

ACTIVITY RECORD FOR BILLING

VIH-00199881 IP-00060254

Master SYED UMARUDDIN

01-07-2025 0 Y 11 M 11 D (M)

Name: ---Dr. KODICHERLA VISHNU VARDHAN-----

UHID No :



----- Consultant : -----

Dept : -----

Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Mohd abdul khald	12/6/2026	3089523	
2.	Dr. Archana Vemalgudi	9/6/2026	003088518	
3.	Class checked by Jand	12/6/26		at 3:30 p
4.	Dr. Akhila	12/6/26	2089888	
5.	Dr. Neha Jain	13/6/26	2089889	
6.				
7.				
8.				
9.				
10.				

ACTIVITY

VIH-00199881 IP-00060254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 3 D (M)
Dr. KODICHERLA VISHNU VARDHAN

NG

Name: ---



UHID No

Consultant: ---

Dept: paediatric

Date of Admission: 6/6/26

Time: 9:43m

Date of Discharge: ---

Time: ---

Room / Bed No: PIW

Ward: PIW

Suggested Billable bed type: ---

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/6/26	10:20m	ER	PIW	[Signature]
12/6/26		PIW	1st floor (63)	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Prapulla Sindura	8/6/26	3087985	[Signature]
2.	Dr. Mustaza Kamal	8/6/26	3088123	Neha
3.	Dr. ^{mohd abdul} Mahidhar _{khalid}	8/6/26	3088273	Neha
4.	Dr. Anurag	8/6/26	3088410	Neha
5.	Dr. Poyappa Sai	9/6/26	3088421	[Signature]
6.	Dr. P. Sindhu	9/6/26	3088517	[Signature]
7.	Dr. Akhila Venaraju	3088518	9/6/26	[Signature]
8.	Dr. Sindhu	10/6/26	3088857	[Signature]
9.	Dr. Nageshwar Rao	10/6/26	3088870	[Signature]
10.	Dr. Akhila Venaraju	11/6/26	3089147	Jag

11. DR. Sandhya

11/6/26

3089294

[Signature]

INVESTIGATIONS

Date	Investigations	Order No.	Sign
6/6/26	CRP, CRP, Blood c/s	26019551	[Signature]
	PTAPTT, LFT, S/W		
	Creatinine, Urea		
	Calcium, Magnesium		
	HIV test		
	VABG ①		
	① GRBS - 35mg/dl	26019552	
	② GRBS - 8F mg/dl	26019553	
07/6/26	VABG ② at 2am	26019560	[Signature]
	GRBS at 2am 100mg/dl	26019561	[Signature]
06/6/26	Fesletin, PCT	26019555	[Signature]
7/6/26	CUE	26019565	[Signature]
07/6/26	x-ray chest	009112	[Signature]
06/5/26	x-ray chest	009108	[Signature]
07/6/26	LDH, Reticulocyte count,	26019567	[Signature]
	Iron & Iron Binding capacity		
7/6/26	ABG ③ - RBS - 94 mg/dl - 8:30	26019574	[Signature]
7/6/26	LFT, proBNP, Troponin I,	26019590	[Signature]
	Urea, creatinine, PTAPTT		
7/6/26	RBS - 102 mg/dl VABG	26019605	[Signature]
7/6/26	CBP, SF, cal, Uric Acid,		
	TRiglycerides, Fibrinogen,	26019603	[Signature]
	PIL panel - 2		



VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 6 D (M)
 Dr. KODICHERLA VISHNU VARDHAN

ATTENTION SHEET

Patient

Age :

F - I.P. No. :

Date	Investigation	Ward	Nurse Signature	Bill No.	Received Date & Signature
7/8	HBAIC ^x HPLC	PW	R	26019610	R
7/6	CXR	PW	R	26009122	R
7/6/26	Blood grouping	PICU	J	26019604	J
8/6/26	LFT, PT/APTT/INR	PICU	R	26019627	26019628
8/6/26	ABC ABC	PICU PICU	R R	26020182	ended on 12/6/26
8/6/26	RBS - 130mg/dl (12am)	PICU	R	26019617	R
	Clos checked by Jyothi		08/6/26	at 12am	
8/6/26	RBS, ABU - 101mg/dl @ 8am	PW	X	26019654	
8/6/26	Ammonia	PW	J	26019641	
8/6/26	Bone marrow Aspiratin/Biops	PICU	Y	26019655	
8/6/26	CBP	PICU	R	26019704	
8/6/26	Electrolyte	PICU	R	2609705	
8/6/26	CSF analysis	PICU	R	26019710	
8/6/26	RBS - 139 mg/dl	PICU	R	26019713	
8/6/26	abg - 6	PICU	R	26019734	
8/6/26	2 Decho	PICU	R	26009190	
8/6/26	USG abdomen	PICU	R	26009199	
8/6/26	Bone marrow c/s	PICU	R	26019658	
09/6/26	ABG 2am	PICU	R	26019779	
09/6/26	Electrolytes, urea, creatinine, LFT	PICU	R	26019764	
09/6/26	PT/APTT/INR	PICU	R	26019785	
09/6/26	Calcium, magnesium, electrolytes	PICU	R	26019777	

3



DAILY INVESTIGATION SHEET

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 8 D
 Patient Dr. KODICHERLA VISHNU VARDHAN (M)
 Age :

F - I.P. No. :

Date	Investigation	Ward	Signature	Bill No.	Received Date & Signature
9/6/26	ECG	PICU	[Signature]	26019822	[Signature]
9/6/26	ABG u: 46 am	PICU	[Signature]	26019820	[Signature]
9/6/26	VBG - 11:30 AM	PICU	[Signature]	26019799	[Signature]
9/6/26	RBS - 11:30 AM	PICU	[Signature]	26019808	[Signature]
Cross checked by Yashwanth 9/6/26 at 1 PM.					
9/6/26	VBG	PICU	[Signature]	26019816	[Signature]
9/6/26	Electrolytes, CRP, DCT	PICU	[Signature]	26019814	[Signature]
9/6/26	VBG	PICU	[Signature]	26019824	[Signature]
9/6/26	EEG	PICU	[Signature]	26009241	[Signature]
9/6/26	SE	PICU	[Signature]	26019833	[Signature]
9/6/26	VBG @ 4 pm	PICU	[Signature]	26019856	[Signature]
10/6/26	CBP, electrolytes, Ferritin LFT	PICU	[Signature]	26019849	[Signature]
10/6/26	VBG 6 am	PICU	[Signature]	26019857	[Signature]
10/6/26	GRBS 9:00 AM	PICU	[Signature]	26019858	[Signature]
Cross checked by [Signature] 10/6/26 at 6 am					
10/6/26	VBG 12 pm 99 mg/dl	PICU	[Signature]	26019917	[Signature]
10/6/26	Electrolyte	PICU	[Signature]	26019926	[Signature]
10/6/26	VBG 3 pm	PICU	[Signature]	26019927	[Signature]
10/6/26	2 Echo	PICU	[Signature]	26009317	[Signature]
11/6	VBG	PICU	[Signature]	(26019956)	[Signature]
12/6	CBP, CRP, LFT, urea creat SIE	PICU	[Signature]	(26020104)	[Signature]
10/6/26	2 day	PICU	[Signature]	009254	[Signature]
Cross checked by [Signature] 12/6/26 at 3 PM					
	Upper GI study	PICU	[Signature]	26009164	[Signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/6/26	Replacement	2	3087634	ghy
6/6/26	1/2 placement	1	3087686	gho
07/6/26	ET. Intubation	1	3087687	gho
7/6/26	Catheterisation	1	3087732	Neha
7/6/26	arterial line	1	3087759	Neha
7/6/26	iv placement	1		Neha
7/6/26	Nebulization	4	3087839	Rn
7/6/26	central line	1	3087845	Rn
7/6/26	Blood transfusion	1	3087892	gho
8/6/26	1/2 Ig transfusion	1	3087973	gho
8/6/26	Bone Marrow	1	3087974	gho
8/6/26	Lumbar puncture		3088092	Neha
9/6/26	Nebulisation	6	3088541	Bauli
10/6/26	nebulisation	3	3088612	gho
<p>ANY OTHER INFORMATION <i>(clear) checked by ghoo 10/6/26 at 6a</i></p>				
10/6/26	nebulisation	3	3088618	gho
11/6/26	nebulization	5	3089022	Rn
12/6/26	nebulization	4	3089426	Rn
12/6/26	GI Study	1	009424	gho
<p><i>(clear) checked by ghoo 12/6/26 at 3pm</i></p>				
Date :	Time :	Prepared By :		
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor	

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
6/6/26	00.00	9:30pm - Neb - 2 Levallin +		
	01.00	Budecort	3087829	<u>Rameef</u>
7/6/26	02.00	2AM - Neb - 2 Levallin	(A)	
	03.00	9AM - Neb - 2 Levallin + Budecort		
	04.00	2pm - Neb - 2 Levallin	3088618	<u>Keef</u>
9/6/26	05.00	4:40pm - Adren Levallin (3)	(3)	
9/6/26	06.00	1:40pm - Adrenalin (1)	3088511	<u>Rameef</u>
	07.00	1:25pm - Neb - Budecort	(3)	
	08.00	1:00pm - Neb - 2 Levallin		
	09.00	10pm - Neb - 2 Levallin		
	10.00	2AM - Budecort	3088618	
10/6/26	11.00	3AM - Levallin	(3)	<u>Keef</u>
	12.00	Class Checked by Rameef 10/6/26 at 6C		
10/6/26	13.00	2pm - 2 Levallin +		
	14.00	Budecort		
	15.00	10AM Hyp Hyp Res neb		
	16.00	10pm - Levallin	(5) (3089022)	
11/6/26	17.00	2AM - Budecort		
	18.00	6AM - Levallin		
11/6/26	19.00	2pm - Levallin + Budecort		
	20.00	10pm - Levallin		
12/6/26	21.00	2AM - Budecort	(4) (3089426)	
	22.00	6AM - Levallin		
	23.00			

Name	Master SYED UMARUDDIN	UHID	VIH-00199881
Father/Guardian	SYED KHALEELUDDIN	Age/Gender	0 Y 11 M 10 D/Male
Address	H NO 5-87/A, DOULTABAD, SIDDIPET DIST, TELENGANA, Makkarajpet, Medak, Telangana, INDIA, 502247		
IP No	IP-00060254	Admission Date	06-06-2026
Ref Doctor	DR. E SURESH	Discharge Date	13-06-2026

DISCHARGE AT REQUEST SUMMARY

Consultant: Dr. KODICHERLA VISHNU VARDHAN REDDY

MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)
Fellow in Pediatric and Cardiac Intensive Care
(RCPCH Birmingham Children's Hospital UK)
Fellow in Pediatric Retrieval Medicine (KIDS-NTS UK)
APMC/FMR/79982

**Diagnosis: SEPSIS WITH MULTIORGAN DYSFUNCTION
SECONDARY HAEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS
OROPHARYNGEAL DYSPHAGIA TO LIQUIDS SECONDARY TO
? PSEUDOBULBAR DYSFUNCTION
KNOWN CASE OF SPINAL (D2-D4) MYELOMENINGOCELE
(OPERATED) WITH ? ARRESTED HYDROCEPHALUS**

History: Master SYED UMARUDDIN is a 11 M 10 D boy presented with history of high grade intermittent fever, cold since 3 days and dull activity since 2 days prior to admission. For the above complaints, he was treated at referral center, but in view of persistence of symptoms, he was referred to Rainbow Children's Hospital for further management.

Past History : Child had myelomeningocele, operated at day 3 of life.

Developmental History: Sits without support, stands with support
Bisyllables
Recognizes parents

Name

Master SYED
UMARUDDIN

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VIH-00199881

Examination: He was afebrile, not maintaining saturations (88%) at room air. Heart rate- 180/min, blood pressure - 90/60 mmHg and respiratory rate 18/min. Respiratory distress was present in the form of tachypnea, intercostal, subcostal and suprasternal retractions. On auscultation of chest, air entry was bilaterally equal with bilateral wheeze, normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, he was drowsy(GCS-10/15). Bilateral lower limb spasticity was present. Physiological status - compensated shock with encephalopathy.

Weight on admission : 8.5 kgs.

Investigations: Enclosed.

Management: He was admitted in Pediatric Intensive Care Unit and was started on HFNC, IV fluids and IV antibiotics. He was treated symptomatically with antipyretics and antacids.

Course in Pediatric Intensive Care Unit:

Encephalopathy: Child had poor sensorium and bradypnea during admission. Initially thought to be due to raised ICP secondary to hydrocephalus so CT scan was done on 07.06.2026 showed operated case of D2-D4 myelomeningocele, moderately dilated supratentorial ventricular system with normal extracerebral CSF spaces, tonsillar ectopia up to the level of arch of C1 vertebra causing effacement of 4th ventricular outlet and dorsal CSF spaces at foramen magnum, no evidence of leptomeningeal / parenchymal enhancing pathology, as compared to the previous MRI dated 19.02.2026 there is no significant interval change in the extent of supratentorial ventricular dilatation. Neurosurgeon opinion was taken advised for conservative management Neurologist opinion with Dr. P. Sindhura was taken and advised followed.

Name

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Chest x-ray showed haziness of right middle lobe ? Secondary to aspiration.
Venous blood gas showed pH -7.13, pCO₂- 48.9 mmhg, pO₂ - 46mmhg, HCO₃
- 16.4 mmol/l, BE: - -11.4 mmol/l, Lactate-6.1mmol/l.

After 6 hours of admission repeat blood gas was done. In view of hypercapnia,
respiratory distress, Bradypnea, poor sensorium child was intubated and put on
mechanical ventilation (SIMV PCV+PS).

Arterial blood gas showed pH - 7.29, pCO₂- 48 mmhg, pO₂ - 149 mmhg,
HCO₃ - 23 mmol/l, BE: - -3.2 mmol/l.

In view of anemia with hepatomegaly and high Fio₂ requirement in mechanical
ventilation, child was transfused with PRBC. HPLC / Hb electrophoresis showed
no evidence of hemoglobin variants with normal limit of HbF and HbA₂.

Invasive hemodynamic monitoring was started. Serial arterial blood gas and
chest X-rays were done, accordingly ventilatory settings were optimized.
Child's ventilator parameter was adjusted to maintain adequate oxygenation
and ventilation. After 48 hours as his sensorium started improving his
ventilatory settings were weaned off. After Spontaneous breathing trail child
was extubated to HHHFNC.

In view of chest signs, child was nebulized with Levolin and Budecort. Child
was empirically started on Syrup. Oseltamivir. As child's respiratory distress
reduced, child was weaned off from HHHFNC to low flow oxygen support.
Nebulizations were titrated accordingly.

Cardiac dysfunction: Child had mild Right ventricular dysfunction. Injection
Thiamine given.

2D echo showed mild LV dysfunction, Troponin-I and NT Pro BNP were elevated.
Cardiology opinion with Dr. Murtaza Kamal was taken and started on milrinone
infusion, furosemide infusion along with Nor-Adrenaline - 0.05 mcg/kg/min,
which was gradually tapered and stopped as child improved.

Name

Master SYED
UMARUDDIN

UHID

VIH-00199881

Secondary HLH: On admission, complete blood picture showed hemoglobin 7.7gm%, white blood cells count of 24,930cells/cumm, platelet count of 2.04 lakhs/cumm and C-Reactive Protein 48 mg/l. Procalcitonin- 33.4 ng/ml, Serum Ferritin- 1200 ng/ml, LDH- 920 U/L, Plasma Fibrinogen- 97.96 mg/dl, Triglyceride- 167 mg/dl. In view of suspected HLH, Bone marrow biopsy was done which showed Erythroid Hyperplasia and Hemophagocytes. The child was transfused with 1gm/kg of IVIg.

Haemto-oncology opinion with Dr. Anurag & Dr. Sandhya Vaddadi was taken and advice followed. Injection Methylprednisolone was given for 5 days and changed to oral steroids, planned to taper and stop over 2 weeks.

Primary immunodeficiency panel was sent, showed low levels of IgA. In view of above, child was advised for whole exome sequencing to rule out immunodeficiency or hyperinflammatory syndromes.

Blood culture was sterile after 48 hours of incubation and Bone marrow culture was sterile after 24 hours of incubation.

Repeat hemogram done on 12.6.2026 showed hemoglobin 10.9 gm%, white blood cells count of 16,180 cells/cumm, platelet count of 1.20 lakhs/cumm and C-Reactive Protein 10 mg/l. Ferritin was 185 ng/ml.

Acute liver injury: His liver function tests showed SGPT 1395 U/L, SGOT 2252U/L, ALP 153U/L, total serum bilirubin was 0.3mg/dl with direct fraction 0.1 mg/dl and indirect fraction 0.2 mg/dl, serum albumin was 3.4g/dl, total protein was 6.4 g/dl, S.globulin was 3g/dl. Coagulation profile showed PT 29.1 sec, INR 2.07, APTT 37.8sec. Injection Vitamin-K given .

Ultrasound abdomen showed minimal ascites, right minimal pleural effusion, mild gallbladder wall edema.

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Gastroenterologist opinion with Dr. M. Naga Venkata Poushya Sai was taken and child was started on Ursodeoxycolic acid and N acetyl cysteine infusion was started. He was regularly monitored for liver enzymes and coagulation parameters. As the parameters improved, stopped NAC infusion.

On 12/06/2026, liver function tests showed SGPT 928 U/L, SGOT 325 U/L, ALP 95 U/L, total serum bilirubin was 0.7mg/dl with direct fraction 0.1 mg/dl and indirect fraction 0.6 mg/dl, serum albumin was 2.9g/dl, total protein was 6.7g/dl, S.globulin was 3.8g/dl.

Child was started on IV fluids, later started on NG feeds and IV fluids were tapered and stopped.

Suspected pseudobulbar palsy under evaluation: Post-extubation, child had pooling of oral secretions. Oromotor assessment was done. Child had swallowing difficulties of liquids and tolerating solids, hence planned for upper GI contrast study which showed Tracheal aspiration of contrast in swallowing phase with ill-defined parenchymal haziness and increased bronchial wall thickness in central lung regions with normal Distal esophageal sphincter and no evidence of gastroesophageal reflux.

Counselling: Parents were counselled in their understandable language regarding need of multi-disciplinary approach for difficulty in swallowing. It involves Neurology, ENT and Gastroenterology opinion. Till the cause is evaluated, he should be continued on NG feeds and parents were trained for the same. Child was advised for MRI brain and Whole exome sequencing to rule out immunodeficiency, hyperinflammatory syndrome and primary HLH.

Also counselled about risk of recurrent of HLH and need to rule out primary HLH by genetic evaluation.

As he remained hemodynamically stable, maintaining saturations at low flow

and accepting NG feeds, he was shifted to ward for further management.

During the ward stay, his vitals were regularly monitored. Low flow oxygen was tapered and stopped. He further improved gradually and he remained hemodynamically stable. He needs further evaluation for suspected pseudobulbar palsy and was advised for continuation of care, but parents wants to get discharge at request with the following advice.

Parents were explained regarding the identification of warning signs and trained in basic life support (BLS).

At the time of discharge: He is active, afebrile and hemodynamically stable.

Discharge Advice:

1. Diet as advised (continue NG feed) - parents trained in NG feeds.
2. Oromotor stimulation.
3. Limb & chest physiotherapy.
4. Nasogastric feeds 100-120ml /3rd hourly (after confirming NG position).
5. Syrup Cefixime (5ml=100mg) 2ml, 12th hourly for 5 days (Refrigerate after reconstitution).
6. Syrup Omnacortil Forte (5ml=15mg)
 - 3.5ml 12th hourly till 17.06.2026
 - 2.5 ml 12th hourly from 18.06.2026 to 20.06.2026
 - 1.5 ml 12th hourly from 21.06.2026 to 23.06.2026
 - 1.5ml once daily from 24.06.2026 to 26.05.2026 and stop
7. Syrup Ranitidine (5ml=75mg) 1.2 ml 12 hourly for 2 weeks.
8. Syrup Domperidone suspension (1ml=1mg) 1.5 ml 8th hourly for 2 weeks.
9. Tablet Lansoprazole (15mg) 1 tablet to dilute in 10 ml of water and give 5 ml once daily for 2 weeks.
10. IQ Norm DHA drops, 1ml once daily for 3 months.

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11. Syrup Calcimax Plus 3.5ml, 12th hourly for 2 weeks.
12. Bevon drops, 1ml, once daily for 1 month.
13. Vitamin-D3 drops (1ml=800IU) 0.5ml once daily till 1 year of age.
14. Oral Enterogermina mini bottle, 1 bottle, 12th hourly for 7 days.
15. Plan to do MRI brain & Whole exome sequencing on follow up.
16. To do CBP, CRP, LFT after 5 days and review with reports.
17. Plan to start direct feed under supervision after Neurology and Physiotherapy assessment on follow up.
18. Kindly consult Dr. K. Vishnu Vardhan Reddy, Consultant Pediatric Intensivist & Pediatrician, after 5 days in OPD with prior appointment (This consultation will be charged).
19. Kindly consult Dr. Sindhura Pappula, Consultant Neurologist, after 5 days in OPD with prior appointment (This consultation will be charged).

In case of Fever:

Paracetamol drops (1ml=100mg), 1.3ml SOS if fever > 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.

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

Master SYED
UMARUDDIN

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VIH-00199881

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Admitting PICU fellow : Dr. Jayasree

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



Registrar/Resident/C.M.O

Dr. KODICHERLA VISHNU VARDHAN REDDY
MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)
Fellow in Pediatric and Cardiac Intensive Care
(RCPCH Birmingham Children's Hospital UK)
Fellow in Pediatric Retrieval Medicine (KIDS-NTS UK)
APMC/FMR/79982



LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN
00199881
AGE : 0Y 11M 6D
GENDER : Male
OP / IP / DG :

REFERRED : DR.KODICHERLA VISHNU
BY VARDHAN REDDY
RAINBOW CHILDRENS MEDICARE PVT LTD
VIKRAMPURI
LAB MR# : AAMP01530274
VISIT NO : VAMP26209106
COLLECTED ON : 07-06-2026 23:40
RECEIVED ON : 08-06-2026 00:30
APPROVED ON : 08-06-2026 18:04
REPORT STATUS : Final Report



Test Name	Result	Biological Ref. Interval	Unit
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HAEMATOLOGY

Flowcytometry - Lymphocyte subset enumeration (B/T/NK quantification) - CD3, CD4, CD8, CD19, CD56, CD45 (Peripheral Blood)

Total Leukocyte Count <i>coulter principle</i>	11.5	6.0 - 16.0	10 ³ /μl
Absolute Lymphocyte Count	2.70 L	3.5-11	10 ³ /μl
Absolute CD3 Counts(T Cells)	1,063 L	1500-5400	Cells/μL
CD3 %	39.4 L	49-76	%
Absolute CD19+ Counts(B Cells)	1,583.00	610-2600	Cells/μL
CD19%	57.80 H	14-37%	%
Absolute CD56/16+ Counts(NK Cells)	26.00 L	160 - 950	Cells/μL
CD56/16%	0.94 L	3-15	%
Absolute CD4 Counts	594 L	1000-3600	Cells/μL
CD4 %	22.0 L	31-56	%
Absolute CD8 Counts	426 L	600-2200	Cells/μL
CD8 %	15.8	12-24	%
CD4/CD8 Ratio	1.4		
COMMENTS	-		

Interpretation:

Clinical Use

- For enumeration of lymphocyte subsets.
- In confirmed COVID-19 patients, CD3+CD4+ and/or CD3+CD8+ lymphocyte counts can also be used as an aid in determining the risk of intubation with mechanical ventilation, and the risk of mortality, in conjunction with clinical findings and the results of other laboratory testing.
- CD4 and CD8 T-cells are important for triggering antibody response and viral killing respectively. Several published studies have shown that individuals with COVID-19 typically exhibit a decrease of CD4 and/or CD8 counts with increasing disease severity.
- Cutoffs for CD4+ (250 cells/μL) and CD8+ (100 cells/μL) T-cell counts were predetermined for the risk of IMV and mortality based on analysis of previously published cohorts of COVID-19 patients.
- Relative risks are ~5-6x higher for IMV and 4.5x higher for mortality for patients with T-cell subset counts below cut-offs (CD4+<250 cells/μl and/or CD8+<100 cells/μl). *





LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN
00199881
AGE : 0Y 11M 6D
GENDER : Male
OP / IP / DG :
#

REFERRED : DR.KODICHERLA VISHNU
BY VARDHAN REDDY
RAINBOW CHILDRENS MEDICARE PVT LTD
VIKRAMPURI
LAB MR# : AAMP01530274

VISIT NO : VAMP26209106
COLLECTED ON : 07-06-2026 23:40
RECEIVED ON : 08-06-2026 00:30
APPROVED ON : 08-06-2026 18:04
REPORT STATUS : Final Report



Test Name	Result	Biological Ref. Interval	Unit
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Chinnari

Dr. Kondaveeti Chinnari
MBBS, MD (PATHOLOGY)
Consultant Pathologist

Disclaimer:

1. All results released pertain to the specimen as received by the lab for testing and under the assumption that the patient indicated or identified on the bill/test requisition form is the owner of the specimen.
2. Clinical details and consent forms, especially in Genetic testing, histopathology, as well as wherever applicable, are mandatory to be accompanied with the test requisition form. The non-availability of such information may lead to delay in reporting as well as misinterpretation of test results. The lab will not be responsible for any such delays or misinterpretations thereof.
3. Test results are dependent on the quality of the sample received by the lab. In case the samples are preprocessed elsewhere (e.g., paraffin blocks), results may be compromised.
4. Tests are performed as per the schedule given in the test listing and in any unforeseen circumstances, report delivery may be affected.
5. Test results may show inter-laboratory as well as intra-laboratory variations as per the acceptable norms.
6. Genetic reports as well as reports of other tests should be correlated with clinical details and other available test reports by a qualified medical practitioner. Genetic counselling is advised in genetic test reports by a qualified genetic counsellor, medical practitioner or both.
7. Samples will be discarded post processing after a specified period as per the laboratory's retention policy. Kindly get in touch with the lab for more information.
8. If accidental damage, loss, or destruction of the specimen is not attributable to any direct or negligent act or omission on the part of Ampath Labs or its employees, Ampath shall in no event be liable. Ampath lab's liability for a lack of services, or other mistakes and omissions, shall be restricted to the amount of the patient's payment for the pertinent laboratory services.





