

Name	Baby A.YASHNA SRI	UHID	VIH-00205925
Father/Guardian	Mr ANNARAM KRISHNA CHAITANYA	Age/Gender	0 Y 11 M 6 D/Female
Address	H.NO:1-5-53,BRAHMANA WADA MANDAL,SANGAREDDY MEDAK ,TELANGANA., Sangareddy, Medak, Telangana, INDIA, 502001		
IP No	IP-00060351	Admission Date	15-06-2026
Ref Doctor	avinash	Discharge Date	20-06-2026

DISCHARGE SUMMARY

Consultant: Dr. PREETHAM KUMAR

MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

Diagnosis:

**MYOCARDITIS WITH SEVERE BIVENTRICULAR DYSFUNCTION
R/O CARDIOMYOPATHY (? GENETIC)**

History: Baby A. YASHNA SRI is a 11 M 6 D girl presented with history of cold and fast breathing since 3 days prior to admission. History of weight loss present. For the above complaints, she was treated at referral center, in view of left ventricular dysfunction, persistence of symptoms, she was referred to Rainbow Children's Hospital for further management.

Outside Investigations: Complete blood picture done on 14.06.2026 showed hemoglobin 10.9 gm%, white blood cells count of 10,000 cells/cumm, platelet count of 3.6 lakhs/cumm and C-reactive protein was 2.2 mg/l. Elevated Troponin I, 2D ECHO showed Left ventricular dysfunction (EF 35%), suggestive of myocarditis.

Past history: History of bronchiolitis and hospital admission on 27 May, 2026.

Name	Baby A.YASHNA SRI	UHID	VIH-00205925
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Examination: She was afebrile, maintaining saturations at room air. Heart rate 150/min, blood pressure 85/50 mmHg and respiratory rate 51/min. Respiratory distress was present in the form of tachypnea, intercostal, subcostal retractions. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, she was conscious and alert. Examination of other systems including spine was normal.

Weight on admission : 5.7 kgs.

Investigations: Enclosed.

Management: Child was admitted in the Pediatric Intensive Care Unit.

Course in Pediatric Intensive Care Unit:

Myocarditis:

At admission, child had no features of congestive cardiac failure, chest x-ray showed cardiomegaly, functional ECHO showed full and collapsible IVC, poor cardiac function.

Venous blood gas showed pH - 7.34, pCO₂-35.4 mmHg, pO₂ - 26 mmHg, HCO₃ -19 mmol/l, BE: -6.3 mmol/l.

ECG showed prolonged QT interval, Dilated LA, LV Dr. Murtaza Kamal, Pediatric Cardiologist opinion was taken. She was started on milrinone infusion and Injection Furosemide. Thiamine was given.

NT PRO BNP and Troponin I sent were elevated hence she was started on Methyl prednisolone in view of suspected myocarditis. Child was started on Aspirin prophylaxis.

Name	Baby A.YASHNA SRI	UHID
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Vitamin D3 levels were sent, which were normal.
Thyroid profile and Free T4 was normal.

On Day-2 of admission, 2D ECHO on 16.06.2026 showed situs solitus levocardia, global hypokinesia of LV, severe LV dysfunction (EF 33%), dilated LA/LV, severe MR, trivial PR/trivial TR, left arch, no CoA.

She was serially monitored for acidosis and electrolyte disturbances and corrected accordingly.

Repeat 2D ECHO done on 17.06.2026 showed situs solitus levocardia, global hypokinesia, severe LV dysfunction (EF 35 %) Dilated LA/LV, moderate MR/mild TR, trivial PR, IVC collapsing, no pericardial effusion, no clot, left arch, no COA.

On Day-3 & 4 of admission, milrinone was tapered and stopped and added on Lisinopril.

Child was started on IV fluids as oral intake poor, later IV fluids gradually tapered and stopped as oral intake improved.

INVESTIGATIONS: On admission, complete blood picture showed hemoglobin 11.0 gm%, white blood cells count of 8,760 cells/cumm, platelet count of 4.30 lakhs/cumm and C-reactive protein was 7 mg/l. Blood culture was sterile after 48 hours of incubation. Liver function tests showed SGPT 26 U/L, SGOT 51 U/L, ALP 213 U/L, total serum bilirubin was 1.2 mg/dl with direct fraction 0.1 mg/dl and indirect fraction 1.1 mg/dl, serum albumin was 4.4 g/dl, total protein was 6.4 g/dl, S.globulin was 2.0 g/dl. Serum electrolytes showed serum sodium 142 mmol/L, serum potassium 5.2 mmol/L and serum chloride 107 mmol/L. Serum creatinine 0.4 mg/dl, calcium 10.6 mg/dl, magnesium 2.3 mg/dl, blood urea 25.5 mg/dl.

Name	Baby A.YASHNA SRI	UHID	VIH-00205925
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On Day-5 of admission, as child remained asymptomatic, normotensive, maintaining saturations at room air, accepting feeds well, started on oral furosemide and was shifted to ward for further management.

During the ward stay, her vitals were regularly monitored. Cardiology consultation with Dr. Murtaza Kamal was taken, 2D Echo showed global hypokinesia with severe LV dysfunction (EF -15%). Parents were counselled, whole exome sequencing was sent. She is being discharged with the following advice.

Counselling notes: Parents were counselled regarding the condition of child that there is severe reduction in heart pumping function. There is risk for worsening of heart failure, arrhythmias and cardiac arrest. There is possibility of prolonged illness and prognosis is variable.

Possible causes of the current condition is explained that it can be due to genetic disorders, viral myocarditis, neuromuscular or metabolic disorders, mitochondrial disease, Nutritional deficiencies or idiopathic. Child further needs genetic workup with whole exome sequencing.

At the time of Discharge : She is active, afebrile and normotensive.

General precautions:

- Avoid excessive exertion and physical activity, stop activity if breathlessness increases, sweating becomes excessive, dizziness / syncope occurs, chest pain develops.
- Infection prevention as respiratory infections can precipitate decompensation, to maintain hand hygiene, avoid sick contacts, vaccinations upto date, influenza vaccination.
- Avoid excessive salt intake.
- Do not stop medications.
- To seek medical attention when there is dull activity, fast breathing, swelling of face or feet, decreased urine output, severe sweating.

Name	Baby A.YASHNA SRI	UHID
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Discharge Advice:

1. Diet as advised.
2. Syrup Cefixime (5ml=100 mg) 3ml 12th hourly for 3 days (Refrigerated after reconstitution).
3. Tablet Lisinopril (2.5mg) Dilute 1 tablet in 10 ml of water and give, 2ml 12th hourly (6am-6pm) till further advice.
4. Tablet Cardivas (3.125mg) Dilute 1 tablet in 10ml of water and give, 2.5ml 12th hourly (10am -10pm) till further advice.
5. Tablet Minilactone (Furosemide+Spironolactone 20+25) Dilute 1 tablet in 10ml of water and give 2.5ml, 12th hourly (8am-8pm) till further advice.
6. Tablet Aspirin (75 mg) Dilute 1 tablet in 10 ml of water and give 3.5 ml (once daily (2pm) till further advice.
7. Nexpro sachet (10mg) Dilute 1 tablet in 15ml of water and give, 7.5ml once daily (7am) (30 minutes before breakfast) for 3 weeks.
8. Syrup Omnacortil Forte (5ml-15mg)
 - 3.6 once daily (1pm) after food for 2 days
 - 3.2 once daily (1pm) after food for 2 days
 - 2.8 once daily (1pm) after food for 2 days.
 - 2.4 once daily (1pm) after food for 2 days.
 - 2 once daily (1pm) after food for 2 days.
 - 1.6 once daily (1pm) after food for 2 days.
 - 1.2 once daily (1pm) after food for 1 day.
 - 0.8 once daily (1pm) after food for 1 day.
 - 0.4 once daily (1pm) after food for 1 day.
9. Tablet Thiamine (100mg) 1 tablet to dilute in 10 ml water and give 5 ml once daily at 2 PM
10. Syrup Calcimax plus 3ml, (9am-9pm) for 5 weeks.
11. Syrup Carnisure 1.5 ml, (12am, 8am-4pm) till further advice.
12. To collect Whole exome sequencing report.

Name	Baby A.YASHNA SRI	UHID	VIH-00205925
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13. Kindly consult Dr. Murtaza Kamal, Consultant Pediatric Cardiologist, on 26.06.2026 (Friday) in OPD with prior appointment (This consultation will be charged).
14. Kindly consult Dr. Preetam Kumar, Senior Consultant Pediatrics, on 26.06.2026 (Friday) in OPD with prior appointment (This consultation will be charged).

In case of Fever:

Paracetamol drops (1ml=100mg), 0.9ml (if needed) if fever more than 99.6°F (maximum 4-6 hourly).

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

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

In Case of Emergency Contact 040-42462200, Extn: 2010 (or) 7337357870 for increasing breathing difficulty, dullness or high fever.

If any IV antibiotics - will be given in Emergency Room between 6am - 7am for morning dose, between 2pm - 3pm for afternoon dose and between 10pm - 11pm for evening dose (Outside IV medication shall not be allowed with in the hospital as per the hospital protocol).

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained to me.

Name	Baby A.YASHNA SRI	UHID
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Name :

Signature :

Relationship with patient :

This summary has been explained by :

Admitting Doctor : Dr. Ch Ganesh

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

Registrar/Fellow

Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

PatientName : Baby A.YASHNA SRI Inpatient No. : IP-00060351
 Age/Gender : 0 Y 11 M 3 D/ Female Admit Date : 15-06-2026
 Ward/Bed : N 0 GF-EMERGENCY/ ER 103 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
CALCIUM (Arsenazo dye)	10.6	mg/dl	8 - 11.1



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
HEMOGLOBIN (Colorimetry)	11.0	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.13	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	31.0	VOL% L	33 - 49
MCV (Calculated)	75.0	fL	70 - 86
MCH (Calculated)	26.6	pg/cells	23 - 31
MCHC (Calculated)	35.5	g/dL	30 - 36
RDW-CV (Calculated)	12.6	%	11.5 - 16
PLATELET COUNT (DC Detection Method)	430	10 ⁹ /L	150 - 450
MPV (Calculated)	8.5	fL	6.5 - 10
WBC COUNT (DC Detection Method)	8.76	10 ⁹ /L	6 - 17

Differential Count

NEUTROPHILS (Microscopy, Leishman stain)	23	%	15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	70	%	45 - 76
MONOCYTES (Microscopy, Leishman stain)	5	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	2	%	1 - 7

PERIPHERAL SMEAR (Microscopy, Leishman stain)

RBC : NORMOCYTIC / HYPOCHROMIC
 WBC : MORPHOLOGY NORMAL
 PLATELETS : ADEQUATE



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08

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040-42462200, Ext 2000,2001,2002,

PatientName : Baby A.YASHNA SRI Inpatient No. : IP-00060351
Age/Gender : 0 Y 11 M 3 D/ Female Admit Date : 15-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 103 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	7.0	mg/L	<10



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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
CREATININE (Enzymatic)	0.4	mg/dl	0.03 - 0.5



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
SODIUM (Direct ISE)	142	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.2	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	107	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
HIV TEST (CARD METHOD) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
HIV TEST (CARD METHOD)	Non-reactive		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 15:08
TOTAL BILIRUBIN (Azobilirubin)	1.2	mg/dl	<1.3

PatientName : Baby A.YASHNA SRI
Age/Gender : 0 Y 11 M 3 D/ Female
Ward/Bed : N 0 GF-EMERGENCY/ ER 103

Inpatient No. : IP-00060351
Admit Date : 15-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	1.1	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	51	U/L	20 - 63
SGPT (ALT) (Kinetic with P5P)	26	U/L	12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)213		U/L	120 - 470
PROTEIN (Biuret method)	6.4	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	4.4	g/dL	1.9 - 4.7
GLOBULIN (Calculated)	2	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	2.2		1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

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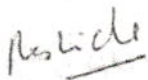
Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
MAGNESIUM (Formazon dye)	2.3	mg/dl	Order Date :15-06-2026 15:08 1.6 - 2.6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
NT-PROBNP (N-TERMINAL PRO-B-TYPE NATRIURETIC PEPTIDE) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
NT PRO BNP	21200	pg/mL	Order Date :15-06-2026 15:08 H <300



Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081



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MC-7373

PatientName : Baby A.YASHNA SRI	Inpatient No. : IP-00060351
Age/Gender : 0 Y 11 M 4 D/ Female	Admit Date : 15-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 103	Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
THYROID FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :15-06-2026 15:08
TRIIODOTHYRONINE (T3) (Eclia)	147.9	ng/dL	86 - 265
THYROXINE (T4) (Eclia)	9.19	µg/dl	5.67 - 16
THYROID STIMULATING HORMONE (TSH) (Eclia)	2.56	µIU/ml	0.73 - 8.35

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

PatientName : Baby A.YASHNA SRI Inpatient No. : IP-00060351
Age/Gender : 0 Y 11 M 4 D/ Female Admit Date : 15-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 103 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
TROPONIN I (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :15-06-2026 15:08	
TROPONIN - I	0.474	ng/ml	H <0.034

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :15-06-2026 15:08	
UREA (Kinetic, Urease)	25.5	mg/dl	9 - 30

Srujana

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :15-06-2026 15:09	
RANDOM BLOOD GLUCOSE (GOD/POD)	69	mg/dl	L 70 - 140
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :15-06-2026 18:53	
RANDOM BLOOD GLUCOSE (GOD/POD)	92	mg/dl	70 - 140

Srujana

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :16-06-2026 05:56	

PatientName	: Baby A.YASHNA SRI	Inpatient No.	: IP-00060351
Age/Gender	: 0 Y 11 M 4 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE (GOD/POD)	107	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :17-06-2026 06:20
SODIUM (Direct ISE)	143	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.3	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	98	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :18-06-2026 05:09
SODIUM (Direct ISE)	141	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.0	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	95	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
NT-PROBNP (N-TERMINAL PRO-B-TYPE NATRIURETIC PEPTIDE) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :18-06-2026 11:07
NT PRO BNP	11900	pg/mL	H <300



Dr. HAFSA AHMAD, MBBS,DCP

CONSULTANT CLINICAL PATHOLOGY, Reg No : 36473

Investigation	Result	Unit	Biological Reference Interval
TROPONIN I (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :18-06-2026 11:07
TROPONIN - I	0.109	ng/ml	H <0.034



Dr. HAFSA AHMAD, MBBS,DCP

CONSULTANT CLINICAL PATHOLOGY, Reg No : 36473

Investigation	Result	Unit	Biological Reference Interval
This is an interim report. The final report will be released after 24 hours.			

Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002,



PatientName : Baby A.YASHNA SRI
Age/Gender : 0 Y 11 M 8 D/ Female
Ward/Bed : N 0 GF-EMERGENCY/ ER 103

Inpatient No. : IP-00060351
Admit Date : 15-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :20-06-2026 06:41
SODIUM (Direct ISE)	139	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.7	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	96	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB
Consultant Pathologist, Reg No : 39356

Laboratory Report

Baby A.YASHNA SRI

7659037393

0 Y 11 M 5 D

VI26020467

Female

15-06-2026 03:11 PM

IP-00060351

15-06-2026 03:26 PM

VIH-00205925

Dr. PREETHAM KUMAR

N 0 GF-EMERGENCY / ER 103

BLOOD CULTURE AND SENSITIVITY (Specimen :BLOOD)

RESULT

TEST RESULT STATUS : REPORT ENTERED

Culture : -

Second Report - No growth after 48 hrs of incubation

..... End of the Report

Baby A.YASHNA SRI

7659037393

0 Y 11 M 4 D

R26-009626

Female

16-06-2026 09:03 AM

IP-00060351

16-06-2026 09:16 AM

VIH-00205925

16-06-2026 09:16 AM

PREETHAM KUMAR

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA , IVC COLLAPSING
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	DILATED
Inter atrial septum	Intact
Mitral Valve	SEVERE MR
Tricuspid Valve	TRIVIAL TR , RVSP=25mmHg
Right ventricle	Normal
Left ventricle	DILATED , SEVERE LV DYSFUNCTION
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	TRIVIAL PR
Coronaries	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 16-06-2026 09:16 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Baby A.YASHNA SRI

7659037393

0 Y 11 M 4 D

R26-009626

Female

16-06-2026 09:03 AM

IP-00060351

16-06-2026 09:16 AM

VIH-00205925

16-06-2026 09:16 AM

PREETHAM KUMAR

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.1		Tricuspid Annulus		
LA	2.0		Mitral Annulus		
IVSd	0.5		Aortic Annulus		
LVIDd	4.1		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.6		LPA		
LVIDS	3.5		MPA		
LVPWs	0.5		AO Isthmus		
EF	33%		LV Mass		
FS	15%		Others		

Impression

SITUS , SOLITUS, LEVOCARDIA

GLOBAL HYPOKINESIA OF LV

SEVERE LV DYSFUNCTION

DILATED LA/LV

SEVERE MR

TRIVIAL PR /TRIVIAL TR

LEFT ARCH , NO COA

Baby A.YASHNA SRI

7659037393

0 Y 11 M 4 D

R26-009626

Female

16-06-2026 09:03 AM

IP-00060351

16-06-2026 09:16 AM

VIH-00205925

16-06-2026 09:16 AM

PREETHAM KUMAR

Dr. MURTAZA KAMAL

MBBS, MD, DNB, DrNB
Reg No: TSMC/FMR/26664

Baby A.YASHNA SRI

R26-009680

0 Y 11 M 5 D

Female

17-06-2026 10:34 AM

IP-00060351

17-06-2026 11:32 AM

VIH-00205925

17-06-2026 11:32 AM

PREETHAM KUMAR

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA ,ivc collapsing
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	dilated
Inter atrial septum	Intact
Mitral Valve	SEVERE MR
Tricuspid Valve	TRIVIAL TR , TR GR=25mmHg
Right ventricle	Normal
Left ventricle	DILATED , SEVERE LV DYSFUNCTION
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	TRIVIAL PR
Coronaries	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 17-06-2026 11:32 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Baby A.YASHNA SRI

7659037393

0 Y 11 M 5 D

R26-009680

Female

17-06-2026 10:34 AM

IP-00060351

17-06-2026 11:32 AM

VIH-00205925

17-06-2026 11:32 AM

PREETHAM KUMAR

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.1		Tricuspid Annulus		
LA	2.0		Mitral Annulus		
IVSd	0.6		Aortic Annulus		
LVIDd	4.2		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.6		LPA		
LVIDS	3.3		MPA		
LVPWs	0.5		AO Isthmus		
EF	35%		LV Mass		
FS	16%		Others		

Baby A.YASHNA SRI

0 Y 11 M 5 D

Female

IP-00060351

VIH-00205925

PREETHAM KUMAR

R26-009680

17-06-2026 10:34 AM

17-06-2026 11:32 AM

17-06-2026 11:32 AM

Impression

SITUS ,SOLITUS , LEVOCARDIA
GLOBAL HYPOKINESIA OF LV
SEVERE LV DYSFUNCTION
DILATED LA/LV
SEVERE MR
TRIVIAL PR/TRIVIAL TR
NO CLOTS
IVC COLLAPSING
LEFT ARCH,NO COA

Dr. MURTAZA KAMAL

MBBS, MD, DNB, DrNB

Reg No: TSMC/FMR/26664

Baby A.YASHNA SRI

7659037393

0 Y 11 M 7 D

R26-009819

Female

19-06-2026 10:34 AM

IP-00060351

19-06-2026 11:51 AM

VIH-00205925

19-06-2026 11:51 AM

PREETHAM KUMAR

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	DILATED
Inter atrial septum	Intact
Mitral Valve	SEVERE MR
Tricuspid Valve	TRIVIAL
Right ventricle	Normal
Left ventricle	DILATED
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 19-06-2026 11:51 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Baby A.YASHNA SRI

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Female

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VIH-00205925

19-06-2026 11:51 AM

PREETHAM KUMAR

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.2		Tricuspid Annulus		
LA	1.6		Mitral Annulus		
IVSd	0.4		Aortic Annulus		
LVIDd	4.0		PA Annulus		
LVPWd	0.5		RPA		
IVSs	0.3		LPA		
LVIDS	3.6		MPA		
LVPWs	0.4		AO Isthmus		
EF	15 %		LV Mass		
FS	8 %		Others		

Baby A.YASHNA SRI

0 Y 11 M 7 D

Female

IP-00060351

VIH-00205925

PREETHAM KUMAR

R26-009819

19-06-2026 10:34 AM

19-06-2026 11:51 AM

19-06-2026 11:51 AM

Impression

SITUS , SOLITUS , LEVOCARDIA
GLOBAL HYPOKINESIA OF LV
SEVERE LV DYSFUNCTION
DILATED LA/LV
SEVERE MR
IVC COLLAPSING
LEFT ARCH, NO COA

Dr. MURTAZA KAMAL
MBBS, MD, DNB, DrNB
Reg No: TSMC/FMR/26664

Print Date/Time : 19-06-2026 11:51 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 3 of 3



Name	: BABY.A YASHNA SRI VIH-00205925	TID/SID	: UMR4717740/ 32052898
Age / Gender	: 11M(s) / Female	Registered on	: 16-Jun-2026 / 01:53 AM
Ref.By	: DR PREETHAM KUMAR	Collected on	: 16-Jun-2026 / 01:34 AM
Req.No	: 26NRLH0221749	Reported on	: 17-Jun-2026 / 18:13 PM
Sample Type	: Serum	Client Name	: RAINBOW CHILDREN HOSPITAL -S

TEST REPORT

DEPARTMENT OF LCMS

1,25-Dihydroxy Vitamin D

Investigation	Observed Value	Biological Reference Interval
1, 25-Dihydroxy Vitamin D, Serum Method:LCMS-MS	52.52	19.9-79.3 pg/mL

Comment

1,25 dihydroxy Vitamin D is the major biologically active form of Vitamin D. Its concentration is only 1/1000 that of 25, hydroxyl Vitamin D and has half life of 5 to 6 hrs. Circulating levels are regulated by PTH, phosphate & calcium. While 1, 25-dihydroxy vitamin D is the most potent vitamin D metabolite, levels of the 25-OH forms of vitamin D more accurately reflect the body's vitamin D stores. However, in the presence of renal disease, 1, 25-dihydroxy vitamin D levels may be needed to adequately assess vitamin D status.

Uses

- Differentiation of Primary hyperparathyroidism from Hypercalcaemia of cancer
- Differentiation of Vitamin D dependent and Vitamin D resistant rickets
- Monitoring Vitamin D status in Chronic renal failure
- Assessing compliance of 1,25 dihydroxy Vitamin D therapy

Increased levels

- Granulomatous disease
- Primary hyperparathyroidism
- Lymphoma
- 1,25 dihydroxy Vitamin D intoxication
- Vitamin D dependent Rickets type II

Decreased levels

- Renal failure
- Hyperphosphatemia
- Hypomagnesemia
- Hypoparathyroidism
- Pseudohypoparathyroidism
- Vitamin D dependent Rickets Type I
- Hypercalcemia of malignancy

* Sample processed at National Reference Laboratory, Tenet Diagnostics 54, Kineta Towers, Journalist Colony, Banjara Hills

--- End Of Report ---





PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE

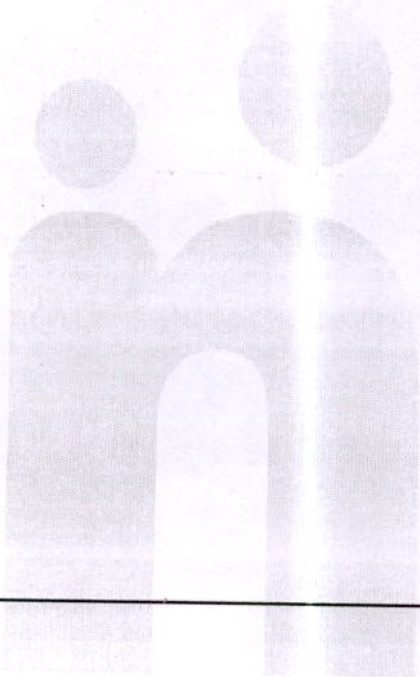


Name : **BABY.A YASHNA SRI VIH-00205925**
Age / Gender : 11M(s) / Female
Ref.By : DR PREETHAM KUMAR
Req.No : 26NRLH0221749
Sample Type :

TID/SID : UMR4717740/
Registered on : 16-Jun-2026 / 01:53 AM
Collected on :
Reported on :
Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

Dr Afreen Anwar
Consultant Biochemist
Regd No: 65041



VIH-00205925 IP-00060351
Baby A.YASHNA SRI
12-07-2025 0 Y 11 M 3 D (F)
Dr. PREETHAM KUMAR



ACTIVITY RECORD FOR BILLING

Name: -----
UHID No : ----- IP No : ----- Consultant : ----- Dept : Pediatric
Date of Admission : 15/6/26 Time : 2:25PM Date of Discharge : ----- Time: -----
Room / Bed No : ----- Ward : PICU Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/6/26	3:50u.	FR	PICU	Sarjay
18/6/26	1pm	PICU	1st floor 132	Piji

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr Murtaza Kamal	16/6/26	009676	Jay
2.				
3.	Dr Murtaza Kamal	16/6/26	3090743	Jay
4.	(VOI) checked by Yashwanth 17/6/26 at 10:30am.			
5.	Dr Murtaza Kamal	17/6/26	3091113	Jay
6.	Cross checked by 18/6/26 @ 12:30pm			
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
19/6/26	CRAB (POCT) - 69 mg/dl WBC	26009468	Dewatri
	CRAB, CRP, Electrolytes	26009467	
	creatinine, calcium magnesium, urea.		
	UFT, HIV		
15/6/26	Vitamin D3	26009485	R
	RBS - 92 mg/dl 6 fm	26009492	R
16/6/26	ECG	26009618	Nes
16/6/26	Electrolytes	26009515	Nes
16/6	RBS - 103 mg/dl 6 AM	26009516	Nes
16/6/24	2D Echo	26-009626	Jay
17/6/26	Electrolytes	26009602	Nes
17/6/24	ECG	26009675	Nes
	CRAB ordered by favoura 17/6/26 of 10:30am.		
17/6	Pray 2030am	26009680	✓
18/6	Electrolytes	26009788	Nes
18/6	Troponin I	26020119	Prajakta
	UFT - 100 BNP		
	checked by 18/6/26 at 12:30pm		
	soluble electrolytes	26020966	✓
	abdominal	26009689	✓

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/6/26	IV placement	2	3096573	Dr. Rajyalam
<p><i>Cross checked by syfatu 18/6/26 @ 12:30pm</i></p>				
	1000 W placement	1	3092408	S
<p><i>Cross checked by Kingalle r</i></p>				

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET



Registration Details :

Admission No : IP-00060351

Admit Date : 15-Jun-2026

Admit Time : 02:25 PM UHID : VIH-00205925

Patient Details :

Patient Name : Baby A.YASHNA SRI

Age : 0 Y 11 M 3 D

Guardian : Mr ANNARAM KRISHNA CHAITANYA

DOB : 12-07-2025 01:00 AM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : H.NO:1-5-53,BRAHMANA WADA MANDAL,
SANGAREDDY MEDAK ,TELANGANA.
Sangareddy Medak Telangana INDIA 502001

Phone No : 7659037393/ 8985458348

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 ANNARAM KRISHNA CHAITANYA

Relationship : Father

Contact Address : H.NO:1-5-53,BRAHMANA WADA
MANDAL,SANGAREDDY MEDAK
,TELANGANA. Sangareddy Medak Telangana
INDIA 502001

Phone No : 7659037393

Kishu

Signature

Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR

Specialisation : GENERAL PEDIATRICS

Referral Doctor : avinash

Phone No : 9963841399

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



PATIENT TRANSFER FORM

VIH-00205925 IP-00060351 Baby A.YASHNA SRI 12-07-2025 0 Y 11 M 6 D (F) Dr. PREETHAM KUMAR 		Date & Time of Admission <i>15/6/26 @ 2:25 pm</i>	Date & Time of Transfer Order <i>12/6/26 @ 1 pm</i>
Consulting Consultant Name <i>Dr. Preetham Kumar</i>		Transfer Ordered by <i>Dr. Sreety</i>	Reason for Transfer <i>stable</i>
From Unit <i>picu</i>	To Unit <i>1st floor R.No: 132</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>50</i>	Number of Imaging Films <i>CRAY-2 VBS-1</i>	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.	exray ^{sup} <i>calcium plus</i>	1	
2.	<i>5cc</i>	2	
3.	<i>fusimide drop</i>	1	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Rajeshwari</i>		Name of Person Ordered Transfer <i>Dr. Sreety</i>	
Patient & Clinical Records Received by : <i>Indu</i>			
Date & Time of Patient Received : <i>01:50pm</i>			

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



VIH-00205925 IP-00060351 Baby A.YASHNA SRI 12-07-2025 0 Y 11 M 3 D (F) Dr. PREETHAM KUMAR 	Date & Time of Admission 15/6/26 @ 2:25pm	Date & Time of Transfer Order 15/6/26 @ 3:50u
	Transfer Ordered by Sameera	Reason for Transfer Admission
From Unit ER	To Unit PICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 21	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? OP file given to King...
Medications / Consumables / Surgicals / Hand over		
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 Sameera	Name of Person Ordered Transfer Sameera	
Patient & Clinical Records Received by : Sushma		
Date & Time of Patient Received : 15/6/26 @ 4pm		

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

ATTENT TRANSFER FORM

1-800-800-8000

Call the 1-800-800-8000
to transfer your call to the
department you need.

Call
1-800-800-8000

Call the 1-800-800-8000
to transfer your call to the
department you need.

Call
1-800-800-8000

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to transfer your call to the
department you need.

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department you need.

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1-800-800-8000

Call the 1-800-800-8000
to transfer your call to the
department you need.

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 15/6/26
 Source of Admission: OPD Ward Other: ER
 Reason for Admission: Fast breathing x 2 days, cold x 2 days
 Admission Diagnosis: Past viral myocarditis
 Accompanied By: Parent Guardian Other Name:
 Primary Language: Telugu English Hindi Other Specify
 Do you require an interpreter? Yes No
 Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify Nil

Source of Information: <input type="checkbox"/> Family <input type="checkbox"/> Patient <input type="checkbox"/> Others, Specify			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	On May 27th 2026 @ 10 month of age for Bronchoalveolitis	Nil	on May 27th 2026 @ 10 month of age for Bronchoalveolitis
	Family History: Nil		
	Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please list Nil Was the child's birth normal? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, please describe problems: Are the child's immunization up to date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
CURRENT MEDICATIONS	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Observations: Weight: 5.7kg Length: Head Circumference (< 2 years): Temp: 98.6°F HR: 142 bpm RR: 51 bpm BP: 95/56(68) Pain Score: 0 Specify Site: (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Score: 14 (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score 21) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

- Sleeping ~~Crying~~ Calm Distressed/Consolate Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

- Mobility problem Walking Problem No Abnormality Detected
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

Orientation has been given regarding the following aspects:

- ID Band in situ
 Bedside safety explained
 PICU Routine: Doctor's rounds/Medication time
 Visiting policy explained

Orientation given to: Family Others specify

Name of Person Orientation was given to: mother

Orientation not given Reason:

Nurse Name: Sr. Sushma

Nurse Signature: [Signature]

Date & Time: 15/6/26 4:15 Pm.

DISCHARGE PLAN

Source of Information: Family Friend

Will patient require transportation arrangements to go home: Yes No

Will Physiotherapy require at home: Yes No

Is home medical equipment anticipated: Yes No

Is home oxygen therapy anticipated: Yes No

Are dressing needs at home anticipated: Yes No

Any other needs anticipated: Yes No If Yes Specify

Discharge Medications: Yes No

Details:

Final Diagnosis: 9 part viral myocarditis

Nurse Name: Sr. Sushma

Nurse Signature: [Signature]

Date & Time: 15/6/26 @ 4:15 Pm

Patient Name : Baby. A.YASHNA SRI UHID : VIH-00205925 IPD : IP-00060351 Gender : Female Age : 0 Y 11 M 3 D

VIH-00205925 IP-00060351
 Baby A.YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR



wt-5.7kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Yashna Age: 11 months Gender: Male Female

Date: 15/6/26 Time of Arrival: 1:27pm

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: 98.3°F PR: 152b/m BP: Cosyng RR: 40b/m SpO₂: 99%

Chief Complaints: Last breathing x 2 days, Cold x 2 days

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Unstable : <input checked="" 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

Preetham Kumar
 Signature of Parent / Guardian
 Triage Completion Time : 1:30pm

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 : Sri. Renu

Signature of Triage Nurse: [Signature]

Date & Time : 15/6/26 @ 1:30pm

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

Patient Name : Baby. A.YASHNA SRI UHID : VIH-00205925 IPD : IP-00060351 Gender : Female Age : 0 Y 11 M 3 D

VIH-00205925 IP-00060351
Baby A.YASHNA SRI
12-07-2025 0 Y 11 M 3 D (F)
Dr. PREETHAM KUMAR



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/6/26 Time of arrival : 1:32pm
Chief Complaints : fast breathing, cold x 2 days RBS: 84mg/dL
Height : — Weight : 5.7kg 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 checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input 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 checked="" 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>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>
---	--

Psychological Screening: No Significant Findings
Unusual concerns about patient's Psychological Status: Yes No
If Yes Consultant Notified: — (Date/Time): —
Social History: Lives With Family
Siblings in household Yes No (if yes How Many?) —
Time of Initial assessment completed by ER Nurse : 1:34pm

Patient Name : Baby. A.YASHNA SRI UHID : VIH-00205925 IPD : IP-00060351 Gender : Female Age : 0 Y 11 M 3 D

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

Time	Nursing Notes
1-27 PM	*pt Came to ER
1-29 PM	*vitals checked and Recorded
1-32 PM	*ER Doctor & PICU Doctor seen the Pt & advised admission in PICU
1-40 PM	pt admission process Done.
1-42 PM	pt IV placement done and sample sent to Lab
3:50 PM	pt shift ER TO PICU

Samples collected by: S.S. Royalaxmi

Time: 1:40 PM

Samples sent by:

Time: 1:45 PM

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: 153b/m BP: CFT: L28cc	Shift - out from ER to: PICU
RR: 35b/m SPO ₂ : 98%	Time of Shift - out: 15/6/26 @ 3:50
GCS: 15/15 Temperature: 98.2 F	Handover given to: <u>S. Seshma</u>
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): IV cannulization done.

