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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

ACTIVITY RECORD G

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

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

Date of Admission : 26/4/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/4/26	11:20pm	ER	PICU	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
24/6/26	CBP	10307	
	CRP		
	S. creatinel.		
	LFT		
	calcium, magnesium		
	NBC	10306	
	Blood clg (T)	10308	
25/6/26	MRI Brain with contrast	7538	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/6/26	Invasive monitoring	25/6/26 @12am		8049	[signature]
	Infusion pump	25/6/26 12am			

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
24/6/16	w placement	1	8024	[signature]

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o ear pain, ear discharge (lt) ear x 2dys
C/o upward gaze, uprolling of eyes x overnight.

History of present illness :

Pt was apparently alright 2 days before then mother noticed excessive cry, ear discharge from left ear since 2 dys.

C/o upward gaze, uprolling of eyes 3-4 episodes at residence each lasted for 30 sec - 1 minute

1 episode noticed at ER, aborted with Midazolam (1 puff) nasal spray

No H/o fever / cold / loosestools

H/o 2 episodes of vomiting in ER

Pediatric Multiorgan History & Physical Examination

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

Nothing significant.

Birth & Neonatal History :

T/ (38wy) | 3.24 kg | CIAB | EL-LSCS.

Birth & Socio Economic History :

About Father :

About Mother : —

Any additional Information :

Developmental History :

Developmentally normal.

Immunization History :

Vaccinated till 14 weeks. according to NIS.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 5.8 kg (Centile _____)

On Examination :

Temperature : 98.8°F Pulse Rate: 142. Description _____

B.P. _____ SPO2 98% at RA.

Resp. rate and type of breathing : 28 cpm.

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : B/L NVBS

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1>2 heard.

Any murmur : No murmur

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : No organomegaly

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System : excessive cry (+) irritable.

Level of Consciousness : AVPU/GCS Score : Normal.

Cranial Nerves : (N).

Motor System :

Nutrition : Normal

Tone : Normal. Power Normal.

Co-ordinator : +

Posture :

Involuntary Movements : Absent.

Reflexes : (N).

DTR **Superficials :**

Plantars

Sensory System : (N).

Bladder / Bowel :

Clinical Summary & Diagnostic :

Seizure under evaluation

? It ear Asom. ? Meningitis.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP, VBG.
Blood C/S.
Sr. Calcium
Magnesium
Sr. Creatinine.
LFT

N/b Anupam

Planned Management :

- Inj. leviteractam. (40mg/kg) stat
- Inj. leviteractam. BD (20mg/kg/dose)
- Inj. ceftriaxone OD
- MRI Brain c̄ Contrast
- Inj. lacosamide 5mg/kg (further convulsions)
- PAC

N/b Anupam

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 ____________

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26 11pm	c/s/by. Dr. Pritch	
	Unproved Seizure.	c/d/w - Dr Abhishek.
	? ASOM ? meningitis.	
		Ear discharge (+)
	Vital stable.	Multiple Episode of Paroxysmal activity (+)
	HR = 149/min	— 2 Episode of vomiting.
	Temp Afebrile	
	RR – 40/min	
	SpO2 – 98%. RA.	
	GRBS – 128 mg/dl	Plan
		— IV fluids.
	S/E	— Inj CEFTRIAXONE.
	Tone (N)	— Inj CEVITERATAM.
	CNS – Irritable (+).	CD → PMD.
		— Check Head Circumference.
		— further consulting
		Inj LACOSAMID.
		. Inj PHENO
		— MRI Brain c contrast
		— PAC.
		— (T) sample.
		— w/f further seizure activity.