Name	: MASTER.SYED UMARUDDIN VIH-00199881	TID/SID	: UMR4681849/ 32000167
Age / Gender	: 11M(s) 6D(s) / Male	Registered on	: 08-Jun-2026 / 11:50 AM
Ref.By	: DR KODICHERLA VISHNU VARDHAN REDDY	Collected on	: 08-Jun-2026 / 11:50 AM
Req.No	: 26NRLH0211885	Reported on	: 09-Jun-2026 / 16:27 PM
Sample Type	: Whole Blood	Client Name	: RAINBOW CHILDREN HOSPITAL -S

TEST REPORT

DEPARTMENT OF HEMATOPATHOLOGY - I

Hb Variant Analysis with Beta Thalassemia Screening - HPLC/Hb Electrophoresis

Investigation	Hematology	Biological Reference value
Hemoglobin Variant Analysis(Hb-HPLC) with RBC indices		
HPLCNO	31955/26	
Hemoglobin(Hb)	8.2	11.1-14.1 gm% g/dL
HCT	23.8	30-38 vol%
RBC Count	3.64	3.90-5.10 mill /cu.mm
MCV	65.3	72-84 fL
MCH	22.5	25-29 pg
MCHC	34.5	32-36 g/dL
RDW	17.6	11.6-14.0 %
RBC	Anisocytosis, microcytic hypochromic with normocytes, elongated forms and occasional target cells.	
Foetal Hemoglobin (HbF)	4.0	1.3-5.0 %
Hemoglobin A0 (Hb A0)	77.7	
Hemoglobin A2 (HbA2)	2.9	2.0-3.3 %

Chromatographic Profile Summary

HbF and HbA2 are within normal limits. No HbS HbD or other hemoglobin variants seen.

Comments.

Chromatographic profile shows no evidence of hemoglobin variants however, no conclusive opinion is possible on beta thalassemia trait in view of age.

Note

Repeat analysis for conclusive opinion with a fresh sample after 3yrs of age.

Kindly correlate clinically and with Serum ferritin, iron studies.

Interpretation:

1. All results have to be correlated with age and history of blood transfusion. If there is history of blood transfusion in the last 3 months, repeat testing is advised after 3 months from last date of transfusion. 2. In case of hemoglobinopathy, parental or family studies and counseling are advised. 3. This test detects Beta thalassemia and hemoglobinopathies. DNA analysis is recommended to rule out alpha thalassemia and silent carriers. 4. Mild to moderate increase in fetal hemoglobin can be seen in some acquired conditions like pregnancy, megaloblastic anemia, thyrotoxicosis, hypoxia, chronic disease, recovering marrow, MDS, aplastic anaemia, PNH and medications (Hydroxyurea, Erythropoietin) etc.

References:

1. Reference range values for pediatric care 2nd edition
2. Dacie and Lewis practical hematology 12th edition.



PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE



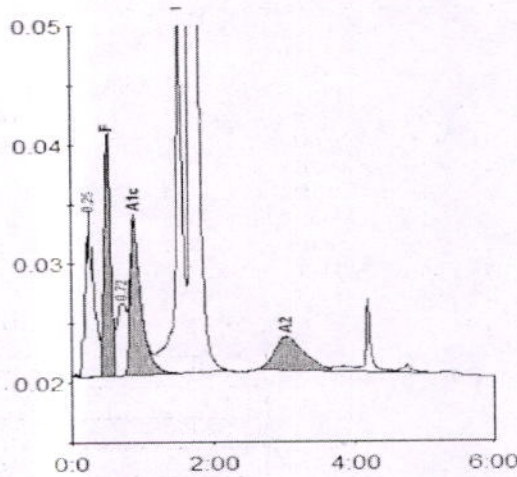
Name : MASTER.SYED UMARUDDIN VIH-00199881
Age / Gender : 11M(s) 6D(s) / Male
Ref.By : DR KODICHERLA VISHNU VARDHAN REDDY
Req.No : 26NRLH0211885
Sample Type : Whole Blood

TID/SID : UMR4681849/ 32000167
Registered on : 08-Jun-2026 / 11:50 AM
Collected on : 08-Jun-2026 / 11:50 AM
Reported on : 09-Jun-2026 / 16:27 PM
Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

Patient report

Bio-Rad DATE: 06/08/2026
D-10 TIME: 03:28 PM
S/N: #DJ7I378402 Software version: 4.30-2
Sample ID: 32000167
Injection date 06/08/2026 02:06 PM
Injection #: 27 Method: HbA2 F
Rack #: --- Rack position: 5



Peak table - ID: 32000167

Peak	R.time	Height	Area	Area %
A1a	0.25	14097	117199	3.6
F	0.52	20240	125742	4.0
LA1c/CHb-1	0.72	6079	52138	1.6
A1c	0.89	12934	138395	5.8
P3	1.53	30095	215539	6.6
A0	1.70	554469	2552912	77.7
A2	3.02	2816	82521	2.9
Total Area:		3284446		

Concentration:	%
F	4.0
A1c	5.8
A2	2.9

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

--- End Of Report ---

S. Rifath



Name : MASTER.SYED UMARUDDIN VIH-00199881
Age / Gender : 11M(s) 6D(s) / Male
Ref.By : DR KODICHERLA VISHNU VARDHAN REDDY
Req.No : 26NRLH0211885
Sample Type :

TID/SID : UMR4681849/
Registered on : 08-Jun-2026 / 11:50 AM
Collected on :
Reported on :
Client Name : RAINBOW CHILDREN
HOSPITAL -S

TEST REPORT

Dr Rifath Shaik
Consultant Pathologist



LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN VIH-00199881
AGE : 0Y 11M 7D
GENDER : Male
OP / IP / DG # :
REFERRED : DR.KODICHERLA VISHNU BY VARDHAN REDDY
RAINBOW CHILDRENS MEDICARE PVT LTD. VIKRAMPURI
LAB MR# : AAMP01530911
VISIT NO : VAMP26209979
COLLECTED ON : 08-06-2026 20:53
RECEIVED ON : 08-06-2026 21:01
APPROVED ON : 09-06-2026 17:17
REPORT STATUS : Partial Report



Test Name	Result	Biological Ref. Interval	Unit
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HAEMATOLOGY

Bone Marrow Aspirate Morphological Assessment (Bone marrow aspirate / Peripheral Blood (EDTA/Heparin))
(Staining and Microscopy)

Bone Marrow Aspirate Morphological Assessment
Staining and Microscopy

Bone marrow No: BM26/1712

Final Impression: Bone marrow is showing Erythroid hyperplasia and presence of hemophagocytosis .

Specimen:

Peripheral blood EDTA-1 vacutainer, smears 4 unstained labelled.

Bone marrow aspirate in EDTA-2, vacutainers, smears-14, imprint smears-6 unstained labelled.

Recent peripheral blood counts:

Hemoglobin	7.9 g/dL	Hematocrit	27.6 %	RBC count	3.67 x10 ⁶ / µl
MCV	75.3 fL	MCH	21.5 pg	MCHC	28.6 g/dL
RDW-CV	22.1 %	WBC count	23.4 x10 ³ /µl	Platelet count	177 x10 ³ / µl

Peripheral blood smear examination

RBCs: Normocytic normochromic, normocytic hypochromic, target cells are seen.

WBCs: Neutrophilic leucocytosis.

Platelet: Mild thrombocytopenia.





LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN VIH-00199881
AGE : 0Y 11M 7D
GENDER : Male
OP / IP / DG #
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RAINBOW CHILDRENS MEDICARE PVT LTD VIKRAMPURI
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Test Name	Result	Biological Ref. Interval	Unit
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Bone marrow aspirate and imprint examination

Cellularity: Particulate and normocellular.

Megakaryopoiesis

Cellularity: Adequate.

Morphology: Normal. Few hypolobated megakaryocytes seen , Fragmented nuclei and micromegakaryocytes seen.

BM nucleated cells differential counts – cells counted

Promyelocytes	02 %	Eosinophils	02 %
Myelocytes	17 %	Lymphocytes	10-11 %
Metamyelocytes	14 %	Plasma cells	01-02 %
Neutrophils	19 %	Erythroid precursors	44 %

M: E - 1.5:1

Erythropoiesis:

Cellularity: Moderately increased.

Morphology: MicroNormoblastic and mild megaloblastic maturation.





LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN VIH-00199881
AGE : 0Y 11M 7D
GENDER : Male
OP / IP / DG # :
REFERRED : DR.KODICHERLA VISHNU
BY : VARDHAN REDDY
RAINBOW CHILDRENS MEDICARE PVT LTD
VIKRAMPURI
LAB MR# : AAMP01530911
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Test Name	Result	Biological Ref. Interval	Unit
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Myelopoiesis:

Cellularity: Moderately reduced.

Morphology: Normal maturation pattern.

Blasts: Excess is not seen.

Lymphocytes & Plasma cells : Normal in number & morphology.

Macrophages: Scattered macrophages seen and are increased . Hemophagocytosis seen.

Imprint smear: Shows similar features.

Perl's Stain : Depleted . Grade I . No ringed sideroblast are seen .

Final Impression: Bone marrow is showing Erythroid hyperplasia and presence of hemophagocytosis.

Advice: Await report on Trepine biopsy. Correlation with biochemical parameters for HLH.

Result/s to Follow : BONE MARROW BIOPSY





LABORATORY REPORT

NAME : MASTER SYED UMARUDDIN VIH-00199881
AGE : 0Y 11M 7D
GENDER : Male
OP / IP / DG # :
REFERRED : DR.KODICHERLA VISHNU
BY VARDHAN REDDY
RAINBOW CHILDRENS MEDICARE PVT LTD
VIKRAMPURI
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Test Name	Result	Biological Ref. Interval	Unit
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Sachin Johari

Dr.Sachin Johari
Consultant Pathologist

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Visit ID	: YOD1387387	UHID/MR No	: YOD.0001328649
Patient Name	: Master.SYED UMARUDDIN	Client Code	: YOD-TS-0281
Age/Gender	: 0 Y 11 M 7 D/M	Barcode No	: YD18401
DOB	:	Registration	: 2026-06-07 10:12
Ref Doctor	: KODICHERLA VISHNU VARDHAN REDDY	Collected	: 2026-06-07 12:42
Client Name	: RAINBOW CHILDREN HOSPITAL VIKR	Received	: 2026-06-07 13:27
Client Add	: Plot.No:C16&17, Vikrampuri, Ka	Reported	: 2026-06-07 13:50
Hospital Name	:		

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
IRON / TIBC				
Sample Type : SERUM				
SERUM IRON LEVELS	99.6	ug/dl	33 - 193	Ferrozine
TOTAL IRON BINDING CAPACITY	270.6	ug/dl	250 - 400	Calculated
UIBC	171	ugm/dL	130 - 375	Ferrozine
TRANSFERRIN SATURATION INDEX	36.81	%	14 - 50	Calculated

About :

Ingested iron is absorbed primarily from the intestinal tract and is temporarily stored in the mucosal cells as ferritin (Fe[III]). Ferritin provides a soluble protein shell to encapsulate a complex of insoluble ferric hydroxide-ferric phosphate. On demand, iron is released into the blood by mechanisms that are not clearly understood, to be transported as Fe(III)-transferrin.

Transferrin is the primary plasma iron transport protein, which binds iron strongly at physiological pH. Transferrin is generally only 25% to 30% saturated with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). The total iron-binding capacity (TIBC) can be indirectly determined using the sum of the serum iron and UIBC. Knowing the molecular weight of the transferrin and that each molecule of transferrin can bind 2 atoms of iron, TIBC and transferrin concentration is interconvertible.

Percent saturation is usually normal or decreased in persons who are iron deficient, pregnant, or are taking oral contraceptive medications. Persons with chronic inflammatory processes, hemochromatosis, or malignancies generally display low transferrin.

Serum iron, total iron-binding capacity, and percent saturation are widely used for the diagnosis of iron deficiency. However, serum ferritin is a much more sensitive and reliable test for demonstration of iron deficiency.

References

<https://www.mayocliniclabs.com/test-catalog/overview/34624#Clinical-and-Interpretive>

*** End Of Report ***

This is an Autoapproved Report

Verified By :
ARSHIYA ANJUM



Approved By :

Arshya

DR ARSHIYA ANJUM
MBBS, MD, BIOCHEMISTRY
CONSULTANT BIOCHEMIST
REG NO : 68219

PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 5 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
CALCIUM (Arsenazo dye)	7.4	mg/dl	L 8.5 - 11



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 :06-06-2026 22:16			
HEMOGLOBIN (Colorimetry)	7.7	g/dL	L 10.5 - 13.5
RBC COUNT (DC detection method)	3.33	10 ¹² /L	L 3.7 - 5.6
PCV/HCT (Calculated)	22.1	VOL%	L 33 - 49
MCV (Calculated)	66.5	fL	L 70 - 86
MCH (Calculated)	23.1	pg/cells	23 - 31
MCHC (Calculated)	34.8	g/dL	30 - 36
RDW-CV (Calculated)	16.4	%	H 11.5 - 16
PLATELET COUNT (DC Detection Method)	204	10 ⁹ /L	150 - 450
MPV (Calculated)	7.3	fL	6.5 - 10
WBC COUNT (DC Detection Method)	24.93	10 ⁹ /L	H 6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	45	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	53	%	45 - 76
MONOCYTES (Microscopy, Leishman stain)	1	%	L 4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	1	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : ANISOCYTOSIS WITH NORMOCYTIC / NORMOCHROMIC, NORMOCYTIC / HYPOCHROMIC, MICROCYTES(++) WBC : LEUCOCYTOSIS WITH NEUTROPHILS SHOWING TOXIC GRANULES 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 :06-06-2026 22:16			

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN Inpatient No. : IP-00060254
Age/Gender : 0 Y 11 M 5 D/ Male Admit Date : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	48.0	mg/L	H <10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
CREATININE (Specimen : SERUM)			
CREATININE (Enzymatic)	0.9	mg/dl	H 0.03 - 0.5



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
ELECTROLYTES (Specimen : SERUM)			
SODIUM (Direct ISE)	135	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.7	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	104	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
HIV TEST (CARD METHOD) (Specimen : SERUM)			
HIV TEST (CARD METHOD)	Non-reactive		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
LIVER FUNCTION TEST (Specimen : SERUM)			
TOTAL BILIRUBIN (Azobilirubin)	0.2	mg/dl	<1.3

Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002,



PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 5 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	2463	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	975	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	121	U/L	120 - 470
PROTEIN (Biuret method)	5.0	g/dL	L 5.9 - 7
ALBUMIN (Bromocresol Green)	2.7	g/dL	2 - 4.7
GLOBULIN (Calculated)	2.29	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1.1		L 1.4 - 3.4

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16
MAGNESIUM (Formazon dye)	2.8	mg/dl	H 1.6 - 2.6

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16
PT (Optical Clot Detection)	29.1	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	2.07		
APTT (Optical Clot Detection)	37.8	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

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Emergency ☎ 040 - 4246 2300 Emergency ☎ 040 - 4246 2100 Emergency ☎ 040 - 4246 2400 Emergency ☎ 040 - 7111 1333 Emergency ☎ 040-69313233

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 5 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 22:16			
UREA (Specimen : SERUM)			
UREA (Kinetic, Urease)	104.3	mg/dl	H 4 - 28



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT ENTERED Order Date :06-06-2026 22:23			
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			
RANDOM BLOOD GLUCOSE (GOD/POD)	35	mg/dl	L 70 - 140

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT ENTERED Order Date :06-06-2026 22:23			
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)			
PH (Reagent Strip/Double PH Indicator)	7.13	unit	L 7.35 - 7.45
pCO2	48.9	mm Hg	H 35 - 48
pO2	46	mm Hg	L 83 - 108
HCO3	16.4	mmol/L	
BE	-12.9	mmol/L	
O2 Sat	68	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT ENTERED Order Date :06-06-2026 22:24			
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			
RANDOM BLOOD GLUCOSE (GOD/POD)	87	mg/dl	70 - 140

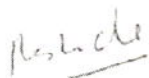
Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :06-06-2026 23:44			
FERRITIN (Specimen : SERUM)			
FERRITIN (CLIA)	1200	ng/ml	H 12 - 327

INTERPRETATION

Ferritin is a protein that stores iron in the body.
Low levels may indicate iron deficiency anemia or chronic blood loss.
High levels can be seen in inflammation, liver disease or iron overload disorders such as hemochromatosis.
All the abnormal results are to be correlated clinically.

DISCLAIMER

Test results released pertain to the specimen submitted. All test results are dependent on the quality of the sample received by the laboratory. Test Result may show interlaboratory variations. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the referring physician.



Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

PatientName : Master SYED UMARUDDIN

Inpatient No. IP-00060254

Age/Gender : 0 Y 11 M 6 D/ Male

Admit Date : 06-06-2026

Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
PROCALCITONIN (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :06-06-2026 23:44	
PROCALCITONIN	33.4	ng/ml	H <0.5

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Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :07-06-2026 02:33	
RANDOM BLOOD GLUCOSE (GOD/POD)	100	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :07-06-2026 02:37	
PH (Reagent Strip/Double PH Indicator)	7.20	unit	L 7.35 - 7.45
pCO ₂	52.5	mm Hg	H 35 - 48
pO ₂	38	mm Hg	L 83 - 108
HCO ₃	20.6	mmol/L	
BE	-7.5	mmol/L	
O ₂ Sat	59.9	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
COMPLETE URINE EXAMINATION (Specimen : URINE)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :07-06-2026 04:11	

PHYSICAL

COLOUR (Visual Examination)	PALE YELLOW	
APPEARANCE (Gross Examination)	CLEAR	
pH (Double pH indicator)	6.0	5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.005	1.005 - 1.030
SEDIMENT (Gross Examination)	NIL	NIL

CHEMICAL

PROTEIN (Protein error of pH indicator)	Trace	NIL
GLUCOSE (GOD POD method)	NIL	NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE	NEGATIVE
BILE SALTS (Hay's Sulfur Test)	ABSENT	ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT	ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE	NEGATIVE
BLOOD (Peroxidase reaction)	PRESENT +	ABSENT

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040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN Inpatient No. : IP-00060254
Age/Gender : 0 Y 11 M 6 D/ Male Admit Date : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
LEUCOCYTES (Esterase reaction)	NEGATIVE		NEGATIVE
<u>MICROSCOPY</u>			
PUS CELLS	3 - 5	HPF	L 0 - 5
EPITHELIAL CELLS	2 - 3	HPF	L 0 - 5
RBCS.	4 - 6	HPF	L 0 - 2



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



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040-42462200, Ext 2000,2001,2002,



PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 6 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060294
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
LDH (LACTATE DEHYDROGENASE) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :07-06-2026 06:34
LDH (L to P-IFCC Ref. PROC.,Calibrated)	920	U/L	H 170 - 580

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Reg No : HMC13081

DISCHARGE SUMMARY

DISCHARGE SUMMARY

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040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 6 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
RETICULOCYTE COUNT (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 06:34
RETICULOCYTE COUNT (Microscopy, New methylene blue stain)	0.5	%	L 1 - 3



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Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :07-06-2026 09:39
PH (Reagent Strip/Double PH Indicator)	7.24	unit	L 7.35 - 7.45
pCO2	50.8		
pO2	101	mm Hg	83 - 108
HCO3	20.1		
BE	-5.2	mmol/L	
O2 Sat	96.6	mmol/L	
HCT (Pulse Height Detection)	26	%	10 - 75

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :07-06-2026 09:39
RANDOM BLOOD GLUCOSE (GOD/POD)	91	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 12:29
CREATININE (Enzymatic)	0.5	mg/dl	0.03 - 0.5



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Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 12:29
TOTAL BILIRUBIN (Azobilirubin)	0.3	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<1.1

PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 6 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
SGOT (AST) (Kinetic with P5P)	2252	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	1395	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	153	U/L	120 - 470
PROTEIN (Biuret method)	6.4	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	3.4	g/dL	2 - 4.7
GLOBULIN (Calculated)	3	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1.1		L 1.4 - 3.4



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Investigation	Result	Unit	Biological Reference Interval
NT-PROBNP (N-TERMINAL PRO-B-TYPE NATRIURETIC PEPTIDE) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 12:29
NT PRO BNP	27200	pg/mL	H <300



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Investigation	Result	Unit	Biological Reference Interval
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 12:29
PT (Optical Clot Detection)	28.0	Seconds	
INR	2.0		
APTT (Optical Clot Detection)	34.0	Seconds	



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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TROPONIN T/I (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 12:29
TROPONIN - I	0.087	ng/ml	H <0.034

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040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN Inpatient No. : IP-00060254
Age/Gender : 0 Y 11 M 6 D/ Male Admit Date : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
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UREA (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :07-06-2026 12:29

UREA (Kinetic, Urease) 51.6 mg/dl H 4 - 28



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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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CALCIUM (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :07-06-2026 17:07

CALCIUM (Arsenazo dye) 8.3 mg/dl L 8.5 - 11



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Investigation	Result	Unit	Biological Reference Interval
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COMPLETE BLOOD PICTURE (Specimen : BLOOD)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :07-06-2026 17:07

HEMOGLOBIN (Colorimetry) 7.6 g/dL L 10.5 - 13.5
RBC COUNT (DC detection method) 3.26 10¹²/L L 3.7 - 5.6
PCV/HCT (Calculated) 21.5 VOL% L 33 - 49
MCV (Calculated) 65.9 fL L 70 - 86
MCH (Calculated) 23.2 pg/cells 23 - 31
MCHC (Calculated) 35.2 g/dL 30 - 36
RDW-CV (Calculated) 16.2 % H 11.5 - 16
PLATELET COUNT (DC Detection Method) 181 10⁹/L 150 - 450
MPV (Calculated) 6.9 fL 6.5 - 10
WBC COUNT (DC Detection Method) 12.85 10⁹/L 6 - 17

Differential Count

NEUTROPHILS (Microscopy, Leishman stain) 65 % H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain) 27 % L 45 - 76
MONOCYTES (Microscopy, Leishman stain) 07 % 4 - 12
EOSINOPHILS (Microscopy, Leishman stain) 01 % 1 - 7

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040-42462200, Ext 2000,2001,2002,



PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 6 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No: IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : ANISOCYTOSIS WITH MICROCYTIC / HYPOCHROMIC ELLIPTOCYTES++ WBC: MORPHOLOGY NORMAL PLATELETS : ADEQUATE		

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Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 17:07
SODIUM (Direct ISE)	151	mmol/L	H 134 - 144
POTASSIUM (Direct ISE)	2.6	mmol/L	L 3.5 - 6.1
CHLORIDE (Direct ISE)	116	mmol/L	H 98 - 108

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Investigation	Result	Unit	Biological Reference Interval
PLASMA FIBRINOGEN (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 17:07
PLASMA FIBRINOGEN	97.96	mg/dl	L 157 - 360

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MC-7373

PatientName	: Master SYED UMARUDDIN	Inpatient No.	: IP-00060254
Age/Gender	: 0 Y 11 M 6 D/ Male	Admit Date	: 06-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
TRIGLYCERIDES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 17:07
TRIGLYCERIDES (Enzymatic with end point)	167	mg/dl	H <75

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PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 6 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
URIC ACID (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :07-06-2026 17:07
URIC ACID (Uricase)	6.6	mg/dl	H 1.2 - 5.6

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Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :07-06-2026 17:26
BLOOD GROUP	A		
RH (D) TYPE	POSITIVE		

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Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :07-06-2026 17:27
PH (Reagent Strip/Double PH Indicator)	7.29	unit	L 7.35 - 7.45
pCO2	48		
pO2	149	mm Hg	H 83 - 108
HCO3	23.0		
BE	-3.2	mmol/L	
O2 Sat	98.9%	mmol/L	
HCT (Pulse Height Detection)	25%	%	10 - 75
ctHb	8.0	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :07-06-2026 17:27
RANDOM BLOOD GLUCOSE (GOD/POD)	102	mg/dl	70 - 140
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :08-06-2026 00:33
RANDOM BLOOD GLUCOSE (GOD/POD)	130	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :08-06-2026 05:42

HIMAYATHNAGAR Emergency ☎ 040 - 48873009 BANJARA HILLS (JCL NABH & NABL Accredited) Emergency ☎ 040 - 4466 5555, 91609 25516 HYDERNAGAR (NABH Accredited) Emergency ☎ 040 - 4246 2300 KONDAPUR OUTPATIENT CLINIC (JCI Accredited IVF) Emergency ☎ 040 - 4246 2100 SECUNDERABAD (NABH Accredited) Emergency ☎ 040 - 4246 2200 KONDAPUR ACCREDITED CLINIC (NABL Accredited) Emergency ☎ 040 - 4246 2400 KAKAGUDA Emergency ☎ 040 - 7111 1333 KAKAGUDA Emergency ☎ 040-69313233

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040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 7 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
TOTAL BILIRUBIN (Azobilirubin)	0.5	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.4	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	2203	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	1816	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)142		U/L	120 - 470
PROTEIN (Biuret method)	6.3	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	3.5	g/dL	2 - 4.7
GLOBULIN (Calculated)	2.8	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1.2		L 1.4 - 3.4



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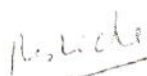
Investigation	Result	Unit	Biological Reference Interval
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 05:15
PT (Optical Clot Detection)	24.2	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.72		
APTT (Optical Clot Detection)	28.8	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		



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Investigation	Result	Unit	Biological Reference Interval
AMMONIA (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 10:01
AMMONIA	60	µmol/L	H 11 - 35



Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 7 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)		TEST RESULT STATUS : REPORT ENTERED Order Date :08-06-2026 12:11	
PH (Reagent Strip/Double PH Indicator)	7.51	unit	H 7.35 - 7.45
pCO2	41.2		
pO2	83	mm Hg	83 - 108
HCO3	32.5		
BE	8.7	mmol/L	
O2 Sat	96.8	mmol/L	
HCT (Pulse Height Detection)	34%	%	10 - 75
ctHb	32.5	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED Order Date :08-06-2026 12:11	
RANDOM BLOOD GLUCOSE (GOD/POD)	101	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 15:22	
HEMOGLOBIN (Colorimetry)	9.7	g/dL	L 10.5 - 13.5
RBC COUNT (DC detection method)	3.98	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	27.4	VOL%	L 33 - 49
MCV (Calculated)	68.8	fL	L 70 - 86
MCH (Calculated)	24.3	pg/cells	23 - 31
MCHC (Calculated)	35.4	g/dL	30 - 36
RDW-CV (Calculated)	17.5	%	H 11.5 - 16
PLATELET COUNT (DC Detection Method)	164	10 ⁹ /L	150 - 450
MPV (Calculated)	7.3	fL	6.5 - 10
WBC COUNT (DC Detection Method)	12.21	10 ⁹ /L	6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	77	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	17	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	05	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7

