

**ACTIVITY RECORD FOR BILLING**

VIH-00206259 IP-00060487

Baby B/O YOGITA THAKUR

25-06-2026 0 Y 0 M 0 D 1 H (F)


Name: - Dr. PREETHAM KUMAR -----

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

Date of Admission : 25/6/26 Time : 10:24pm Date of Discharge : ----- Time: -----

Room / Bed No : 220-1 Ward : L10 Suggested Billable bed type : -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
26/6/26	02:50 AM	L10	Room (108)	

**Cross Consultation Visit**

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







# DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VH-00206259      IP-00060487  
**Baby B/O YOGITA THAKUR**  
 25-06-2026      0 Y 0 M 0 D 9 H (F)  
**Dr. PREETHAM KUMAR**



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	02	-	-	
4	Patient Transfer Forms	01	-	-	
5	In-patient Medical Record	04	-	-	
6	Doctors Progress Sheets	01	-	-	
7	Nurses Progress notes	02	-	-	
8	Consultation Sheets				
9	General Consent for Treatment				
10	Consent for Surgery				
	Consent for Blood Transfusion				
	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)	01	-	-	
	Drug Chart (Regular prescription)	01	-	-	
	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				
	<i>Others</i>	06	-	-	
		<u>24</u>			
	Total No. of Pages				

Noted by Anitha  
 26/6/26  
 @ 9:20 AM

Signature and Date :

## **ERROR LOG**

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE



### ADMISSION SHEET

#### Registration Details :



Admission No : IP-00060487

Admit Date : 25-Jun-2026

Admit Time : 10:27 PM UHID : VIH-00206259

#### Patient Details :

Patient Name : Baby B/O YOGITA THAKUR

Age : 0 D

Guardian : Mr B S AJIT SINGH

DOB : 25-06-2026 09:54 PM

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : 7-2-682/1,OPP OLD JAIL MONDA MARKET  
STREET Bus Station Hyderabad Telangana  
INDIA 500003

Phone No : 9030448444/ 8096979943

E-mail : na@gmail.com

#### Admission Details :

Bed Type : BASINET

Bed No : CRDL-LW-220-1

Ward Name : N 2F-LABOUR WARD

Room No : CRDL-LW-220-1

Admission Type : First Visit

#### Contact Details :

Name : Mr B S AJIT SINGH

Relationship : Father

Contact Address : 7-2-682/1,OPP OLD JAIL MONDA MARKET  
STREET Bus Station Hyderabad Telangana  
INDIA 500003

Phone No : 9030448444



Signature

#### Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR

Specialisation : NEONATOLOGY

Referral Doctor :

Phone No :

Co-Consultant :

#### Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



## NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: B/o. Yogita Thakur Mother's Name: Mrs. Yogita Thakur  
 Date of Birth: 25/6/26 Time of Birth: 9:54 pm Gender:  Male  Female  
 Birth Weight: 3.162 Kgs HC: 36 cm Length: 47 cm  
 Meconium in Liquor:  Yes  No Cried at Birth:  Yes  No  
 Term / Pre-term / Post-term: F-T  
 Resuscitated:  Yes  No Blood Group: Mother: A positive Baby: -  
 Feeding:  Breast Feeding  Formula  Both First Feed Time: 10:30 am

VIH-00199540 IP-00060478  
 Mrs YOGITA THAKUR  
 11-07-1998 27 Y 11 M 15 D (F)  
 Dr. MADHUMITA ANIRUDDHA GITAY



Mode of Delivery:  Normal  LSCS - Emergency/ Elective  Instrumental  AVD  
 Indication: Normal

**Physical Assessment of New Born:**

Temp: 36.2 °C HR: 150b/min RR: 46b/min BP: — SpO<sub>2</sub>: 96%  
 Pain Score: 0 (Follow N Pass)  
 Fall Risk Assessment:  Yes  No Score: 15 (Fill the Humpty Dumpty Sheet)  
 Risk in Pressure Sore:  Yes  No (Braden Q Score) (Fill the Braden Q Sheet)  
 Behaviour Status on admission:  Sleeping  Crying  Calm  Drowsy

