

VII-00205659 IP-00060303  
Baby B/O MADASU NIHARIKA  
05-06-2026 0 Y 0 M 5 D (F)  
Dr. AKHEEL SYED RIZWAN



**ACTIVITY RECORD FOR BILLING**

Name: -----  
UHID No : ----- IP No : ----- Consultant : ----- Dept : -----  
Date of Admission : 10/6 Time : ----- Date of Discharge : ----- Time: -----  
Room / Bed No : 217 Ward : ----- Suggested Billable bed type : -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<u>10/6</u>	<u>3:35pm</u>	<u>ER</u>	<u>217</u>	<u>nee</u>

**Cross Consultation Visit**

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







VIH-00205859 IP-00080303  
 Baby B/O MADASU NIHARIKA  
 05-05-2026 0 Y 0 M 8 D (F)  
 Dr. AKHEEL SYED RIZWAN

# IST OF MEDICAL CASE SHEET



IP.No:

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	01	-	-	
4	Patient Transfer Forms	01	-	-	
5	In-patient Medical Record	03	-	-	
6	Doctors Progress Sheets	01	-	-	
7	Nurses Progress notes	02	-	-	
8	Consultation Sheets				
9	General Consent for Treatment	01	-	-	
10	Consent for Surgery				
	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
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	-	-	
	Drug Chart (Regular prescription)				
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Medical reconciliation	01	-	-	
	Humpty Dumpty	01	-	-	
	Checklist Thrombophlebitis	01	-	-	
	pain assessment	01	-	-	
	Braden - 9	01	-	-	
	others	02	-	-	
	Total No. of Pages	30			

Signature and Date: 11/6/26  
 Nazeem @ 1pm

# ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE



ADMISSION SHEET

Registration Details :



Admission No : IP-00060303

Admit Date : 10-Jun-2026

Admit Time : 03:02 PM UHID : VIH-00205659

Patient Details :

Patient Name : Baby B/O MADASU NIHARIKA

Age : 0 Y 0 M 5 D

Guardian : Mr MANISH CHOUTI

DOB : 05-06-2026 02:49 PM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : flat no 203 indu residency kompally  
Kulsumpura Hyderabad Telangana INDIA  
500067

Phone No : 7702603730/

E-mail : na@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 103

Ward Name : N 0 GF-EMERGENCY

Room No : ER 103

Admission Type : First Visit

Contact Details :

Name : Mr MANISH CHOUTI

Relationship : Father

Contact Address : flat no 203 indu residency kompally Kulsumpura Hyderabad Telangana INDIA 500067

Phone No : 7702603730 / 8801134613

  
Signature

Doctor Details :

Doctor Name : Dr. AKHEEL SYED RIZWAN

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR.BHAVANA K

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

VIH-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 03-06-2026 0 Y 0 M 3 D (F)  
 Dr. AKHEEL SYED RIZWAN



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 10.10.26 Time of arrival : 2:30 pm

Chief Complaints : 10. yellowis discoloration of skin RBS : -

Height : - Weight : 2.61 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: 0 Pain Tool Used:  N Pass  FLACC  Wong Baker

Character -  Location -  Frequency -  Duration -

<p><b>RISK FOR FALL:</b></p> <p><input type="checkbox"/> If patient is &lt; 6 years tick below fall risk intervention directly</p> <p><input checked="" type="checkbox"/> If Patient is &gt; 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>• Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>• Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Escort while ambulating</li> <li><input type="checkbox"/> Assist Patient</li> <li><input type="checkbox"/> Educate patient and family on fall precautions/prevention</li> </ul>	<p><b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mobility Problem</li> <li><input type="checkbox"/> Walking Problem</li> <li><input type="checkbox"/> Developmental Delay</li> <li><input type="checkbox"/> Musculoskeletal Congenital Abnormality</li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p>.....</p> <p>.....</p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Underweight</li> <li><input type="checkbox"/> Overweight</li> <li><input type="checkbox"/> Feeding Problem</li> <li><input type="checkbox"/> Special diet</li> <li><input type="checkbox"/> Special feeding method</li> </ul> <p><b>Inform consultant for positive criteria</b></p>
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Psychological Screening:  No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

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

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : @ 2:35 pm.