PERIPHERAL SMEAR (Microscopy, Leishman stain) RBC : NORMOCYTIC / HYPOCHROMIC,MICROCYTES(+)
WBC : MORPHOLOGY NORMAL
PLATELETS : ADEQUATE

PatientName	: Master SYED UMARUDDIN	Inpatient No.	: IP-00060254
Age/Gender	: 0 Y 11 M 7 D/ Male	Admit Date	: 06-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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ELECTROLYTES (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :08-06-2026 15:26

SODIUM (Direct ISE)	142	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.6	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	100	mmol/L	98 - 108



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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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CSF ANALYSIS (Specimen : CSF)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :08-06-2026 16:03

COLOUR (Visual Examination)	COLOURLESS		
APPEARANCE (Gross Examination)	CLEAR		
PH (Reagent Strip/Double PH Indicator)	8.0	unit	H 7.35 - 7.45
CLOT FORMATION	NO CLOT		
CSF PROTEIN	66	mg/dl	H 15 - 45
CSF GLUCOSE (Trinder)	85	mg/dl	60 - 90
CELL COUNT	3 CELLS		
CELL TYPE	100% LYMPHOCYTES 1-2RBC/HPF		



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Investigation	Result	Unit	Biological Reference Interval
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RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT ENTERED

Order Date :08-06-2026 16:32

RANDOM BLOOD GLUCOSE (GOD/POD)	139	mg/dl	70 - 140
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Investigation	Result	Unit	Biological Reference Interval
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ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)

TEST RESULT STATUS : REPORT ENTERED

Order Date :08-06-2026 18:39


PH (Reagent Strip/Double PH Indicator)	7.46	unit	H 7.35 - 7.45
pCO2	50.0		
pO2	80	mm Hg	L 83 - 108

PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 7 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
HCO3	34.6		
BE	10.9	mmol/L	
O2 Sat	96.1	mmol/L	
HCT (Pulse Height Detection)	36	%	10 - 75
ctHb	11.7	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-06-2026 04:58
CREATININE (Enzymatic)	0.3	mg/dl	0.03 - 0.5


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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-06-2026 04:58
SODIUM (Direct ISE)	138	mmol/L	134 - 144
POTASSIUM (Direct ISE)	8.3	mmol/L	H 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
LIVER FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-06-2026 04:58
TOTAL BILIRUBIN (Azobilirubin)	0.6	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.4	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	720	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	1485	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	133	U/L	120 - 470
PROTEIN (Biuret method)	8.8	g/dL	H 5.9 - 7
ALBUMIN (Bromocresol Green)	3.4	g/dL	2 - 4.7
GLOBULIN (Calculated)	5.4	g/dL	H 1.6 - 3.5

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040-42462200, Ext 2000,2001,2002,

PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 8 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
A/G RATIO (Calculated)	0.6		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 04:58			
UREA (Specimen : SERUM)			
UREA (Kinetic, Urease)	28.5	mg/dl	H 4 - 28



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 05:01			
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			
PT (Optical Clot Detection)	21.0	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.5		
APTT (Optical Clot Detection)	31.0	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 06:49			
CALCIUM (Specimen : SERUM)			
CALCIUM (Arsenazo dye)	9.1	mg/dl	8.5 - 11



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 8 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-06-2026 06:49
SODIUM (Direct ISE)	134	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.2	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	88	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-06-2026 06:49
MAGNESIUM (Formazon dye)	1.0	mg/dl	L 1.6 - 2.6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :09-06-2026 07:45
PH (Reagent Strip/Double PH Indicator)	7.53	unit	H 7.35 - 7.45
pCO2	47.3		
pO2	70	mm Hg	L 83 - 108
HCO3	39.8		
BE	15.6	mmol/L	
O2 Sat	95.1	mmol/L	
HCT (Pulse Height Detection)	37	%	10 - 75

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :09-06-2026 07:49
PH (Reagent Strip/Double PH Indicator)	7.54	unit	H 7.35 - 7.45
pCO2	42.3		
pO2	105	mm Hg	83 - 108
HCO3	36.2		
BE	12.5	mmol/L	
O2 Sat	98.3	mmol/L	
HCT (Pulse Height Detection)	40	%	10 - 75

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PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 8 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT ENTERED Order Date :09-06-2026 11:33			
PH (Reagent Strip/Double PH Indicator)	7.48	unit	H 7.35 - 7.45
pCO2	57	mm Hg	H 35 - 48
pO2	34	mm Hg	L 83 - 108
HCO3	42.2	mmol/L	
BE	16.8	mmol/L	
O2 Sat	69.7	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			
TEST RESULT STATUS : REPORT ENTERED Order Date :09-06-2026 12:47			
RANDOM BLOOD GLUCOSE (GOD/POD)	118	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 14:27			
CRP (Immunoturbidimetry)	15.0	mg/L	H <10



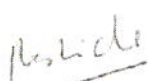
Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 14:27			
SODIUM (Direct ISE)	138	mmol/L	134 - 144
POTASSIUM (Direct ISE)	3.8	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	85	mmol/L	L 98 - 108



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

Investigation	Result	Unit	Biological Reference Interval
PROCALCITONIN (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 14:27			
PROCALCITONIN	8.63	ng/ml	H <0.5



Dr. RASHIDA MAHREEN, MBBS, MD
 This is an interim report. The final report will be released after 24 hours.

PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 8 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
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VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)

TEST RESULT STATUS : REPORT ENTERED

Order Date :09-06-2026 14:54

PH (Reagent Strip/Double PH Indicator)	7.48	unit	H 7.35 - 7.45
pCO ₂	58.2	mm Hg	H 35 - 48
pO ₂	43	mm Hg	L 83 - 108
HCO ₃	41.9	mmol/L	
BE	18.1	mmol/L	
O ₂ Sat	81	mmol/L	

VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)

TEST RESULT STATUS : REPORT ENTERED

Order Date :09-06-2026 17:29

PH (Reagent Strip/Double PH Indicator)	7.46	unit	H 7.35 - 7.45
pCO ₂	58.2	mm Hg	H 35 - 48
pO ₂	39	mm Hg	L 83 - 108
HCO ₃	39.7	mmol/L	
BE	16.2	mmol/L	
O ₂ Sat	76.4	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
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ELECTROLYTES (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-06-2026 19:56

SODIUM (Direct ISE)	139	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.5	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	88	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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COMPLETE BLOOD PICTURE (Specimen : BLOOD)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :10-06-2026 05:29

HEMOGLOBIN (Colorimetry)	10.8	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.43	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	30.7	VOL%	L 33 - 49
MCV (Calculated)	69.3	fL	L 70 - 86
MCH (Calculated)	24.3	pg/cells	23 - 31
MCHC (Calculated)	35.1	g/dL	30 - 36
RDW-CV (Calculated)	16.6	%	H 11.5 - 16

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040-42462200, Ext 2000,2001,2002.

PatientName : Master SYED UMARUDDIN **Inpatient No.** : IP-00060254
Age/Gender : 0 Y 11 M 9 D/ Male **Admit Date** : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
PLATELET COUNT (DC Detection Method)	135	10 ⁹ /L	L 150 - 450
MPV (Calculated)	7.9	fL	6.5 - 10
WBC COUNT (DC Detection Method)	7.89	10 ⁹ /L	6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	65	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	30	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	04	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC , NORMOCYTIC / HYPOCHROMIC WBC - MORPHOLOGY NORMAL PLATELETS - REDUCED		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

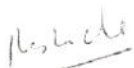
Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :10-06-2026 05:29
SODIUM (Direct ISE)	138	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.0	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	96	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
FERRITIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :10-06-2026 05:29
FERRITIN (CLIA)	185	ng/ml	12 - 327



Dr. RASHIDA MAHREEN, MBBS,MD

CONSULTANT BIOCHEMIST, Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
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H.No.3-7,-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
040-42462200, Ext 2000,2001,2002,



PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 9 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-06-2026 05:29	
TOTAL BILIRUBIN (Azobilirubin)	0.7	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.6	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	474	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	1057	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	107	U/L	L 120 - 470
PROTEIN (Biuret method)	6.7	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	2.8	g/dL	2 - 4.7
GLOBULIN (Calculated)	3.9	g/dL	H 1.6 - 3.5
A/G RATIO (Calculated)	0.7		L 1.4 - 3.4

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :10-06-2026 06:16	
PH (Reagent Strip/Double PH Indicator)	7.45	unit	7.35 - 7.45
pCO2	61	mm Hg	H 35 - 48
pO2	35	mm Hg	L 83 - 108
HCO3	42.3	mmol/L	
BE	16.5	mmol/L	
O2 Sat	69.4	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :10-06-2026 06:17	
PH (Reagent Strip/Double PH Indicator)	7.43	unit	7.35 - 7.45
pCO2	61.1	mm Hg	H 35 - 48
pO2	34	mm Hg	L 83 - 108
HCO3	40.6	mmol/L	
BE	14.7	mmol/L	
O2 Sat	66.9	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED	
		Order Date :10-06-2026 06:18	

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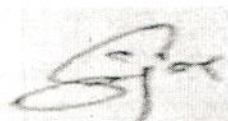
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana ,INDIA ,500009.
040-42462200, Ext 2000,2001,2002,

PatientName	: Master SYED UMARUDDIN	Inpatient No.	: IP-00060254
Age/Gender	: 0 Y 11 M 9 D/ Male	Admit Date	: 06-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE (GOD/POD)	97	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :10-06-2026 16:32
PH (Reagent Strip/Double PH Indicator)	7.43	unit	7.35 - 7.45
pCO2	57.1	mm Hg	H 35 - 48
pO2	32	mm Hg	L 83 - 108
HCO3	34.7	mmol/L	
BE	11.7	mmol/L	
O2 Sat	62.1	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :10-06-2026 18:21
SODIUM (Direct ISE)	137	mmol/L	134 - 144
POTASSIUM (Direct ISE)	4.1	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	100	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :10-06-2026 18:45
PH (Reagent Strip/Double PH Indicator)	7.40	unit	7.35 - 7.45
pCO2	55.9	mm Hg	H 35 - 48
pO2	33	mm Hg	L 83 - 108
HCO3	34.1	mmol/L	
BE	8.6	mmol/L	
O2 Sat	62.5	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :11-06-2026 05:17
PH (Reagent Strip/Double PH Indicator)	7.31	unit	L 7.35 - 7.45
pCO2	49	mm Hg	H 35 - 48
pO2	35	mm Hg	L 83 - 108
HCO3	30.7	mmol/L	
BE	5.4	mmol/L	
O2 Sat	67.4%	mmol/L	

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 : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 10 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :12-06-2026 04:23			
HEMOGLOBIN (Colorimetry)	10.9	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.47	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	31.2	VOL%	L 33 - 49
MCV (Calculated)	69.9	fL	L 70 - 86
MCH (Calculated)	24.4	pg/cells	23 - 31
MCHC (Calculated)	34.9	g/dL	30 - 36
RDW-CV (Calculated)	17.6	%	H 11.5 - 16
PLATELET COUNT (DC Detection Method)	120	10⁹/L	L 150 - 450
MPV (Calculated)	8.1	fL	6.5 - 10
WBC COUNT (DC Detection Method)	16.18	10 ⁹ /L	6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	85	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	12	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	02	%	L 4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC , NORMOCYTIC / HYPOCHROMIC WBC - TC NORMAL WITH NEUTROPHILIA PLATELETS - REDUCED		

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 :12-06-2026 04:23			
CRP (Immunoturbidimetry)	10	mg/L	<10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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GREATININE (Specimen : SERUM) TEST RESULT STATUS : REPORT AUTHORISED

Order Date :12-06-2026 04:23

1800 2122

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040-42462200, Ext 2000,2001,2002.

PatientName : Master SYED UMARUDDIN Inpatient No. : IP-00060254
Age/Gender : 0 Y 11 M 11 D/ Male Admit Date : 06-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Enzymatic)	0.2	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 :12-06-2026 04:23
SODIUM (Direct ISE)	134	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.2	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	100	mmol/L	98 - 108



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 :12-06-2026 04:23
TOTAL BILIRUBIN (Azobilirubin)	0.7	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.6	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	325	U/L	H 22 - 63
SGPT (ALT) (Kinetic with P5P)	928	U/L	H 12 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)95		U/L	L 120 - 470
PROTEIN (Biuret method)	6.7	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	2.9	g/dL	2 - 4.7
GLOBULIN (Calculated)	3.8	g/dL	H 1.6 - 3.5
A/G RATIO (Calculated)	0.7		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :12-06-2026 04:23

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PatientName : Master SYED UMARUDDIN
Age/Gender : 0 Y 11 M 11 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060254
Admit Date : 06-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
UREA (Kinetic, Urease)	12.2	mg/dl	4 - 28

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

DISCHARGE

Laboratory Report

Master SYED UMARUDDIN

8639460407

0 Y 11 M 7 D

VI26019551

Male

06-06-2026 10:18 PM

IP-00060254

06-06-2026 10:41 PM

VIH-00199881

Dr. KODICHERLA VISHNU VARDHAN REDDY

N 0 GF-EMERGENCY / ER 101

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

Master SYED UMARUDDIN

0 Y 11 M 7 D

VI26019603

Male

07-06-2026 05:09 PM

IP-00060254

07-06-2026 05:16 PM

VIH-00199881

08-06-2026 09:04 AM

KODICHERLA VISHNU VARDHAN REDDY

N 1F-PICU / PICU 140

IMMUNODEFICIENCY PANEL PID.2 (Specimen :SERUM)

IMMUNODEFICIENCY PANEL PID.2

Investigation	Observed Value	Biological Reference Interval
Immunoglobulin A (IgA)	39.3 mg/dl	70 - 400 mg/dl
Immunoglobulin G (IgG)	972 mg/dl	700 - 1600 mg/dl
Immunoglobulin M (IgM)	84.6 mg/dl	40 - 230 mg/dl
Immunoglobulin E (Ige)	51.1 iu/ml	<60 iu/ml

Method : Rate Nephelometry.

***** End of report *****

Dr. VIJENDRA KAWLE MD DNB
(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER
MD FRCPATH DNB DPB
CONSULTANT MICROBIOLOGIST
Reg No :64038

Laboratory Report

Patient Name	Master SYED UMARUDDIN	Patient Ph. No	8639460407
Age	0 Y 11 M 9 D	Requisition No	VI26019658
Gender	Male	Collected on	08-06-2026 12:29 PM
IP / Bill No.	IP-00060254	Received on	08-06-2026 01:22 PM
UHID No.	VIH-00199881	Reported on	
Ref Doctor	Dr. KODICHERLA VISHNU VARDHAN REDDY	Ward/Bed No	PICU 140

BONE MARROW CULTURE & SENSITIVITY (Specimen :BONE MARROW)

RESULT

TEST RESULT STATUS : REPORT ENTERED

Culture : -

Second Report - No growth after 48 hrs of incubation

..... End of the Report

Master SYED UMARUDDIN

0 Y 11 M 5 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009108

06-06-2026 10:50 PM

12-06-2026 04:07 PM

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Right mild pleural effusion.

Haziness in right mid and lower zones.

Domes of diaphragm are normal.

CP angles are clear.

Bones and soft tissues normal.

No subdiaphragmatic pathology.

Print Date/Time : 12-06-2026 04:07 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 1

Master SYED UMARUDDIN

8639460407

0 Y 11 M 6 D

R26-009112

Male

07-06-2026 04:37 AM

IP-00060254

12-06-2026 04:13 PM

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Right minimal pleural effusion.

Mild haziness in right hemithorax.

NG tube, central line, ET tube in situ.

Domes of diaphragm are normal.

Bones and soft tissues normal.

No subdiaphragmatic pathology.

Master SYED UMARUDDIN

R26-009190

0 Y 11 M 7 D

Male

08-06-2026 05:45 PM

IP-00060254

08-06-2026 05:50 PM

VIH-00199881

08-06-2026 05:50 PM

KODICHERLA VISHNU VARDHAN REDDY

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	Normal
Inter atrial septum	Intact
Mitral Valve	Normal
Tricuspid Valve	trivial tr
Right ventricle	Normal
Left ventricle	mild 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	Normal
Coronaries	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 08-06-2026 05:50 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Master SYED UMARUDDIN

8639460407

0 Y 11 M 7 D

R26-009190

Male

08-06-2026 05:45 PM

IP-00060254

08-06-2026 05:50 PM

VIH-00199881

08-06-2026 05:50 PM

KODICHERLA VISHNU VARDHAN REDDY

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.2		Tricuspid Annulus		
LA	1.8		Mitral Annulus		
IVSd	0.5		Aortic Annulus		
LVIDd	2.3		PA Annulus		
LVPWd	0.7		RPA		
IVSs	0.7		LPA		
LVIDS	1.5		MPA		
LVPWs	0.9		AO Isthmus		
EF	50%		LV Mass		
FS	25%		Others		

Impression

SITUS , SOLITUS , LEVOCARDIA

MILD LV DYSFUNCTION

NORMAL RV FUNCTION

NORMAL SIZED CARDIAC CHAMBERS

TRIVIAL TR

LEFT ARCH ,NO COA

Master SYED UMARUDDIN

0 Y 11 M 7 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009190

08-06-2026 05:45 PM

08-06-2026 05:50 PM

08-06-2026 05:50 PM

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

Master SYED UMARUDDIN

0 Y 11 M 7 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009199

08-06-2026 06:41 PM

12-06-2026 03:46 PM

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 8.4 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions. Portal vein and hepatic veins are normal and color uptake and waveform.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN :Normal in size 6.6 cm and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS :

Right kidney : 68x29 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 68x34 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal. Foley's bulb insitu. No lymphadenopathy. No evidence bowel wall thickening /edema.

Print Date/Time : 12-06-2026 03:46 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 2

Master SYED UMARUDDIN

8639460407

0 Y 11 M 7 D

R26-009199

Male

08-06-2026 06:41 PM

IP-00060254

12-06-2026 03:46 PM

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

Impression

- 1. Minimal ascites.**
- 2. Right minimal pleural effusion.**
- 3. Mild gallbladder wall edema.**

Suggested clinical correlation.

Master SYED UMARUDDIN

0 Y 11 M 9 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009254

10-06-2026 07:39 AM

12-06-2026 04:55 PM

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Prominent right bronchovascular markings.

CVL, NG tube in situ.

Air distended bowel loops in right lumbar region.

Domes of diaphragm are normal.

CP angles are clear.

Bones and soft tissues normal.

No subdiaphragmatic pathology.

Print Date/Time : 12-06-2026 04:55 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 1

Master SYED UMARUDDIN

0 Y 11 M 9 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009317

10-06-2026 05:47 PM

10-06-2026 05:54 PM

10-06-2026 05:54 PM

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	Normal
Inter atrial septum	Intact
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
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	LMCA=2.1 ZScore:+1.01 LAD=1.6 ZScore:+0.84 RCA=1.5 ZScore:+0.07
PDA	Normal
Pericardium	Nil
Others	Nil

Print Date/Time : 10-06-2026 05:54 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Master SYED UMARUDDIN

8639460407

0 Y 11 M 9 D

R26-009317

Male

10-06-2026 05:47 PM

IP-00060254

10-06-2026 05:54 PM

VIH-00199881

10-06-2026 05:54 PM

KODICHERLA VISHNU VARDHAN REDDY

DOPPLER / TISSUE Variables		Gradients		Regurgitation	
Mitral flow					
Tricuspid flow					
Aortic flow					
Pulmonary flow					
Mitral	E'	A'	S'		
Medial LV	E'	A'	S'		
Tricuspid	E'	A'	S'		
Time intervals	IVRT	IVCT	DT		
Others					

MEASUREMENTS:

Master SYED UMARUDDIN

0 Y 11 M 9 D

Male

IP-00060254

VIH-00199881

KODICHERLA VISHNU VARDHAN REDDY

R26-009317

10-06-2026 05:47 PM

10-06-2026 05:54 PM

10-06-2026 05:54 PM

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.2		Tricuspid Annulus		
LA	1.8		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	3.1		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.4		LPA		
LVIDS	2.1		MPA		
LVPWs	0.5		AO Isthmus		
EF	60%		LV Mass		
FS	30%		Others		

Impression

LMCA=2.1 ZScore:+1.01

LAD=1.6 ZScore:+0.84

RCA=1.5 ZScore:+0.07

NORMAL CORONARIES

GOOD BIVENTRICULAR FUNCTION

LEFT ARCH , NO COA

NO VEGETATION , NO CLOTS

Dr. NAGESWARA RAO KONETI

MBBS,MD,DM,FELLOWSHIP IN PAEDIATRIC CARDIOLOGY

Reg No: 19320

Print Date/Time : 10-06-2026 05:54 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 3 of 3

Master SYED UMARUDDIN

8639460407

0 Y 11 M 11 D

R26-009424

Male

12-06-2026 12:20 PM

IP-00060254

12-06-2026 12:33 PM

VIH-00199881

12-06-2026 02:07 PM

KODICHERLA VISHNU VARDHAN REDDY

Upper GI study

Technique: Multiple fluoroscopic images of the esophagus, stomach I were obtained after the oral administration of diluted omnipaque

Findings & Impression:

Tracheal aspiration of contrast in swallowing phase.

Ill defined parenchymal haziness and increased bronchial wall thickness in central lung regions.

Distal esophageal sphincter is normal.

No evidence of gastroesophageal reflux.

No evidence of gastric outlet obstruction.



Dr. MOHD ABDUL KHALID

MBBS,MD,DNB

Reg No: 82767

ADMISSION SHEET

Registration Details :

Admission No : IP-00060254 Admit Date : 06-Jun-2026 Admit Time : 09:43 PM UHID : VIH-00199881

Patient Details :

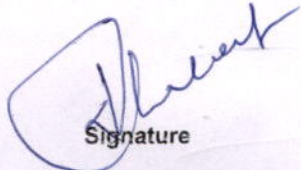
Patient Name : Master SYED UMARUDDIN Age : 0 Y 11 M 5 D
Guardian : SYED KHALEELUDDIN DOB : 01-07-2025 01:00 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : H NO 5-87/A, DOULTABAD, SIDDI PET DIST, Phone No : 8639460407
TELENGANA Makkarajpet Medak Telangana E-mail : KHALEELUDDIN143@GMAIL.COM
INDIA 502247

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 : SYED KHALEELUDDIN Relationship : S/O
Contact Address : H NO 5-87/A, DOULTABAD, SIDDI PET DIST, Phone No : 8639460407
TELENGANA Makkarajpet Medak Telangana
INDIA 502247


Signature

Doctor Details :

Doctor Name : Dr. KODICHERLA VISHNU VARDHAN Specialisation : GENERAL PEDIATRICS
REDDY
Referral Doctor : DR. E SURESH Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : HDFC ERGO GENERAL INSURANCE
CO LTD

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 6 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 06-06-26
 Source of Admission: OPD Ward Other: ER
 Reason for Admission: clo-feres, cold & cough since 3 days, dull activity, vomiting, loose stools since yesterday
 Admission Diagnosis:
 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

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
	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	Family History:		
	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, 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 type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Observations: Weight: <u>8.8 kg</u> Length: <u>-</u> Head Circumference (< 2 years): <u>48 cms</u> Temp.: <u>98.6°F</u> HR: <u>151 b/m</u> RR: <u>16 b/m</u> BP: <u>102/62 (74)</u> Pain Score: <u>0</u> Specify Site: <u>-</u> (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Score: <u>12</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>22</u>) (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: *father*

Orientation not given Reason:

Nurse Name: *Sr. kunthi*

Nurse Signature: *(Key)*

Date & Time: *6/6/26 @ 10:30 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: *sepsis incephalopathy*

Nurse Name: *Sr. kunthi*

Nurse Signature: *(Key)*

Date & Time: *6/6/26 @ 10:30 pm*

Patient Name : Mast. SYED UMARUDDIN UHID : VIH-00199881 IPD : IP-00060254 Gender : Male Age : 0 Y 11 M 5 D

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 5 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



wt - 8.8"

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Syed Umaruddin Age : 11M Gender: Male Female

Date : 6/6/26 Time of Arrival : 9:28 PM

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: 102.2 F PR: 126/1m BP: 96/25/82 RR: 34b/m SpO₂: 98.502

Chief Complaints: CI - Fever, cold & cough since 3 days. All activity since yesterday. Vomiting, loose stool.

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Sick Looking <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input type="checkbox"/> Normal <input type="checkbox"/> Increased <input checked="" type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Unstable : <input 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 checked="" type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input 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

Signature of Parent / Guardian
 Triage Completion Time : 9:32 PM

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 : B. Sreedhar
 Date & Time : 6/6/26 @ 9:32 PM

Signature of Triage Nurse : _____

Patient Name : Mast. SYED UMARUDDIN UHID : VIH-00199881 IPD : IP-00060254 Gender : Male Age : 0 Y 11 M 5 D

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 5 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/6/26 Time of arrival : @ 9:30am 2nd - 8 mg tid
1st - 35 mg qd
 Chief Complaints: e/c: Fever, cold & cough since 3 days. RBS:
 Height : - Weight : 8.80 kg BMI : - Head Circumference (<2 years) : 48 cms.
 Allergies: Yes No Medication 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 type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input checked="" 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 checked="" type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" 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>_____</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> <p>_____</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 Parents

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

Time of Initial assessment completed by ER Nurse : @ 9:38 pm -

Patient Name : Mast. SYED UMARUDDIN UHID : VIH-00199881 IPD : IP-00060254 Gender : Male Age : 0 Y 11 M 5 D

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

Time	Nursing Notes
@ 9:28m	Patient come to ER, vitals checked & recorded.
9:30m	Dr. Ganesh & Dr. Jayaraj seen the patient.
9:33m	Doctor advice for PICU admission, Admission done -> IV placement done.
9:42m	Blood Sample collected & Send to Lab.
9:48m	GRBS checked & recorded.
10:23m	patient shifted to PICU.

