Rainbow® Children's Hospital
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Your Right to a Safe Delivery.

ACTIVITY REC

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

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

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

Date of Admission : ---17/6--- Time : ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---113--- Ward : ---1st F--- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6	~~13~~ 11.00 pm	ER	113	Lam

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
17/6/26	CBP, CRP, S/E, S.Cr, B/C/S	26020700	
	LFT, PCT		Sam
	CXR	26020764	Sr
	CBP, CRP	26020829	Sr
	Urinalysis	26020764	Sr
	procalcitonin	26020845	Sr
	Usg abdomen	26009766	Sr
	Urine Culture by Sanjana		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
17/06	Infusion pump	11:10pm	18/6/20 1Am	3091452	[signature]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
17/6/26	IV placement	✓	3091451	Lam

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	Elizabeth Thomas		

Name	Master OM DARSH DIMRI	**UHID**	CUV-00097223
Father/Guardian	Mr MAYANK PRASAD DIMRI	**Age/Gender**	5 Y 8 M 18 D/Male
Address	68, RAMAPURAM COLONY , VIJAYAWADA., Poranki, Krishna, Andhra Pradesh, INDIA, 521137		
IP No	IP-00060387	**Admission Date**	17-06-2026
Ref Doctor	SELF	**Discharge Date**	19-06-2026

DISCHARGE SUMMARY

Consultants:

Dr. GEETHA CHANDA
MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr. Sindhura Pappula
MBBS, MD, DrNB (Pediatric Neurology), FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. RAMESH KONANKI,
MD Pediatrics (AIIMS),
DM Pediatric Neurology (AIIMS),
CONSULTANT PEDIATRIC NEUROLOGIST, APMC-49226

Co-Consultant: Dr. SIVA NARAYAN REDDY VENNAPUSA
DCH., DNB (Paeds), Fellowship in Neonatology,
SENIOR CONSULTANT PEDIATRICS
APMC- 48300

Diagnosis: Acute onset headache with fever ? post viral

Name	Master OM DARSH DIMRI	UHID	CUV-00097223

History: Master OM DARSH DIMRI, 5 Y 8 M 18 D, boy presented with history of high grade intermittent fever, severe headache 3-4 episodes of ? projectile non-bilious vomitings, dull activity, neck pain on the day of admission. For the above complaints, he was admitted at Rainbow Children's Hospital for further management.

Birth History: Born to non consanguineous couple, 1st in birth order, moderate preterm/LSCS/Birth weight - 2.3 Kgs/Cried immediately after birth / NICU admission for 5 days.

Developmental History: Appropriate for age.

Examination: He was afebrile, maintaining saturations at room air. HR-98/min, BP- 100/60 mmHg and RR - 22/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard.

Neurological examination: Child was conscious. Pupils were bilaterally equal and reacting to light. EOM Full. DTR elicitable. Tone normal. Power moving all limbs against gravity. Plantars flexor. There were no signs of raised intracranial pressure. Meningeal signs - absent

Weight on admission : 23.2 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and started on IV fluids and IV antibiotics. He was treated symptomatically with antacids and laxatives.

His complete blood picture showed Hb 10.4 gm%, WBC count of 7,780 cells/cumm, platelet count of 2.38 lakhs/cumm and C-reactive protein was 15 mg/l. PCT was 11.9 ng/ml. Serum electrolytes, creatinine and liver function

tests were normal. Blood culture was sterile after 24 hours of incubation. CUE was normal. Urine culture was sent - report awaited. Ultrasound abdomen showed mild splenomegaly, bowel gas in peripheral and central abdomen.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters & neurological status. His fever spikes and other symptoms gradually settled & had no seizure episodes during hospital stay. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Neurological condition at the time of discharge:

He is conscious.
EOM full.
Pupils are bilaterally equal and reacting to light.
Tone normal.
Power normal.
No meningeal signs

Advice:

1. Diet as advised.
2. Trace urine culture report.
3. Kindly consult with primary pediatrician for any issues.

Syrup CEFIXIME (5ml=100mg)	5ml, 12th hourly for 5 days
Syrup SMUTH	10ml at night for 3 days

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

Name	Master OM DARSH DIMRI	UHID	CUV-00097223

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

In Case of Emergency Contact 040-42462200, Extn: 2010 (or) 733735/870 for increasing breathing difficulty, dullness or high fever.

