HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 27 D (M)
Dr. SINDHURA MUNUKUNTLA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	24			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 22/06/26

(P.T.O)

DISCHARGE SUMMARY

Name	Master K SIDHARTH	**UHID**	HNH-00015644
Father/Guardian	Mr K VENUGOOPAL	**Age/Gender**	0 Y 6 M 26 D/ Male
Address	subhash nagar, Sirsilla, Karimnagar, Telangana, INDIA, 505301		
IP No	IP26-00006621	**Admission Date**	20-06-2026
Ref Doctor	Self.		
Discharge Date	22.06.2026		

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

DIAGNOSIS	ICD CODE
COMPLICATED BILATERAL ASOM	

History: Master K SIDHARTH, 0 Y 6 M 26 D , old boy presented with history of moderate to fever since 2 days, ear discharge from both ears and vomitings since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was febrile(100 F), maintaining saturations at room air. His heart rate was 125/min and Respiratory Rate - 36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry

Name	Master K SIDHARTH	UHID	HNH-00015644
IP No	IP26-00006621	Admission Date	20-06-2026

was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Local examination of both the ears showed yellowish discharge along with mastoid tenderness.

Weight on admission: 8.3 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 10.6 gm%, White Blood Cell count of 2390 cells/cumm, platelet count of 3.84 lakhs/cumm and C-Reactive Protein of 55 mg/l.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics . He was treated symptomatically with antacids and antipyretics. Symptomatic management was given for pain and vomitings.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters, oxygen saturations and any signs of respiratory distress. His fever spikes and other symptoms gradually settled.

In view of bilateral ear discharge ,pus swab culture sent and report awaited .
Antibiotics to continue till culture report and to plan accordingly on followup .

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

Name	Master K SIDHARTH	**UHID**	HNH-00015644
IP No	IP26-00006621	**Admission Date**	20-06-2026

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

Medication during hospital stay:
Injection. Ceftriaxone
Injection. Esmoprazole
Injection. Ondansetron
Syp. Xyzal
Ciplox ear drops
Syp. Linezolid

Advice:
* Diet as advised.

Name	Master K SIDHARTH	UHID	HNH-00015644
IP No	IP26-00006621	Admission Date	20-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
01.	INJ CEFTRIAXONE (dilute in 15ml NS and give over 1hour)	800MG/ IV	OD	1 DAY
02.	SYRUP LINEZOLID(100MG/5ML)	4ML/ORAL	TID	3days
03.	SYRUP XYZAL(2.5MG/5ML)	2.5ML/ORAL	BEDTIME (OD/HS)	3DAYS
04.	NASIVION MINI	1 DROP IN EACH NOSTRIL	TID	3DAYS
05	CIPLOX EAR DROPS	1 DROP IN EACH EAR	TID	3DAYS
06	SYP ONDEM(2MG/5ML)	4ML/ORAL	SOS	
07.	SYP CROCIN(100MG/ML)- 1.2ML PER ORAL SOS IF FEVER/PAIN IS NOTED.			

Plan: To get Ear culture and sensitivity reports on Wednesday followup(24/6/26) .

Fever Management

* Crocin Drops (Paracetamol - 1ml/100mg) 1.2 ml after food as and whenever

Name	Master K SIDHARTH	UHID	HNH-00015644
IP No	IP26-00006621	Admission Date	20-06-2026

required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

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

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

* **Antiemetics** can be taken before food.

* **Analgesics** without food/empty stomach can cause gastrointestinal irritation, frequent use of these drugs lowers the absorption of folate and Vit-C. **Analgesics** can be taken with food & recommonded diet to be followed.