Samples collected by: } Sr. Shanitha Karmari Time: } @ 9:05m
 Samples sent by: } Sr. Swagatika Time: } @ 9:15m

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
@ 9:00pm	10% Dextrose	IV	30ml	}	}
@ 9:12pm	inj. Paracetamol	IV	12ml		
@ 9:20	inj. Ceftriaxone	IV	400mg		
@ 9:42m	Neb. Levofloxacin	PIN	0.63 mg.		
@ 9:47m	Neb. Budecort	PIN	0.5mg.		
@ 9:20m	3% NS	IV	40ml		
@ 9:57m	DNS	IV	16ml		

Condition of patient at time of shift - out :	Details of Shift - out
HR: 163b/min - BP: 89/58 (67) CFT	Shift - out from ER to: PICU.
RR: 23 - SPO ₂ : 100% 5ut	Time of Shift - out: @ 10:20m
GCS: - Temperature: 97.26m	Handover given to: Sr. Shanitha
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable): -	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):


IV placement done.

Name of the Nurse: Swagatika

Signature of the Nurse: [Signature]

Date & Time: 6/6/20 @ 10:20m

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00199881 IP-00060254 Master SYED UMARUDDIN 01-07-2025 0 Y 11 M 11 D (M) Dr. KODICHERLA VISHNU VARDHAN 		Date & Time of Admission 6/6/2026 @ 9:42pm	Date & Time of Transfer Order 12/6/26 @ 5:30pm
		Transfer Ordered by DR. Vishnu Vardhan	Reason for Transfer stable
From Unit plw	To Unit 1st floor (103)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 160 + 10	Number of Imaging Films ABG - (16) UP - GI - X-ray - (2) CT - (2)	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.	Syp - Pantac 5ml x 2mg	①	
2.	Syp - domstal 1ml x 2mg	①	
3.	Syp - pot kloa	①	
4.	Syp - vdeament	①	
5.	Syp - sucral	①	
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Kuntli		Name of Person Ordered Transfer DR. Jayasri	
Patient & Clinical Records Received by : Ss. Benonika			
Date & Time of Patient Received : 12/6/26 @ 5:30 pm			

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

- * Syn - Calcimed - t - (D)
- * Otericon - wach - (D)
- * Chloridol nu wa - (D)
- * Omnicapil - (D)
- * Forte
- * Ns-100mc - (D)
- * Lanzol - (12)
- * VC - (D)
- * VCC - (D)
- * 200 - (D)
- * 500 - (D)
- * D-wash - (D)
- * Refren Ey drop - (D)
- * Hypoal wa - (D) (D)
- * Dudesal - (D)



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00199881 IP-00060254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 5 D (M)
Dr. KODICHERLA VISHNU VARDHAN

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

No fever since (5) days (4/6)
Drowsiness since (2) days
(5/6) (attending)

History of present illness :

High grade fever
sukritat cold since (5) days

Loose stools
naprojectile vomitings
containing food particles
No medicine
No vomit, no diarrhea

Excessive sleepiness and not opening eyes
since (2) days



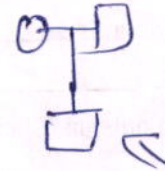
Pediatric Multiorgan History & Physical Examination

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

Smaller of age - admitted for
mycoplasma pneumoniae
for 2 days
2 days of life operated for meningococci

Birth & Neonatal History:

NCM, Prem born
Prem, Sg, CSU



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

→ stands without support
→ Bilingual

Immunization History :

up to date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) 48cm (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 8.5 kg (Centile _____)

On Examination :

Temperature : 102° F Pulse Rate : 100/min B.P. 90/60 SPO2 88% RA

Resp. rate and type of breathing : 18/min, SR (+)

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____ None, no wheeze (+)

Air entry & breath sounds : _____ clear (+)

Any addes sounds : _____ None

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____ S1, S2 (+)

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

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : _____ None

Spine : _____ External Genitalia : Normal Liver palpable

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 10/15

Cranial Nerves : -

Motor System:

Nutriton : -

Tone: Lower limbs Power -

Co-ordinator : -

Posture : -

Involuntary Movements : -

Reflexes : UL + L + R

DTR

Plantars -

Superficials:

Sensory System :

Bladder / Bowel : -

Clinical Summary & Diagnostic:

Sepsis
encephalopathy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Cardiorespiratory failure

Desired goals of the treatment:

Haemodynamic stability

Planned Labs:

CBP / ~~check~~ ~~copy~~, VBG
CRP / ~~beta~~
PT, aPTT, INR
UFT
RFT
S/E
S/E⁺ S. mp⁺ L

Planned Management

HRNC
ZVF
2ND-3% N/S
2m. PARACETAMOL / 60
Syr. OXELTAMINE
ANT - CEFTRIAZONE
SNT - PAMIDINOLE

Noted by Shoukhe

06/6/26 @ 10:19 pm

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Jayasree

Date & Time: 7/6/26 am

Signature of the Consultant: [Signature]

Name of the Consultant: [Signature]

Date & Time: [Signature]



VIH-00199881
RIZWA
1 Y 5 M
LATHA

19

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>9/9/26</u>	<u>Acute life threatening event</u>	
	Child on P. SIMU PCTDs made PC-13 Rep 8 Fiq 45 M-40	
5:30pm	<p>Suddenly child had sudden bradycardia upto 45/min immediately bag & mask ventilation started child heart rate improved to 101/min cool & saturations upto 98% with good A/LAE & child was reconnected to MV and</p> <p>1) Blood gas sent 7.58/42-3/105/36.2 (o2 sat -2.2) 132/7.25/95</p> <p>2) Serum electrolytes, blood urea, creatinine, LFT PT aPTT etc sent</p> <p>3</p> <p>Immediately in view of high potassium 1) Neb levalbutal 0.6mg x3 given 2) 4g furosemide → 8mg/w/given</p> <p>CXray done → Pneumothorax rule out to</p> <p>Insulin - 1g/l Insulin → 0.1u/kg + 1g/l glucose } given over 1hr. 0.8 units + 85ml of 10% D</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	K Binder 1g/kg → 8gm / PR / given	
	12 ECG done	
	<p>Forecast ECGs done</p> <p>good BU contractility</p> <p>↓ PVC Disturbed but stable.</p>	
	1) Potassium containing or potassium sparing drug were discontinued.	
	2) Child was kept NPO	
	3) CCF DNS → 10ml/hr	
	4) Left radial arterial line removed as there is color discoloration	
	Repeat Serum electrolytes at 6:50 PM	
	Na ⁺ - 134	
	K ⁺ - 5.2	
	Cl ⁻ - 88	
	Magnesium - 1	
	Calcium - 9.1	
	<p>↓</p> <p>dy Magnesium loading + 10ml/hr</p> <p>ceaser / hr</p>	
	Case was referred to	

↓
 Dr Vishnu

Noted by
 Dr. Vishnu
 01/07/2025
 @5:20 PM



20

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	USG Pao fever	D6 of T11 map D4 of admission D2 of central line D4 of catheter
8:45 pm	Sepsis with MODS	Phenir Sen - 3 1) Encephalopathy 2) Liver → transaminas (Encephalopathy) 3) Coe dra (nuduud)
	Hyper inflammatory condition	→ Cytokine Storm / 2 weeks
	[1 subs:-] Encephalopathy → under sedation EUTM ₄	
	- Transaminas (Encephalopathy) → better - Coe dra (nuduud) → contractile eg better.	
	→ Sepsis + hyper inflammation: no fever = 2/3ly cutg + 1/2 methylprednisolone } 2mg/kg/d	
	→ Dys electrolytic → hyper kalemia → corrected	8-3 → 5-1
	→ Atelectasis therapy with	→ brady arrhythmia
		P. 20

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>Drainage: Open Scissors case closed 3S capped ET tube fixed at 12cm Breeds: Bimv Petrus mode PC Day fix HQ T1 13 8 35 40 053</p>	
	<p>BAE ⊕ Spz: 98 RR: 22</p>	
	<p>Circulation HR: 138-148 CRT 35 sec Pratt ⊕ Bp: 77/42 (x3)</p>	<p>1) On milorone → 0.5 mg/kg/min 2) on Noreadrenaline → 0.05 mg/kg/min 3) of Lepir → 0.2 mg/kg/hr</p>
	<p>Disability: → E1 Up m4 → pupils 1mm equal → Ready for tube</p>	<p>1) on morphic 40 mg/kg/hr.</p>
	<p>Exposure: Cannula site Sealed → thrombo plug</p>	
	<p>Fluids: CWC DNS → 10ml/hr → 12ml/hr + Includy drops } 60% min + Includy drops + infusion</p>	
	<p>GUT: NPO from 6AM bed feed at 2PM.</p>	
	<p>Heart: Trace Bore normal reports</p>	
	<p>Infects: no fever</p>	<p>1) meropenam D3 2) Vancomycin D3</p>



21

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Infernoctoy:- 2g/kg wdy on Day 2 metylprednisolone (2mg/kg/day)	
	kidney:- $\frac{I}{O}$ 913-4 urosalicyl net con 103-1	-117-6
		cumulative (-) $\boxed{-669ml}$ 128 111
	Plan → Extubate after → Pushy nas CW.	Cardiac Consultation CW.
		[Signature]
	Noted by Sis-dea at 8:26 @ 8:15 AM	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/25		
	<u>Clonus of mother</u>	
8:50pm	<p>Ref'd 20cteo was assessed</p> <p>Fetal life threaten and upmed</p>	
	<p>Ref'd 20cteo → showed improved cardiac Contradicty. AOC categorically</p>	
	<p><u>Plan</u></p> <p>1) Can extubate the child if good efforts</p>	<p>2 mltz.</p>
	<p>2) Can should continue</p>	<p>1) Gt Noradrenaline 2) Gt Milrinone 3) Gt Gase } Gt for next 12 hours Gt re-asses</p>
<p>Noted by Dr. Ramulu 9/6/25 at 8:50pm</p>		<p>2 mltz.</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	<u>9/6/26</u>	
<u>9/6/26</u>	SEPSIS + MODS	
	Hyperkalemia syndrome → CBS/20/14.	
8/5/26		
	DRUGS to change to CPAP once child is active with good effort	
	↓ blood gas	
	2) PCr for excretion	
	3) Glycerol Suppository PR/STAT	
	4) Naloxone → 10/STAT	
	Dilute → 0.4mg in 20ml NS	
	↓ give 0.1ml/kg dose	
	↓ 0.9ml/dose	
	Can be repeated after 2 mins.	
		p=2.0

Noted by
 Dr. Ramulu
 9/6/26
 8:50 P

...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	1) NPO for 6 hours post extubation	
	2) ^{after 30 min} CRP → ABG → extubation → ABG	
8:50am	3) Chest Xray total 60% - 12	
	4) Caedie :- continue 1) mlt/mine } 2) Casiz } continue	
	5) monitor :- Serum electrolytes → Chitly	
	6) PCA to do <u>CMP & PCT today</u>	
	7) physiotherapy limb	
		Noted by Br. Bannu 9/6/2025 8:50AM
		Z MS

127m



23

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/16/20 10.00 AM	Counselling by Dr. Vishnu Sir	
	Current condition of child explained, The child is stable on ventilation, and inotropic support.	
	The child had sudden bradycardia, which occurred due to hyperkalemia, which was started as a result of hypokalemia due to furosemide/aldosterone. Yesterday, Nephrologist saw the child, who stated, hyperinflammation of body as a result of infection/ that can be viral or bacterial.	
	Next laboratory sequencing can be done to detect the cause, but treatment will be more or less similar. Regular medicine for flu is ongoing.	
	The child in history had history of ingestion of buffalo milk ingestion, sometimes cow milk/ buffalo milk ingestion can cause allergy and might cause increased permeability along gut wall that might lead to gut biome translocation. We might plan to celebrate today, and we will see his response.	
	The treatment is already ongoing like IVIG and steroids, as bone marrow test will require some time.	
	CSF analysis is normal, so, discussed with Neuro team and not needed for PCR.	



(24)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 2.00PM	<u>EXTUBATION NOTE</u>	
	<p>Under all aseptic and antiseptic condition. the child was extubated with to HFNC. Post extubation, the child was given Nebulisation with levosalbutamol, budesonide & adrenaline nebulisation given. Child connected for HFNC.</p>	
	<p>Fio₂: 90% Flow: 15L/min.</p>	
	<p>Postextubation: Report Arouse at 2.30PM</p>	
<p><u>Noted by</u> Dr. Ramu 9/6/26</p>		<p><u>Dr.</u> 9/6/2026</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/2026 3:30 PM	c/s/b Dr. Vishnu svr	
	D ^o - sepsis & MOPS Estimated @ on HRMC 15 Lit / 40% maintaining saturation	
	B/E Bradypnea ⊕ RR - 5-18/min No retractions Chest clear SpO ₂ - 93/95 (95) min w/ O ₂ P/r ⊕	Plan 1) HRMC 15 Lit / 40% O ₂ 2) Naladrenline taper & stop 3) stop c/s/v 4) ABU @ 6:30 PM
	9/6/2026 5:10 PM	
	ABU @ 5 PM → metabolic alkalosis ⊕ ↓ No plan to start OAS 20ml / 3 hr	

Noted by
 Dr. Vishnu
 9/6/2026

(25)

... GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/06/2026 6:30 PM	<p>counseling notes (Dr. Akhmed Sir)</p> <p>Child is intubated, on HANG, maintaining saturation but there are poor respiratory efforts. hence planned for NAE tomorrow, if there is same.</p> <p>No or any respic support and maintaining blood pressures</p>	<p>Dr. Akhmed</p> <p>Dr. Akhmed</p> <p>Dr. Akhmed</p> <p>Dr. Akhmed</p> <p>A. Prabhakar</p>
9/6/2026 6:30 PM	<p>Child Dr. Akhmed Sir</p> <p>Breached Rho</p> <p>→ Wc collapsed</p> <p>→ Saturation good</p>	<p>1835</p> <p>Mer</p> <p>→ stop Gsib</p> <p>Dr. Akhmed</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/16/2026 7:20 AM	<p>4/3/18 on Vishnu SV</p>	
	<p>D¹ Sepsis c MODS</p>	
	<p>Estimated</p>	
	<p>on HENC 15LH 40% Rm</p>	<p>Plan</p>
	<p>Maintain saturation No fever spikes</p>	<p>1) Change Thromine @ Pantoprazole / to oral</p>
	<p>Increase ↓ Drowsiness (↓)</p>	<p>2) stop GASTIX</p>
	<p>BP @ 50th centile</p>	<p>3) Discuss Echo findings with cardiologist & decide on milrinone infusion</p>
<p>Noted by Dr. Vardhan 9/16/26 7:20 AM</p>	<p>4) S/E @ 8 PM</p>	<p>ABC @ 11 PM - 5 AM</p>
<p>VIM</p>	<p>5) ORS 20 ml/3rd HRLY</p>	<p>6) transfer assessment T/M</p>
	<p>st was 2 chest physiotherapy</p>	
	<p>7) Dr. Aravind opinion on immunosuppression</p>	



(26)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/06/2020 8:20 AM	<p><u>Counseling notes (Dr. Indhira Nam)</u></p>	
	<p>Child is having poor respiratory efforts during sleeping, MR need to be done tomorrow depending on sensorium & respiratory efforts.</p> <p>Do not give hydrocephalus, need font closure.</p>	
	<p>P. Singh</p> <p>mother TANVIR</p>	<p>FATHER Murad</p>
16/06/2026 9:30 AM	<p>of Dr. Dr. Mustafa Sr <u>(Ped. cardiologist)</u></p>	
	<p>Family who shared current status of child explained</p> <p>↓ <u>Non</u></p> <p>if no taper & stop milurone</p>	
Next day 16/6 @ 9:30 PM		<p>Signature</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/06/2026 12:30 PM	<p><u>C/S/B Prevalence</u></p> <p>D¹¹ - Sepsis E MOPS Cardiac dysfunction (resolved) Transaminitis (resolving) Correction Anabolism</p>	
	<p>on HHC 15 Lit 40/210</p>	<p><u>Plan</u></p>
	<p>Maintaining saturation Bradycardia No ratchets No fever spikes BP > 50th centile Apil → 2mm neck Atrial</p>	<p>1) Do stop K⁺ containing fluids</p> <p>2) Do stop taper maintenance and stop by 6 AM 11M</p>
	<p>See passed stool</p> <p>M stool, Mucousy stool</p>	<p>3) UET .. Tembin CBP S/E M/C</p> <p>11M 6AM</p>
	<p>on 5 Lit (7)</p>	<p>4) OBS 20 ml 2nd HRU for ↓ N.P.O from 7 AM</p>
		<p>5) RT 70 % maintenance</p>
		<p>6) MRB Brain set 11M</p> <p>7) MR - Lower support</p>

Marked by
 S/S
 9/6/26
 @ 11:30 PM

[Signature]

(27)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/16/2026 7 AM	<p>4/5/26 12:00 Follow up</p> <p>1's - sepsis i MODS</p> <p>→ metabolic Alkalosis</p> <p>Issues → Encephalopathy - resolving</p> <p>Transaminitis (resolving)</p> <p>Akinesia (smallpox page transfusion done)</p> <p>Cardiac dysfunction (resolved)</p> <p>pneumonia (resolved)</p> <p>Drainage open & maintaining on HMEC, 13 Lit, 30% FiO₂ maintaining saturation</p> <p>NO retractions, Bradypnea (P)</p> <p>Chest function zero → low risk of collapse</p> <p>contacting guard</p> <p>Rel (W), DR @ 50th centile</p> <p>Plv (W), CR @ 50th centile</p> <p>APO fetal spikes</p> <p>MO Alert (GCL-15/15)</p> <p>24 70-1. maintenance</p> <p>N.P.O since 7 AM</p> <p>on ceftriaxone vancomycin</p> <p>meropenem</p> <p>oseltamivir (P)</p>	
		<p>metabolic → no potassium in fluid / supplement</p>
		<p>4M1 → 9 amp/dl</p> <p>on calcium & y magnesium (supplement)</p>
	<p>2 720.9</p> <p>0 563 (+157.9)</p>	<p>Cumulative balance → 584 ml</p> <p>cutt</p> <p>○ 658 ml</p>

u/o = 2.7 cc/hr

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Plan</u>	
	1) TO continue AFMC	13 Lit 30% Pw
	to taper 2 Lit every 4 th HBL	
	At reaching 9 Lit, to shift to AFMC	
	Target SpO ₂ > 95%	
	2) Review cardiologist opinion	
	3) Plan on MRI to decide on MEG	
	4) collect Remittin Yegore	
	HPCC	
	5) chest & sinus PT	
	6) oximetry assessment today	
	At 5 th HBL / Sat Paediatric Pw	
	89 (w/A) poor respiratory effort / ↑ heart rate / shallow breathing	
	pupil monitoring	
	- eqv.	
	- < 10 RR/min	
	- Drowsiness	
		2/27-2025

Noted by
 Jagmani
 10/6/25
 at 6:10 PM

maruddin (28)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2025 11 AM		Counselling by Dr. Sridhara
	As the Bone marrow aspiration showed HLH changes. So parents were told to stage out Brain MRI Brain is necessary. Despite the child showed improvement in Sensorium, Resp. rate, activity.	
	Still CNS HLH must be staged out and MRI Brain is necessary.	
Sridhara	maruddin	JANU 6/25



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2025	C/S/B Dr. Vishnu Siv	
10:30 AM	<p>1st - Septic E (MOR)</p> <p>2nd MCH</p>	
	<u>Plan</u>	
	1) Continue ZF 80 y.	
	(Respect for clude Peds)	
	2) To decide on MRP	
	(Early i and resolution)	
	3) If any deterioration neurologically	
	Antisepic and do MRP	
	3) Continue NAC (10 y)	
	Vbx @ 12 PM	
	4) Continue Antibiotics	
	5) Cardiology consultation (physical)	
	6) To look in peripheral smear for	
	Dysicranocytes	
	7) No decide on NAC infusion	
	8) Remove urinary catheter	

Noted by
 Jagrani
 10/6/25
 at 10:30 AM

[Signature]
 Vishnu



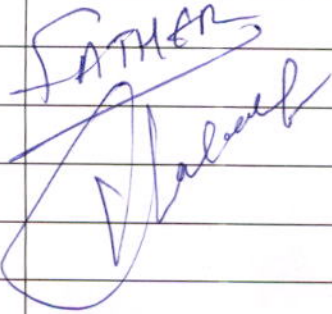
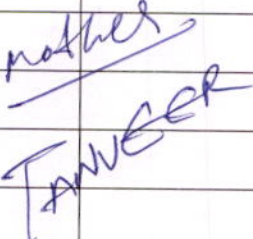
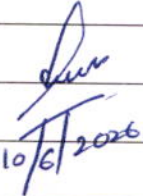
29

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/07/2025 11:00 AM	Counseling by Dr. VISHNU VARDHAN To mother, father	
	<p>The current condition of child explained. Child is currently stable on IVNC.</p> <p>As Bone marrow report, showing hemophagocytosis, for CNS involvement via HLH, we are planning to do MRI. But as child is currently stable, and for MRI Brain, the child again might need sedation and also might need reintubation again. The child is having better respiratory rate & improvement in sensorium. But, if MRI Brain might be needed. If child again has poor sensorium/seizure ↓ in further breath rate.</p> <p>If MRI is done, the and shows any involvement, the child might be needing ↑ in dose of steroid.</p> <p>Liver function, inflammatory marker, fever spike are improved.</p> <p>Improvement in sensorium, liver function, inflammation & fever.</p> <p>- For kidney urine output is good, and will remove catheter today.</p> <p>The child needs MRI Brain, but at the same time as child is having improvement, MRI Brain we will do by oral sedation first.</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2026 1.00PM	<p>As the child sensorium has improved compared to yesterday, along with improvement in respiratory depression.</p> <p>The child might again need sedation and SOS intubation, but after understanding all the importance and SOS plan for MRI Brain, the parents wants to keep MRI - Brain on hold for now.</p>	
	<p>Adv: ① Re-connect the child on VPNC! FiO_2: 30%, Flow 20L/min. ② Monitor vitals.</p>	
<p>FATHER </p>	<p>MOTHER </p>	<p> 10/6/2026</p>

(31)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2026 A. 01 PM	c/o/w Do	Ponshya Maam.
	- As emergency doc advice to stop	improving, NAC infusion.
	efp	Sire
	lab frequency: VBG: - SE: - NTP _{ro} BNP - LFT, APTT, PT-INR.	
10/6/2026 5:30 PM	c/s/B Do	Akheel sir
	- NTP _{ro} BNP } /M - VBG	
	- Do not do any invg if ^(unless) if child deteriorate	Sire

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/20 5.30 PM	Counselling by Dr Akheda	
	<p>The current condition of child explained, leading to: The child is currently stable. The child had secondary ALM; due to infection. The heart as per Echo is normal. The liver enzymes are improving. As NT-ProBNP was high, we will send tomorrow along with VBe tomorrow morning. The child is on steroid and that is ongoing due to ALM. IVle might be needed again, if child had only deteriorating. The child is on HFNC and maintaining on 10L & 30% FiO2. We will gradually taper the HFNC and observe. We need to keep the child on PICU for further 2-3 days if child remains stable.</p>	
	<p>Maher Signature</p>	<p>Sm + Rizwan 1736</p>

VH-00198881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 9 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



32

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2026 6:00PM	child stable on c/s/B Do HFNC.	Vishnu Sir
	<ol style="list-style-type: none"> 1) Plan: ↑ full feed. 2) HFNC H/M stop 3) Trace hb%. NPLC 4) xi Hold NT Pro BNP 5) SE now. 6) T/M: VBG 7) Oro motor assessment. 8) Monitor u/o & do bladder USG. 9) HFNC: 5L/min at 12AM Low flow at 5AM 	<p>upto 100ml/3hr. [Formula & Kitchen feed]</p> <p>to LF (low flow)</p> <p>IFM - VBG</p> <p>Vinc</p> <p>→ VBG at 7AM</p>
10/6/2026 6:00PM	Counseling by Dr. Vishnu Sir	<p>10/6/2026</p>
	<p>- Mother was counselled about current condition of child, as child is stable on HFNC.</p> <p>- The child will be on NC feed today and HFNC</p> <p>Mohu</p> <p>Jad</p>	<p>Noted by Jaganma</p> <p>10/6/26</p> <p>6pm</p>




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2025 8:00AM	<p>Δ: Sepsis with MODS with Secondary HLH.</p>	
	<p>Issues: (1) Child was on mechanical ventilation and got extubated. (2) Poor Sensorium with bradypnoea improved. (3) Cardiac involvement i/v/o the Ventricular dysfunction present got resolved. (off / decompensated, inotropes). (4) Liver dysfunction (transaminits) improved</p>	
	<p>Airway: (1) On low flow oxygen @ 24/min open, maintainable</p>	
	<p>Breathing: R/R: Bradypnoea improved, Chest: B/V Aff present. SpO₂: 98-100%</p>	
	<p>Circulation: CRT < 3sec. BP within normal limit Peripheral pulses well felt</p>	
	<p>Disability: Sensorium improved</p>	
	<p>Exposure: No fever spikes in last 24 hours.</p>	

33

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Fluid: stopped Feed: Full. feed: 100ml/3 hourly.	
	<u>Plan:</u> ① Try oral feed. ② taper & stop oxygen. ③ Plan for Methylprednisolone Dose taper ④ Trache NPLC	
11/6/2020 BO. 3 rd Am.	child stable on low flow @ 2 L/min c/s B Dr Vishnu Sr	11/6/2020
	① Try oral feed (after Oromotor assessment) ② stop vancomycin (as Blood & Bone marrow c/s negative) ③ Remove central line ④ if taking orally, then plan to shift ⑤ Hematology → steroid duration for "course of steroid" ⑥ Plan: MRI Brain SOS ⑦ CBP, CRP, LFT, RFT, Gram ⑧ ph physiotherapy	
	[CBP, CRP, LFT, RFT T/m]	
	Noted By Sr. Devika 11/6/20 4:00 AM	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/06/2025 10:23 AM		Counselling by Dr. Vishnu
	<p>Parents were told about the plan to start oral feeds, and duration of steroids will be discussed. All the hyper inflammation was started present & controlled on steroid. Will be discussed with hematocologist.</p> <p>If baby ready can be shifted to ward.</p> <p>Moved to taper & stop oxygen.</p> <p>If child is hemodynamically stable can be discharged.</p>	
		<p>(Signature)</p>



32

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/06/2026		
12:00 PM		
	<p>C/D/W Dr. Anand (Haematologist)</p>	
	<p>D¹¹ - Respil E MORS</p>	
	<p>- 2^o HCTH</p>	
	<p>No fever spikes</p>	
	<p>Activity & sensation improved</p>	
	<p>As per further levels (↓)</p>	
	<p>on (P₄) of MPS 2mg/kg/dose - 12 Hrs</p>	

[Signature]

Noted By
 Sr. Devika
 11/6/26
 at 12pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>11/6/26</u> <u>17:40</u>	<p style="text-align: center;"><u>Dr B & Vishnu</u></p> <p>A Sepsis with MODS with secondary HLH</p> <p><u>Current status:</u></p> <ul style="list-style-type: none"> - on low flow O₂ 0.3 lit/min - fully NG feeds <p><u>Plan</u></p> <ul style="list-style-type: none"> - Counsel family about no motor skills fully as baby is poor in swallowing liquids - CBP, CRP, LFT, RFT T/m - Upper GI contrast T/m i/v/o suspected TEF with gurgly sounds present - All feeds to be given by mother & position of NG to be checked - Plan to shift to room T/m 	
<p>② Dhruv</p>	<ul style="list-style-type: none"> - Supposed semi-solid feeds V/M 	<p style="text-align: right;"> Noted By Dr. Maheshwari 12/6/26 17:40pm (P.T.O) </p>

VIH-00199881 IP-00080254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 10 D (M)
Dr. KODICHERLA VISHNU VARDHAN

35

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/25		
18:00		

Counseling Done By Dr Vishnu

Parents have been extensively counselled about the child's difficulty to swallow liquids & the persistent problem of being able to not swallow (liquids) have to be evaluated. & the need for genetic evaluation about HHT to be done possibility of TEF also explained & need for upper GI study.

