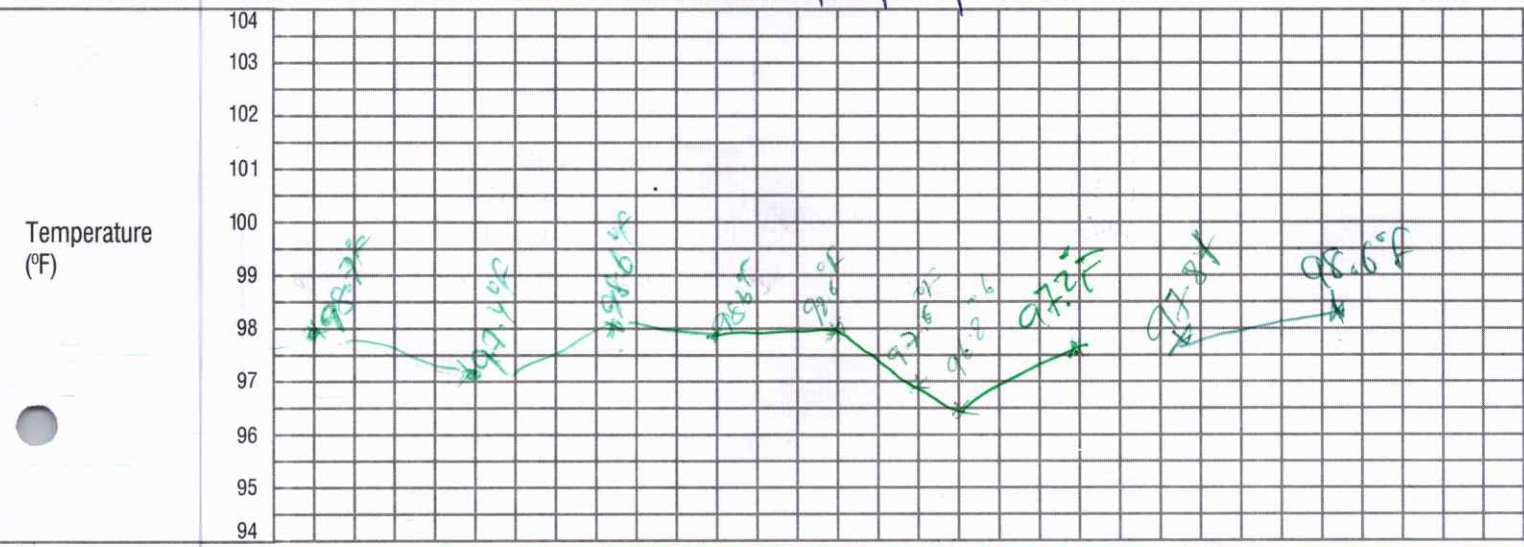
**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**



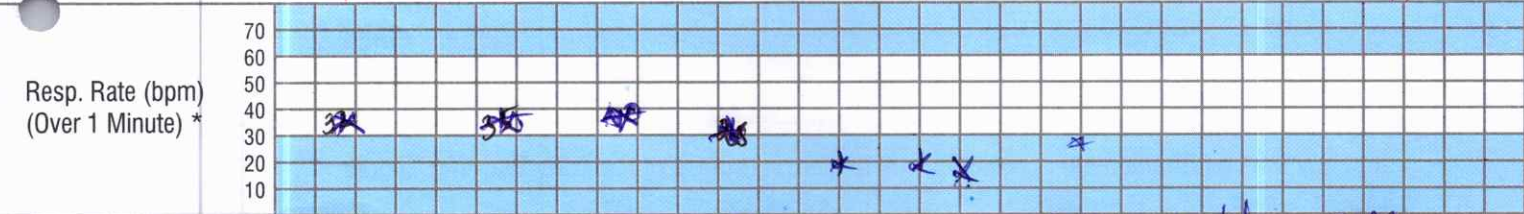
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 26/6/25 Time: 9AM 10AM 12pm 2PM 3 4 5 7:30 8:30pm 9AM

Doctor/Nurse/Family Concern? pm pm pm pm



Heart Rate (Number) 141 139 156 152 112 114 132 145 131



Resp Rate (Number) 32 35 40 28 20 25 20 28 26 28

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) 1L 1L 2L 2L 1/lt 1/lt 1/lt  
 O<sub>2</sub> Saturations (%) 99% 99% 100% 100% 100% 100% 100% 96% 99% 99%

Conscious Level Normal Altered

GCS \*

<b>TOTAL SCORE</b>										
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0
Observer's Initials	J	K	L	M	N	O	P	Q	R	S

- ACTIONS**
- 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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- NB: Scores 3 should be recorded overleaf

\* 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.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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- 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.