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

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

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been

Name	Master K SIDHARTH	**UHID**	HNH-00015644
IP No	IP26-00006621	**Admission Date**	20-06-2026

explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006621 **Admit Date** : 20-Jun-2026 **Admit Time** : 11:17 PM **UHID** : HNH-00015644

Patient Details :

Patient Name	: Master K SIDHARTH	**Age**	: 0 Y 6 M 25 D
Guardian	: Mr K VENUGOOPAL	**DOB**	: 26-11-2025 04:46 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: subhash nagar Sirsilla Karimnagar Telangana INDIA 505301	**Phone No**	: 6300322596/ 8688291664
		E-mail	: tbhanuteja2105@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 K VENUGOOPAL **Relationship** : Father

Contact Address : subhash nagar Sirsilla Karimnagar Telangana INDIA 505301 **Phone No** : 6300322596

T. Sravanthi

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** : 15000.00

Payor Name : SELFPAY

PATIENT TRANSFER FORM

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Master K SIDHARTH
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Dr. SINDHURA MUNUKUNTLA

	Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name	20/6/26 @ 11:17 PM	20/6/26 @ 12 AM
Transfer Ordered by: Dr. Sreeghan	Reason for Transfer: Admission	
From Unit: ER	To Unit: Ward	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Bindu	Dr. Sreeghan

Patient & Clinical Records Received by : Mounika.

Date & Time of Patient Received : @ 12:30AM, 21/6/26

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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ACTIVITY RECORD FOR BILLING

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

UHID No : ---------- IP No : ---------- Consultant : ---------- Dept : ----------

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	12:31PM	ER	ward	[illegible] / Manjush

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Allu chandana	22/6/26	7756	Sandhya
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
21/6/24	CBP, CRP, other c/s CUE ~~pending~~	10/02	
	(Pus) checked by		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
21/6/26	IV placement	1	207638	
21/6/26	NHA	1	~~7697~~	

Typed checked by

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : SIDHARTH/ 6 months

Patient ID# : HNH-00015644 IP26-00006621
Master K SIDHARTH
25-11-2025 0 Y 6 M 25 D (M)

Consultant : Dr. SINDHURA MUNUKUNTLA

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/O 1) Fever since 2 days,

2) Eye discharge from both eyes

History of present illness:

Baby was apparently asymptomatic 2 days back when he had fever which was initially low grade but later had high-grade fever spike.

Eye discharge started 2 days back = purulent from both eyes

Pediatric Multiorgan History & Physical Examination

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Dr. SINDHURA MUNUKUNTLA

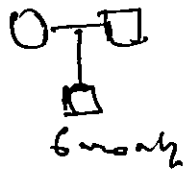
Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History :

Term / LSCS / Hyl CIAB

NICU Admission - 1 day

MAJ



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

NIS schedule - up-to-date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs)____8.3kg____ (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 ____ 96% ____ at ___ RA ____

Resp. rate and type of breathing : _____

Rash_____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : ____ BLE-AEE⊕ ____

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : ____ S1+S2⊕ ____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : ____ P/A-NAD ____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

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Central Nervous System :

Level of Consciousness : AVPU/GCS Score : A

Cranial Nerves : N

Motor System :

Nutrition : Normal

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars B

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

BLL ASOM complicated
Evolving LRTI
? Acute Mastoiditis

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV Antibiotics

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Desired goals of the treatment :

Fever Subsidence

Planned Labs :

- CBC
- CRP
- Blood C/S - Collect
- CVE (DUE)
- Consult C/S

Noted By Peadis

Planned Management :

- Inj. CEFTRIAXONE 800mg IV OD
- Inj. ONDANSETRON 1mg TID
- Drop. CLOCIN 1.2ml 6HL
- Syp. IBUGESIC 2.5ml SOS/8hr
- Inj. ESMOPRAZOLE 8mg IV OD
- XYZAL
- Syp. LINEZOLID 4ml TID

Please fill up the following details Noted By Peadis

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

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg No: 86670

Doctor's Signature Name _____ Date 2/6/26 Time 10 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/12/25 12 AM	Case d/w Dr Sindhura Δ Complicated BLL - AIOM	Add oral Linezolid. CROCIN drops 6th hrly IVF NS @ 30 ml/hr ENT Surgeon opinion on Monday Send for swab C/S Noted By Prabin

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 8:15AM	c/s/by: Dr Anusha	
	Δ:- Complicated B/L ASOM	
	k/c/o fever: 4th admission.	Plan.
	Nb vomiting	
	irritability (+)	- ct Antibiotics. CEFTRIAXONE < LINEZOLID.
	Tragal sign (+).	
	S/E	- ct ONDANSETRON
R/S	B/L AE (+) NVBS (+)	- ct CROSIN QGwly.
CVS	S1S2 (+) No murmur.	- (T) CUE Ear swab c/s.
		- Monitor vitals.