④
Amu



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/16/26 8 AM	<p><u>CLSB Resident</u></p>	<p>10th Day of illness <u>7th DOA</u></p>
	<p>Δ Sepsis with MOOS with secondary HLH</p>	
	<p>Current Issues: → unable to swallow liquids</p>	
	<p>Current Stats → M Room Air M NG feeds Tolerably well vitals stable</p>	
	<p><u>Plan</u> → Keep NPO → Plan for Upper GI Study today → Continue Same → If not maintaining sec low flow</p>	
<p>Al Vishnu</p>		<p>Noted By Dr. Deshpande 12/16/26 8 AM</p>

36

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10:10 AM	<p><u>CLS/B Dr Vishnu</u></p> <p>Asepsis with MODS with Seedy HX</p>	
	<p><u>Current status</u></p>	
	<ul style="list-style-type: none"> - on low flow O₂ - Prolonged secretions present in mouth - VIT status 	
	<p><u>Plan</u></p>	
	<ul style="list-style-type: none"> - After 2pm dose of methylpred 	
	<p>Syp omnicortil</p>	<p>10mg BD x 5 days 7.5mg BD x 3 days 5mg BD x 3 days 5mg OD x 5 days</p>
	<ul style="list-style-type: none"> - Inj Meropenem till Day 7 	
	<ul style="list-style-type: none"> - Neuro review / poor swallowing ! pseudobulbar muscle weakness 	
<p>Dr. Vishnu</p>	<ul style="list-style-type: none"> - Plan to send WES after 3 weeks 	<p>months</p>

Noted by Sr. Devika

15/6/26
 10 AM

VIM (P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/2025 12:40 PM	Counselling notes (Vishnu)	
	<p>She is better today. sensorium improved But there is difficulty in swallowing, as per tray cartnot studies showed aspiration of feed contents to trachea Hence need follow up with ENT, neuro and gastroenterologist This is due to impaired coordination of swallowing. shifted to room now, but to be continued on Neurogen feeds</p>	
12/06/2025 12:40 PM	<p>CLIA Dr Vishnu sir O-keppin + Mon then</p>	
	<ol style="list-style-type: none"> 1) Add component of NMTAC 2) shift to room 3) continue monitoring 4) neurology opinion ENT opinion. Gastro opinion. 	<p>Noted By Sr. Devika 12/6/25 12:40 PM</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/2026 2:30 PM	<u>Shifting notes</u>	
	D's - Sepsis with multiorgan dysfunction Secondary HLH	
	No fever since ② days & drowsiness since ② days. chx	
	Past history: child had operated for R-L myelomeningocele @ ② days of age child had bradypnea with respiratory distress & poor sensorium.	
	He was intubated and kept on mechanical ventilation. In view of poor sensorium and previous history ventriculomegaly CT brain was done functional echo showed ventricular dysfunction (EF ~ 50%). Cardiology opinion was taken and started on midrange, lasix infusion and nor-adrenaline	
	As the sensorium improved child was extubated and kept on HNC. later to room air child had hyperkalemia with symptoms which was managed with plasma resuscitation & potassium binders.	
	As the cardiac function improved, inotropes were tapered & stopped. child had tramamide, NAC infusion given. child has elevated fast ferritin, low high triglycerides and low fibrinogen	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>In view of suspected HLH, bone marrow biopsy was done features suggestive of HLH. HLH methyl prednisolone was given for 5 days, followed by intravitil. Post intubation child had pooling of secretions, bronchomotor assessment showed difficulty in liquids but not for solids. Hence, upper GI contrast studies were done. showed tracheal aspiration. She hence planned for gastroenterology, or neurology opinion. and continued on N4 feeds. As the child is haemodynamically stable, he is being shifted to ward.</p>	
		<p>Plan</p> <ol style="list-style-type: none"> 1) IV: Meropenem. 2) Syp. Ranitidine 3) Syp. Domitol 4) Tab. Levofloxacin 5) Syp. Calcium gly 6) Syp. Omnescolik Ark (Grape) dose 7) WNC 0.2 lit 8) Carbon monox
	<p>HR - 127/min SpO2 - 100% @ 0.2 lit RR 26/min</p> <p>of the</p>	

Noted by
 SLS - doc
 12/11/25
 @ 4pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/07/25 5:45 PM	<p>cf/s/s Dr. Vishnu</p> <p>1) - sepsis in neon</p> <p>- Pseudo Bulbar palsy</p>	<p>None</p>
	<p>1) NG tube position should be checked by both mother & Nursing staff</p>	
	<p>2) continuous vital monitoring</p>	
	<p>3) Neuro review T/M</p>	
	<p>4)</p>	
	<p>5)</p>	
	<p>6)</p>	
	<p>7)</p>	
		<p>Noted by Bernike 13/6 @ 1 pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/06/2025 8:30 AM	C/S/B prev follows	
	D ^{II} sepsis (MOD) pseudo-D-dimer play & evaluation	
	on room air from 7:30 AM maintaining saturation, RR (25-28/min)	
	RR (20) PR (20)	
	on NG feeds (low volume / any / tolerating) w/ free spitz passing urine.	
	BP 106/60 mm Hg RR - 26/min SpO ₂ = 93-96% on O ₂	1) No feeds to continue
	2) phototherapy	
	3) meningococci today & stop	
	4) w/ decontamination	
	5) ENT, neurology & gastroenterology consultation today	
	[Signature]	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/2026 10:00 AM	c/s/B Dr Vishnu Var	(DOR) Discharge on request
	(1) Spine EMGDS & MRI (2) Dysphagia to s/o Pseudobulbar palsy off oxygen	
	Adv: (1) On follow up CBP, CRP, LFT (to repeat) (2) Continue NG tube (3) Dr Archita: Oromotor stimulation, limbs, physiotherapy (Tran pacis)	
	<u>Cancelled by Dr Vishnu Var</u>	
	<p>The parents counselled about current difficulty in feeding/swallowing & chance of aspiration. Parents were advised for continuation of case, but parents want to get discharged at request.</p>	
		Noted by Benprika 13/6 @ 1 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>1/c/o spinal myelomeningocele</p> <p>- Sepsis in Lndry NLN</p> <p>- Oropharyngeal dysphagia to liquid.</p> <p>*Keji (Secondary to Pseudobulbar dysfunction)</p> <p>Discharge on Repeat</p>	<p>Operated</p> <p>Armed with Hydrocaps</p>
	<p>Advice:</p> <p>(1) Continue NG feed as advised</p> <p>(2) Train mother in NG feed & position checks</p>	
	<p>(3) BLS training to teach - (Disposable Ambu Bag)</p> <p>(4) Domstal Ranbax Lanzol } 2 weeks</p>	
	<p>(5) Steroid tapering over 2 weeks</p> <p>(6) Calcimax P.</p> <p>(7) Multivitamin</p> <p>(8) Ziprax (100mg Sust) 2ml BD X 5 days</p> <p>(9) Draft Entero-gemina X 1 week</p>	
	<p>(10) To do CBP, CRP, LFT on follow up after 5 days</p>	
	<p>(11) To follow up with Dr Vishnu Sir Dr Sindhu Maam.</p>	
	<p>(12) Plan: To direct start feed under supervision after Neurology & Physiotherapy assessment.</p>	
	<p>(13) Plan: MRI Brain & WES on follow up.</p>	

[Handwritten signature]

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: <u>6/6/26</u>	Diagnosis: <u>Sepsis & encephalopathy & MODS.</u>	Surgery / Procedures: <u>-</u>		
	Allergies:		Post OP Day: <u>-</u>		
	Date:	<u>11/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	
	Area				
	Shift Time	<u>PIU Morning</u>	<u>PIU Evening</u>	<u>PIU Night</u>	
	Diet:	<u>NG feed</u>	<u>NG feeds</u>	<u>NG feeds</u>	
Ventilation (RA, NP, NIV, VENTI)	<u>O2</u>	<u>O2 on lips NP</u>	<u>O2 0.3 wt</u>		
INVASIVE LINES	1.	<u>central line</u>	<u>IV cannula</u>	<u>IV cannula</u>	
	2.	<u>IV cannula</u>			
	3.	<u>-</u>			
	4.	<u>-</u>			
ASSESSMENT	Infusions / Transfusions	<u>-</u>	<u>Nil</u>	<u>Nil</u>	
	PU Prophylaxis	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
	DVT Prophylaxis	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
	Vitals	BP	<u>122/75 (90)</u>	<u>104/86 (63) mmHg</u>	<u>113/60 (73)</u>
		PR	<u>65 b/m</u>	<u>102 b/m</u>	<u>79 b/m</u>
		RR	<u>69 b/m</u>	<u>17 b/m</u>	<u>20 b/m</u>
		SpO ₂	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Temp	<u>98.7°F</u>	<u>98.6°F</u>	<u>98.6°F</u>
	Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	
	LOC (Alert, Conscious, Confusion, Unconscious)	<u>Conscious</u>	<u>conscious</u>	<u>conscious</u>	
	Skin Integrity (Intact / Bedsore / Any other condition)	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	
	Restraints If any	Physical	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
		Chemical	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
Fall Risk (Vulnerable Y/N) if yes score	<u>10</u>	<u>10</u>	<u>10</u>		
(Ambulation, walking, moving with assistance, bed ridden)	<u>Bed ridden</u>	<u>Bed ridden</u>	<u>Bed ridden</u>		
ADL (Dependent / Non-Dependent)	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>		
Critical Lab Test / Values (if any)	<u>-</u>	<u>Nil</u>	<u>Nil</u>		

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


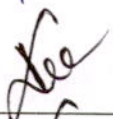
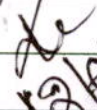
RECOMMENDATIONS	Date:		11/6/26	11/6/26
	Area	Shift Time	plw Morning	plw evening
			plw Night	
	Ordered / Planned	plan to stop O2	* CBP, CRP, LFT RFT +IM	* N/G feeds 3rd hand type
	Due	Nil	Nil	Nil
	Reports Pending	HPLC due	HPLC due.	HPLC
	Referrals (If any)	Nil	Nil	Nil
Remarks (Special Interventions like, Drainage tube flushing etc.)	Nil	Nil	Nil	
Handed Over By Name :	Sr-Devika	Supriya	Moheswarani	
Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	11/6/26	11/6/26	12/6/26	
Time:	2pm	@ 8pm	@ 8Am	
Taken Over By Name :	Supriya	Moheswarani	Sr-Devika	
Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	11/6/26	11/6/26	12/6	
Time:	2pm	@ 8Am	8Am	



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA:	Diagnosis: <u>Sepsis encephalopathy</u>	Surgery / Procedures:	
	Allergies:	<u>ε MODS</u>	Post OP Day:	
	Date:	<u>12/6/26</u>		
	Area	<u>picu</u>	<u>picu</u>	
	Shift Time	<u>M</u>	<u>E</u>	
	Diet:	<u>NPO</u>	<u>Not feeds</u>	
Ventilation (RA, NP, NIV, VENTI)	<u>O2</u>	<u>O2</u>		
INVASIVE LINES	1.	<u>IV cannula</u>	<u>IV cannula</u>	
	2.	<u>-</u>	<u>-</u>	
	3.	<u>-</u>	<u>-</u>	
	4.	<u>-</u>	<u>-</u>	
ASSESSMENT	Infusions / Transfusions	<u>DNS 20ml/hr</u>	<u>DNS @ 20ml/hr</u>	
	PU Prophylaxis	<u>Nil</u>	<u>Nil</u>	
	DVT Prophylaxis	<u>Nil</u>	<u>Nil</u>	
	Vitals	BP	<u>106/70 (86)</u>	<u>113/69 (81) mmHg</u>
		PR	<u>110b/m</u>	<u>96b/m</u>
		RR	<u>22b/m</u>	<u>24b/m</u>
		SpO ₂	<u>96%</u>	<u>98%</u>
		Temp	<u>98.6°F</u>	<u>98.6°F</u>
	Pain Score	<u>0</u>	<u>0</u>	
	LOC (Alert, Conscious, Confusion, Unconscious)	<u>conscious</u>	<u>conscious</u>	
	Skin Integrity (Intact / Bedsores / Any other condition)	<u>Intact bed ridden</u>	<u>Intact</u>	
	Restraints If any	Physical	<u>Nil</u>	<u>Nil</u>
		Chemical		
Fall Risk (Vulnerable Y/N) if yes score	<u>14</u>	<u>14</u>		
(Ambulation, walking, moving with assistance, bed ridden)	<u>bed ridden</u>	<u>bed ridden</u>		
ADL (Dependent / Non-Dependent)	<u>dependent</u>	<u>dependent</u>		
Critical Lab Test / Values (If any)	<u>-</u>	<u>-</u>		

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

RECOMMENDATIONS	Date:	12/6/26		
	Area	<div style="display: flex; justify-content: space-between;"> PCU NI </div>		PIU C
	Shift Time			
	Ordered / Planned	today plan to do upper GI study	→ ENT CLIN → gastro u NURO CLIN	
	Due	Nil	Nil	
	Reports Pending	Nil Nil	Nil	
	Referrals (if any)	Nil	Nil	
Remarks (Special Interventions like, Drainage tube flushing etc.)	Nil	Nil		
Handed Over By Name :		Sr. Devika		
Signature :				
Date:		12/6/26		
Time:		2pm		
Taken Over By Name :				
Signature :				
Date:		12/6/26		
Time:		2pm		

CONSULTATION FORM



Doctor Name :

Date : Hour :

Hospital :

Referred for : Opinion Co-Management
 Transfer of care

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
 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 :

Follow up case

child feeds - no oxygen requirement

Respiration efforts better

- Difficulty in swallowing liquids → 2 to
- No difficulty in swallowing solids

occasional pooling of secretions

no water retention

no constipation

no vomiting

Consultant :

Name : *Dr. Sindhu P.* Signature : *[Signature]* Date & Time : *13/8/26*

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

What - (2)
 We took in situ

concerns, active

partic - in canal reactions

Form - full

control hypothesis

good at memories

the best

practice with error

copy 21

→ technical application in
 unnecessary phase

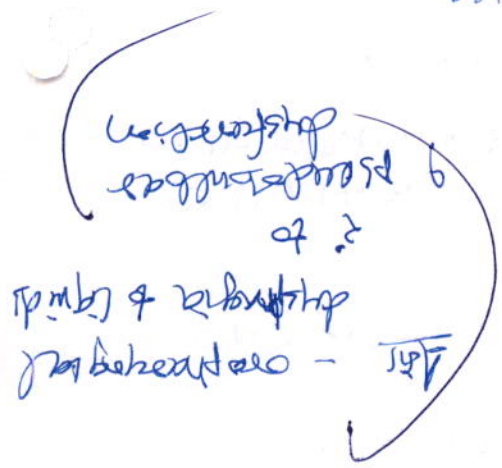
Plan

- generator simulation
- physiology - limb & chest
- continue with food for

5 days

→ MPI based on ~~with~~ on follow up

→ In room with drops
 1ml one daily
 x 3 months



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: 1st floor (103)

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	SYP. CARCIMAX PLUS	3.5ml	PO/NG	12 HRLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Tab. MERO PENEM	240mg	PO	8 HRLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	DOMPRIDONE SUSPENSION (1mg/ml)	1.5ml	PO/NG	8 HRLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	SYP. RANITIDINE	1.2ml	PO/NG	12 HRLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	P. LANSOPRAZOLE	1/2 TABS	NG/PO	ONCE DAILY		<input checked="" 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. Jayaram

Date & Time: 12/06/2026, 4:30 PM

Nurse Name & Signature: Kee

Date & Time: 12/6/26 @ 4:30pm

IP-00060254
 V/H-00199881
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 0 D (M)
 Dr. KODICHERLA VISHNU VARDHAN

Ref. No. : F / HW/CONS.F/INPR / 01

CONSULTATION FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Doctor Name : Dr. Jaanaki Ram

Date : 10/6/26 Hour : 3V

Hospital : RCH

Type of Referral : Emergency (within one hr.)

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

Referred for : Opinion Co-Management

Date : 10/6/26 Time : By :

Transfer of care

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 :

c/o - Acute febrile encephalopathy.
 (Recovering) / mdds for Bedside echo.

Echo

⇒ Structurally normal heart
 ⇒ normal cardiac chambers.
 ⇒ Trivial TR / MR.
 ⇒ Normal coronaries
 Lmca - 2.1mm (Z score + 1.08)
 LAD - 1.6mm (+0.84)
 RCA - 1.5mm (Z score +0.07)
 ⇒ No eff vegetation / clots.

Consultant :

Name : Dr. Nagarenpao Signature : _____ Date & Time : 10/6/26 af

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

→ NO e/o Para System -
Shunt.

→ Instruct IAS (Iy).

→ CUBVF

→ Left axis / no CO-A HL

C/O/w Dr. SHWETA mam

→ No cardiac involvement.

→ Normal (proponer).

→ Review (ST)

→ Rpt NTPo BNB

June
Dr. Jankaram.

CONSULTATION FORM



Doctor Name : Dr. Sindhu

Date : 6/6/26 Hour : 10 AM

Hospital : RCH

Type of Referral : Emergency (within one hr.)

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

Referred for : Opinion Co-Management

Date : 6/6/26 Time : 10 AM By :

Transfer of care

Reason for Consult:

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 11 D (M)
 Dr. KODICHERLA VISHNU VARDHAN

Specify the particular need, especially in the absence of a second

Diagnosis:

Signature: _____

M.D. _____

Report of Findings and Recommendations :

follow up case

CHITRA BEEPER

respiratory efforts good

(etc)

E4 V5 M6

conscious,

APATS - RL equal, reaching

Consultant :

Name : Dr. P. Sindhu Signature : [Signature] Date & Time : 6/6/26

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

8/1

→ Physiology



→ MET Brain with Central



(Adv)

Raise DR
Bill make comes the



CONSULTATION FORM



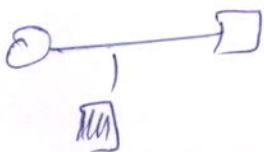
Doctor Name : Dr. Sandhya V
 Date : 11/6/26 Hour : _____

Hospital : RCH Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
 Referred for : Opinion Co-Management
 Transfer of care Date : 11/6/26 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/o spinal myelomeningocele operated

Blood c/s
 smc/s } me

feutin 1200 → 185

cost / arsted
 wt / arsted

sepsis - hyperfeverance - leuc dysfunction
 improving? ^{AKH}

received IV Ig +
 skund

clinical details noted

(P)

manosphaly

us
 A

→ to do oral steroids for
 growth (tapirup doses)

→ at supportare care

→ to do wts for (PID/ AKH)

→ change methyl pred to
 oral steroid after 2 days

Consultant :

Name : Dr. Sandhya V Signature : _____ Date & Time : 11/6/26

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

VIH-00199881 IP-00060254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 9 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Ref. No. : F / HW/CONS.F/INPR / 01

CONSULTATION FORM



Doctor Name : Ashita Venaraju
Date : 11-06-26 Hour : 12:30pm

Hospital : RIH

Type of Referral : Emergency (within one hr.)

Referred for : Opinion Co-Management

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

Transfer of care

Date : 11/6/26 Time : 12:30pm By :

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

swallowing Assessment

Signature: _____

M.D.

Report of Findings and Recommendations :

S/S physician report

sepsis E mode.

→ Swallowing Assessment.
liquid → small quantities
↳ good.
↳ large quantities.
not c/o ⊕ → mild incoordi
solids - good; able to swallow well.

Consultant :

Name : Ashita Venaraju Signature : Ashita Date & Time : 11-06-26 12:30pm

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

RESTRICTED ANTIMICROBIAL USE JUSTIFICATION FORM

Patient Name : Syed Umarrudin Age : 11 months Gender : Male Female

UHID No. : VIN - 00199881 Department : _____ Date of Admission: 6/6/2026

Diagnosis : Sepsis with MODS

Brief Clinical History:

① Fever x 3 day
② Dull activity x 2 day.

Clinical Features & Relevant Investigations Suggestive of Infection

Date	6/6/2026	6/6/2026			
Fever	for 3 day				
Other C/F					
HB		7.7			
TLC		21,930			
N,L,E		13.6/53.9			
PLT		2.04 lakh			
CRP		48			
PCT/ESR		33.4			
WIDAL					
MP Optimal					
WEIL-FELIX					
CUE		Normal			
BODY FLUID CYTOLOGY					
LATEX					

Restricted Antimicrobial Use

Antimicrobial	Date	DOA	Justification	Antimicrobial	Date	DOA	Justification
1. VANCOMYCIN	6/6/2026	6/6/2026	High CRP	5.			
2. MEROPENEM	7/6/2026	7/6/2026	High Fever & Inflammatory markers	6.			
3.				7.			
4.				8.			

Any Other Comment:

		Date	DOA	Result	Date	DOA	Result	Date	DOA	Result	
A.	Blood	6/6/2026		Awaited							
B.	Urine										
C.	CSF										
D.	E T			Secretion							
E.				BAL							
F.				Mini BAL							
G.	Body Fluids										
H.	PCR										

Elaboration:

If no please justify *Resistant face with high inflammatory marker and multi-organ dysfunction.*

At Day 7 De-Escalation done: Yes No

If no please justify

Justification:			
I	Risk Factor for ESBL	I	Risk Factor for MDR Infection
11	Prior Antibiotic use (within 90 days)	11	Prior Antibiotic use (within 90 days)
12	Recent hospitalization (>2d, within 90 days)	12	Recent hospitalization (>2d, within 90 days)
13	current hospitalization of (>5 days)	13	current hospitalization of (>5 days)
14	Immunosuppression	14	Chronic / Nursing Home Care
15	Prolonged Mechanical Ventilation (>3days)	15	Dialysis
16	<input checked="" type="checkbox"/> Suspected Septic Shock-hit First Hit hard Policy	16	Immunosuppression
17	Other	17	<input checked="" type="checkbox"/> Suspected Septic Shock-Hit First Hit Hard Policy
		18	Others
K	Risk Factors for Invasive Candidacies / Candidemia	L	Risk Factors for MRSA
K1	Immunosuppression	L1	Immunosuppression
K2	Dialysis	L2	Dialysis
K3	Prolonged Hospitalization (>5 days)	L3	Exposure to MRSA
K4	Previous Broad Spectrum Antibiotic Use	L4	<input checked="" type="checkbox"/> Central Lines, ICD, PD, Catheter, ET Tubes
K5	CVP/HD Catheter / PA Catheter	L5	Chronic / Nursing Home Care
K6	Total Parenteral Nutrition	L6	Multi Focal Candida Coloniation
K7	Others	L7	<input checked="" type="checkbox"/> Suspected Septic Shock-Hit First Hit Hard Policy
		L8	Others

Signature of Consultant

Signature of Microbiologist

WARNING SCORE: CHILDREN'S UNIT

Date: 12/6/25	Time:	8	9	10	11	12	1	2	3	4	5	6	7
Doctor/Nurse/Family Concern?		PN	PN	PN	PN	PN	PN	PN	PN	PN	PN	PN	M
Temperature (°F)		98.8	98.6	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8
Heart Rate (bpm) and Blood Pressure (mmHg) *		133/130	136/138	126/127	125/108	108/112	117/120	128/130	131/133	133/135	133/135	133/135	133/135
Heart Rate (Number)		133	136	126	125	108	117	128	131	133	133	133	133
Resp. Rate (bpm) (Over 1 Minute) *		32	35	34	35	36	30	29	28	27	28	28	28
Resp Rate (Number)		32	35	34	35	36	30	29	28	27	28	28	28
Resp Mod/ Severe Distress None / Mild		N	N	N	N	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min)		0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
O ₂ Saturations (%)		96	98	97	99	98	98	99	100	98	97	99	98
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
TOTAL SCORE		2	2	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes		2	2	0	0	0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		PN	PN	PN	PN	PN	PN	PN	PN	PN	PN	PN	M

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



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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/11/26	Time: 9 11
Doctor/Nurse/Family Concern?	am am
Temperature (°F)	98.6 98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *	120 125
Resp. Rate (bpm) (Over 1 Minute) *	32 35
Resp Distress	N N
Receiving O ₂ (l/min)	0 0
O ₂ Saturations (%)	99 98
Conscious Level	N N
GCS *	15 15
TOTAL SCORE	
Number of shaded boxes	0 0
Pain Score	0 0
Observer's Initials	B B

*Noted by
 Revanika
 12/11/26
 @ 1 PM*

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.