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<b>R</b>	<b>RECOMMENDATION:</b> 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)

HNH-00016171 IP26-00006648  
 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	DNS	milk	20ml								
	12:00 am	DNS		20ml								
	01:00 am	DNS	milk	20ml								
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am	DNS		20ml								
	03:00 am	DNS	milk	20ml								
	04:00 am	DNS		20ml								
	05:00 am	DNS	milk	20ml								
	06:00 am	DNS		20ml								
	07:00 am	DNS	milk	20ml								
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am		10ml	10ml						✓	0	}	
	09:00 am	Y <sub>2</sub>		10ml							0		
	10:00 am	W <sub>3</sub>		10ml						✓	0		
	11:00 am	P		10ml							0		
	12:00 pm	D	B	20							0		
	01:00 pm	N <sub>5</sub>	m	20ml							0		
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm	D <sub>1</sub>		20ml							1	}	
	03:00 pm	N <sub>5</sub>		25ml							1		
	04:00 pm			15ml							1		
	05:00 pm			15ml					✓		1		
	06:00 pm			15ml							1		
	07:00 pm										1		
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm									✓	1	}	
	09:00 pm										1		
	10:00 pm										1		
	11:00 pm		milk	NA						✓	1		
	12:00 am			NA							1		
	01:00 am			NA							1		
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am										1	}	
	03:00 am										1		
	04:00 am		milk	NA						✓	1		
	05:00 am			NA							1		
	06:00 am			NA							1		
	07:00 am			NA					✓		1		
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							

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# NURSING CARE RECORD



Date: .....

- 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							
Afternoon							
Night	8pm   8am	Assess the Baby General Condition checked vital & recorded medication given as per doctor order	8pm   8am	Assessed Baby general Condition checked vital & recorded Medication given as per doctor advice	st is stable	checked vital	D

HNH-00016171 IP26-000066/e  
 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



# NURSING CARE RECORD



Date: 26/6/26

**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							
Afternoon	5pm to 8pm						
Night	8pm	Assess the Baby Condition Check vital & record Administer medication as per doctor advice maintain T/O chart	8pm	Assessed the Baby Condition Checked vital & recorded Administered medication as per doctor advice	pt is stable	rechecked vital	<i>[Signature]</i>



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <sup>25/6</sup>			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	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-		NA	NA	NA	NA				
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	NA				
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	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-		NA	NA	NA	NA				
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 of Ward In Charge :

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

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

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 Baby YASHNA ISHANVI CHANDRA  
 27-10-2025 0 Y 8 M 0 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



## CHECKLIST FOR THROMBOPHLEBITIS

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										
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										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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										
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										
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										
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 of Ward In Charge :

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

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

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 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



# BRADEN 'Q' SCALE



Date : 27/10/2025  
 Time : 12:00

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	9	7	9
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	9	7	9
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	9	7	9
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	9	7	9
<b>FRICITION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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."	9	7	9
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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.	9	7	9
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	9	7	9

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

Docu. No. : RCH /FRM / CLINICAL / 119

<b>TOTAL SCORE</b>	28	28	28
<b>Evaluator's Name</b>	U	U	U

Risk Score	Category	Action	<b>Support Surfaces</b> (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	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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 Baby YASHNA ISHANVI CHAUDRA  
 27-10-2025 0 Y 7 M 29 D (F)  
 Dr. ABHISHEK RAVINDRA JAIN



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	25/10	26/10/25	26/10/25			
	Shift	NC	MS	NC			
	Medical Condition (Any special condition to be noted):	-	-	-			
	Diet:	-	-	-			
<b>ASSESSMENT</b>	Allergy:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-			
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.0 F	98.6 F	98.8 F		
		Res:	28b/m	20b/m	22b/m		
		SpO <sub>2</sub> :	99%	100%	99%		
		Pulse:	120b/m	105b/m	109b/m		
		BP:	-	-	-		
		LOC:	-	-	-		
	Fall Risk Score:	-	-	-			
Pain Score:	-	-	-				
Skin Integrity	-	-	-				
<b>Recommendations</b>	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	Yes	Yes			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	-	-	-			
	Critical Lab Test / Values:	-	-	-			
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	dependent	dependent				
Post Operative Procedure Special Orders:		NA	NA	NA			
Handed Over By Name :		Moulishi	Rang	Moulishi			
Signature / ID :		26/10/25	26/10/25	26/10/25			
Date:		26/10/25	26/10/25	26/10/25			
Time:		8pm	8pm	8pm			
Taken Over By Name :		Moulishi	Moulishi	Moulishi			
Signature / ID :		26/10/25	26/10/25	26/10/25			
Date:		26/10/25	26/10/25	26/10/25			
Time:		2pm	8pm	8pm			