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/06/2026 11am	S/B Dr. Sindhura M Complicated	B/L ASOM
	no fever since admission asleep. vomitings - better feeding - better ifebrile/activity (+)	Plan 1) ~~IV~~ ct Ceftriaxone Linezolid 2) ~~IV~~ Stop regular cerocin 3) Trace CVE Ear swab c/s 4) ~~IV~~ ENT consultation T/m 5)
		NB Sunanda Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No. 66970 DR MUNUKUNTLA-00
21/6 3:45pm	C/S/B Dr. Pranav / Dr. Nazneen Complicated BL ASOM	
	No fever 2) ear discharge Vomiting -↓ Baby accepting feeds Vitals Stable	Plan 1) Inj Ceftriaxone Inj Linezolid 2) Trace Swab C/S 3) ENT consult - T/m 4) O2 Support as 5) Monitor Vitals NB-Mouth wash @ 6:30 pm Pranav

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6	S/B Dr. Nameen / Dr. Pranav	
7AM		
	Complicated B/L AOM.	
	Fever spikes ~ None	Plan
	Irritability - better now (Mode @ Night)	① Ct Ceftriaxone Intravenous
	Chest ~~clear~~ Conducted Sounds ⊕	② Ct Supportive management
	Ear discharge (+)	③ Trace earwax c/s
	mastoid tenderness - No	④ ENT consultation today
	oral intake - good	⑤ ~~Doa~~ Monitor vitals 4th
	Nose block ⊕	⑥ SOS Crocin
		NB-Mobile (350)
		Pranav

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26 10:30 AM	S/B Dr. Sindhuja	
	Δ^{days} r Complicated B/L ASOM	
	d/o fever : admission	Adv.
	B/L ear discharge (+)	- Discharge
	No c/o vomitings	- ct IV Antibiotic x 1 day (Ceftriaxone)
	oral intake - fair	discontinue if no spikes for 72 hours
	No mastoid tenderness noted	
	O/E vitally stable	
		- Review on wed (24/6/26)
		± ear c&s reports (ct Linezolid syp. until then)
	S/E	
	RS - AEBE	- Monitor for fever spikes
	B/L conducting sounds (+)	- ct frequent feeds
		- ct ceocin drops (SOS)
		- ENT consult
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970
		noted by Sr. Sandhya 22/6/26 10:30 am

Patient Sticker

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DRUG CHART

Date of Admission: 20/6/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: Drop. CROCIN				Date / Time
Dose	Route	Frequency	Start Date	
1.2ml	oral	sos/6th	20/6	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions: Paracetamol (Imf/kg)				

DRUG: Syp. IBUGESIC				Date / Time
Dose	Route	Frequency	Start Date	
2.5ml	oral	sos/8th	20/6	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions: IBUPROFEN (5ml/kg)				

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

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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

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REGULAR PRESCRIPTIONS

Weight. 8.3kg Ward. .....

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
800mg	IV	OD	20/6

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

Additional Instructions: dilute in 15ml NS give over 2 hours

Daily Doctor's Endorsement by a Sign

Date/Time: 20/6 21/6 22/6

10PM 11PM 3° 11AM

DRUG : Drop. CROCIN

Dose	Route	Frequency	Start Date
1.2ml	oral	6th hly	20/6

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

Additional Instructions: (1ml/100mg-Paracetamol)

Daily Doctor's Endorsement by a Sign

Date/Time: 20/6 21/6

5AM 11AM 5PM 11PM

Stop

DRUG : CIPLOX eye drops

Dose	Route	Frequency	Start Date
1°	eye	TID	20/6

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 20/6 21/6 22/6

6AM 2PM 10PM

DRUG : Syp. XYLAL

Dose	Route	Frequency	Start Date
2.5ml	oral	bedtime	20/6

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

Additional Instructions: Levocetrizine (5ml/2.5mg)

Daily Doctor's Endorsement by a Sign

Date/Time: 20/6 21/6

10PM

Verified by Dr. Dhakshayani
Verified by Dr. Dhakshayani
Verified by Dr. Dhakshayani
Verified by Dr. Dhakshayani

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

SIDHARTH

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 8.3kg Ward .....