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

Name : Signature :
Relationship with patient :
This summary has been explained by :

Summary prepared by :Dr. Nikesh
DEO :MD Younus Pasha

Registrar/Resident/C.M.O

Consultants:

Dr. GEETHA CHANDA
MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr.Sindhura Pappula
MBBS, MD, DrNB (Pediatric Neurology),
FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. RAMESH KONANKI,
MD Pediatrics (AIIMS),
DM Pediatric Neurology (AIIMS),
CONSULTANT PEDIATRIC
NEUROLOGIST, APMC-49226

DEFICIENCY CHECK MEDICAL CASE SHEET

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

CUV-00097223 IP-00060387
Master OM DARSH DIMRI (M)
01-10-2020 5 Y 8 M 17 D
Dr. GEETHA CHANDA

Patien IP.No:

Ward: DOA:

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	03	–	–	
7	Nurses Progress notes	03	–	–	
8	Consultation Sheets				
9	General Consent for Treatment	01	–	–	
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	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	03	–	–	
26	Intake and Output chart (fluid Chart)	02	–	–	
	Drug Chart (Regular prescription)	02	–	–	
28	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 Educatlon Form				
	others	12	–	–	
		38			
	Total No. of Pages				

Posted by Anitha 19/6/26 @9.30AM

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-00060387 **Admit Date** : 17-Jun-2026 **Admit Time** : 09:57 PM **UHID** : CUV-00097223

Patient Details :

Patient Name	: Master OM DARSH DIMRI	**Age**	: 5 Y 8 M 16 D
Guardian	: Mr MAYANK PRASAD DIMRI	**DOB**	: 01-10-2020
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 68, RAMAPURAM COLONY , VIJAYAWADA. Poranki Krishna Andhra Pradesh INDIA 521137	**Phone No**	: 9176933166
		E-mail	: MAYANK238@REDIFFMAIL.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 MAYANK PRASAD DIMRI **Relationship** : S/O

Contact Address : 68, RAMAPURAM COLONY , VIJAYAWADA. Poranki Krishna Andhra Pradesh INDIA 521137 **Phone No** : 9176933166 / 8247378937

Signature

Doctor Details :

Doctor Name : Dr. GEETHA CHANDA **Specialisation** : PEDIATRIC NEUROLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. SIVA NARAYANA REDDY VENNAPUSA

Payment Details :

Deposit Amount : 0.00

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

Patient Name : Mast. OM DARSH DIMRI UHID : CUV-00097223 IPD : IP-00060387 Gender : Male Age : 5 Y 8 M 16 D

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

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est:- 23.2kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master. omdarsh Age : 5 Years Gender: ☑ Male ☐ Female

Date : 17/6/26 Time of Arrival : 9:35 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: 96.8°F PR: 103b/M BP: 105/63(78) RR: 19b/M SpO2: 100%

Chief Complaints: fever, neck pain since evening vomiting 3 episodes

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 : 9:39pm

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 : Swathi

Signature of Triage Nurse : .....

Date & Time : 17/6/26 @ 9:39pm

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

Patient Name : Mast. OM DARSH DIMRI UHID : CUV-00097223 IPD : IP-00060387 Gender : Male Age : 5 Y 8 M 16 D

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/6/26 Time of arrival : 9:40pm

Chief Complaints: fever, neck pain since evening, vomiting 3 episodes RBS: —

Height : — Weight 23.2kg BMI : — Head Circumference (<2 years) —

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

If yes , identify —

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 1 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character Aching ☐ Location neck pain ☐ Frequency Intermed ☐ Duration evening

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 9:40pm

Patient Name : Mast. OM DARSH DIMRI UHID : CUV-00097223 IPD : IP-00060387 Gender : Male Age : 5 Y 8 M 16 D

