

INVESTIGATIONS

Date	Investigations	Order No.	Sign
6/6	USG abdomen	R26-009076 26019490 ✓	Ok
	RAT - Neg	26019490 ✓	
	CBP CRP St		
	CR. PCT LFT mp	26019478 ✓	J
	Bloods		
	Dengue IgM		
	Widal	26019492 ✓	J
08/06/26	CBP CRP	26019630 ✓	Ref
<p style="color: red;">Cross checked done by Ref - 08/06/26</p>			

ADMISSION SHEET

Registration Details :



Admission No : IP-00060248

Admit Date : 06-Jun-2026

Admit Time : 11:14 AM UHID : BAH-00489170

Patient Details :

Patient Name : Baby VARANASI RAGA HARSHINI

Age : 12 Y 2 M 26 D

Guardian : Mr RAJASEKAR

DOB : 11-03-2014

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : ~ Malkajgiri Hyderabad Telangana INDIA
500047

Phone No : 8008552636

E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr RAJASEKAR

Relationship : Father

Contact Address : ~ Malkajgiri Hyderabad Telangana INDIA
500047

Phone No : 8008552636


Signature

Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : BAJAJ ALLIANZ GENERAL
INSURANCE CO LTD

Patient Name : Baby. VARANASI RAGA HARSHINI UHID : BAH-00489170 IPD : IP-00060248 Gender : Female Age : 12 Y 2 M 26 D

BAH-00489170 IP-00060248
 Baby VARANASI RAGA HARSHINI
 11-03-2014 12 Y 2 M 26 D (F)
 Dr. PREETHAM KUMAR



wt - 33.7 kg
 Ht - 154 cm
 Gender: Male Female

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Raga Harshini Age : 12 years
 Date : 6/6/26 Time of Arrival : 10:59 AM

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.3 F PR: 92b/m BP: 97/65(75) RR: 20b/m SpO₂: 100%

Chief Complaints: fever x 10 days, Burning sensation of eyes, Stomach pain

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

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.

V. Neel
 Signature of Parent / Guardian
 Triage Completion Time : 11:02 AM

* CTAS - Canadian Triage and Acuity Scale

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 : Dr. Lema

Signature of Triage Nurse AW

Date & Time : 6/6/26 @ 11:02 AM

Patient Name : Baby. VARANASI RAGA HARSHINI UHID : BAH-00489170 IPD : IP-00060248 Gender : Female Age : 12 Y 2 M 26 D

BAH-00489170 IP-00060248
 Baby VARANASI RAGA HARSHINI
 11-03-2014 12 Y 2 M 26 D (F)
 Dr. PREETHAM KUMAR




NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/6/26 Time of arrival : 11:03 AM
 Chief Complaints : fever x 8 days, Burning sensation of eyes, Stomach pain RBS : -
 Height : 154cm Weight : 33.7kg 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 -

RISK FOR FALL:
 If patient is < 6 years
 tick below fall risk intervention directly
 If Patient is > 6 years
 Assess the below parameters
 History of Falling: within past 3 months Yes No
Ambulatory Aids:
 • Wheelchair Yes No
 • Uses furniture for support Yes No
Gait/Transferring:
 • Bedrest / immobile Yes No
 • Weak Yes No
 • Impaired Yes No
Mental Status: Forgets limitations Yes No
IF YES FOR ANY CATEGORY = RISK FOR FALLING
Fall Risk Intervention:
 Escort while ambulating
 Assist Patient
 Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected
 Mobility Problem
 Walking Problem
 Developmental Delay
 Musculoskeletal Congenital Abnormality
Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected
 Underweight
 Overweight
 Feeding Problem
 Special diet
 Special feeding method
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?) 1 (Sister)
 Time of Initial assessment completed by ER Nurse : 11:05 AM

Patient Name : Baby. VARANASI RAGA HARSHINI UHID : BAH-00489170 IPD : IP-00060248 Gender : Female Age : 12 Y 2 M 26 D