DRUG : NASIVION MINI

Dose	Route	Frequency	Start Dt.
1 drop	nasal	TID	2016

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 20/6 21/6 22/6

6AM X 2PM X 10PM 12AM

DRUG : Inj. ESMOPRAZOLE

Dose	Route	Frequency	Start Dt.
8 mg	IV	OD	2016

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 21/6 22/6

6AM 2AM

DRUG : Syp. LINEZOLID

Dose	Route	Frequency	Start Dt.
4ml	oral	TID	2016

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

Additional Instructions: LINEZOLID (5ml/100g)

Daily Doctor's Endorsement by a Sign

Date/Time: 21/6 22/6

6AM X 9AM 2PM X 5PM 10PM 2AM

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Dt.
1 mg	IV	TID	2016

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

Additional Instructions: 1 mg

Daily Doctor's Endorsement by a Sign

Date/Time: 22/6

6AM 2PM 10PM

Docu. No. : RCH /FRM / CLINICAL / 108

Verified by Dr. Dhakshayani
Signature
VERIFIED BY : Name

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

Patient Sticker

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

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

Date	.....	Position of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

VERIFIED BY · Name ..... Signature .....

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315

RESULT SHEET

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Date	20/6/26					
Time						
Hb	10.6					
PCV	29.5					
RBC	4.20					
WBC	23.90					
N/L	48.0 / 44.1					
Platelets	384					
CRP	55					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Date						
Time						
CUE-Alb	Presented					
CUE-Sugar	Nil					
CUE - Ketones	Present					
CUE-PUS Cells	6–8					
CUE - RBC Cells	Nil					
CUE						
Nitrite	Negative					
epithelial cells	3–5					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

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

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INICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/6/26 Time:	11:00 AM			6 AM			10 AM			2 PM			5 PM			10 PM			2 AM			6 AM		
Doctor/Nurse/Family Concern?																								

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

99.0°F Crocin given | 97.4°F | 97.5°F | 98°F | 98.5°F | 97.4°F | 96.9°F

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

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

Heart Rate (Number)	125bpm			128bpm			130bpm			128bpm			128bpm			142bpm						138bpm		

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

70 60 50 40 30 20 10

Resp Rate (Number)	36bpm			38bpm			32bpm			35bpm			32bpm			30bpm						30bpm		

Resp Distress: Mod/ Severe / None / Mild																								
Receiving O_2(l/min) O_2Saturations (%)	99%			99%			99%			99%			99%			NOT						99%		
Conscious Level: Normal / Altered																								
GCS *	15/15			15/15			15/15			15/15														
TOTAL SCORE Number of shaded boxes	0			0			0			0			0			0						0		
Pain Score	0			0			0			0			0			0						0		
Observer's Initials	[illegible]			[illegible]			[illegible]			[illegible]			[illegible]			[illegible]						[illegible]		

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	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 :**						
21/6/26	02:00 am	1		1							1	
	03:00 am	0	Milk	0							0	
	04:00 am											
	05:00 am	1	Milk	1								
	06:00 am				— NA			— NA		L		
	07:00 am		Milk									
Total Intake :						**Total Output :**				U-1	M—	

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
21/6/26	08:00 am											
	09:00 am		Milk									
	10:00 am	0									0	
	11:00 am		Milk				0					
	12:00 pm											
	01:00 pm											
Total Intake :								Total Output :				
21/6/26	02:00 pm		Milk									
	03:00 pm											
	04:00 pm	0	Milk								0	
	05:00 pm						0					
	06:00 pm		Milk									
	07:00 pm											
Total Intake :								Total Output : U-			M-	
21/6/26	08:00 pm											
	09:00 pm											
	10:00 pm	0	Milk								0	
	11:00 pm											
	12:00 am		Milk									
	01:00 am											
Total Intake :								Total Output : U-			M-	
22/6/26	02:00 am											
	03:00 am		Milk									
	04:00 am	0									0	
	05:00 am											
	06:00 am		Milk									
	07:00 am											
Total Intake :								Total Output : 0-			M-	