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

Time	Nursing Notes
9:35pm	✱ patient Came to ER
9:39pm	✱ vital checked & Recorded
9:43pm	✱ Doctor seen the patient Adviced Admission
9:47pm	✱ Admission process done
10:22pm	✱ IV placement done
10:30pm	✱ Blood sampler collecte set to lab
10:55pm	✱ patient shifted to ward[113]

Samples collected by: } moglesha
Samples sent by :

Time: @ 10:22pm
Time: @ 10:30pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
10:23pm	Inj:- Dexa	IV	4mg	Dr Shinkar	
10:33pm	Inj:- ondam	IV	2mg		

Condition of patient at time of shift - out :		**Details of Shift - out**
HR: 101 bpm	BP: 101/66/72	CFT: 2sec
RR: 19 bpm	SPO_2 : 100%	
GCS: 15/15	Temperature : 98.2°F	
Pain Score: "0"		
Repeat RBS (if applicable): —		

Shift - out from ER to: 113
Time of Shift - out: 17/6/26 @ 11:00 AM
Handover given to: SR. Subhasm
(Nurse's Name) SR- Suvana

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse : Suvana
Signature of the Nurse :

Date & Time : 17/6/26 @ 11:00 pm

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 17 D (M)
Dr. GEETHA CHANDA

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: ? meningitis

Arrival Time: 11.10 pm Mode of Arrival: By walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: 23.0 Kg

No Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Yes	Nil	No

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: .....

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

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

Observations: Weight: 23.2 kg Length: – Head Circumference (< 2 years): Nil

Temp.: 98.1°F HR: 107 b/m RR: 26 b/m BP: 105/66(73)

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (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: Nil (Date/Time): .....

Social History: Lives With family

Siblings in household ☐ Yes ☑ No (if yes How Many?) 0

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: Subham Date: 17/6/26 Time: 11:39pm Signature

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
CUV-00097223 IP-00060387 Master OM DARSH DIMRI 01-10-2020 5 Y 8 M 16 D (M) Dr. GEETHA CHANDA	17/6/26 @ 9:57 PM	17/6/26 @ 11:00 PM
	Transfer Ordered by Dr. Shrikar	Reason for Transfer Admission
From Unit ER	To Unit 113	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 21	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
Nagarjuna	Dr. Shrikar.

Patient & Clinical Records Received by :

Date & Time of Patient Received : 17/6 @ 11:10 PM

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

Rainbow®
Children's
Hospital

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PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Name : OM DARSH Age/Sex 5½ y

Information given by: Mother Relationship ~~Relation~~ Father

Chief Presenting Complaints & Duration (Chronologically)

- H/o fever : Today.
- H/o Dull Activity
- vomitings 3-4 episodes

History of present illness :

→ H/o fever : Today
103.4°F
a/w severe headache
more over frontal region
non Radiating
a/w 2 vomitings ? Projectile ↔ [no nausea seen]
non Bilious.
Dull Activity noted by parents
→ less interaction
Prefers to lie down

→ Neck Pain ⊕;

no H/o Photophobia, Seizures; Altered Sensorium

→ no H/o head trauma; travel H/o; Recent contact H/o.

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

...istory & Physical Examination

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

→ Dengue fever → 2022

Birth & Neonatal History:

FMPT | LSCS | 2-3kg | CIAB | NICU - 5 days.
oligohy

Birth & Socio Economic History:

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

Developmental History :

Kiddo ASD - on occupation therapy
mild sensory issues
speech (N) | No motor delay.

Immunization History :

- upto date

(P.T.O.)

