



DEFICIENCY CHECK LIST OF CASE SHEET

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DISCHARGE SUMMARY

Name	Baby Of MAHESHWARI	UHID	HNH-00016035
Father/Guardian	Mr SANDEEP SINGH	Age/Gender	0 Y 0 M 3 D/ Male
Address	h no 14-10-1383, jali hanuman, Dhoolpet, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006616	Admission Date	20-06-2026
Ref Doctor	Self.		
Discharge Date	21.06.2026		

Consultant:

Dr. PRITESH NAGAR

MBBS MD

Medical Registration No. 47184

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of MAHESHWARI is a 0 Y 0 M 3 D old baby boy presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 14.3 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Name	Baby Of MAHESHWARI	UHID	HNH-00016035
IP No	IP26-00006616	Admission Date	20-06-2026

Birth history: Baby Of MAHESHWARI is a term (39 weeks) baby girl, delivered to a G6P2L2A3 mother by NVD on 17.06.2026 at outside hospital. Birth weight not known.

Examination: He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 129/min and Respiratory Rate - 40/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Mother's Blood group is B positive.

Baby's blood group sent, report awaited.

Weight on admission : 2.330 kilo grams.

Weight at discharge : 2.420 kilo grams.

Investigations: Enclosed reports.

Management: He was admitted in ward. His Transcutaneous bilirubin was 14.3 mg/dl on admission done on OP basis. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Last serum bilirubin on 4 day of life was 9.1mg/dl with indirect fraction of 8.7mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

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

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

Name	Baby Of MAHESHWARI	UHID	HNH-00016035
IP No	IP26-00006616	Admission Date	20-06-2026

Advice:

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

Plan:

- To collect Baby's blood group and TSH report on followup.**

Review consultation with Dr. PRITESH NAGAR on Wednesday (24.06.2026) in OPD at Himayatnagar with prior appointment with reports **(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

Name	Baby Of MAHESHWARI	UHID	HNH-00016035
IP No	IP26-00006616	Admission Date	20-06-2026

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**


Registrar/Resident/C.M.O

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006616 Admit Date : 20-Jun-2026 Admit Time : 01:42 PM UHID : HNH-00016035

Patient Details :

Patient Name : Baby Of MAHESHWARI Age : 0 Y 0 M 3 D
Guardian : Mr SANDEEP SINGH DOB : 17-06-2026 01:00 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : h no 14-10-1383, jali hanuman Dhoolpet Phone No : 9573402607/ 7416377079
Hyderabad Telangana INDIA 500006 E-mail : 9573402607@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 SANDEEP SINGH Relationship : Father
Contact Address : h no 14-10-1383, jali hanuman Dhoolpet Phone No : 9573402607
Hyderabad Telangana INDIA 500006