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 22/6/26

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							
Night	8pm / 8AM	→ Assess the general Condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication	8pm / 8AM	→ Assessed the general Condition of pt. → Monitored vitals → Maintained I/O chart → Administered medication	P1 is Stable	Re-assess vitals	

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NURSING CARE RECORD

Date: 21.6.26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	- Assess the pt Condition - Monitor vitals & I/O chart - drug as per chart - provied Comfortable position - . .		- Assed the pt Condition - Monitored vitals & I/O chart - Duged as per chart - proveded Comfortable positio	Baby is stable	-> Rechecked vitals	
Afternoon	2pm to 8pm	- Assess the pt Condition - Monitor the v/s - Maintain the I/O - Drug as per chart	2pm to 8pm	- Assess the pt Condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now baby is stable	- Rechecked the v/s	
Night	8PM 8AM	-> Assess the general Condition of pt. -> Monitor vitals -> Maintain I/O chart. -> Administer medication. -> Drug as per as chart	8PM 8AM	-> Assessed the general Condition of pt. -> Monitored vitals -> Maintained I/O chart. -> Administered medication. -> Drug as per as chart.	Baby is stable	Re-assess vitals	

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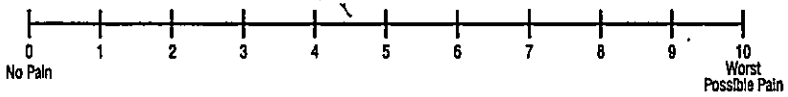
PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/6/26	9AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/6/26	10Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/6/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 20/11/25			DAY-2 21/11/25			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			0	0	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	0	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			0	0	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			0	0	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	0	NA	NA				
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Patient Sticker

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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										
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										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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										
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										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE

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					Date : 20/6/26	21/6/26	21/6/26	21/6/26
					Time : 2AM	10AM	2PM	NT
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	3	3	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	2	2	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	3	3	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	3	3	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	3	3	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	21	21	28
				Evaluator's Name				

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

Patient HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

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T HAND OVER FORM - WARD

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

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	20/6/26 N1	21/6/26 M6	21/6/26 E2	21/6/26 N1		
	Medical Condition (Any special condition to be noted):	–	–	–	–		
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4°F	98.1°F	98.3°F	98.4°F		
	Res:	40b/m	40b/m	42b/m	40b/m		
	SpO_2:	100%	100%	100%	100%		
	Pulse:	142	140	142b/m	140b/m		
	BP:	–	–	–	–		
	Fall Risk Score:	0	0	0	0		
	Pain Score:	0	0	0	0		
Recommendations	Safety Needs:	–	–	Yes	Yes		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–	–	–	–		
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–	–	–	–		
Post Operative Procedure Special Orders:		–	–	–	–		
Handed Over By Name :		Mouthuki	Apiya	Sunanda	Mouthuki		
Signature :							
Date:		20/6/26	21/6/26	21/6/26	22/6/26		
Time:		8AM.	2pm	8pm	8AM.		
Taken Over By Name :		Apiya	Sunanda	Mouthuki			
Signature :							
Date:		21/6/26	21/6/26	21/6/26			
Time:		8AM	2pm	8pm			

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

HNH-00015644 IP26-00006621
Master K SIDHARTH
6-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/6/26 Time: 9:30 am.

Weight: 8.3 Kg Centile: 50th

Height: — Centile: —

Inference: Well nourished child

RDA: — Calories: 108 Kcal/Kg/day Protein: 2.1 gms/Kg/day

Diet Recommendations: Breastfeeding + Complementary foods

Re-Assesment: No Junk, Oily spicy food.

