DISCHARGE AT REQUEST

Name	Master MOHAMMED ALI UDDIN	**UHID**	HNH-00013990
Father/Guardian	Mr MOHAMMED TAMEEM UDDIN	**Age/Gender**	1 Y 9 M 14 D/ Male
Address	9-10-430/22/A ROSHAN COLONY., Golconda, Hyderabad, Telangana, INDIA, 500008		
IP No	IP26-00006523	**Admission Date**	06-06-2026
Ref Doctor	SELF		
Discharge Date	08.06.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS WITH DEHYDRATION	

History: Master MOHAMMED ALI UDDIN, 1 Y 9 M 14 D , old boy presented with history of high grade intermittent fever since 3 days , associated with cough since 1 day and decreased acceptance of feeds prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

OPD BASIS:
Initial hemogram showed Hemoglobin of 9.6 gm%, White Blood Cell count of

Name	Master MOHAMMED ALI UDDIN	UHID	HNH-00013990
IP No	IP26-00006523	Admission Date	06-06-2026

17200 cells/cumm, platelet count of 4.13 lakhs/cumm and C-Reactive Protein of 10 mg/l. Complete urine examination shows 6-8 pus cells, 3-5 epithelial cells.
Blood culture and sensitivity shows no growth after 24 hours of incubation

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 130 /min, and Respiratory Rate - _35 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output, dull looking, tachycardia, dry oral mucosa, sunken eyes, flushing . On auscultation, air entry was bilaterally equal , no added sounds . Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: kilo grams.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics.

He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

Parents are counselled about the nature severity of illness and possible prognosis of the childs condition. They were also counselled about the need for

Name	Master MOHAMMED ALI UDDIN	UHID	HNH-00013990
IP No	IP26-00006523	Admission Date	06-06-2026

further hospital stay. How ever parents were unwilling for further management on personal grounds and requested the child to be discharged on IV antibiotics and to be continued till culture reports. Hence child is being Discharge on Request.

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

Medication during hospital stay:
Injection. Ceftriaxone
Metatop nasal spray
Syrup. Xyzal
Injection. Esmoprazole

Advice:
* Diet as advised.
REVIEW WITH FINAL B/C/S REPORT AND U/C/S REPORT .

Name	Master MOHAMMED ALI UDDIN	**UHID**	HNH-00013990
IP No	IP26-00006523	**Admission Date**	06-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	INJ CEFTRIAXONE	1.2GM IN 50ML NS IV OVER 2 HOURS	once daily	TILL FURTHER ORDERS
2	METATOP NASAL SPRAY	1 PUFF NASAL	twice daily	TILL FURTHER ORDERS
3	Syrup. XYZAL (2.5MG/5ML)	2.5 ml	once daily at bed time	For 3 days
4	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect final blood culture report on followup.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on WEDNESDAY (10.06.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged).**

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours

Name	Master MOHAMMED ALI UDDIN	**UHID**	HNH-00013990
IP No	IP26-00006523	**Admission Date**	06-06-2026

after food based on tolerance of stomach.

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

If any IV antibiotics - will be given in Emergency Room between 7am - 8am for morning dose, between 2pm-3pm for afternoon dose and between 8pm-9pm for evening dose (Outside medication shall not be allowed within the hospital as per the hospital protocol).

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

Name	Master MOHAMMED ALI UDDIN	**UHID**	HNH-00013990
IP No	IP26-00006523	**Admission Date**	06-06-2026

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

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 : IP26-00006523 **Admit Date** : 06-Jun-2026 **Admit Time** : 03:21 PM **UHID** : HNH-00013990

Patient Details :

Patient Name	: Master MOHAMMED ALI UDDIN	**Age**	: 1 Y 9 M 14 D
Guardian	: Mr MOHAMMED TAMEEM UDDIN	**DOB**	: 23-08-2024 04:20 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 9-10-430/22/A ROSHAN COLONY. Golconda Hyderabad Telangana INDIA 500008	**Phone No**	: 7075953687/
		E-mail	: fatimaferdous535@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER03 **Ward Name** : GF -EMERGENCY

Room No : ER03 **Admission Type** : First Visit

Contact Details :

Name : Mr MOHAMMED TAMEEM UDDIN **Relationship** : Father

Contact Address : 9-10-430/22/A ROSHAN COLONY. Golconda Hyderabad Telangana INDIA 500008 **Phone No** : 7075953687

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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

UHID N ---------- Consultant : ---------- Dept : Pediatric

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
6/06/26	4:35 PM	ER	3rd Floor(301)	