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

Time	Nursing Notes
10:59 AM	* Pt Came to ER from Dr. Siva side op
11 AM	* vitals checked and Recorded
11:05 AM	* ER Doctor seen the pt & gave intimation for admissions
11:14 AM	* Admission Done
11:55 AM	* Iv Placement Done
12:10 PM	* Samples Collected & sent to lab
12:20 PM	* Pt shifted to ward

Samples collected by: Sr. Hema

Time: @ 11:55 AM

Samples sent by: Sr. Jyothi

Time: @ 12:10 PM

Medication given in ER:

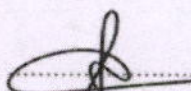
Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
<i>nil</i>					

Condition of patient at time of shift - out:	Details of Shift - out
HR: 92b/m BP: 97/65(95) CRT: 103 sec	Shift - out from ER to: 137
RR: 20b/m SPO ₂ : 100%	Time of Shift - out: 6/6/26 @ 12:35
GCS: 15/15 Temperature: 97.3°F	Handover given to: Sr. Priyanka PM
Pain Score: -	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): Iv Placement

Name of the Nurse : Sr. Suvanna

Signature of the Nurse : 

Date & Time : 6/6/26 @ 12:35 pm



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 3:30 pm	<p><u>CS/B Resident</u></p> <p>Asic: AFI - Div of illness ? enteric fever.</p> <p>No fever spikes ∴ Admission.</p>	
MP → (-ve)		
CRP → 32	<p><u>O/E</u></p> <p>Child Alert</p>	
WBC → 1-32	<p>Vital stable</p>	<p><u>Plan</u></p>
PLT → 1-53	<p>CU: SIS ⊕</p> <p>RU: BILAC ⊕</p> <p>PLA: SOFT</p> <p>CNS: NAD</p>	<p>- Inj-cyproxone</p> <p>- IVP</p> <p>- Trae b/ds,</p>
Dr. Prakash		<p>Deryu: gm, widel 4 4/ds.</p>
<p><i>[Signature]</i> Dr. Manisha 6/6/26 5 pm</p>		<p>Noted By Manisha 6/6/26 @ 8 pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 9:00 AM	<p>AFI (D11) ↓ Evaluation</p> <p>— No fevers</p> <p>— Active.</p> <p>— orally - (N)</p> <p>— U.O - (N)</p> <p>— vitals stable.</p> <p>No clo abd. pain.</p>	<p>? viral (dengue)</p> <p>? Enteric.</p>
CBD CRP	<p>↑ Im.</p> <p>CVS</p> <p>CMS</p> <p>RS (N)</p> <p>PA</p>	<p>Plan</p>
<p>Dr. Manisha</p> <p>7/6/26 10 AM</p>		<p>Trace reports</p> <p>Antipyretics (as)</p> <p>Ins. Ceftriaxone (as)</p> <p>Antacid</p> <p>vitals 7th hrly</p> <p>Inform Sel</p> <p>cl. [unclear]</p>
		<p>Noted By Manisha 7/6/26 2:20 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26	<u>AST - I Qualitation</u>	
4:00pm		
	No fever spikes - today.	
	O/I - Better.	
	No do Abd-pain	
	Widal - (-ve)	
	MP (-ve)	
	Dengue IgM (-ve)	
	PCR - 9.82	
	Depression!	
		<u>Plan</u> - Trace B/Lds. - Ij uprioxone - O2 - Montelukast - Duplex (P1)
		- CBP, CRP - T/m.

noted by
 sushila
 7/6/26
 at 7pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	AFI ↓ evaluation	
8:00 AM	No fever spikes & hrs.	
	O/T - Butta	
	C/P - Adequate	
37 ↓ CRP → 23	O/E	
WBC → 1.69K	Child Alert & active	
	Vital stable	
	C/M: $\text{Hct} \uparrow$	Plan
	M: SLUDGE	
	P/A: full	- Ty up vision - D3
	C/M: NAD	- O/C today
		- Broad Antibiotic
<p>8/6/26 Dr. Preetham Kumar</p>		