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 23.2 kg (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate : 98/min B.P. _____ SPO2 98/RA

Resp.rate and type of breathing : 20 CPM / Regular / Abd. thoracic

Rash –

Lymphadenopathy –

Oedema : –

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BAE (+)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur :

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

Per Abdomen :

Inspection

Palpation : Soft

Ausculation :

Spine : (N) External Genitelia :

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

01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15. Alert

Meningeal signs → 1) Neck stiffness ++ 2) weak learning

Cranial Nerves : intact

Bl c pupils — Reactive

Motor System:

Nutriton :

Tone: (N) Power 4/5 in all (4) Limbs

Co-ordinator :

Posture : (N)

Involuntary Movements : —

Reflexes :

DTR — (R) Brisk (L) ↓ **Superficials:**

Plantars (↑)

Sensory System :

(N)

Bladder / Bowel : — no incontinence noted

Clinical Summary & Diagnostic:

— ? Meningitis

(P.T.O.)

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment : To fix current conditions

Planned Labs:

CBP, CRP, SLE, S.UA, B/Cs, UA, CUE, PET: Explain (1)

MRI — Thy after Rounds.

Planned Management

D/w & Dr. Geetha Mam

- IV Ceftriaxone
- Inj Dexamethasone
- Start.
- IV fluids.
- NPO from 5 am.

noted by Swami @12:00 AM

Signature of the Doctor: S

Name of the Doctor: Dr Shrikar

Date & Time: 17/6/26 | 9:40 pm

Signature of the Consultant:

Name of the Consultant:

Date & Time:

Co-consultant - Dr Sirisha Sir.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. Geetha mam	
	S/B. Resident	
19/6/20. 8:00am	? Meningitis	
	Review: ~~fever~~ meningeal signs. no	
	no focal spike.	
	high inflammatory markers → PCT - 11.9	
	O/E	snoring (+)
	Euthenic	constipation (+)
	CVS - S1S2 (+)	Reports awaited
	RS BAE (+)	- B/Cs.
	P/A S/NT	- Send U/Cs.
	CNS - no FND.	- USG Abdomen.
		- add Amikacin
		- add Syp Smuttle
	Plan	
	if further Neurological deterioration — MRI (SOS).	
	Inj Ceftriaxone	
	Inj Pantop.	
	Dr Sneha MRSR	Dr Sneha. 19/6/20

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01-10-2020 5 Y 8 M 17 D (M)
Dr. GEETHA CHANDA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 1:40pm	S/B Resident	
	Acc : Aft c ? meningitis.	
	NO fever spikes	
	Headache (+).	
	c/o Giddiness - intermittently	
	Snoring (+)	
	O/E	
	Child alert	
	Euthermic	
	Vitals stable	
	CVS - S1S2 (+)	
	R/S - BAE (+)	
	P/A - NAD	
		plan
		1) Trace B/c/s, U/c/s
		2) Inj Ceftriaxone 2gm IOV
		2) Inj Amikacin -
		3) Syp. Sinarest.
		4) Pf further neurological detoriation - MRI (SOS).
Dr. Nishmitha.		5) CBP/CRP - Extraplasm T/m
		noted by manisha 18/6/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6		
7:30pm	fever episode 11 times ? viral	
		Plan
	No pain No vomiting	R/M CBP, CRP
		noted by Anitha 18/6/20 @8pm
	D/A	
	P	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 8AM	S/B Resident	
	Asis - AFI	
	No fever spikes	
	No Vomittings	
	Neckpain (+)	
	O/E	
	Cloud alert	Urine (N)
	Euthermic	Oral intake good
	Vitals stable	
	CVS - S1S2 (+)	
	RS - BAE (+)	
	P/A - soft	
		Plan
		1) Trace B/C/S, U/E/S
		2) Inj ceftriaxone - 4th dose
		3) Inj Amikacin 2nd dose
		4) Syp. emeset
		5) Trace CBP, CRP reports
		6) plan for d/s - after Neuro Review.
Dr. Vishwaja	Dr. Anu 18/6/26	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	(IP Neurology)	
19/6		
9 AM	1 HT - Acute onset headache ? Post viral headache	with vomiting with fever
	NO fever NO headache NO vomiting	Adm PTon D/C today - TCD PLT
20/6	Vitals - N Conscious, oriented Pupil - equal, reacting EOM - full N tone Power - 5/5 DTR ++2 No neck rigidity Romberg sign (-ve)	Noted by Geetha 19/6 @09.30AM
	Dr Geetha 19/6/26 10:52	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