Cross Consultation Visit

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

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
6/6/26	~~I v placement~~		
	Blood G/S, Urine	Done on op Basis	
	G/S, CBP, CRP,		
	~~CUE~~ CUE		
		Cross checked on 8/6/26	

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/6/26	Infusion pump	5pm	@8AM 8/6/26	4841	Sit

Cross Checked done
8/6/26

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
6/6/26	Iv placement	(1)	204813	

Cross checked done 8/6/26

ANY OTHER INFORMATION

6/6/26 6pm Don't Charge for NHA

Dr. Sathwika-S

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

HNH-00013990 IP26-00005523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

Mohd. Aliuddin/1y9month

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Name : _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

1) Fever since 3 days
2) Cough since 1 day
3) Decreased oral intake since 2 days

History of present illness:

Child was apparently asymptomatic 3 day back after which he had fever which is high grade intermittent responding to oral paracetamol

Cough started 1 day back day non productive

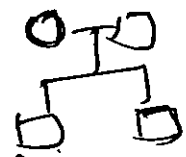
Child has decreased oral intake since 1 day

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Term LSCS (SIAB)



2nd born by twin

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

NIS schedule - 16 months vaccine pending.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs)__12.2 kg__(Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____Description _____

B.P. _____SPO2__96 %__ at RA

Resp. rate and type of breathing : _____

day 1: PS ⊕

Rash dry oral mucosa ⊕

Lymphadenopathy Submandibular

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE ⊕

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection Planar

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : Normal

Motor System :

Nutrition : (N)

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars (F)

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Δ AFI Edehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV fluids

Desired goals of the treatment :

Fever subsidence

Planned Labs :

Blood C/S

Urine C/S

Extra plain - 1

Resp. panel – not willing.

CBP
CRP
CUE on OPD basis
done

NIB shifting

Planned Management :

- Inj. CEFTRIAXONE 1.2gm IV OD
- ~~Inj~~. Syp. XYLAL 2.5ml bedtime
- Syp. CROCIN. 3.5ml (5ml/24kg SOS) 6HL
- ~~Syp~~. METATOP Neb 1 Spray / puff BD

NIB shifting

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 Dr. Sindhura M on whose name the patient is being referred

Doctor's Signature Name Dr. Sindhura M Date 6/8/18 Time 10:15pm

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/9/24 10PM	C/S/O Dr. Sindhura.	
	AFI ? dehydration.	
	- fever spikes (+).	
	- Oral intake - poor.	
	O/E - vitals stable.	
	S/E - WNL.	Plan - Trch blood/urine C/S.
		- fever monitoring QHH.
		- ct. ceftriaxone.
		IVFs

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No. 66970

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

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/8/24	S/B. Dr Prabhath / Dr Varun.	
8/8/24	△AFI c dehydration	
	Fever spikes - 2nd @ 8pm yesterday.	
	Oral intake - Poor	Adv
	fresh c/o -	
		- Fever monitoring QHH
	O/E Vitals	
	Stable.	- Trace blood c/s
		Urine c/s
	S/E WNL.	
		- CT Pelvis with
		N/B protocol

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 9am	c/o/B Dr. Sindhuja AFI c dehydration	
	- fever spikes (+) - oral intake : fair	
	O/E - vitals : stable - CVE - normal	Plan 1) Inj. ceftriaxone 2) Leave Blood cs urine cs. 3) Rest it. as per Rx chart 4) monitor vitals Noted by Divya 7/6/26 9AM
7/6/26 2:30pm	c/o/B Dr. Thanmi AFI c dehydration	
	- last spike e 8am - 101 - oral intake : fair - no vomit cs. O/E - vitals : stable CVE - (N)	Plan 1) Inj. ceftriaxone 2) Leave Blood cs urine cs 3) Rest it. as per Rx chart. Noted by Divya 7/6/26

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 15 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 8 am	UTI & Pneumonia AFI & dehydration	
	- no fever spikes : morning	
	- no fresh complaints	
	- oral intake : fair	
	O/E Vitals : stable S/E : RS : BAE (+) P/A : soft	Plan 1) Inj. ceftriaxone 2) Trace Blood sugars 3) Rest as per Rx chart 4) monitor vitals. Dr MS Ofcl.

