

DISCHARGE SUMMARY

Name	Baby Of SEEMA MAIYA	UHID	HNH-00015801
Father/Guardian	Mr SANAL S MENON	Age/Gender	0 Y 0 M 4 D/ Male
Address	3-4-812/1 ,g-12, Barkatpura, Hyderabad, Telangana, INDIA, 500027		
IP No	IP26-00006538	Admission Date	08-06-2026
Ref Doctor	Self.		
Discharge Date	10.06.2026		

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

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of SEEMA MAIYA is a 0 Y 0 M 4 D old baby boy presented with history of yellowish discolouration of skin and eyes since 2 days prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 15 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Name	Baby Of SEEMA MAIYA	UHID	HNH-00015801
IP No	IP26-00006538	Admission Date	08-06-2026

Birth history: Baby Of SEEMA MAIYA is a Late Preterm (35 weeks + 3 days) baby boy, delivered to a G3P1A1L1 mother by normal vaginal delivery on 04.06.2026 at 06:43 pm with birth weight of 2.42 kgs in Rainbow Children's Hospital, Himayatnagar, Hyderabad. Baby cried immediately after birth. Apgar scores were 8/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Examination: He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 142/min and Respiratory Rate - 38/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.30 kilo grams.
Weight at discharge : 2.360 kilo grams.

Investigations: Enclosed reports.

2d Echo shows

Situs Solitus Levocardia
Normal sized cardiac chambers
Good biventricular function
PFO with left to right shunt
Left arch, No COA

Management: He was admitted in ward. His Transcutaneous bilirubin was 15 mg/dl on admission done on OP basis. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. On day 4 of life as serum bilirubin was 22mg/dl for which baby shifted to NICU

Name	Baby Of SEEMA MAIYA	UHID	HNH-00015801
IP No	IP26-00006538	Admission Date	08-06-2026

and started on triple surface phototherapy and IV fluids + measured feeds . Serial serum bilirubin values were done which were in decreasing trend , hence shifted to ward on day 5 of life . Last serum bilirubin on day 6 of life was 7.3 mg/dl with indirect fraction of 7.2 mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

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

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: Done on 08.06.2026 showed Bilateral normal outer hair cells functioning.

Newborn screening advanced / Newborn sreening-4 : Sent on 08.06.2026, report awaited.

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

Advice:

Warmth care.

Exclusive breast feeding.

Continue direct breast feeds + measured feeds as advised.

Burping after each feed.

Monitor urine output.

Immunization to be given as per schedule.

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.

Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

- 1. Collect Newborn screening advanced report on followup.**

Name	Baby Of SEEMA MAIYA	UHID	HNH-00015801
IP No	IP26-00006538	Admission Date	08-06-2026

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

Review back to Hospital:

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970



Registrar/Resident/C.M.O

R/n. Seema mayya

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-05-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA

PEDIATRIC ECHOCARDIOGRAM REPORT

nlrco



ME

UHID :

DATE / TIME

00015801

9/6/28

Looping	Situ, solitu, Levocardia
Systemic Veins	RA
Pulmonary Veins	LA
Atrio ventricular connection	concordant
Ventricular arterial connection	concordant
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L→R shunt
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	1+ Arch, NO COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	NO PDA
Pericardium	Nil
Others	Nil

Blo. Secma mayya

PATIENT NAME

UHID :

DATE / TIME

9/6/20

DOPPLER / TISSUE VARIABLES		Gradients		Regurgitation
Mitral flow				
Tricuspid flow				
Aortic flow				
Pulmonary flow				
Mitral	E'	A'	S'	
Medial LV	E'	A'	S'	
Tricuspid	E'	A'	S'	
Time intervals	IVRT	IVCT	DT	
Others				

MEASUREMENTS:

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	0.3		Tricuspid Annulus		
LA	0.5		Mitral Annulus		
IVSd	0.2		Aortic Annulus		
LVIDd	1.4		PA Annulus		
LVPWd	0.3		RPA		
IVSs	0.5		LPA		
IVIDS	0.8		MPA		
LVPWs	0.4		AO Isthmus		
EF	69 %		LV Mass		
FS	35 %		Others		


IMPRESSION:

- situs solitus, levocardia
- Normal sized cardiac chambers
- good Blv function
- PFO L→R shunt
- 1+ Arch, no COA

DR. NAGESWARA RAO KONETI
(CONSULTANT PEDIATRIC CARDIOLOGIST)

Echo Done by : *[Signature]*

PATIENT TRANSFER FORM

HNH-00015801 IP26-00006538 Baby Of SEEMA MAIYA 04-06-2026 0 Y 0 M 4 D (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission <i>8/6/26 @ 3:35pm</i>	Date & Time of Transfer Order <i>9/6/26 @ 11AM</i>
From Unit <i>NICU</i>		Transfer Ordered by <i>Dr. Pranav</i>	Reason for Transfer <i>Baby is stable</i>
To Unit <i>306</i>		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>15</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Sis. Jyothi</i>		Name of Person Ordered Transfer <i>Dr. Sindhura</i>	
Patient & Clinical Records Received by : <i>Sapruja</i>			
Date & Time of Patient Received : <i>11:34AM @ 9/6/26</i>			

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

PATIENT TRANSFER FORM

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA


Date & Time of Admission <i>8/6/26 @ 12:03pm</i>		Date & Time of Transfer Order <i>8/6/26 @ 3:35pm</i>
Treating Consultant Name <i>Dr. Sindhura</i>	Transfer Ordered by <i>Dr. Subant</i>	Reason for Transfer <i>TSP T</i>
From Unit <i>3rd floor</i>	To Unit <i>NICU</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>20</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>←</i>	
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Madhuri</i>		Name of Person Ordered Transfer <i>Dr. Subant</i>
Patient & Clinical Records Received by : <i>Shubhi 8/6/26 @ 3:35pm</i>		
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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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 : IP26-00006538 Admit Date : 08-Jun-2026 Admit Time : 12:03 PM UHID : HNH-00015801

Patient Details :

Patient Name	: Baby Of SEEMA MAIYA	Age	: 0 Y 0 M 4 D
Guardian	: Mr SANAL S MENON	DOB	: 04-06-2026 06:43 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 3-4-812/1 ,g-12 Barkatpura Hyderabad Telangana INDIA 500027	Phone No	: 9966408873/ 9966408874
		E-mail	: seema_maiya85@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 SANAL S MENON Relationship : Father
Contact Address : 3-4-812/1 ,g-12 Barkatpura Hyderabad
Telangana INDIA 500027 Phone No : 9966408873