Name of the Nurse : Dwajathilak

Signature of the Nurse : [Signature]

Date & Time : 15/6/26 @ 3:50 PM



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

VIH-00205925 IP-00060351
Baby A.YASHNA SRI
12-07-2025 0 Y 11 M 3 D (F)
Dr. PREETHAM KUMAR



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____
Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

_____ Cold & fast breathing ∴
12th June

History of present illness :

_____ Asymptomatic before 12th June

_____ Presented with cold & runny nose

_____ New fast breathing ∴ 12th June
& wt. loss ∴ 1 month

_____ (no H/O fever, cough, ↓ activity,
↓ intake)

_____ (visited Sahasra Sangareddy
Hospital
on 4th June.

_____ 2D echo (14 June)
↳ 35% LVEF (Lv dysfunction
suggestive of myocarditis

_____ CRP (14/6/2026)
Hb - 10.9
A/L - 35/58. - S.E - (N)

_____ WBC - 10,000
Plt - 361 /kch - Trop - > 603.8
_____ CRP - 2.2



Pediatric Multiorgan History & Physical Examination

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

_____ Admissions

_____ 1st - on. May 27th 2026 @ 10 months

_____ for Bronchialitis

_____ 2nd - now.

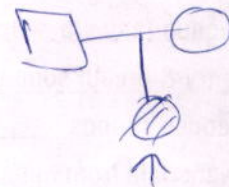
1kg
of
age.

Birth & Neonatal History:

_____ Term / 2.6kg

_____ no perinatal insult.

_____ Non



Birth & Socio Economic History:

About Father : _____ Non-Consanguineal Couple

About Mother : _____

Any additional Information : _____ Class III

Developmental History :

_____ (N) in all 4 domain

Immunization History :

_____ upto date.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 5.7kg (Centile _____)

On Examination :

Temperature : 98.3 F Pulse Rate : 154/min irreg B.P. _____ SPO2 99%

Resp. rate and type of breathing : _____

_____ 51/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ B/L NVDS

Any addes sounds : _____ occasional

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____ S₁S₂

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____ Soft

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____ *Intact*

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

_____ *? Post-viral myocarditis* _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment: _____

Planned Labs:

- ✓ CBP, CRP, SE, CXR (SOS)
- ✓ Sr (Ca²⁺, mg/L)
- ✓ Urea, Sr-Creatine
- ✓ (FTI)
- ✓ NT Pro BNP, Trop-I
- ✓ Thyroid function test (T₃, T₄, TSH)
- ✓ BCLs, VBGs
- ✓ Extra plain - (1)
- ✓ Extra. EDTA - (1)

Planned Management

- CLSB & CIDW Dr. Murthy
- Dr. Sweety Dr. Preetham
- (1/2) maintenance
- laxative therapy 1L daily
- stat thiamine
- milrinone (peripheral)
- continuous vitals
- (BP, HR, RR, SpO₂) monitoring.

~~Noted by: _____ on 15/06/2025 @ 4 PM~~

Signature of the Doctor: *[Signature]*
 Name of the Doctor: C.H. GANESH
 Date & Time: 15/6/2025

Signature of the Consultant: *[Signature]*
 Name of the Consultant: Dr. Preetham
 Date & Time: 15/6/25 4 PM



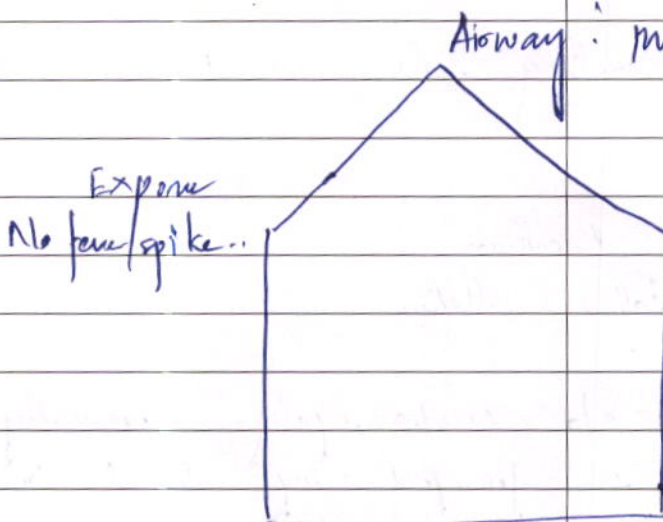
①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15.6.26	Counselling <u>Mother</u> in <u>ER</u>	
3:30 PM	<p>Done by: Dr. Preetham Attended by: Father & Mother</p> <ul style="list-style-type: none"> - History noted -> Chest X-ray s/o cardiomegaly. Normally 70% of blood is pumped by heart to all parts of body - But currently the heart is weak & pumping approximately 25-30% of blood. All the blood the should is staying in the heart - We should start medicine to improve the functioning of heart & also find out the cause of this condition. -> It can be either due to viral infection or sometimes due to genetic cause. -> Currently there is tachycardia & child needs continuous monitoring. 	
	Sameer	
	(Dr. Sameer)	
		Kishor



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2020 4:00 PM	<p>Airway: maintainable in Room air. (92-95%)</p>  <p>Exposure No fever/spike...</p>	<p>Breathing: Tachypnea ± mild crackles (+) clear, no added sound (+) w/ stetho spo₂: 92-95%, ↓ room air</p>
	<p>Disability - Irritable - CRBS: 84 → 69 mg/dL</p>	<p>Circulation: CRT < 3 sec BP: Peripheral circulation (N) perfusion (+)</p>
	<p>Δ: Respiratory distress</p>	
	<p>History: - spo₂: Acute infection (3 day history) with outside injury:</p>	
	<p>→ CXR s/o cardiomegaly → H/o wt loss: 18% (7.9 kg to 5.7 kg in 15 days)</p>	
	<p>- Outside Echo: Myocarditis EF: 30%, ↓ Global hypokinesia</p> <p>W. Prasad 15/6/2020 - Plan: POCUS.</p>	

[Signature]
15/6/2020

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2026 4.00PM	POCUS Done for this child	
	- LV dysfunction noted with hypokinesia & slowly reverses contracting - EF: 25%	
	- IVC: collapsible.	
15/6/2026 4.10 PM	c/D/w Dr. Murali Rao, Sr	15/6/2026
	Adv: ① Give lax @ 1mg/kg B.D ② start Milrinone @ 0.3 mcg/kg/min ③ sos Tab Aspirin @ 5mg/kg/dose OD if child orally allowed.	
	noted by Gushma 15/6/26 @ 4:10pm	15/6/2026



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2025 5:00 PM	counseling notes	(Dr. Preetham SR)
	Heart function is poor, there is poor clinically, reason of this condition to be known After that any steroid (or) drug should be avoided	or avoided
15/6/2025 10 PM	↓ respiratory & cardiac	
	child in room air, maintain saturation (Dachyprax)	
	Accepting orally	
	HR - 130-150/min	✓
	pO ₂ (✓)	→ DO continue same
	pH (✓)	
	NO HSM	
	SpO ₂ > 90% c/o	→ Rely
		→ DO send VIT by m
		see sup

→ Ste Pan



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/06/2026 8:15 AM	<p>also a Mucrona (feed. coelotologic)</p> <p>? Myocarditis & evaluation</p>	<p>(12)</p>
	<p>ECG findings consistent with myocardial</p> <p>No reversible cause → Hypodemia</p>	<p>QT prolongation</p>
		<p>Hypokalemia</p> <p>Immune deficiency</p> <p>VIT A deficiency</p>
	<p>Plan</p>	
	<p>1) To decide the on day 2/3</p> <p>2) to start with 1mg/kg/day for 3 days</p>	
	<p>3) continue Milmsone</p>	
	<p>4) if stable, can be shifted to oral easily</p>	
	<p>5) Avoid QT prolongation drugs</p>	
<p>16/6/26 SA Dr. Preetham</p>		<p>Dr. Jayaram</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/06/2025 8:10 am	<p>4th floor New fellow</p>	
	<p>Diagnosis - myocarditis & endocarditis</p>	
	<p>on room air, maintain saturation (>92%) tachypnea @ (45-55/min)</p>	
	<p>on milrinone infusion, low protein diet</p>	
	<p>Plv @ Bl - 5th centile Accepting orally</p>	<p>[Function also → Dilated LV, RA, AA → RV, collapsible ET 2.8cm]</p>
	<p>U/b → 9cc/kg/day</p>	
	<p>Balanced (-330ml)</p>	<p>plan</p>
	<p>(Great feeds not included)</p>	<p>To add 5ml kcal in PRF</p>
	<p>2 125.6ml</p>	<p>Continue milrinone</p>
	<p>0 458ml</p>	<p>collect vit F₂ report</p>
		<p>get cardiology consultation</p>
<p>16/6/25 Preetham</p>	<p>Dr. Sushma</p>	<p>Noted by Sushma 16/6/25 8:30 AM</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/2026 9:10 AM	Counseling notes (Dr. Preetham)	
	child has poor cardiac function, normal function is 70%, but child is having poor function of 25-30% only.	
	There is elevated cardiac inflammation markers @ indicating infection.	
	The higher level The treatment should be to stop inflammation hence started on steroid and placed for intg	
	For better functions, started on Milrinone infusion to reduce stress on heart, Furosemide is being given for fluid removal	
	There are high risk of arrhythmias in such children due to heart dilation and conduction anomalies	
	war heart	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/2025 13:20PM	Δ Acute myocarditis & prob ^{severe} LV dysfunction of s/B Dr. Preetham Sr. with global hypokinesia.	(B)
	POCUS: - EF: 35.3% - contractility & prob dilated LV dysfunction	Input: 50.4ml/DBF Output: 143ml
	- On milrinone: 0.3mcg/kg/min. Lasix @ 2mg/kg/dose - Inj MPS @ 2mg/kg/dose OD. - Aspirin Tab.	U/O: @ 2.7ml/hp
	Plan: <ol style="list-style-type: none"> ① TMS, GCMS } on follow up ② Genetic testing } ③ T/M: ECG, (EATG) } { - SF 	
Noted by Maheshwari 16/6/25 2:20pm		Counselling by Dr. Preetham Sr.
	- The child will be on milrinone and other medication supportive. - Wt will review tomorrow & will decide on milrinone.	
<u>Mohua</u>		16/6/25



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order						
17/6/2025 8.00 AM	<p>Δ: Acute Myocarditis with severe LV dysfunction & global hypokinaemia.</p>							
	<p>Airway: Maintainable at Room air Breathing: Tachypnoea ⊕ SpO₂: 99-100% in room air</p>							
	<p>Circulation: CRT ⊕ BP: within normal limit Peripheria warm</p>	<table border="1"> <thead> <tr> <th>Input</th> <th>Output</th> </tr> </thead> <tbody> <tr> <td>DBF + 123.8ml</td> <td>440ml</td> </tr> <tr> <td></td> <td>@ 3.2ml/h</td> </tr> </tbody> </table>	Input	Output	DBF + 123.8ml	440ml		@ 3.2ml/h
Input	Output							
DBF + 123.8ml	440ml							
	@ 3.2ml/h							
	<p>On milrinone @ 0.3mcg/kg MPS/lax Thiamine/Aspirin.</p>							
	<p>Disability: Irritability is kept</p>							
	<p>Exposure: No fever spike.</p>							
	<p>Plan: ① vit D₃ reprod- ② Plan for repeat 2D Echo: Plan of milrinone/IVIG ③ IVF: Plan to stop. ④ Plan for SE & (KCl)</p>							
<p>Wofealby Gulmoy 17/6/25 @ 8 AM</p>		<p>17/6/25</p>						



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/2026 9:00 AM	C/D/W Dr <u>Mustaza Sir</u>	
	Δ: Acute Myocarditis, with severe LV dy ^s & global hypokinesia. Q _{Tc} : Borderline.	
	f ARB T/M) - Milrinone - Aldactone (tab): 1/4 - Carniums Syrup	(B Blocker, diuretic) (Till tachy phases resolve, then taper) Tab B.D.
		over 17/6/2026
17/6/2026 9:30 AM	C/S/B Dr <u>Vishwas</u> child	
	Δ: Myocarditis c LVdy ^s	
	① Xray chest ② IVC:] Echo & cardiology consultation	
	③ Plan: To taper & stop Milrinone: [0.2 every 4hly	
	④ send TMS GCMS Genetic]	
	⑤ Trace vitD ₃ report. ⑥ vitD ₃ drops	Noted by Sushmita 12/6/26 9:00 AM



PROGRESS NOTES AND DOCTOR'S ORDER

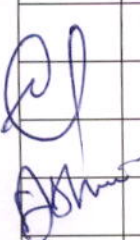
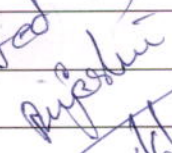
Date & Time	Progress Notes	Doctor's Order
<u>17/6/25</u>	<p>course by Dr. Vikram Vikram yash</p>	
<u>4/8/25</u>	<p>Child is better now we will try to taper the IV medicine of Sca As we already discuss the condition of the child it might not due to acute we need to work on in favor of genetics & other investigators to look for etiology -> so that treatment will be decided accordingly if stable by tapering of IV medication which supports we might stop the child to oral formula It looks more of like muscle involvement -> cardiac / heart involvement child will stay here in psw today</p>	
	<u>Facts</u>	
		2 1/1/2025

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26	<u>Repeat 2D Echo screening</u>	
12/12/25	<p>→ JVC as calcification -) Dilated LV -) EF 30% T2-25</p> <p>↓</p> <p><u>C/DCA Di murmur su</u></p>	
	<p>1) Plethora of foetal ch 2) Slowly taper of maternal veins</p>	<p>4 step of lactose any 2 milk → easy to digest</p>
17/6/26	<u>Refusal / withhold sign</u>	
	<p>In view of dilated cardiomyopathy @ poor ejection fraction. Cardiologists, PICU consultants advised TMS, Cxms and whole genome sequencing to find out about the clue (etiology). But due to personal reasons parents/ attenders want to withhold the above investigations.</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 8 AM	<u>CLB Resident</u>	(24)
	Myocarditis ± Severe LV dysfunction ± dilated LV chambers ↑ viral ↑ genetic	
	<u>Current stats</u> - in Room Air - in milrinone 0.2 ml/hr - (0.1 mcg/kg/min) - vitals stable - 70 kcal oral feed	
	<u>Plan</u> - Stop milrinone by afternoon, on the tappy - 2 ceftriaxone by 4 - plan to shift to ward	
		Noted by  18/6/26 @ 9 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/25	<u>CLS/B Dr Vishnu</u>	
9:50 AM	myocardial dyspnea	
	w/ dyspnea	
	<u>Current status</u>	
	- on RA	
	- Metformin stopped	
	<u>Plan</u>	
	- 2 Deeds & discuss with Dr. Murtuza	
	about ACE inhibitor, beta blocker, MFS	
	- shift to Room	
	- furosemide drops	
	- Top 2 of probiop	
	to send	

18/07/25
9:50 AM

CLS/B Dr Vishnu

myocardial dyspnea
w/ dyspnea

Current status

- on RA
- Metformin stopped

Plan

- 2 Deeds & discuss with Dr. Murtuza about ACE inhibitor, beta blocker, MFS
- shift to Room
- furosemide drops
- Top 2 of probiop to send