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 Dr. ABHISHEK RAMINDRA JAIN



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
	Pain Score:							
	Skin Integrity							
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:								



wt - 5.7 kg RBS - 96 mg/dl



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Yashna Age : 7 Gender:  Male  Female

Date : 25/6/26 Time of Arrival : 8:20pm

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: 98.6 PR: 138 BP: ..... RR: 36 SpO<sub>2</sub>: 97%

Chief Complaints: cb cough since 3 days, seizures activity mal episode

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	<input checked="" type="checkbox"/> Stable
<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Unstable:
<input checked="" type="checkbox"/> Sick Looking	<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening
<input checked="" type="checkbox"/> Normal	Circulation / Colour	<input type="checkbox"/> Life - Threatening
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Bleeding	

Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient	<input type="checkbox"/> 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 : 8:22pm

## Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- 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

- 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: .....
- 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 : Anupam

Signature of Triage Nurse : A.P

Date & Time : 25/6/26 @ 8:25pm

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## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/26 Time of arrival : 8:20 PM

Chief Complaints : cb cough since 3 days, seizures, Acute RBS: 1 episode

Height : ..... Weight : 5.7 kg BMI : ..... 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  
tick below fall risk intervention directly
- If Patient is > 6 years  
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 Family .....

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

Time of Initial assessment completed by ER Nurse : 9:30 PM .....

**Nursing Notes (Including Labs / Medications / Other Care):**

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Time	Nursing Notes
	Assessed the patient condition vital checked.

Samples collected by: *vidya*

Time:

Samples sent by: *vidya*

Time: *8:30pm*

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
<i>(Diagonal line)</i>					

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>142</i> BP: ..... CFT: ..... RR: <i>39</i> SPO <sub>2</sub> : <i>96%</i> GCS: ..... Temperature: <i>98.3</i> Pain Score: <i>0</i> Repeat RBS (if applicable): .....	Shift - out from ER to: <i>218</i> Time of Shift - out: <i>10:30pm</i> Handover given to: <i>Moufadh</i> (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): .....

Name of the Nurse : *Amfarn*

Signature of the Nurse : *AS*

Date & Time : *25/10/25 @ 8:30pm*



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## NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/0/26 Time: 9:30am

Weight: 5.7kg Centile: 5<sup>th</sup>

Height: \_\_\_\_\_ Centile: \_\_\_\_\_

Inference: Underweight child

RDA: \_\_\_\_\_ Calories: 98 Kcal/kg/day Protein: 1.6 gms/kg/day

Diet Recommendations: DM + Complementary food NPO till further Order.

