

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. _____

Date of Adm. _____

Room / Bed No : _____

Ward : _____

Consultant: _____

Dept : _____

Date of Discharge : _____

Time: _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/6/26	2:30 AM	ER	109	BS

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174945 Admit Date : 10-Jun-2026 Admit Time : 01:49 AM UHID : BAH-00658551

Patient Details :


Patient Name : Master JAMBULA ADVAITH Age : 2 Y 4 M 6 D
Guardian : Mr JAMBULA NIKHIL DOB : 04-02-2024
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : #3-5-118/P ROAD NO 01, KRISHNA NAGAR Phone No : 9866498678/ 9701641142
Hyderguda Hyderabad Telangana INDIA E-mail : nomalid@gmail.com
500048

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 109 Ward Name : 1F-VIBGYOR
Room No : SPVT 109 Admission Type : First Visit

Contact Details :

Name : Mr JAMBULA NIKHIL Relationship : Father
Contact Address : #3-5-118/P ROAD NO 01, KRISHNA NAGAR Phone No :
Hyderguda Hyderabad Telangana INDIA 500048


Signature

Doctor Details :

Doctor Name : Dr. UJJWALA DESAI Specialisation : GENERAL PEDIATRICS
Referral Doctor : SELF Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

Master Advait

UHID ID: _____

BAH-00658551 IP5-00174945
Master JAMBULA ADVAITH
04-02-2024 2 Y 4 M 6 D (M)
Dr. UJJWALA DESAI

Department: _____



Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Master ADVAITH Age/Sex 2 yr / m.
Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever x 3 days
Cold x 2 day
Poor Oral intake x 1 day.
& ↓ urine output

History of present illness :

40 Fever x 3 days
high grade, intermittent
every 3-4 hrs using syp Paracetamol.
& 1 Bugenic sos

also Rash over left elbow, left shoulder
and back.
↳ reddish, non blanching

not associated with seizures.

associated 2 nose blockage - 12 days.
no loose stools
no vomiting

also poor oral intake & ↓ urine output
1 day.

H/O Travel from USA on Saturday
was well for 1 day followed
by above symptoms

no other family member has
H/O cold, cough, fever



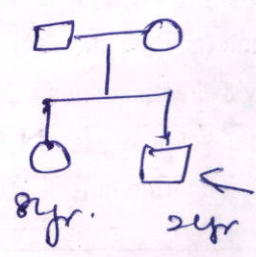
Pediatric Multiorgan History & Physical Examination

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

Klco esom using
medication as and when
advised

Birth & Neonatal History:

Normal Perinatal &
antenatal transition



Birth & Socio Economic History:

About Father : _____
About Mother : _____ upper middle.
Any additional Information : _____

Developmental History :

Attained appropriately for age.

Immunization History :

1st 4 months in India
vaccinated in USA after 4 months
of age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 91cm (Centile _____)
Weight (kgs)) 11 kg (Centile _____)

On Examination :

Temperature : 98.8 F Pulse Rate : 136 bpm B.P. 107/49 SP02 98% @ RA
Resp. rate and type of breathing : 24 bpm

Rash over left elbow, (L) shoulder, back

Lymphadenopathy left elbow - Red

Oedema : swollen

Allergies (if any): (cats) -

Respiratory System :

Inspection (any s/o distress) : Normal

Air entry & breath sounds : BAE (+), clear airways

Any addes sounds : nil

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

Cardiovascular System :

Inspection of procordium : Normal

Heart Sounds : S1, S2 (+)

Any murmur : nil

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

Per Abdomen :

Inspection Normal

Palpation : Soft, non tender

Auscultation : bowel sounds heard

Spine : (+) External Genitalia : (+)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : Intact

Motor System:

Nutrition : adequate

Tone: good, Bk Equal Power 4/5

Co-ordinator : good

Posture : _____

Involuntary Movements : nil

Reflexes :

DTR +++

Superficials: +++

Plantars flexion

Sensory System :

Intact

Bladder / Bowel : adequate stool output
↓ urine output

Clinical Summary & Diagnostic:

AFI & dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis, Severe Dehydration

Desired goals of the treatment: Resolution

Planned Labs:

- CBP
 - CRP
 - Viral Panel
 - RP-2
 - Blood c/s
 - CUE
 - Urine c/s
- Stool
culture
2:15 PM*