IID

ULTRA SOUND ABDOMEN REQUEST FORM

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01-10-2020 5 Y 8 M 17 D (M)
Dr. GEETHA CHANDA

PATIENT NAME **JHID:** **DATE:** 18/6/26 @ 11:16AM

LIVER : Normal in size 11 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : ~~Normal in size~~ 8 cm ~~and echotexture.~~

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS : Right kidney : 74 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 82 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.
~~No ascites / Lymphadenopathy.No evidence bowel wall thickening /edema.~~

IMPRESSIONL: ~~**No obvious sonological abnormality in abdomen.**~~

Rest unremarkable

Suggested clinical correlation.

(1) Mild splenomegaly
- No focal lesions

(2) Bowel gas in peripheral and central abdomen

DR MOHD ABDUL KHALID MD, DNB.

~~***DR V. MAHIDHAR (MD)***~~

~~***DR VAISHNAVI REDDY B (MD)***~~

(Consultant Radiologist)

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Patient Sticke

126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/6 Time:	12	2	5	7
Doctor / Nurse / Family Concern?	AM	AM	AM	AM
Temperature (°F)	98.5°F	98.6°F	98.0°F	97.7°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	99 / 63			
Note: BP does not score in early warning scoring				
Heart Rate (Number)	104	100	106	102
Resp. Rate (bpm) over 1 Minute) *				
Resp Rate (Number)	33			22
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min) O_2 Saturations (%)	99	100	96	97
Conscious Level: Normal / Altered	N	N	N	N
GCS *	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	SK	SK	SK	SK

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)

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Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 17 D (M)
Dr. GEETHA CHANDA

oc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	9	11	1	3	5	7	10	1	3	5	7
Doctor / Nurse / Family Concern?	AM	AM	PM	PM	PM	PM	PM	AM	AM	AM	AM

18/6/26

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

98.6°F 98.6°F 98.6°F 98.4°F 98.6°F 98.6°F 98.6°F 98.6°F 98.6°F 98.6°F 98.4°F

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

Note: BP does not score in early warning scoring

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

112/79 (63) | 108/68 (43) | 99/56 (60) | 101/75 (81)

Heart Rate (Number)	114	103	109	108	100	103	82	90	102	102	98

Resp. Rate (bpm) over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number)	28	30	27	28	26	25	28		22		27

Resp Distress: Mod/ Severe / None / Mild	N	N	N	N	N	N					
Receiving O_2 (l/min) O_2 Saturations (%)	98	99	99	98	98	99	99	100	96	97	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	M	M	M				SK	SK	SK	SK	SK

ACTIONS
NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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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Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 17 D (M)
Dr. GEETHA CHANDA

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/6/26 Time:	9
Doctor / Nurse / Family Concern?	Am
Temperature (F) (scale 104–94)	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 190–50) Note: BP does not score in early warning scoring	106 / 90 / 60
Heart Rate (Number)	100
Resp. Rate (bpm) over 1 Minute) * (scale 70–10)	
Resp Rate (Number)	24
Resp Distress — Mod/ Severe	
Resp Distress — None / Mild	N
Receiving O_2(l/min)	
O_2Saturations (%)	98
Conscious Level — Normal	N
Conscious Level — Altered	
GCS *	15
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	[illegible]

Noted by [illegible] 19/6 @ 9.30Am

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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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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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)

Pa

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FLUID CHART

Sheet No. : 1

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
	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											
17/6	11:00 pm		Jelly	DNS								
	12:00 am		water	40ml								
	01:00 am			40ml						✓		
Total Intake :		80ml				**Total Output :**						
	02:00 am											
	03:00 am			40ml						✓		
18/6	04:00 am			40ml								
	05:00 am		NPO	40ml								
	06:00 am			40ml								
	07:00 am		NPO							✓		
Total Intake :		160ml				**Total Output :**						