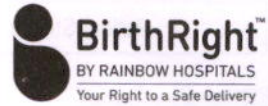
Dr. Vishnu

Dr. Vishnu

18/07/25
9:55

1/5 RD

VH-00205025 IP-00060351
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 12-07-2025 0 Y 11 M 5 D (F)
 Dr. PREETHAM KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/2025 10:20 AM	<p><u>consulting notes (Anurag)</u></p> <p>Stable today</p> <p>Moved to med toward, and cardiac consultation</p> <p>to decide on genetic workup, but it is to be done to rule out congenital myopathies and metabolic disorders</p> <p>takes time to ^{see} improvement in cardiac pathology only 1/3 children recover.</p> <p>needs consultation and discharge on regular basis</p>	
	<p><u>Mother</u></p> <p><u>Anurag</u></p>	<p><u>Father</u></p> <p><u>himself</u></p>
		<p><u>Signature</u></p>

VIH-00206006 IP-00060385
 Master ATHIRALA .SAI BATHVIK
 04-04-2009 17 Y 2 M 13 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>18/6/16</u>	<u>Child on morker su</u>	
<u>10:30am</u>	<p>add</p> <p>① Tab (restor) 2.5mg</p> <p>1/5th tab / BD</p>	
	<p>② pen to add p blocker</p>	<p>to mario</p> <p>my team</p>
<p>Noted by Prakash</p> <p>18/6 @ 10:30 Am</p>		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/2026 11:30 AM	<u>SHIFTING NOTE</u>	
	<p>The child was referred as case of Acute viral myocarditis with Echo done outside showing low ejection fraction & global hypokinesia. There was no signs of CCF, with normal perfusion & no signs of shock. POCUS shows LV dysfunction & LV dilatation along with low ejection fraction.</p>	
	<p>Cardiology consultation with Dr. Mudra was taken and started with Infusion Milrinone, & Digoxin and other supportive management.</p>	
	<p>The child was gradually tapered and stopped. The supportive medication is continuing. The child is stable and hence shifted to ward.</p>	
Adv:		
①	Shift to ward with	continuous monitor.
②	W/F signs of CCF /	Respiratory distress.
③	T/M Cardiology	C/N or for RCH.
④	Continue oral	medication
⑤	Trace NTProBNP &	Trop I level.
⑥	To decide - on Methylprednisolone	dose (oral) (Tomorrow) - Discharge medication
		<p>Noted by Preetham 18/6/2026 12:15 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/R Resident	
18/6/26		
	Myocardial dysfunction & LV dysfunction	
	O/T	
	Child active	
	Afebrile	
	Vitals stable	
	CVC - size (+)	
	P/A - BAE (+)	
	P/A - soft	
		plan
		1) W/O signs of CCF / Resp distress
		2) Cardiology c/w T/m or SDI RHF
		3) Trace Trop I & NTproBNP
		4) To decide - on methyl pred ↓ dex (ord)
		T/m c/w medetm
		5) Inj ceftazoxime-Dy
		6) Tab. Aspirin 75mg
		7) Sus methyl pred DS
		8) Syr. Calcimes
		9) Syr. Levocarnitine
		10) Tab. Spirinolactone
		11) Tab. Lintol
		12) Neo pro sachet
		13) furosemide

on methylpred

*Noted by
 Anasa
 18/6
 @ 6:30pm*

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 Baby A. YASHNA SRI
 12-07-2025 0 Y 11 M 6 D (F)
 Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/25 8AM.	<p><u>S/R Resident</u></p> <p>myocarditis with severe LV deepening</p>	
	<p>of child stable</p> <p>CRT < 3500.</p> <p>apleural</p> <p>cus - S3 ⊕</p> <p>RS - BAE ⊕, clear</p> <p>P/A - soft</p>	
		<p><u>Plan</u></p>
		<ol style="list-style-type: none"> 1) Cardiology c/o Today - or see RCH 2) Perf ceftriaxone 3) Tab. Aspirin 4) Perf metoprolol → to tab → to be decided
<p>Dr. Yashna 19/6/25 10AM</p>		<ol style="list-style-type: none"> 5) Sy. calceolax 6) Sy. levocarnitine 7) Tab. Spironolactone 8) Tab. Enalapril 9) Nexpro Sachet 10) Supped drops 11) B.P monitoring baby.
	<p>noted by Manasa 19/6 01:30pm</p>	

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9/6/24	<u>Close no mirtazapine</u>	
10:30 AM	EFUS. JUC non graded 1) tab mirtazapine 2) Tab lisdra 3) Tab GrUI-dol 4) Tab Aspirin 5) Can taper methylprednisolone 6) per to scd costs for study 7) if stable can be Discharge tomorrow	
	Synporminacohol (5ml = 5mg) MPS Tablet (1 TAB = 4mg) ↓ 5ml once daily x 5 day (5mg) ↓ 2.5ml once daily x 5 day (2.5mg) (26-30) ↓ 1.5ml once daily x 5 day (1.5mg) then stop (1-15)	wt: 5.7kg @ 2mg/kg/dose. OD. = 12mg X 5 day Plan to taper over 2wk. 19/6/2024

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19.6.26 3:00PM	<p><u>s/B Requies</u> <u>Myocarditis with severe LV dysfunction</u></p>	
	<p>no further complaint o/e child stable CRT < 3500 apfevul CVS - S, S (✓) RS - BAE (✓) clear P/B - soft</p>	<p>Plan → B.P monitoring help → Cont. all medication as advised → Cont. Spironolactone & Furosemid till T. Minidactone is available → Whole exome sequen → w/e R.D/ skull scan → S. electrolyte T/m</p>
19/6/26 4PM J. Kulkarni		
	<p>Parent were counselled abt the nature of illness & WES should be done to know the cause & cause of illness. But parent wanted to get it done after 1 week.</p> <p>Sincerely (Dr. Sameer)</p>	<p>noted by Sulekh 19/6/26 6:00pm</p>



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/2026 8.15AM.	C/S/B Dr. Vishnu Sr	
	Di. Myocarditis etc. Dilated cong cardio myopathy.	
	Adv. ① D/A today	
	② Counselled about Genetic testing (Mention in summary)	
	③ R/v after 1 week	
	④ Stop Antibiotic	
	⑤ Continue medication by ① Cardiology team.	
	No Vit D	② Omnacortol for 2wk [Reduce by 10%] every 5 days
	Counselled by Dr Vishnu Sr	
	Current condition of child explained. As child	
	stable but has underlying myocarditis with	
	? Dilated cardiomyopathy.	
	The child will need genetic testing on follow up.	
		20/6/2026

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/2025 8-20/6/25	Steroid tapering Plan:	
	- Methylprednisolone	12mg OD X 5day ↓

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/25 9AM	<p>8/3 Resident</p> <p>Myocardites ? ^{dilated} congenital Cardiomyopathy</p>	
20/6/25	diagnosis	
↓		<ul style="list-style-type: none"> → oral Acyclovir → steroid therapy → Calcimex.
Dr. KUNJUNIA 25/6/25 9AM		
		<p>noted by manasa 20/6 09:30am</p>

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 Dr. PREETHAM KUMAR

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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 15/6/26	Diagnosis: Post viral myocarditis	Surgery / Procedures: Nil		
	Allergies: NO		Post OP Day: Nil		
	Date:	17/6/26	17/6/2026		
	Area	PCU	PCU	PCU	
	Shift Time	8am - 2pm	2pm - 8pm	8pm - 8am	
	Diet:	Soft diet	Soft diet	Soft diet	
Ventilation (RA, NP, NIV, VENTI)	R/A	Room air	R/A		
INVASIVE LINES	1.	IV cannula R	peripheral line (2)	peripheral line	
	2.	IV cannula L		-	
	3.	Nil		-	
	4.	Nil		-	
ASSESSMENT	Infusions / Transfusions	DNS + 5ml kcal 5ml / hr mg Mithracinom 0.6 ml / hr	DNS - 2ml/hr nothing - 0.4ml/hr	DNS - 2ml/hr	
	PU Prophylaxis	Nil		Nil	
	DVT Prophylaxis	Nil	Nil	Nil	
	Vitals	BP			96/63 (83) mmHg
		PR			102 b/m
		RR			28 b/m
		SpO ₂			98%
		Temp			98.6°F
	Pain Score	0	0	0	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	
	Restraints If any	Physical	Nil	Nil	
Chemical		Nil	Nil		
Fall Risk (Vulnerable Y/N) if yes score	11	11	11		
(Ambulation, walking, moving with assistance, bed ridden)	Bed Ridden	making with assistance	Moving with assistance		
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent		
Critical Lab Test / Values (If any)			Nil		

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	17/6/26	17/6/2026	17/6/26
	Area	PLU	PLU	PLU
	Shift Time	8pm-2pm	2pm-8pm	8pm-3am
	Ordered / Planned	Plan send Tms/Gcms Genetic	Plan - Gcms - Genetic → plan to do mitochondria stop	+ study allow
	Due	Nil	Nil	Nil
	Reports Pending	Vitamin D3 Pending	Vitamine D3	Vitamine B3
Referrals (if any)	Nil	Nil	Nil	
Remarks (Special Interventions like, Drainage tube flushing etc.)	Nil	Nil	Nil	
Handed Over By Name :	Soni Sushma	Rajewadi	Sursiya	
Signature :				
Date:	17/6/26	17/6/26	18/6/26	
Time:	@ 2pm	@ 8pm	@ 8am	
Taken Over By Name :	Rajewadi	Sursiya	Rajewadi	
Signature :				
Date:	17/6/26	17/6/26	18/6/26	
Time:	@ 2pm	@ 8pm	8am	

VIH-00205025

IP-00060351

Baby A. YASHNA SRI
12-07-2025 0 Y 11 M 6 D (F)
Dr. PREETHAM KUMAR



(4)



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 15/6/26	Diagnosis: post viral myocarditis	Surgery / Procedures:	
	Allergies: Nil		Post OP Day:	
	Date: 18/6/26			
	Area: PICU	Shift Time: 8 AM - 2 PM		
	Diet: soft diet			
	Ventilation (RA, NP, NIV, VENTI)	Room air		
INVASIVE LINES	1.	Iv cannula		
	2.	Iv cannula		
	3.	-		
	4.	-		
ASSESSMENT	Infusions / Transfusions	only on flow		
	PU Prophylaxis	nil		
	DVT Prophylaxis	nil		
	Vitals	BP		
		PR	110/61mm	
		RR	26/1m	
		SpO ₂	97%	
		Temp	98.6f	
	Pain Score	0		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact		
	Restraints If any	Physical	Y nil	
		Chemical		
Fall Risk (Vulnerable Y/N) if yes score	11			
(Ambulation, walking, moving with assistance, bed ridden)	bed ridden			
ADL (Dependent / Non-Dependent)	dependent			
Critical Lab Test / Values (if any)	-			

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	18/6/26		
	Area	PICU		
	Shift Time	8am-2pm		
	Ordered / Planned	orally allowed soft diet		
	Due	will		
	Reports Pending	will		
Referrals (if any)	will			
Remarks (Special Interventions like, Drainage tube flushing etc.)	will			
Handed Over By Name :	P. Singh			
Signature :	<i>[Signature]</i>			
Date:	18/6/26			
Time:	1pm			
Taken Over By Name :	Indu			
Signature :	<i>[Signature]</i>			
Date:	18/6			
Time:	11:30			



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>myocarditis</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <u>nil</u>						
	Surgery / Procedure: <u>nil</u>	Post OP Day: <u>nil</u>						
BACKGROUND	Date	18/6 M	18/6 E	18/6 N	18/6 M	19/6/2025 E	19/6/2025 M/PM	
	Shift							
	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	
ASSESSMENT	Diet:	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.6°</u>	<u>98.3°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>97.6°</u>
		Res:	<u>20b/m</u>	<u>26b/m</u>	<u>22b/m</u>	<u>26b/m</u>	<u>25b/m</u>	<u>35b/m</u>
		SpO ₂ :	<u>98%</u>	<u>97%</u>	<u>99%</u>	<u>97%</u>	<u>98%</u>	<u>100%</u>
		Pulse:	<u>118b/m</u>	<u>112b/m</u>	<u>99b/m</u>	<u>120b/m</u>	<u>118b/m</u>	<u>128b/m</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>101/66/98</u>	<u>98/75</u>	<u>92/59/65</u>
		LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
Fall Risk Score:	<u>14</u>	<u>14</u>	<u>14</u>	<u>14</u>	<u>14</u>	<u>14</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Skin Integrity	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>		
Recommendations	Safety Needs:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<u>nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	<u>s.diet</u>	
	Critical Lab Test / Values:	<u>nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	<u>nil</u>	<u>nil</u>	
	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	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>		
Post Operative Procedure Special Orders:	<u>nil</u>	<u>nil</u>	<u>Nil</u>	<u>nil</u>	<u>nil</u>	<u>nil</u>		
Handed Over By Name :	<u>Arda</u>	<u>manasa</u>	<u>Subham</u>	<u>manasa</u>	<u>sreekanth</u>	<u>Subham</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>18/6/25</u>	<u>18/6</u>	<u>19/6</u>	<u>19/6</u>	<u>19/6/25</u>	<u>20/6/25</u>		
Time:	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :	<u>manasa</u>	<u>Subham</u>	<u>manasa</u>	<u>sreekanth</u>	<u>Subham</u>	<u>manasa</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>18/6</u>	<u>18/6</u>	<u>18/6</u>	<u>19/6/25</u>	<u>19/6/25</u>	<u>20/6</u>		
Time:	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>		

VIH-00205025 IP-00060351
 Baby A. YASHNA SRI
 12-07-2025 0 Y 11 M 8 D (F)
 Dr. PREETHAM KUMAR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>myocardial infection</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>nil</i>					
	Surgery / Procedure: <i>-</i>	Post OP Day: <i>-</i>					
BACKGROUND	Date	<i>20/6</i>					
	Shift	<i>M</i>					
	Medical Condition (Any special condition to be noted):	<i>Nil</i>					
	Diet:	<i>S. diet</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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.1°</i>				
		Res:	<i>26/LM</i>				
		SpO ₂ :	<i>98%</i>				
		Pulse:	<i>115b/m</i>				
		BP:	<i>96/50/10</i>				
		LOC:	<i>com Gao</i>				
		Fall Risk Score:	<i>74</i>				
Pain Score:	<i>0</i>						
Skin Integrity	<i>intact</i>						
Recommendations	Safety Needs:	<input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<i>nil</i>					
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>S. diet</i>					
	Critical Lab Test / Values:	<i>nil</i>					
	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	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<i>dependent</i>						
Post Operative Procedure Special Orders:	<i>nil</i>						
Handed Over By Name :	<i>manasa</i>						
Signature / ID :	<i>[Signature]</i>						
Date:	<i>20/6</i>						
Time:	<i>09:30</i>						
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

*Noted by
Manasa
20/6
09:30*



(1)

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	16/6
	3 to less than 7 years old	3					4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	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	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	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture/ Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	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					
Total			14	14	14	14	14

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		x	✓	✓	✓	x
Other Intervention(s) Specify						
Nurse's Name:		Vaishu	Neeraj	Neeraj	Neeraj	Supriya
Signature:		Vaishu	Neeraj	Neeraj	Neeraj	Supriya
Date:		15/6/24	16/6	16/6	16/6	16/6
Time:		2:30pm	2:45pm	8:45am	2:30pm	10:00pm



2

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	17/6	17/6	17/6	18/6	18/6
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	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	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	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	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						
Total			1/4	1/4	1/4	1/4	1/4

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	x	x	x	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		x	x	x	x	x
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Supriya	Rajwan	Supriya	Supriya	Riji
Signature:		(Sgt)	(Ref)	(Sgt)	(Sgt)	(U)
Date:		17/6	17/6	17/6	18/6	18/6
Time:		7Am	3Pm	11pm	7Am	2Pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			18/6	19/6	19/6	19/6/16	20/6
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	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	1	1	1
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None	1	1	1	1	1	1	
Total			13	13	13	13	13

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	x	x	x	x
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		x	x	x	x	x
Other Intervention(s) Specify						
Nurse's Name:		manasa	Subhan	manasa	Subhan	Subhan
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		18/6	19/6	19/6	19/6/16	20/6
Time:		4PM	12AM	12M	4PM	12AM



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/6/26	3pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Vaishul
16/6/26	2Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Neha
16/6/26	8Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Jeep
16/6/26	2pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	neehi
16/6/26	10pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Supriya
17/6/26	7Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Supriya
17/6/26	3pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Rajawar
17/6/26	11pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Supriya
18/6/26	7Am	0	✓	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	supriya
18/6/26	2pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Rupjio