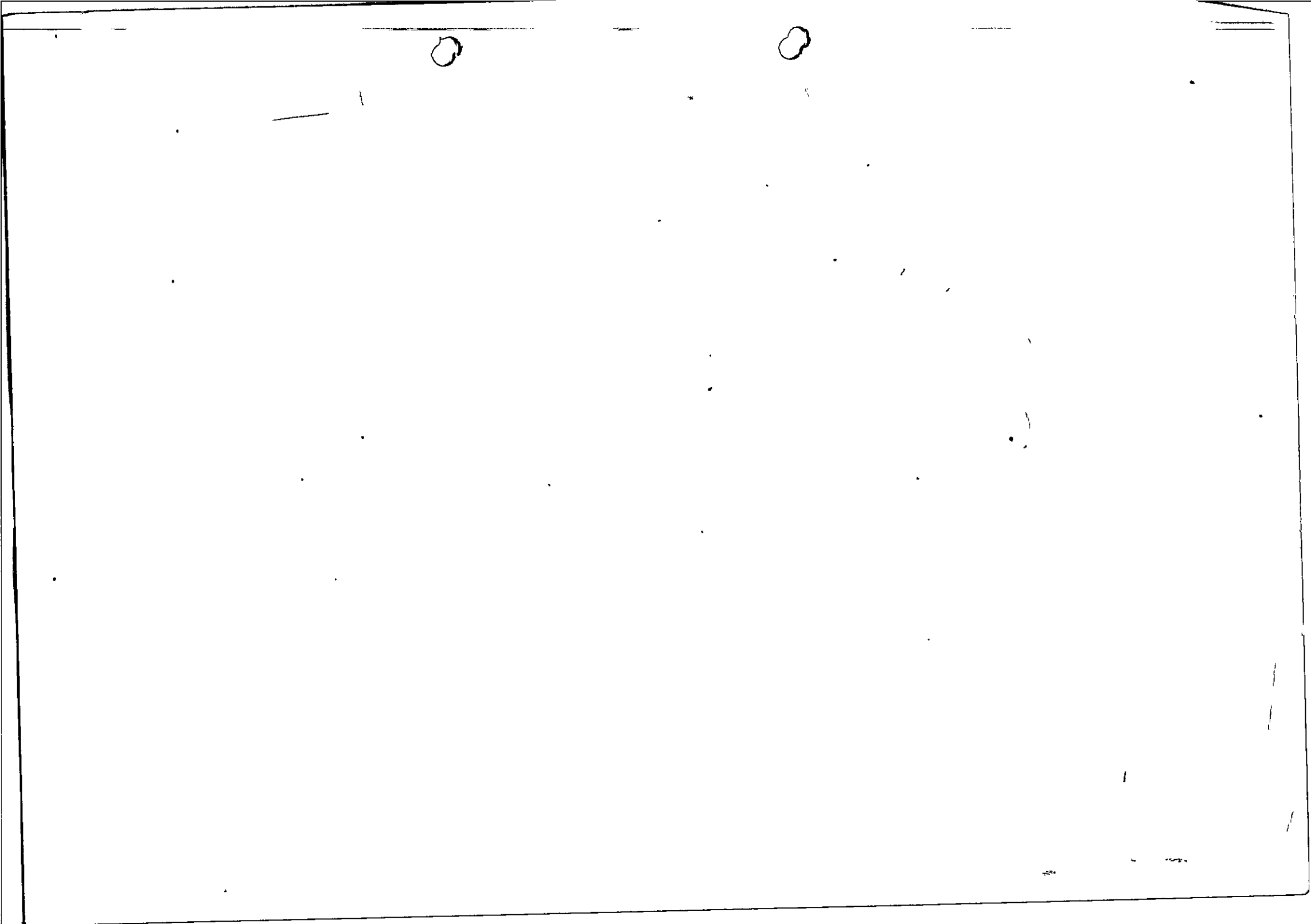

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : SELFPAY



CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT



Name: B/ **HNH-00015801** **IP26-00006538** Age: 4d Gender: Male Female
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
 UHID.No : **Dr. SINDHURA MUNUKUNTLA** Date: 8/6/26



I S/o, D/o, W/o hereby declare that our patient Mr. / Ms who is related to me as is getting admitted in the Neonatal 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 :
Neonatal hyperbilirubinemia - SBR - 22 mg/dl

The doctors have clearly explained to me that my patient B/o during his / her stay in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, 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 Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal 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 B/o in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Neonatal 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 : Seema
 Name : Seema Maiya
 Relationship with Patient: mother
 Date & Time : 8/6/26

Witness :
 Signature : Dhaya
 Name : Dhaya...
 Date & Time : 8/6/26 @ 3:30pm

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : PRANAV
 Date & Time : 8/6/2026



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Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



Patient Name : B/o Seema maiya.

Patient ID# : _____

Consultant : _____

Final Diagnosis : NNH.

Pediatric Multiorgan History & Physical Examination

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. BINDHURA MUNUKUNTLA



Name : S/o Seema A

Informant Mother Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Yellowish discoloration of eyes & skin x
2 days.

History of present illness :

Yellowish discoloration of eyes & skin
all night involving palms & soles since
2 days.

- No h/o food feeding, lethargy.

T.C.B - 15

(8-6-26)

(04/6/26)

B.W - 2420 gms.

T.W - 2300 gms

D.W - 2320 gms.

9. - 57.

Pediatric Multiorgan History & Physical Examination

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



Anthropometry

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

Weight (kgs) 2.30kgs (Centile _____)

On Examination :

Temperature Afebrile Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

Tachypnea (+)

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE (+), NUB (+)

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 :

SMA, NR.

Inspection _____

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power 73/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

NEONATAL HYPERBILIRUBINEMIA.

Pediatric Multiorgan History & Physical Examination

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

SBR,

NBS

O/AE

NBS shirishu

Planned Management :

- DSPT eye & joints covered.

- DBF + PF ~~ST~~ adlib.

- of SBR 20mg, shift to NICO & start T&P.

NBS shirishu

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. Sindhu on
whose name the patient is being referred

Doctor's Signature Name [Signature] Date 8/6/26 Time CPM

ACTIVITY RECORD FOR BILLING

HNH-00015801 IP26-00006538
N Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
U Dr. SINDHURA MUNUKUNTLA



----- Consultant : ----- Dept : *pediatric*

Di ----- Time : ----- Date of Discharge : ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>8/6/26</i>	<i>12:36pm</i>	<i>ER</i>	<i>3rd Floor (306)</i>	<i>[Signature]</i>
<i>8/6/26</i>	<i>3:35pm</i>	<i>3rd Floor</i>	<i>NICU</i>	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.				
2.				
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/16/26 2:30 PM	4/5/16 Dr. Sindhura	
	- on Dept.	
	- Baby is euthermic.	Plan
	- Passing stools urine.	- Trace SBR.
		- If SBR > 20
	Tone } Good.	↓ shift to MW
	Activity }	← start TSPT.
		- DBF 424.
		M. Sindhura
		Dr. Sindhura

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		c/s/b. Dr. Sindhura
08/06/24		
2:40 PM	<u>NINDS</u> <u>examined</u> .	
	T. B. by Gerthman	
	by T. B. of Actovig	
	Zefence	RIND SWAN - 0
	vitals: stable	
		Ach
		Start TSPT
		Shift to NICA
		Repeat SISR @ 9 PM
	my BND my	today
	my	IV push 100mg fentanyl
		and
	① - send SISR at 9 PM	and
		NINDS
	Feed - 2oz/02H	NINDS
		NINDS
		NINDS
		NINDS
		NINDS
		NINDS