**Findings:**

General Appearance: Posture:  Well-Flexed  Asymmetry  
 Skin:  Pink  Meconium Stain  Others, Specify: —

**Nursing Management:** (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: ~~Yes~~ / No  
 Routine Care Provided: ~~Yes~~ / No  
 Capillary Blood Glucose Monitoring Done: ~~Yes~~ / No

**Neonatal Screening Done:** ~~Yes~~ / No

1. Nutritional Screening: Feeding Problem Yes / ~~No~~  
 2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / ~~No~~  
 3. Socio History: Siblings ~~Yes~~ / No  
 All information obtained from  Mother  Father  Other Family Member

Newborn Screening Discussed: ~~Yes~~ / No

Nurse Name: Prathyusha Signature: [Signature] Date & Time: 25/6/26 @ 11 pm

# PATIENT TRANSFER FORM

VIH-00206259 IP-00060487

Baby B/O YOGITA THAKUR  
25-06-2026 0 Y 0 M 0 D 1 H (F)  
Dr. PREETHAM KUMAR



Date & Time of Admission 25/6/26 @ 10:27pm		Date & Time of Transfer Order 26/6/26 @ 2:50am
Treating Consultant Name	Transfer Ordered by Dr. Vishal	Reason for Transfer Observation
From Unit LW	To Unit Room (108)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File - 1x -	Number of Imaging Films - Nil -	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

Sl.No.	Item Name	Quantity
1.	Small boschi'S - (1)	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes  No

Dr. Vishal

Name & Signature of Person who is Transferring Dr. Prathyshe	Name of Person Ordered Transfer Dr. Vishal
---	---

Patient & Clinical Records Received by :

Dr. Bhowiker

Date & Time of Patient Received :

26/6/26 @ 2:55 Am

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

Unavailable Bed

Nurse not Available

Available Bed not ready



## NEONATAL IN-PATIENT MEDICAL RECORD

### ADMISSION INFORMATION

Mother's Name : Mrs Yogita Thakur. Age : 27 Father's Name : ..... Age : .....  
 Date of Birth : 11/7/96. Date of Admission : 24/6/26. UHID No. : .....  
 NICU Consultant : Dr. Preetham Sir. Referring Consultant : Dr. Madhumita.  
**Transferring Unit :**  OT  Labour Room  ER  Ward  
**Transported ?**  Yes  No - If yes :  Long (> 30 kms)  Short (< 30 kms)

### BIRTH INFORMATION

Name : B/O Yogitha Mother's Blood Group : A Positive  
 Gender :  M  F Blood Group : .....  
 Date of Birth : 25/6/26. Time of Birth : 9.54 PM Birth Weight (gms) : 3.102 kg Length (cms) : .....  
 Place of Birth : RCH, VVP OFC (cms) : .....  
 Estimated Gesth Age : 38+1 weeks.

Current Obstetric History : (Booked / Unbooked Case)  Booked /  Unbooked Case  
 Maternal Age : 27 yrs. Ht : 158. Wt : 70. BMI : ..... Married Life : 3 yrs. LMP : 1/10/25 EDD : 8/7/26.  
 Conception : Spontaneous or with Rx. : Spontaneous conception.  
 Booked at what GA : 8+1 weeks, since conception AN Steroids Drugs / Doses : .....  
 Last Scans Details : (22/5/26) => SLUF; Cephalic, Plt-A, H, 2.07619.  
 TT Immunization and Iron / Folic Acid : given

### MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> &lt;18 yrs <input type="checkbox"/> &gt; 35yrs                  Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                  If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3  <b>H/o PIH (after 20 weeks) / PE</b>                  How many Drugs / Doses / Since how long : .....                  H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : .....                  IUGR - when detected : .....                  Doppler ( Increased Resistance / ADEF / REDF / Redistribution in MCA ) / Ductus Venosus : .....                  AFI : 11.4 cm.</p>	<p><b>H/o GDM/ pre GDM/ on diet or insulin</b>                  Controlled or not, recent values, HbA1 values : .....                  Compliance with Rx : .....                  Scans : LGA, TIFFA, Fetal Echo : .....  <b>H/o Hypothyroidism : when diagnosed? Medication?</b>                  25+6 weeks &amp; on Thyroxine 12.5mcg od.                  Any other Chronic Medical Problems, when detected drugs ? .....                  ( Anemia, SLE, Jaundice, CHD, Heart Disease )                  Infection : H/O, Fever .....                  ( <input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV )                  UTI : when : ..... Any culture : .....</p>
---	---

**PPROM** : Duration : .....  Uterine Tenderness  Foul Smelling Liquor  HVS (if taken) - Results : .....  
 Medication during Pregnancy : ..... Duration : .....