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26. 1 30 AM	c/s/by Dr. Anusha	
	Seizure under Evaluation	
	? ASOM.	
		Plan
	Baby comfortable.	- ct IV fluids
	Vitals:- HR = 154/min. SpO2 = 98%. Afebrile.	- ~~Send~~ Blds - (T) :
		- Inj CEFTRIAXONE LEVIPIL.
	No further seizure after admission.	- N/f further seizure episodes.
	No fever.	- MRI Brain c̄ Contrast
		- PAC
		- (T) remaining sample
		- Monitor vitals
	[signature]	

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

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6 7:00AM	C/S/L3 Dr. Naipunya / Dr. Anushee.	
	Seizure ↓ evaluation ? ASOM ? Meningitis	
	No fever.	plan
	vitals – HR= 142bpm, RR- 28cm, SpO$_2$ - 98%.	– Trace. B/C/s. pus C/S (outside)
	R/S - B/L AE (+).	– Cont Inj ceftriaxone. Inj. levipil.
	P/A - soft, NT	– MRI brain. c̄ contrast at 10:30AM.
	PAC Done	– Monitor vitals
	U/O/P - 2.5ml/kg/hr.	– Cont IVF.

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 9 AM	C/B Dr Abhishek	
	Δ seizure ↓ evaluation	
	? ASOM ? Meningitis	
	No fever	
	child stable	
		Adv
	O/E HR 172/min	
	RR 34/min	- Trace B/C/S
	SpO2 100%	prev C/S outside
	P/A BAE+	
		- MRI Brain c̄ Contrast (Dr Nihal) Report.
		- MRI Requisition form.
		Abhishek

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26	Counselling	
am		
	Chewing Movements,	Staring Moments, ~~a~~ fits
	Due to Brain condition -	Genetic
	-	Infection (Meningitis)
	-	Brain structural defect.
	TLC 17K	
	Started on Ceftriaxone.	
	Culture sent - Report	awaited
	To decide about CSF →	To Check infection +/-
	✓ MRI brain c̄ Contrast to be	done today
	✓ CSF to be done after MRI	
	~~Rab~~ If infection (+) in CSF	2wk - 4wk. Antibiotic
	EEG should be done	T/m.
Inj	Levipil being continued	if no fits ↓ Convert to Oral
	Headache, Photophobia,	Irritability ? only in older Children
	< 6 months → asymptomatic,	subtle symptoms +
	If ~~MRI~~ Baby stable	

plan to shift to ward.

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00018155 IPZ6-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : CROSIN DROPS.	Dose	Route	Frequency	Start Date	Date / Time
	0.8ml	PO.	SOS	24/6.	
Doctor's Signature	Valid Period	Pharm.			
Additional Instructions: (100mg/1ml)					

DRUG : MIDAZOLAM SPY.	Dose	Route	Frequency	Start Date	Date / Time
	1puff	Nasal.	SOS	24/6	
Doctor's Signature	Valid Period	Pharm.			
Additional Instructions: (1.25mg/1puff)					

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

VERIFIED BY Name Sign Date

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

REGULAR PRESCRIPTIONS

Weight. 5.8kg Ward. .....

DRUG : Inj CEFTRIAXONE.

Dose	Route	Frequency	Start Date
200mg	iv	BD	24/6/26.

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions: (100mg/kg/day). stop.

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Inj LEVITERACTAM.

Dose	Route	Frequency	Start Date
120mg	iv	BD.	24/6/26

Name & Signature of the Doctor Starting the Drugs: Af.

Additional Instructions: maintain (20mg/kg/dose) dose

Date / Time 25/6 10AM 10PM

Daily Doctor's Endorsement by a Sign

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
500mg	iv	OD	24/6

Name & Signature of the Doctor Starting the Drugs: Af.

Additional Instructions:

Date / Time 25/6 10PM 12AM

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time

Daily Doctor's Endorsement by a Sign

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

Weight. 58kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/6/26	11:05 pm	Inj LEVITERACTAM (40mg/kg)(LD)	240mg iv over 20min	iv.	Af.	AP
24/6/26	11:30pm	Inj ONDAN.	1.2mg stat	iv	Af	AP
24/6/26	11:30pm	Inj ESMOPRASOLE	6mg stat	iv	Af	AP
24/6/26	11:15pm	NEOMAC suppositry	80mg.	PR.	Af.	AP