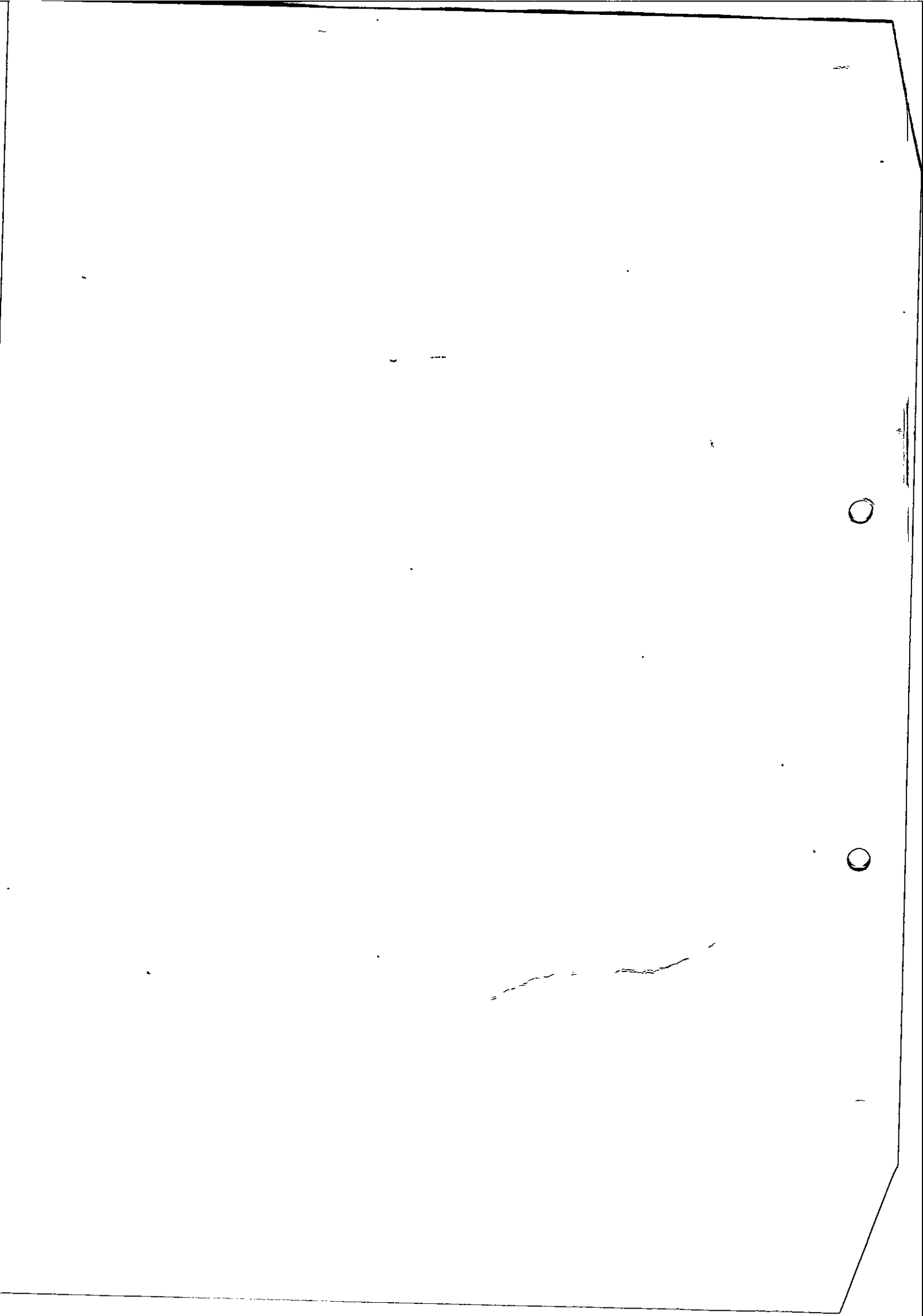

Signature

Doctor Details :


Doctor Name : Dr. PRITESH NAGAR Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 20000.00
Payment Mode : DC/CC Card Payor Name : SELFPAY




ACTIVITY RECORD FOR BILLING

HNH-00016035 IP26-00006616
 Name: Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR
 UHID N  Consultant: _____ Dept: Neonatal
 Date of Admission: _____ Time: _____ Date of Discharge: _____ Time: _____
 Room / Bed No: _____ Ward: _____ Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/6/26	@ 2:20 pm	ER	3 rd floor (305)	Shrishe / Sy

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sindhu (Lactation) Dr. Kiran	20/6/26.	2592	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



Patient Name : _____

Patient ID# : _____

Consultant : Dr. PRITESH NAGAR.

Final Diagnosis : NNH.

Pediatric Multiorgan History & Physical Examination

MNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



Name : BABY OF MAHESHWARI

Age

Informant

Reliability

Good

Chief Presenting Complaints & Duration (Chronologically):

Yellowish discoloration of eyes & skin x 1 day.

History of present illness :

No yellowish discoloration of eyes & skin since 1 day involving palms & soles.

- on exclusive DIF + lactogen I feeds.

- No febrile, local irritation.

(20/6/26) - TCB
14.1
14.3



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

nil previous

Birth & Neonatal History :

G6 P2 L2 A3, 35 Wks /
NVD / Male

DOB - 17 - 6 - 2026 @ 9:20 AM.

MBSG	B + ve
BBS	Not done

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Birth wt - Unknown
18/5/26 - 2.45 kgs.

Developmental History :

- (N) -

Immunization History :

Birth vaccination done

Pediatric Multiorgan History & Physical Examination

HNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



Anthropometry

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

Weight (kgs) 2.33 kgs (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 105 at RA

Resp. rate and type of breathing : _____

Rash _____] Tetanus (+)

Lymphadenopathy _____] Absent

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..) _____

Cardiovascular System :

Inspection of precordium : _____] (+)

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____] SNT, NT, BS (+)

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power 7/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : (N)

Clinical Summary & Diagnostic :

NEONATAL HYPERBILIRUBINEMIA

Pediatric Multiorgan History & Physical Examination

HNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

① SBR tomorrow ^(to be decided in round)
~~TSH/NBC~~ → if parents willing.

- DSPT.
- Worm care.
- DIBF @ 2H + RF.
- Nutrition consult & counseling.

② TSH tomorrow.
NBC if parents willing.

Noted by shishke
20/6/26
@ 2pm

Noted by shishke
20/6/26
@ 2pm

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	c/s/b	Dr. Prabhakar
2:38 PM	L.T. (39 wks) / AGA	Plan
	- Baby is asymptomatic	
	- Cry Tone Activity	
	} Guided	
	} Start D'SPT.	
	- WNL.	
		- DB FQ 2M + PF.
		- Rpt. SBR tumours
		↓ time to be decided in rounds.
		- Rpt. NBS if parents willing; otherwise TSM.
		✓



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cls/b Dr. Pritesh	
20/6/26		
5:30 PM	<u>Term (AGA) Male (NNH)</u>	
	Baby is euthermic.	
	- Cong	
	Ine	
	Activity } Good.	
		Plan
	qE - vitals stable.	CF - DQPT
		DBF (Q2H + FF)
		Rpt. SBR / TSH / BGT
	sE - WNL.	folic acid at 10cm.
		N/B ^{Suplyn}
		@ 5:30pm
		J (initials)




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>ds/ky Dr Annu</u>	
21/6/26 8 AM	<p>Ten / A GA / NNH / Male. Y = 2-330 T.Wt 2.120</p>	
	on DSPT.	<u>90g ↑</u>
	Baby Euthic	- sample @ 10AM
	<u>vital</u> stable.	SBR, TSH, B/G/T
	S/E NIAD	- DSPT
	Rls - B/L AC (+)	- DBF Que jlb hum. +FF
	NVPX (+)	- Monitor temp vitals.
	(USS - SLD (+) no mass.	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> N/B Mantosh? @ 8A </div>
	A	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26 9:50 AM	S/O Dr. Pritesh Δ Tem (ACU A / NNJ) / Moh Ph on phototherapy	- CE DSPT
	WS - S ₄ S ₁₀ R ₁ - B ₁₁ - ACC @	- Trace SBA Blood group
	PIA - S ₁₀ CIA ₁₀₀₁	- Flup - TIM report in OPD
	T. wt - 2.420 kg (T 90 gm)	- Plan discharge
		- CE DBF + KE + Bupiv 2 nd y NIB Supⁿ @ 9:55 AM 

HNH-00016035 IP26-00006616
 Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR

305

RESULT SHEET

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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

HNH-00016035

IP26-00006616

Patient Sticker

Baby Of MAHESHWARI

17-06-2026

0 Y 0 M 3 D

(M)

ICAL / 124

Dr. PRITESH NAGAR



INFANT (<1 year)