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		(Dr. Sindhura)
8/6 6:30pm	B/O Seema	
	Baby Jaundice level - 22.4 mg/dl	
	↓	
	Will need 3 surfaces of Phototherapy (Triple Surface PT)	
	TSPT - These light help jaundice pigment in the skin to be dissolved by photooxidation & help excrete in urine & stool	
	Reason for risk - Possibly Preterm baby	
	Mechanism - Jaundice pigment - cross into brain & cause injury to baby's brain	
	Will repeat SBR at 9pm	to see response to TSPT
	↓	
	Mostly will reduce. If not responding or increasing possibility of blood exchange transfusion	
	But less likely as not blood group incompatibility	
	Currently BIND score - '0' - (0) as baby cry / Tom good	
	Baby on both feeds & IV fluid to help prevent dehydration & prevent hemoconcentration	
	Based on SBR report of night - decide when to do next SBR test	
		Munukuntla Sindhura (Father)



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6 6:15pm	<p>AS/E Dr. Sindhura m</p> <hr/> <p>NNH13 - SBR-22-4</p>	
	<p>Baby & TSPT</p>	<p>Ph</p>
	<p>Accepted feed - 20ml/2hr</p>	<p>1) IV - 150ml/kg ↓ 50ml/kg - IVF</p>
	<p>Cong - Good Temp - (N)</p>	<p>& best Ad lib feed of TSPT to eye & genital cones</p>
	<p>Vital</p>	<p>2) 2D echo - T/m</p>
	<p>HR - 164/min</p>	<p>3) SBR @ 9pm</p>
	<p>RR - 36/hr</p>	
	<p>SpO₂ - 97%</p>	<p>4) Monitor Vital BIND Scan</p>
	<p>BIND score - 0</p>	<p>5) Injn sos</p>
	<p>Back on Night SBR</p>	
	<p>↓ To stop IVF</p>	<p><i>[Signature]</i> ANJANA-M.</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6	C/S LIS Dr. Naipunya / Dr. prashantha	
10:00pm	on room air	Plan
	under TSPT	- OG feed 30ml / 2ndly
	Athenic	sh / burping
	Vitals - stable	- STOP IVF
	Rls - BL AE	= Trace SBR
	PA - soft, ND	- 2D echo tomorrow
	Uo/P - Adequate	- Monitor vitals
		Def
		Noted by <i>Caro</i> 10:00pm

HNH-00015801 IP26-00006538
 Baby Of SEEMA MAIYA (M)
 04-06-2026 0 Y 0 M 4 D
 Dr. SINDHURA MUNUKUNTLA

4



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/L/B <u>Dr. Naipunya / Dr. Prashantini</u>	
9/6		
7:00 AM	LPT (3513) / AGA / IDM / male / NNT	
	on room Air.	plan
	HR - 132	
	Vitals - RR - 42	= 60 feed. 30ml / 2nd hourly
	- SpO2 - 97%	
	RCS - BLA AEP	- 2D echo today
	PLA - soft, not	- monitor vitals
	T-wt - 2.340	- Warmth Care
	(140g)	- plan shift out today.
		Def

noted by team
 9/6/26
 7 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 9:50 AM	S/B Dr. Sindhura. M <u>ANN</u>	
	Baby alert & DSP	
	BIND - 'O' feeds well	
	HR - 10/min	
	RR - 25-30 /min	
	BP - 65/43 mmHg	
	CVS - S1, S2	
	Lungs - clear	
		<ul style="list-style-type: none"> - Adv - Shift to Room 612
		<ul style="list-style-type: none"> - Continue DSP
		<ul style="list-style-type: none"> - Repeat SBR at 9 PM today
		<ul style="list-style-type: none"> - 2D Echo today
		<p><i>[Signature]</i></p>
	<p>NB - Supra</p>	<p><i>[Signature]</i></p>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/06/26 6 PM	<p>U/LG. D. Sindhura Sindhura / Dr. Sankhuff</p>	
	<p>Baby on DSAT C/A - good vitals - stable Hydration - good</p>	
		<p><u>Ado</u></p> <ul style="list-style-type: none"> ✓ Cont DSAT ✓ Repeat STSR @ 9 PM today ✓ Rest continue same ✓ Monitor vitals and Temp
		<p>M. Mielino Sindhura - M</p>
		<p>NA - Supriya 8 PM @ 9/6/26</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>10/6/26</u>	<u>S/B Dr. Prabhath.</u>	
8:00 AM	LRT (35 ⁺ 3) / AGA / IDM / Male / NNJ.	
	Baby pink accepting feed passing No clots of vitals stable PA ST	AFO CT - DBF Q24 Plan discharge
		N/B Suprign @ 8 AM
<u>10/6/26</u>	<u>Cl/S/B Dr. Sindhura</u>	
10:30 AM	LPT / AGA / Male / IDM / NNH. - Baby is pink. - of - vitals stable. S/E - LONL.	Plan - CT - DBF + PF. - D/S today - R/v on Friday. H. Sindhura Dr. Sindhura (M)

noted by Sandhya
10/6/26
11:00



REGULAR PRESCRIPTIONS

Weight. 2.30kg Ward.

DRUG : VITAMIN D3 DROPS				Date Time	9/6/26
Dose	Route	Frequency	Start Date		
1ml	PO	OD	9/6/26		
Name & Signature of the Doctor Starting the Drugs:				[Signature]	
Additional Instructions:				(400IU/ml)	
Daily Doctor's Endorsement by a Sign					

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

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

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



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INTENSIVE CARE UNIT
CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: Baby's Blood Group: Sheet No:

Gest Age: Birth Weight: 2.30 kg

Date: <u>9/5/26</u>	Date: <u>10/5/24</u>	Date:
DOL <u>D5</u> Weight <u>2.340 kg</u>	DOL <u>D6</u> Weight <u>2.360 kg</u>	DOL Weight
Problems: <u>NNJ</u>	Problems:	Problems:
Rs. <u>30-60bim</u> Exam <u>done</u> Vent. Setting <u>R/A</u> ABG CXR <u>550s</u>	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>Normal</u> HR <u>120-160bim</u> BP <u>66/50</u> Map Cap Refil <u>< 28</u>	CVS HR BP Map Cap Refil	CVS HR BP Map Cap Refil
F/E/N T. Fluids CC/kg/day I/O/RBS: <u>90mg/dL</u> U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment <u>Done</u>	Assessment	Assessment
Plan <u>RBS - OD</u>	Plan	Plan

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: Baby's Blood Group: Sheet No:

Gest Age: Birth Weight:

Date:	Date:	Date:
DOL Weight	DOL Weight	DOL Weight
Problems:	Problems:	Problems:
Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS HR BP Map Cap Refill	CVS HR BP Map Cap Refill	CVS HR BP Map Cap Refill
F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment	Assessment	Assessment
Plan	Plan	Plan

HNH-00015801 IP26-00006538
 Baby Of SEEMA MAIYA 0 Y 0 M 4 D
 04-08-2026 Dr. SINDHURA MUNUKUNTLA (M)