Re-Assessment: No Junk, oily, spicy food

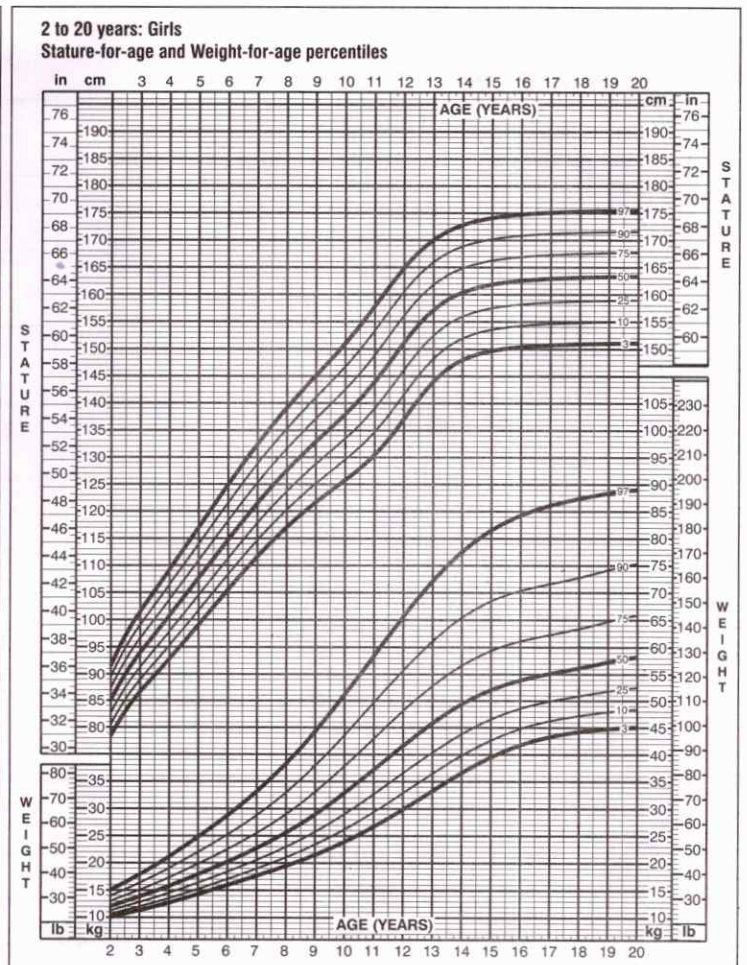
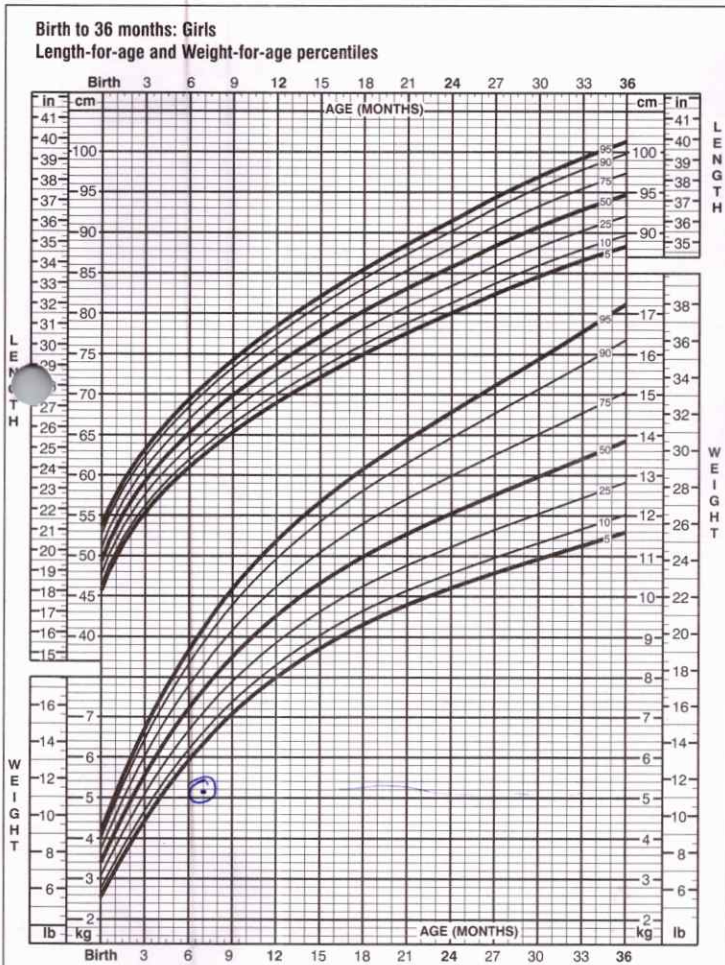
Food Allergies: No Veg/Non-veg Non Veg

Diagnosis: Unprovoked Seizure & RTI

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Chaudhary

### GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya





**GENERAL CONSENT FOR TREATMENT**

Patient Name: Baby YASHNA ISHANVI CHANDRA Age : 0 Y 7 M 29 D  
IP No: IP26-00006648 Sex: Female  
Consultant: Dr. ABHISHEK RAVINDRA JAIN Ward/Bed No: GF -EMERGENCY/ER02

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:.....Chaudhary)