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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
24/6/26.	11:15pm	. IV fluids DNS. (2/3 M)	iv	80ml/h. ↓	Af.		24/6	Af.	
		(1/2 M).		40ml/h ↓	Af		25/6	Af.	
25/6/26	8AM.	IV fluid (2/3)M.		16 ml/h	Af				

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis: Seizure			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	24/6/26 N	25/6/26 M				
	Medical Condition (Any special condition to be noted):	Seizures	Seizure				
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4F	98.6F				
	Res:	24 b/m	28 b/m				
	SpO_2:	100%	98%				
	Pulse:	158 b/m	149 b/m				
	BP:	-	-				
	Fall Risk Score:	-	-				
	Pain Score:	-	-				
Recommendations	Safety Needs:	-	yes				
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	-	-				
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	NA				
Post Operative Procedure Special Orders:		NA	NA				
Handed Over By Name :		Saisree	Seizure				
Signature :							
Date:		25/6/26	25/6/26				
Time:		8PM	8PM				
Taken Over By Name :		Sairam					
Signature :							
Date:		25/6/26					
Time:		8AM					

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

BRADEN 'Q' SCALE

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 24/6	25/6/26		
					Time : AM	MS		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	27	27		
				Evaluator's Name		SS		

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

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

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

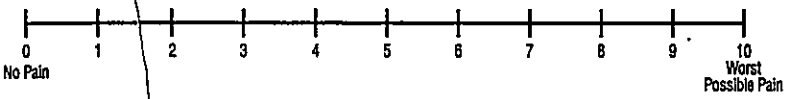
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6/26	12AM	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[illegible]
25/6/26	8AM	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 24/6			25/6 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					
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					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			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					
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					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA					
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

Signature : ..... Name : Sujatha

Docu. No. : RCH /FRM / CLINICAL / 137

HNH-00018155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 25/6/26	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position						
	Call device within reach						
	Wheels Locked						
	Room free of clutter						
	Adequate lighting						
	Wheel chair support						
	Other Intervention(s) Specify						
	Nurse's Name:						
	Signature:						
	Date:						
	Time:						

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

HNH-00016155 IP26-00006638
Name: ..... Master VALLURI NAGA YASHWIN ..... Age: ..... Gender: Male ☐ Female ☐
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN
UHID.No : .... Date: 24/6/26.

I ..... S/o, D/o, W/o, ... hereby declare that our patient Master/Baby ..... who is related to me as ..... is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on .....

The doctors have explained to me in a language understood by me that my child has following health related issues :

..... Seizures (Recent Episodes)
..... S/o discharge.
.....

The doctors have clearly explained to me that my patient Master / Baby ..... during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : Naga yashwin ..... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: .....
Name: Harish
Relationship with Patient: Father
Date & Time: 25/6/26 @ 1 PM

Witness :

Signature: .....
Name: Saisri
Date & Time: 25/6/26 @ 1PM

Doctor (who is taking the consent) :

Signature: .....
Name: Anusha.
Date & Time: 25/6/26

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

wt- 5.8 kg

GRBS 128 mg/dl

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Naga Yashwin Age : 4m **Gender:** ☑ Male ☐ Female

Date : 24/6/26 Time of Arrival : 10:5 Pm

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 PR: 149 BP: ..... RR: 48 SpO_2: 98%

Chief Complaints: c/o cough, pain, fever

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal
☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 10:7 Pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Anusha

Signature of Triage Nurse : AP

Date & Time : 24/6/26 @ 10:10 Pm

Docu. No. : RCH /FRM / CLINICAL / 085

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/6/14 Time of arrival : 10.50 PM

Chief Complaints: c/o ear Pain since 2-3 days.