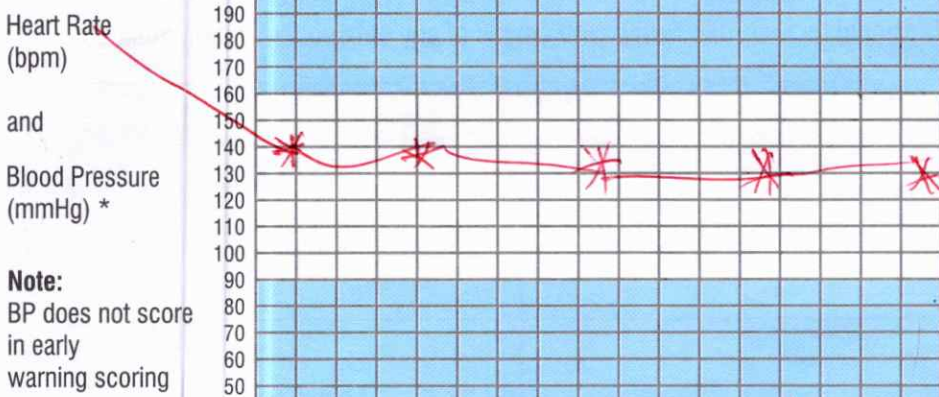
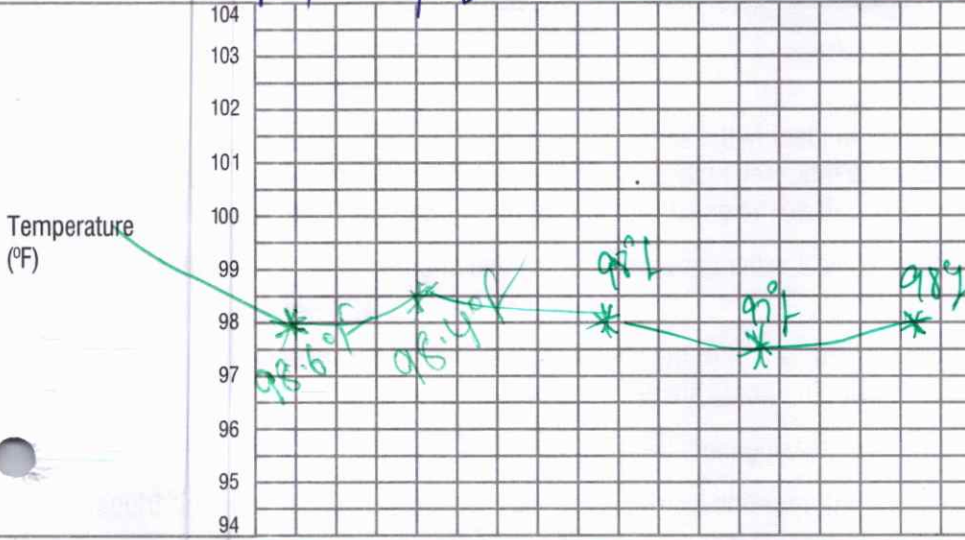
RESULT SHEET

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

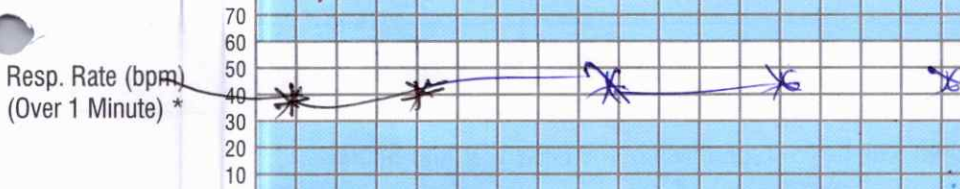
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/6/26 Time: 12 5 10 PM 2 AM 6 AM

Doctor/Nurse/Family Concern? PM PM 10 PM 2 AM 6 AM



Heart Rate (Number) 143b/m 140b/m 136b/m 136b/m 136b/m



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

Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered

GCS * 15/15 15/15

TOTAL SCORE Number of shaded boxes Pain Score 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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00015801 IP26-00006538
 Baby Of SEEMA MAIYA
 04-06-2026 0 Y 0 M 4 D (M)
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
9/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm		DBF+EBM									
	12:00 pm						✓					
	01:00 pm											
Total Intake :						Total Output : U-1 M-1						
9/6/26	02:00 pm		DBF+EBM									
	03:00 pm											
	04:00 pm		EBM									
	05:00 pm											
	06:00 pm		GBM-50ml									
	07:00 pm											
Total Intake :						Total Output : U- M-						
9/6/26	08:00 pm											
	09:00 pm		EBM									
	10:00 pm											
	11:00 pm		EBM									
	12:00 am											
	01:00 am		DBF									
Total Intake :						Total Output :						
9/6/26	02:00 am											
	03:00 am		DBF									
	04:00 am											
	05:00 am		EBM									
	06:00 am											
	07:00 am		EBM									
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015801 IP26-00006538
 Baby Of SEEMA MAIYA (M)
 04-06-2026 0 Y 0 M 4 D
 Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

Date: 9/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	12pm	→ To assess the baby condition → To check the vitals & record	12pm	→ To assessed the baby condition → To checked the vitals & recorded	→ Baby is stable now	→ Baby is stable → re-checked the vitals → I/O	Sindhura
	10am	→ DBF + FF 2nd hourly → DSPT contd.	10am	→ DBF + FF 2nd hourly → DSPT contd.	→ DSPT contd		
	2pm	→ I/o chart maintained	2pm	→ I/o chart maintained	→ SBR 9pm.		
Afternoon	Day Duty						
Night	8pm	→ Assess the Baby Condition → monitor vitals I/O → chart	8pm	→ Assessed the Baby Condition → monitor vitals & about → DBF 2nd hourly	Baby is stable	rechecked vitals	
	8am	DBZ 2nd hourly					

Patient Sticker

NURSING CARE RECORD



Date:

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							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date / Shift	8/6/26 NI	9/6/26 MS	9/6/26 NI	/	/	
	Medical Condition (Any special condition to be noted):	-	-	-	/	/	
	Diet:	-	-	-	/	/	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	/	/	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	36.6°	36.5°	36.2	/	/
		Res:	30b/m	32b/m	30b/m	/	/
		SpO ₂ :	100%	99%	99%	/	/
		Pulse:	145b/m	140b/m	141b/m	/	/
		BP:	66/50	59/42	-	/	/
		LOC:	N10-1	-	-	/	/
	Fall Risk Score:	-	-	-	/	/	
Pain Score:	-	-	-	/	/		
Skin Integrity	-	-	-	/	/		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-	-	-	/	/	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	-	-	-	/	/	
	Critical Lab Test / Values:	-	-	-	/	/	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	/	/		
Post Operative Procedure Special Orders:		-	-	-	/	/	
Handed Over By Name :		Lavin	Amit	Anita	/	/	
Signature / ID :		@	140	B	/	/	
Date:		9/6/26	9/6/26	10/6/26	/	/	
Time:		8 PM	8 PM	8 AM	/	/	
Taken Over By Name :		Ajay	Ajay	Ajay	/	/	
Signature / ID :		@	@	@	/	/	
Date:		9/6/26	9/6/26	9/6/26	/	/	
Time:		8 AM	8 PM	8 PM	/	/	

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

HNH-00015801
 Baby Of SEEMA MAIYA
 04-08-2026 0 Y 0 M 4 D
 Dr. SINDHURA MUNUKUNTLA (M)

IP26-00006538

BRADEN 'Q' SCALE



It takes a lot to treat the little.

BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

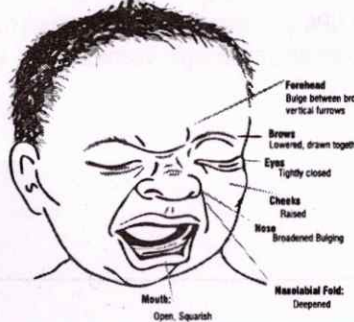
				Date :	8/6	9/8/26		
				Time :	NI	240		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	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.	4	4		
FRICITION-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 meat 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	28	28		
				Evaluator's Name	2	16		

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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-00015801 IP26-00006538
 Baby Of SEEMA MAIYA
 04-08-2026 0 Y 0 M 4 D (M)
 Dr. SINDHURA MUNUKUNTLA

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	
						8/8	9/8						
						Nr	35						
						Procedure →							
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	0	0						
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)	0	0						
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0						
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	0	0						
Vital Signs RR, BP, SaO₂	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	0	0						
 <p>Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age</p> <p>Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention</p>	Gestational Age / Corrected Age	1	1										
	Total Pain / Agitation Score	1	1										
	Intervention	1	1										
	Effectiveness	1	1										
	Signature												

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	<ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Stimulate the infant and observe and select a score for each behavior. Select only one numeric value (Highest) per behavior. 	<ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Select only one numeric value per behavior.
Scoring/ Documentation	<ul style="list-style-type: none"> Sedation scores are negative scores only Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) NPASS Sedation total score has a range from 0 to -10 possible. Document total NPASS Sedation score in the medical record. 	<ul style="list-style-type: none"> Pain/Agitation scores are positive scores only Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. NPASS Pain/Agitation total score has a range from 0 to 13 possible. Document the total NPASS Pain/Agitation score in the medical record
Interpretation	<ul style="list-style-type: none"> Desired levels of sedation vary according to the situation. Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 Reassess patient per frequency in local sedation policy A negative score without the administration of opioids/ sedatives may indicate: <ul style="list-style-type: none"> The premature infant's response to prolonged or persistent pain/stress Neurologic depression, sepsis, or other pathology 	<ul style="list-style-type: none"> Does not provide pain intensity rating. Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). Reassess patient per frequency of local pain policy. If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.

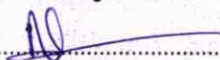
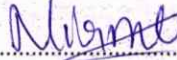


CHECKLIST FOR THROMBOPHLEBITIS


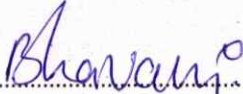
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs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

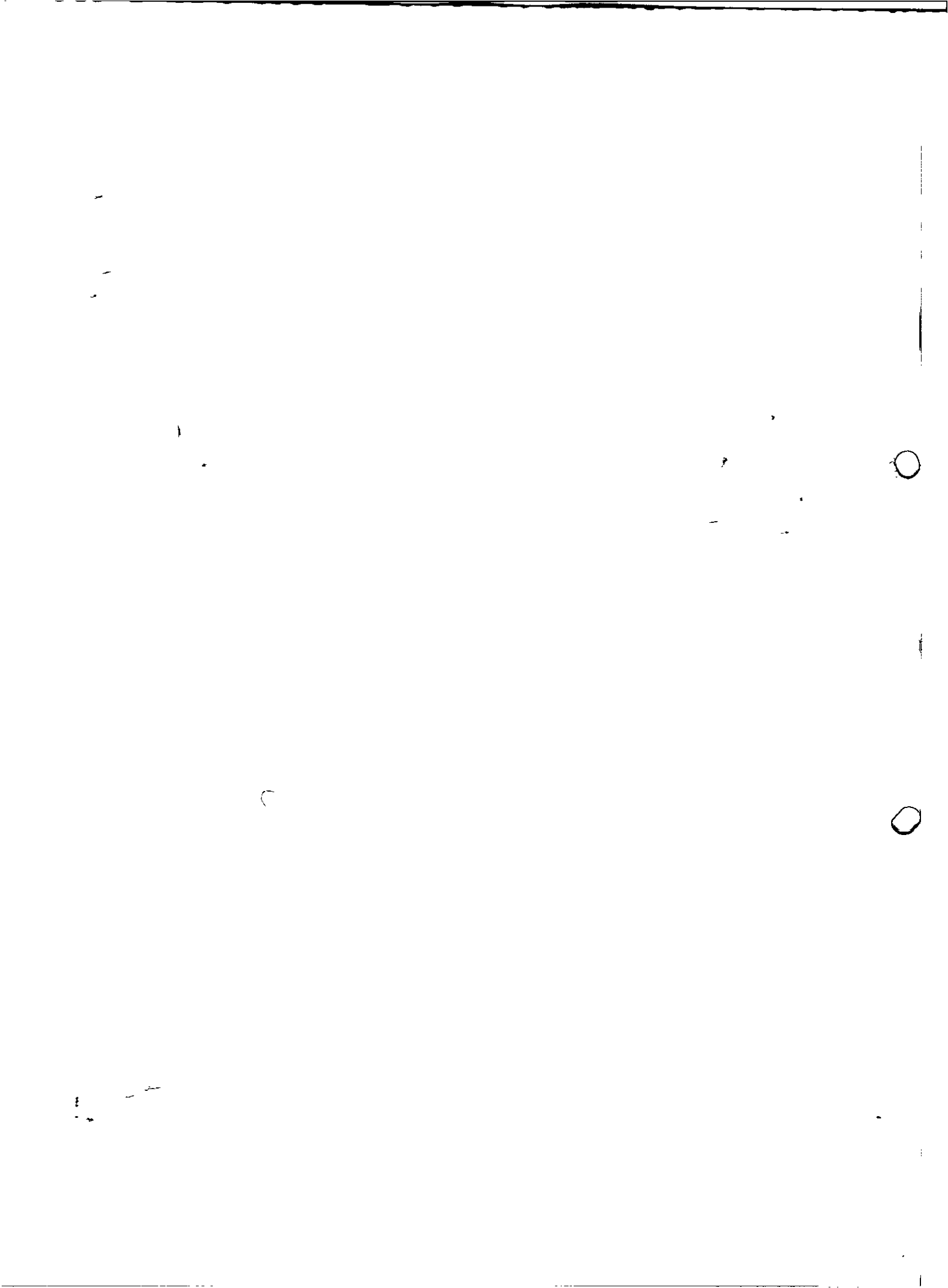
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 





MEDICATION RECONCILIATION FORM

Drug Allergies: nil 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: 3rd floor (306)