**PAST OBSTETRIC HISTORY**

G : ..... P : ..... A : ..... L : .....

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details

**PERINATAL HISTORY**

Treating Obstetrician : D. Madhumita Hospital : RCH, V.K.P.  Inborn  Outborn

<p><b>Duration of Labour</b></p> <p>First stage (&gt; 18 hours sig)</p> <p>Second stage (&gt; 2 hours after dilation) <u>NVD.</u></p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : .....</p> <p>Specify the reason : .....</p> <p>Augmentation of Labour : <input checked="" type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : .....</p> <p>Resuscitation : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cord ABG : .....</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : .....</p>
---	---

**NEONATAL RESCUSTITION DETAILS**

**APGAR SCORE**

Gestational Age : ..... Weeks : .....

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry: Hypoventilation	Good, Crying

**TOTAL**

1 Minute	5 Minutes	10 Minutes
<u>1</u>	<u>2</u>	
<u>2</u>	<u>2</u>	
<u>1</u>	<u>2</u>	
<u>2</u>	<u>2</u>	
<u>2</u>	<u>2</u>	
<u>8/10</u>	<u>10/10</u>	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

**Snapee II Score**

	> 30 (0)	20-29 (9)	< 20 (19)	
Mean BP (mmHg)	> 96 (0)	96-95 (8)	< 95 (15)	
Lowest Temp (oF)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)
Pao2 / Fio2 (mmHg%)	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)	
Lowest Serum PH	No (0)	Yes (19)		
Multiple Seizures	> = 1 (0)	0. 1-0.9 (5)	<0.1 (18)	
U. Output (ml / kg / hr)	> = 7 (0)	< 7 (18)		
Apgar Score	> = 1kg (0)	750 - 999 (10)	< 750 (17)	
Brith Weight	> 3rd percentile (0)	< 3rd (12)		
SGA				

**POSTNATAL / HISTORY OF PRESENT ILLNESS**

Chief Complaints :



Baby was delivered via NVD in vertex presentation

Baby cried immediately after birth.

HR  $> 100$ /min, Baby was pink

Delayed cord clamping done for 1 min.

oro nasal suction done

Baby received in dry linen cloth.

umbilical cord clamped & cut under

Investigation details in previous Hospital :

aseptic conditions.

Inj Vit K given.

Feeding History :

Past History :

Family History :

Socio Economic History :



### GENERAL EXAMINATION ON ADMISSION

General Disposition :

C/A - good

VITALS : Temperature : *Euthermic* HR : *170/min* RR : *48/min* NIBP : *-* CFT : *< 3 sec*

Color of the extremities : *Pink*

Jaundice : *-* Pallor : *-* SpO2 : *96% RA*

Anthropometry : Birth Weight : *3.162 Kg* Length : *-* HC : *-* Present Weight : *3.152 Kg*

Ponderal Index : *-* AGA : *✓* SGA : *-* LGA : *-*

### HEAD TO TOE EXAMINATION

HEAD :  
Fontanelles :  
Sutures :  
Shape / Moulding : *N*  
Edema / Bruising :  
Size - (H.C.) :

Facies :  
(Any Facial Dymorphism) *- NO facial dymorphism -*

NECK and CLAVICLES :  
Range of Motion :  
Asymmetry : *N*  
Masses :

EYES :  
Symmetry :  
Red Reflex : *→ not done*  
Discharge :

EARS, NOSE MOUTH and THROAT :  
Ear set / Shape :  
Periauricular Pits / Tags :  
Nasal shape / Patency :  
Palate : *N*  
Gums :  
Lips :  
Tongue :