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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)



FLUID CHART

Sheet No. :

12/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm		Dal water							✓	0		12/6/26	
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

100

CPY
1799
SN cut
S2

FLUID CHART

Sheet No. :

12/6/28

- 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			
	08:00 am												
	09:00 am												
	10:00 am	Soup			100ml								Bevika
	11:00 am												12/6
	12:00 pm												@ 2pm
	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 :							

Noted by
Bevika
12/6
@ 1pm

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													
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Total Intake :						Total Output :								
	02:00 pm													
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Total Intake :						Total Output :								
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Total Intake :						Total Output :								
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	06:00 am													
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake						Total 24 hrs. Output								



DRUG CHART

Date of Admission: 6/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>ENTR PARACETAMOL</u>				Date Time
Dose <u>10mg</u>	Route <u>PW</u>	Frequency <u>to every</u>	Start Date <u>6/06</u>	<u>7:10 AM</u>
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	<u>12:00 PM</u>
Additional Instructions: <u>10-15 up to 1000</u>				<u>6:30 PM</u>
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Signature: S. Nancy Kamal 6/6/26

VERIFIED BY - Name

REGULAR PRESCRIPTIONS

Weight 8.5 kg Ward PSW
 (out side)

112 Jashika
 S. macey Komala 6/6/26
 110 Jashika
 S. macey Komala 6/6/26
 101 Jashika
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 3 Jashika
 S. macey Komala 6/6/26
 2 Jashika
 S. macey Komala 6/6/26
 1 Jashika
 S. macey Komala 6/6/26

DRUG : <u>SYP. OSELANIVIR</u>				Date	<u>7/6</u>	<u>8/6</u>	<u>9/6</u>
				Time	<u>7/6</u>	<u>8/6</u>	<u>9/6</u>
Dose	Route	Frequency	Start Date				
<u>2ml</u>	<u>PO</u>	<u>12 hourly</u>	<u>6/06</u>				
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Jayashree</u>			
Additional Instructions:				<u>3mg/kg dose</u>			
Daily Doctor's Endorsement by a Sign							
DRUG : <u>2M. CEFTRIAXONE</u>				Date	<u>8/6</u>	<u>7/6</u>	
				Time	<u>8/6</u>	<u>7/6</u>	
Dose	Route	Frequency	Start Date				
<u>400mg</u>	<u>IV</u>	<u>12 hourly</u>	<u>6/06</u>				
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Jayashree</u>			
Additional Instructions:				<u>50 mg/kg dose</u> <u>in 10 ml NS</u>			
Daily Doctor's Endorsement by a Sign							
DRUG : <u>2M. VANCOMYCIN</u>				Date	<u>7/6</u>	<u>8/6</u>	<u>9/6</u>
				Time	<u>7/6</u>	<u>8/6</u>	<u>9/6</u>
Dose	Route	Frequency	Start Date				
<u>120mg</u>	<u>IV</u>	<u>8 hourly</u>	<u>6/06</u>				
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Jayashree</u>			
Additional Instructions:				<u>15 mg/kg dose</u> <u>in 15 ml NS</u>			
Daily Doctor's Endorsement by a Sign							
DRUG : <u>8M. PANTOPRAZOLE</u>				Date	<u>6/6</u>	<u>7/6</u>	<u>8/6</u>
				Time	<u>6/6</u>	<u>7/6</u>	<u>8/6</u>
Dose	Route	Frequency	Start Date				
<u>8mg</u>	<u>IV</u>	<u>ONCE DAILY</u>	<u>6/06</u>				
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Jayashree</u>			
Additional Instructions:				<u>1mg/kg dose</u>			
Daily Doctor's Endorsement by a Sign							

Patient Name	I.P. No.	Sheet No. (7)	Wards (P12)	Weight (kg) (6.5kg)
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REGULAR PRESCRIPTIONS

S. maay bamaq 6/16/26

DRUG : NED. LEVOSALBUTAMOL Date/Time 7/6 3AM

Dose	Route	Frequency	Start Dt.
0.63mg	Pln	6 Hourly	6/16

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

Additional Instructions: 1 Pepple = 0.63 mg

Daily Doctor's Endorsement by a Sign.

S. maay bamaq 6/16/26

DRUG : NED. BUDESONIDE Date/Time 7/6 9AM

Dose	Route	Frequency	Start Dt.
0.5mg	lv	12 hourly	6/16

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

Additional Instructions: stop

Daily Doctor's Endorsement by a Sign.

Dr. J. Jeyaree 7/16/26

DRUG : ENT. VITAMIN K Date/Time 7/6 8/16 9/16

Dose	Route	Frequency	Start Dt.
2.5mg	lv	once daily	7/16

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

Additional Instructions: 0.3mg/kg For 3 days

Daily Doctor's Endorsement by a Sign.

Chithru 7/16/26

DRUG : REFRESH EYE DROPS Date/Time 7/6

Dose	Route	Frequency	Start Dt.
2°	Eye	2nd hourly	7/6

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

Additional Instructions: see the chart

Daily Doctor's Endorsement by a Sign.

Rai: VIH-00199881 IP-00060254
 Chi: Master SYED UMARUDDIN
 Hos: 01-07-2025 0 Y 11 M 6 D (M)
 Dr. KODICHERLA VISHNU VARDHAN

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

Pat		I.P. No.	Sheet No.	Wards	Weight (kg)
				plw	8.5kg

REGULAR PRESCRIPTIONS

DRUG: MEROPENEM				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
300 mg	IV	8 HOURLY	7/6																
Name & Signature of the Doctor starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG: MEROPENEM				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
340mg	IV	12 HOURLY	7/6																
Name & Signature of the Doctor starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG: MUPROICIN oint				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
1/2	1/2	8 hourly	7/6																
Name & Signature of the Doctor starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG: INJ THIAMINE				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
50mg	IV	12hr HOURLY	7/6																
Name & Signature of the Doctor starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

Renal Adjusted dose
 Chrtg 7/6/25
 Chrtg 7/6/25

OK

Patient Name	I.P. No.	Sheet No. (2)	Wards PW	Weight (kg) 8.5kg
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...GULAR PRESCRIPTIONS

7/6/26
Chith

DRUG: INJ FUROSEMIDE				Date	7/6														
Dose	Route	Frequency	Start Dt.	Time	7/6														
5mg	IV	12hr	7/6/26	Am	X														
Name & Signature of the Doctor starting the Drugs:																			
Dr Sweetsy																			
Additional Instructions:																			
0.5mg/kg/dose																			
Daily Doctor's Endorsement by a Sign.																			

Dr J gbla
Chith 7/6/26

DRUG: INJ MEROPENEM				Date	7/6	26/6/26													
Dose	Route	Frequency	Start Dt.	Time	7/6	26/6/26													
340mg	IV	8 Hourly	7/6/26	Am	X														
Name & Signature of the Doctor starting the Drugs:																			
Dr Sweetsy																			
Additional Instructions:																			
40mg/kg/dose																			
Daily Doctor's Endorsement by a Sign.																			

Dr J gbla
Chith 7/6/26

DRUG: INJ PARACETAMOL				Date	7/6	26/6/26													
Dose	Route	Frequency	Start Dt.	Time	7/6	26/6/26													
120mg	IV	6 Hourly	7/6/26	Am	X														
Name & Signature of the Doctor starting the Drugs:																			
Dr Sweetsy																			
Additional Instructions:																			
10-15mg/kg/dose																			
Daily Doctor's Endorsement by a Sign.																			

Dr J gbla

DRUG: SYRUP URODEOXY				Date	7/6	26/6/26													
Dose	Route	Frequency	Start Dt.	Time	7/6	26/6/26													
3.5ml	NG	12hr	7/6/26	Am	X														
Name & Signature of the Doctor starting the Drugs:																			
Dr Sweetsy																			
Additional Instructions:																			
5ml = 125mg 0.5mg/kg/dose																			
Daily Doctor's Endorsement by a Sign.																			

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

DRUG : SYP. POTUOLUR

Dose	Route	Frequency	Start Dt.	Date	Time
4 ml	PO	8 hourly	8/6		

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

Additional Instructions: *& me 1ly/day (Kad = 20 me)*

Daily Doctor's Endorsement by a Sign.

DRUG : INS METHYLPREDNISOLONE

Dose	Route	Frequency	Start Dt.	Date	Time
10mg	IU	12hrly	8/6/26		

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

Additional Instructions: *2x 10ml over 1 hour (in 1mg/9 dose)*

Daily Doctor's Endorsement by a Sign.

DRUG : INS METHYLPREDNISOLONE

Dose	Route	Frequency	Start Dt.	Date	Time
10mg	IU	12hrly	8/6/26	8/6	9/6

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

Additional Instructions: *2x 10ml over 1 hour (in 1mg/9 dose) K 5 days*

Daily Doctor's Endorsement by a Sign.

DRUG : T. SPIRINOLACTONE (ALDACTONE)

Dose	Route	Frequency	Start Dt.	Date	Time
3mg (3.5ml)	PO	8th/ly	8/6	8/6	9/6

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

Additional Instructions: *2 tab = 25 mg 1 tab bd dilute in 10ml give 3.5ml*

Daily Doctor's Endorsement by a Sign.

Dr. Jayashree

Dr. Jayashree

As per doctor order Chik 8/6/26

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 7 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



I.P. No.

Sheet No. 3

Wards RICU

Weight (kg) 8.5 kg

REGULAR PRESCRIPTIONS

as per doctor advice,
 Chikku 8/6/20

DRUG : <u>SYP POTK LOR</u>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
<u>4ml</u>	<u>PO</u>	<u>8hrly</u>	<u>8/6/20</u>	<u>4PM</u>																	
Name & Signature of the Doctor starting the Drugs:																					
<u>Z. N. Vardhan</u>																					
Additional Instructions:																					
<u>(2mg/kg/day)</u> <u>1.5ml = 20mg/kg</u>																					
Daily Doctor's Endorsement by a Sign.																					

DRUG : <u>SYP SUCRAL</u>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign.																						

DRUG : <u>SYP SUCRALFATE</u>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
<u>2.5ml</u>	<u>PO</u>	<u>8th hrly</u>	<u>9/6</u>																			
Name & Signature of the Doctor starting the Drugs:																						
<u>Dr. Vardhan</u>																						
Additional Instructions:																						
<u>(5ml-1g)</u> <u>15min before feeds</u>																						
Daily Doctor's Endorsement by a Sign.																						

DRUG : <u>SYP CACIMAX-P</u>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
<u>2.5ml</u>	<u>PO</u>	<u>12th hrly</u>	<u>9/6</u>																			
Name & Signature of the Doctor starting the Drugs:																						
<u>Dr. Vardhan</u>																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign.																						

Patient Name



I.P. No.

Sheet No. (4)

Wards PIW

Weight (kg) 8.51kg

REGULAR PRESCRIPTIONS

DRUG: INJ. FURUSEMIDE

Dose	Route	Frequency	Start Dt.	Date	Time
5mg	IV	8thly	9/6		

Name & Signature of the Doctor starting the Drugs: *A. Anur*

Additional Instructions: 0.5 - 1mg/kg/dose

Daily Doctor's Endorsement by a Sign.

DRUG: SUP. CALCIUM PLUS

Dose	Route	Frequency	Start Dt.	Date	Time
3.5ml	PO	12 HRly	9/06	9/6	10/6

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

Additional Instructions: 100 mg/kg/day

Daily Doctor's Endorsement by a Sign.

DRUG: SUP. OSELTAMIVIR

Dose	Route	Frequency	Start Dt.	Date	Time
2ml	PO	12 HOURly	6/06	10/6	11/6

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

Additional Instructions: 3 mg/kg/dose

Daily Doctor's Endorsement by a Sign.

DRUG: INJ. VANCOMYCIN

Dose	Route	Frequency	Start Dt.	Date	Time
10mg	IV	8 hrly	6/06	10/6	11/6

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

Additional Instructions: 15mg/kg/dose
3ml NS over 15min

Daily Doctor's Endorsement by a Sign.

AS per Dr Vishnu vardhan
 Chithr 9/6/26
 Dr Jayashree
 Chithr 9/6/26
 Dr Jayashree
 Chithr 9/6/26
 Dr Jayashree
 Chithr 9/6/26

SS

*5 AM 10/6
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*5 AM 10/6
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 5 AM 10/6
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 12/6*

STOP

STOP

VIH-00167802 IP-00060250
 Master D CHERITH RUDRA
 13-05-2018 8 Y 0 M 27 D (M)
 Dr. PREETHAM KUMAR

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



I.P. No. Sheet No. Wards **PICO** Weight (kg) **8.5 kg**

REGULAR PRESCRIPTIONS

As per doctor order
 Rudra 09/16/2025 at 10:15
 Rudra 09/16/2025 at 10:15
 Rudra 09/16/2025 at 10:15
 Rudra 09/16/2025 at 10:15
 Rudra 09/16/2025 at 10:15

DRUG: INJ. METHYL PREDNISOLONE

Date/Time	10/6	11/6	12/6
Dose	10 mg		
Route	IV		
Frequency	12 hourly		
Start Dt.	8/1/20		
Name & Signature of the Doctor starting the Drugs: <i>Dr Jayapree</i>			
Additional Instructions: 2x 10 cc NS over 1 HOUR stop 14 days			
Daily Doctor's Endorsement by a Sign. (B) (P) (P)			

DRUG: SIP. SUCRALFATE

Date/Time	9/6	10/6	11/6	12/6
Dose	2.5 ml			
Route	PO/IV			
Frequency	8 hourly			
Start Dt.	9/6			
Name & Signature of the Doctor starting the Drugs: <i>Dr Jayapree</i>				
Additional Instructions: 8ml = 1g = 100mg				
Daily Doctor's Endorsement by a Sign.				

DRUG: NRB. LEVOJACETAMOL

Date/Time	9/6	10/6	11/6	12/6
Dose	0.63 mg			
Route	IN			
Frequency	8 hourly			
Start Dt.	9/6			
Name & Signature of the Doctor starting the Drugs: <i>Dr Jayapree</i>				
Additional Instructions: 1 respire = 0.63 mg				
Daily Doctor's Endorsement by a Sign.				

DRUG: NRB. BUDESONIDE

Date/Time	10/6	11/6	12/6
Dose	0.5 mg		
Route	IN		
Frequency	12 hourly		
Start Dt.	9/6		
Name & Signature of the Doctor starting the Drugs: <i>Dr Jayapree</i>			
Additional Instructions: 1 respire = 0.5 mg			
Daily Doctor's Endorsement by a Sign.			



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

⑤ PICU 8.5 kgs

REGULAR PRESCRIPTIONS

DRUG: INS. MEROPENEM

Dose	Route	Frequency	Start Dt.	Date/Time	10/6	11/6	12/6	13/6
340 mg	IV	8 hourly	7/6		AM	PM	AM	PM
Name & Signature of the Doctor starting the Drugs: Dr. Jayaraj					AM	PM	AM	PM
Additional Instructions: 40 mg/kg dose in 10 CCM, over 3 hours					AM	PM	AM	PM
Daily Doctor's Endorsement by a Sign.					PM	PM	PM	PM

DRUG: TAB. LANSOPRAZOLE

Dose	Route	Frequency	Start Dt.	Date/Time	10/6	11/6	12/6
8 mg	PO	once daily	9/6		AM	PM	AM
Name & Signature of the Doctor starting the Drugs: Dr. Jayaraj					AM	PM	AM
Additional Instructions: 1 TAB = 15 mg Dilute in 5ml, give 3ml					AM	PM	AM
Daily Doctor's Endorsement by a Sign.					AM	PM	AM

DRUG: TAB. THIAMINE

Dose	Route	Frequency	Start Dt.	Date/Time	10/6	11/6	12/6
50 mg	PO	12 hourly	9/6		AM	PM	AM
Name & Signature of the Doctor starting the Drugs: Dr. Jayaraj					AM	PM	AM
Additional Instructions: 1 TAB: 100 mg 10 dilute in 5ml, give 2.5ml					AM	PM	AM
Daily Doctor's Endorsement by a Sign.					AM	PM	AM

DRUG: SUP. URSO DEOXY CHOLIC ACID

Dose	Route	Frequency	Start Dt.	Date/Time	10/6
3.5 ml	NG/PO	12 hourly	9/6		AM
Name & Signature of the Doctor starting the Drugs: Dr. Jayaraj					AM
Additional Instructions:					AM
Daily Doctor's Endorsement by a Sign.					AM

Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM

Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM
 Jayaraj 09/16/26 at 10:10 AM

Patient Name :  I.P. No. _____ Sheet No. _____ Wards PICU Weight (kg) 8.5 kg's

REGULAR PRESCRIPTIONS

DRUG : DOMPERIDONE SUSPENSION Date/Time 12/6/25

Dose	Route	Frequency	Start Dt.
<u>1.5 ml</u>	<u>NH</u>	<u>8 hourly</u>	<u>12/06</u>

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

Additional Instructions: (1ml = 1mg)
1-2mg / 1p/dose

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

DRUG : SUP. RANTIDINE Date/Time 12/6/25

Dose	Route	Frequency	Start Dt.
<u>1-2ml</u>	<u>NH</u>	<u>12 hourly</u>	<u>12/06</u>

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

Additional Instructions: (1ml = 75mg)
2mg / 1p/dose

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

DRUG : ONSOPRACET Date/Time 12/6

Dose	Route	Frequency	Start Dt.
<u>1/2 tabs</u>	<u>NH</u>	<u>once daily</u>	<u>12/06</u>

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

Additional Instructions: OAD = 15mg
Divide in 5ml and give 2.5ml

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

DRUG : SUP. ONNACORTIC RORTIZ Date/Time 12/6

Dose	Route	Frequency	Start Dt.
<u>3.3ml</u>	<u>NH</u>	<u>12 hourly</u>	<u>12/06</u>

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

Additional Instructions: 1ml = 15mg
10 mg / 1p/dose

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

As per doctor daily
Dose 12/6/25

Dose 12/6/25
at 4pm

Dose 12/6/25
at 4pm

Handwritten notes on the right margin, including a signature and some illegible text.

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

DRUG : <i>SYP. OMNACORTIN FORTE</i>				Date																
				Time																
Dose	Route	Frequency	Start Dt.																	
		<i>12 hourly</i>	<i>12/06</i>																	
Name & Signature of the Doctor starting the Drugs:																				
<i>M. Jayaraj</i>																				
Additional Instructions:																				
<i>5ml = 15mg 10mg/dose</i>																				
Daily Doctor's Endorsement by a Sign.																				

DRUG : <i>SYP. OMNACORTIN FORTE</i>				Date																
				Time																
Dose	Route	Frequency	Start Dt.																	
		<i>12 hourly</i>	<i>12/06</i>																	
Name & Signature of the Doctor starting the Drugs:																				
<i>M. Jayaraj</i>																				
Additional Instructions:																				
<i>10mg/dose</i>																				
Daily Doctor's Endorsement by a Sign.																				

DRUG : <i>SYP. OMNACORTIN FORTE</i>				Date																
				Time																
Dose	Route	Frequency	Start Dt.																	
<i>3.3ml</i>	<i>Nb</i>	<i>12 hourly</i>	<i>13/06</i>																	
Name & Signature of the Doctor starting the Drugs:																				
<i>M. Jayaraj</i>																				
Additional Instructions:																				
<i>5ml = 15mg 10mg/dose</i>																				
Daily Doctor's Endorsement by a Sign.																				

DRUG : <i>SYP. CALCIUM PLUS</i>				Date																
				Time																
Dose	Route	Frequency	Start Dt.																	
<i>3.5ml</i>	<i>PO/Nb</i>	<i>12 hourly</i>	<i>9/06</i>																	
Name & Signature of the Doctor starting the Drugs:																				
<i>M. Jayaraj</i>																				
Additional Instructions:																				
<i>100mg/dose</i>																				
Daily Doctor's Endorsement by a Sign.																				

*30
13/6/26 @ 7 am*

*As per doctor order by Dr. Jayaraj
12/5/26 at 5 pm*



STAT / ONCE ONLY DRUGS

Name:

Weight: 8.5 kg kgs

Sheet No: 09

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
9/6/25	4:50am	Jus Furosemide	8mg	IU	[Signature]	[Signature]	[Signature]
9/6/25	4:50am	NIB CEVOPROBUTOL	(1mg/1.5ml) = 0.67g x 3	PN	[Signature]	[Signature]	[Signature]
9/6/25	5:15am	K BINDER	8gm in 25ml	PR	[Signature]	[Signature]	[Signature]
9/6/25	5:20am	INSULIN	0.8 units/hour over 1 hour	IU	[Signature]	[Signature]	[Signature]
9/6/25	5:20am	10% DEXTROSE	85ml over 1 hour	IU	[Signature]	[Signature]	[Signature]
9/6/25	7am	PARACETAMOL	120mg	IU	[Signature]	[Signature]	[Signature]
9/6/25	7:30am	Jus MAGNESIUM SULPHATE	0.8ml + 2ml NS over 1 hour	IU	[Signature]	[Signature]	[Signature]
9/6/25	11AM	GLYCEROL SUPPOSITORY	1gm	PR	[Signature]	[Signature]	[Signature]
9/6/25	9:05am	2mg NALOXONE	0.4mg in 20ml NS	IU	[Signature]	[Signature]	[Signature]
		4 IUE (0.1ml/kg)	→ give 1ml (0.1mg) (1st dose)	IU	[Signature]	[Signature]	[Signature]
9/6/25	9:25am	NALOXONE	0.02mg - 1ml (2nd dose)	IU	[Signature]	[Signature]	[Signature]
9/6/25	10A	NALOXONE	0.2mg - 1ml x 2 dose	IU	[Signature]	[Signature]	[Signature]

9/6/25 at 5:15

9/6/25 at 7:30

10/6/25

9/6/25

STAT / ONCE ONLY DRUGS

Name:

Weight: 8.5 kg kgs

Sheet No: 2

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
		5ml of KCl + 50ml of NS					
8/6/26	6:20 AM	POTASSIUM CHLORIDE	5ml of KCl + 50ml of NS OVER 3 HOURS	IV	dr.	dr.	dr.
8/6/26	7:00 AM	INJ CALCIUM GLUCONATE	8ml + 8ml of 5% D OVER 1 HOUR	IV	dr.	dr.	dr.
		(UNDER STRICT CARDIAC MONITORING)					
8/6/26	12 PM	SYP POTASSIUM	4ml	PO	dr.	dr.	dr.
8/6/26	12 PM	SYP POTASSIUM	4ml (5mg)	PO	dr.	dr.	dr.
8/6/26	11 AM	SYP POTASSIUM	4ml (5mg)	PO	dr.	dr.	dr.
8/6/26	6 PM	INTRAVENOUS IMMUNOGLOBULIN 5gm over 4 HRS	12.5 ml/hr	IV	dr.	dr.	dr.
8/6/26	7 PM	INS FUROSEMIDE	3mg	IV	dr.	dr.	dr.
8/6/26	7:30 PM	INS 10% CALCIUM GLUCONATE	9ml + 9ml 5% D OVER 1 HOUR	IV	dr.	dr.	dr.
9/6/26	3 AM	INS 10% CALCIUM GLUCONATE	9ml + 9ml 5% D OVER 1 HOUR	IV	dr.	dr.	dr.
9/6/26	8:00	INS VITAMIN K	5mg	IV	dr.	dr.	dr.



STAT / ONCE ONLY DRUGS

Name:

Weight: 3.5 kgs

Sheet No: ①

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
7/6/26	12:50 AM	ENT. VIT K	2.5mg	or	[Signature]	[Signature]	[Signature]
7/6	2 AM	ENT. CALCIUM GLUCONATE	8ml + 8ml 57 D	or	[Signature]	[Signature]	[Signature]
7/6	3 AM	ENT. 3-1-NS	40 ml	or	[Signature]	[Signature]	[Signature]
7/6	8:10 AM	ENT. 4 FRAMM B/2	500 mg	or	[Signature]	[Signature]	[Signature]
7/6	1 PM	INJ THIAMINE	100mg	IV	[Signature]	[Signature]	[Signature]
7/6	11 AM	INJ FUROSEMIDE	5mg	IV	[Signature]	[Signature]	[Signature]
7/6	5 PM	INJ METHYLPREDISOLONE	10mg	IV	[Signature]	[Signature]	[Signature]
7/6	6 PM	INJ KCl 4.3ml + 50ml of NS OVER 3 HOURS	4.3ml + 50ml of NS	IV	[Signature]	[Signature]	[Signature]
7/6	10 PM	PRBC TRANSFUSION	50ml OVER 5 HOUR	IV	[Signature]	[Signature]	[Signature]
		INJ FUROSEMIDE (MID WAY)	2mg	IV	[Signature]	[Signature]	[Signature]
		INJ FUROSEMIDE (END WAY)	2mg	IV	[Signature]	[Signature]	[Signature]
7/6/26	10 PM	INJ CHLORPHENIRAMINE	2mg	IV	[Signature]	[Signature]	[Signature]
8/6/26	7:15 AM	IVIG Transfusion (200ml → 10gm OVER 12 HOUR)	0.5ml/HOUR x 15min 2ml/HOUR x 15min 8ml/HOUR x 15min 16ml/HOUR till end of transfusion	IV	[Signature]	[Signature]	[Signature]



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	
	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.	