Sudden 18/6 @7AM

Total 24 hrs. Intake	240ml	Total 24 hrs. Output	3 times

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FLUID CHART

Sheet No. : 2

18/6/26

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							
18/6/26	08:00 am		Jelly water	40ml							0	Manisha 18/6/26 @2pm
	09:00 am			40ml						✓		
	10:00 am			40ml								
	11:00 am			40ml								
	12:00 pm			40ml						✓		
	01:00 pm											
Total Intake : 200 ml						**Total Output :**						
	02:00 pm			40ml								
	03:00 pm		Rice	40ml								Anitha 18/6 @8pm
	04:00 pm		water	40ml								
	05:00 pm									✓		
	06:00 pm											
	07:00 pm											
Total Intake : 120ml						**Total Output :**						
18/6	08:00 pm											
	09:00 pm		Rice									
	10:00 pm											
	11:00 pm		water									
	12:00 am									✓		
	01:00 am											
Total Intake :						**Total Output :**						Sukshma 19/6 @2am
19/6	02:00 am											
	03:00 am									✓		
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am									✓		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	320 ml	Total 24 hrs. Output	6 times

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FLUID CHART

Sheet No. : 3

19/6/26

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							
19/6	08:00 am		Tdly 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
19/6
@9.30 AM

Total 24 hrs. Intake		Total 24 hrs. Output	

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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: CR Shifted to: 113

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. Shriker

Date & Time : 17/6/26 @ 10:10 AM

Nurse Name & Signature: Maggie/Nee

Date & Time : 17/6/26 @ 10:10 AM

CUV-00097223 IP-00060387
Master OM DARSH DIMRI
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

IP-00060387 CUV-00097223

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 *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 : INJ PARACETAMOL				Date / Time
Dose	Route	Frequency	Start Date	
350mg	IV	4 6H	17/6	
Doctor's Signature		Valid Period	Pharm.	
Dr Shariken				
Additional Instructions: 10-15mg/kg/dose T>100°F				

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

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

Meg 8 Plus 17/6

Signature .....

VERIFIED BY : Name .....

Master OM DAKSH DHAKAD
01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

REGULAR PRESCRIPTIONS

Weight. 23 kg Ward. .....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1g	IV	12th hrly	17/6

Name & Signature of the Doctor Starting the Drugs: Dr Smith

Additional Instructions: 50 mg/kg/dose (After test dose)

Date / Time	17/6	18/6	19/6
6 AM	✓		
10 PM			
6 PM		Given	

Daily Doctor's Endorsement by a Sign

DRUG : INJ. PANTOPRAZOLE

Dose	Route	Frequency	Start Date
20mg	IV	ONCE DAILY	18/6

Name & Signature of the Doctor Starting the Drugs: Dr Smith

Additional Instructions: 1mg/kg/dose

Date / Time	18/6	19/6
6 AM		

Daily Doctor's Endorsement by a Sign

DRUG : INJ. AMIKACIN

Dose	Route	Frequency	Start Date
170mg	IV	12th hrly	18/6

Name & Signature of the Doctor Starting the Drugs: DR. Vishwaja

Additional Instructions: 7.5mg/kg/dose

Date / Time	18/6	19/6
6 AM		
12 PM		
6 PM		

Daily Doctor's Endorsement by a Sign

DRUG : SYP. SMUTH

Dose	Route	Frequency	Start Date
10ml	PO	12th hourly	18/6

Name & Signature of the Doctor Starting the Drugs: DR. Vishwaja.

Additional Instructions: 1ml/kg/day

Date / Time	18/6	19/6
6 AM		
6 PM		

Daily Doctor's Endorsement by a Sign

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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
17/6/26	10.23 PM	INJ. DEXAMETHASONE	8mg	I/V		NLC 2am
17/6/26	10:33 PM	INJ. ONDANSETRON	4mg	I/V		NLC 2am

NLC 17/6

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01-10-2020 5 Y 8 M 16 D (M)
Dr. GEETHA CHANDA

I.V. FLUIDS CHART

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

Composition of I.V. Fluid (sion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
17/7 11:30 PM DNS (2/3 RD m)	I/V	40 ml/h		Sadiq / Subha			

Maggi 8gm 17/6

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