TH BREASTS : Position of Nipples and Number : 1 (N)

ABDOMEN and UMBILICUS :  
Shape :  
Organomegaly :  
Bowel Sounds :  
Umbilical Stump : → 2A, IV  
Discharge :

GENITILIA :  
Labia / Hymen :  
Testicles/penis :  
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMETIES :  
Fingers / Toes :  
Deformities :  
Hip Joint Examination :  
Arms / Legs :  
Mobility :

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern :  Regular  Periodic  Shallow  Gasping

Mention If baby has Respiratory distress : RR : 50/min SCR / ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on :  Hood box  CPAP  Ventilator

Settings :

SpO<sub>2</sub> : 96% RA Auscultation : BAE (N) Breath Sounds : Chest clear Added Sounds :

Cardiovascular System :

HR : 160/min BP : Precordial Activity :

Femoral Pulses : 1 well felt Murmurs : (N)

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : (N) Hernia orifice : - (N)

Palpation : (N) Anal Patency : - (N)

Palpable masses : First urine passed : Not passed

Abdominal girth : Meconium passed :

System : Higher intellectual functions (Sensorium) : .....

State of wakefulness : .....

Prechtle Score : .....

Nerves : .....

C/F/A (N)

**Motor System :**

Passive Tone : .....

Active Tone : .....

Neonatal Reflexes : .....

Grasp :  Palmar  Plantar  Sucking  Rooting  Crossed adductor : .....

Moro's : *B/L complete symmetrical.* DTR : *-*

ATNR : *-* Skull and Spine : *-*

Any Congenital Anomalies : *No visible congenital anomalies.*

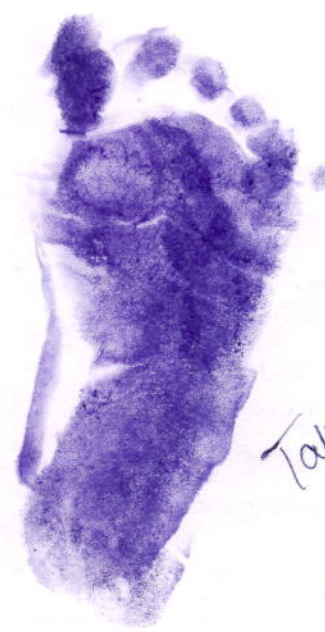
Diagnosis : *FF / 38+1 weeks / 3.152 Kg / AGA / 1m / Female / ~~NSD~~ / <sup>XVD</sup> CIAB.*

**FOOT PRINTS**

Left Side :



Right Side :



*Taken by  
 P. Prathima  
 @ 10:30 PM  
 27/6/26*

**Resident Doctor :**

Signature : *[Signature]*

Name : *D. Vishal*

Date & Time : *25/6/26 10:15 PM*

**Consultant :**

Signature : *[Signature]*

Name : *P. Prathima*

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

**DISCHARGE**



Information given by:  Family  Friend

Will patient require transportation arrangements to go home:  Yes  No  NA

Will Physiotherapy require at home:  Yes  No  NA

Is home medical equipment anticipated:  Yes  No  NA

Is home oxygen therapy anticipated:  Yes  No  NA

Breastfeeding  Yes  No  NA

Formula Feed  Yes  No  NA

Are dressing needs at home anticipated:  Yes  No  NA

Any other needs anticipated:  Yes  No If Yes Specify .....

Feeding Plan at the time of shifting : .....

.....

.....

.....

.....

.....

.....

.....

**Screenings done during NICU Stay :**

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

**Discharge Details:**

**Neonatal Condition at Discharge:**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



**Feeding:**  Breastfeeding Exclusively  Breastfeeding and Formula Feeding  Formula Feeding

Vitamin K given:  Yes  No

Vaccinations given  BCG  Hepatitis B  Others: .....

Neonatal Screen Taken:  Yes  No, parents advised to have Neonatal Screen at National screening

program center on: ...../...../.....