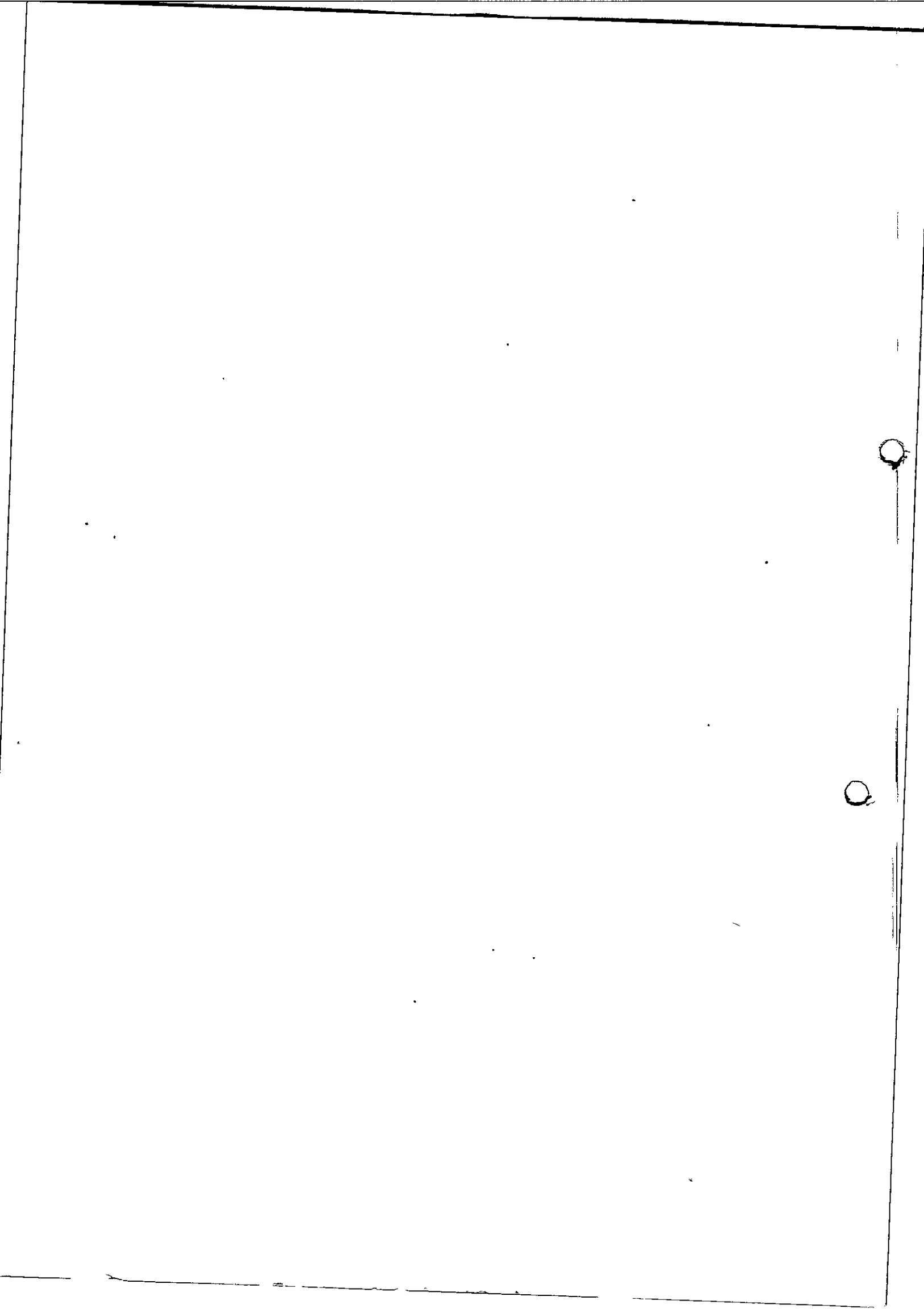
- 3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
- 4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: Chae

Name: Chaudhary  
Relationship: Father  
Date: 25/06/2026  
Witness Name: [Signature]  
Witness Signature: [Signature]



Patient Address:  
1-7-1002/43/A Ram Nagar Hyderabad  
Telangana INDIA 500020

Time: 9 PM



# PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00016171      IP26-00006648 Baby YASHNA ISHANVI CHAUDRA 27-10-2026      0 Y 7 M 29 D (F) Dr. ABHISHEK RAVINDRA JAIN 		Date & Time of Admission 25/6/26 @	Date & Time of Transfer Order 25/6/26 @
		Transfer Ordered by Dr. praveen	Reason for Transfer admission
From Unit ER	To Unit	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 14	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. praveen	
Patient & Clinical Records Received by : Moutushi			
Date & Time of Patient Received :      @ 11 PM, 25/6/26			

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-00016171 IP26-00006648  
Baby YASHNA ISHANVI CHANDRA (F)  
27-10-2025 0 Y 7 M 29 D  
Dr. ABHISHEK RAVINDRA JAIN

## BILLING POLICY

- **Billing cycle:** - With effective from 1<sup>st</sup> 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 tpain 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).

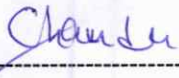
Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested 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.

  
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Name & signature of Patient/Attendant

  
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(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.

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