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 15 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 10:30 AM	c/s/o Dr. Sindhura APA c dehydration. - No fever spikes since the morning. - Oral intake - fair O/E - vitals stable. S/E - WNL. - R/s - BAE(A), NVBS.	Plan - Ct. ceftriaxone post D/s. - Trace blood glucose d/s. - Discharge at request. - Monitor vitals. - R/v on Wednesday (10-6-2026). Noted by Divya 8/6/26

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-05-2024 1 Y 9 M 15 D (M)
Dr. SINDHURA MUNUKUNTLA

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

301

RESULT SHEET

Rainbow® Children's Hospital
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Date	6/6/26					
Time						
Hb	9.6					
PCV	29.0					
RBC	5.33					
WBC	17.20					
N/L	68.3/24.5					
Platelets	413.					
CRP	10.					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Date	6/6/26					
Time						
CUE-Alb	Nil					
CUE-Sugar	Nil					
CUE - Ketones	Negative					
CUE-PUS Cells	6-8					
CUE - RBC Cells	Nil					
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

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

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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/ CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

WARNING SCORE: CHILDREN'S UNIT

Date : 6/5/26

Time:	5:30 Pm	8Pm	10pm	11pm	12am	2am	4am	8am
Doctor / Nurse / Family Concern?								
Temperature (°F) (104 – 94)	103.4°F	100.2°F?	98.1°F	101.5°F	98.3°F	98.9°F?	98.2°F?	101.0
Heart Rate (bpm) and Blood Pressure (mmHg) * (190 – 50)								
Heart Rate (Number)	128 b/m	130 b/m	118 b/m	120 b/m		118 b/m		120 b/m
Resp. Rate (bpm) (Over 1 Minute) * (70 – 10)								
Resp Rate (Number)	28 b/m	30 b/m	28 b/m	28 b/m		30 b/m		28 b/m
Resp Distress: Mod/ Severe								
Resp Distress: None / Mild								
Receiving O_2(l/min)								
O_2 Saturations (%)		100%	99%	100%		99%		100%
Conscious Level: Normal								
Conscious Level: Altered								
GCS *								
TOTAL SCORE Number of shaded boxes		0	0	0		0		0
Pain Score		0	0	0		0		0
Observer's Initials		[initials]	[initials]	[initials]		[initials]		[initials]

Temperature chart annotations: Syp. Ibugesic given; Sponging given; (P-250 given); (P-250 given)

Note: BP does not score in early warning scoring

ACTIONS		
NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

IP28-00000525
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 15 D (M)
Dr. SINDHURA MUNUKUNTLA

H/ FRM / CLINICAL / 125

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

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/6 Time: 10 | 2 | 5:50 | 8:30 | 10pm | 12am | 10am | 6am

Doctor / Nurse / Family Concern? am | pm | pm | PM

Temperature (F)

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

Note: BP does not score in early warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	100%	99%
Conscious Level	Normal / Altered
GCS *	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0		
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE >3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DNS		30ml								
	06:00 pm	DNS		30ml								
	07:00 pm	DNS		30ml								
Total Intake :						**Total Output :**						
	08:00 pm			40ml								
	09:00 pm			40ml								
	10:00 pm			40ml								
6/6/26	11:00 pm	DNS	Kachi	40ml								
	12:00 am		ORS	40ml								
	01:00 am			40ml								
Total Intake :						**Total Output :**						
	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am			40ml								
7/6/26	05:00 am	DNS	ORS	40ml								
	06:00 am			40ml								
	07:00 am			40ml								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Master MOHAMMED ALI UDDIN (M)
23-08-2024 1 Y 9 M 15 D
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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
7/10/26	08:00 am	DNS		40ml							1	
	09:00 am	DNS		40ml								
	10:00 am	DNS	Sips	40ml	NA			NA		✓	0	D
	11:00 am	DNS		20ml								
	12:00 pm	DNS		20ml			✓			✓	1	
	01:00 pm	DNS		20ml								
Total Intake : Taken						Total Output : U – M –						
7/10/26	02:00 pm	↑	Upma	20ml								
	03:00 pm			20ml						✓		
	04:00 pm			-								
	05:00 pm	DNS		20ml	NA			NA		✓	0	Npm
	06:00 pm			20ml								
	07:00 pm	↓		20ml								
Total Intake : Taken						Total Output : U- M-						
	08:00 pm			20ml								
	09:00 pm			20ml								
	10:00 pm			20ml						✓	0	
	11:00 pm			—				NA				
	12:00 am			—								
	01:00 am			20ml	NA						1	Npm
Total Intake :						Total Output :						
8/10	02:00 am	↑		20ml								
	03:00 am			20ml								
	04:00 am	DNS		20ml	NA						0	
	05:00 am			20ml				NA				
	06:00 am			20ml						✓		
	07:00 am	↓		20ml							1	Npm
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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23-08-2024 1 Y 9 M 14 D
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Sticker