Hearing Test:  Yes  No

Jaundice:  NIL  Slight  Moderate

Passed Urine:  Yes  No

Passed Meconium:  Yes  No

Weight at discharge: .....

Appointment was given for follow-up at OPD:  Yes  No

Date of Discharge: ...../...../.....

Discharge to  Home  Other: .....

Against Medical Advice:  Yes  No

Referred to another hospital:  Yes  No

**Discharge Medications:**  Yes  No

Details: .....

Final Diagnosis: .....

DBP f/b bp x 3<sup>rd</sup> hly.  
Warm Care, Cord Care  
Immunizations as per schedule  
OAE, NBS, SBR before discharge  
Monitor vitals.  
Inform SDS.

Noted  
by  
Pradhyota  
@ 10:24 PM

25/6/26 at 10:24 PM  
GRBS = 68mg/dl

Doctor Signature: .....

Doctor Name: .....

Date & Time: .....







### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>PT (384 Dwt) / 3.162 kg / AGA / 5m / Female / LVD / CSAB</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>25/6</i>	<i>25/6</i>	<i>26/6</i>				
	Shift	<i>N</i>	<i>Night</i>	<i>M</i>				
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>Nil</i>	<i>Nil</i>				
	Diet:	<i>DBF</i>	<i>DBM</i>	<i>DBM</i>				
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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>				
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>36.2 F</i>	<i>98.6 F</i>	<i>98.6 F</i>			
		Res:	<i>15 blm</i>	<i>20 blm</i>	<i>50 blm</i>			
	SpO <sub>2</sub> :	<i>96%</i>	<i>99%</i>	<i>99%</i>				
	Pulse:	<i>146 blm</i>	<i>140 blm</i>	<i>142 blm</i>				
	BP:	<i>-</i>	<i>-</i>	<i>-</i>				
	LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>				
	Fall Risk Score:	<i>15</i>	<i>16</i>	<i>16</i>				
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>					
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>					
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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:	<i>-</i>	<i>nil</i>	<i>nil</i>				
	Others Specify:	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<i>DBF</i>	<i>DBM</i>	<i>DBM</i>				
	Critical Lab Test / Values:	<i>-</i>	<i>nil</i>	<i>nil</i>				
	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 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 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 checked="" 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):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>					
Post Operative Procedure Special Orders:	<i>-</i>	<i>nil</i>	<i>nil</i>					
Handed Over By Name :	<i>Pragya</i>	<i>Benonika</i>		<i>Noted by Anitha 26/6/26 @ 9:20 AM</i>				
Signature / ID :	<i>[Signature]</i>	<i>2018727</i>						
Date:	<i>26/6/26</i>	<i>26/6/26</i>						
Time:	<i>@ 3:50 AM</i>	<i>@ 8 AM</i>						
Taken Over By Name :	<i>Benonika</i>	<i>Anitha</i>						
Signature / ID :	<i>2018727</i>	<i>249050100</i>						
Date:	<i>26/6/26</i>	<i>26/6/26</i>						
Time:	<i>@ 2:55 AM</i>	<i>@ 8 AM</i>						

## 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
	ADL (Dependent / Non Dependent):						
	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	
	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	
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						



# NURSING CARE RECORD

Date: 26/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	11am  4am	Breast feeding  → Provide warm care and cord care.	11am	provide mother's breast milk  → Provided warm care and cord care	provided mother's breast milk 2nd hourly.  → Baby comfortable → Prevent infection	Baby was Sucking well  Baby is stable	Prathish @na 26/6/26

VIH-00206259 IP-00060487  
 Baby B/O YOGITA THAKUR  
 25-08-2026 0 Y 0 M 0 D 9 H (F)  
 Dr. PREETHAM KUMAR



# NURSING CARE RECORD



Date: 26/6/26

**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: Nil

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9.10Am	Discharge note :-		Doctor Come for rounds & advice Discharge			
Afternoon							<del>Noted by Anitha 26/6/26 @9.20Am</del>
Night							



## THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			25/6/26	26/6			
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3	-				
	7 to less than 13 years old	2	-				
	13 years old and above	1	-				
Gender	Male	2	-				
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4	-				
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope/ Dizziness, etc.	3	-				
	Psych/ Behavioral Disorders	2	-				
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3	-				
	Forget Limitations	2	-				
	Oriented to own ability	1	-				
	History of Falls or Infant-Toddler Placed in Bed	4	4	4			
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture/ Lighting (Tripled Room)	3	3	3			
	Patient Placed in Bed	2	-				
	Outpatient Area	1	-				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	-				
	Within 48 hours	2	-				
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3	-				
	Hypnotics	3	-				
	Barbiturates	3	-				
	Phenothiazines	3	-				
	Antidepressants	3	-				
	Laxatives/ Diuretics	3	-				
	Narcotics	3	-				
	One of the Meds listed above	2	-				
	Other Medications / None	1	1	1			
<b>Total</b>			15	15			

**Intervention:**

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		-	Crib			
Call device within reach		-	-			
Wheels Locked		Yes	-			
Room free of clutter		-	-			
Adequate lighting		Yes	-			
Wheel chair support		Yes	✓			
Other Intervention(s) Specify		-	✓			
Nurse's Name:		Prathima Bhat				
Signature:		P Bhat				
Date:		25/6/26	26/6			
Time:		8 AM				

**GENERAL CONSENT FOR TREATMENT**

**Patient Name:** Baby B/O YOGITA THAKUR      **Age :** 0 Y 0 M 0 D 0 H  
**IP No:** IP-00060487      **Sex:** Female  
**Consultant:** Dr. PREETHAM KUMAR      **Ward/Bed No:** N 2F-LABOUR WARD/CRDL-LW-220-1

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 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: Hjit Singh.  
 Relationship: Father  
 Date: 25/6/2026  
 Witness Name:  
 Witness Signature: 

Patient Address:  
 7-2-682/1,OPP OLD JAIL MONDA  
 MARKET STREET Bus Station  
 Hyderabad Telangana INDIA 500003

Time: 10:27 pm.



# CONSENT FOR FORMULA FEEDS

Patient Name : B/O YOGITA THAKUR Age : .....

Gender : M  F  IP No : 0060487 Reg. No. : .....

Department : 1st FLOOR Date : 26/6/26

I Mr / Mrs. : ..... S / W / D / o. : .....

aged ..... years. Hereby declare that I have admitted my son / daughter .....

~~in~~ the NICU of Rainbow Children's Hospital, Hyderabad on ..... Here by giving consent for formula feeding for my child. Doctors have explained me about the formula feeding benefits and risks involved in the language I best understand.

**Patient Attendant :**

Signature : Yogita Thakur

Name : Yogita Thakur

Relationship with Patient : Mother

Date & Time : 26/6/26 @ 10:45 AM

**Witness :**

Signature : .....

Name : .....

Date & Time : .....

**Doctor (who is taking the consent) :**

Signature : M. Vishwaja

Name : M. Vishwaja

Date & Time : 26/6/26 10:25 AM

**డబ్బా పాలు పట్టించుటకు అనుమతి పత్రం**

రోగి పేరు : ..... వయస్సు : ..... లింగం : పు  స్త్రీ

రిజిస్ట్రేషన్ నం : ..... ఐ.పి. నం : .....

నేను శ్రీ/శ్రీమతి : ..... S/W/D/O: .....

వయస్సు : ..... సంవత్సరాలు, నా కుమార్తెని/కుమారుడును రెయిన్ బో పిల్లల ఆసుపత్రి, ఎన్ ఐ సి యు లో అడ్మిట్ చేసినాము మరియు డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుతున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు ఉపయోగాలు మరియు నష్టాల గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు :  
సంతకము : \_\_\_\_\_  
పేరు : \_\_\_\_\_  
తేది మరియు సంతకము : \_\_\_\_\_

సాక్షి  
సంతకము : \_\_\_\_\_  
పేరు : \_\_\_\_\_  
తేది మరియు సమయము : \_\_\_\_\_

డాక్టర్ :  
సంతకము : \_\_\_\_\_  
పేరు : \_\_\_\_\_  
తేది మరియు సమయము : \_\_\_\_\_