Planned Management

- ① IVF DNS @ 40ml/hr
- ② Inj CEFTRIAXONE 550mg
- ③ Inj PANTOPRAZOLE 10mg IV
- ④ Inj PARACETAMOL (SOS)
- ⑤ Monitor vitals hourly

Signature of the Doctor: Soheli

Name of the Doctor: Dr. Soheli

Date & Time: 10/06/26 2:00pm

Signature of the Consultant: DR. UJJWALA DESAI

Name of the Consultant: DR. UJJWALA DESAI

Date & Time: 10/06/26

PROGRESS NOTES AND DOCTOR'S ORDER


Date & Time	Progress Notes	Doctor's Order
10/6/24 8:30 AM	Seen by Resident;	Dr Ujjwala Desai
	<p>ASis = Acute febrile illness = Dehydration No fever !! 3d nose block !! 2d poor oral intake !! 1 day O/E child asleep, afebrile hemodynamically stable chest clear, ? conducted sounds abdomen soft</p>	<p>Plan 1. Continue medication as charted 2. monitor vitals & inform SOS 3. Trace urine c/s, blood c/s, Adeno-Abent-Sp NASIVION-P</p>
10/6/24 5 PM	<p>Seen by Resident ASis - Af1 = dehydration Fever - 6 AM - 102°F 10 AM - 101.2°F</p>	<p>DR. UJJWALA DESAI Plan</p>
	<p>oral intake poor. No fever issues. O/E child asleep, afebrile nose block ⊕ chest clear = mild conducted sounds - SOS abdomen soft CVT - 3-4 yrs cells</p>	<p>1. Continue medications as charted. 2. Trace Adeno. 3. Trace blood c/s, urine c/s 4. monitor vitals by inform SOS Dr. Ujjwala Desai Registration No: 9450 5 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11) 06/2024 8 AM	C/S/B Resident	
	<p>1) : AFI ± dehydration</p> <p>On Room Air</p> <p>Hemodynamically stable</p>	<p>Plan</p> <p>Continue medication as charted</p> <p>INT. CEFTRIAXONE-₂</p>
	<p>- Last fever spike yesterday 10:20 AM - 101.2°</p> <p>- Max temp after that now - 99.5°</p> <p>- RS - BILABLS, clear</p> <p>- NOSE block ⊕</p> <p>- Oral intake - good</p>	<p>- True final blood cs</p> <p>Urine cs</p> <p>- Monitor vitals</p> <p>- R/V D/C & adding multivitamin, Abendazole at discharge.</p>
		<p><u>Plat:</u> (Dr. Nandan)</p>
	<p>Fever Resolving</p> <p>Adenovirus -ve</p>	<p>contin. fu anti-biotic till tomorrow</p> <p>1 am iv</p> <p>today - 12 noon, 500mg</p>
	<p>Relent plus</p> <p>nasiviv</p>	<p>Review tomorrow in OPD</p> <p>DR. UJJWALA DESAI Registration No: 90550</p> <p>DR. Ujjwala Desai 10:45 AM 9a (P.T.O)</p>

BAH-00658551 IPS-00174945
 Master JAMBULA ADVAITH
 04-02-2024 2 Y 4 M 6 D (M)
 Dr. UJJWALA DESAI




RESULT SHEET

Date	10/6/26			
Time	2.42AM			
Hb	9.4			
PCV	30.1			
RBC	4.20			
WBC	9460			
N/L	65.2/27.8			
Platelets	363000			
CRP	34.0			
ESR				
PCT				
RBS				
Na	135			
K	4.8			
Cl	104			
Ca/Mg				
Phosphate				
Urea	24			
Creatinine	0.4			
ALP				
SGPT				
SGOT				
T.Bill/Conj				
T.Protein				
S.Albumin				
S.Globulin				
A/G Ratio				
Uric Acid				
S.Amylase				
Sr.Lipase				
Blood Lactate				
S.Cholesterol				
PT/INR				
APTT				
CSF Protein / Sugar				
Cells				
N/L Bicarbonate	20			

Master Advait

Patient

BAH-00658551 IP5-00174945
Master JAMBULA ADVAITH
04-02-2024 2 Y 4 M 6 D (M)
Dr. UJJWALA DESAI



IN 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: Shifted to:

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. Sohela (Sohela)

Date & Time : 10/06/26 2:00am

Nurse Name & Signature: Subaru

Date & Time : 10/6/26 at 2pm



REGULAR PRESCRIPTIONS

Weight. 11kg Ward.