Noted by
 Abanish
 08/06/26
 @ 10 AM



TEENAGE (12 + years)
 Children's Observation &
 Early Warning Scoring Chart



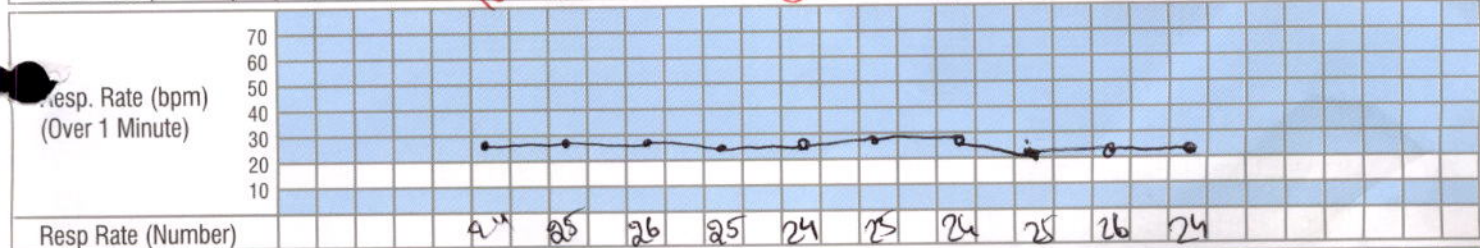
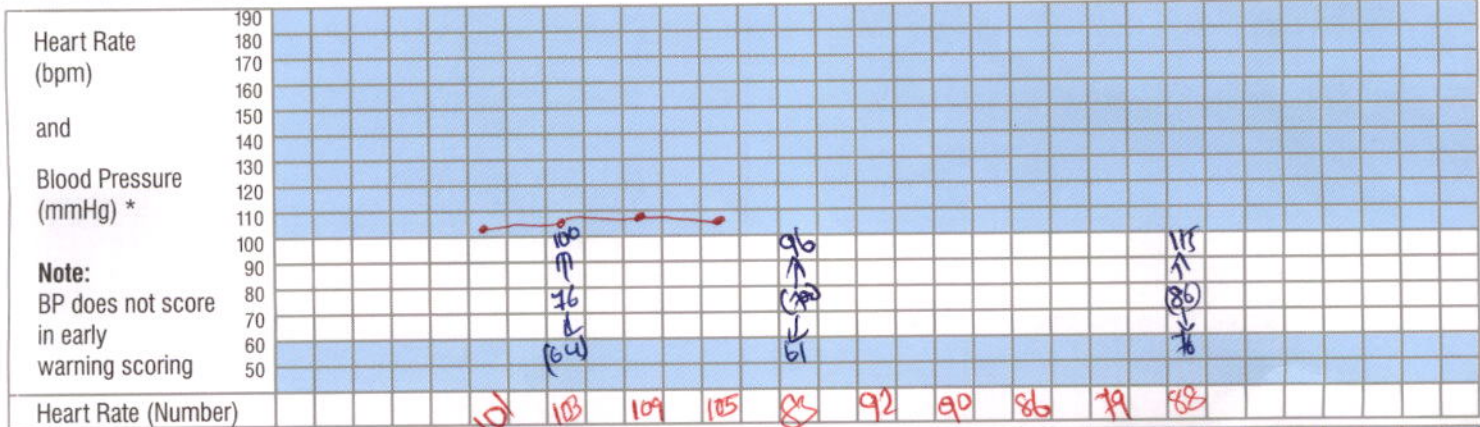
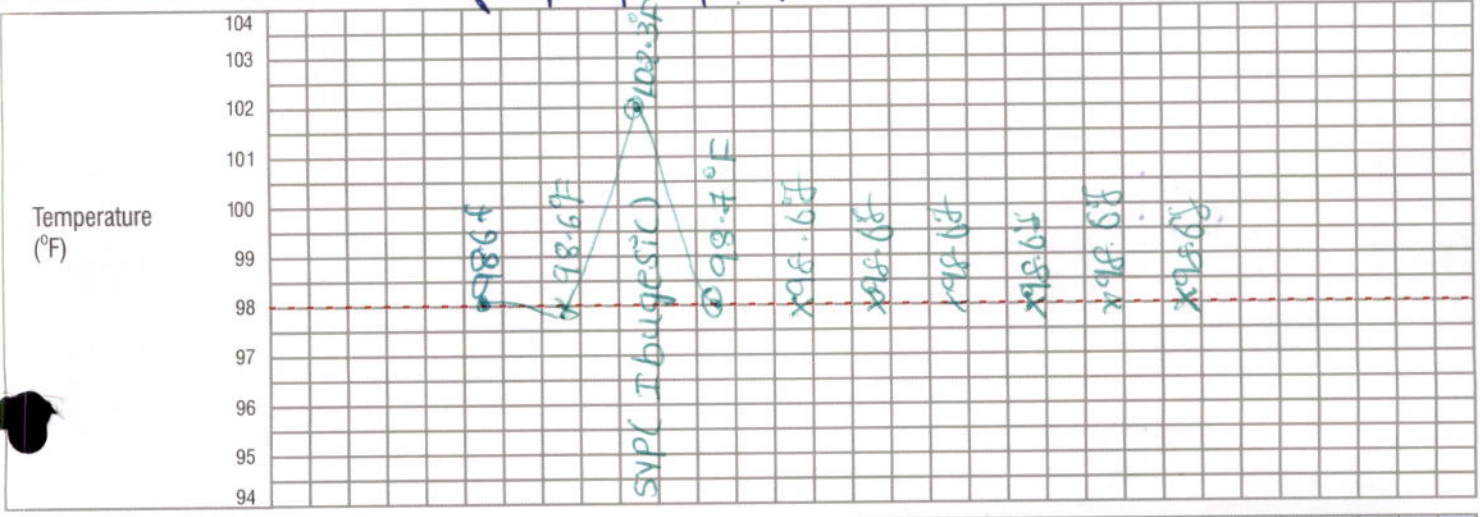
Pat