Re-assessment Frequency:

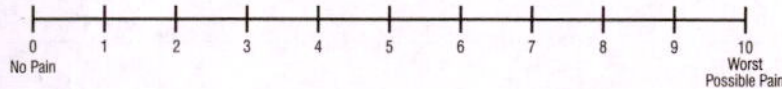
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/6	4pm	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Q
19/6	12AM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Subhan
19/6	11AM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Q
19/6/20	4PM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	—	Subhan
19/6/20	11PM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Subhan
20/6	9AM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Q
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

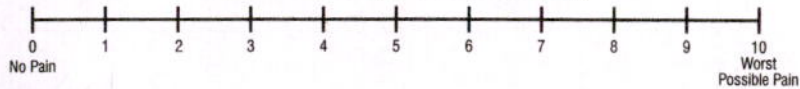
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
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Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst



7

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-	-	-	-	
Signature of the Nurse				Varid									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

VIH-00205925 IP-00060351
 Baby A. YASHNA SRI
 12-07-2025 0 Y 11 M 5 D (F)
 Dr. PREETHAM KUMAR

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/6 DAY-1			14/6 DAY-2			20/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-			
Signature of the Nurse				Subh	Subh	Subh	Subh	Subh	Subh	Subh			

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : *[Signature]* Name : *Cayathri*

Signature of Ward In Charge :

Signature : *Elizabeth* Name : *Elizabeth*



BRADEN 'Q' SCALE

					Date :	15/6/20	16/6/20	16/6	16/6
					Time :	3pm	2 AM	8 AM	2 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3	3
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		3	3	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	21	21	21	21
					Evaluator's Name	Vaish	Neha	Deep	Neha

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



BRADEN 'Q' SCALE

					Date :	16/6/26	17/6/26	18/6/26	19/6/26
					Time :	4pm	6Am	2Pm	10Pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	3	3	3	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3	3	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories and minerals for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					21	21	21	25	
Evaluator's Name					Sri	Sri	Sri	Sri	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

VH-00205025

IP-00060351

Baby A.YASHNA SRI

12-07-2025

0 Y 11 M 5 D

(F)

Dr. PREETHAM KUMAR



BRADEN 'Q' SCALE



					Date :	18/6	18/6	19/6	19/6
					Time :	6 AM	2 PM	12 AM	11 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	3	3
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		3	3	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	24	21	15	20
					Evaluator's Name	ay	ay	ay	ay

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



①

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 15/6/26.	Diagnosis: Post-viral myocarditis.	Surgery / Procedures: -		
	Allergies: -	Post OP Day: -			
	Date: 15/6/26.				
	Area	ER	PICU	PICU	
	Shift Time	Evening.	Evening	8pm - 8am	
	Diet:	-	-	Soft diet allowed	
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)	RA	RIA	room air	
	1.	-	Tr cannula	IV cannula	
	2.	-	-	-	
	3.	-	-	-	
	4.	-	-	-	
ASSESSMENT	Infusions / Transfusions	Nil	DNS @ 11 ml/hr	* DNS 5ml/hr on flow	
	PU Prophylaxis	-	-	-	
	DVT Prophylaxis	-	-	-	
	Vitals	BP	Crying.	95/56 (68)	96/53 (68) mttg
		PR	158 b/m.	142 b/m	159 b/min
		RR	48 b/m.	52 b/m	31 b/min
		SpO ₂	98 %	98 %	97 %
		Temp	98.3°F	98.2°F	98.6°F
	Pain Score	0	0	0	
	LOC (Alert, Conscious, Confusion, Unconscious)	conscious	conscious	conscious	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact.	Intact	intact	
	Restraints If any	Physical	-	-	} Nil
		Chemical	-	-	
	Fall Risk (Vulnerable Y/N) if yes score	11	11	11	
(Ambulation, walking, moving with assistance, bed ridden)	-	-	-		
ADL (Dependent / Non-Dependent)	dependent	dependent	dependent		
Critical Lab Test / Values (if any)	-	-	-		

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:			
	Area	ER	ICU	PIU
	Shift Time	Evening	Evening	Night
	Ordered / Planned	-	→ cardiologist consult → 2D Echo	* ECG to be done
	Due	-	-	- 2D Echo
	Reports Pending	-	-	- Blood ck
Referrals (If any)	-	-	-	
Remarks (Special Interventions like, Drainage tube flushing etc.)	-	-	-	
Handed Over By Name :	Sudhakar	Sudhakar	Supriya	
Signature :	[Signature]	[Signature]	[Signature]	
Date:	15/6/26	15/6/26	16/6/26	
Time:	@ 3:50 PM	@ 8 PM	8 AM	
Taken Over By Name :	Sudhakar	Supriya	Sri. Sashu	
Signature :	[Signature]	[Signature]	[Signature]	
Date:	15/6/26	15/6/26	16/6/26	
Time:	@ 4 PM	8 PM	@ 8 AM	

①

NURSING CARE RECORD

Date: 15/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	15/6 6 pm	<ul style="list-style-type: none"> → Assess the Patient general condition → vitals checked & Recorded. → Maintain fluid Balance. 		<ul style="list-style-type: none"> → Assessed the Patient general condition → vitals checked & Recorded. → Maintain fluid Balance 	<ul style="list-style-type: none"> → Assessed the Patient general condition → vitals checked & Recorded → Maintain fluid Balance 	<ul style="list-style-type: none"> → Assessed the Patient general condition → vitals are stable → Maintain fluid Balance. 	<p>Maha</p> <p>15/6/26</p> <p>@Spm</p>
Night	9pm	<ul style="list-style-type: none"> * Assessment * vitals * medications. 	9pm	<ul style="list-style-type: none"> * Assessed the Baby condition * monitored vitals & lo chat * medications given. 	<ul style="list-style-type: none"> * Baby is active * vitals are normal 	<ul style="list-style-type: none"> * Baby is Hemodynamically stable 	<p>Supsize</p> <p>16/6/26</p> <p>@Spm.</p>

NURSING CARE RECORD

Date: 16/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9Am	Assess the child condition Provide comfortable position Orally Allowed	9pm	Assessed the child condition IV F.DNS + 5ml kcal 5ml w log malsocinome 0.6 ml l w	Vitals checked & Recorded 110 chaunt 60hl w maintain.	child is maintain Room air	Sushma 16/6/26 @ 2pm
Afternoon	2pm	Assess the child condition vitals monitoring ensure safety	2pm	Assessed the child condition DAS + vitals monitored provided site rails	Assessed the child condition vitals monitored provided site rails	child is active Provide Serial serum	Mehta 16/6/26 SP
Night	8pm	- Assessment - vitals - Medications	8pm	- Assessed the general condition - Monitored vitals & Recorded - Medications given as per physician advice	- vitals are normal	- hemodynamically stable.	Supriya 17/6/26 8pm



2

NURSING CARE RECORD

Date: 12/06/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9 AM	→ Assessment → vitals checked and recorded → Maintain personal hygiene	9 AM	⇒ Assessed the child condition → I/F DNS 5ml/hour ⇒ I/NJ milimine 0.6ml /hour	⇒ Baby is active ⇒ provided comfortable position	vitals are stable	Gushma 18/6/26 @2PM
Afternoon	2 PM	⇒ Assessment ⇒ Vitals ⇒	2 PM	⇒ Assessed the general condition of the patient. ⇒ Vitals checked & recorded.	⇒ Baby is active ⇒ vitals stable	⇒ hemodynamically stable	Rejini
Night	9 PM	⇒ Assessment ⇒ Vitals ⇒ Medications	9 PM	⇒ assessed the child condition ⇒ monitored vitals & DO chart ⇒ Medications given.	⇒ child is active. ⇒ vitals are normal.	⇒ child is hemodynamically stable	Supriya 18/6/26 @2AM



NURSING CARE RECORD



Date: 18/6/25

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	9am	→ ASSESS the child condition → vitals		→ Assessed the child condition → I/V DNS 0.2 ml/hr → Diligirone 0.2 ml/hr	→ child is active → I/O chart maintained	→ vitals are stable	Preetham 18/6 1 PM
Afternoon	4 pm	→ maintain airway and oxygenation	4:30 pm	→ monitored vital signs	→ to maintain saturation	→ patient is stable	Preetham
Night	8pm	→ Assess → vital signs	8pm	→ Assess the child condition → vitals are checked 2x/10m	→ child is active → vitals are normal	→ now child is stable	Preetham 19/6 @ 8 PM

NURSING CARE RECORD



Date: 19/6/2026

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							
Afternoon	4pm	→ vital signs monitoring		checked vitals 1 hrly	To know the TPRBP.	- Patient is stable	} Subbu 05/19/2026 @ 8pm
Night	9pm	→ maintain good nutritional status	9pm	→ check oral intake is good	→ maintain hydration	→ patient is stable	
	10pm	→ Ensure safety	10pm	→ side rails kept up	→ Prevent from fall risk		Subbu 20/6 @ 8pm

Baby Yashna

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



WELL'S CRITERIA FOR ASSESSING DVT

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

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			15/6/26	16/6	17/6	18/6	19/6	
			Time:	Time:	Time:	Time:	Time:	Time:
			6 PM	6 AM	6 AM	6 AM	6 AM	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0	0	
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0	0	
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0	0	
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0	0	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0	0	
Total Score			0	0	0	0	0	
Signature of the Nurse			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	

Intervention: HIL

High Risk = >2 Score
 Moderate Risk = 1-2 Score
 Low Risk = <1 Score

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

Patient Name	Baby A.YASHNA SRI	Patient Ph. No	7659037393
Age	0 Y 11 M 7 D	Requisition No	R26-009819
Gender	Female	Billed on	19-06-2026 10:34 AM
IP / Bill No.	IP-00060351	Scanned on	19-06-2026 11:51 AM
UHID No.	VIH-00205925	Reported on	19-06-2026 11:51 AM
Ref. Doctor	PREETHAM KUMAR	Ward / Bed No	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	DILATED
Inter atrial septum	Intact
Mitral Valve	SEVERE MR
Tricuspid Valve	TRIVIAL
Right ventricle	Normal
Left ventricle	DILATED
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print D

Print Date/Time : 19-06-2026 11:51 AM

Printed By : RANGANATH
RELANGI

Page: 1 of

For Further Details
Scan QR Code



CONSULTATION FORM



VH-00205925
 Baby A. YASHNA SRI IP-00060351
 12-07-2025 0 Y 11 M 7 D (F)
 Dr. PREETHAM KUMAR



Dr. NUKHARA KANNA

Childs. Cord to left R,

Hour :

Hospital : *19/06/2021*

Referral : Emergency (within one hr.)

Referred for : Opinion Co-Management

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

Transfer of care

Date : Time : By :

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

Signature: _____

M.D. _____

Report of Findings and Recommendations :

A c/o myopelias c⁺ sex.

Malocclusion

Referred - General

*6/7yr on Decapellenti
 Afected velvny exent.*

*clinically suprised
 mainly headpues*

d/c

no u/s

No Deparment

Consultant :

Name : Signature : Date & Time :

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

LECHO

SS / Lennox

Global hypokalemia e Ferric

in dysphagia

LVCF 2157.

mid rail

Distal Left Hand.

(N) Coronaries, no CLOT, no MOTO
no DC / CLOT / pupa.

h₂

1. cancelled premed

2-70 reviews e ne after 1 week/52

3. TAB MINILACTONE (25/20)
↳ Juvederm

1/4 TAB 10/0 BD

4. TAB LISINAPIL (2.5MG)

0.5MG (1/5 TAB) P/O BD

5. TAB LANIBATEOL (3.125ug)

1/4 TAB P/O BD

6. TAB Aspirin / ECOSIN

25mg P/O qd • post meals

7. ce- Carnitine / 2 tabs Benalgin (100mg)

8. Cati B-Complex

1/2 TAB P/O qd

[Handwritten signature]



CONSENT FORM FOR HIV

Patient Name : Yashna Sri Age : 11 M.
 Gender : M F - IP No. 205925 Marital Status :
 Ward / Bed No. : PICU IP/OP No. : 60351 Date : 15/6/20

I have to say that I have been counseled about the test and the reason for undergoing the test has been clearly explained to me. I have also been explained about the implications of the test result-positive, negative or indeterminate All the details pertaining to HIV, its transmission, testing procedure Its limitations and interpretation of the results have been explained to me in language that I can understand.

I, hereby give my willful consent for the HIV test to be conducted on me in order to ascertain my HIV sero status. The status of my HIV test will be confidential

Patient Attendant :

Signature : Kaishna
 Name : Kaishna Chaitanya
 Relationship with Patient: Father
 Date & Time : 15/06/20 & 03:37

Parent (when patient is minor) :

Signature :
 Name :
 Relation :
 Date & Time :

OR (Next to kin in case of unconscious patient) :

Signature : Name :
 Relation : Date & Time :

I, certify that the Consent form for the HIV test has been signed in my presence and patient has been given pre-test counseling and post-test counseling is ensured by me and my team.

Doctor :

Signature : Dr. Samra
 Name : Dr. Samra
 Date & Time : 15-6-20 ; 3:27 PM

హెచ్.ఐ.వీ పరీక్ష అంగీకార పత్రం

రోగి పేరు వయస్సు లింగం పు స్త్రీ

వివాహస్థితి వార్డు / బెడ్ నెంబర్.....

హెచ్.ఐ.వీ టెస్ట్ గురించి నాకు అవగాహన కల్పించటమైనదనియు మరియు పరీక్ష చేయించుకోవలసిన కారణము నాకు స్పష్టముగా వివరించటమైనది అప నేను చెప్పుచున్నాను. ఈ టెస్ట్ ఫలితం యొక్క పర్యవసానాలకు పాజిటివ్, నెగిటివ్ లేక నిర్ధారణ విధానము, దాని పరిమితులు మరియు ఫలితాల వివరణకు నాకు అర్థమయ్యే భాషలో వివరించారు.

నా హెచ్.ఐ.వీ. రోగిస్థితి అంచనా వేయటానికి నాపై జరుపబడే టెస్టుకు నేను ఇష్టపూర్వకంగా తెలుపుతున్నాను. నా

హెచ్.ఐ.వీ. పరీక్ష ఫలితం రహస్యంగా వుంచాలి.

రోగి సాక్షి

సంతకము: సంతకము:

పేరు: పేరు:

బంధము: బంధము:

తేదీ మరియు సంతకము: తేదీ మరియు సమయము:

(రోగి అపస్మారక స్థితిలో వున్నచో అతని దగ్గరి రక్త బంధువు)

పేరు:..... సంతకము:

సంబంధము : తేదీ మరియు సంతకము:

హెచ్.ఐ.వీ. టెస్ట్ అంగీకార పత్రంపై నా సమక్షంలో సంతకం చేయబడిన దనియు, టెస్టుకు ముందు ఇవ్వవలసిన సలహా ఇవ్వబడిన దనియు మరియు టెస్ట్ తర్వాత ఇవ్వవలసిన అవగాహన ఖచ్చితంగా ఇవ్వగలమని నేను నా బృందం ధృవీకరిస్తున్నాము.

