

HNH-00015936 IP26-00006622
 Baby Of SAMIKSHA JAISWAL
 12-06-2026 0 Y 0 M 9 D (M)
 Dr. DILNAAZ FAROOQUI



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
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3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
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10	Consent for Surgery				
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12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
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21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
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25	Pre operative check list				
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29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)				
33	Nebulization chart				
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35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
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43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	<u>21</u>			

Signature and Date : 22/06/26
 Jyotsna (P.T.O.)

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006622

Admit Date : 21-Jun-2026

Admit Time : 11:24 AM UHID : HNH-00015936

Patient Details :

Patient Name : Baby Of SAMIKSHA JAISWAL

Age : 0 Y 0 M 9 D

Guardian : Mr ABHISHEK JAISWAL

DOB : 12-06-2026 02:48 PM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : 11-6-454 nampally Agapura Hyderabad
Telangana INDIA 500001

Phone No : 8639762994

E-mail : na@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 ABHISHEK JAISWAL

Relationship : Father

Contact Address : 11-6-454 nampally Agapura Hyderabad
Telangana INDIA 500001

Phone No : 8639762994



Signature

Doctor Details :

Doctor Name : Dr. DILNAAZ FAROOQUI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 30000.00

Payment Mode : DC/CC Card

Payor Name : SELFPAY

DISCHARGE SUMMARY

Name	Baby Of SAMIKSHA JAISWAL	UHID	HNH-00015936
Father/Guardian	Mr ABHISHEK JAISWAL	Age/Gender	0 Y 0 M 9 D/ Male
Address	11-6-454 nampally, Agapura, Hyderabad, Telangana, INDIA, 500001		
IP No	IP26-00006622	Admission Date	21-06-2026
Ref Doctor	SELF		
Discharge Date	22.06.2026		

Consultant:
Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of SAMIKSHA JAISWAL is a 0 Y 0 M 9 D old baby boy presented with history of yellowish discolouration of skin and eyes since 2 days prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 17.5 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Name	Baby Of SAMIKSHA JAISWAL	UHID	HNH-00015936
IP No	IP26-00006622	Admission Date	21-06-2026

Birth history: Baby Of SAMIKSHA JAISWAL is a term (37 weeks + 4 days) baby boy, delivered to a G2A1 mother by emergency LSCS on 12.06.2026 at 02:48 pm with birth weight of 2.80 kgs in Rainbow Children's Hospital, Himayatnagar, Hyderabad. Baby cried immediately after birth. Apgar scores were 8/10 at 1 min, 10/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done . Fetal presentation was Vertex.

Examination: He was euthermic, euvoletic & maintaining saturations at room air. Heart Rate- 120/min and Respiratory Rate - 40/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.65 kilo grams.
Weight at discharge : 2.78 kilo grams.

Investigations: Enclosed reports.

Management: He was admitted in ward. His Transcutaneous bilirubin was 17.5 mg/dl on admission done on OP basis. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Last serum bilirubin on 10 days of life was 8.5 mg/dl with indirect fraction of 8.0 mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

He remained hemodynamically stable and is being discharged with the following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Name	Baby Of SAMIKSHA JAISWAL	UHID	HHN-00015936
IP No	IP26-00006622	Admission Date	21-06-2026

Advice:

- Warmth care.
- Exclusive breast feeding.
- Continue direct breast feeds + measured feeds as advised.
- Burping after each feed.
- Monitor urine output.
- Immunization to be given as per schedule.
- Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.
- Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Review consultation with Dr. DILNAAZ FAROOQUI on Wednesday(24.06.2026) in OPD at Himayatnagar with prior appointment (**Review consultation will be charged**).

Review back to Hospital:

If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements 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.

Name	Baby Of SAMIKSHA JAISWAL	UHID	HNH-00015936
IP No	IP26-00006622	Admission Date	21-06-2026

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



Registrar/Resident/C.M.O.



Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

ACTIVITY RECORD FOR BILLING

Name: **HNH-00015936 IP26-00006622**
Baby Of SAMIKSHA JAISWAL
12-06-2026 0 Y 0 M 9 D (M)
Dr. DILNAAZ FAROOQUI

UHID No:  Consultant: _____ Dept: *Neonatal*

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>21/06/26</i>	<i>11:48 AM</i>	<i>ER</i>	<i>322 (1002/317)</i>	<i>[Signature]</i>

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00015936 IP26-00006622
Baby Of SAMIKSHA JAISWAL
12-06-2026 0 Y 0 M 9 D (M)
Dr. DILNAAZ FAROOQUI



Patient Name : _____ *g/o SAMIKSHA*

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____



Pediatric Multiorgan History & Physical Exarr

Name : B/o Samiksha

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

cl0 Yellowish discoloration of eyes & skin w 2dy

History of present illness :

cl0 Yellowish discoloration of eyes & skin :: 2dy

FT / 37⁺4 wk / 2-8 kg / uses

MBS | ABT
BBG | A + u

MBS }
OAK }

BY - WT - 2-8 kg

Yest WT - 2.65 kg

Today WT - 2-68 kg (↑ 30g)

↓ 1kg :: both
(5% wt loss)

Tc B - 17-5mg/dl



Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 2.68 kg (Centile _____)

On Examination :

Temperature : 38 Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

Rash _____ Itchy

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : R/LAS

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection Dr

Palpation : soft

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 : CTIA - Good

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials : Normal

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Normal

Pediatric Multiorgan History & Physical Examination

HNH-00015936 IP26-00006622
Baby Of SAMIKSHA JAISWAL
12-06-2026 0 Y 0 M 9 D (M)
Dr. DILNAAZ FAROOQUI



Preventive aspects of the treatment :

BIND

Desired goals of the treatment :

Treat MNHB

Planned Labs :

Planned Management :

SBR - T/M 6 AM

NIB skin signs

DSPT to eye & genital covered

-> DBF J/B palpation & ...

sof - formula - 35 - kcal/oz

- vit D3 dose

NIB skin signs

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 Dilnaaz

Dr. Dilnaaz Farooqui
Consultant Pediatrician
Reg. No: 27478

Date 21/6/26 Time _____



DRUG CHART

Date of Admission: 21/06/26 Drug Allergies: ALLA Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

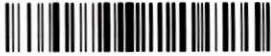
Weight. ...2.684... Ward.

DRUG : VITAMIN - D ₃ D ₁₂				Date Time	21/6															
Dose	Route	Frequency	Start Date																	
0.5ml	PO	OD	21/6																	
Name & Signature of the Doctor Starting the Drugs: Rana				[Signature]																
Additional Instructions: 1ml = 800 IU																				
Daily Doctor's Endorsement by a Sign																				

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



PROGRESS NOTES AND DOCTOR'S ORDER


Date & Time	Progress Notes	Doctor's Order
21/6 1pm	C/S/B Dr. Pranam / Dr. Nazreen	
	Dg/FT / 37 th wk / LSCS / 2.8kg / male / NNTB	
	Baby ↓ DSPT	P2
	Baby Euthanasia	1) CT - DSPT
	C/T/A good	2) DBF j/lb burping O ₂ 11 + FF
	on DBF + FF	3) Vit D ₃ drops
		4) Warm Com
		5) Monitor Vital
		N/B Suppign
		@1pr Pranam
	S/S Dr. Nameem / Dr. Pranam	
	D10 / FT / 37 th wk / LSCS / 2.8kg / male / NNT	
	Baby ↓ DSPT	Plan
	Euthanasia, C/T/A good accepting feeds well	① ct. DSPT if eyes and genitalia covered.
	T.Wt - 2.780 kg (↑ 100g)	② DBF every 2nd hly flb burping
		③ dent SBR @ 6am - Team
		④ Monitor Vital
		N/B - Monitor Vital
		Pranam