Patient Name : B/O. MADASU NIHARIKA UHID : VIH-00205659 IPD : IP-00060303 Gender : Female Age : 0 Y 0 M 5 D

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

Time	Nursing Notes
2:25m	* Patient come to ER
2:30m	* vitals checked & recorded.
2:36m	* Dr. Vishwanaja Seen the patient.
2:40	* Doctor advice for admission, Admission done.
3:00m	* SBR - 16.2
3:35r	* Patient shifted to ward.

Samples collected by: } - Nil -  
 Samples sent by: } - Nil -

Time: } - Nil -  
 Time: } - Nil -

Medication given in ER:

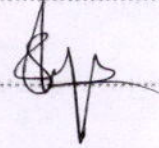
Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
/ Nil /					

Condition of patient at time of shift - out :	Details of Shift - out
HR: 148 b/m. BP: Craying RR: 25 b/m. SPO <sub>2</sub> : 99% GCS: A1a1 & Conscious Temperature: 98.2°f Pain Score: 0 Repeat RBS (if applicable): -	Shift - out from ER to: 217 Time of Shift - out: @ 3:35r. Handover given to: Sr. Padma. (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

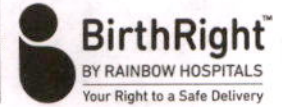
Procedures done with details (if any): -


Name of the Nurse : Swagatika

Signature of the Nurse : 

Date & Time : 10/01/26 @ 3:35pm

# PATIENT TRANSFER FORM



Patient Name & UHID No.  VIH-00205659 IP-00060303 Baby B/O MADASU NIHARIKA 05-06-2026 0 Y 0 M 5 D (F) Dr. AKHEEL SYED RIZWAN 		Date & Time of Admission  10/6/26 @ 3:02pm	Date & Time of Transfer Order  10/6/26 @ 3:36pm
		Transfer Ordered by  Dr. Vishwas	Reason for Transfer  Admission
From Unit  ER	To Unit  217	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File  28	Number of Imaging Films  —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what? OFFICE GIVER	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring  Magi Suelma		Name of Person Ordered Transfer  Dr. Vishwas	
Patient & Clinical Records Received by :  Doolma			
Date & Time of Patient Received :  10/6/26 @ 3:40pm			

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<sup>®</sup>  
Children's  
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

VIH-00205659 IP-00060303  
Baby B/O MADASU NIHARIKA  
05-06-2026 0 Y 0 M 5 D (F)  
Dr. AKHEEL SYED RIZWAN



Patient Name: \_\_\_\_\_

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_





### Pediatric Multiorgan History & Physical Examination

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

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**Birth & Neonatal History:**

Term / CLEAR / amicus / 2.839 kg

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G2A1

**Birth & Socio Economic History:**

About Father : \_\_\_\_\_ } class II  
About Mother : \_\_\_\_\_ }  
Any additional Information : \_\_\_\_\_

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**Developmental History :**

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**Immunization History :**

RLG / OPV / HepB - 06/6/26

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### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)  
Weight (kgs) 2.73 kg (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 98.6°F Pulse Rate : 156/min B.P. crying SPO2 99%  
Resp. rate and type of breathing : 26/min

Rash ⊖  
Lymphadenopathy ⊖  
Oedema : ⊖  
Allergies (if any): ⊖

#### Respiratory System :

Inspection (any s/o distress) : ⊖  
Air entry & breath sounds : B/C AE ⊕  
Any addes sounds : NO  
Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

#### Cardiovascular System :

Inspection of procordium : ⊖  
Heart Sounds : S1S2 ⊕  
Any murmur : NO  
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : \_\_\_\_\_

#### Per Abdomen :

Inspection ⊖  
Palpation : soft  
Auscultation : BS ⊕  
Spine : ⊖ External Genitalia : \_\_\_\_\_  
Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

Level of Consciousness : AVPU/GCS score : Awake

Cranial Nerves : \_\_\_\_\_

#### Motor System:

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power 4/5 all limbs

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : ⊖

Reflexes : +

DTR +

Superficials:

Plantars Extensor

#### Sensory System :

Bladder / Bowel : NB ~~present~~ ⊕

#### Clinical Summary & Diagnostic:

NN+TB



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Kernicterus

Desired goals of the treatment : To treat Jaundice

**Planned Labs:**

**Planned Management**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 1) DSPT
  - 2) DBF 1by Burping 02H
  - 3) Repeat CBE 1m after rounds.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

*Noted by Dr. Akheel @ 3:25 PM*

Signature of the Doctor: AK

Signature of the Consultant: AM

Name of the Doctor: Dr. Vishwajit

Name of the Consultant: Dr. Akheel Sr

Date & Time: 10/6/26

Date & Time: 11/6/26 1230



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10.6.26 4.00 PM	S/B Regular	
	Term / AGA / baby girl / <u>not</u> Neonatal Hypocalcaemia o/e baby warm, On DSPT reg. tone activity } (4) A/L - NAD P/A - soft	Plan → SBR T/m at 12.00PM → Warm care → DBM + FF → Trace TET
	Sameera (Dr. Sameera)	
	Noted by	Padma. 10/6/26 @ 3pm



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
11/6/26 9AM	<u>Cl/B Residual</u>	
	<u>Neonatal Hyperbilirubinemia</u>	
	M D S P T	
	Admity SBR-16	
	T.Wt - 2.55 kg (↓60gm)	<u>Plan</u>
O/E	Behrwan	- Continue D&PT
	CIT/A good	- DBF flb burp etc
	CULT 3850	
	C/S - S/S (⊙)	- SBR at 12pm
	R - B/LA (⊙)	
	PA - SGT	- follow up on Monday
	Vuy S tag	
		Sm
		A Rizwan
AD	Noted by Sr. Nazim 11/6/26 CIP	
ASW		



### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <b>NNHB</b>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....				
	Surgery / Procedure: <b>Nil</b>	Post OP Day:				
BACKGROUND	Date / Shift	10/6 ER	10/6/26 E	10/6/26 N	10/6/26 M	
	Medical Condition (Any special condition to be noted):	Nil	Nil	-	-	
	Diet:		DBF	DBF	DBF	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.2°F	98.6f	98.2°F	97.9f
		Res:	26 blm	30blm	30blm	11blm
		SpO <sub>2</sub> :	99%	99%	99%	99%
		Pulse:	148 blm	149 blm	150 blm	141 blm
		BP:	crying	-	-	-
	LOC:	conscious	conscious	conscious	conscious	
	Fall Risk Score:	0	0	0	0	
Pain Score:	0	0	0	0		
Skin Integrity	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	Nil	Nil	Nil	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	DBF	DBF	DBF	DBF	
	Critical Lab Test / Values:	-	Nil	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	Dependent	dependent	dependent	dependent		
Post Operative Procedure Special Orders:	-	SBR @ 12pm	SBR @ 12pm	-		
Handed Over By Name :	Deepika padma	Deepika				
Signature / ID :	606329	607489				
Date:	10/6/26	10/6/26				
Time:	@ 8:35 pm	@ 8pm				
Taken Over By Name :	padma	Deepika	Bhanu			
Signature / ID :	606329	607489	17887			
Date:	10/6/26	10/6/26	10/6/26			
Time:	@ 4pm	@ 8 AM	8pm			

Noted by  
 Dr. Rizwan  
 11/6/26



## NURSING SHIFT HAND OVER FORM

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

VIH-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA (F)  
 05-06-2026 0 Y 0 M 5 D  
 Dr. AKHEEL SYED RIZWAN



# NURSING CARE RECORD

Date: 10/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	3pm	* maintain Personal Hygiene. & ensure safety		- Provided warm and cold care.	- DBF 2 <sup>nd</sup> hourly given.	- vitals 4 <sup>th</sup> hourly checking.	Padma 10/06/26 @ 8pm
Night	8pm	Ensure Safety	11pm	To provide side rails	To provide safety	Re-Assessment was done baby is safe & stable	Dusri 11/6/26 @ 8AM
	3AM	Maintain Good Nutritional status	8pm	To give feed + Burp 2nd hly.	To prevent dehydration		



# NURSING CARE RECORD



Date: .....11.06.26.....

