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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

ACTIVITY REC

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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

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

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : 138 Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/6	2:15AM	ER	138	Lam

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sindhura	27/6/26	3095083	
2.	Cross checked by		27/6/26	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
27/6/26	CBP, CRP, S/E, S.Ca,	26021664	Lan
	S.Mg, Blood cls,		
	RBS :- 140 mg/dl	26021665	Lan
27/6	CUE	26021674	
	Cross checked by 27/6/26.		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
27/6	Infusion pump	7.30Am	28/6 @11AM	3095053	[signature]
	Cross checked by [signature] 27/6/26				

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
27/6/26	IV placement	done on	outside	Sam
	Gross	0		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	1st floor Kalpana.		

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Pa Dr. SIVA NARAYANA REDDY

IP.No:

Wa

DOA:

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Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	-	-	
2	Discharge Summary	02	-	-	
3	Nursing Initial assessment form	03	-	-	
4	Patient Trasfer Forms	01	-	-	
5	In-patient Medical Record	03	-	-	
6	Doctors Progress Sheets	02	-	-	
7	Nurses Progress notes	03	-	-	
8	Consultation Sheets	01	-	-	
9	General Consent for Treatment	01	-	-	
10	Conset for Surgery				
11	Consent for Blood Transfusion				
	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	02	-	-	
26	Intake and Output chart (fluid Chart)	02	-	-	
27	Drug Chart (Regular prescription)	02	-	-	
	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01	-	-	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	others	12	-	-	
		24			
	Total No. of Pages				

Noted by Anitha 28/6/25

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital - Secunderabad
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060495 **Admit Date** : 27-Jun-2026 **Admit Time** : 06:04 AM **UHID** : VIH-00206300

Patient Details :

Patient Name	: Master BRIJESH RAJAN SRIYANSH	**Age**	: 1 Y 2 M 1 D
Guardian	: Mr G S BRIJESH RAJAN	**DOB**	: 26-04-2025 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO;169,KHARKHANA,NEAR GANESH TEMPLE CONTONMENT,SECUNDERABAD, HYDERABAD,TELANGANA. Karkhana Hyderabad Telangana INDIA 500009	**Phone No**	: 8121167319/ 7981170672
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 101 **Ward Name** : N 0 GF-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr G S BRIJESH RAJAN **Relationship** : Father

Contact Address : H.NO;169,KHARKHANA,NEAR GANESH TEMPLE CONTONMENT,SECUNDERABAD,HYDERABAD,TELANGANA. Karkhana Hyderabad Telangana INDIA 500009 **Phone No** : 8121167319

Signature

Doctor Details :

Doctor Name : Dr. SIVA NARAYANA REDDY VENNAPUSA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

Patient Name : Mast. BRIJESH RAJAN SRIYANSH UHID : VIH-00206300 IPD : IP-00060495 Gender : Male Age : 1 Y 2 M 1 D

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27/6/26 Time of arrival : 5:31 AM

Chief Complaints: Fever since 1 day, seizures 1 episode RBS: 141 mg/dl

Height : - Weight : 10.8 kg BMI : - 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
tick below fall risk intervention directly

☐ If Patient is > 6 years
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 : 5:34 AM

Patient Name : Mast. BRIJESH RAJAN SRIYANSH UHID : VIH-00206300 IPD : IP-00060495 Gender : Male
Age : 1 Y 2 M 1 D

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

Time	Nursing Notes
5:28AM	Patient came to ER.
5:30AM	Check vitals & record.
5:32AM	Doctor seen the Pt.
5:35AM	Advaice Admission
5:45AM	Admission process done.
5:34AM	GRBS checked & record.
6:50AM	Sample collection done Pt shifted to 1st floor

Samples collected by: Moglisha Time: 6:50AM

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
27/6 5:30AM	Syp- Ibugesic	P/O	5ml	Sa	S

Condition of patient at time of shift - out :

HR: 150 bpm BP: — CFT: —
RR: 28 bpm SPO_2 : 98% RA
GCS: 15/15 Temperature : 99.6 F
Pain Score: 0
Repeat RBS (if applicable):

Details of Shift - out

Shift - out from ER to: 138
Time of Shift - out: @ 7:15AM
Handover given to: Sr - Vaishnavi
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Sabin Signature of the Nurse : S