డాక్టర్

సంతకము

పేరు

తేదీ మరియు సమయము

**CONSENT FOR ADMISSION
IN PEDIATRIC INTENSIVE CARE UNIT**



Name: Yashna Sri Age: 11 Months Gender: Male Female
 UHID.No: 205925 Date: 15/6/26

I A. Krishna Chaitanya (S/O) D/o, W/o, A. Prabhakar hereby declare that our patient Master/Baby Yashna Sri who is related to me as Daughter is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 15/6/26

The doctors have explained to me in a language understood by me that my child has following health related issues :
Tachycardia
Myocarditis

The doctors have clearly explained to me that my patient Master / Baby A. yashna Sri during his/ her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : A. yashna Sri in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :
 Signature: Krishna
 Name: Krishna Chaitanya
 Relationship with Patient: Father
 Date & Time: 15/06/26 9.03:37

Witness :
 Signature: _____
 Name: _____
 Date & Time: _____

Doctor (who is taking the consent) :
 Signature: Someers
 Name: Dr. Someers
 Date & Time: 15.6.26 3.37 PM

VIH-00205925 IP-00060351
 Baby A.YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR

FRM / CLINICAL / 124

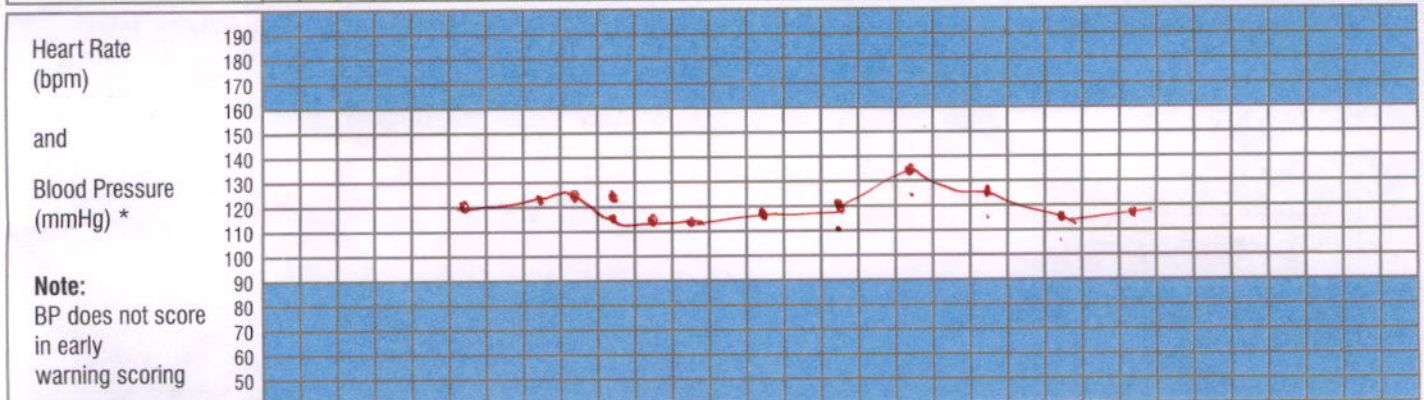
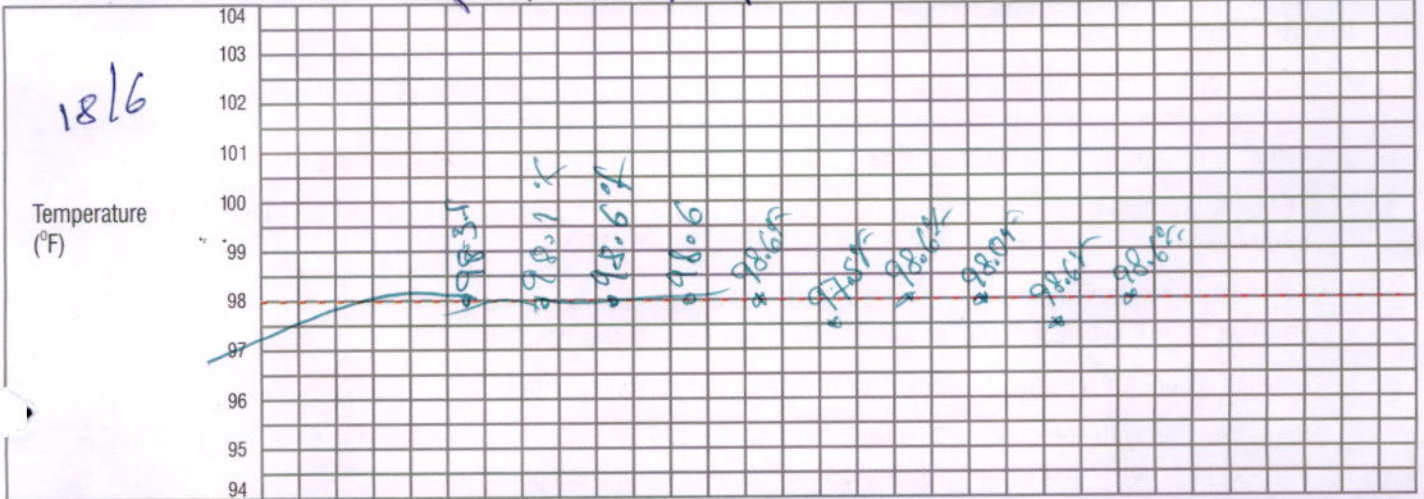
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



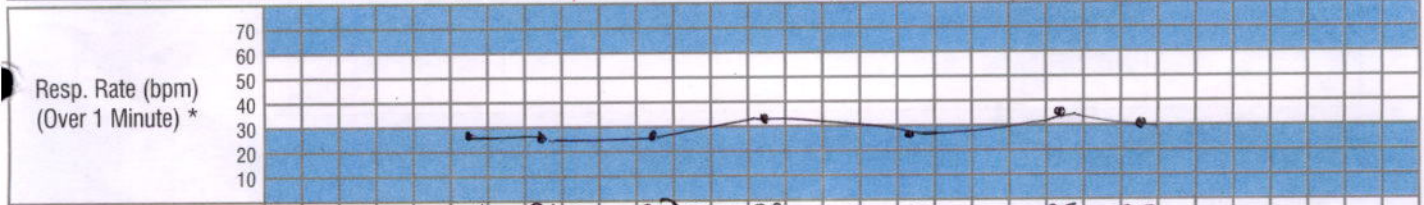
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 1 3 5 7 9 11 2 4 6 8

Doctor/Nurse/Family Concern? *pn pm pm pm pm pm pm pm pm pm*



Heart Rate (Number) *120 125 125 115 115 120 120 135 125 115 120*



Resp Rate (Number) *25 26 27 32 27 35 30*

Resp Distress | Mod/ Severe | None / Mild

Receiving O₂ (l/min) | O₂ Saturations (%)

0 0 0 0 0 0 0 0 0 0

Conscious Level | Normal | Altered

N N N N N N N N

GCS * *15 15 15 15 15 15 15 15*

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

Pain Score *0 0 0 0 0 0 0 0*

Observer's Initials *SK SK SK SK SK SK*

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 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

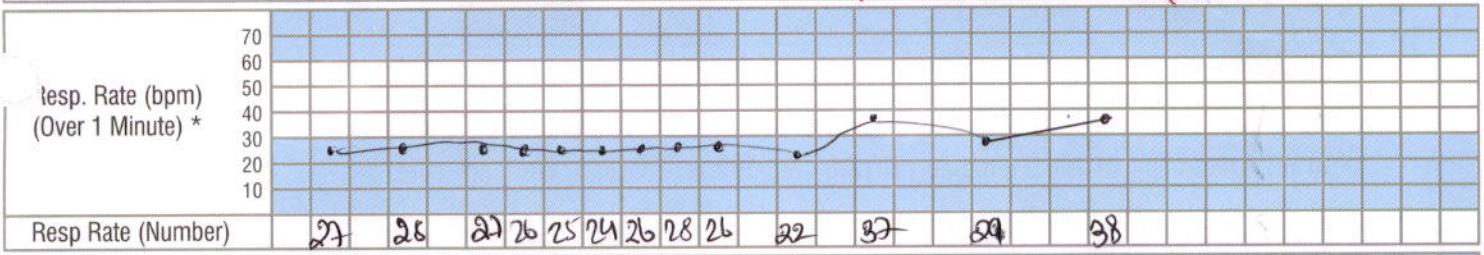
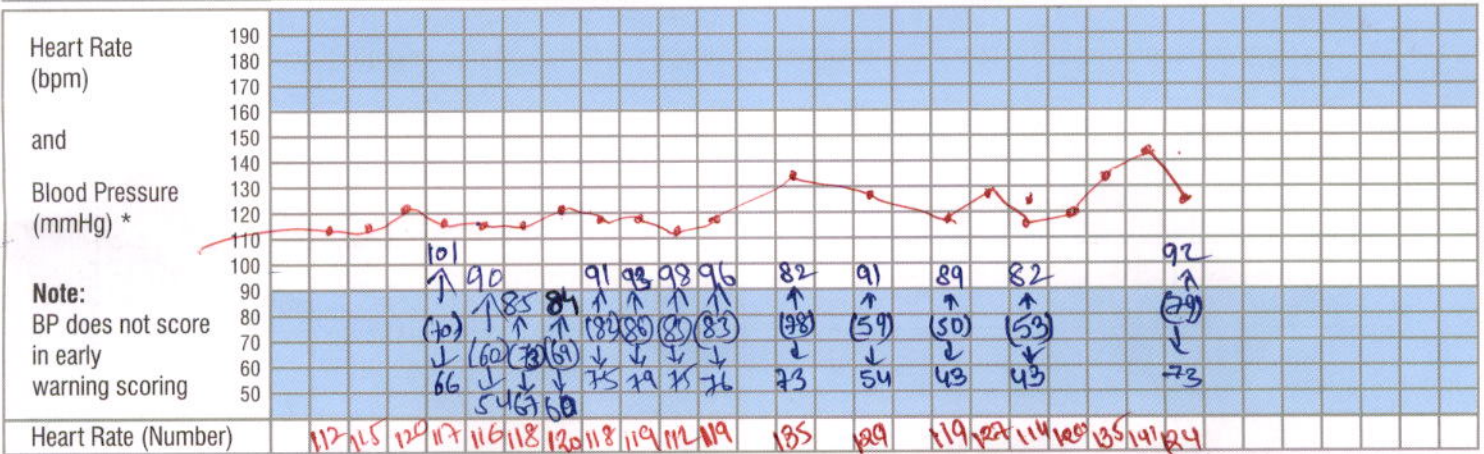
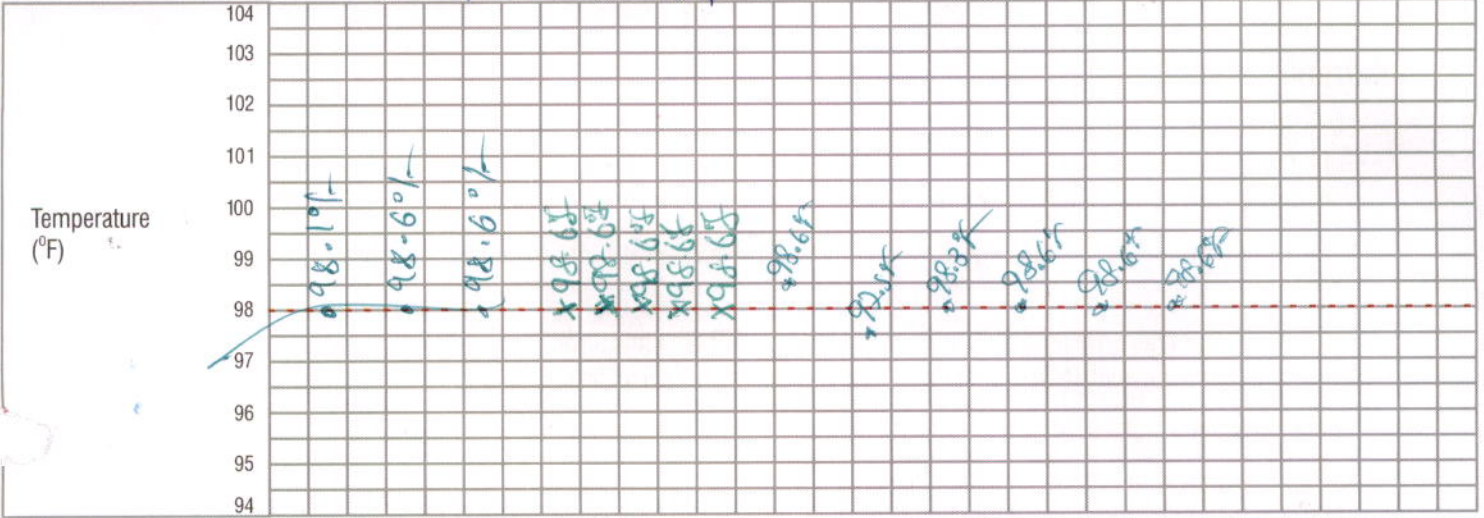
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/6/25 Time: 9 11 12 1 2 3 4 5 6 7 10 12 2 4 6 7

Doctor/Nurse/Family Concern? Am Am pm pm pm pm pm pm pm pm pm Am Am Am Am Am Am



Resp Distress	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	97	98
Conscious Level	Normal	Altered
GCS *	15	15

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	SR

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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

* 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.
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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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VIH-00205825 IP-00060351
 Baby A.YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR



FLUID CHART

Sheet No. : 2

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			
16/7			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm		DBF										
	01:00 pm												
Total Intake :						Total Output :							
18/6	02:00 pm												
	03:00 pm		CEXAC							✓			
	04:00 pm												
	05:00 pm												
	06:00 pm		DBF							✓			
	07:00 pm												
	Total Intake :						Total Output :						
18/6	08:00 pm												
	09:00 pm		DBF										
	10:00 pm												
	11:00 pm		DBF							✓			
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
19/6/26	02:00 am		DBF										
	03:00 am												
	04:00 am		DBF							✓			
	05:00 am												
	06:00 am		DBF										
	07:00 am									✓			
	Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output stims

FLUID CHART

Sheet No. : 2

19/6/26

- 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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/6	08:00 am	Celac											
	09:00 am												
	10:00 am	DBM											
	11:00 am												
	12:00 pm	Celac											
	01:00 pm												
Total Intake :						Total Output :							
19/6	02:00 pm	DBM											
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
19/6	08:00 pm												
	09:00 pm	Khichdi											
	10:00 pm	water											
	11:00 pm												
	12:00 am	DBM											
	01:00 am												
Total Intake :						Total Output :							
20/6	02:00 am												
	03:00 am	DBM											
	04:00 am												
	05:00 am	DBM											
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output 5 times

BIO A. Yashna Sai
 Patient Sticker
 VHM - 00205925



FLUID CHART

Sheet No. :

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

Date	Time	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		DBM										
	10:00 am												
	11:00 am		DBM										
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

B

Benarice

2016

@10am

Noted by

Benarice

2016

@10am

VIH-00205925 IP-00060351
 Baby A. YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR



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: ICU Shifted to: ICU

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						<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. Sameera / [Signature]

Date & Time : 15/6/26 @ 9:30u

Nurse Name & Signature: Durgam / [Signature]

Date & Time : 15/6/26 @ 3:30 m.

MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: picu Shifted to: 1st floor

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	INJ CEFTRIAZONE	250mg	IV	12 hr HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	TAB ASPIRIN (75mg)	4ml	PO	ONCE DAILY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	INJ METHYL PREDNISOLONE	12mg	IV	ONCE DAILY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	SYRUP CALCIUM PLUS	3ml	PO	12 hr HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	SYRUP LEVO CARNITINE	1.5ml	PO	8 hr HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
6	TAB SPIRONOLACTONE	1/4 hr (2.5ml)	PO	12 hr HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
7	TAB LISTRIL	1/5 hr (1ml)	PO	12 HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
8	NEXPRO SACHET	1/2 SACHET (7.5ml)	PO	ONCE DAILY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
9	FUROSED DROPS	0.5ml	PO	TWICE DAILY		<input checked="" 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 Swadey

Date & Time: 18/6/2026 11.30 AM

Nurse Name & Signature: Rajeshwari

Date & Time: 18/6/26 @ 1pm

VIH-00205925 IP-00060351
 Baby A YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)

Patient Name **Dr. PREETHAM KUMAR** I.P. No. Sheet No. **1** Wards **PIW** Weight (kg) **5.7kg**

REGULAR PRESCRIPTIONS

DRUG : TAB. ASPIRIN 75mg

Date/Time	Dose	Route	Frequency	Start Dt.
15/6	30mg	PO	ONCE DAILY	15/6
16/6				
17/6				
18/6				

Name & Signature of the Doctor starting the Drugs: *Dr. Jayaraj*

Additional Instructions: *1 TAB LET TO dilute in 10ml water give (4mg) Singly kg base*

Daily Doctor's Endorsement by a Sign. *[Signature]*

DRUG : SYR. CALUMAX PROS

Date/Time	Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs: *Dr. Jayaraj*

Additional Instructions: *5ml = 90 mg Ca⁺⁺*

Daily Doctor's Endorsement by a Sign. *[Signature]*

DRUG : TAB. METAL PREDNISOLONE

Date/Time	Dose	Route	Frequency	Start Dt.
16/6	12mg	SV	ONCE DAILY	16/6
17/6				
18/6				
19/6				
20/6				

Name & Signature of the Doctor starting the Drugs: *Dr. Jayaraj*

Additional Instructions: *To dilute in 10ml, give in 10am, 2mg/kg/day DOR*

Daily Doctor's Endorsement by a Sign. *[Signature]*

DRUG : TAB. THIAMINE

Date/Time	Dose	Route	Frequency	Start Dt.
16/6	50mg	IV	ONCE DAILY	16/6
17/6				
18/6				
19/6				
20/6				

Name & Signature of the Doctor starting the Drugs: *Dr. Jayaraj (x3dm)*

Additional Instructions: *dilute in 10ml, give over 1 hour*

Daily Doctor's Endorsement by a Sign. *[Signature]*

15/6/26 6.30pm
 Eligible
 16/6/26 6.30am
 Eligible
 17/6/26 6.30am
 Eligible

18/6/26 6.30am
 Eligible
 19/6/26 6.30am
 Eligible
 20/6/26 6.30am
 Eligible

VIH-00205925 IP-00060351
 Baby A.YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR

Ref. No. : F / HW / DC / RP / INPR / 05.a

I.P. No.	Sheet No. (2)	Wards (PICU)	Weight (kg) (5.7kg)
----------	---------------	--------------	---------------------

REGULAR PRESCRIPTIONS

DRUG : SYL-C ACCENTOP PLUS
 Date: 16/6, 17/6, 18/6, 19/6
 Time: 10 AM, 10 AM, 10 AM, 10 AM
 Dose: 3ml
 Route: PO
 Frequency: 12 hourly
 Start Dt: 16/6

Name & Signature of the Doctor starting the Drugs: Dr. Preetham Kumar

Additional Instructions: 5ml = 250mg (A-Case)
50 mg t.i.c. daily

Daily Doctor's Endorsement by a Sign.