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	* maintain Personal Hygiene.	8Am	Educated about Personal hygiene	To prevent infection	Baby is active	11/6/26 Nay
	10Am	* Ensure safety	10Am	Baby kept in crib	To prevent from falls.		1pm
Afternoon							
Night							

noted by  
 N. Nay  
 11/6/26  
 CIP

**GENERAL CONSENT FOR TREATMENT**

**Patient Name:** Baby B/O MADASU NIHARIKA      **Age :** 0 Y 0 M 5 D  
**IP No:** IP-00060303      **Sex:** Female  
**Consultant:** Dr. AKHEEL SYED RIZWAN      **Ward/Bed No:** N 0 GF-EMERGENCY/ER 103

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

Patient, be deemed advisable or necessary.

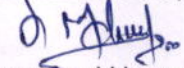
I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality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

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


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


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

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

Receivers Signature:.....) 

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

Signature of Patient/Relative: 

Name: MANISH CHOUFI  
 Relationship: father  
 Date: 10/06/2026  
 Witness Name: Seema  
 Witness Signature: 

Time: 03:02 P.M

Patient Address:  
 flat no 203 indu residency kompally  
 Kulsumpura Hyderabad Telangana  
 INDIA 500067

VIM-00205859 IP-00080303  
 Baby B/O MADASU NIHARIKA  
 05-08-2028 0 Y 0 M 5 D (F)  
 Dr. AKHEEL SYED RIZWAN



: RCH/ FRM / CLINICAL / 124

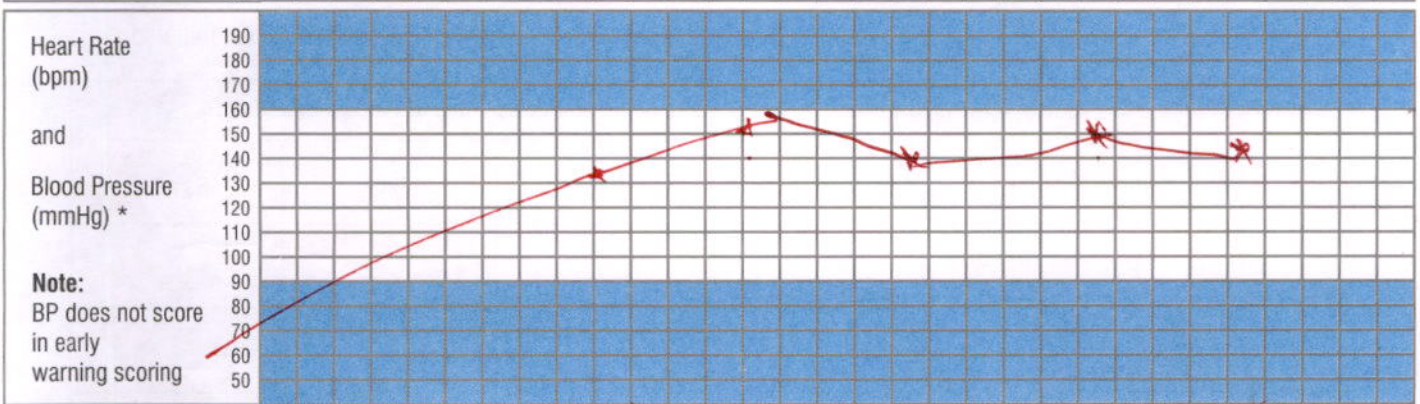
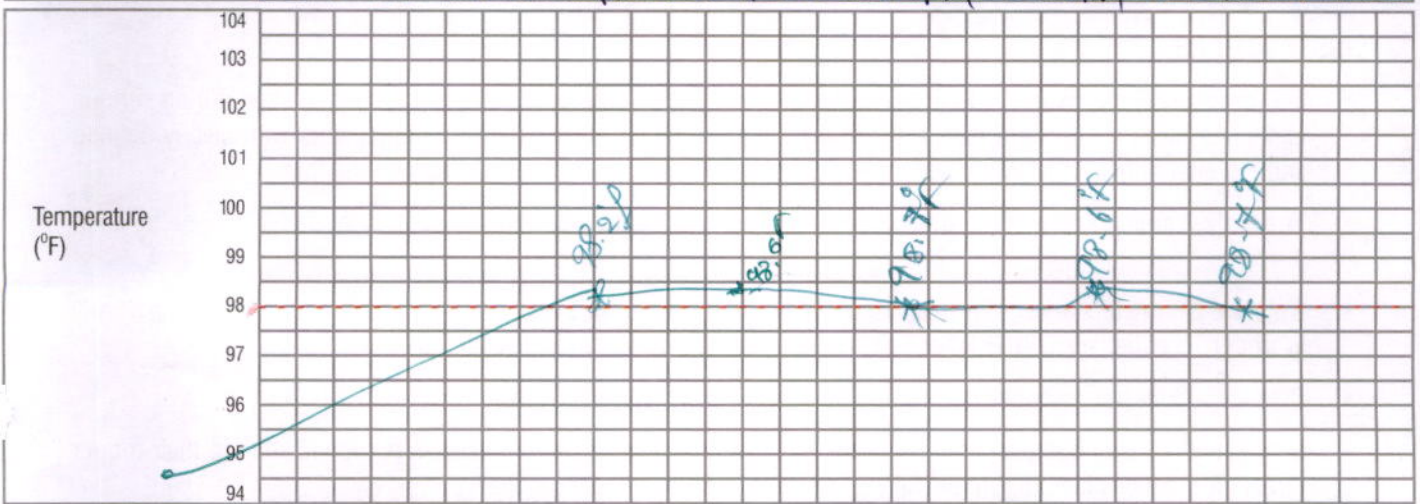
**INFANT (<1 year)**  
 Children's Observation &  
 Early Warning Scoring Chart