Height : ..... Weight : 5.8kg Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character N/A ☐ Location N/A ☐ Frequency N/A ☐ Duration N/A

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☑ No

If **'Yes'** tick below fall risk intervention directly

If Patient is > 6 years

If **'Yes'** Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
- ☑ Assist Patient
- ☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☑ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse @ 11.30 PM

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

Time	Nursing Notes
11pm	=> Assessed the general condition
	=> Vitals checked and recorded
	=> IV Cannula
	=> Sample collected

Samples collected by: [illegible] Time: [illegible]

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
24/6/26	Anmol Suppo	Rectal	80mg Dr. [illegible]	[illegible]	[illegible]
24/6/26	Inj Levipil	IV	250mg Dr. [illegible]	[illegible]	[illegible]
	Midazolam	1 puff	intranasal Dr. [illegible]	[illegible]	[illegible]

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 126b BP: .... CFT: <2sec	Shift - out from ER to: PW
RR: 28 SPO2 at FiO2: 99%	Time of Shift - out: ....
GCS: 15 Temperature : 98.4	Handover given to: .... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse: [illegible] Signature of the Nurse : [signature]

Date & Time : 24/6/26 @ 11:20pm

PATIENT TRANSFER FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016155 IP26-00006638 Master VALLURI NAGA YASHWIN 11-02-2026 0 Y 4 M 13 D (M) Dr. ABHISHEK RAVINDRA JAIN	24/6/26 @	24/6/26
	Transfer Ordered by	**Reason for Transfer**
	Dr. Naipun	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	PICU	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
10	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[illegible]	Dr. Naipun

Patient & Clinical Records Received by : Saisri / [signature] 25/6/26 @12AM

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

Docu. No. : RCH /FRM / CLINICAL / 102

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: nill ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: PICU

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Maiguy

Date & Time : 24/6/26 @ 11:10am

Nurse Name & Signature: [illegible]

Date & Time :

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

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	24/6/26					
Time	11:27pm					
Hb	11.3					
PCV	31.6					
RBC	4.0					
WBC	17.03					
N/L	29.3/58.1					
Platelets	477					
CRP	15.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg	11.6/2.0					
Phosphate						
Urea						
Creatinine	0.3					
ALP	234					
SGPT	22					
SGOT	31					
T.Bill/Conj	0.2/0.1					
T.Protein	7.1					
S.Albumin	4.7					
S.Globulin	2.4					
A/G Ratio	1.9					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006638 **Admit Date** : 24-Jun-2026 **Admit Time** : 11:19 PM **UHID** : HNH-00016155

Patient Details :

Patient Name	: Master VALLURI NAGA YASHWIN	**Age**	: 0 Y 4 M 13 D
Guardian	: Mr HARISH VALLURI	**DOB**	: 11-02-2026 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 1-1-336/98 ST NO : 8 VIVELK NAGAR Chikkadpally Hyderabad Telangana INDIA 500020	**Phone No**	: 7032856308/ 9010532147
		E-mail	: NO@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 HARISH VALLURI	**Relationship**	: Father
Contact Address	: 1-1-336/98 ST NO : 8 VIVELK NAGAR Chikkadpally Hyderabad Telangana INDIA 500020	**Phone No**	: 7032856308

V. Harish

Signature

Doctor Details :

Doctor Name	: Dr. ABHISHEK RAVINDRA JAIN	**Specialisation**	: PEDIATRIC NEUROLOGY
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	: Dr. PRITESH NAGAR		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: MEDI ASSIST INSURANCE TPA PVT LTD

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Name: Valleri Naga Yashwa Age: 4month Sex: Male UHID.No : HNH 00016156

Date: 25/6/2026 Time: 6.18a.m Proposed Operation: MRI Brain c contrast

Diagnosis: Seizure for evaluation ? meningitis

B.P: 87/56 H.R: 144 Weight: 5.8kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

24/6/26

Hgb: 11.3	Glucose:	Protein:	HIV:	X-Ray:
PCV: 31.6	Urea:	Alb:	HBS Ag:	ECG:
WBC: 17.03	Creat: 0.3	Total Bill:	HCV:	2D Echo:
Plate: 477	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++: 12	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT: 31/22		

Allergies:

Medical History: CVS : (-) LSCS | Term | 3.4kg | CIAB | No NICU admission

RESP (-) Diabetes :

CNS : H/o seizure since yesterday → eye rolling

Renal : (-)

Hepatic / GE : (-) Physical Activity: active, feeding well

Others : (-)

Past Anaesthetic History: (-)

Physical Exam: No fever, urine output N.