NURSING CARE RECORD

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Date: 6/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm – 8am	→ Assess the patient general condition → monitor vitals → DNS @ 40ml/hr to continue	8pm – 8am	→ Assessed the patient general condition → Monitored vitals → Administered medications as per doctor's orders	Patient is stable	Rechecked vitals	

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NURSING CARE RECORD

Date: 7/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am – 9am	→ Assess the pt condition → monitor vitals → maintain I/O chart → pt is on soft diet → Administer medication as per drug chart → IV cannula present → Ct IV fluids	8am – 2pm	→ Assessed the pt condition → monitored vitals & recorded → maintained I/O chart → medication as per drug chart → IV cannula present	→ pt is stable	→ rechecked vitals	[signature]
Afternoon		Day					
Night	8pm – 8am	Assess the baby [illegible] the VS Administer [illegible] Maintain [illegible]	8pm – 8am	Assessed the baby [illegible] VS administer [illegible] [illegible]	[illegible]	[illegible]	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: AFI & dehydration

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: .....

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	6/6/26 N1	7/6/26 M6	7/6/26 E2	8/6 8M		
Medical Condition (Any special condition to be noted):	—	—	—	—		
Diet:	—	—	Soft	—		

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	—	—	—	—		
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	97.8F	97.4°F	98.4°F	98.8°F		
Res:	28/m	28b/m	28b/m	32b/m		
SpO_2:	100%	99%	99%	100%		
Pulse:	106/m	116b/m	116b/m	122/m		
BP:	—	—	101/63	—		
LOC:	—	—	—	—		
Fall Risk Score:	—	—	—	—		
Pain Score:	—	—	"0"	—		
Skin Integrity	—	—	Good	—		

Recommendations

Safety Needs:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	—	—	—	—		
Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	—	—	Soft	—		
Critical Lab Test / Values:	—	—	—	—		
Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	—	—	—	—		
Post Operative Procedure Special Orders:	—	—	—	—		

Handed Over By Name :	Priyanka	Divya	Supriya	Priyanka		
Signature / ID :						
Date:	7/6	7/6/26	7/6/26	8/6		
Time:	8AM	2PM	8pm	8AM		
Taken Over By Name :	Priyanka	Supriya				
Signature / ID :						
Date:	7/6/26	7/6/26	7/6			
Time:	8AM	2pm	8PM			

Patient Sticker

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NURSING SHIFT HAND OVER FORM

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

HNH-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE

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					Date : 6/6/26	6/6/26	7/6/26	7/6/26
					Time : 6PM	10PM	6AM	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	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name				

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

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-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 15 D (M)
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BRADEN 'Q' SCALE

Rainbow® Children's Hospital
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					Date : 7/6/24 8/6			
					Time : E2			
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.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
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.	3	3		
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	23	19		
				Evaluator's Name				

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

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-00013990 IP26-00006523
Master MOHAMMED ALI UDDIN
23-08-2024 1 Y 9 M 14 D (M)
Dr. SINDHURA MUNUKUNTLA

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CHECKLIST FOR THROMBOPHLEBITIS

6/6/26 7/6/26

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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

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DRUG CHART

Date of Admission: 6/06/26 Drug Allergies: NKA ☐ 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: SYP. CROCIN-D

Dose	Route	Frequency	Start Date
3.5ml	oral	SOS/6th L	

Doctor's Signature: [illegible] | Valid Period | Pharm.

Additional Instructions: Paracetamol (5ml/240mg)

Date/Time

DRUG: SYP. IBUGESIC (100mg/5ml)

Dose	Route	Frequency	Start Date
2ml	PO	SOS	

Doctor's Signature | Valid Period | Pharm.

Additional Instructions:

Date/Time 6/6/26 5:30 PM

DRUG: SYP. P250

Dose	Route	Frequency	Start Date
3.5ml	PO	SOS/6th H	

Doctor's Signature | Valid Period | Pharm.

Additional Instructions:

Date/Time 7/6 11 PM 7/6 5:55 PM

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

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Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 12.2 kg Ward. .....