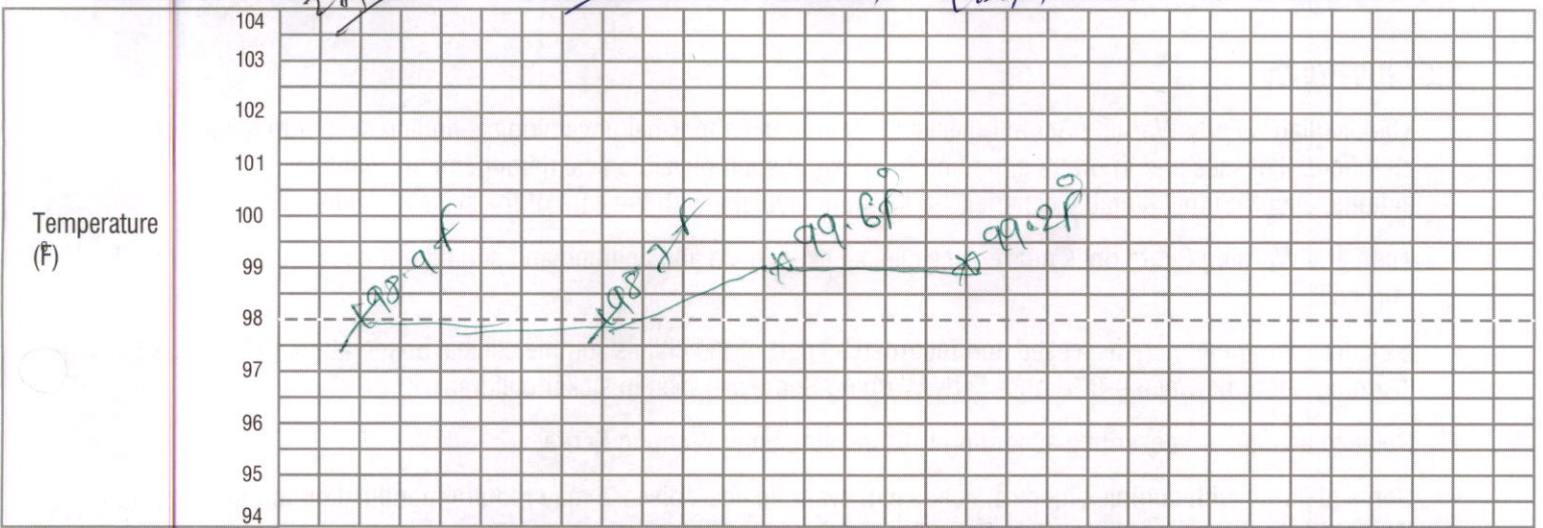
DRUG : INJ CEFTRIAXONE				Date Time	10/6 11/6															
Dose	Route	Frequency	Start Date																	
50mg	I.V	BID	10/06	6am sam 5pm sam 10am sam 11/6 Sully																
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				50mg/kg/dose 6pm 10/6 Sully																
Daily Doctor's Endorsement by a Sign				\$																
DRUG : Inj PANTOPRAZOLE				Date Time	10/6 11/6															
Dose	Route	Frequency	Start Date																	
10mg	I.V	OD	10/06	6am sam 5pm sam 10am sam 11/6 Sully																
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				10mg/kg/dose																
Daily Doctor's Endorsement by a Sign				\$																
DRUG : Syrup RELIANT				Date Time	10/6 11/6															
Dose	Route	Frequency	Start Date																	
3ml	PO	12hrly	10/6	10AM 11AM 12PM 11/6 Sully																
Name & Signature of the Doctor Starting the Drugs:				Sahitri																
Additional Instructions:				10PM 11/6 Sully																
Daily Doctor's Endorsement by a Sign				\$																
DRUG : NASU 1000 P				Date Time	10/6 11/6															
Dose	Route	Frequency	Start Date																	
0.5ml	ose	12hr	10/6	10AM 11AM 12PM 11/6 Sully																
Name & Signature of the Doctor Starting the Drugs:				Sahitri																
Additional Instructions:				2 drops each nested 10PM 11/6 Sully																
Daily Doctor's Endorsement by a Sign				\$																