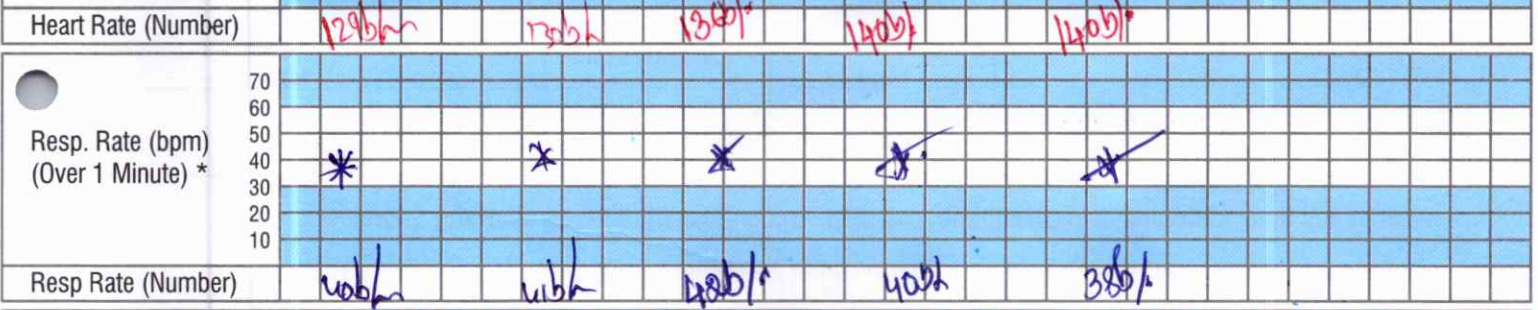
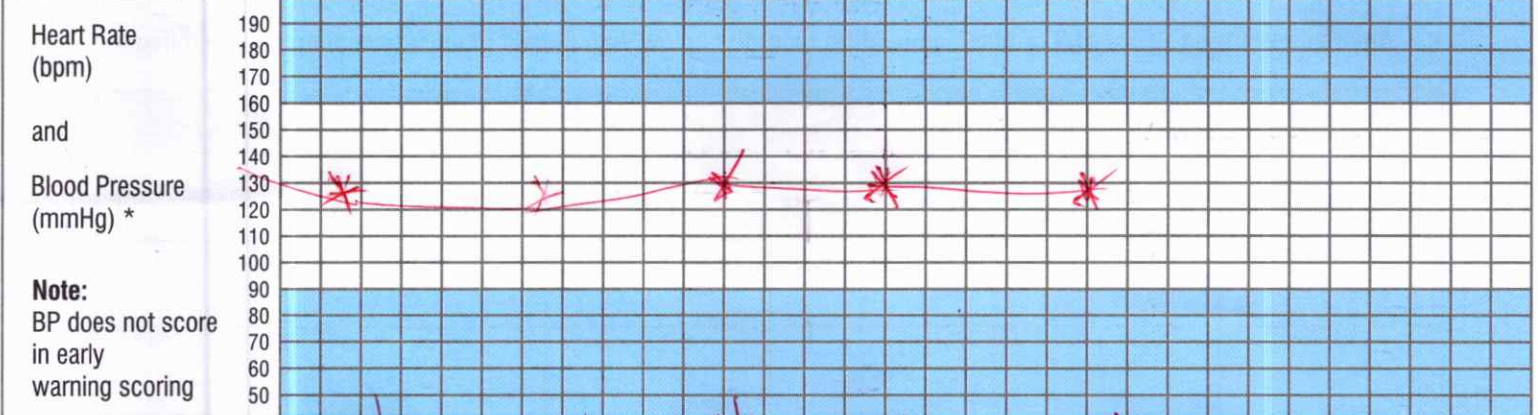
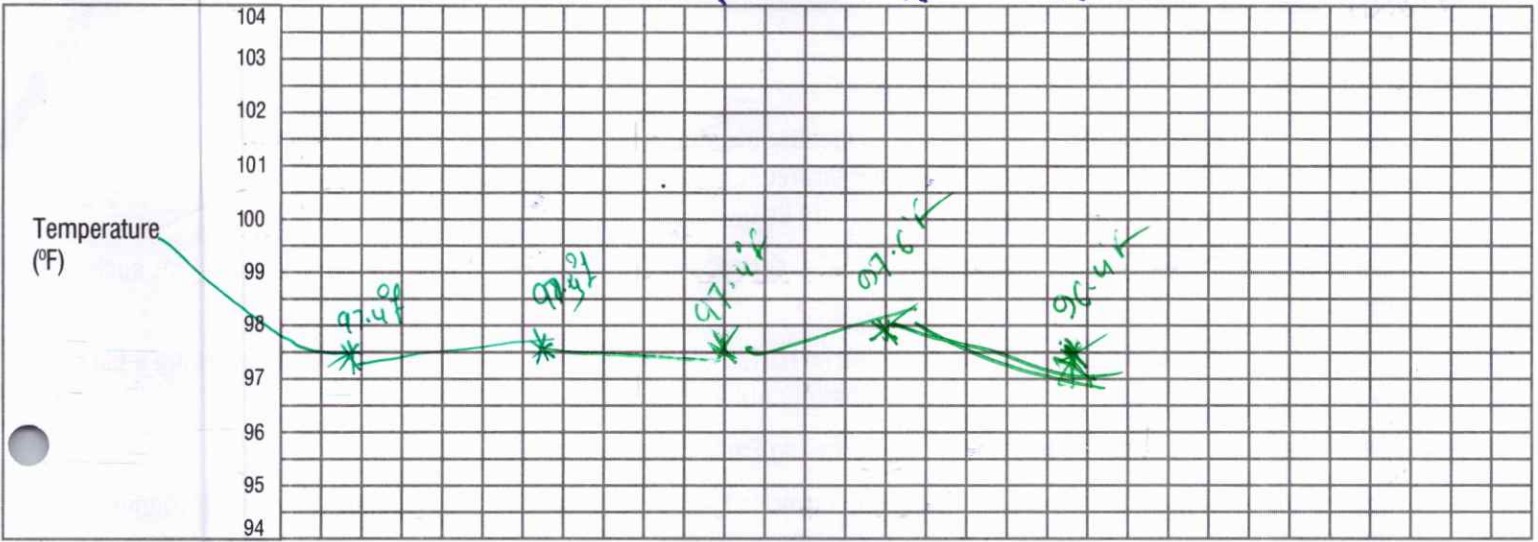
Children's Observation & Early Warning Scoring Chart



WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26 Time: 12:20pm

Doctor/Nurse/Family Concern?



Resp Distress: Mod/ Severe / None / Mild

Receiving O₂ (l/min): 0.2, 0.2, 0.2, 0.2, 0.2

O₂ Saturations (%): 99.5, 99.5, 99.5, 99.5, 100

Conscious Level: Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes: 0, 0, 0, 0, 0

Pain Score: 0, 0, 0, 0, 0

Observer's Initials: [Signatures]

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

H-00016035 IP26-00006616
 Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR



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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
20/6/26	02:00 pm	↓	DRB T ₁₂	20ml								
	03:00 pm	↓	DRB T ₁₂									
	04:00 pm	↓	DRB T ₁₂									
	05:00 pm	↓	DRB T ₁₂									
	06:00 pm	↓	DRB T ₁₂									
	07:00 pm	↓	DRB T ₁₂									
Total Intake :						Total Output :						
20/6/26	08:00 pm	↓	DRB T ₁₂									
	09:00 pm	↓	DRB T ₁₂									
	10:00 pm	↓	DRB T ₁₂									
	11:00 pm	↓	DRB T ₁₂									
	12:00 am	↓	DRB T ₁₂									
	01:00 am	↓	DRB T ₁₂									
Total Intake :						Total Output :						
20/6/26	02:00 am	↓	DRB T ₁₂									
	03:00 am	↓	DRB T ₁₂									
	04:00 am	↓	DRB T ₁₂									
	05:00 am	↓	DRB T ₁₂									
	06:00 am	↓	DRB T ₁₂									
	07:00 am	↓	DRB T ₁₂									
Total Intake :						Total Output :						

Total 24 hrs. Intake []

Total 24 hrs. Output []