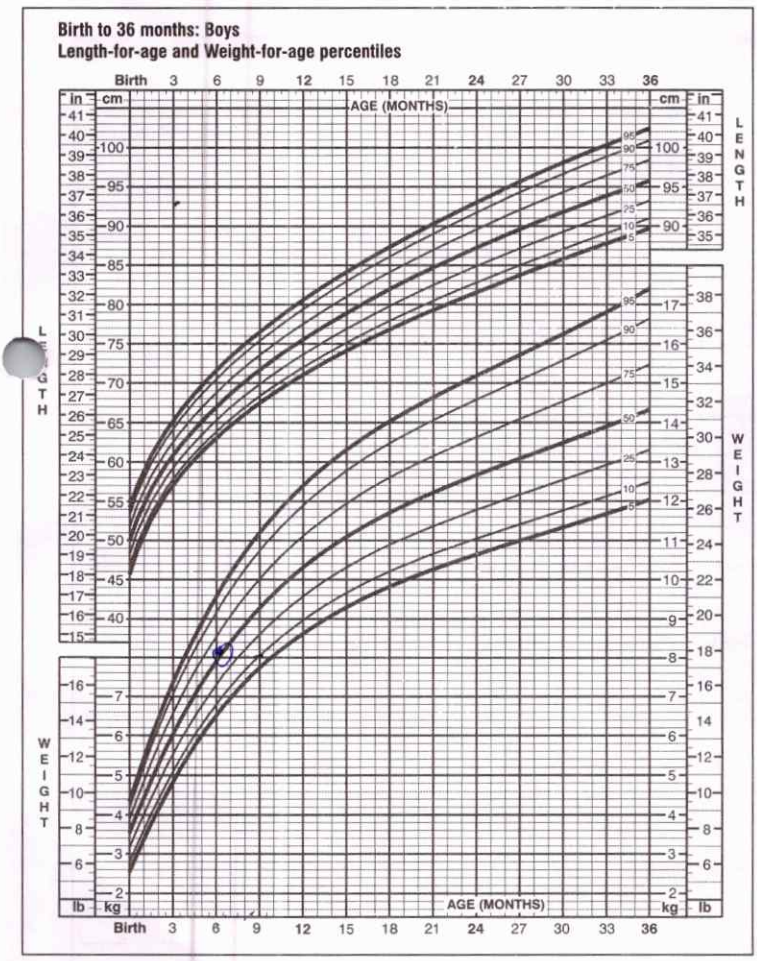
Food Allergies: No FA Veg/~~Non-veg~~ Non veg