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26	S/B Dr. Dilnaaz	
10 AM	D ₁₀ O ₁ FT Local Mex / NMT.	
	y. wt - 2.68 kgs	Adv
	T. wt - 2.78 kgs	
	Repeat SBR - 8-5	- Cf breastfeeding hourly
	feeding well	- keep baby warm
	de	- Cf DSPT until discharge
	vitality stable	- Discharge.
		- Flw on wednesday
		(24/6/26)
	cns - active	
		Dr. Dilnaaz Farooqui Consultant Pediatrician Reg. No. 27476 Dilnaaz
		noted by Sr. Sandhya
		22/6/26
		10:am

PATIENT TRANSFER FORM

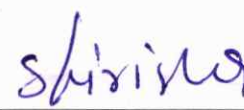


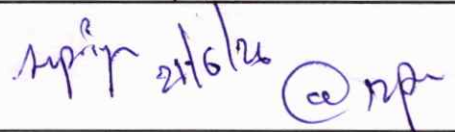
Patient Name & UHID No. HNH-00015936 IP26-00006622 Baby Of SAMIKSHA JAISWAL 12-06-2026 0 Y 0 M 9 D (M) Dr. DILNAAZ FAROOQUI 	Date & Time of Admission 21/06/26 @ 11:24 AM	Date & Time of Transfer Order 21/06/26 @ 11:58 AM
	Transfer Ordered by Dr. Poojara	Reason for Transfer Admission
From Unit ER	To Unit 3rd floor (317)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 154	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 No

Name & Signature of Person who is Transferring 	Name of Person Ordered Transfer Dr. Poojara
---	--

Patient & Clinical Records Received by :
 21/6/26 @ NP.

Date & Time of Patient Received :

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



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A 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 1008 (317)

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	VITAMIN-D3 Day	0.5 ml	PO	OD	20/6	<input checked="" 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 : Pranav KP

Date & Time : 21/6/26 at 11 AM

Nurse Name & Signature: Shiksha

Date & Time : 21/06/26 @ 11:48 AM

HNH-00015936 IP26-00006622
 Baby Of SAMIKSHA JAISWAL
 12-06-2026 0 Y 0 M 9 D (M)
 Dr. DILNAAZ FAROOQUI

BIF



RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
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					
Cells					
N/L					

HNH-00016936
 Baby Of SAMIKSHA JAISWAL
 12-06-2026
 Dr. DILNAAZ FAROOQUI
 IP26-00006622
 0 Y 0 M 9 D
 (M)