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/16 Time: _____

Doctor / Nurse / Family Concern? 2 AM 6 AM 8:30 AM 9:15 AM



Heart Rate (bpm)	190	
and	180	
Blood Pressure (mmHg) *	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)	112 bpm	120 bpm

Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)	28 bpm	22 bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 92% 98%

Conscious Level Normal Altered

GCS * 14/5 14/5

TOTAL SCORE Number of shaded boxes 1 1

Pain Score 0 0

Observer's Initials on on

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
 - Score 2 : Shift in charge nurse to be informed and continue hourly observations
 - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 - Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.
- NB: 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.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

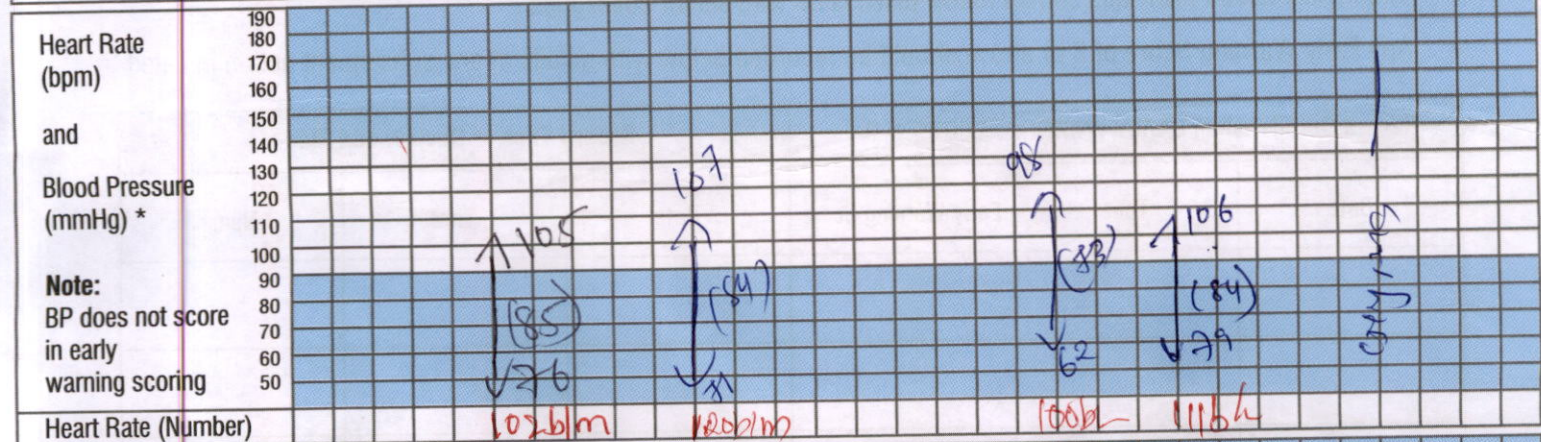
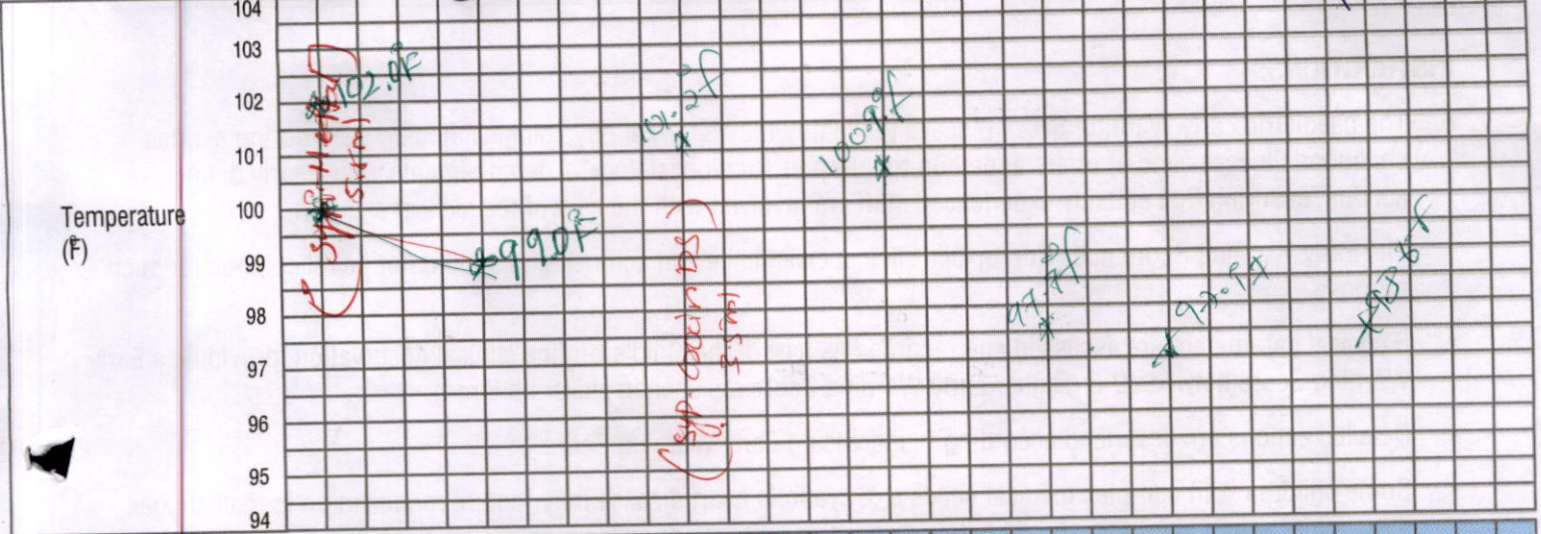
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/6 Time: _____