DRUG : SYRUP CARBITONE
 Date: 17/6, 18/6, 19/6, 20/6
 Time: 6 AM, 6 AM, 6 AM, 6 AM
 Dose: 1.5ml
 Route: PO
 Frequency: 8 hourly
 Start Dt: 17/6

Name & Signature of the Doctor starting the Drugs: Dr. Preetham Kumar

Additional Instructions: 5ml = 500mg
2.5mg t.i.c. daily

Daily Doctor's Endorsement by a Sign.

DRUG : TAB. SPIRONOLACTONE
 Date: 17/6, 18/6, 19/6
 Time: 4 AM, 4 AM, 4 AM
 Dose: 1/TAB
 Route: PO
 Frequency: 12 hourly
 Start Dt: 17/6

Name & Signature of the Doctor starting the Drugs: Dr. Swamy, MD

Additional Instructions: 1 TAB = 25mg
DIL IN 10ML & give 2.5ml

Daily Doctor's Endorsement by a Sign.

DRUG : TAB LISTRIL
 Date: 18/6, 19/6, 20/6
 Time: 6 AM, 6 AM, 6 AM
 Dose: (1/5th)
 Route: PO
 Frequency: 12 hourly
 Start Dt: 18/6

Name & Signature of the Doctor starting the Drugs: Dr. Preetham Kumar

Additional Instructions: DIL IN 5ml.
9 1ml

Daily Doctor's Endorsement by a Sign.

16/6/26 9:30 AM Dr. Preetham Kumar
 17/6/26 12:30 PM Dr. Preetham Kumar
 18/6/26 12:30 PM Dr. Preetham Kumar

5925 IP-00060351
 RASHNA SRI
 025 0 Y 11 M 6 D (F)
 BETHAM KUMAR

Ref. No.: F / HW / DC / RP / INPR / 05.a

I.P. No. 60351
 Sheet No. (3)
 Wards PICU
 Weight (kg) 50.7 kg

REGULAR PRESCRIPTIONS

DRUG: TAB. *[Handwritten]*

Dose	Route	Frequency	Start Dt.	Date	Time

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG: NEXPRO SACHET

Dose	Route	Frequency	Start Dt.	Date	Time
1/2 sachet	PO	ONCE DAILY	18/6/26	18/6	20/6

Name & Signature of the Doctor starting the Drugs: Dr. Sreejith

Additional Instructions: 1 sachet = 10mg. MIX WITH 15ml of DW (Distilled water), give 7.5ml

Daily Doctor's Endorsement by a Sign.

DRUG: FURONED DROPS

Dose	Route	Frequency	Start Dt.	Date	Time
0.5ml	PO	TWICE DAILY	18/6/2026	18/6	19/6

Name & Signature of the Doctor starting the Drugs: Dr. Sreejith

Additional Instructions: 1ml = 10mg @ 1mg/kg/day

Daily Doctor's Endorsement by a Sign.

DRUG: TAB. MINILACTONE

Dose	Route	Frequency	Start Dt.	Date	Time
1/4 tab	PO	12 hrly	20/6		

Name & Signature of the Doctor starting the Drugs: Dr. Sameera

Additional Instructions: FUROSEMIDE (20mg) + SPIRONOLACTONE (25mg)

Daily Doctor's Endorsement by a Sign.

Rain
Child
Hosp

VH-00205925 IP-00060351
Baby A.YASHNA SRI
12-07-2025 0 Y 11 M 7 D (F)
Dr. PREETHAM KUMAR

Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient	I.P. No.	Sheet No.	Wards	Weight (kg)
---------	----------	-----------	-------	-------------

REGULAR PRESCRIPTIONS

DRUG : TAB CARVIDOLOL				Date Time	19/6
Dose	Route	Frequency	Start Dt.		
1/4 tab	PO	12 th hrly	19/6		
Name & Signature of the Doctor starting the Drugs: Dr. Sameera. Sameera				10 AM	10 PM
Additional Instructions: (3.125mg)					
Daily Doctor's Endorsement by a Sign.					

Dr. Sameera

DRUG : TAB ASPIRIN (75mg)				Date Time	19/6
Dose	Route	Frequency	Start Dt.		
25mg	PO	ONCE DAILY	19/6		
Name & Signature of the Doctor starting the Drugs: Dr. Sameera. Sameera				6 AM	6 PM
Additional Instructions: Take Dilate 75mg tab in 5ml DW & give after food 1.5ml					
Daily Doctor's Endorsement by a Sign.					

Dr. Sameera

DRUG : TAB THIAMINE (100mg)				Date Time	19/6
Dose	Route	Frequency	Start Dt.		
1/2 tab	PO	ONCE DAILY	19/6		
Name & Signature of the Doctor starting the Drugs: Dr. Sameera. Sameera				2 PM	2 PM
Additional Instructions:					
Daily Doctor's Endorsement by a Sign.					

Dr. Sameera

DRUG : NASOCLEAR NASAL DROPS				Date Time	19/6 20/6
Dose	Route	Frequency	Start Dt.		
2 drop	PN	6 HOURS	19/6	6 AM	6 PM
Name & Signature of the Doctor starting the Drugs: Dr. Swati, Swati					
Additional Instructions:				6 PM	6 PM
Daily Doctor's Endorsement by a Sign.					

Swati 19/6/26



I.V. FLUIDS CHART

Weight. 5.7kg Ward. P/W

Signature
VERIFIED BY : Name

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/6	4pm	IV DNS C/2 maintained	IV	11		Rindal Seth	15/6		Sapira Mela
15/6	9 PM	2NF DNS	IV	5		Sapira Mela	16/6/2026		
15/6	8:30 AM	2NF DNS + 5ml Kcl	IV	5			17/6		
17/6	2:30 AM	IVF DNS	IV	5	San.	Sushma Jagan	17/6/24		Sushma Jagan
17/6/24	12:30 PM	IVF DNS	IV	2		Sushma Jagan	18/6/24		

REGULAR PRESCRIPTIONS

Weight. 5.7kg Ward. P1.W

DRUG: INJ. CEFTRIAXONE Date/Time: 15/6 16/6 17/6 18/6 19/6 20/6

Dose	Route	Frequency	Start Date
<u>250mg</u>	<u>IV</u>	<u>12th hly</u>	<u>15/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: for 10ml
50mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: INJ. DANIAPRAZOLE Date/Time: 15/6 16/6 17/6 18/6

Dose	Route	Frequency	Start Date
<u>6mg</u>	<u>IV</u>	<u>24th hly</u>	<u>15/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: 1mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: INJ. FUROSEMIDE Date/Time: 16/6 17/6 18/6

Dose	Route	Frequency	Start Date
<u>5mg</u>	<u>IV</u>	<u>12th hly</u>	<u>15/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: 1mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: TAB. ASPIREN 75mg Date/Time: 15/6

Dose	Route	Frequency	Start Date
<u>29mg</u>	<u>PO</u>	<u>once daily</u>	<u>15/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: to dilute in 10ml and give 3ml
Anti platelet dose
5mg/kg/dose OD

Daily Doctor's Endorsement by a Sign

15/06/26
 15/06/26
 15/6/26
 15/6/26
 15/6/26

Baby A. YASHNA SRI
12-07-2025 0 Y 11 M 3 D (F)
Dr. PREETHAM KUMAR



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/6/26		INJ. THIAMINE	50mg in 10ml 5% Dextrose over 1/2 hr.	IV	[Signature]	
15/6/26	3.25 PM	INJ. FUROSEMIDE	6mg	IV	[Signature]	Rajitha, Srujanika
15/6/26	4.40 PM	INJ. THIAMINE	50 mg in 10ml 5% Dextrose 30mins	IV	[Signature]	Sushanta, [Signature]
20/6/26	AM	FUROPED DROP	0.5ml	PO	[Signature]	[Signature]
20/6/26	AM	TAB SPIRONOLACTONE	1/4th TAB	PO	[Signature]	[Signature]

Signature
VERIFIED BY: [Signature]

VH-00205925 IP-0060351
 Baby A.YASHNA SRI 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR

Ref. No. : F / ICU / INO / VAS /

IV INFUSION MEDICATION CHART (INOTROPES & VASOPRESSORS)

(All the drugs in this category belong to "High Risk / High Alert" medicines. Please watch for tachycardia / bradycardia, hypertension / hypotension any cardiac arrhythmia, patency of IV line, status of skin at IV site and color and perfusion of the fingers and toes while administering these drugs)

Rainbow Childre Hospital
 It takes a lot to treat the little.

BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Patient Name : Baby. A. yashna Sri Age : 11m Gender : M F
 Weight : 5.7kg I.P. No. : 60351 Sheet No. : ①

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.
15/6/26	4 P.M.	MILRINONE INFUSION	8.5mg in 50ml of 5% DEXTROSE	0.6ml/hr - 1.5ml/hr (0.3mcg/kg/min - 0.75mcg/kg/min)	<i>[Signature]</i>	<i>[Signature]</i>	17/6	<i>[Signature]</i>	<i>[Signature]</i>
		MILRINONE INFUSION (PERIPHERAL DILUTION)	4.3ml in 50ml of 5% DEXTROSE	1.2ml/hr - 3ml/hr (0.3mcg/kg/min - 0.75mcg/kg/min)			17/6		
15/6	6 AM	MILRINONE INFUSION	8.5mg in 50ml of 5% DEXTROSE	0.5ml/hr - 1.0ml/hr (0.25mcg/kg/min)	<i>[Signature]</i>	<i>[Signature]</i>	18/6	<i>[Signature]</i>	<i>[Signature]</i>

Do Not Delete

CALCULATIONS FOR SOME COMMONLY USED DRUGS:

Dopamine : Wt. x 30 mg in 50ml of 5% Dextrose ; 0.5 - 1ml/hr - 5-10mcg/kg/min
Dobutamine : Wt X 30mg in 50ml of 5 Percent Dextrose 0.5-1ml/hr; 5-10 mcg/kg/min
Epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 0.1-0.5mcg/kg/min - 1-5ml/hr
Nor-epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 1-5ml.hr - 0.1-0.5mcg/kg/min

Milrinone : Wt. X 1.5mg in 50ml of 5% Dextrose ; 1ml/hr - 1.5ml/hr - 0.5-0.75mcg/kg/min
Sodium Nitroprusside : 3mg/kg in 50ml D5 ; 0.5ml/hr - 4ml/hr (0.5-4mcg/kg/hr)
Nitroglycerine : 3ml/kg in 50ml D5 ; 0.5ml/hr - 5ml/hr (0.5-mcg/kg/min)
Labetalol : 0.25 - 3mg/kg/hr ; (1ml=5mg) ; take 2ml in 18ml NS(1ML-0.5 MG) 0.5- 1.5ml/kg/hr (0.25 - 3mg/kg/hr)

IV INFUSION MEDICATION CHART (SEDATION & PARALYTICS)

(All the drugs in this category belong to "High Risk / High Alert" medicines.

Please watch for bradycardia, hypotension and respiratory depression while administering these drugs)



Patient Name : Age : Gender : M F

Weight : I.P. No. : Sheet No. :

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.

CALCULATIONS FOR SOME COMMONLY USED DRUGS:

- Fentanyl** : 1ml = 50mcg vial, take 4ml in 16 ml NS thus 1ml = 10mcg ; 0.1-0.4 ml/kg/hr (1-4mcg/kg/hr)
- NOTE** : In older children more than 20kg weight, take 8ml in 12ml of NS thus 1ml=20 mcg;0.2-0.8ml/kg/hr (1-4 mcg/kg/hr)
- Midazolam** : (Undiluted) 1ml = 1mg ; 0.1-0.5 ml/kg/hr (1.6-8 mcg/kg/min)
- Ketamine** : Weight x 30 mg/kg in 50ml NS ; 1-4ml/hr (10-40mcg/kg/min)
- Dexmedetomidine** : 1ml (100mcg) in 24 ml NS ; 1ml = 4mcg ;0.05 -0.2 ml/kg/hr (0.2 - 0.7 mcg/kg/hr)

- Morphine** : Weight x 1 mg/kg in 50ml 5% Dextrose 1-3 ml/hr - 20-60 mcg/kg/hr
- Propofol** : 1ml = 10mg ; 0.1-0.4 ml/kg/hr (1-4mg/kg/hr)
- Vecuronium Powder** : 4mg, diluted with 4ml NS (1ml-1mg), take 2ml in 8ml NS (1ml-0.2mg) 0.25 ml/kg/hr - 1.3 ml/kg/hr (0.05-0.15mg/kg/hr)
- Pancuronium** : (1ml -2mg) take 1ml in 9ml NS(1ml-0.2mg) 0.1ml/kg/hr-0.3ml/kg/hr (0.02-0.06mg/kg/hr)

VIH-00205925 IP-00060351
 Baby A.YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR



RESULT SHEET

Date	15/6/26	16/6/26	16 17/6/26	18/6/26	20/6
Time	3:08 PM	6 AM	6 AM	5:09 AM	6:41 AM
Hb	11.0				
PCV	31.0				
RBC	4.13				
WBC	8.76				
N/L	22.8/69.2				
Platelets	430				
CRP	7				
ESR					
PCT					
RBS					
Na	142	141	143	141	139
K	5.2	3.6	4.3	4.0	4.7
Cl	107	100	98	95	96
Ca/Mg	10.6/2.3				
Phosphate	2.13				
Urea	25.5				
Creatinine	0.4				
ALP	2.13				
SGPT	26				
SGOT	51				
T.Bill/Conj	1.2 < 0.1 1.1				
T.Protein	6.4				
S.Albumin	4.4				
S.Globulin	2.0				
A/G Ratio	2				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
15/6/26						
Troponin I =>	0.474	(<0.034)				
NT proBNP =>	21200	(<300)				
TSH =>	2.56	(0.73 - 8.35)				
Thyroxine (T4) =>	9.19	(5.67 - 16)				
Triiodothyronine (T3) =>	147.9	(86 - 265)				

Culture and Sensitivities : 18.6.26 : Troponin I => 0.169 (<0.034)

NTPro BNP => 11900 (<300)

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

QRS : 74 ms
QT / QTcBaz : 398 / 581 ms
PR : - ms
P : - ms
RR / PP : 466 / 468 ms
P / QRS / T : - / 74 / -30 degrees

Sinus tachycardia with short PR
Left ventricular hypertrophy with repolarization abnormality
Abnormal ECG