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : RR - 28/min

Heart: S1 S2 N

CNS: GCS Full

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : 24G (L) hand Spine Exam for regional : not done.

Anaesthetic Plan: ☑ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions: Formula milk given at 5am

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

.....

.....

.....

Signature: Name: Dr Shalini.

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

ANAESTHESIA CHART

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status:
Physical Status:	☐ Patient Identified	☐ Consent Present ☐ Chart Reviewed

H.R:	B.P:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: ..... Operation: ..... , Date : .....

Surgeon: ..... Anaesthesiologist: ..... Technician: .....

TIME
N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:

Antibiotic
Suppository
Blood Loss
NOTES

FIO_2 / SaO_2
$ETCO_2$
ECG
Temperature
Urine Output

Fluids
Blood

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

240 220 200 180 160 140 120 100 80 60 40 20 10 0

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

TV
PIP
PEEP

LAB Values

ABG
GRBS
Others

☐ Equipment Checked and Functional
☐ BP
☐ Cuff Site: .....
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: .....
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ IV: .....
☐ IV: .....

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor : .....
Signature of the Doctor : .....

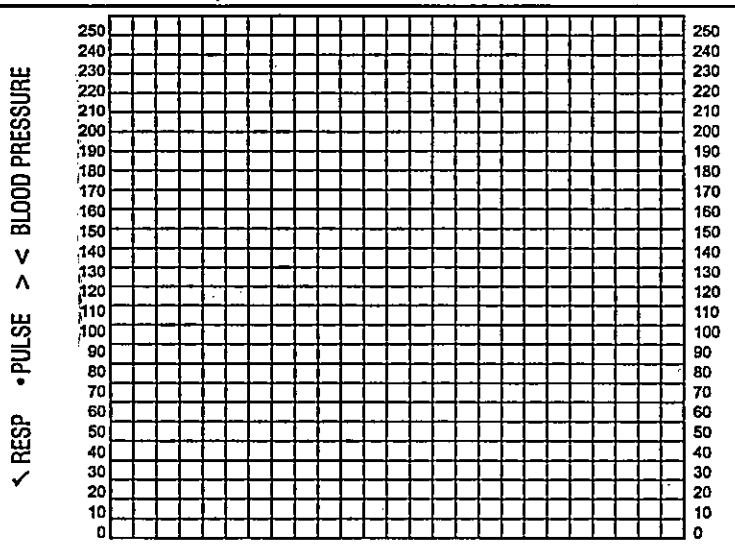
Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No

IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 2	ACTIVITY						A Minimum Total Score of 8 Is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION						
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION						
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS						
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR						
		TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving Intervention
   d. With In 30-60 minutes after pain relief Intervention

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

Transferred to Unit by (PACU): .....
Date & Time: .....

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP and Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

HNH-00016155 IP26-00006638
Master VALLURI NAGA YASHWIN
11-02-2026 0 Y 4 M 13 D (M)
Dr. ABHISHEK RAVINDRA JAIN

CONSENT FORM FOR ANAESTHESIA

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : ..... Age : ..... Gender : Male ☐ Female ☐

UHID NO: ..... Surgeon Name: .....

Anaesthesiologist : ..... Operative procedure planned : .....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : ..... Name : ..... Date & Time : .....

CONSENT FOR SPECIAL SEDATION

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name: Valleru Naga Yashwin Gender: ☒ Male ☐ Female

UHID No: HN4 0001 6156 Department: PICU Date: .....

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

Here by give consent for procedure for my patient : Valleru Naga Yashwin

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : .....
- Possible complications from the procedure of sedation:

  Desaturation, Bronchospasm, Laryngospasm

  .....

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

Patient Attendant :

Signature : Ramya

Name : V. Ramya.

Relationship with Patient: mother.

Date & Time : 25/6/2026 6.20 am

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Shalini

Date & Time : 25/6/2026 6.20 am