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Varun


Date & Time : 8/6/26 @ 12pm

Nurse Name & Signature: Kunjaya Lal

Date & Time : 8/6/26 @ 12:10pm

PATIENT TRANSFER FORM




Patient Name & UHID No. HNH-00015801 IP26-00006538 Baby Of SEEMA MAIYA 04-06-2026 0 Y 0 M 4 D (M) Dr. SINDHURA MUNUKUNTLA 	Date & Time of Admission 8/6/26 @ 12:03 PM	Date & Time of Transfer Order 8/6/26 @ 12:36 PM
	Transfer Ordered by Dr. Varun	Reason for Transfer Admission
From Unit ER	To Unit 3rd Floor (306)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File (10)	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

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

Patient & Clinical Records Received by :

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

1001

1001

1001



1001

wt. 2.13kg



EMERGENCY TRIAGE FORM

Patient's Name: 810, Seema Maiya Age: 4 days Gender: Male Female
 Date: 8/6/26 Time of Arrival: 11:50 AM
 Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known
 Source of Information: Parents Others (Specify) _____
 Mode of Arrival: Ambulatory Wheelchair Ambulance
 Initial Vital Signs: Temp: 98°f PR: 142b/m BP: _____ RR: 50b SpO₂: 99%
 Chief Complaints: cf yellowish discoloration all over the body

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

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 11:50am

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse: [Signature]

Signature of Triage Nurse : [Signature]

Date & Time : 8/6/26 @ 11:50am





NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21.6.26 Time of arrival : 11:45am

Chief Complaints : c/o yellowish discoloration all over the body

Height : Weight : 2.3kg 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?) 1

Time of Initial assessment completed by ER Nurse: [Signature] 12:10 PM

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

Time	Nursing Notes
12:45pm	Assessed the general condition, vitals checked and recorded

Samples collected by: *[Signature]*
 Samples sent by: *[Signature]*

Time: *[Signature]*
 Time: *[Signature]*

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: <i>142/6/4</i> BP: CFT: <i>N/A</i> RR: <i>28/6/17</i> SPO2 at FiO2: <i>98%</i> GCS: <i>15/1</i> Temperature: Pain Score: Repeat RBS (if applicable): <i>N/A</i>	Shift - out from ER to: <i>3rd floor (306)</i> Time of Shift - out: <i>12:35 PM</i> Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

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

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

Date & Time: *2/6/26 @ 12:20 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

HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-08-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA


GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of SEEMA MAIYA Age : 0 Y 0 M 4 D
IP No: IP26-00006538 Sex: Male
Consultant: Dr. SINDHURA MUNUKUNTLA Ward/Bed No: GF -EMERGENCY/ER01

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

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

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

Signature of Patient/Relative: 


Name: SANAL MENON

Relationship: FATHER

Date: 08/06/2026

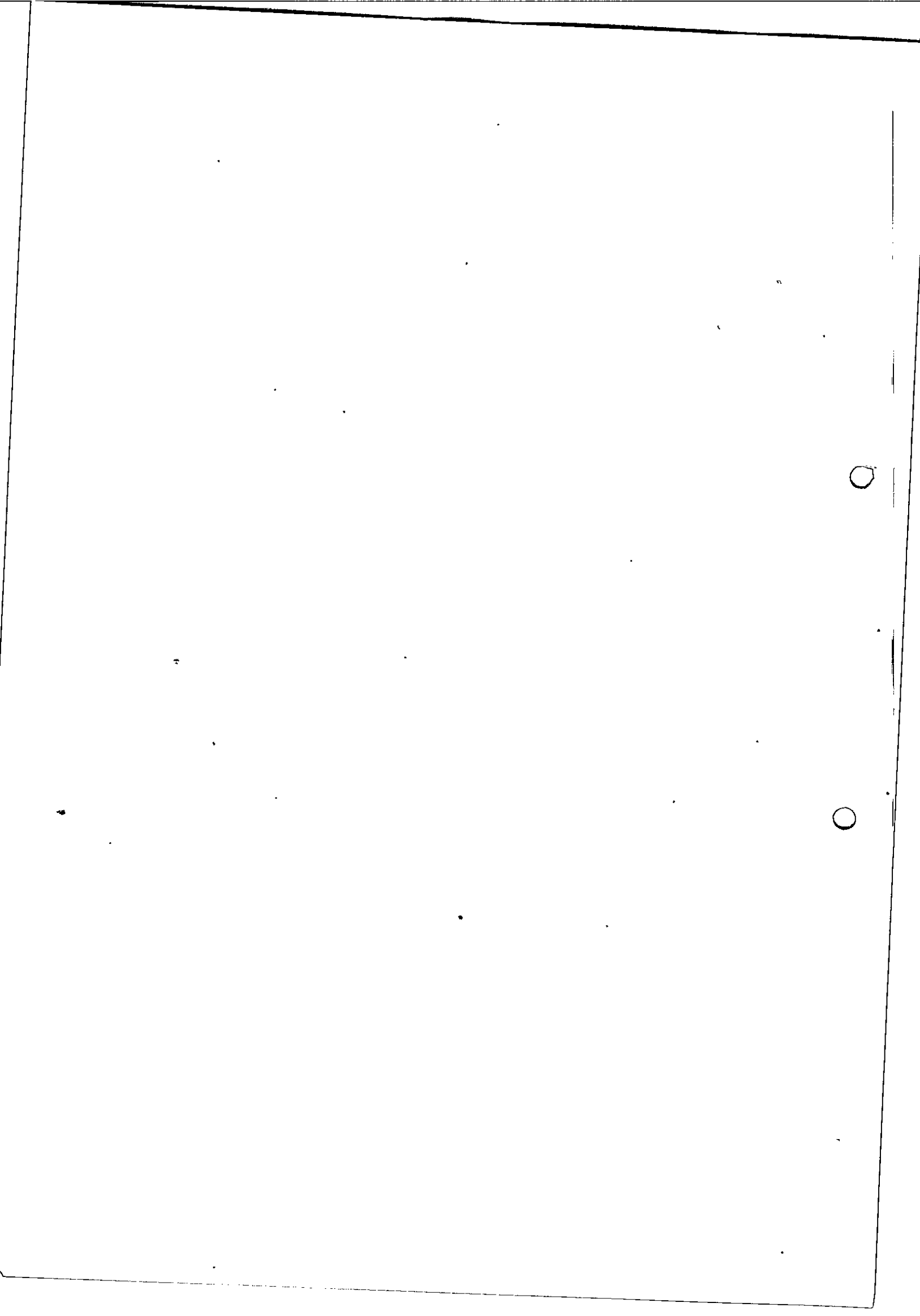
Time: 12:03 .

Witness Name: Yaseen ali Khan

Witness Signature: 

Patient Address:

3-4-812/1 ,g-12 Barkatpura
Hyderabad Telangana INDIA 500027



HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA


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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
at being the quietest light
burning bright, shining bright

BILLING POLICY

- **Billing cycle:** - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card / Demand draft or online payment.
- In 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 30% extra.
- Patient Government ID proof is mandatory to submit during the admission.
- TPA processing charges Rs.500 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

INTERIM BILLING

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 enquire 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.5,000/- 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.