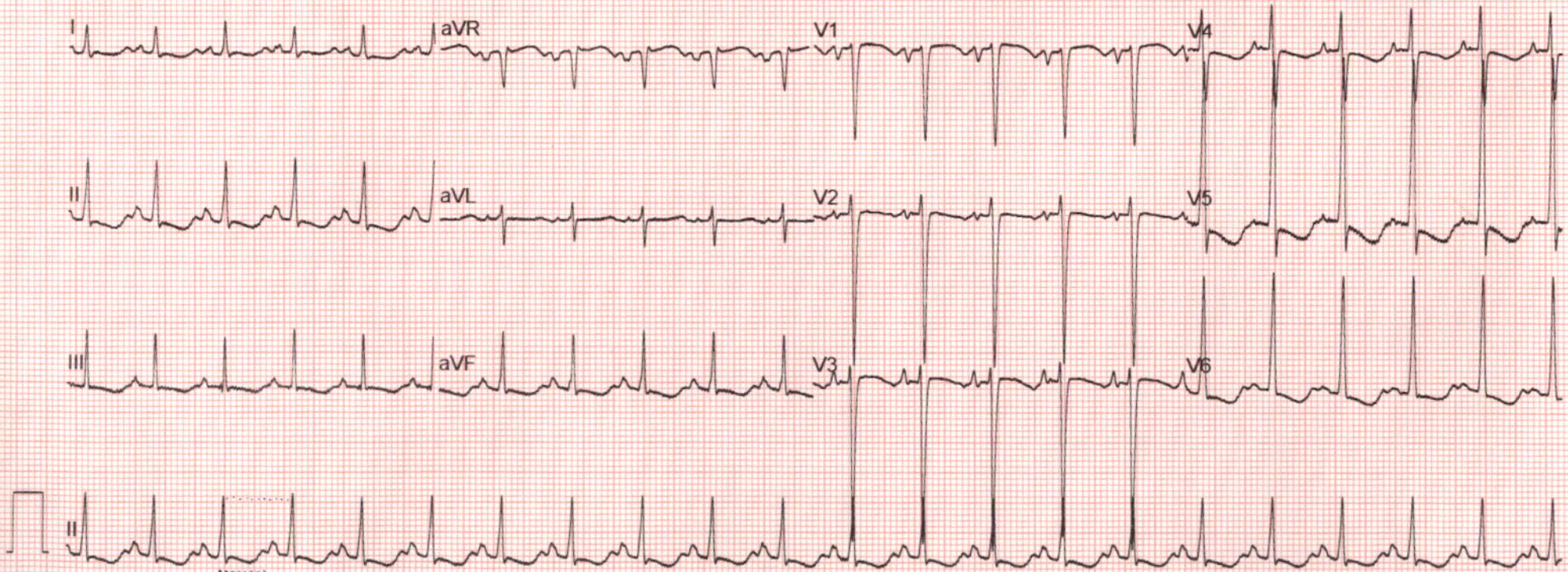
VIH-00205825 IP-00060351
Baby A.YASHNA SRI
12-07-2025 0 Y 11 M 5 D (F)
Dr. PREETHAM KUMAR



$$RR = 11 \text{ boxes} = 0.44 \text{ sec}$$

$$QT_c = 8 \text{ boxes} = 0.32 \text{ sec}$$

$$Q_E = \frac{0.32}{\sqrt{0.44}} = \frac{0.32}{0.66} = 0.48 = 480 \text{ ms (Prolonged)}$$



VIH-00205925 IP-00060351
 Baby A. YASHNA SRI
 12-07-2025 0 Y 11 M 3 D (F)
 Dr. PREETHAM KUMAR

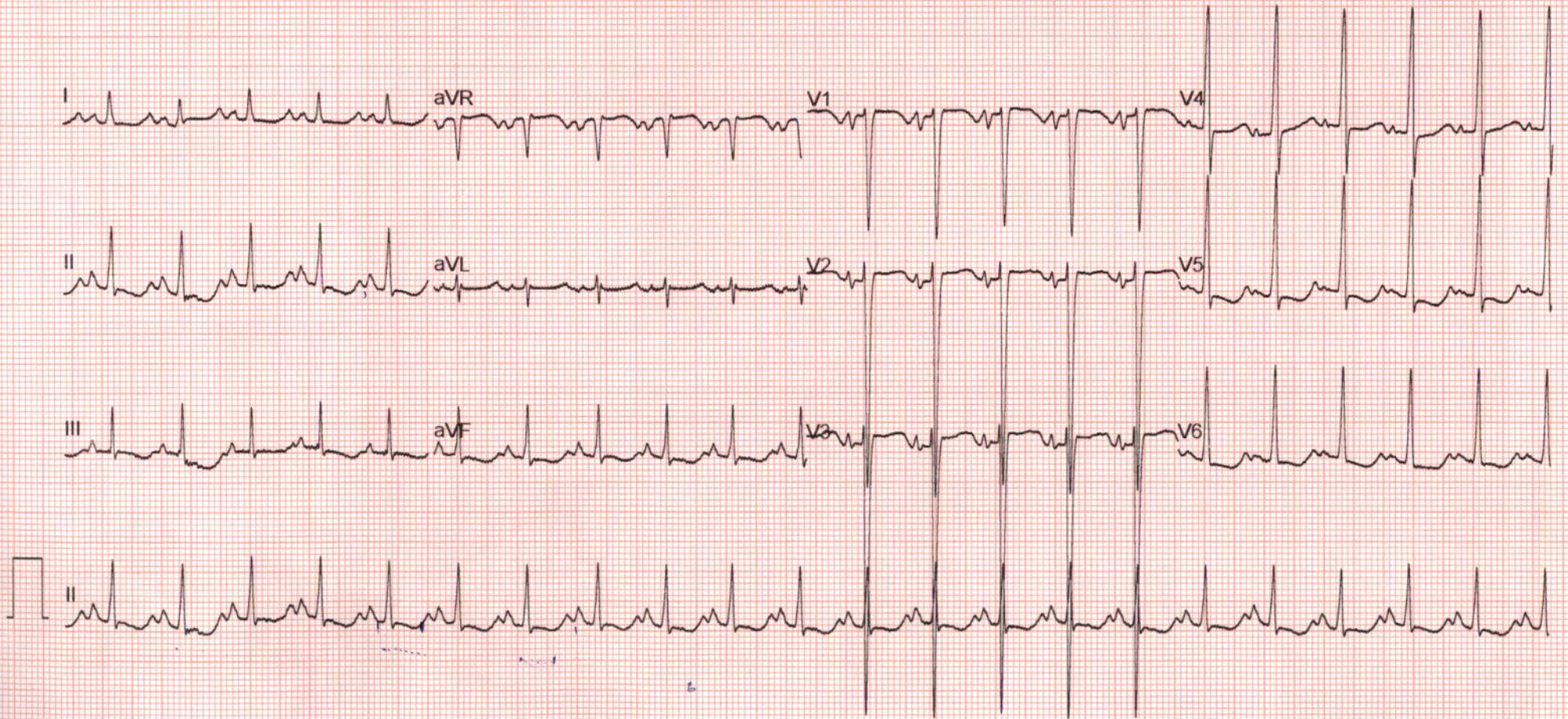


QRS : 74 ms
 QT / QTcBaz : 324 / 478 ms
 PR : 118 ms
 P : 84 ms
 RR / PP : 458 / 458 ms
 P / QRS / T : 58 / 70 / -51 degrees

Sinus tachycardia
 Right atrial enlargement
 Left ventricular hypertrophy with repolarization abnormality
 Abnormal ECG

$$Q_{Tc} = \frac{QT}{\sqrt{RR}} = \frac{324 \text{ ms}}{\sqrt{0.68}} = \frac{324}{0.82} = 395 \text{ ms} \quad (\text{N} : 440 - 460 \text{ ms})$$

↓
Borderline / Prolonged.





PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE

Name : **BABY.A YASHNA SRI VIH-00205925**
Age / Gender : 11M(s) / Female
Ref.By : DR PREETHAM KUMAR
Req.No : 26NRLH0221749
Sample Type : Serum

TID/SID : UMR4717740/ 32052898
Registered on : 16-Jun-2026 / 01:53 AM
Collected on : 16-Jun-2026 / 01:34 AM
Reported on : 17-Jun-2026 / 18:13 PM
Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

DEPARTMENT OF LCMS

1,25-Dihydroxy Vitamin D

Investigation	Observed Value	Biological Reference Interval
1, 25-Dihydroxy Vitamin D, Serum Method:LCMS-MS	52.52	19.9-79.3 pg/mL

Comment

1,25 dihydroxy Vitamin D is the major biologically active form of Vitamin D. Its concentration is only 1/1000 that of 25, hydroxyl Vitamin D and has half life of 5 to 6 hrs. Circulating levels are regulated by PTH, phosphate & calcium. While 1, 25-dihydroxy vitamin D is the most potent vitamin D metabolite, levels of the 25-OH forms of vitamin D more accurately reflect the body's vitamin D stores. However, in the presence of renal disease, 1, 25-dihydroxy vitamin D levels may be needed to adequately assess vitamin D status.

Uses

- Differentiation of Primary hyperparathyroidism from Hypercalcaemia of cancer
- Differentiation of Vitamin D dependent and Vitamin D resistant rickets
- Monitoring Vitamin D status in Chronic renal failure
- Assessing compliance of 1,25 dihydroxy Vitamin D therapy

Increased levels

- Granulomatous disease
- Primary hyperparathyroidism
- Lymphoma
- 1,25 dihydroxy Vitamin D intoxication
- Vitamin D dependent Rickets type II

Decreased levels

- Renal failure
- Hyperphosphatemia
- Hypomagnesemia
- Hypoparathyroidism
- Pseudohypoparathyroidism
- Vitamin D dependent Rickets Type I
- Hypercalcemia of malignancy

* Sample processed at National Reference Laboratory, Tenet Diagnostics 54, Kineta Towers, Journalist Colony, Banjara Hills

--- End. Of Report ---



PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE



Name : **BABY.A YASHNA SRI VIH-00205925**

Age / Gender : 11M(s) / Female

Ref.By : DR PREETHAM KUMAR

Req.No : 26NRLH0221749

Sample Type :

TID/SID : UMR4717740/

Registered on : 16-Jun-2026 / 01:53 AM

Collected on :

Reported on :

Client Name : RAINBOW CHILDREN

TEST REPORT

HOSPITAL - S

Dr Afreen Anwar
Consultant Biochemist
Regd No: 65041



Name : **BABY.A YASHNA SRI VIH-00205925**

Age / Gender : 11M(s) / Female

Ref.By : DR PREETHAM KUMAR

Req.No : 26NRLH0221749

Sample Type : Serum

TID/SID : UMR4717740/ 32052898

Registered on : 16-Jun-2026 / 01:53 AM

Collected on : 16-Jun-2026 / 01:34 AM

Reported on : 17-Jun-2026 / 18:13 PM

Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

DEPARTMENT OF LCMS

1,25-Dihydroxy Vitamin D

Investigation	Observed Value	Biological Reference Interval
1, 25-Dihydroxy Vitamin D, Serum Method:LCMS-MS	52.52	19.9-79.3 pg/mL

Comment

1,25 dihydroxy Vitamin D is the major biologically active form of Vitamin D. Its concentration is only 1/1000 that of 25, hydroxyl Vitamin D and has half life of 5 to 6 hrs. Circulating levels are regulated by PTH, phosphate & calcium. While 1, 25-dihydroxy vitamin D is the most potent vitamin D metabolite, levels of the 25-OH forms of vitamin D more accurately reflect the body's vitamin D stores. However, in the presence of renal disease, 1, 25-dihydroxy vitamin D levels may be needed to adequately assess vitamin D status.

Uses

- Differentiation of Primary hyperparathyroidism from Hypercalcaemia of cancer
- Differentiation of Vitamin D dependent and Vitamin D resistant rickets
- Monitoring Vitamin D status in Chronic renal failure
- Assessing compliance of 1,25 dihydroxy Vitamin D therapy

Increased levels

- Granulomatous disease
- Primary hyperparathyroidism
- Lymphoma
- 1,25 dihydroxy Vitamin D intoxication
- Vitamin D dependent Rickets type II

Decreased levels

- Renal failure
- Hyperphosphatemia
- Hypomagnesemia
- Hypoparathyroidism
- Pseudohypoparathyroidism
- Vitamin D dependent Rickets Type I
- Hypercalcemia of malignancy

* Sample processed at National Reference Laboratory, Tenet Diagnostics 54, Kineta Towers, Journalist Colony, Banjara Hills

--- End Of Report ---





PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE

Name : **BABY.A YASHNA SRI VIH-00205925**
Age / Gender : 11M(s) / Female
Ref.By : DR PREETHAM KUMAR
Req.No : 26NRLH0221749
Sample Type :

TID/SID : UMR4717740/
Registered on : 16-Jun-2026 / 01:53 AM
Collected on :
Reported on :
Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

Dr Afreen Anwar
Consultant Biochemist
Regd No: 65041



M

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 15/6/25 Time: 2:30 PM

Weight: 5.7 kgs Centile: < 5 Centile

Height: Centile:

Inference: Underweight

RDA: 900 kcal Calories: 900 kcal Protein: 15-20 gm/day

Diet Recommendations: on call

Re-Assessment: Formula feed

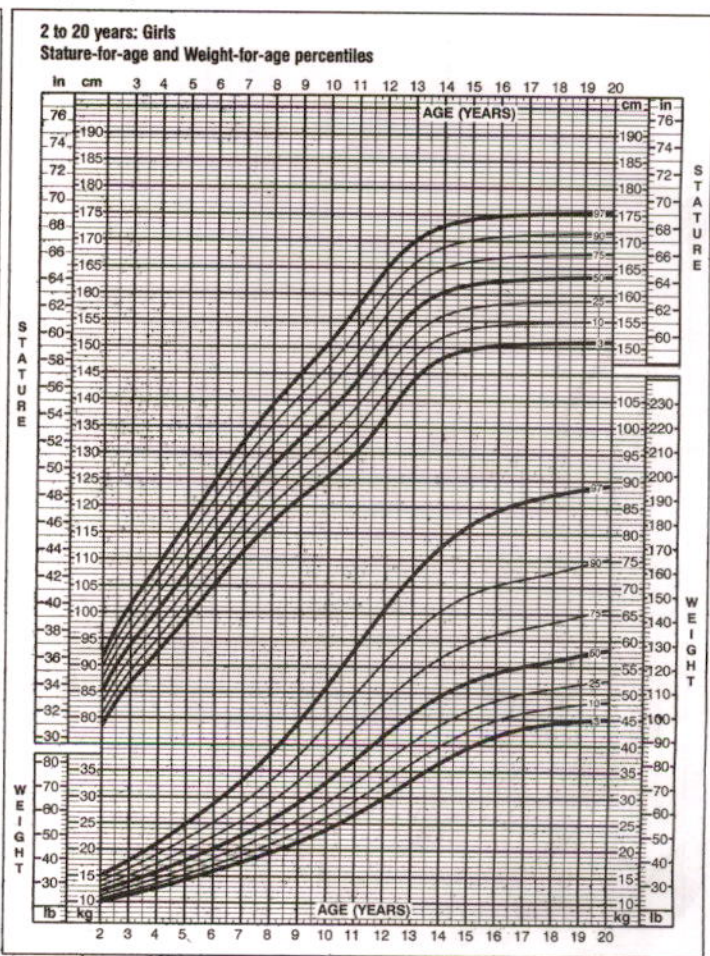
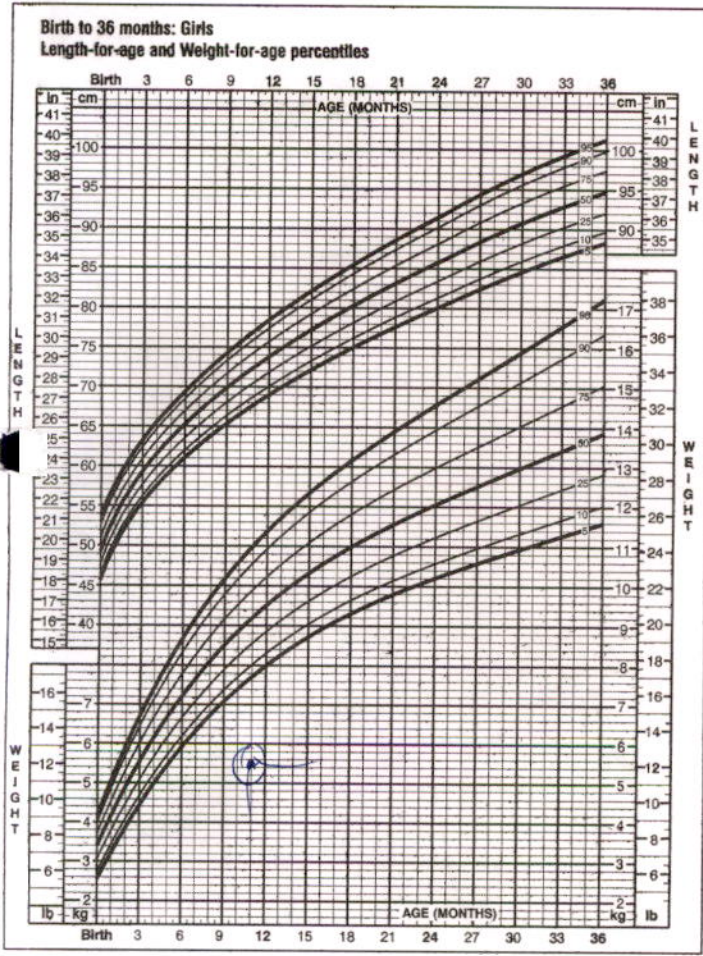
Food Allergies: Nil Veg/Non-veg: Vegetarian

Diagnosis: Post-viral myocarditis

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: (mother)

GROWTH CHART (GIRLS)



Dietician's Name: Zolera

Dietician's Signature: Zolera

