

ACTIVITY RECORDING

BAH-00644780 IP-00060267
Master MAHESWARA REDDY T
15-04-2019 7 Y 1 M 24 D (M)
Dr. JYOTI BOTHRA

Name: -



UHID No:

----- Consultant : -----

Dept : -----

Date of Admission : 8/6/26

Time : -----

Date of Discharge : -----

Time: -----

Room / Bed No : 0.T

Ward : 0.T

Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	11.55 AM	ER	OT	Sanjay
8/6/26	2pm	OT	Recovery Room	Dr

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP-00060267

Admit Date : 08-Jun-2026

Admit Time : 10:51 AM UHID : BAH-00644780

Patient Details :

Patient Name : Master MAHESWARA REDDY T

Age : 7 Y 1 M 24 D

Guardian : Mr APPIREDDY T

DOB : 15-04-2019

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : Kompally, Kompally Hyderabad Telangana INDIA 500014

Phone No : 8309502212/ 9248642322

E-mail : appireddy.nec@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 APPIREDDY T

Relationship : Father

Contact Address : Kompally, Kompally Hyderabad Telangana INDIA 500014

Phone No :

Appireddy
Signature

Doctor Details :

Doctor Name : Dr. JYOTI BOTHRA

Specialisation : PEDIATRIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

Patient Name : Mast. MAHESWARA REDDY T UHID : BAH-00644780 IPD : IP-00060267 Gender : Male Age : 7 Y 1 M 24 D

BAH-00644780 IP-00060267
 Master MAHESWARA REDDY T
 15-04-2019 7 Y 1 M 24 D (M)
 Dr. JYOTI BOTHRA




NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 10:46 AM
 Chief Complaints : patient came for surgery (RT) orchiopexy RBS: -
 Height : 137 CM Weight : 31.3 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>RISK FOR FALL:</p> <p><input type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input checked="" type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input type="checkbox"/> No Weak <input type="checkbox"/> Yes <input type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <ul style="list-style-type: none"> Escort while ambulating <input type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention <input checked="" type="checkbox"/> 	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality <input type="checkbox"/> <p>Inform consultant for positive criteria</p> <p>.....</p> <p>.....</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method <input type="checkbox"/> <p>Inform consultant for positive criteria</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 family
 Siblings in household Yes No (if yes How Many?) 1 (brother)
 Time of Initial assessment completed by ER Nurse: @ 10:50 AM

Patient Name : Mast. MAHESWARA REDDY T UHID : BAH-00644780 IPD : IP-00060267 Gender : Male Age : 7 Y 1 M 24 D

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

Time	Nursing Notes
10:41 AM	patient come to ER
10:45 AM	vital checked & Recorded
10:49 AM	Doctor seen the patient Advised Admission
10:53 AM	Admission process done
11:am	IV placement done
	CBF
	last food : 6:00 AM & last water :- 6:00 AM
11:55 AM	patient shifted to OT

Samples collected by:

→ sis. Hema

Time: — 11:30 AM

Samples sent by:

Time: — 11:35 AM

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: 95b/m BP: 102/66(70) CFT: 355ml	Shift - out from ER to: OT
RR: 20b/m SPO ₂ : 100%	Time of Shift - out: 8/6/26 @ 11:55 AM
GCS: 15/15 Temperature: 98.2°F	Handover given to: SY. Anita
Pain Score: 0	(Nurse's Name) BY. Sanjay
Repeat RBS (if applicable): —	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):



IV placement done

Name of the Nurse : Sanjay

Signature of the Nurse : *[Signature]*

Date & Time : 8/6/26 @ 11:55 AM

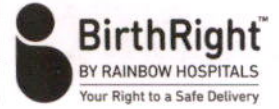
PATIENT TRANSFER FORM


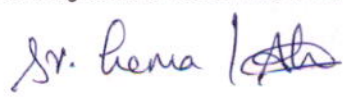

Patient Name & UHID No. 1644780 IP-00060267 MAHESWARA REDDY T 019 7 Y 1 M 24 D (M) DITI BOTHRA 		Date & Time of Admission 08/16/26 @ 10:57 AM	Date & Time of Transfer Order 8/16/26 @ 2 PM
		Transfer Ordered by Dr. Brunda.	Reason for Transfer Post op care
From Unit OT	To Unit Recovery Room	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Brunda.	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- Unavailable Bed Nurse not Available Available Bed not ready

PATIENT TRANSFER FORM



Patient Name & UHID No. BAH-00644780 IP-00060267 Master MAHESWARA REDDY T 15-04-2019 7 Y 1 M 24 D (M) Dr. JYOTI BOTHRA 		Date & Time of Admission 8/6/26 @ 10.51 AM	Date & Time of Transfer Order 8/6/26 @ 11.55 AM
From Unit ER		Transfer Ordered by Dr. Viswaja	Reason for Transfer Admission
To Unit O.T		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File (21)		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 ?			
Medications / Consumables / Surgicals / Hand over <i>OP file given</i>			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. Hema 		Name of Person Ordered Transfer Dr. Viswaja	
Patient & Clinical Records Received by 			
Date & Time of Patient Received : 8/6/26 @ 12 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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	S/B Dr John	
	S/O Dr Chidambaram	
	Stable	
	Adv	
	Can be D/C	
	P	
	P	