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



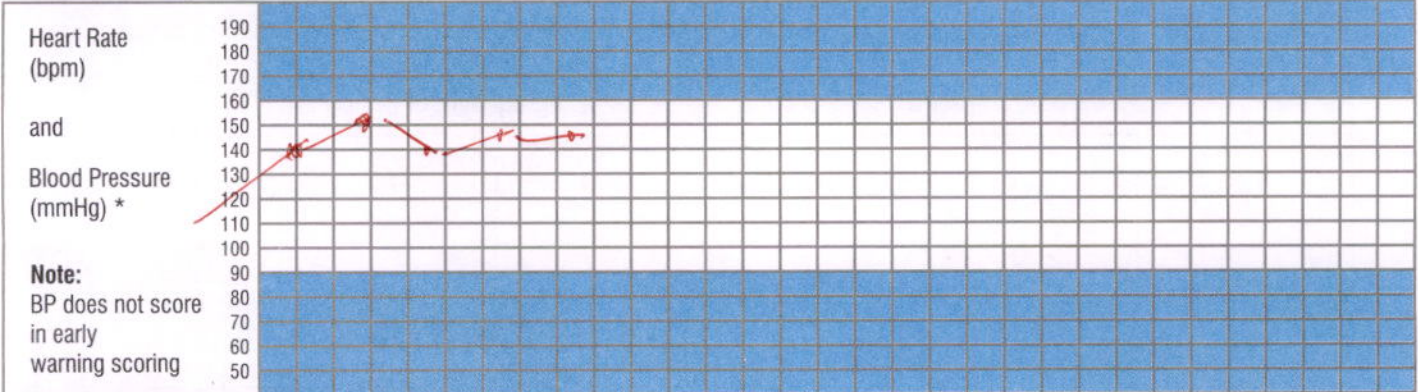
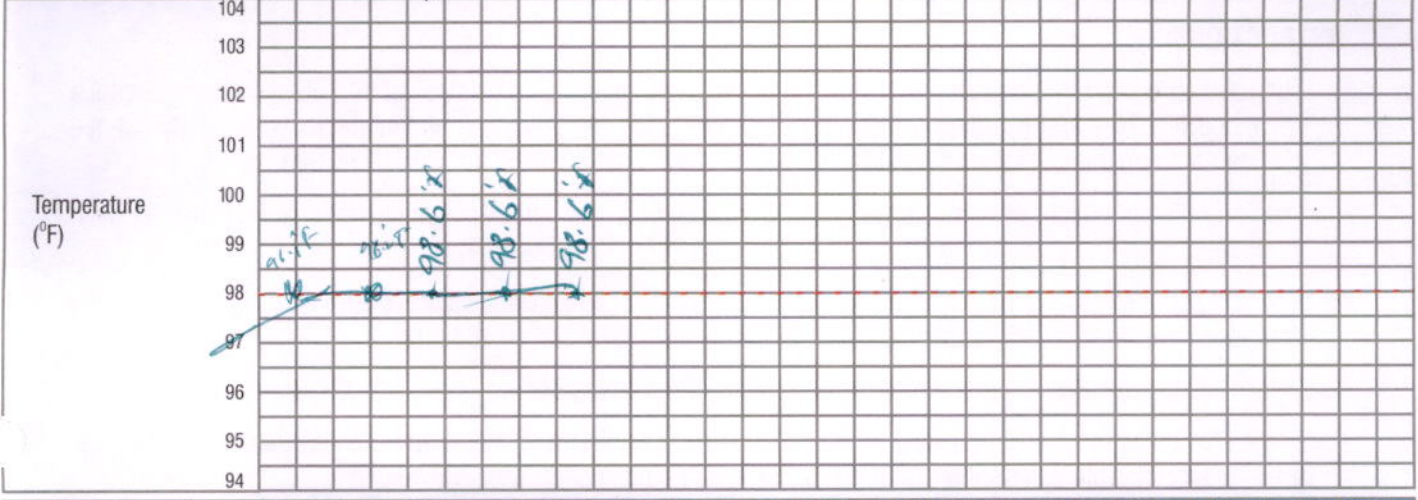
Patient Sticker