Date & Time : 27/6/26 @ 7:15AM

Patient Name : Mast. BRIJESH RAJAN SRIYANSH UHID : VIH-00206300 IPD : IP-00060495 Gender : Male
Age : 1 Y 2 M 1 D

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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wt - 10.8 kg
RBS - 140mg/dl

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mst. Sriyansh Age : 1Y Gender: ☑ Male ☐ Female

Date : 27/6/26 Time of Arrival : 5:28 AM

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ..... ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 100.3°F PR: 138 b/m BP: crying RR: 28 b/m SpO$_2$: 100 %

Chief Complaints: Fever since 1 day 1 seizures 1 episode

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

A. Tejasree
Signature of Parent / Guardian

Triage Completion Time : 5:32 AM

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 : Nikeetha

Signature of Triage Nurse : .....

Date & Time : 27/6/26 @ 5:32 AM

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: AFIC 1st Episode of febrile Seixures

Arrival Time: 1:20 Am Mode of Arrival: Boy Lifting Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 10.8 Kg

Height: — cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Family History: Nil

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: Nil

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☑ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 10.8 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4 °F HR: 136 b/m RR: 26 b/m BP: —

Pain Score: 0 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 14 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Nil Location Nil Frequency Nil Duration Nil

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 ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

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?) ..... Nil .....

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Mother .....

Nurse's Name: ..... Vaishnavi ..... Date: 26/6/26 Time: @7:20 AM Signature Vaishnavi

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00206300 IP-00060495 Master BRIJESH RAJAN SRIYANSH 26-04-2025 1 Y 2 M 1 D (M) Dr. SIVA NARAYANA REDDY	27/6/26 @ 6:04AM	27/6/26 @ 7:15AM
	Transfer Ordered by Dr. Sameera	Reason for Transfer Admission
From Unit ER	To Unit 138	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 25	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
Samuel / Sam	Dr. Sameera

Patient & Clinical Records Received by : Vaishnavi

Date & Time of Patient Received : 27/6/26 @ 7:20 Am

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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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

UHID ID:

Department: _____

Consultant: _____

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH (M)
26-04-2025 1 Y 2 M 1 D
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Name : Mast. Srijansh Age/Sex 1y / M.

Information given by: Mother. Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

c/o fever :: yesterday 11.00 PM
seizure today.

History of present illness :

Mast. Srijansh is a 1y old male child presented with H/o fever → moderate grade
→ not a/w chills
→ :: yesterday 11.00 PM

→ 1 episode of seizure around 4.00 AM in the form of uprolling of eyeballs & stiffening of whole body lasting about ~5 min a/w drooling of saliva f/b ↓ irritability.

→ no H/o cough, cold, loose stool, vomiting, trauma
→ For the above complaint, he was taken to Apollo hospital where he was stabilized & referred to RCH.

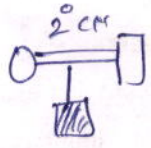
VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Pediatric Multi... tory & Physical Examination

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

Nil significant

Birth & Neonatal History:



FT / LSCS (Ind. Cord around the neck) / B.wt : (N) / BCIAB / no neonatal issues

Birth & Socio Economic History:

About Father :
About Mother : Class II
Any additional Information :

Developmental History :

All Milestones attained on time

Immunization History :

Immunised till date.

(P.T.O.)

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH (M)
26-04-2025 1 Y 2 M 1 D
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10.8 kg (Centile _____)

On Examination :

Temperature : 100.3°F Pulse Rate : 180/min B.P. ~~elevated~~ SPO2 100% RA.

Resp.rate and type of breathing : 26/min

Rash

Lymphadenopathy ND

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BAE (+)

Any addes sounds : clear

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : no murmurs

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) :

Per Abdomen :

Inspection

Palpation : soft, no organomegaly.

Ausculation :

Spine : External Genitelia :

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

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : irritable

Cranial Nerves : [redacted] pupils BERL.
resistive neck meningeal signs.

Motor System:

Nutriton :

Tone: Power 4/5 all limbs

Co-ordinator : (N)

Posture :

Involuntary Movements :

Reflexes : ++ | ++ / ++ | ++

DTR **Superficials:**

Plantars

Sensory System : (N)

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute febrile illness with 1st episode of febrile seizure.

(P.T.O.)

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: N/A.

Desired goals of the treatment : Treat the seizure.

Planned Labs:

→ CRP, CRP, S. electrolyte
S. Ca, S. Mg, blood c/s.
CUE
→ extra plain
→ RBS : 140 mg/dl
→ Dengue NS 1 after
rounds.

Planned Management

→ IVF
→ INJ. CEFTRIAXONE
→ TAB. CLOBAZAM
→ NEUROLOGIST C/N after
rounds
Mother was counselled that
if the child has next episode
of seizure in next 24 hrs
then he will be shifted
to PICU & meningitis work
up would be done.

noted by - Sabin
27/6/26 @ 6AM

Signature of the Doctor: Sameera
Name of the Doctor: Dr. Sameera
Date & Time: 27.6.26 6:06AM

Signature of the Consultant:
Name of the Consultant:
Date & Time:

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 8:00 am.	c/s/B Resident	
	AFI c̄ febrile seizures (1st episode)	
	c/o loose stools - watery yellowish	
	No fever spikes :- Admission.	
	O/E	
	Child awake.	
	CRT<3sec.	
	CVS: S1S2 (+)	
	RS: B/L AE (+)	
	P/A: soft	Plan
	CNS: NAD.	- Inj. ceftriaxone-D1
Dr. prashanth		- Hemo c/o afterounds
		- monitor vitals.
	Dr. Rucha 27/6/26 10 AM	- w/f seizures.
		- Inform SOS.
		- ORS
		- Zentel
		- add probiotics
		- To send CUE.

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Resident	
27/6/25 4pm	A/S/C - Simple febrile seizures.	
	loose stools - 1 episode - watery	
	1 fever spike 11AM : 101°F	
	O/E	
	child active	
	Euthermic	
	Vitals stable	
	CVS - S1S2 (+)	
	RS - BAE (+)	
	P/A - soft	
		plan
		1) Inj ceftriaxone D1
		2) Tab clobazam D1
		3) Enterogermina.
[signature]		

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Resident	
28/6/26 8AM		
	Dx - Simple febrile seizures.	
	loose stools.	
	1 fever spike @ 6:40pm 100.4°F	
	O/E	
	Child active	Urine / Stool (N).
	Euthermic	
	Vitals stable	
	CVS - S1S2 (+)	
	RS - B/L AE (+)	
	P/A - soft	
		Plan
		1) Inj Ceftriaxone Day 3
		2) Tab clobazam 3rd dose
Dr [illegible]		3) Enterogermina
		4) Trace B/c's
		5) Monitor vitals D/C at request
		- R/w after 2 days
		- CBP, CRP -? if needed (-
	[signature]	
	Dr [illegible]	
	28/6/26 9AM	Noted by [illegible]
		28/6 @ 11.20Am

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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ROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: AFI, Febrile seizures

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

Surgery / Procedure: –

Post OP Day: –

BACKGROUND	Date / Shift	27/6/26 N	27/6/26 M	27/6 M	27/6 E	27/6 N	28/6 M
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil	Nil	Nil
	Diet:	S. diet	S diet	S. diet	S. diet	S diet	S. diet
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3 F	98.4°F	98.6 F	98.2 F	98.3°F	98.4 F
	Res:	24 b/m	26 b/m	26 b/m	26 b/m	24 b/m	22 b/m
	SpO_2:	100%	99%	98%	99%	99%	98%
	Pulse:	136 b/m	136 b/m	119 b/m	120 b/m	122 b/m	118 b/m
	BP:	crying	102/62	77/55 (61)	100/62 (74)	104/65	98/64 (72)
	LOC:	conscious	Conscious	Conscious	Conscious	Conscious	Conscious
	Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0	0	0	0	0	0
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	Nil	NPI	Nil	Nil	Nil
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	S. diet	S diet	S. diet	S. diet	S diet	S. diet
	Critical Lab Test / Values:	–	Nil	Nil	Nil	Nil	Nil
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	dependent	dependent	Dependent	Dependent	dependent	Dependent
Post Operative Procedure Special Orders:		Nil	Nil	Nil	Nil	Nil	Nil
Handed Over By Name :		Sabir	Vaishnavi	Anitha	Anitha	Vaishnavi	
Signature / ID :		ID 20216	Asf 90540	Asf 90540	Asf 90540	ID 20216	
Date:		27/6/26	27/6/26	27/6/26	27/6/26	28/6/26	
Time:		7:15 Am	@8Am	@2pm	@8pm	@8Am	
Taken Over By Name :		Vaishnavi	Anitha	Anitha	Vaishnavi	Anitha	
Signature / ID :		ID 20216	Asf 90540	Asf 90540	ID 20216	Asf 90540	
Date:		27/6/26	27/6/26	27/6	27/6/26	28/6	
Time:		@7:20Am	@8Am	@2pm	@8pm	@8Am	

Noted by Anitha @ 11:20 Am 28/6

Patient Sticker

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NURSING SHIFT HAND OVER FORM

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

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NURSING CARE RECORD

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Date: 27/6/26

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				NAD			
Afternoon							
Night	7:30 AM	Maintain Fluid Balance - Ensure Safety	8 AM	- Maintained input / output chart - provided side rails	- To prevent dehydration - To prevent Falls	patient is stable	Vaishnavi 27/6/26 @8AM

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NURSING CARE RECORD

Date: 27/6/21

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
- ☑ Ensure Safety
- ☐ Improve Activity Tolerance
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Good Nutritional Status
- ☐ Patient & Family Education
- ☐ Maintain Skin Integrity

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10AM	→ Maintain fluid Balance		→ Maintained IV fluid ONS 40 ml/hr Balance	→ To maintain Hydration	→ patient is Stable	Anethea 27/6 @2pm
Afternoon	3pm	→ Maintain Aseptic Technique		→ Maintain Aseptic Technique	→ To prevent infection	→ patient is Stable	Anethea 27/6 @8pm
Night	11pm	Maintain fluid Balance - Ensure Safety	11:10 pm	- Maintained input/output chart - provided side rails	- To prevent dehydration - To prevent falls	- patient is stable	Vaishpari 28/6/21 @8AM

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NURSING CARE RECORD

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Date: 28/6/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify..... Nil
- ☐ 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		Discharge Note :-		Doctor Come round Attenders asked for Discharge			
Afternoon					Noted by Anitta 28/6 @11.20Am		
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

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WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a **score of 1** if **'YES'** in **parameter 1 to 9** and **Assign a score** of **-2** if **'YES'** in **parameter No 10**

S.No	Assessment Criteria	Score	Date: 27/6 Time: 8AM	Date: 28/6 Time: 8AM	Date: Time:	Date: Time:	Date: Time:	Date: Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0				
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0				
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0				
5	Entire leg swollen (Assess for both legs)	1	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0				
9	Previously documented DVT (Assess for both legs)	1	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0				
	Total Score		0	0				
	Signature of the Nurse		Vaishali	Vaishali				

Intervention: _____

_____

_____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	~~8~~ 4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3	3	3	3	3	
	Forget Limitations	2					
	Oriented to own Ability	1					
Environmental Factors	History of Falls or Infant - Toddler Placed in Bed	4					
	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	1	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	TOTAL		14	14	14	14	

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

Bed in low position		✓	✓	✓	✓	
Call device within reach		✗	✗	✗	✓	
Wheels Locked		✓	✓	✓	✓	
Room free of clutter		✓	✓	✓	✓	
Adequate Lighting		✓	✓	✓	✓	
Wheel Chair Support		✗	✗	✗	✗	
Other Intervention(s) Specify		✗	✗	✗	✗	
Nurse's Name :		Sowmya	Anitta	Vaishnavi	Vaishnavi	
Signature :		[signature]	[signature]	[signature]	[signature]	
Date :		27/6	27/6	28/6	28/6	
Time :		6AM	4pm	12AM	8AM	

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CHECKLIST FOR THROMBOPHLEBITIS

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C / THROM / 07

War .....
Date .....

S.No	SITE OBSERVATION	STAGE / ACTION	SCORE	I.P. No. 24/6								REMARKS
				N	m	£	✓	m				
1	IV site appears healthy	No signs of phlebitis / **Observe cannula**	0	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	–	–	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 Cannual 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	–	–	–	–	–				

NOTE : Phlebitis > 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 .....

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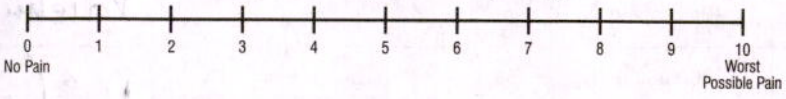
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/6	6AM	0	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	– –	Lan
27/6	4pm	0	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–	Anup
28/6	12AM	0	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–	Vaishnavi
28/6	8AM	0	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–	Vaishnavi
9				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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BRADEN 'Q' SCALE

				Date : / Time :	27/6 6AM	27/6 4pm	28/6 12AM	28/6 11AM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3	3
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	27	27	27
				Evaluator's Name	[illegible]	[illegible]	Vani	[illegible]

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

Ref. No. : F / HW/CONS.F/INPR / 01

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CONSULTATION FORM

Doctor Name : Dr. Sindhura

Date : 27/6/26 Hour : @ 9:30AM

Hospital : VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Referred for :

☐ Transfer of care

Type of Referral : ☐ Emergency (within one hr.)

☐ Urgent (within 6 hrs.) ☐ Non Urgent (within 24 hrs.)

Date : 27/6 Time : .... By : ....

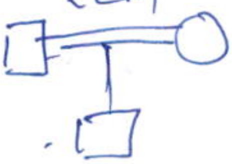
Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: M.D.

Report of Findings and Recommendations :

c/o
- fever x 1 day
- seizures

Loose stools x 1 episode today



L UROEB
with tonic clonic movements
of upper limbs lasted for 5 min
f/b post ictal drowsiness

Birth Hx - LSCS / 2.2kg / CSAB / term [illegible] day
Develop - (N) for age

No family Hx of febrile seizures

Consultant :

Name : Dr. P. Sindhura Signature : .... Date & Time : 27/6/26 09:30AM

NOTE : If more space is required use another consultation sheet as continuation

CIN: L85110TG1998PLC029914 www.rainbowhospitals.in

O/E

HC - 47cm , frontal bossing +ve
No NL markers
pupils - equal, reacting
Eom - full , no facial weakness
Tone
good antigravity movements
DTR - +2
Ataxia - present

Adv

→ CUE

→ T clobazam (5mg)
½ — 0 — ½ — (2) day

Rainbow Children's Hospital - Secunderabad
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master BRIJESH RAJAN SRIYANSH**	**Age :**	**1 Y 2 M 1 D**
IP No:	**IP-00060495**	**Sex:**	**Male**
Consultant:	**Dr. SIVA NARAYANA REDDY VENNAPUSA**	**Ward/Bed No:**	**N 0 GF-EMERGENCY/ER 101**

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

Signature of Patient/Relative:

Name: Brijesh Rajan
Relationship: Father
Date: 27/6/2026 Time: 6:04 Am
Wittness Name:
Wittness Signature:

Patient Address:
H.NO;169,KHARKHANA,NEAR GANESH TEMPLE CONTONMENT, SECUNDERABAD,HYDERABAD, TELANGANA. Karkhana Hyderabad Telangana INDIA 500009

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Patient St :AL / 125

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

Rainbow® Children's Hospital — It takes a lot to treat the little.
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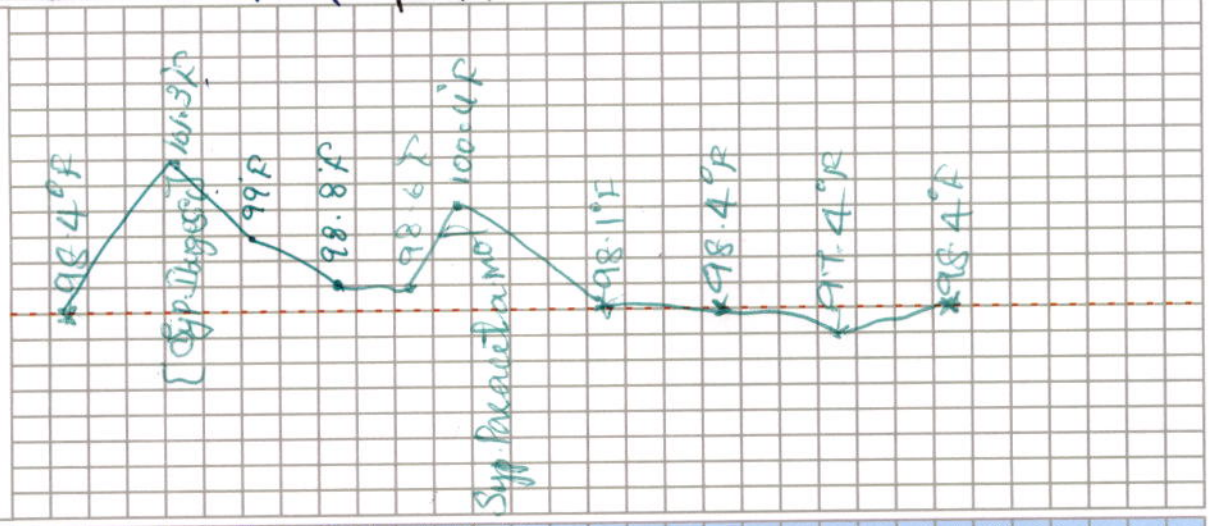
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/6/26 Time: 8 11 1 3 5 6.00 9 12 3 6 8

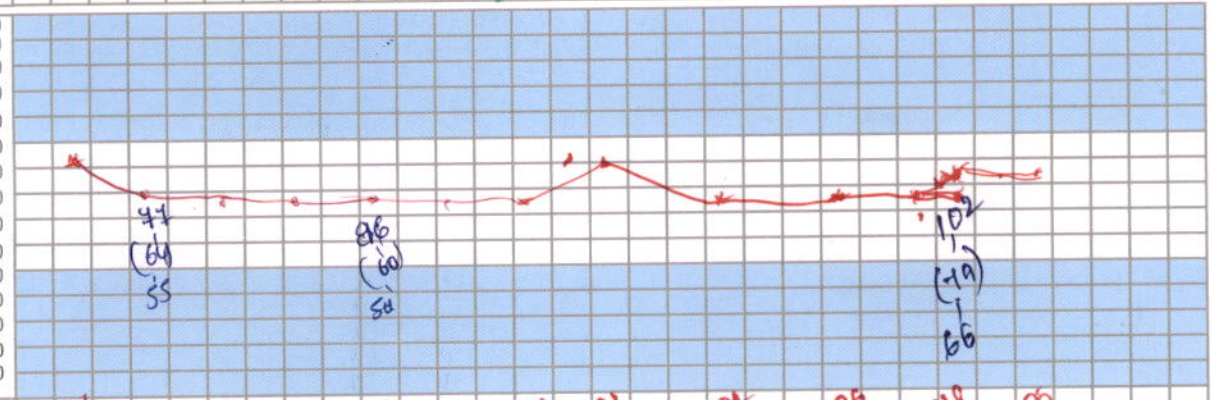
Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM PM AM AM AM AM

Temperature (°F)



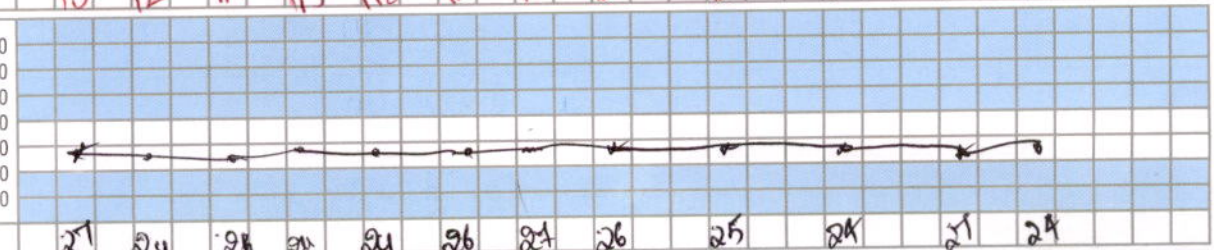
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)	136	120	119	115	118	112	114	131	124	126	112	125

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



Resp Rate (Number)	27	24	28	30	24	26	27	26	25	24	27	24
Resp Distress: Mod/ Severe / None / Mild												
Receiving O_2 (l/min) O_2 Saturations (%)	99	98	99	98	98	100	99	99	98	99	98	
Conscious Level: Normal / Altered	N	N	N	N	N	N	N	N	N	N	N	
GCS *	15	15	15	15	15	15	15	15	15	15	15	
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	0	0	0	0	0	
Observer's Initials	V	A	A	A	A	A	V	V	V	V	V	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Doc. No. : RCH/ FRM / CLINICAL / 125

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	9	11
Doctor / Nurse / Family Concern?	AM	AM
Temperature (°F)	99.8	99.8
Heart Rate (bpm) and Blood Pressure (mmHg) *	98 (61) 58	
Heart Rate (Number)	100	102
Resp. Rate (bpm) (Over 1 Minute) *		
Resp Rate (Number)	24	26
Resp Distress: Mod/ Severe / None / Mild	N	N
Receiving O_2 (l/min) O_2 Saturations (%)	98	99
Conscious Level: Normal / Altered	N	N
GCS *	15	15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	A	A