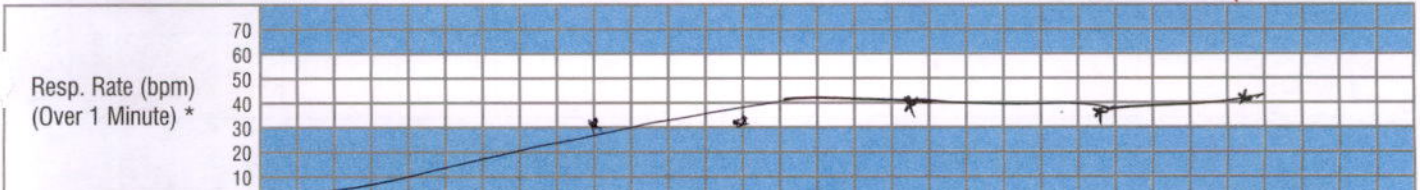
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: 4 PM 7 PM 10 PM 12 AM 4 AM

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



Heart Rate (Number) 141 150 140 150 145



Resp Rate (Number) 40 39 40 39 40

Resp Distress Mod/ Severe None / Mild N N N N

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 0.0 0.0 0.0 0.0 0.0

Conscious Level Normal Altered N N N

GCS \* . . . . .

**TOTAL SCORE**

Number of shaded boxes 0 0 0 0 0

Pain Score 0 0 0 0 0

Observer's Initials B P D B P

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

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

# 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VIH-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 05-06-2026 0 Y 0 M 6 D (F)  
 Dr. AKHEEL SYED RIZWAN