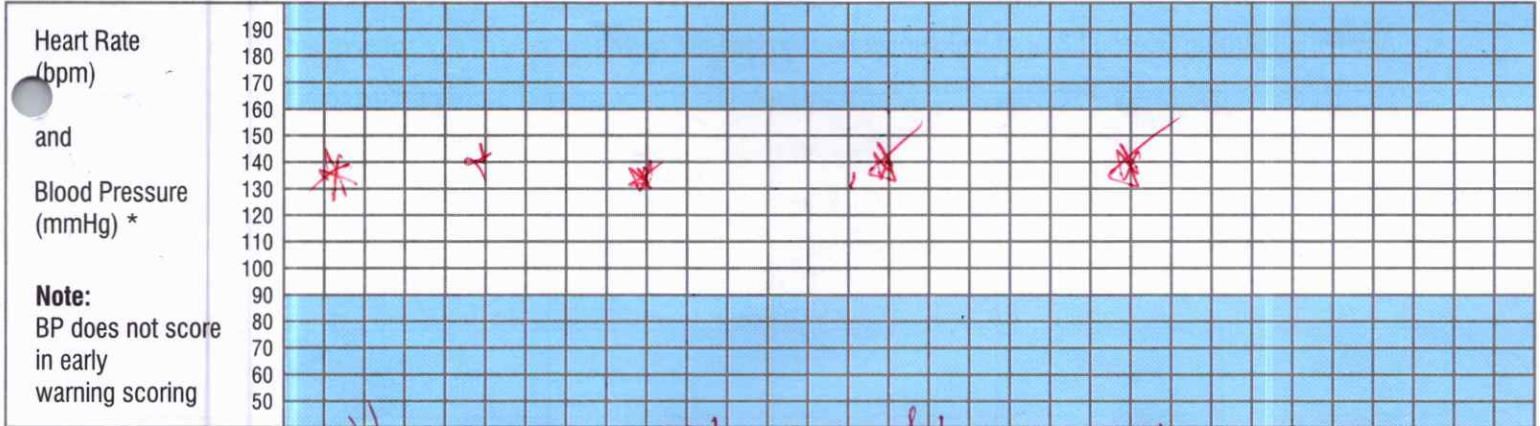
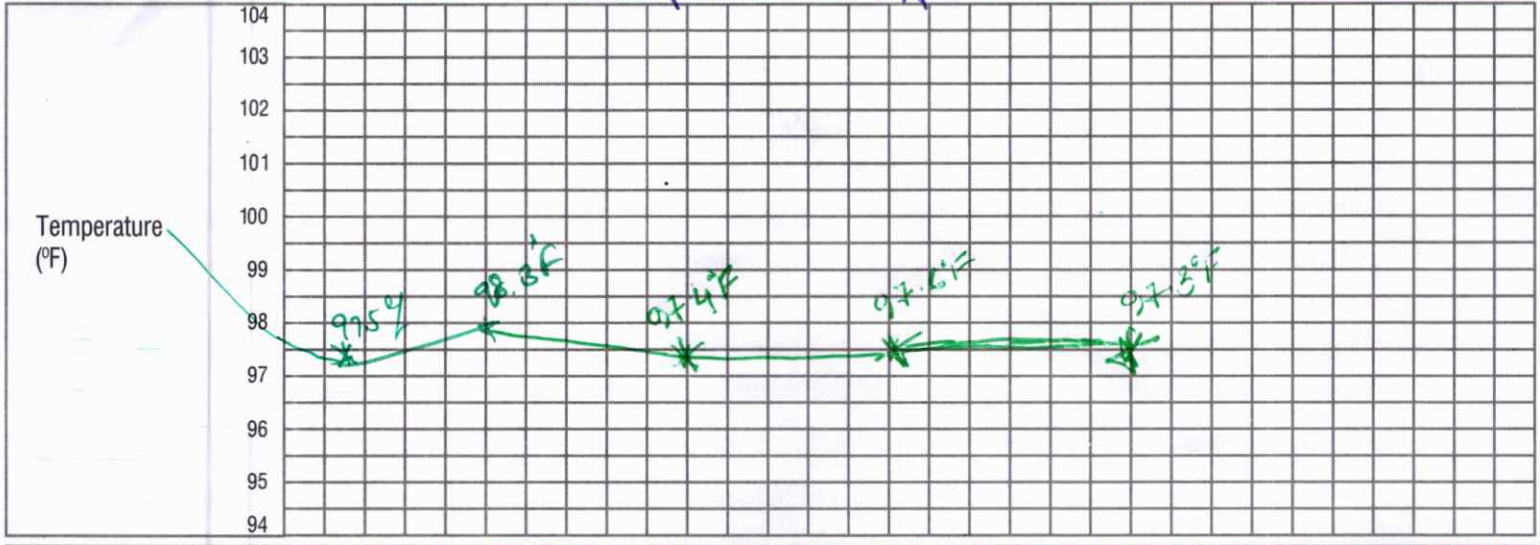
INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart



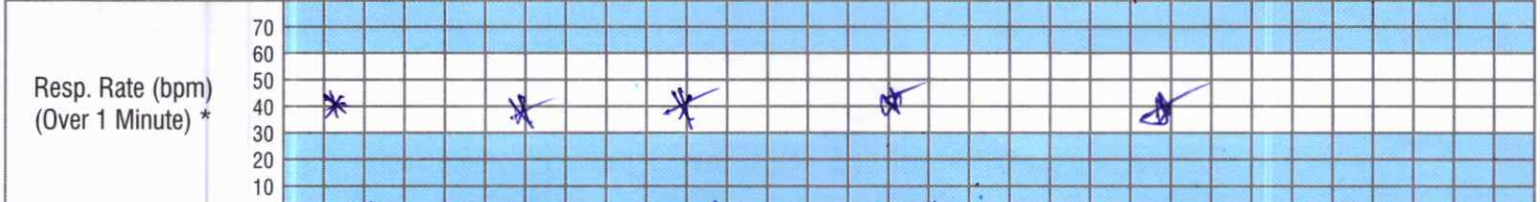
Patient Sticker

SCORE: CHILDREN'S UNIT

Date: 21/6/26 Time: 12 PM 6 PM 10 PM 2 AM 6 AM
 Doctor/Nurse/Family Concern?



Heart Rate (Number) 140b/h 142b/m 143b/l 148b/h 140b/l



Resp Rate (Number) 40b/h 43b/m 42b/l 40b/h 40b/l

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 98% 99% 100% 100%

Conscious Level Normal Altered

GCS *

TOTAL SCORE
 Number of shaded boxes 0 0 0 0 0
 Pain Score 0 0 0 0 0
 Observer's Initials [Signatures]

- 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:

- 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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00015936 IP26-00006622

Baby Of SAMIKSHA JAISWAL

12-06-2026 0 Y 0 M 9 D (M)

Dr. DILNAAZ FAROQUI

Patient Stic



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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/6/26	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm		DBL										
	01:00 pm		TH										
Total Intake :						Total Output :							
22/6/26	02:00 pm												
	03:00 pm		DBF										
	04:00 pm												
	05:00 pm		DBF + PF										
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output : U - M -							
23/6/26	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output : U - M -							
22/6/26	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output : U - M -							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



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					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	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												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm											11	
	04:00 pm											10	
	05:00 pm											1	
	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 :							
	02:00 am												
	03:00 am											11	
	04:00 am											10	
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



wt 2-68kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o Samiksha Jaiswal Age : 9 days Gender: Male Female
 Date : 21/06/26 Time of Arrival : 11:10 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: 98.8° F PR: 120b/m BP: RR: 40b/m SpO₂: 98%

Chief Complaints: cl yellowish discoloration all over the body

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	<input checked="" type="checkbox"/> Stable
<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Unstable :
<input type="checkbox"/> Sick Looking	<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening
Circulation / Colour		<input type="checkbox"/> Life -Threatening
<input checked="" type="checkbox"/> Normal <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 : 11:22 AM

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 : shirina Signature of Triage Nurse : [Signature]
 Date & Time : 21/06/26 @ 11:12 AM
 Docu. No. : RCH / FRM / CLINICAL / 085



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/06/26 Time of arrival : 11:14 AM

Chief Complaints: (10 yellowish discoloration all over the body)

Height : Weight : 2.68 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

<p>RISK FOR FALL: If patient is < 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input type="checkbox"/> Escort while ambulating <input type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality Inform consultant for positive criteria</p> <p>Nutritional Screening: <input type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method Inform consultant for positive criteria</p>
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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 : @ 11:16 AM

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

Time	Nursing Notes
11:18 AM	Assess the patient condition monitor the vital sign.