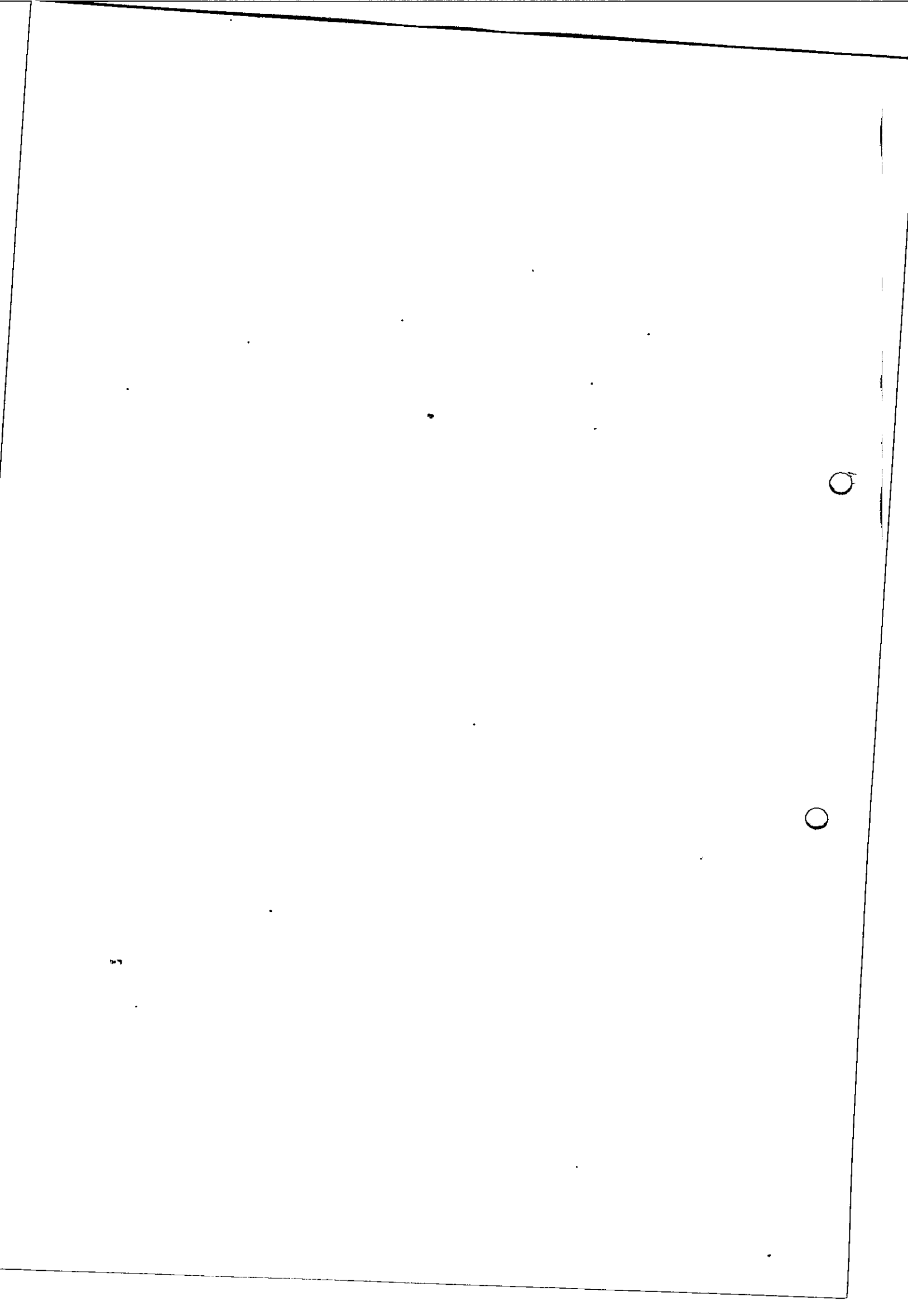
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

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 | HIMAYATNAGAR - 40 488 73000 | MARATHAHALLI, BENGALURU - T:
+91 807111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345

CIN: U85110 TG1998 PTC029914

email : info@rainbowhospitals.in

www.rainbowhospitals.in



HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2026 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



DECLARATION BY PA JANT
(TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 08/06/2026

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

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

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

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

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

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

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

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

Name of the Patient: Blo Seema Maiya

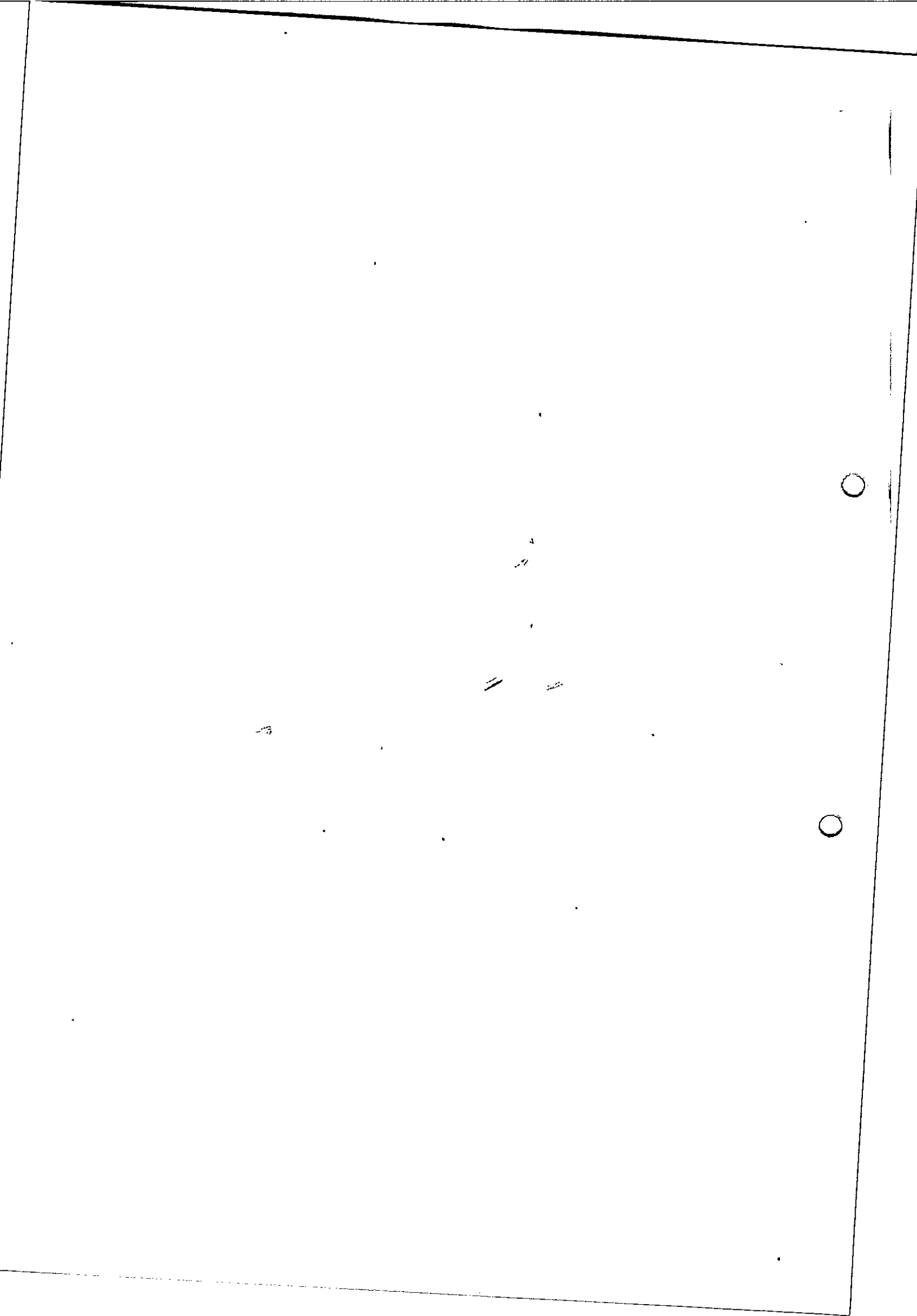
Date & Time of Admission: 08/06/2026 @ 12:03