Noted by Dr. Smita @11.20 Am

Note: BP does not score in early warning scoring

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

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

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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)

Patient Stic

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
27/6/26	08:00 am	D		40ml			✓					Vai
	09:00 am	M	Idly water				✓			✓		
	10:00 am			40ml			✓				0	Anitha 24/6 @1pm
	11:00 am	S		40 ml								
	12:00 pm			40ml						✓		
	01:00 pm			40ml								
Total Intake : 200 ml						**Total Output :**						
27/6	02:00 pm			40 ml								
	03:00 pm		Kichidy water	40 ml						✓		
	04:00 pm			40ml							1	
	05:00 pm			40 ml								Anitha 24/6 @7pm
	06:00 pm			40 ml						✓		
	07:00 pm										1	
Total Intake : 200 ml						**Total Output :**						
27/6	08:00 pm		Rice + Idlie									
	09:00 pm										0	Vaishnavi 28/6/26 @2Am
	10:00 pm											
	11:00 pm											
	12:00 am			40ml			✓			✓		
	01:00 am			40ml							1	
Total Intake :						**Total Output :**						
28/6	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am			40ml								Vaishnavi 28/6/26 @8Am
	05:00 am									✓		
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

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							
28/6	08:00 am		Idly water									
	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 :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Noted by Anitha 28/6 @ 11.20 Am

Total 24 hrs. Intake		Total 24 hrs. Output	

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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: 138

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. Sameera / Dr

Date & Time : 27/6/26 @ 6AM

Nurse Name & Signature: Samuel / Sam

Date & Time : 27/6/26 @ 6AM

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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: TAB. PAR.				Date/Time
Dose	Route	Frequency	Start Date	
3 ml	PO	6th hrly		
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG: SYP. PARACETAMOL (5ml - 240 mg)				Date/Time: 27/6 6.50pm [signature]
Dose	Route	Frequency	Start Date	
3 ml	PO	6th hrly	27/6	
Doctor's Signature: [signature]		Valid Period	Pharm.	
Additional Instructions: Temp > 100° F 15 mg/kg/dose				

DRUG: SYP. IBUPROFEN (5 ml - 100 mg)				Date/Time: 27/6 11.44 [signature]
Dose	Route	Frequency	Start Date	
5 ml	PO	6th hrly	27/6	
Doctor's Signature: [signature]		Valid Period	Pharm.	
Additional Instructions: Temp > 101 F 10 mg/kg/dose				

Neegi Sue 27/6

VERIFIED BY

Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

Neeggithe 26/7

I.V. FLUIDS CHART

Weight. 10.8 Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
27.6.26	6:30am	DNS	IV	40	[signature]	[signature]	28/6	[signature]	[signature]

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

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
27.6.26	5.30 PM	SYP. IBUPROFEN	5 ml	PO	Sasu	Lam Nee
27/6	3pm.	SYP. ALBENDAZOLE (ZENTEL)	5ml	PO	V	Gayathri

VERIFIED Name .... Signature ....

VIH-00206300 IP-00060495
Master BRIJESH RAJAN SRIYANSH
26-04-2025 1 Y 2 M 1 D (M)
Dr. SIVA NARAYANA REDDY

REGULAR PRESCRIPTIONS

Weight. 10.8 Ward. ....

DRUG: INJ. CEFTRIAXONE				Date / Time	27/6	28/6
Dose	Route	Frequency	Start Date	6 AM	7.40 AM	
500mg	IV	12th hly	27/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera				6 PM		
Additional Instructions: After Test Dose 50 mg/kg/dose						
Daily Doctor's Endorsement by a Sign						

Noogi 27/6

DRUG: TAB. CLOBAZAM (5mg)				Date / Time	27/6	28/6
Dose	Route	Frequency	Start Date	10 PM		
	PO	12th hly	27/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera				10 pm		
Additional Instructions: 1/2 — 1/2 0.7 mg/kg/day.						
Daily Doctor's Endorsement by a Sign						

Noogi 27/6

DRUG: [illegible]				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: ENTERO GERMINA				Date / Time	27/6
Dose	Route	Frequency	Start Date	10 am	
1 Bottle	PO	12th hourly	27/6		
Name & Signature of the Doctor Starting the Drugs:				10 pm	
Additional Instructions: 1 mini Bottle					
Daily Doctor's Endorsement by a Sign					