M / CLINICAL / 127

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/6	Time :	1	3	5-45	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?		pm	pm	pm	pm	pm	pm	Am	Am	Am	Am



Resp Distress	Mod/ Severe None / Mild										
Receiving O ₂ (l/min)	O ₂ Saturations (%)	20l	99	99	99	100	99	98	99	100	98
Conscious Level	Normal Altered	N	N	N	N	N	N	N	N	N	N
GCS *		15	15	15	15	15	15	15	15	15	15

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

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

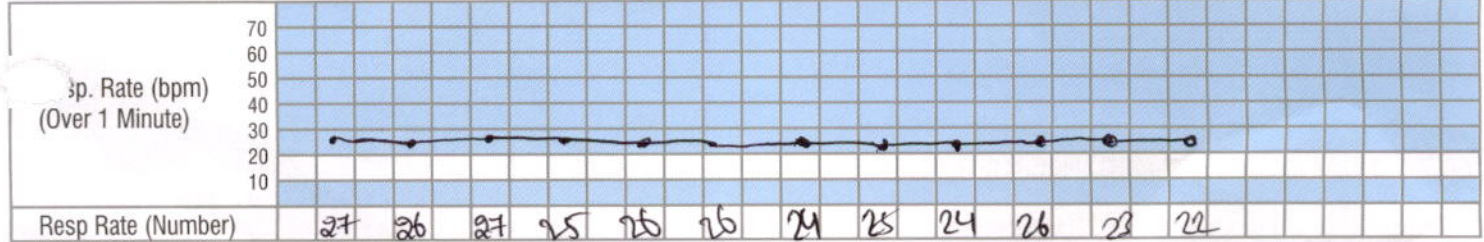
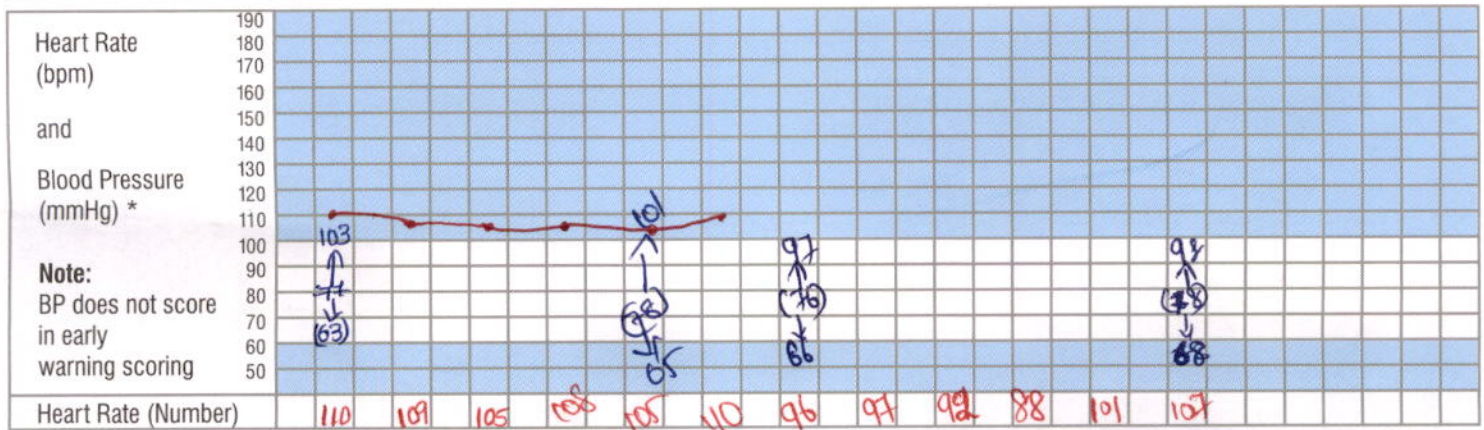
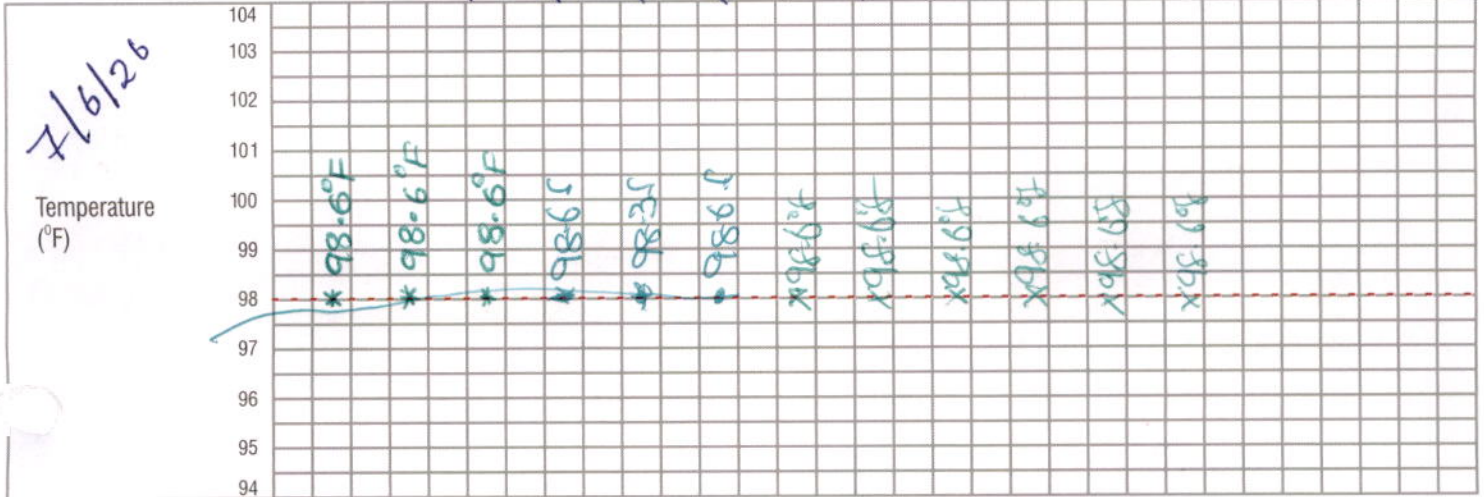
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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 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 :	Time:	9	11	1	3	5	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?		Am	Am	pm	pm	pm	pm	pm	pm	Am	Am	Am	Am