Samples collected by: _____ Time: _____
 Samples sent by: _____ Time: _____

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 120b/m BP: CFT: N/A RR: 20b/m SPO2 at FiO2: 98% GCS: 15/15/15 Temperature: 98.5 F Pain Score: - Repeat RBS (if applicable): N/A	Shift - out from ER to: 2nd floor (317) Time of Shift - out: 11:48 AM Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):
 N/A

Name of the Nurse: skirina Signature of the Nurse: [Signature]

Date & Time: 21/06/26 @ 11:20 AM

HNH-00015936 IP26-00006622
 Baby Of SAMIKSHA JAISWAL
 12-06-2026 0 Y 0 M 9 D (M)
 Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 21/6/24

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	12 AM	Assess the Baby Condition - Monitor vitals & DBF - DBF + H 2nd hourly given		- Assessed the pt Condition - Monitored vitals & DBF - DBF + H 2nd hourly given	Baby is stable	Rechecked vitals	[Signature]
Afternoon	2 PM	- Assess the baby condition - Monitor the v/s - Maintain the I/O - et DSPT - I/M SBR up 6 AM	2 PM to 3 PM	- Assess the baby condition - DBF every 2nd hourly - Maintain the I/O chart	- Now baby is stable - et DSPT	Rechecked the v/s	[Signature]
	3 PM	- Assess the general condition of pt. - Monitor vitals - Plan to give DBF every 2nd hourly. - Continue DSPT.	3 PM	- Assessed the general condition of pt. - Monitored vitals - Maintained vitals chart. - Baby is on continue DSPT.	Baby is stable	Re-assess vitals	[Signature]
Night	8 AM						

Patient Sticker

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							

HNH-00015936 IP26-00006622
 Baby Of SAMIKSHA JAISWAL
 12-06-2026 0 Y 0 M 9 D (M)
 Dr. DILNAAZ FAROOQUI



Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Area	Shift Time	21/6/26 M6	21/6/26 E2	22/6/26 N1		
BACKGROUND	Medical Condition (Any special condition to be noted):		NW	NW	NW		
ASSESSMENT	Allergy:		<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
	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:	97.5 F	98.3 F	98.4 F	
			Res:	16b/m	12b/m	14b/m	
			SpO ₂ :	99%	99%	99%	
			Pulse:	106b/m	142b/m	140b/m	
			BP:	-	-	-	
			Fall Risk Score:	-	-	-	
RECOMMENDATIONS	Safety Needs:		YES	Yes	YES		
	Physiotherapy		<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
	Others Specify:		-	-	-		
	Special Diet:		<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
	Other Special Orders / Medications:		-	-	-		
Post Operative Procedure Special Orders:			-	-	-		
Handed Over By Name :			Amrta	Sunanda	Moutrah		
Signature :							
Date:			21/6/26	21/6/26	22/6/26		
Time:			2pm	3pm	8AM		
Taken Over By Name :			Sunanda	Moutrah			
Signature :							
Date:			21/6/26	21/6/26			
Time:			2pm	8pm			

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	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
	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 ₂ :						
	Pulse:						
BP:							
Fall Risk Score:							
Pain Score:							
Recommendations	Safety Needs:						
	Physiotherapy	<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
	Others Specify:						
	Special Diet:	<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
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of SAMIKSHA JAISWAL Age : 0 Y 0 M 9 D
IP No: IP26-00006622 Sex: Male
Consultant: Dr. DILNAAZ FAROOQUI 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: *Abhishek Jaiswal*)

- 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.