Doctor / Nurse / Family Concern? 8am 10am 6-70am 11am 1pm 6pm 10pm



Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	100% 99% 99% 100% 92%
Conscious Level	Normal Altered
GCS *	15/15 15/15 15/15 15/15 14/15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
	1	0	
	1	0	
	1	0	
	0	0	
	1	0	

ACTIONS

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BAH-00658551 IP5-00174945
 Master JAMBULA ADVAITH (M)
 04-02-2024 2 Y 4 M 6 D
 Dr. UJJWALA DESAI



FLUID CHART



Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												

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	DNS	water	40ml									
	05:00 am		DOSA	40ml									
	06:00 am			40ml									
	07:00 am	↓											

Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/6/26			Mouth	I.V	N.G						0	Sush
	08:00 am			40ml		/				✓	0	
	09:00 am		Idli	40ml		/					0	
	10:00 am	ONS		-		/					0	
	11:00 am			40ml		/					0	
	12:00 pm			40ml		/				✓	0	
Total Intake :			Total Output :									
10/06/26	02:00 pm		Rice			/					0	cher
	03:00 pm			40ml		/					0	
	04:00 pm	ONS		40ml		/				✓	0	
	05:00 pm			40ml		/					0	
	06:00 pm			40ml		/					0	
	07:00 pm					/					0	
Total Intake :			Total Output :									
10/6	08:00 pm			40ml		/					0	Susha
	09:00 pm			40ml		/				✓	0	
	10:00 pm	ONS		-		/					0	
	11:00 pm			-		/					0	
	12:00 am			40ml		/				✓	0	
	01:00 am			40ml		/					0	
Total Intake :			Total Output :									
11/6	02:00 am			40ml		/					0	Susha
	03:00 am			40ml		/				✓	0	
	04:00 am	ONS		40ml		/					0	
	05:00 am			40ml		/					0	
	06:00 am					/				✓	0	
	07:00 am					/					0	
Total Intake :			Total Output :									