Patient Name : Mast. MAHESWARA REDDY T UHID : BAH-00644780 IPD : IP-00060267 Gender : Male Age :

7 Y 1 M 24 D

BAH-00644780 IP-00060267
Master MAHESWARA REDDY T
15-04-2019 7 Y 1 M 24 D (M)
Dr. JYOTI BOTHRA



wt: - 31.3 kg
Ht: - 137 cm

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Maheswara Reddy Age: 7Y Gender: Male Female

Date: 8/6/26 Time of Arrival: 10:41 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: 99.2°C PR: 96/M BP: 103/65 RR: 20/M SpO₂: 98%

Chief Complaints: patient came for surgery (RT) orchiopexy

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

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 checked="" 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

Poojitha
Signature of Parent / Guardian
Triage Completion Time: 10:45 Am

Communicable Disease Triage Screening

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

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

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

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

PART 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: [Signature]

Date & Time: 8/6/26 @ 10:45 Am

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

Rainbow Children's Medicare Ltd.

3-7-222 & 3-7-223, Sy. No. 51 & 54, Opp. New Karkhana Police Station
Karkhana Main Road, Kakaguda, Secunderabad - 500009.

Tel : +91-40-4246 2200, 2789 5050, 2789 6060.

GST: 36AABCR4014M1ZE email: vrchbilling@rainbowhospitals.in

CIN: L85110TG1998PLC029914 www.rainbowhospitals.in


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OPERATION THEATER NOTES

Patient's Name : Master MAHESWARA REDDY T	Age : 7 Y 1 M 24 D	Gender : Male
UHID : BAH-00644780	I.P. NO. -00060267	WEIGHT :31.7KG S
Surgeon : Dr.. JYOTI BOTHRA	Asst surgeon : Dr —	
Anaesthetist : Dr Rama Brunda	OT Nurse : S/N Bharani, Prasanna	
Surgical Procedure :. Right OPEN ORCHIOPEXY		
Indications for Surgery : Right palpable non-descended testis		
Anaesthesia -		
PRE-OPERATIVE PREPARATION- Betadine skin preparation		
OPERATIVE NOTES: Procedure notes: <ul style="list-style-type: none">- Right mid-inguinal lower crease incision.- EOA opened.- Testis at superficial ring.- Right testis - adequate size for age.- Testis mobilised and fixed in right hemiscrotum.- Incision closed in layers.		
DISCHARGE ORDERS: <ol style="list-style-type: none">1. No NBM2. Symp .Crocicn 7.5ml twice daily for 2 days and then sos3. Vitals chart.4. Diet as advised.5. Remove dressing after 3 days and daily bath6. Syrup.Crocicn-DS (5ml/240mg) 7.5ml SOS for pain/fever > 100°F (maximum 6th hourly).		
Kindly consult Dr. Jyoti Bothra, Consultant Pediatric Surgeon & Urologist, after 1 week in OPD with prior appointment (This consultation will be charged).		

Consultants Surgeon's Name

Dr. JYOTI BOTHRA

Date : 8/6/24

Consultant Surgeon's Signature

Time : 1.40 PM





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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/6/20 Time: 1 2 3 4
 Doctor / Nurse / Family Concern? P P

Temperature (°F)	104				
	103				
	102				
	101				
	100	*98.6 F	*98.6 F	*98.6 F	*98.6 F
	99				
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
Blood Pressure (mmHg) *	130				
	120				
	110	10	14	10	10
	100				
	90				
	80				
	70	60	72	60	90
	60				
	50				

Heart Rate (Number)	102	10	89	92
---------------------	-----	----	----	----

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				

Resp Rate (Number)	2	20	24	28
--------------------	---	----	----	----

Resp Distress	Mod/ Severe				
	None / Mild				

Receiving O ₂ (l/min)					
O ₂ Saturations (%)	98	97	98	99	

Conscious Level	Normal				
	Altered				

GCS *	15	15	15	15
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TOTAL SCORE					
Number of shaded boxes	0	0	0	0	
Pain Score	0	0	0	0	
Observer's Initials	P	P	P	P	

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. :

- 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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
8/6/20	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm		NBM								0	}	
	01:00 pm		NBM + RL 30ml/hr								0		
Total Intake :						Total Output :							
	02:00 pm										0	}	
	03:00 pm										0		
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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DRUG CHART

Date of Admission:8/6/20..... 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 :				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:																			

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

VERIFIED BY : Name



ker

Weight. 31.3kg Ward. D.T.....

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.	

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
8/6/26	12:50PM	SUPP DICLOFENAC	25MG	PR	B de	Rajalakshmi Wign
8/6/26	1:30PM	SOL. PARACETAMOL	460MG	IV	B de	Vaishali Wign

Signature
VERIFIED BY : Name