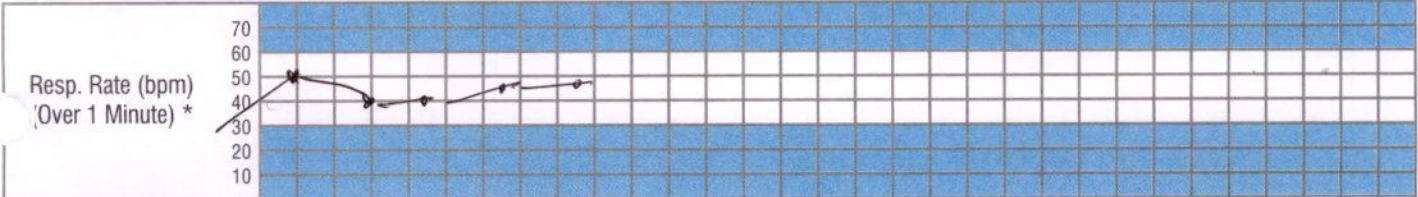
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 25/6/26 Time: 11 1 3 5 7

Doctor/Nurse/Family Concern? PN AN AN



Heart Rate (Number) 142 151 140 145 144



Resp Rate (Number) 51 46 40 45 48

Resp Distress	Mod/ Severe	None / Mild	<u>NP</u>	<u>NP</u>	<u>N</u>	<u>N</u>	<u>N</u>
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)		<u>NP</u>	<u>NP</u>	<u>98</u>	<u>97</u>	<u>98</u>
Conscious Level	Normal / Altered		<u>-</u>	<u>-</u>	<u>N</u>	<u>N</u>	<u>N</u>
GCS *			<u>-</u>	<u>-</u>	<u>15</u>	<u>15</u>	<u>15</u>

<b>TOTAL SCORE</b>					
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>A</u>	<u>Y</u>	<u>B</u>	<u>B</u>	<u>B</u>

<b>ACTIONS</b>	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.

## 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.

<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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



## 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.

<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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



# FLUID CHART

Sheet No. : 17

25/6/26

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 Thrombophlebitis 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												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm	DBF											
	12:00 am												
	01:00 am	DBF											
<b>Total Intake :</b> Good						<b>Total Output :</b>							
	02:00 am												
	03:00 am		DBM										
	04:00 am												
	05:00 am		DBM										
	06:00 am												
	07:00 am		DBM										
<b>Total Intake :</b>						<b>Total Output :</b>							

25/6

Pradeep  
@ 7am  
26/6/26

26/6/26

Benuka  
26/6  
@ 7am

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

VIH-00206259 IP-00060487  
 Baby B/O YOGITA THAKUR  
 25-06-2026 0 Y 0 M 0 D 9 H (F)  
 Dr. PREETHAM KUMAR



# 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.

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
<i>DB 16/26</i>	08:00 am											
	09:00 am		<i>DBM</i>									
	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											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>					<b>Total Output :</b>							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>					<b>Total Output :</b>							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>					<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>					<b>Total 24 hrs. Output</b>							

Noted by Anitha  
 26/6/26  
 @ 9:20 AM



## 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					





Date & Time: 25/6/26; 10:27 pm.

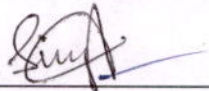
ATTENDANT INFORMATION SHEET

I, Mr/Mrs Ajit Singh s/o \_\_\_\_\_ hereby state that  
my child/Wife Bio. Yogita UHID No: 206259 has been  
admitted in MICU - Crdl.. I understand that  
hospital is taking utmost precautions by standards set by Ministry of health, India.  
The Treating Team has requested us to follow the following instructions.

We are requested to follow below instructions strictly.

1. Always wear MASK
2. Follow strict hand hygiene with Alcohol hand rub frequently
3. Avoid any movement in the hospital (Once admitted will move out only after discharge).
4. Only one attendant is allowed per patient and no visitors are allowed in the hospital.

Name & signature of Legal Guardian and  
relationship with patient: father



Name and signature of Executive taking  
the consent

Shinsha

Name and signature of Witness:

