

Tata AIG Group Medicare



WITH YOU ALWAYS

**Name:** Venkata Rithwik

**Age:** 0

**Policy No:** 0239891162

**DOB:** 17-02-2025

**Member Id:** 500000175721

**Gender:** Male

**Policy Period:** 13-02-2026 - 12-02-2027

**Organisation:** SOUTHERN POWER DISTRIBUTION COMPANY OF ANDHRA PRADESH LIMITED



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Tata AIG General Insurance Company Limited,  
TAGIC Health Claims, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,  
616, Ameerpet, Hyderabad - 500016, Telangana.

క్రమ సంఖ్య 1  
S.No.1



ఆంధ్రప్రదేశ్ ప్రభుత్వం

GOVERNMENT OF ANDHRA PRADESH  
DEPARTMENT OF HEALTH, MEDICAL AND FAMILY WELFARE  
మునిసిపల్ కార్పొరేషన్ నెల్లూరు  
MUNICIPAL CORPORATION NELLORE

ఫా-రెము. 5  
FORM5



జనన ధృవీకరణ పత్రము  
BIRTH CERTIFICATE

(జనన & మరణాల నమోదు చట్టం, 1969, సెక్షన్ 12/17 ప్రకారము మరియు 8/13 ఆంధ్రప్రదేశ్ జనన & మరణాల నమోదు నిబంధనలు, 1999 క్రింద జారీ చేయబడినది)  
(ISSUED UNDER SECTION 12/17 OF THE REGISTRATION OF BIRTHS AND DEATHS ACT, 1969 AND RULE 8/13 OF THE ANDHRA PRADESH REGISTRATION OF BIRTHS & DEATHS RULES 1999)

ఈ క్రింది నమోదారుణ భారతదేశము, ఆంధ్రప్రదేశ్ రాష్ట్రము/కిం. ప్రా. శ్రీ పొట్టి శ్రీరాములు నెల్లూరు జిల్లా నెల్లూరు మండలము/బ్లాకు మునిసిపల్ కార్పొరేషన్ నెల్లూరు జనన మరణాల రిజిస్టరులోని జననానికి సంబంధించిన ఆసలు రికార్డు నుండి తీసుకొనబడినదని ధృవీకరించడమైనది.

THIS IS TO CERTIFY THAT THE FOLLOWING INFORMATION HAS BEEN TAKEN FROM THE ORIGINAL RECORD OF BIRTH WHICH IS THE REGISTER FOR MUNICIPAL CORPORATION NELLORE OF TAHSIL/BLOCK NELLORE OF DISTRICT SRI POTTI SRIRAMULU NELLORE OF STATE/UNION TERRITORY OF ANDHRA PRADESH, INDIA

నామ / NAME: ANDE VENKATA RITHWIK

లింగము / SEX: MALE

అధార్ సంఖ్య / AADHAAR NUMBER:

పుట్టిన తేదీ / DATE OF BIRTH:

17-02-2025 1:40 PM

SEVENTEENTH-FEBRUARY-TWO THOUSAND TWENTY FIVE

పుట్టిన స్థలం / PLACE OF BIRTH:

DR.MADHU LATHA (BHASKAR REDDY HOSPITAL)NELLORE, NELLORE, NELLORE, SRI POTTI SRIRAMULU NELLORE, ANDHRA PRADESH

అమ్మ పేరు / NAME OF MOTHER:

NANDAM SOWMYA

తండ్రి పేరు / NAME OF FATHER:

ANDE SREEKANTH

అమ్మ యొక్క అధార్ సంఖ్య / AADHAAR NUMBER OF MOTHER:

XXXX-XXXX-8208

తండ్రి యొక్క అధార్ సంఖ్య / AADHAAR NUMBER OF FATHER:

XXXX-XXXX-7782

బిడ్డ పుట్టిన సమయంలో తల్లిదండ్రుల నివాసము / ADDRESS OF PARENTS AT THE TIME OF BIRTH OF THE CHILD:

MAIN ROAD, PEDAPUTHEDU, DAGADARTHI, SRI POTTI SRIRAMULU NELLORE, ANDHRA PRADESH, 524317

తల్లిదండ్రుల శాశ్వత నివాసము / PERMANENT ADDRESS OF PARENTS:

MAIN ROAD, PEDAPUTHEDU, DAGADARTHI, SRI POTTI SRIRAMULU NELLORE, ANDHRA PRADESH, 524317

రిజిస్ట్రేషన్ సంఖ్య / REGISTRATION NUMBER:

B202528900540002224

నమోదు తేదీ / DATE OF REGISTRATION:

28-02-2025

మూర్ఖులు (ఏదైనా ఉంటే) / REMARKS (IF ANY):

APPROVED

జారీ చేసిన తేదీ / DATE OF ISSUE:

18-09-2025

Updated On : 18-09-2025 16:20:20



'This QR code can be used to check the authenticity of the certificate'

జారీ చేసిన అధికారి సంతకము / SIGNATURE OF ISSUING AUTHORITY :

రిజిస్ట్రార్ (జననం & మరణం)  
Registrar (BIRTH & DEATH)

మునిసిపల్ కార్పొరేషన్ నెల్లూరు  
MUNICIPAL CORPORATION NELLORE

"ప్రతి జననం మరియు మరణం యొక్క నమోదును నిర్ధారించుకోండి / ENSURE REGISTRATION OF EVERY BIRTH AND DEATH"



**భారత ప్రభుత్వము**  
**Government of India**

**భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ**  
**Unique Identification Authority of India**

రిజిస్ట్రేషన్ సంఖ్య / Enrollment No.: 2710/02374/45826

To  
అందే శ్రీకాంత్  
Ande Sreekanth  
C/O: Ande Vijay,  
main road,  
VTC: Pedaputhedu,  
PO: Peddaputtedu,  
Sub District: Dagadarthi, District: Nellore,  
State: Andhra Pradesh,  
PIN Code: 524317,  
Mobile: 9912277543

38785221



మీ ఆధార్ సంఖ్య / Your Aadhaar No. :

**3339 7754 7782**

నా ఆధార్, నా గుర్తింపు



భారత ప్రభుత్వము  
Government of India



అందే శ్రీకాంత్  
Ande Sreekanth  
పుట్టిన తేదీ / DOB : 05/01/1994  
పురుషుడు / Male

Issue Date : 26/01/2012

**3339 7754 7782**

నా ఆధార్, నా గుర్తింపు

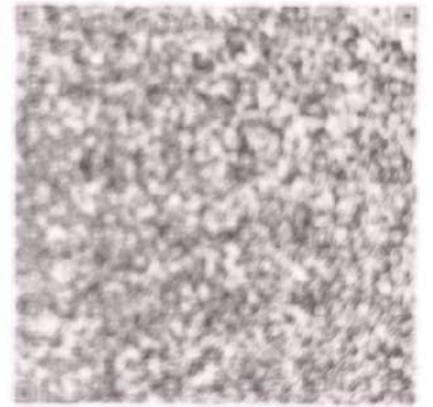
आयकर विभाग  
INCOME TAX DEPARTMENT



भारत सरकार  
GOVT. OF INDIA



स्थायी लेखा संख्या कार्ड  
Permanent Account Number Card  
NGJPS3584K



नाम / Name

**ANDE SREEKANTH**

पिता का नाम / Father's Name

**ANDE VIJAY**

जन्म की तारीख / Date of Birth

**05/01/1994**

*A. Sreekanth*

हस्ताक्षर / Signature

44833

Annexure A1

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Related Person



Important Instructions:

- A) Fields marked with "\*" are mandatory fields.
- B) Tick "✓" wherever applicable.
- C) Please fill the form in English and in BLOCK letters.
- D) Please fill the date in DD-MM-YYYY format.
- E) For particular section update, please tick (✓) in the box section number and strike off the sections not required to be updated
- F) Please read section wise detailed guidelines / instructions at the end.
- G) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
- H) List of two character ISO 3166 country codes is available at the end.
- I) KYC number of applicant is mandatory for update application.

For office use only Application Type\*  New  Update  Delete  
 (To be filled by financial institution) KYC Number  (Mandatory for KYC update request)

1. DETAILS OF RELATED PERSON (Please refer instruction D & E at the end)

Addition of Related Person  Deletion of Related Person  Updation KYC Number of Related Person (if available\*)

Related Person Type\*  Guardian of Minor  Assignee  Authorized Representative

Name\* Prefix First Name Middle Name Last Name  
 Ande SRI KANTH

(If KYC number and name are provided, below details are optional)

Maiden Name  
 Father / Spouse Name Ande SRI KANTH  
 Mother Name Sowmya  
 Date of Birth\* 05-01-1994  
 Gender\*  M- Male  F- Female  T- Transgender  
 PAN\* NGJPS3584K  Form 60 furnished

2. PROOF OF IDENTITY AND ADDRESS\*

I Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- A- Passport Number
- B- Voter ID Card
- C- Driving Licence
- D- NREGA Job Card
- E- National Population Register Letter
- F- Proof of Possession of Aadhaar
- II  E-KYC Authentication
- III  Offline verification of Aadhaar



Address

Line 1\* Pedaputhedu (vi)  
 Line 2 Dagadarthi (M)  
 Line 3 Nellore (Di)  
 District\* Pin / Post Code\* 524317 City / Town / Village\* State / U.T Code\* ISO 3166 Country Code\*

3. CURRENT ADDRESS DETAILS (Please refer instruction B at the end)

Same as above mentioned address (In such cases address details as below need not be provided)

I Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- A- Passport Number
- B- Voter ID Card
- C- Driving Licence
- D- NREGA Job Card
- E- National Population Register Letter
- F- Proof of Possession of Aadhaar
- II  E-KYC Authentication
- III  Offline verification of Aadhaar
- IV  Deemed Proof of Address - Document Type code
- V  Self Declaration

Address  
 Line 1\*  
 Line 2  
 Line 3  
 District\*      Pin / Post Code\*      City / Town / Village\*      State / U.T Code\*      ISO 3166 Country Code\*

4. CONTACT DETAILS

Tel. (Off)      Tel. (Res)      Mobile  
 Email ID

5. REMARKS (if any)

6. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

*A. Lakshmi*

Date: 26-06-2026      Place: Gindrey

Signature /Thumb Impression of Applicant

7. ATTESTATION / FOR OFFICE USE ONLY

- Documents Received       Certified Copies       E-KYC data received from UIDAI       Data received from Offline verification       Digital KYC Process  
 Equivalent e-document       Video Based KYC

KYC VERIFICATION CARRIED OUT BY

Date  
 Emp. Name  
 Emp. Code  
 Emp. Designation  
 Emp. Branch

INSTITUTION DETAILS

Name  
 Code

[Employee Signature]

[Institution Stamp]



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

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

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

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

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

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

GUC-00093101 IP18-00036205  
Baby VENKATA RITHWIK ANDE  
17-02-2025 1 Y 4 M 9 D (M)  
Dr. KARTHIK NARAYANAN R



## Pediatric Multiorgan History &amp; Physical Examination

Name: Venkata Ritvik Anil Age/Sex 1 yr 2 mths / BoyInformation given by: Mother Relationship \_\_\_\_\_Chief Presenting Complaints & Duration (Chronologically) Address - Nellore

## History of present illness :

c/o Runny nose x 3 days

c/o cough x 2 days. - wet - more since

yesterday - more in the evening. No post-tussive vomit  
comfortable at night. / ~~fever x 2 days~~ <sup>fever</sup> even after waking up

c/o fever x 2 days back for 1 day

Temp - ~~not recorded~~ 101°fc/o fast breathing & } 2 days  
chest indrawing } more since yesterdayOral intake red.Activity - good.

Patient Sticker

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

H/o ~~URI~~ URI → cough → distress - since 9 months of age - requiring Lowlin + Budecort inhalation on OP basis twice per month along w/ Prednisolone.

No h/o contact w/ TB

Birth & Neonatal History: Leaking PV

Term / LSCS / Bt.wt - 2.2 kgs  
CIAB / ~~NICU~~ NICU stays for observation 2-3 hrs

Family Chart



Birth & Socio Economic History:

About Father : Allergic rhinitis - to house dust.

About Mother :

Any additional Information :

Developmental History :

Dev. (N)

Immunization History :

Vaccinated upto date - NIS schedule

Anthropometry :

Head Circum (cms) 44.5 cm (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 9.2 kgs (Centile \_\_\_\_\_)

On Examination :

Temperature : 98.6°F Pulse Rate : 170/min B.P. \_\_\_\_\_ SPO2 89-90% RA

Resp. rate and type of breathing : 60/min via nasal prongs

Rash \_\_\_\_\_ Allt  
Lymphadenopathy \_\_\_\_\_ PPWF, CRT 2 sec  
Oedema : \_\_\_\_\_ WOB Ad.

Allergies (if any):

**Respiratory System :**

Inspection (any s/o distress) : mild SCR ⊕, SCR ⊕

Air entry & breath sounds : BL AE ⊕ - (R) AE ↓ed

Any added sounds : (R) crepts ⊕, no wheeze

Relevant data from outside (Chest X-Ray, ABG, etc..) CXR - BL hyperinflation ⊕  
(R) para cardiac infiltrate

**Cardiovascular System :**

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S<sub>2</sub> ⊕

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection : \_\_\_\_\_

Palpation : soft

Auscultation : \_\_\_\_\_

Spine : (R) External Genitalia : (N)

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

**Central Nervous System :**

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

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

**Motor System :**

Nutrition : (N)

bl Tone : (P) el Power > 3/5

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

Posture : (N)

Involuntary Movements : \_\_\_\_\_

Reflexes :

DTR

Plantars

Superficials:

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute exacerbation of wheeze

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBE

CRP, ESR

Sr-IgE

OT, PT

RFT

Mantoux ~~test~~

Dr. Virek for opinion

Planned Management

IVF

IV Hydrocort 5mg/kg - qoh.

Neb. Levolin q4h.

Signature of the Doctor: *[Signature]*

Name of the Doctor: Dr. Kaitha

Date & Time: 26/6/26

1:45pm

Signature of the Consultant: .....

Name of the Consultant: .....

Date & Time: ...

GUC-00003101 IP18-00036205  
 Baby VENKATA RITHWIK ANDE  
 17-02-2025 1 Y 4 M 9 D (M)  
 Dr. KARTHIK NARAYANAN R



# CROSS CONSULTATION FORM

Doctor Name: Dr. Vinck Date: 27/6/26 Time: 6.30 am

Diagnosis: .....

Hospital: .....

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for:  Opinion  Co-Management  Transfer of care

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

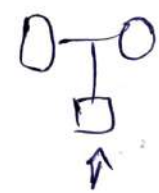
Signature: .....

**Findings and Recommendations :**

Thanks for Referral.

27/6/26  
 30 am

AUC ⊕  
 MSL ⊕ Eout MAS.



⊕ Post natal transition well till 9 months.

No Baseline retractions.

dad - IR ⊕

M/O recurrent viral triggered wheeze episodes - for the last 6 months  
 - Monthly episodes

- Diurnal variation ⊕ - more in the late evening.

→ Response to Nebbs ⊕

(P.T.O)

Consultant :

Name : .....

Signature : .....

Date & Time : .....

Wheezing qualifiers ⊕

No foreign body aspiration /  
no TB contact.

O/E - Throat ⊕

No clubbing

RR - 44-50/min

SCR ⊕.

HR - 130/min

6/c inspiratory crepts

polyphonic expi. wheeze.

marginally 2ed AE on ⊕ basal.

Labs - TC - 24k

N - 75

CRP ⊖

INC - 2

ALL - 2

Rest ⊕.

CXR - viral pattern.

Sr. IgE - 315

Mantoux - to be read tomorrow.

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# CROSS CONSULTATION FORM

Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

Referred for :  Opinion  Co-Management  Transfer of care

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

Assessment

Pre-school wheezer - under 5  
- Recurrent viral phenotype.  
- No atopy in father - AR (+).

Suggested

At the time of discharge -

1) BUDECORT MDI (100)  
1 - 0 - 1 x 12 wks

2) LEVOLIN MDI ~~50~~ (50) - 2 puffs - q4h

**Consultant :**

Name : ..... Signature : ..... Date & Time : ( 30s 3x5 days )

3) Triggers discussed

4) Technique to be checked before discharge - Huff puff kit.

5) If no improvement → review in 4 wks for further evaluation

6) If good improvement → review after 12 wks.

7) Parents counselled,



## PROGRESS NOTES AND DOCTOR'S ORDER

26/6/26  
 5:30

Date & Time	Progress Notes	Doctor's Order
	S/S pr. chandraloge.	
	child reviewed	
	no c/o fever.	
	c/o cough, rhinorrhoea ⊕	
	mild distress & subcostal retractions ⊕	
	RR - 38/min.	
	SpO <sub>2</sub> - 98.1RA.	
	O/E	
	Afebrile	
	CVS - S <sub>1</sub> S <sub>2</sub> ⊕	
	RS - R/LA ⊕	
	B/L wheezes, crepts ⊕	
	PIA - soft	
		Adv
		- monitor vitals
		- w/f Resp distress, tachypnea, desaturation
		- continue nebulizations + hydration
		- pulmonology opinion.
	<i>[Signature]</i>	
	19/12/24	

Patient Sticker



# PROGRESS NOTES AND DOCTOR'S ORDER

27/6/20  
10:20 AM

Date & Time	Progress Notes	Doctor's Order
	S/B dx chand mlegs	
	Acute exacerbation of wheezing, TLRTP	
	child reviewed	
	Alert, active	
	no cl/resp distress, tachypnea	
	no cl/bleed	
	mild subcostal retractions	
	OK	
	Afebrile	
	CVS-SIS ⊕	
	RS-B/LBE ⊕	
	R/L inspiratory crepts	
	occasional wheezing	
	mild subcostal retraction	
	RR - 38/min	
	SpO <sub>2</sub> - 98% @ 2 L O <sub>2</sub>	
	p/A soft	
	<u>Adm:</u>	
	- monitor vitals	
	- nil resp distress, tachypnea	
	- Sy. Hydrocortisone 45mg to bid	
	- Neb Levalbuterol & Rudecort	
	- plan: taper oxygen support	
	- Monitor to lead down	

*[Signature]*

GUC-0003101 IP18-00036205  
 Baby VENKATA RITHVIK ANDE  
 17-02-2025 1 Y 4 M 9 D (M)  
 Dr. KARTHIK NARAYANAN R



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>27/6/2026</del>		

Dr. Karthik

Plan

- To wear off O<sub>2</sub>
- To continue I.V Hydrocortisone
- Mucolite sup  
1.0ml → 1.0ml x 5 days
- chest physiotherapy twice a day

Dr. Karthik  
 on 27/6/2025



**REGULAR PRESCRIPTIONS**

Weight 9.2 kg Ward .....

**DRUG :** Neb. LENSILIN

Dose	Route	Frequency	Start Date	Date Time
0.63mg	Neb	q4h	26/6/26	26/6/26 7/6 12PM / SA

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

Additional Instructions: 12PM / SA  
4PM / SA  
8PM / SA

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Neb. BUD ECORT

Dose	Route	Frequency	Start Date	Date Time
0.5mg	Neb	q12h	26/6/26	26/6/26 10AM / NB PSA

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

Additional Instructions: 10PM / SA  
PSA

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Inj. HYDROCORTISONE

Dose	Route	Frequency	Start Date	Date Time
45mg	IV	q6h	26/6/26	26/6/26 12AM / SA 3AM / SA 6PM / VB VR

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

Additional Instructions: 5mg/kg/dose q6h

**Daily Doctor's Endorsement by a Sign**

**DRUG :**

Dose	Route	Frequency	Start Date	Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**



402

Patient Name :

Registration No.



**NEBULISATION CHART**

Date	Time	Drug	Nurse	Parents Signature
24/6	4:00pm	Neb. levoflo	mfshq	[Signature]
	5:00pm	Neb. levoflo		
	7:00pm	Neb. Budecort		
24/6	3:00pm	Neb. levoflo		
	4:00pm	Neb. levoflo		
	5:00pm	Neb. levoflo		
	6:00pm	Neb. Budecort		
	7:00pm	Neb. levoflo		
	8:00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

# PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Karthik Narayanan

Date: 26/6/26

Type of Admission:  OPD  ER  Referral (if referral, Doctor's Name: \_\_\_\_\_)

Start Time of Assessment: 11:45 am

Weight: 9.2 kgs

Allergic History: \_\_\_\_\_

### Chief Complaints:

old flu cough/cold } x 2 days

Chest indrawing (+)  
Fast breathing

### Pediatric Assessment Triangle

A Appearance - TICLS Good

B Breathing

C Circulation

Normal  
 Abnormal

↑ WOB  
 ↓ WOB  
 Normal  
 Gasping / Apnea

Pallor   
 Cyanosis   
 Mottling   
 Bleeding

Initial Physiological Status:  Stable  Unstable

Life Threatening   
 Non Life Threatening

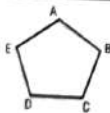
Any urgent interventions needed:  Yes  No  
 If Yes \_\_\_\_\_

Significant Past History: \_\_\_\_\_

Medication History: \_\_\_\_\_

Relevant Investigations: \_\_\_\_\_

### Primary Assessment



#### Airway



Open  
 Maintainable  
 Not Maintainable

Any urgent interventions needed: Yes No

If Yes \_\_\_\_\_

#### Breathing



Rate: 56/min SpO<sub>2</sub> on FIO<sub>2</sub> RA 91-93%

Rhythm: regular

Retractions:  Suprasternal  ICR  SCR  
 Sternal  Supraclavicular  Nasal Flaring

Respiratory Noises:  Stridor  Wheezing  Grunting

Air Entry: (+) AE ↓ ↓ ↓

Palpation Findings (if necessary) \_\_\_\_\_

Any urgent interventions needed:  Yes  No

If Yes nebs. D. m. m.  
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**Circulation**

HR: 140/min

CFT  Central  Peripheral

Any urgent interventions needed:  Yes  No

If Yes .....

BP: ..... mmHg

Pulse Volume:  Central  Peripheral

Murmurs:  Yes  No

Liver Span: .....

If in Shock:  Compensated  Hypotensive

ECG: .....

Any Signs of Heart Failure:  Yes  No

Muffled Heart Sound:  Yes  No

Engorged Neck Veins:  Yes  No



**Disability**

GCS: 15/15 AVPU: Alert

Any urgent interventions needed:  Yes  No

If Yes .....

Pupils:  Responsive  Non-Responsive  
Size  Right  Left 3mm

Active Seizures:  Yes  No Sugars: .....

Signs of Neurological compromise .....

**Exposure**



Temp.: 98.6 F

Any urgent interventions needed:  Yes  No

If Yes .....

Any Rash:  Yes  No

If yes describe the rash .....

Active bleed .....

Lacerations  Abrasions  bruises

Describe: .....

**Final Physiological Status:**  Respiratory Distress  Respiratory Failure  Respiratory Arrest  
 Shock - Compensated  Hypotensive   
 Cardiopulmonary Arrest  Hemodynamically Stable

**Secondary Assessment:** Head to toe examination with positive findings: .....

**Labs Planned:**

Mentioned inside

**Treatment Planned:**

As charted

Need for Oxygen:  Yes  No if yes Low Flow  High Flow  PPV

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by  
Name of the Doctor: Dr. Karthik  
Signature: [Signature]  
Date & Time: 26/6/26 12:00pm

Sr. Doctor on Duty (If necessary)  
Name of the Sr. Doctor: .....