Patient Sticker



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/6/16	08:00 am												
	09:00 am		DRN										
	10:00 am		DRN										
	11:00 am		DRN										
	12:00 pm												
	01:00 pm		DRN										
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00016035 IP26-00006616
 Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR



NURSING CARE RECORD

Date: 20/6/26

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							
Afternoon	8pm	<ul style="list-style-type: none"> - Assess the Baby Condition - Monitor vitals & Apnoea chart - DB+FF 2nd hourly give - Advanced lactation consulting - start DSPT for Baby 		<ul style="list-style-type: none"> - Assessed the Baby Condition - Monitored vital & Apnoea chart - DB+FF 2nd hourly given - Lactation consulting done - DSPT started 	<ul style="list-style-type: none"> -> Baby is stable -> maintaining safety measures -> Baby feel comfortable 	-> Rechecked vitals	
Night	8pm / 8AM	<ul style="list-style-type: none"> -> Assess the general Condition of baby -> Monitor vitals -> Maintain Apnoea chart -> Plan to give DB+FF 2nd hourly 	8pm / 8AM	<ul style="list-style-type: none"> -> Assessed the general Condition of baby -> Monitored vitals -> Maintained Apnoea chart -> Every 2nd hourly DB+FF given 	<ul style="list-style-type: none"> -> Baby stable 	<ul style="list-style-type: none"> -> Recheck SpO2 -> RR 	

Patient Sticker

NURSING CARE RECORD



Date:

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

HNH-00016035
 Baby Of MAHESHWARI IP26-00006616
 17-08-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR



IFT HAND OVER FORM - WARD

Treating Doctor: Dr. Pritesh Department: _____ Date of Admission: 20/6/26

SITUATION	Diagnosis: <u>NOJ</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: _____						
	Area	<u>20/6/26</u> <u>G2</u>	<u>20/6/26</u> <u>N1</u>	<u>21/6/26</u> <u>AB</u>				
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):	<u>NOJ</u>	<u>NNT</u>	<u>NOJ</u>				
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" 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:	<u>97.2</u>	<u>97.4</u>	<u>97.8</u>			
		Res:	<u>39</u>	<u>38</u>	<u>38</u>			
		SpO ₂ :	<u>99</u>	<u>99</u>	<u>99</u>			
		Pulse:	<u>140</u>	<u>142</u>	<u>140</u>			
	BP:	-	-	-				
Fall Risk Score:	<u>NO</u>	<u>0</u>	<u>-</u>					
Pain Score:	-	-	-					
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>				
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	-	-	-				
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Special Orders / Medications:	<u>NOJ</u>	<u>NNT</u>	<u>NOJ</u>					
Post Operative Procedure Special Orders:	-	-	-					
Handed Over By Name :	<u>Apriya</u>	<u>Moutu</u>	<u>Apriya</u>					
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>					
Date:	<u>20/6/26</u>	<u>20/6/26</u>	<u>21/6/26</u>					
Time:	<u>8pm</u>	<u>8pm</u>	<u>8am</u>					
Taken Over By Name :	<u>Moutu</u>	<u>Apriya</u>						
Signature :	<u>[Signature]</u>	<u>[Signature]</u>						
Date:	<u>20/6/26</u>	<u>20/6/26</u>						
Time:	<u>8pm</u>	<u>8am</u>						

NURSING SHIFT HAND OVER FORM - WARD

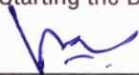
Treating Doctor: Department: Date of Admission:

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



REGULAR PRESCRIPTIONS

Weight. 2.33kgs Ward.