Resp Distress	Mod/ Severe	None / Mild	N	N	N	N	N	N	N	N	N	N		
Receiving O ₂ (l/min)	O ₂ Saturations (%)		99	99	99	98	98	98	100	99	98	100	99	100
Conscious Level	Normal	Altered	N	N	N	N	N	N	N	N	N	N	N	N
GCS *			15	15	15	15	15	15	15	15	15	15	15	15

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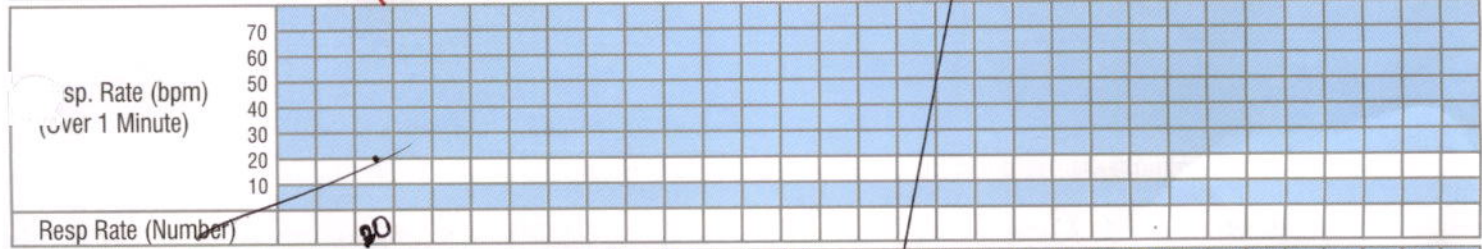
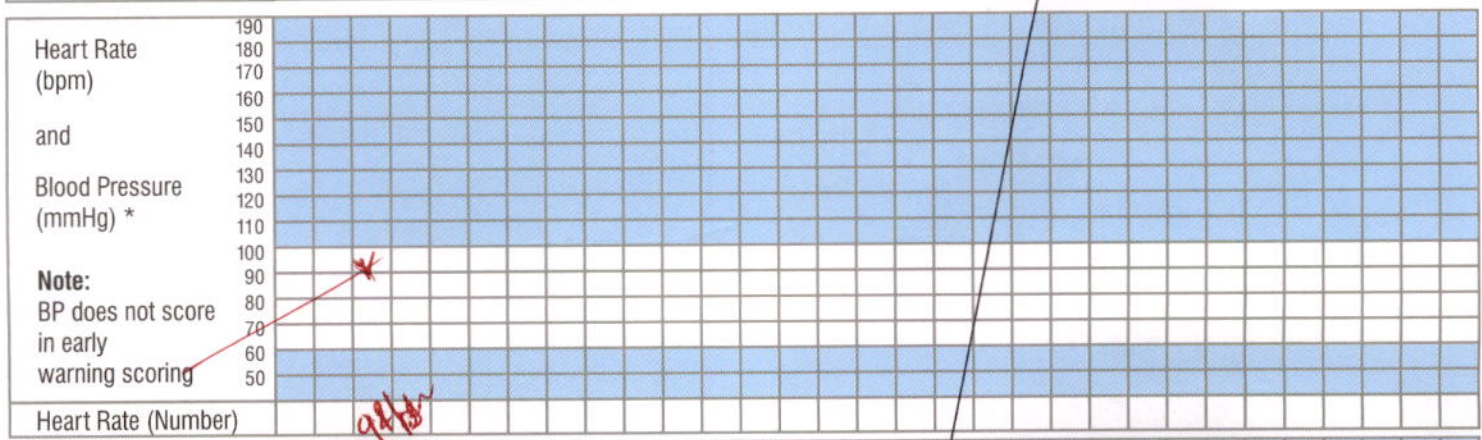
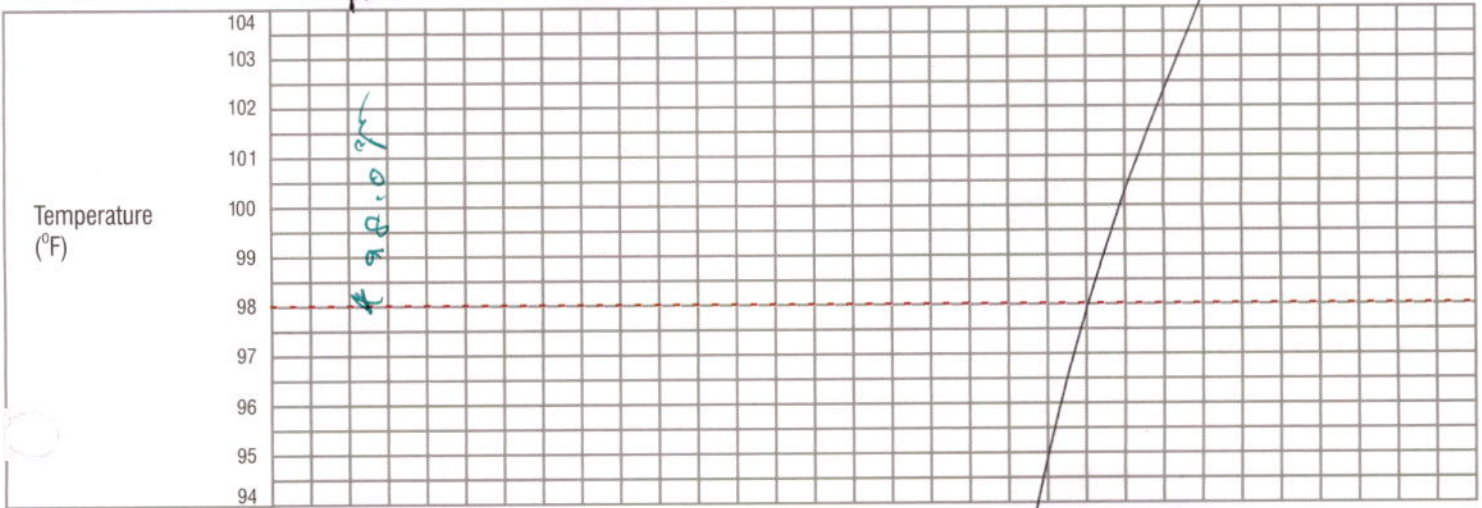
TEENAGE (12 + years)
 Children's Observation &
 Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/6/20 Time: 9