Total 24 hrs. Intake

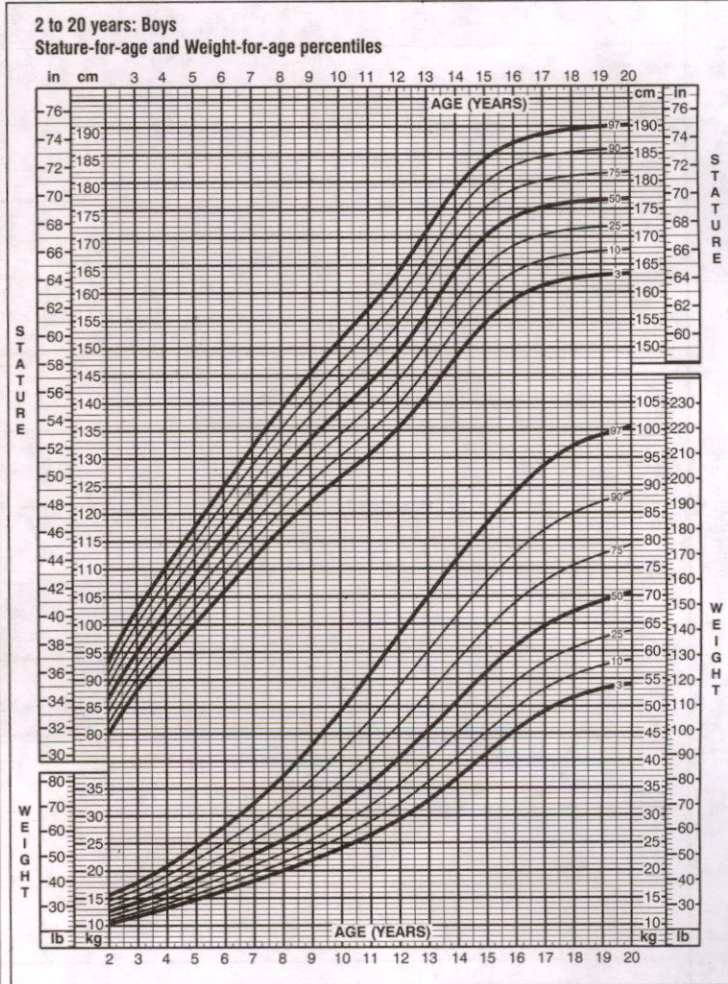
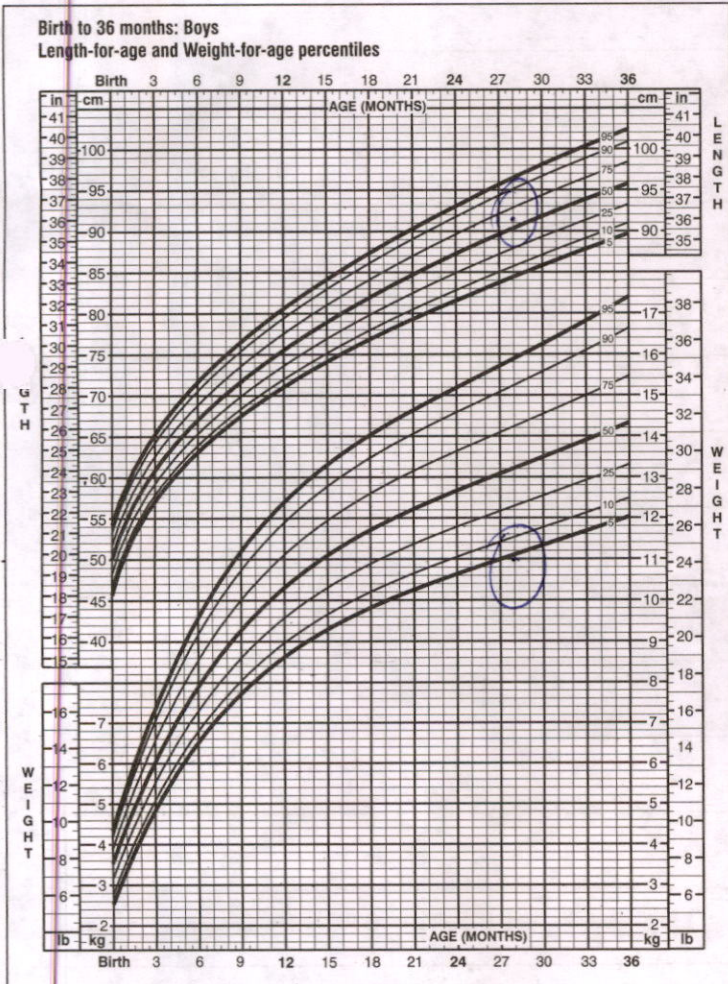
Total 24 hrs. Output

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/6/26 Time: 8 AM

Weight: 11 kgs Centile: 5th
 Height: 91.5 cms Centile: 25th
 Inference: underweight child
 RDA: - Calories: 1250 kcal/d Protein: 21 g/d
 Diet Recommendations: soft diet
 Re-Assessment: avoid spicy, chilled & outside foods.
 Food Allergies: No Veg/Non-veg: Non-veg
 Diagnosis: AFI & dehydration
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: Anika

GROWTH CHART (BOYS)



Dietician's Name: Niritha

Dietician's Signature: Niritha