Name of the Parent / Guardian: Sanal S Menon

Mobile Number: 9966408873

Parent Aadhaar Card Number:

Signature & Relation



HNH-00015801 IP26-00006538
Baby Of SEEMA MAIYA
04-06-2025 0 Y 0 M 4 D (M)
Dr. SINDHURA MUNUKUNTLA



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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
of being the leading light
honoring tradition, history right

UNDERTAKING OF INSURANCE PATIENT/ CREDIT PATIENT FOR ADVANCE PAYMENT

To
The Management,
Rainbow Children's Hospital, Himayat Nagar,
Hyderabad - 500029.

Sub:- Undertaking of Insurance Patient for Advance Payment.

I Mr./Mrs./Ms. Sanal S menon (Father/ Mother/
Other _____) of Master/ Baby/ Baby of/ Mrs. / Ms. B/o Seema Maigh.
was bought to your hospital on Emergency basis on 08/06/2025 at 12/05
approximate charges deposit details were explained by the front office executive on
duty.

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

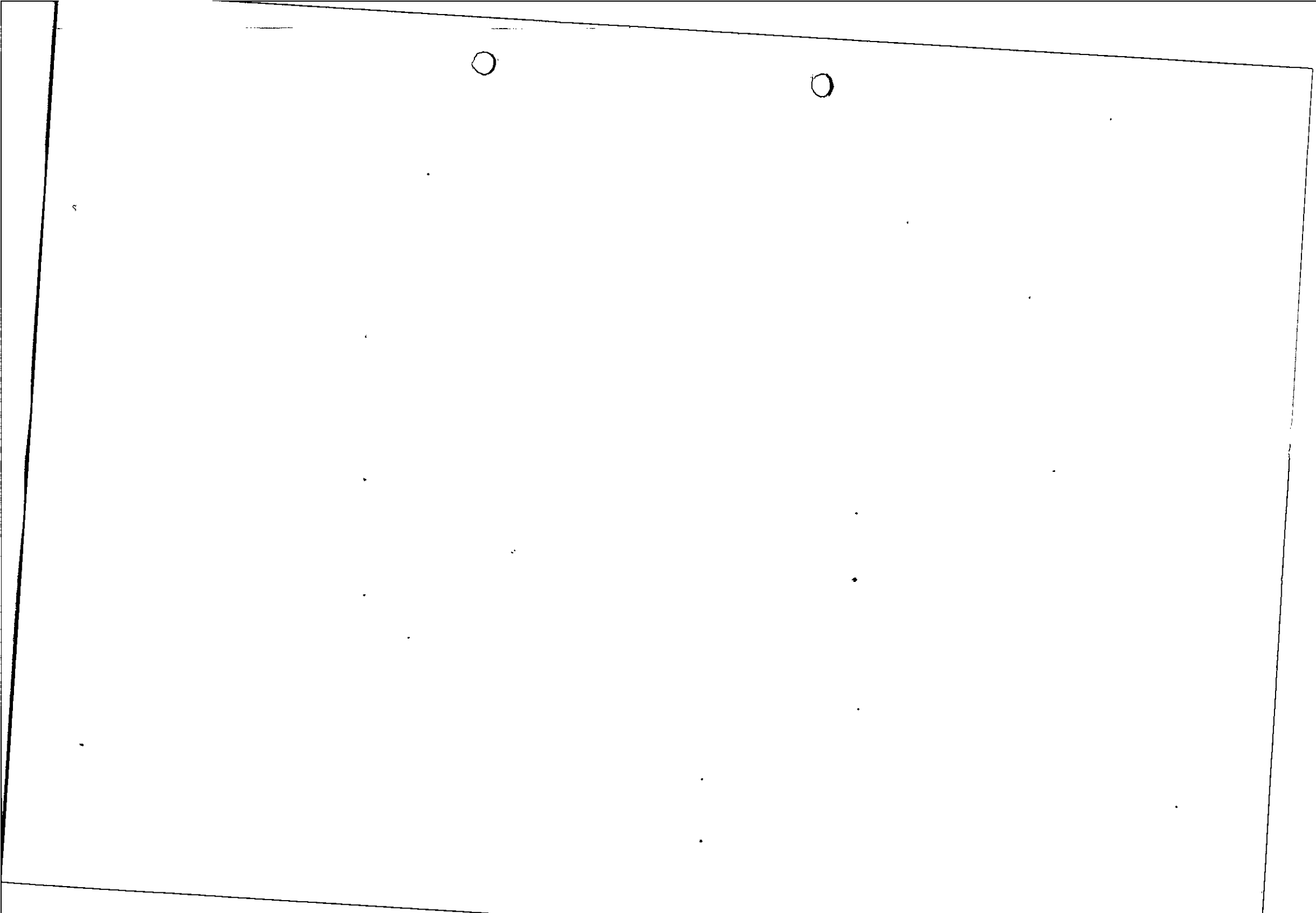
Thanking You



Signature

Name:- _____

Ph. No.:- 9966408874



HNH-00015801 IP26-00006538
 Baby Of SEEMA MAIYA
 04-06-2026 0 Y 0 M 4 D (M)
 Dr. SINDHURA MUNUKUNTLA

COUNSELLING SHEET



Rain

. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State
 housing board Himayatnagar, Hyderabad- 500029

	TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	12 TO 12 NOON BILLING POLICY 12pm - 12pm (12)
BED CHARGES				PHARMACY ✓ INVESTIGATION ✓	
DOCTORS CHARGES				CROSS CONSULTATION ✓ CONSUMABLES ✓	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED)
NURSING CHARGES				BLOOD PRODUCTS ✓ OXYGEN	VISITING HOURS 04:00pm TO 05:00pm.
DIET CHARGES				HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP EQUIPMENT	IN ICU EITHER MOTHER OR FATHER ALLOWED(NO VISITORS)
TOTAL		16,000		PROCEDURE NEBULISATION MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
PATIENT NAME			AGE/SEX		
UHID			INSURANCE NAME	FHPL	

[Signature]
 ATTENDENT SIGNATURE

CAUTION DEPOSIT 10K

[Signature]
 COUNSELLING PERSON SIGNATURE

DSP? - 5000 P/d.

10/10/10
10/10/10
10/10/10

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