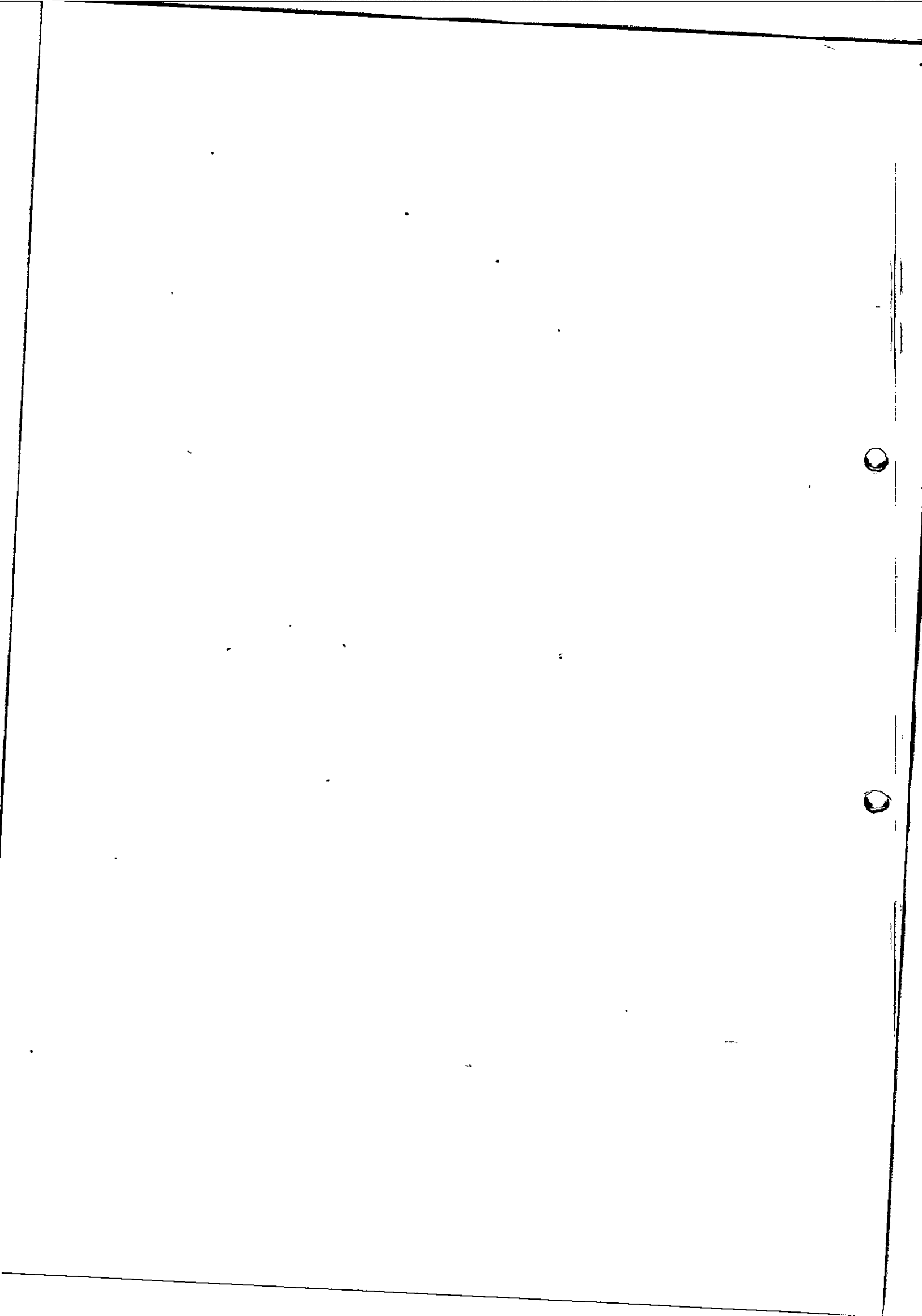
Signature of Patient/Relative:

Name: *Abhishek Jaiswal*
Relationship: ~~Husband~~ father

Patient Address:
11-6-454 nampally Agapura
Hyderabad Telangana INDIA 500001

Date: *21/06/2026* Time: *11:24 am*

Witness Name:
Witness Signature: *[Signature]*



HNH-00015936 IP26-00006622
Baby Of SAMIKSHA JAISWAL
12-06-2026 0 Y 0 M 9 D (M)
Dr. DILNAAZ FAROOQUI



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It takes a lot to treat the little

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
Years
of being the quality right
Nurturing Babies. Shining Bright

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.

Milshet Jaishwal

Name & signature of Patient/Attendant

Puja

(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, Dault 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

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