No. : RCH/ FRM / CLINICAL / 124

**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**

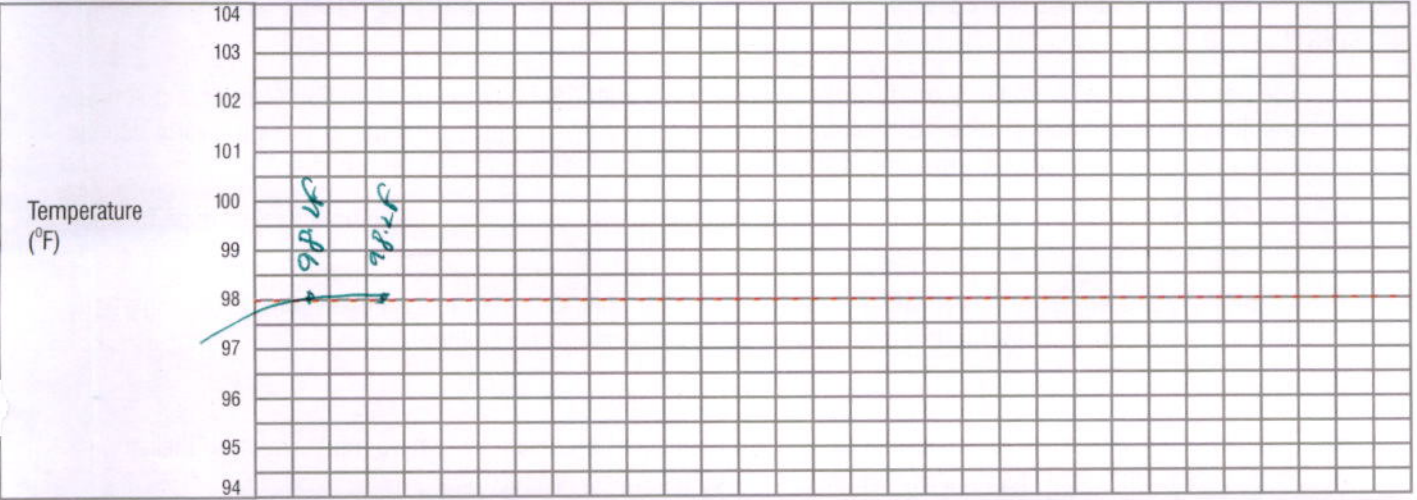
Rainbow Children's Hospital  
 It takes a lot to trust the little.

BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 11/6/26 Time: 9 11 1

Doctor/Nurse/Family Concern? AM A PM



Heart Rate (bpm) and Blood Pressure (mmHg) \*  
 Note: BP does not score in early warning scoring

Heart Rate (Number) 145 142

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

Resp Rate (Number) 42 40

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 98 98 9

Conscious Level Normal Altered 2 2

GCS \* 15 15

**TOTAL SCORE** Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials CA CA

**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.
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*Noted by Dr. [Signature]*

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 05-06-2026 0 Y 0 M 5 D (F)  
 Dr. AKHEEL SYED RIZWAN



# FLUID CHART

Sheet No. : ..... 10/6/26

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.

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

padding 10/6/26 @ 7pm  
 Dupilca 01/11/26 @ 8Am

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

VIH-00205859 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 05-06-2026 0 Y 0 M 5 D (F)  
 Dr. AKHEEL SYED RIZWAN



**FLUID CHART**

Sheet No. : ..... 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
11/6/26	08:00 am	DBF					✓			✓	1	2 Sultra Macy C/M
	09:00 am										0	
	10:00 am	DBF										
	11:00 am											
	12:00 pm	DBF								✓	1	
	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  
 J. M. Sagn  
 11/6/26  
 exp

**Total 24 hrs. Intake** \_\_\_\_\_

**Total 24 hrs. Output** \_\_\_\_\_



## 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: .....

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

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Dr. Vishwas*

Date & Time : *10/6/26 @ 2:30 PM*

Nurse Name & Signature : *Meghna*

Date & Time : *10/6/26 @ 2:30 PM*





**REGULAR PRESCRIPTIONS**

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

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





VIH-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 05-06-2026 0 Y 0 M 5 D (F)  
 Dr. AKHEEL SYED RIZWAN



## RESULT SHEET

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



Patient Name : B/O. MADASU NIHARIKA UHID : VIH-00205659 IPD : IP-00060303 Gender : Female Age : 0 Y 0 M 5 D

VIH-00205659 IP-00060303  
 Baby B/O MADASU NIHARIKA  
 05-06-2026 0 Y 0 M 5 D (F)  
 Dr. AKHEEL SYED RIZWAN



WT: 2.61 kg

### EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o Madasu Niharika Age : 5D Gender:  Male  Female

Date : 10/6/26 Time of Arrival : 2:25 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: 98.1° F PR: 152b/min BP: Craving RR: 26b/min SpO<sub>2</sub>: 99%

Chief Complaints: c/o yellowish discoloration at skin

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

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

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

\* CTAS - Canadian Triage and Acuity Scale

*[Signature]*

Signature of Parent / Guardian

Triage Completion Time : 2:28 PM

### Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Aschitha

Signature of Triage Nurse : *[Signature]*

Date & Time : 10/6/26 @ 2:28 PM

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