DRUG : vit. D3 drops				Date Time	20/6
Dose	Route	Frequency	Start Date		
0.5ml	PO	OD	20/6		
Name & Signature of the Doctor Starting the Drugs:					
					
Additional Instructions:					
(400IU/0.5ml)					
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					

HNH-00016035 IP26-00006616
 Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR

Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature
 VERIFIED BY Name

HNH-00016035 IP26-00006616
 Baby Of MAHESHWARI
 17-06-2026 0 Y 0 M 3 D (M)
 Dr. PRITESH NAGAR



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 (305)

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: 20/6/26 @ 1:50 pm

Nurse Name & Signature: Shinsha

Date & Time: 20/6/26 @ 2:07 pm

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016035 IP26-00006616 Baby Of MAHESHWARI 17-06-2026 0 Y 0 M 3 D (M) Dr. PRITESH NAGAR 		Date & Time of Admission 20/6/26 @ 1:42 PM	Date & Time of Transfer Order 20/6/26 @ 2:17 AM
		Transfer Ordered by Dr. Pritesh Nagar	Reason for Transfer Admission
From Unit ER	To Unit (305) 3 rd floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <u>21</u>	Number of Imaging Films	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 Shivisha / 		Name of Person Ordered Transfer Dr. varun	
Patient & Clinical Records Received by:  @ 2:25 PM			
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

wt = 2.33kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby of maheshwari Age : 3 days Gender: Male Female

Date : 20/06/26 Time of Arrival : 1:30 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: 97.6° PR: 113b/min BP: RR: SpO₂: 98%

Chief Complaints: clo yellowish discoloration all over the body

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

Signature of Parent / Guardian: [Signature]
 Triage Completion Time:

Communicable Disease Triage Screening

- PART A. The following questions should be asked to all patients at the initial screening:**
- Have you had fever (elevated temperature) in the past 2 weeks Yes No
 - Have you had cough or a rash in the past 2 weeks Yes No
 - Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

- PART 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 B. For patients reporting fever and respiratory/rash symptoms:** Not applicable
- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
 - Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

- PART 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 : Shirisha

Signature of Triage Nurse : [Signature]

Date & Time : 20/6/26 @ 1:32pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/6/26 Time of arrival : 1:30pm
 Chief Complaints: c/o yellowish discoloration all over the Body
 Height : Weight : 2.33 Kg 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 Location Frequency Duration

<p>RISK FOR FALL: If patient is < 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If 'Yes' tick below fall risk intervention directly If Patient is > 6 years If 'Yes' Assess the below parameters History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input type="checkbox"/> Escort while ambulating <input checked="" type="checkbox"/> Assist Patient <input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality Inform consultant for positive criteria Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method Inform consultant for positive criteria</p>
--	---

Psychological Screening: No Significant Findings
 Unusual concerns about patient's Psychological Status: Yes No
If Yes Consultant Notified: (Date/Time):
Social History: Lives With parents
 Siblings in household Yes No (if yes How Many?)
 Time of Initial assessment completed by ER Nurse : @ 1:35 pm

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

Time	Nursing Notes
1:30pm	Assess the Baby General condition Monitoring the vitals signs

Samples collected by: _____

Time: _____

Samples sent by : _____

Time: _____

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 110 bpm BP: _____ CFT: _____ RR: _____ SPO2 at FiO2: 95% GCS: _____ Temperature: 96.7 F Pain Score: 0 Repeat RBS (if applicable): _____	Shift - out from ER to: 3rd floor (305) Time of Shift - out: @ 2: 20 PM Handover given to: _____ (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): _____

NA

Name of the Nurse : Shinisha

Signature of the Nurse : [Signature]

Date & Time : 20/6/26 @ 2: 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:	Baby Of MAHESHWARI	Age :	0 Y 0 M 3 D
IP No:	IP26-00006616	Sex:	Male
Consultant:	Dr. PRITESH NAGAR	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 P 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: Sandeep Singh

Relationship: father

Date: 20/06/2026

Time: 13:42

Wittness Name: Yaseen ali Khan

Wittness Signature: [Signature]

Patient Address:
h no 14-10-1383, jali hanuman
Dhoolpet Hyderabad Telangana INDIA
500006

HNH-00016035 IP26-00006616
Baby Of MAHESHWARI
17-06-2026 0 Y 0 M 3 D (M)
Dr. PRITESH NAGAR



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
Years of being the golden age
Nurturing smiles, 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

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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:
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