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1.2gm	IV	OD	6/6

Name & Signature of the Doctor Starting the Drugs: B. Sneha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 6/6 7/6 8/6

6PM 12PM

DRUG : METATOP nebl 1/4

Dose	Route	Frequency	Start Date
1 puff	nebl.	BD	6/6

Name & Signature of the Doctor Starting the Drugs: B. Sneha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 6/6 7/6 8/6

10AM 10PM

DRUG : Syp. XYZAL

Dose	Route	Frequency	Start Date
2.5ml	Oral	bedtime	6/6

Name & Signature of the Doctor Starting the Drugs: B. Sneha

Additional Instructions: Levocetrizine (5mg/2.5ml)

Daily Doctor's Endorsement by a Sign

Date/Time: 6/6 7/6

11:40pm 10PM

DRUG : Inj. ESMOPRAZOLE

Dose	Route	Frequency	Start Date
10mg	IV	OD	6/6

Name & Signature of the Doctor Starting the Drugs: B. Sneha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 6/6 7/6 8/6

6AM 6PM

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Dr. SINDHURA MUNUKUNTLA

Weight. ..... 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

Sig and ... Name ...

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Dr. SINDHURA MUNUKUNTLA

I.V. FLUIDS CHART

Weight. ..... Ward. .....

Date	Time	position 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
6/6	4PM	DNS	IV	~~40~~ wle			7/6		
7/6	9am	IVF DNS (½ main)	IV	20 ml/hr			8/6		

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

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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: ER Shifted to: ward (301)

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. Sreeja

Date & Time : 6/06/26 @ 3:11 PM

Nurse Name & Signature: S. Lisiya

Date & Time : 6/06/26 @ 4:38 PM

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00013990 IP26-00006523 Master MOHAMMED ALI UDDIN 23-08-2024 1 Y 9 M 14 D (M) Dr. SINDHURA MUNUKUNTLA	6/06/26 @ 3:24 PM	6/06/26 @ 4:35 PM
	Transfer Ordered by Dr. Sreeja	Reason for Transfer Admission
From Unit ER	To Unit ward (30)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15-1-	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant 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
Shirisha	Dr. Sreeja

Patient & Clinical Records Received by : Divya 5PM 6/6/26

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

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wt. 12.2 kgs

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EMERGENCY TRIAGE FORM

Patient's Name : mohammed Ali Uddin Age : 1 year **Gender:** ☐ Male ☐ Female

Date : 6/06/26 Time of Arrival : 3:50 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: 101.6 F PR: 120b/M BP: ..... RR: 36b/M SpO_2: 94%

Chief Complaints: c/o fever since 3 days cough since 1 days

INITIAL PHYSIOLOGICAL CATEGORIZATION	**INITIAL PHYSIOLOGICAL STATUS**
Appearance: ☐ Normal ☐ Sick Looking Circulation / Colour: ☐ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☐ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☐ 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 : 3:59 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 : shyny

Signature of Triage Nurse : .....

Date & Time : 6/06/26 @ 3:48 PM

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/06/26 Time of arrival : 3:54pm

Chief Complaints: c/o fever since 3 days cough since 1 days

Height : ..... Weight : 12.2kgs Head Circumference (<2 years) .....

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

If yes , identify .....

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

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☑ No

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

If Patient is > 6 years

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

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With family

Siblings in household ☑ Yes ☐ No (if yes How Many?) 1

Time of Initial assessment completed by ER Nurse : @ 8:56pm

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

Time	Nursing Notes
3:58 PM	Assess the patient condition monitor the vital sign

Samples collected by: / Apurba Time: / 4:10 PM

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: 120 b/M BP: ..... CFT: N/A RR: 38 b/M SPO2 at FiO2: 98% / ..... GCS: 15 / ..... Temperature : ..... Pain Score: ..... Repeat RBS (if applicable): N/A	Shift - out from ER to: 3rd Floor (30) Time of Shift - out: 4:35 PM Handover given to: ..... (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV Placement done

Name of the Nurse : Shirin Sing Signature of the Nurse : Sig

Date & Time : 6/06/26 @ 3:58 PM

Rainbow Childrens Hospital-Himayatnagar

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master MOHAMMED ALI UDDIN**	**Age :**	**1 Y 9 M 14 D**
IP No:	**IP26-00006523**	**Sex:**	**Male**
Consultant:	**Dr. SINDHURA MUNUKUNTLA**	**Ward/Bed No:**	**GF -EMERGENCY/ER03**

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:.....)

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: Ferdous

Name: Ferdous Fatima

Relationship:

Date: 06/06/26 Time: 3.53 pm.

Witness Name: Sowmya Nayee

Witness Signature:

Patient Address:

9-10-430/22/A ROSHAN COLONY.
Golconda Hyderabad Telangana INDIA
500008

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25 Years

BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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