Doctor / Nurse / Family Concern? AN



Heart Rate (Number) 98

Resp Rate (Number) 20

Resp Distress: Mod/ Severe None / Mild

Receiving O₂ (l/min) 0

O₂ Saturations (%) 98

Conscious Level: Normal Altered C

GCS * 15

TOTAL SCORE

Number of shaded boxes 0

Pain Score 0

Observer's Initials AN

ACTIONS

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
6/6	08:00 am												Sandy 02pm 6/6
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm		Rice		74ml								
Total Intake :			74ml			Total Output :							
6/6/26	02:00 pm	Rice		74ml								Manisha 6/6/26 @ 8pm	
	03:00 pm	Water		74ml					✓				
	04:00 pm			74ml									
	05:00 pm			74ml						✓			
	06:00 pm			74ml									
	07:00 pm			74ml									
Total Intake :			444ml			Total Output :					2 hrs		
	08:00 pm			74ml								Sneha 7/6/26 @ 8am	
	09:00 pm			74ml					✓				
	10:00 pm			74ml									
	11:00 pm			74ml									
	12:00 am			74ml						✓			
	01:00 am			74ml									
Total Intake :			444ml			Total Output :					2 hrs		
	02:00 am			74ml									
	03:00 am			74ml									
	04:00 am			74ml									
	05:00 am												
	06:00 am												
	07:00 am									✓			
Total Intake :			222ml			Total Output :					1 hrs		
Total 24 hrs. Intake			1184ml			Total 24 hrs. Output					5 hrs		



FLUID CHART

Sheet No. :

7/6/26

- 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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
7/6/26	08:00 am	Idly + water								✓		manisha 7/6/26 @ 2pm
	09:00 am											
	10:00 am										0	
	11:00 am											
	12:00 pm											
	01:00 pm										✓	

Total Intake : _____ **Total Output :** 2 times

7/6/26	02:00 pm			7um								Rishika 7/6/26 at 7pm
	03:00 pm			7um								
	04:00 pm	Rice + water			35ml					✓		
	05:00 pm				35ml						0	
	06:00 pm				35ml							
	07:00 pm									✓		

Total Intake : 253ml **Total Output :** 2 times

	08:00 pm											Sreebusha 8/6/26 8 AM
	09:00 pm			35ml						✓		
	10:00 pm			35ml								
	11:00 pm			35ml								
	12:00 am			35ml								
	01:00 am			35ml						✓		

Total Intake : 175ml **Total Output :** 2 times

	02:00 am			35ml								
	03:00 am			35ml								
	04:00 am			35ml								
	05:00 am			35ml								
	06:00 am			35ml								
	07:00 am			35ml						✓		

Total Intake : 210ml **Total Output :** 1 time

Total 24 hrs. Intake 638ml

Total 24 hrs. Output 7 times

BAH-00489170 IP-00060248
 Baby VARANASI RAGA HARSHINI
 11-03-2014 12 Y 2 M 26 D (F)
 Dr. PREETHAM KUMAR



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		
	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										
	05:00 am										
	06:00 am										
	07:00 am										
Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output					



FLUID CHART

Sheet No. : 8/6/26

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

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											} Maish 8/6/26
	09:00 am		Polyt 160						✓			
	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											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

Patient Sticker



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												
	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												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake	
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Total 24 hrs. Output	
-----------------------------	--



REGULAR PRESCRIPTIONS

Weight. 33.7 kg. Ward. 136

Dr. Jyoti

DRUG : INT. CEFTRIAZONE				Date Time	6/6	7/6	8/6													
Dose	Route	Frequency	Start Date	6	AM	PM	ESW	ESW												
1.7gm	IV	12 th hrly	6/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera																				
Additional Instructions: After Test Done 50 mg/kg/dose.				6 10PM ESW PM Kalpana																
Daily Doctor's Endorsement by a Sign																				

Dr. Jyoti

DRUG : INT. PANTOPRAZOLE				Date Time	6/6	7/6	8/6													
Dose	Route	Frequency	Start Date	6	AM	PM	ESW	ESW												
35mg	IV	ONCE DAILY	6/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera																				
Additional Instructions: 1 mg/kg/dose																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

187

Patient Name : —

BAH-00489170 IP-00060248
Baby VARANASI RAGA HARSHINI
11-03-2014 12 Y 2 M 26 D (F)
Dr. PREETHAM KUMAR

Registration No.:



MEDICATION
NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
7/6/26	00.00			
	1.00	6am Pnj PANTOPRAZOLE 85mg (OD)		
	2.00	Pnj CEFTIAZONE 1.7 gm (BD)		
	3.00			
	4.00			
	5.00			
	6.00	6pm		
	7.00	Pnj CEFTIAZONE 1.7 gm (BD)		
	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			