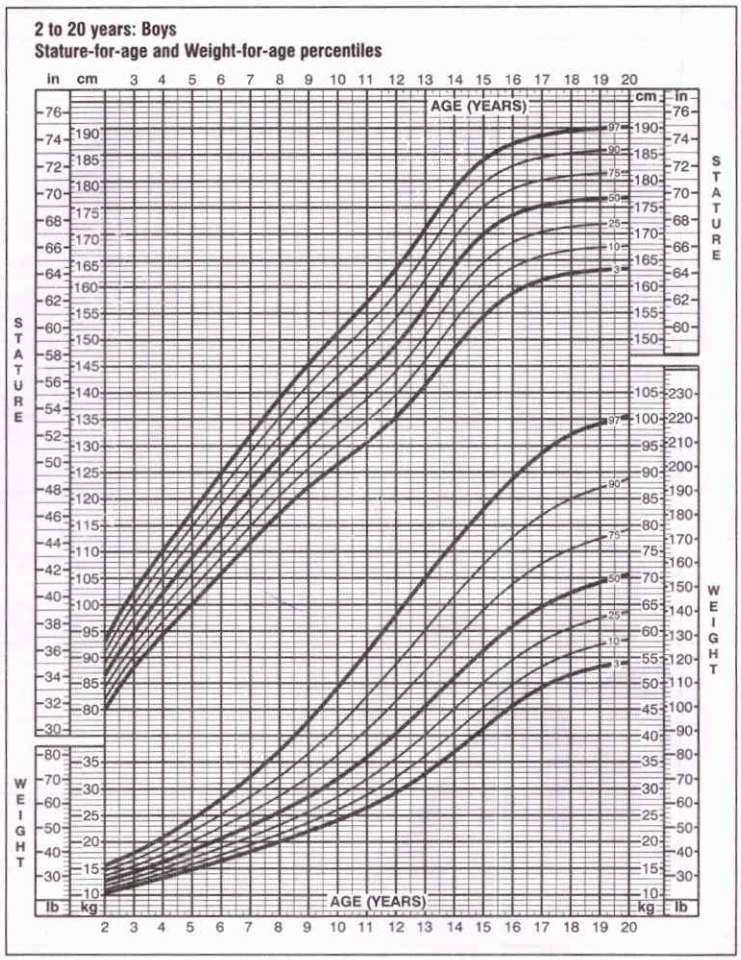
Diagnosis: Complicated BLASON

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: T. Sravanthi

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Docu. No. : RCH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes:

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

Wt- 9.20 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : K. Siddharth Age : 6 month **Gender:** ☑ Male ☐ Female

Date : 20/6/26 Time of Arrival : 11:10 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: 99.2°F PR: ..... BP: ..... RR: ..... SpO_2: .....

Chief Complaints: C/o Fever since 3 days cold and excessive cry.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 11:12 Pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Reabin

Signature of Triage Nurse : .....

Date & Time : 20/6/26 @ 11:12 Pm

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/6/26 Time of arrival : 8'10 PM

Chief Complaints: C/O cold Fever since 3 days.

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

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

If yes , identify .....

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

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

RISK FOR FALL:

If patient is < 6 years	☑ Yes	☐ No
If **'Yes'** tick below fall risk intervention directly		
If Patient is > 6 years		
If **'Yes'** Assess the below parameters		
History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 11:14 PM

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

Time	Nursing Notes
	-> Assessed the pt condition
	-> Checked the pt vitals

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: ..... BP: ..... CFT: 2sec	Shift - out from ER to: ward
RR: ..... SPO2 at FiO2:	Time of Shift - out: 12'31 AM
GCS: 15/15 Temperature : 99.2°F	Handover given to: Mathew
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Pradin Signature of the Nurse : .....

Date & Time : 20/6/26 @ 11:12 PM

Patient Sticker

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ER ..... Shifted to: Ward .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Sreeghan .....

Date & Time : 20/6/26 @ 11:25 PM .....

Nurse Name & Signature: Prabin .....

Date & Time : 20/6/26 @ 11:25 PM .....

Rainbow Childrens Hospital-Himayatnagar

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master K SIDHARTH**	**Age :**	**0 Y 6 M 25 D**
IP No:	**IP26-00006621**	**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 a[illegible] 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 c[illegible]rance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature: T.Sravanthi)

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.

T.Sravanthi
Signature of Patient/Relative:

Name: T. Sravanthi
Relationship: Mother
Date: 20/06/2026 Time: 11.17pm.
Witness Name:
Witness Signature: Surendra Mallick

Patient Address:
subhash nagar Sirsilla Karimnagar
Telangana INDIA 505301

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 D (M)
Dr. SINDHURA MUNUKUNTLA

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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 tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

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

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

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

MODE OF PAYMENT & REFUNDS

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

T. Sravanthi T. Sravanthi
Name & signature of Patient/Attendant

Surender Malek
(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.
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CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

HNH-00015644 IP26-00006621
Master K SIDHARTH
26-11-2025 0 Y 6 M 25 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 years

UNDERTAKING FOR BALANCE DEPOSIT

To

The Management,

Rainbow Children's Hospital, Himayatnagar

Hyderabad-500029

Sub:- **Undertaking Balance Deposit**

I Mr./Mrs./Ms. K VENUGOPAL (Father/ Mother/ Other _____) of Master/ Baby/ Baby of/ Mrs./ Ms. K. SIDHARTH was bought to your hospital on 20/06/26 at 11.17 PM. Admitted in _____. Approximate charges deposit details were explained by the Front office/ Billing executive on duty.

I have to pay the amount of 5k as a caution deposit but for now I'm depositing 10k. The remaining amount I'll deposit on 21/06/26 at 10.00 AM.

Thanking You

T. Sravanthi
Signature

Name:- T. Sravanthi

Ph. No.:- 6300322596