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	
	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
6/6/26	@ 9:00 pm	2ND. 10 + D	30ml	IV	[Signature]	Sueyab Shanthi
6/6/26	@ 9:12 pm	2ND. PARACETAMOL	12ml (120mg)	IV	[Signature]	Sueyab Shanthi
6/6/26	@ 9:20 pm	2ND. CEFTRIAXONE	400mg	IV	[Signature]	Sueyab Shanthi
6/6/26	@ 9:20 pm	2ND. 3 + 1.25	40ml once	IV	[Signature]	Sueyab Shanthi
6/6/26	@ 9:43 pm	NBS. CLOLV	0.63	IV	[Signature]	Sueyab Shanthi
6/6/26	@ 9:47 pm	NBS. BUPRENOR 7	0.5	IV	[Signature]	Sueyab Shanthi
6/6/26	10:30 pm	2ND NS	80ml	IV	[Signature]	Kan Bindu
			0.2 @ 1 hour	IV	[Signature]	Kan Bindu
6/6/26	11 pm	2ND. DEBANTHABIT 0.15mg/kg/dose	1.5 mg	IV	[Signature]	Kan Bindu

VERIFIED Name Signature

06/6/26 at 10:15

I.V. FLUIDS CHART

Weight: 8.5kg outside Ward: P20

Signature
 S. marayya male
 6/6/26

Signature

VERIFIED BY: Name

Position 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
6/6/26	@ 9:58 AM 2vk DNS (2/3m)	2v	23	2/	Yash Binky	7/6		Yash Binky
6/6/26	2:20 PM 2 ADD 2NS 20 ml NS	2v	8	2/	Yash Binky	7/6/26	2/	Yash Binky
7/6/26	6 AM 2vk DNS	2v	15	2/	Yash Binky	7/6/26	2/	Yash Binky
7/6/26	11 AM IVF DNS + 5ml KCl	IV	11.5ml	2/	Ram M	7/6/26	2/	Yash Binky
7/6/26	5 PM IVF DNS + 5ml KCl	IV	20	2/	Yash Binky	8/6/26	2/	Yash Binky
7/6/26	5 PM INFUSION FUROSEMIDE IV 20mg (2ml) + 22ml of NS (@ 0.1mg/kg/hr → 1ml/hr)	IV	1	2/	Yash Binky	8/6/26	2/	Ram Yash
7/6/26	6 PM IVF- DNS + 10ML KCL	IV	20	2/	Yash Binky	8/6/26	2/	Ram Yash
8/6/26	11 AM 2NJ N-ACETYL CYSTEAINE 4ml + 20 ml SF.D	2v	1	2/	Ram Yash	10/6/26	2/	
8/6/26	12 PM 2NJ FUROSEMIDE 20mg (2ml) + 10ml 1ml = 1.7 mg	2v	0.5	2/	Ram Yash	9/6/26	2/	Ram Yash



I.V. FLUIDS CHART

Weight Ward

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
9/6/25		2VR DNS + 10ml Kel (100%)	IV	19	[Signature]			[Signature]	
9/6/25	4PM	2VR DNS + 10ml Kel (100%)	IV	22	[Signature]	[Signature]	9/6/25 9:30am	[Signature]	[Signature]
9/6/25	9:30PM	2VR DNS (100%)	IV	22	[Signature]	[Signature]	10/6/26	[Signature]	[Signature]
10/6/26	7 AM	IVF DNS 70%	IV	23					
10/6/26	7 PM	IVF DNS	IV	10	[Signature]	[Signature]	11/6/26	[Signature]	[Signature]
12/6	8am	IV Fluid DNS	IV	20	[Signature]	[Signature]	14/6/27		

Signature
VERIFIED BY : Name

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 07/06/26 Time: 9:00 AM

Weight: 8.5 kg Centile: > 10 centile
 Height: 68 cm Centile: -

Inference: Appropriate for Age

RDA: 700 kcal Calories: 900 kcal Protein: 12-15 gm/day

Diet Recommendations: Nb Peels Start (Bowl) n/o started on
(no food Peels taken weekly at 7 months)

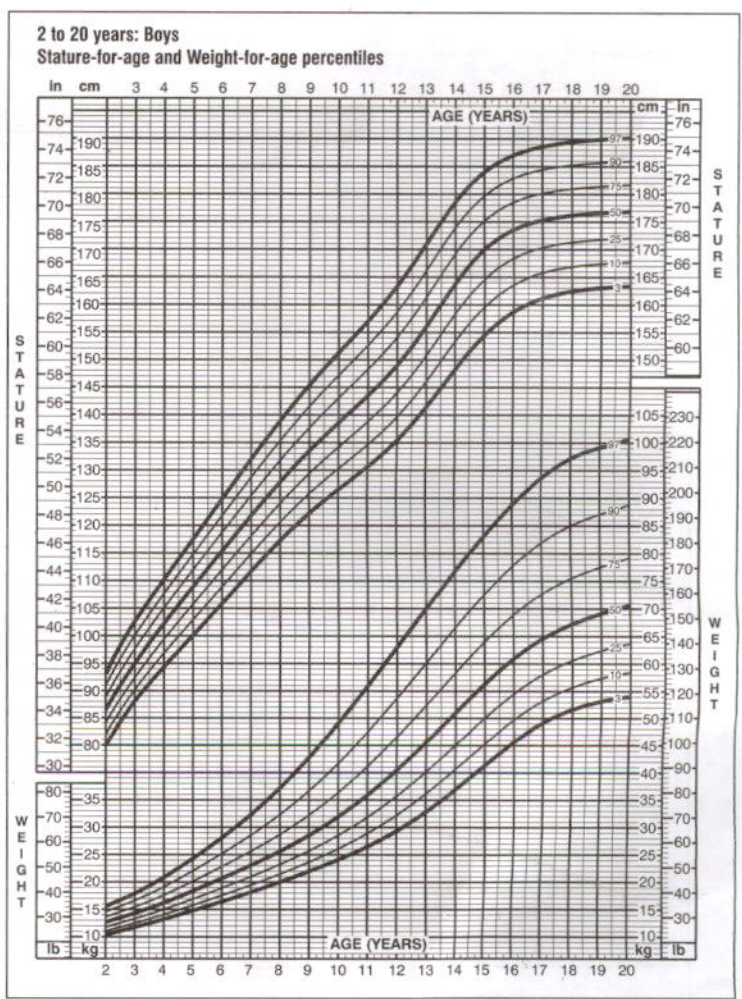
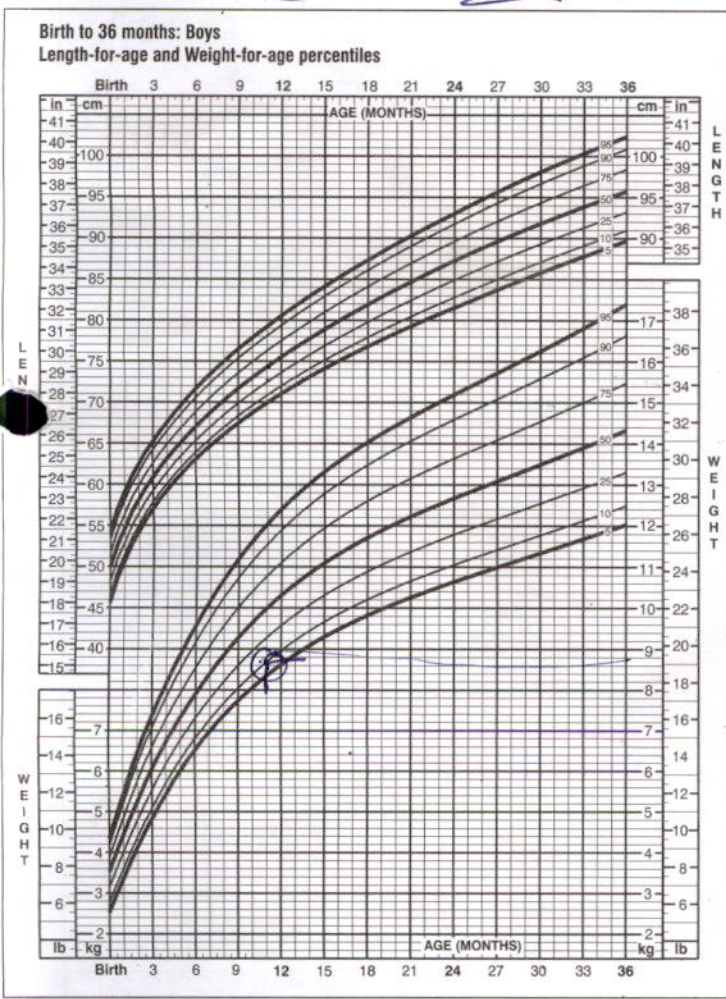
Re-Assessment: - Nil - Veg/Non-veg: - Both

Food Allergies: - Nil - Diagnosis: Septic Shocks, Encephalopathy

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: (Mother) [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Zohra

Dietician's Signature: [Signature]

Daily Notes:

8/6/26 Increased the feed 50ml - 3hrly off
10AM

9/6/26 Increased the feed 50ml - 3hrly off
9AM

11/6/26 N/A Red as per sheet 2us
100ml xshely 8:30am

12/6/26 no feed for GP off
8:30am

13/6/26 No feeds off
8:30am

LRBC



CONSENT FOR BLOOD TRANSFUSION

Name: MASTER SYED UMARODDIN Age: 11/19 Gender: Male Female

UHID.No : 00199881 Date: 7/6/28

Type of Blood Product:

<input type="checkbox"/> Fresh Frozen Plasma	<input checked="" type="checkbox"/> <u>LRBC</u> Packed Red Blood Cells	<input type="checkbox"/> Random Donor Platelets
<input type="checkbox"/> Cryoprecipitate	<input type="checkbox"/> Single Donor Platelet	<input type="checkbox"/> Whole Blood
<input type="checkbox"/> Albumin	<input type="checkbox"/> Red Blood Cell	<input type="checkbox"/> Others

I SYED KHALBE LUDDIN hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: [Signature] Signature: [Signature]

Name: SYED KHALBE LUDDIN Name: Dr Sweeny

Date & Time 07/06/28 @ 9:30pm Date & Time 07/06/28 @ 9:30pm

Witness

Signature:

Name:

Date & Time

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|--|
| <input type="checkbox"/> తాజా మణిభరించిన ప్లాస్మా | <input type="checkbox"/> ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | <input type="checkbox"/> Randonm Donor Platelets |
| <input type="checkbox"/> క్రయాప్రెసిపిటేట్ | <input type="checkbox"/> ఒకే దాత ప్లేటిలెట్స్ | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> మొత్తం రక్తం | <input type="checkbox"/> ఎర్ర రక్త కణం | <input type="checkbox"/> ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫ్రి ఆసుపత్రిలో అడ్మిట్ అయి

ఉన్నప్పుడు పూర్తి బికిత్తులో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ బి యాంటీ బడిస్, హైపటైటిస్ బి సర్వేస్ యాంటిబడిస్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిప్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్లిత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్ల సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం చుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

నేను పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి బికిత్తు చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. బికిత్తు చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్లాజెన్ ప్లాస్మా, క్రయాప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటొనైంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 7/6/26 Time: 10pm

Blood Group of the Patient: A+ve Blood Group on the Blood Bag: A Rh positive

Blood Bank Issue No: BATH26-01313 Date of Collection: 2/15/26 Date of Expiry: 12/17/26

Date & Time of Starting Transfusion: 7/6/26 Planned duration of Transfusion: 1 hour

Check for Correct Unit: Correct Patient: @ 10pm

Blood products cross checked by: Nurse 1: Kell Nurse 2: Rindee

Before starting transfusion vitals: Temp: 98.6 HR: 142 RR: 40 BP: 84/47 SpO₂: 91%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>7/6/26</u>	15 Min	<u>141</u>	<u>98.6</u>	<u>92/49</u>	<u>91%</u>	—	—	—	—
	15 Min	<u>142</u>	<u>98.6</u>	<u>98/60</u>	<u>98%</u>	—	—	—	—
	30 Min	<u>138</u>	<u>98.6</u>	<u>101/72</u>	<u>100%</u>	—	—	—	—
	30 Min	<u>136</u>	<u>98.6</u>	<u>100/69</u>	<u>99%</u>	—	—	—	—
<u>8/6/26</u>	30 Min	<u>128</u>	<u>98.6</u>	<u>99/62</u>	<u>98%</u>	—	—	—	—
	1 Hr	<u>127</u>	<u>98.6</u>	<u>91/62</u>	<u>98%</u>	—	—	—	—
	1 Hr	<u>135</u>	<u>98.6</u>	<u>101/64</u>	<u>100%</u>	—	—	—	—

Comments: Nil

Name of the Incharge-Nurse: Rindee

Name of the Nurse: Kell

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 8/6/26 @ 3A

Date & Time: 8/6/26 @ 3A

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LR-LEUCO REDUCED BLOOD CELLS IP PEDIA-2

Qty. 70 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./
SAGM Solution.



Rh Positive

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: **BAH26-01313**
Blood Group: **A Rh Positive**
Collection Date: **31/May/2026**
Expiry Date: **12/Jul/2026**

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) Check Blood Group on Label & Recipient's
Group and Name Before Administration. 5) Use Sterile Transfusion Set
With Filter. 6) Do Not Dispense Without Prescription. 7) Do Not Use if
There is Any Visible Evidence. 8.) Store Between 2° C to 6° C 9)
Appropriate Compatible Cross Matched Blood Without Atypical
Antibodies in Recipient Should Be Used.

Issue Label / CrossMatching Report

Patient : **MASTER SYED UMARUDDIN .**
Patient's Blood Group : **A Rh Positive**
Hosp/Dr : **Rainbow Childrens Hospital, Duty Doctor**
UHID No. : **VIH-00199881** Wd-Bed No.:

Product : **LR-PRBC Pedia-2**
Blood Group : **A Rh Positive**

Unit No. : **BAH26-01313**
XMatching Report: **Compatible**
X-matched by: **Nachiket**

Issue Dt : **07/Jun/2026**
Colln. Dt : **31/May/2026**
Exp. Dt : **12/Jul/2026**
Issued By : **Nachiket**

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/11D/TS/2018/BB/G

CONSENT FOR SPECIAL PROCEDURES

Patient Name : SYED UMARUDDIN Gender: Male Female
UHID No : VIH - 00199801 Department : PICU Date : 7/6/2026

I, SYED. KHALEELUDDIN S/D/W/O SYED. RAHEEMUDDIN

Here by give consent for procedure of : Central Line Placement

The doctors have clearly explained to me that the procedure has following possible complications:
- Bleeding, thrombosis, Infection.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
- Nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient / Patient Attendant:
Signature : [Signature]
Name : SYED. KHALEELUDDIN
Relationship with Patient: FATHER
Date & Time : 7/6/26 at 7:30 PM

Witness :
Signature : TAWVEER
Name : TAWVEER
Date & Time : 7/6/26 @ 7:30 PM

Doctor (who is taking the consent) :
Signature : [Signature]
Name : P2 Shweta
Date & Time : 7/6/26 @ 7:30 PM

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Syed Umaruddin Gender: Male Female

UHID No : 0199881/060254 Department : PIW Date : 7/6/26

I SYED. KHALEELUDDIN S/D/W/O SYED. RAHEEMUDDIN

Here by give consent for procedure of : Arterial line

For my patient, Named : Syed Umaruddin

The doctors have clearly explained to me that the procedure has following possible complications:

- Thrombosis, Bleeding, Gangrene

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr Sweety

Patient Attendant :
Signature : [Signature]

Name : Syed Khaleeluddin

Relationship with Patient: Father

Date & Time : 7/6/26 @ 12 Am

Witness :
Signature : TANVEER

Name : TANVEER

Date & Time : 7/6/26 @ 11 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr Sweety

Date & Time : 7/6/26 @ 11 AM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా గోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....
.....
.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Syed Umaruddin Gender: Male Female

UHID No : 0199881/060254 Department : P.I.U. Date : 7/6/20

I, SYED KHACELUDDIN S/D/W/O SYED RAHEEMUDDIN

Here by give consent for procedure of : Foley's catheter

The doctors have clearly explained to me that the procedure has following possible complications:

- Infection, leakage

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr Sweehy

Patient / Patient Attendant :

Signature : [Signature]

Name :

Relationship with Patient: Father

Date & Time : 7/6/20 @ 9 AM

Witness :

Signature : TANVEER

Name : TANVEER

Date & Time : 7/6/20 @ 9 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr Sweehy

Date & Time : 7/6/20 @ 9 AM

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



Name: Master Syed Umaruddin Age: 11 months Gender: Male Female
 UHID.No: 199881 Date: 6/6/26
 I, SYED. KHACEELUDDIN S/o, D/o, W/o, SYED. RAHGEEMUDDIN hereby
 declare that our patient Master/Baby SYED. UMAR who is related to me as SON
 is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 6/6/26

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

- Sepsis - Multi organ dysfunction

The doctors have clearly explained to me that my patient Master / Baby Syed Umaruddin 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 : Syed Umaruddin 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.

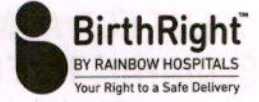
The doctors have explained to me in the language best understood to me.

Patient Attendant :
 Signature: [Signature]
 Name: SYED. KHACEELUDDIN
 Relationship with Patient: FATHER
 Date & Time: 10:05 pm on 6/6/26

Witness :
 Signature: TANVEER
 Name: TANVEER
 Date & Time: 6/6/26 @ 10:05 PM

Doctor (who is taking the consent) :
 Signature: [Signature]
 Name: M. GAVESH
 Date & Time: 6/6/26 10:05 pm

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**



రోగి పేరు వయస్సు లింగం పు స్త్రీ

యు.హె.ఐ.డి

నేను s/o. d/o. w/o

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ఫోర్స్ పిల్లల అనుపత్రి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి జడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి _____ పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి . పెరిఫెరల్ ఇన్ఫర్డ్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్సర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక జడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకము
పేరు	పేరు
వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)	తేదీ మరియు సమయము
సంతకము	
పేరు	



CONSENT FORM FOR HIV

Patient Name : Masr Syed Umaruddin Age : 11 months
 Gender : M F - IP No : 60254 Marital Status : -
 Ward / Bed No. : PICU IP/OP No. : 60254 Date : 6/6/26

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 : [Signature]
 Name : SYED. KHALELUDDIN
 Relationship with Patient : FATHER
 Date & Time : 6/6/26 10:03 pm

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 : [Signature]
 Name : DR. CANESH
 Date & Time : 6/6/26 10:03 pm

హెచ్.ఐ.వి పరీక్ష అంగీకార పత్రం

రోగి పేరు వయస్సు లింగం పు స్త్రీ

వివాహస్థితి వార్డు / బెడ్ నెంబర్.....

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

VIH-00199881 IP-00060254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 8 D (M)
Dr. KODICHERLA VISHNU VARDHAN



Right™

Hospital
It takes a lot to treat the little.



BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSULTATION FORM

Doctor Name : Dr. P. Sindhu

Date : 9/6/26 Hour : 2pm

Hospital : RCH

Type of Referral : Emergency (within one hr.)

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

Referred for : Opinion Co-Management

Date : 9/6/26 Time : 2pm By :

Transfer of care

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 :

9/6/26

9:20 PM

Extubation done
↳ put on VENTILATOR

- poor respiratory efforts
- good cardiopulmonary movements on stimuli

FEK - diffuse starving

Plan

MRI brain with contrast
tomorrow Plan

Consultant :

Name : Dr. P. Sindhu Signature : _____ Date & Time : 9/6/26

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

10/16
Q10/11

11/13
NIOSSEPT

Plan

white gutter
Resinatory tape
baffle

MI Brain
Concast

EATM

NUTS - all equal,
washing

BRICK STR

Amice elements test



CONSULTATION FORM



Doctor Name : Dr. M N V Poushya Sai

Date : 9/6/26 Hour : 10:30 Am

Hospital : JRCH

Type of Referral : Emergency (within one hr.)

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

Referred for : Opinion Co-Management

Date : 9/6/26 Time : 10:30 Am By :

Transfer of care

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 :

Sepsis / MODS / SEC HLH

Transaminites - Improving

- urea ↓
- creat ↓

Adv:

① Inj. Methyl pred 1mg/kg/dose BD
To continue for 3 days.
↓
gradually taper & stop.

Culture - ne

② Inj. Pantop @ ~~100mg~~ till prednisone
sup. tural ic ongoing
② 5 days
2.5ml TID

③ sup. calcimax - P. 2.5ml BD.

Consultant :

Name : Dr. M N V Poushya Signature : [Signature] Date & Time : 9/6/26 / 10:30 Am

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

CONSULTATION FORM



Doctor Name : Ashika Venkatesh
Date : 09-06-26 Hour : 5pm

Hospital : RCH

Type of Referral : Emergency (within one hr.)

Referred for : Opinion Co-Management

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

Transfer of care

Date : 9/6/26 Time : 5pm By :

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

Physiotherapy

Signature: _____

M.D.

Report of Findings and Recommendations :

S/B physiotherapist

Klelo - Post op clo -> myelomeningocele -
Sepsis & Pneumonia
Encephalopathy

-> PROM ex's for BLE VL etc.
-> Joint compression ex's

Consultant :

09-06-26

Name : Ashika Venkatesh Signature : Ashika Date & Time : 5pm

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

VIH-00199881 IP-00080254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 6 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Ref. No. : F / HW/CONS.F/INPR / 01

CONSULTATION FORM

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

BIRTHRIGHT
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Doctor Name : Dr. P. Sindhuera

Date : 7/6/26 Hour : 2p

Hospital : Ref

Type of Referral : Emergency (within one hr.)

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

Referred for : Opinion Co-Management

Date : 7/6/26 Time : 2pm By :

Transfer of care

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 :

4/6 - fever
+ vomiting
+ loose stools
not in activity
! cold

5/6 → Bulky - no fever, vomiting
↓ loose stools

5/6
↳ in afternoon → swelling of face
→ drowsiness

6/6 → fever - mild
→ excessive drowsiness

on admission

↳ drowsy
not responding to voice

at adm
TCS - 12.4 mm4
Bradypnea
Pupils - R/L
Cannal
Veiling

Consultant :

Name : P. Sindhuera Signature : [Signature] Date & Time : 7/6/26 2p

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

— Decrease 2x. Need to 4 million

— the price

— CSF analysis TM after records


Plan

options for central bank at 23 of 2012
— at present
 on website - EVM, (W...)
 on message selection
 - causal, amm, ...
 will see the
 performance (9 dit...)
 DR + 3
 process - ...

CONSULTATION FORM



Doctor Name : Dr. P. Sindhuca
 Date : 8/6/26 Hour : 2pm

Hospital : VIH-00199881 IP-00060254 Master SYED UMARUDDIN 01-07-2025 0 Y 11 M 7 D (M) Dr. KODICHERLA VISHNU VARDHAN Referred for :  it <input type="checkbox"/> Transfer of <u>care</u>	Type of Referral : <input type="checkbox"/> Emergency (within one hr.) <input type="checkbox"/> Urgent (within 6 hrs.) <input type="checkbox"/> Non Urgent (within 24 hrs.) Date : <u>8/6/26</u> Time : <u>2pm</u> 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 :

Follow up CMC
 Accept onset encephalopathy in a case of
 operated MML with noted motor delay

No fracture deposition
 1 focus spine



Vitals - stable on vent
 APTC - connected,
 sluggish reactivity

Consultant :
 Name : Dr. P. Sindhuca Signature : [Signature] Date & Time : 8/6/26 2pm

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

low end
high TA specificity
all other domains are

reading
pupils - equal

EA VTM

①

no active
components

critical better

②

- phonological
- extraction TID

③

- J. Hammer
- CSF analysis - plan in evening
- CBP before CSF
- EEC TID

④

Anchor domains (in
domains)

phonological

DRE = +3

high TA specificity

both use the


⑤

→ secondary HSN

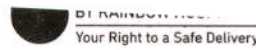
→ what wrong with

CONSULTATION FORM

VIH-00199881 IP-00060254
 Master SYED UMARUDDIN
 01-07-2025 0 Y 11 M 7 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



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



Your Right to a Safe Delivery

Doctor Name : Dr. Amurag
 Date : 8/6/26 Hour : 8 pm

Hospital : 2 CH

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
 Date : 8/6/26 Time : 8 pm By :

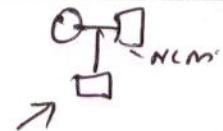
Referred for : Opinion Co-Management
 Transfer of care

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 :

S/B Dr. Amurag



acute history of illness

Δ : sepsis e modis
 ? 2^o HLH

2/6
 8 pm

O/E: sedated
 HR 83 bpm
 RR: 34 bpm
 SpO2: 95%

on indinavir
 on MV
 407.5 ml
 8 PRP

fever 100
 WBC: high
 ALB ↓
 transaminases ↑
 triglycerides: 167
 fibrinogen 97

Cvs: S1S @
 RL: BLA @


BMA done
 sugars @
 IV Ig on floor
 Ammonia 60
 mod LL

Consultant :
 Name : Dr. Amurag Signature: [Signature] Date & Time :

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

Feb

- to trace BMA report
- 2: MPB 1mg/ly/dose 8/124.
- review 100.


R. Anthony



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>Fever (A) (E)</p> <p>10L of</p> <p>ANTIPYRETIC and given</p> <p>(D)</p> <p>GCS → E, V, M4</p> <p>Resp → 12/min reactive</p> <p>(C)</p> <p>per-look</p> <p>Plv (N)</p> <p>BP - 98/52 (71)</p> <p>Pulse ox → 100% (71)</p> <p>Punctured Eno → conductivity good → PC → opened as he</p> <p>200 ml NS 10ml/kg bolus given</p> <p>AND 30 ml NS 40 ml bolus given (5ml/kg)</p>	<p>(A) open</p> <p>Retraction (A)</p> <p>No ventup studies</p> <p>DL used (A)</p> <p>SpO2 - 98% on</p> <p>Arterial → 10/100</p> <p>connected to CVC system</p> <p>(A/B) HMC</p> <p>RESOLUTION clear given</p> <p>N4 placed</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2026	c/d/w Dr Vishnu SV	
10:20 PM	D ¹¹ - sepsis i encephalopathy	
	(Post op. c/o nystromyocle (13-14))	
	<u>Plan</u>	
	1) HPLC	
	2) ANT. CEFTRIAZONE	
	3) IN. VANCOMYCIN	
	4) N/A signs of raised ICP	
	5) SOS Mechanical Ventilation	
	6) PO send PLT	
	H Repeat blood gas @ 12:30 AM	

2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/06/2026 11:40 AM	C/O In Dr. Sindhura (Neurologist)	
	D's - Post op C/O Myelo-meningocele (L3-L4)	operated V @ 2 days of life
	- Sepsis + meningococcal meningitis	
	- Transaminitis	
	History explained ACS - E, V, M, Y (9/15) - 2nd ventricle post op pupil - 2mm reactive Equal	<u>Plan</u>
	AF - Flat	1) CT - confirm brain 2) 2ND. DEPARTMENTAL CONSULTING 3) NO CONTROL ST. M stat
		$\frac{sp}{anytime}$

slated by
 S. S. S.
 6/6/26 AM
 @ 11:40



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/06/2026 2:00PM	<u>counselling notes</u> (Dr.)	
	<p>chilodcondition of child is explained in organ understande lagage but there is CNS involvement in form of encephalopathy causing decreased and respiratory depression, in form of bradypnea, leading to and CO₂ retention this is not good for the child. There are elevated infection markers and respiratory distress, Pneumonia.</p> <p>This shows Multi-organ involvement may be due to sepsis.</p> <p>At present due to poor respiratory efforts, child needs to be intubated. and kept on mechanical ventilation.</p>	
	<p>Dr. Vishnu Vardhan</p> <p>[Signature]</p>	<p>[Signature]</p>



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/16/2026 2:30 PM	CT findings discussed with Neurosurgeon ↓ No active surgical intervention	(Carproneeth)
7/16/2026 2:00 PM	ABG → pH 7.2 pCO ₂ - 52.5 PO ₂ → 38 lactate → 2.0 mmol/L	on HFNC 15 Ltr, FiO ₂ 40% ⊕ Bradypnea ⊕ per respiratory status ↓ Plan intubation & mechanical ventilation
Noted by 7/16/26 2:00 AM		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2025 3:30 PM		
	<p style="text-align: center;"><u>Intubation notes</u></p>	
	<p>Indication → Altered sensorium Poor respiratory efforts / Bradypnea</p>	
	<p>ACS → 9/15, RR - 12/min, SpO₂ - 98% on 4LNC HR - 154/min BP - 94/66 (72) mm of Hg</p>	
	<p>Preoxygenation done with 100% oxygen with BVM for 3 min</p>	
	<p>INJ. ketamine & RO succinylcholine given Neuromuscular blockade with rocuronium done</p>	
	<p>Endotracheal intubation done with ET of 3.5 mm cuffed tube, fixed at 10cm at lip</p>	
	<p>Post intubation Bile air entry present End tidal CO₂ detected Chest xray done.</p>	
7/6/2025 2:15 PM	<p>child connected to ventilator</p> <p>HR - 158/min SpO₂ - 100% BP - 96/50 mm of Hg</p>	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>PIP - 14 cm MEAN - 6 cm P₉₅ - 40 + P/E - 1:1.5 RR - 40/min Ti - 10.63 sec</p> </div>

Handwritten notes:
 Noted by
 Siddharth
 7/6/2025
 2:15 PM

4

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/8/2026 4:45 AM	Chest auscultation	
	on mechanical ventilator Asynchronous (P)	Plan
Per (C) M (C)	1) to send	S-LDH Pulse count
BM @ 10 ^{AM} culture	4	Pur profile to decide
	5) HPLC before transfusion	
	6) VITAMIN B12 stat IV	
	7) Optimize ventilator settings	
7/8/2026 8:00 AM	AD as per Urinary catheter note	
Waked by 2:15 AM 7/6/28 0 units	under aseptic precautions, 6 hr, urinary catheter is placed. Post procedure procedure - thermodynamic state	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order								
7/10/2025 8:50 AM	<p><u>CP/B Plev follow</u></p>									
	<p>D¹¹ - sepsis & pneumonia Encephalopathy Transaminitis & Coagulopathy Anaemia</p>	<p><u>Phenylephrine</u> ① PF → 252 ① INR > 1.3 ① Lactate ③</p>								
	<p>Issues → Hypoglycaemia Hypoalbuminaemia Encephalopathy Transaminitis</p>									
	<p>Airway → Intubated 3.5 mm cuffed tube Breathing → Mechanical ventilator SIMV [PCV+PS] Manting sedation</p>	<table border="1" data-bbox="1000 1231 1408 1345"> <thead> <tr> <th>PIP</th> <th>PEEP</th> <th>FiO₂</th> <th>NR</th> </tr> </thead> <tbody> <tr> <td>22</td> <td>8</td> <td>40%</td> <td>40</td> </tr> </tbody> </table> <p>SpO₂ → 100% Fi → 0.5 L/min</p>	PIP	PEEP	FiO ₂	NR	22	8	40%	40
PIP	PEEP	FiO ₂	NR							
22	8	40%	40							
	<p>Circulation PF → 252 WHO</p>									
	<p>ventilation → CM 3 sec RR ⑤ PR ② BP monitoring at 50th centre no ketoprofen</p>									
	<p>Mobility → ON morphine sedation 40 mg/kg/hr Pupils → 2mm reactive</p>									



5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Exposure → Fever spike (A)	
	Fluids → Total 80 + maintenance (including enteral)	
		SRF → 40ml/hr
		3+ NS → 8ml/hr
		Magnesium → 2ml/hr
	UBT → N.P.O (Plan to start Nephic feeds)	
		ORS 20ml / 3 rd Hourly
	Neurology → Deranged cognition makes → 2ml verapamil per gen	
		Anemia (LFT ↑)
		to collect reticulocyte report
	Infections → on ceftriaxone	
		vancomycin
		Plurix
	Kidney →	
		$eFR = \frac{0.45 \times 76}{0.9} \Rightarrow 38$
		ml/min/1.73m ²
		v/o → 4.8 cc/kg/hr (over 12 hrs)
		$\frac{2}{0} \begin{array}{r} 346 \\ 494 \end{array} (-148ml)$
	ECG → Nil	
	Metabolic → Hypoglycemia (corrected) & resolved	
		Hypokalemia → Added 5ml Kcl in fluid
		Hypocalcemic → Calcium gluconate 100mg



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Plan</u>	
	1) continue mechanical ventilation [Circuit 90 @ 95%]	
	2) normotension normoglycemia normotension	
	3) cardiologist opinion neurologist opinion	
	4) Pass arterial line	
	5) Repeat ECG & Hb/Hct	
	6) PT, aPTT, INR Urea Creat Serum electrolytes LFT, Ca, SE, CBP.	@ 12 PM (NPLC sample) Genetic sample.
	7) collect debris count at intervention report	
	8) gentle physiotherapy	
	9) Pressure relief	

Noted by
 BR-Parul
 7/5/2025
 10am

[Signature]

11) To monitor blood transfusion (not) and tag
 (to collect Hb & Hct before)

6

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/07/2025		
10:40 AM	<p>CSLB Dr. Vishnu Sir</p> <p>Dr - Hepatitis E mAb</p>	
	<p>on mechanical ventilator</p>	<p>maintaining sedation plan</p>

- 1) continue ventilation
- 2) neuro consultation & EEG
- 3) SOS LP & CSF analysis
(P₇, aPTT, etc to be checked)
- 4) Trace genital & renal count
& hematology consultation
- 5) HCM criteria
- 6) start Trophic feeds 20 ml / 3rd Hourly
- 7) Diet 20% (Do not include Trophic feed)
- 8) G₁ ASA @ 5AM
- 9) usg Abdomen & pelvis (T/M)
- 10) 20. Vitamin B₁₂ 5mg 12/12 Hourly
- 11) 20. Thiamine
- 12) central line SOS
- 13) Hourly PUPIL monitoring

(13) Hematoco.

Noted by
 Dr. Gautham
 21/07/2025
 10:50 AM

Dr. Vishnu
 21/07/2025
 10:40 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/06/2026 11:00 AM	counseling notes (Dr. Vishnu sir)	
	History reviewed.	
	child is having severe infection and seen in	
	inflammatory markers which are very high.	
	Response depends on inflammatory response of the child.	
	This severe infection, has affected multiple organs.	
	Due to poor sensorium, intubated and kept on	
	ventilator	
	To decide on further practice now	
	Gut factor is better due to parents with mild	
	decrease in parameters	
	Liver function test as elevated.	
	Heart function is also mod. decrease and it now	
	due to infection	
	Needs to be worked regularly for full trace.	
	Hematology investigation, need to be taken. Due to	
	possible chances of HLL, if diagnosed will be	
	detected accordingly.	
	He needs to be continuously monitored for 72 hours	
	for response and decontamination	
	There are possible chances of cardiopulmonary arrest	
	during the course of event.	
	FATHER	
	Mother	
	[Signature]	
	[Signature]	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 10.40 AM	c/D/w Dr. Murtaza Sr	
	Mild to mod dysfunction,	Dilated Right ventricle.
	① Trop I, NT-pro BNP (send)	
	② Thiamine 100mg stat & BD (50mg)	
	③ Inj lactix 2mg /kg BD	
	④ if needed, & no improvement →	Milrinone ses might be needed!
	<u>Fluid Calculation for next 24 hours:</u>	wt: 8.5 kg Sum 7/6/2026
	70% fluid: ≈ 600ml.	Total volume: 100ml/kg: 850ml
	left after: ≈ 270ml.	Trophic feed: 20ml/3hrs.
	Fluid: @ 11.5ml/hour.	Infusion: 3% → 8ml/hr: 192] stop
	→ 70%: 600ml	Morphine: → 2.5ml/h: 60
		Vawo: 45ml
		Moro (TID): 30ml



PROGRESS NOTES AND DOCTOR'S ORDER



Date & Time	Progress Notes	Doctor's Order
	HLH criteria:	
	(1) Molecular dx consistent with HLH.	
	(2) 5/8 criteria	
	(a) Fever (+)	
	(b) Splenomegaly (-)	
	(c) Cytopenias (>2 lineage) : Hb% < 9g/dl (-)	
		Infant: PLT: $100 \times 10^9/L$ Neutro: $1.0 \times 10^9/L$
	(d) Triglyceridemia and/or hypofibrinemia: (-)	
	Fasting TG: $\geq 265 \text{ mg/dl}$ (167 mg/dl) (-)	
	fibrinogen: $\leq 1.5 \text{ g/L}$ (97.96 mg/dl) (+) or $< 150 \text{ mg/dl}$	
	(e) Hemophagocytosis in BM of spleen/LN (-)	
	(f) Low or absent NK cell activity (-)	
	(g) Ferritin $\geq 500 \text{ ug/L}$ (+)	
	(h) Soluble. CD25 $\geq 2400 \text{ U/L}$ (-)	
	(i)	
	Supportive: Neurologic sym, CSF pleocytosis, conjugable hyperbilirubinemia, Transamite, Hypoalbuminemia, Hyponatremia.	
	Pending invg: - Triglyceride level - Fibrinogen level - NK cell activity - CD25 Soluble level	
		Shu 7/6/2026



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 12:00 PM	<u>Arterial Line Placement</u>	
	<p>Under all aseptic and antiseptic condition, Arterial line Placement was done in Left Radial Artery.</p> <p>Good Backflow observed.</p> <p>Line secured & connected to Hep NS infusion.</p>	<p style="text-align: right;"> 7/6/2026 </p>
7/6/2026 1:30 PM	C/S/B	<u>Dr Vishnu Sir</u>
<p style="transform: rotate(-45deg);"> Dr Sandhya 7/6/2026 1:30 PM </p>	<p>Adv: ① Send CBP, SE, Ca, ABG at 5PM</p> <p>② \uparrow Hb less, discuss with Dr Sandhya and take Hb MPLC sample.</p> <p>③ \uparrow feed: 30ml/3hr (Kitchen feed)</p> <p>④ Discuss with Neurology team and Hematooncology.</p>	<p style="text-align: right;"> 7/6/2026 </p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 3.00PM.	c/d/w Dr Sindhura Maam.	
	- Child history & CT scan film shared.	
	- Plan: ① EEG now ② Assessment following EEG ③ SOS LP. T/M.	
		 7/6/2026
7/6/2026 3.00PM	c/d/w Dr Sandhya Maam.	
	① Case history, Blood report shared. History s/o	
	② <u>Cytokine Storm</u> (To r/o AML, PID)	
	Adv: ① Send Uric acid	
	② Methylpred 2mg/kg/day to be considered.	
	③ IVIG 1g/kg. today as child appears sick	
	④ To send PID-2 panel before starting IVIG	
	⑤ LP & BMA to be done once	
	Coagulation parameters	
	improve.	
	Moted by Jagannath 7/6/26 3 PM	 7/6/2026



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026		
A.00PM	At 5PM,	
	- CBP, SE, Calcium, Uric acid	
	- Triglyceride level ✓	
	- Fibrinogen level ✓	
	- PID-2 panel ✓	
	(Flu panel) w/h	
	(Hep B, A, TMS, GCMS, (Hlx. HPLC) w/h.	
7/6/2026	c/s/B Dr Vishnu Sr.	
A. 15PM	- 3% NS stopped	- if Bradycardia/Hypotension stop 3% NS
	- CXR tomorrow	- FiO ₂ : 30% (Plants ↓)
	- T/M: LFT, APTT, PT-INR	Vishnu
	- BMA & culture,	
7/6/2026	- CSF Analysis	
A. 30PM	Counseling by Dr Vishnu Sr	Noted by Sr. Jagran 7/6/26 @ 4:15PM
	- Current condition of child explained.	
	- The child might have hyperinflammation due to many causes.	
	- We have discussed with Dr Neurologist and he planned for IVIG and will repeat tomorrow.	
	Blood parameters,	
	- We might need to do the Bone marrow & LP tomorrow and if needed coagulopathy	
	- We will send investigation to rule out causes.	
	- The child have many deranged parameters, and on supportive treatment	



10

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>Heart is also affected along with liver, pneumonia & Brain involvement. The child is in critical phase of illness, and needs further monitoring & Blood investigation.</p> <p>The child might deteriorate further and might even die if child does not respond to all other supportive care.</p>	
	<u>Mother</u>	<u>Father</u>
7/6/2026 15:00 PM	C/S/B	Dr Vishnu Sir
	<p>Adv: ① 0.1mg/kg/hours: Furosemide infusion ② Mefenyl pred: 10mg stat before IVIG. ③ PRBC: 50ml over 6 HOUR. (<7 or <8 ml/kg) then IVIG. ④ 1mg PCM, 6 hourly,</p>	<p>↓ 7/6/2026</p>
In.	<p>Noted by Sr. Jagrani 7/6/26 @ 5PM</p>	<p>(- Persistent tachycardia - Hypodynamic Heart - Sepsis)</p> <p>↓ To decrease load on Heart)</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2025 6.00PM	CBP: Hb 7.6g/dl	
	<p>As child having - RV dysfunction, - with persistent tachycardia. - IVC full.</p>	
	<p>① Planned for 5ml/kg of PRBC over 5 HOUR ② IV furosemide infusion started. ③ Following PRBC transfusion ↳ Planned for IVIG transfusion ④ Hb HPLC to be sent. before transfusion ⑤ Collect sample for TMS</p>	<p>Noted by Sr. Jaganani 7/6/25 @ 6PM</p> <p>Shu 7/6/25</p>
7/6/2025 7.00PM	<p>c/d/w Dr Mustaza High level of TroP/NTProBNP informed Repeat 2DECHO video shared</p>	
	<p>- Advise s/o RV dysfunction</p>	
	<p>Adv: ① Cumulative laxix : 3mg/kg/day (≈ 25.5mg/day) ② Milrinone infusion @ 0.5mcg/kg/min. ③ Continue Injamine BD</p>	
	<p>Noted by Sr. Jaganani 7/6/25 @ 7PM</p>	<p>Shu 7/6/25</p>

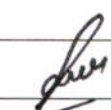
VH-00199551 IP-00000254
Master SYED UMARUDDIN
01-07-2025 0 Y 11 M 6 D (M)
Dr. KODICHERLA VISHNU VARDHAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 7.15PM	<u>Central Line Placement:</u>	
	Under all aseptic and antiseptic condition, 4.5' Fr / 6cm central line placement was done in Right IVC.	
	Good Backflow checked and line secured with suture.	
	Line Position confirmed with Xray.	
Note & by Sr. Jagrani 7/6/26 @ 7.15PM		Done 7/6/2026.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2026 9.00PM	9/5/B Dr Vishnu Sir	
	Adv: ① ↑ laxix infusion to 0.2mg/kg/hr. ② Add low dose noradrenaline. ③ Send PT, APTT, INR, CFT ABG at 6AM	
	④ T/M C/N with ⑤ T/M sos FFP	Hematologist → followed by Bone marrow aspiration & culture & CSF analysis.
		<p style="text-align: right;">  7/6/2026 </p>
	- USG Abdomen T/M	
7/6/2026 7.00AM	<p style="color: blue;"> Noted by S. S. S. S. 7/6/2026 9 AM </p>	



12

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12.00AM	POCUS : ① Contractility : Good. EF eF: 67.9%	
8/6/2026	② 4 chamber view. good contractility	
	③ From TR jet; Peak velocity: $\approx 2.3\text{m/s}$ (229.95cm/s) Pressure gradient = 21.15mmHg .	
	Risks $RVSP = 4 \times (TV)^2 + RAP$ or $\Delta P + RAP$	RAP depends on IVC collapsibility: ① (N): $\leq 3\text{mmHg}$ if small, measuring $\leq 2.1\text{cm}$
	IVC diamete: 1.32.	
	But hardly changing of diameter,	Collapses by $>50\%$.
	so,	② Borderline: 8mm (5-10)
	RVSP: $21.15 + 15\text{mmHg}$ $= 36.15\text{mmHg}$ (mildly elevated	③ Elevated RAP: 15mmHg (10-20)
	(N) value : $< 25-30\text{mmHg}$.	Dilated, measuring $> 2.1\text{cm}$ Collapses $< 50\%$.
	④ TAPSE : Tricuspid Annular Plane systolic Excursion Dist ⁿ : 2.50cm (25mm)	(Normal).
	(N) $\geq 17\text{mm}$	
	⑤ IVC: Hardly collapsible.	
	<u>Interpretation</u> : ④ ventricular dysf ⁿ $\hat{=}$ mildly elevated RVP.	<div style="text-align: right;"> 8/6/2026 </div>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2025 6.00AM	ABG s/o hypokalemia & hypocalcemia with Resp & met alkalosis.	
	-Neg Balance: -598ml.	
	Plan: ① Pocus: s/o: diff ↓ in IVC calibre are prepared.	
	② lasix infusion @ 0.1mg/kg/hr.	
	③ BP: > 90th percentile → NAdr ↓.	
	④ CO ₂ ↓ on ABG, → R/R ↓. IE (1:LS).	

Noted by
 SS-dee
 8/6/25
 @ 6:00am

SS-dee
 8/6/2025

8/6/2025
 7.30AM

Q/D/W Dr Vishnu Sir

- Adv: ① Nor adrenaline @ 0.02mcg/kg/min.
- ② ~~so~~ Neurology [for sor FFP].
- ③ formal L/N with Gastroenterology and Hematology
- ④ If only FFP needed for LP
 ↳ withhold LP & do BMA + culture.

Noted by
 SS-dee
 8/6/25
 @ 7:30

SS-dee
 8/6/2025

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	spo ₂ : 95-99%	
	<u>Circulation</u> : BP: 50/40 & 90/60. CRT < 3sec Peripheral pulses well felt	
	Pocus s/o (R) ventricular dysfunction, but IVC: Hardly collapsing.	
	Child on Milrinone @ 0.5 mcg/kg/min / Noradr @ 0.025 mcg/kg/min / Lasix @ 0.1 mg/kg/hr	
	<u>Neurology</u> : Child under MV, & sedation B/L pupil: 1mm, sluggishly reacting to light	
	ColBS: maintained. CSF analysis to be done, CT scan report awaited	
	<u>Exposure</u> : Fever spike: 1 spike at 1 PM	
	<u>Fluid</u> : 70% Total fluid (Infusion & medication) Aiming Balance by Neg 400ml.	
	<u>Gut</u> : - On trophic feed: 30ml/3hrs → Kept NPO for procedure since 5AM - USG abdomen awaited.	
	<u>Hematology</u> : - In view of low Hb%, persistent tachycardia & hyperdynamic heart, the child transferred with @ 5ml/kg of PRBC. - I/V/O High inflammatory markers → IVIG @ 1g/kg given	



10

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p><u>Infection:</u></p> <ul style="list-style-type: none"> - Child on Oseltamivir, Moxipenem & Vancomycin - Blood c/s report awaited - Bone marrow culture & aspiration awaited. 	
		Input: 899.5 ml.
		Output: 1361 ml
		Balance: Neg: 551 ml
	Plan: ① Fluid recalculation:	Cumulative: Neg: 699 ml
		u/o: 2.6 ml/kg/hr.
	② SE, to be sent so:	
	③ USG abdomen	
	④ CT scan report collection	
	⑤ PID-2 panel, Hb HPLC report awaited.	
	⑥ CSF analysis & BMA & c/s	
	⑦ Consultation: ① 2DECHO + Cardiology	
	② Hematology - Dr	
	③ Gastroenterology	
	<p><i>Noted by</i> <i>Dr. Ramiah</i> <i>8/6/2025</i></p>	<p><i>Dr</i> <i>8/6/2025</i></p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/16/2025 10.00 AM	<p>c/s/b Dr Vishnu Sir - Sep sis i MODS & cytokine storm.</p>	
	<p>- Under MV, on BIMV PLTPS, On Milrinone, lasix, Npr - Stable currently.</p>	<p>adrenalin</p>
	<p>① Fluid: 60% including infusion excluding NG feed: 40ml/3ly.</p>	
	<p>② TV: Target: 55 ↓ PC above Peep: if TV(E) above 55</p>	
	<p>③ Hepatotoxicity of Acyclovir. ④ Wait for Resp Panel. ⑤ Send Ammonia ✓</p>	
	<p>⑥ - Cardiology consultation - continue lasix, Mil, Noadr. 4 HOURLY POCUS</p>	
	<p>⑦ ECGs to be done ✓</p>	
	<p>⑧ USG abdomen ✓</p>	
	<p>⑨ Collect CT report, PID-2 panel, Hb HPLC.</p>	
	<p>⑩ Double concentrate Morphine, fentanyl.</p>	
	<p>⑪ Bone marrow Aspirization + Biopsy + Culture</p>	
	<p>⑫ Consultation with - Hemato-oncologist: Dr Anurag Reddy - Gastroenterologist: Dr Poushynha</p>	
	<p>⑬ Keep Neg Balance: ≈ 400ml (5%)</p>	<p>(video) No teckly Dr. Vishnu 8/16/2025 10:17</p>
	<p>⑭ Blood Involv: - CBP, ABGs, CRBS OD - After IVIG → send SE</p>	<p>⑮ Start NAC infusion, ⑯ ImvitK Smg today.</p>

(Signature)
 VIH

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	Counseling by Dr. VISHNOU VARDHAN & Dr. Sudhanshu	TO monitor, follow
	Syed is stable now but not yet out of danger	
9:35 AM	Repeat xray is better after ventilation blood tests explained	
	MOUTH } Head → Support is by 2 IV medications ORGAN } kidney → on 3 IV medications	
	Liver → still transaminitis & Coagulopathy is persist → but stable after treatment	
	PS MODS it is due to infection/inflammation	
	we need to do Bone marrow to rule out any malignancy and we need to start on steroids	
	already child is on Antibiotic & IVIG	
	But still there is high chance of increased Swelling in brain, bleed in brain & lungs	
	[Brain] history noted → Seizure CT brain was there is Infection → for which Antibiotic is started	
	we need to see what infection & whether any other focus of inflammation.	
	when other organs like liver is involved it also show effect on brain & function of brain there is persisting	
	we will do lumbar puncture once	

PROGRESS NOTES AND DOCTOR'S ORDER

NE
 (M)

Date & Time	Progress Notes	Doctor's Order
	<p>Child is stable on ventriculostomy & IVig & low medication IVig transfusion will have effect slowly MAS of new child is stable with multi organ involvement and on medications for organ support we need to involve multi disciplinary approach → hematology & gastroenterologist</p>	
	<p>Father Mother</p>	
	<p>(mother) (father)</p>	
		<p>1/2 M. K. K. K.</p>

16

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/25/26	1) ABG 6AM - 6PM	
	2) CBP slit } @ 8PM slit	
	3) CMSS @ 6AM	
8/25/26 12:00 PM	Bone marrow Biopsy note	
	Under aseptic conditions, Bone marrow Aspirate and biopsy done. Aspirate -> suspected MCH, no start second biopsy no adverse events Post procedure	
	HR - 128/min BP - 93/60 mmHg 100-oi increased ventilator, mandatory	Send - Bone marrow culture - Bone marrow Aspirate - Bone marrow Biopsy
Noted by BS-Banuh 8/26/26 12P	8/26 12:00 PM	Clotw by Poushyam V Dex 1/4 mg prednisolone after Bone marrow slit left LFT, PT, aPTT, ure

2
M/26/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2025 12:30 PM	<p>of Dr. Dr. Anurag Reddy</p>	<p>Haemostatic agents</p>
	<p>Dⁿ - Sepsis with mass of in dysfunction Suspected HCT</p>	
	<p>Plan</p> <p>1) to give methylprednisolone</p>	<p>long/low/BD</p>
8/6/2025 6:30 PM		<p>2) oxygen</p>
	<p>of Dr. Dr. Vishnu SV</p>	
	<p>Plan</p> <p>1) to send CBP & Plan for CP</p> <p>2) to give 1mg Sgm after 1st dose</p>	
		<p>2) oxygen</p>
		<p>Noted by Jyoti 8.16.25 08:12:50 P</p>



17

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/15/2026	e/p/w Dr. Amurkare	
	Eye dilated Rev dilation (+) [Improved than yesterday]	Aldactone 8mg / tid Continue Milumone & Lasix
8/16/2026 4pm	LP notes Under aseptic conditions with proper precautions sedation, skin was prepared with Betadine. Child was positioned in a 'C' shaped manner, with 3cc needle. CSF was obtained at/below the level of anterior superior iliac spine. Pre and Post-Procedure events uneventful.	
Noted by 8/16/26 of 4pm	Post-procedure vitals HR - 109/min SpO2 - 98% BP 112/36	CRBS - 13 gm/L



18

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
gld's	Counselor by <u>Dr. Akhmed Rizwan</u>	
6:15 pm	History noted	No motor, fever, 2 attacks of h's/lt
	<p>Child is sick → due to infection → & it involved heart, brain, liver → multiple organs involved Usually the outcome here not good Child is on mechanical ventilation & multiple res. medications used to support the organ Explain about initial blood gas, co-oximetry, co-oximetry, high lactates.</p>	
	<p>Child has been stable since admission Explain about reports - high inflammatory markers Started on inotropes support multidisciplinary team is involved haematology, gastroenterology so infection → likely to informatics → Secondary HLT.</p>	<p>SM A. Rahman</p>
<p><u>Infected</u> <u>motus</u></p>	<p><u>Infected</u> <u>motus</u></p>	<p><u>SM</u> <u>A. Rahman</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	<u>Child Mr. Vishnu</u>	
	Informed blood gas & CRP & Lp Report	
	1) White blood cell count report viral CSF panel	
	2) Increase RD 35-60	
6:50 pm	3) Ch. Count - 3y 1.0/1st	
	4) ABC - 8hrly → 2 Am, 10 Am, 6 pm	
	5) LFT, PT/PTT/INR, ST creat, Blood urea SE at 6 Am	
N		N M/16 Am
	Noted by Dr. Sagar 8/6/26 6:50 pm	<u>Functioned 2 DEHTO</u> - good contractility - EF ~ 60% - IUC - ordered
		M/16 Am