


ACTIVE VIH-00151395 IP-00060308
Baby T SRI VISHWAIKA JG
29-10-2017 8 Y 7 M 13 D (F)
Dr. PREETHAM KUMAR

Name: ---  -----
UHID No: ----- IP NO: ----- Consultant: ----- Dept: PICU

Date of Admission: ----- Time: ----- Date of Discharge: ----- Time: 11:15 pm

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/06/26	12:10 AM	Shushrasha Hospital	PICU	Nandisuran
<u>Local Transfustation</u>				
14/6/26	11:15 AM	PICU	1st floor	Jed

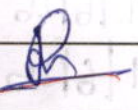

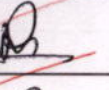
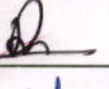
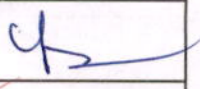
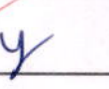

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr Nageswara Rao	11/6/26	3089143	Jed
2.	Koneti			
3.	DR Mohd Abdul	11/6/26	3089196	Khalid
4.	Khalid MD			
5.	(100) checked by Jed	14/6/26	at 10a	
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
	CBP, CRP, creatinine		
11/06/26	electrolytes, urea, LFT		
11/06/26	PT/APTT/INR, PCT	26019943	Ph
	Ferritin		
	HIV	26019944	Ph
11/6/26	ABG	26019945	Ph
11/6/26	Bgt	26019946	Ph
11/6/26	RBS - 122 mg/dl	26019948	Ph
11/6/26	CXR	26009336	Ph
11/6/26	Blood cbs	26019951	Ph
11/6/26	Dengue NS1t IgM, LDH	26019965	Ph
11/6/26	CBP, PT/INR	26019969	Ph
11/6/26	CUE	26019973	Ph
11/6/26	ABG 4Am	26019974	Ph
11/6/26	ABG, RBS-262 mg/dl	26019975	Ph
11/6/26	Tropoin-I	26019977	Ph
11/6/26	Plasma Fibrinogen, Triglycerid	26019979	Ph
11/6/26	2D Echo	26-009368	Ph
11/6/26	USG Abdomin	R96-009381	Ph
11/6/26	CBP, CRP, CLF		
	LFT 4Pm	26020028	Ph
11/6/26	ABG	26020027	Ph
	RBS-217 mg/dl 6Pm	26020059	Ph

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
11/6/26	inv- monitor infusion pump oxygen Syringe pump NORA	12:22 Am	12/6/26 7am 12/6 @ 6pm	3088975	
11/6/26	Syringe pump Adren	1:30 Am	12/6 @ 10 AM	3088976	
11/6/26	Syringe pump HEPUS	4 Am	13/6/26 3 PM	3088990	
11/6/26	HEMC	5 Am	12/6/26 5 AM	3089035	
11/6/26	Syringe pump (Lasix)	10 AM	12/6 @ 11 AM	3089109	
11/6/26	Syringe pump (Robusta)	10 AM	12/6 @ 2 PM	3089160	
(COB) checked by				14/6/26	at 10c

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/6/26	w/plant	②	3088724	JR
11/6/26	Arterial line	①	3088724	JR
11/6/26	Urinal cath			
11/6/26	cannor line	①	3089004	JR
	conscious sedation			
(C/O) checked by Band 11/6/26 at 10a				

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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DAILY INVESTIGATION SHEET

VH-00151395 IP-00060308

Baby T SRI VISHWAIKA
29-10-2017 8 Y 7 M 13 D (F)
Pa Dr. PREETHAM KUMAR



Ag

□ F - I.P. No. :

Date	Investigation	Ward	Nurse Signature	Bill No.	Received Date & Signature
11/6/16	ABG	puw	Rn	26020073	Rn
12/6/16	ABG, RBS-156 mg/dl/8am	puw	Rn	26020103	Rn
12/6/16	CBP, PT/INR, LFT, S/E	puw	Rn	26020102	Rn
12/6/16	CXR	puw	Rn	26009400	Rn
12/16	RBS-118 mg/dl 6AM	PICU	NIR	26020123	
12/16	CBP, S/E	PICU	Rn	26020185	
11/6	Amonia	PICU	HO	26020013	
13/6	CBP, S/E, PT/INR, Ferritin	puw	Rn	(26026229)	
13/6	CRP, LFT	PICU	NIR	(26020240)	
14/6	CBP, S/E, urea, creat	puw	Rn	(26020336)	
(C/O) checks by Prasad 14/6/16 at 10am					
15/6	CBP, CRP, urea, Creatinine, LFT, electrolytes	1 st floor	Rn	26020418	Rn
17/6	CBP, CRP, LFT, RP-2	"	"	26020603	Rn
Case checked by Prasad 17/6.					

Name	Baby T SRI VISHWAIKA	UHID	VIH-00151395
Father/Guardian	Mr RAJKUMAR TIRTHALA	Age/Gender	8 Y 7 M 14 D/Female
Address	2-26/3 EDULAGATTE PALLY MANAKONDUR KARMINAGAR, Mana Kondur, Karimnagar, Telangana, INDIA, 505469		
IP No	IP-00060308	Admission Date	11-06-2026
Ref Doctor	DR.INDU PRIYA	Discharge Date	17-06-2026

DISCHARGE SUMMARY

Consultant: Dr. PREETHAM KUMAR

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

Diagnosis: Septic shock with multiorgan dysfunction (cardiac & liver) and hyperinflammation

History: Baby T. SRI VISHWAIKA is a 8 Y 7 M 14 D girl presented with history of high grade intermittent fever since 3 days along with mutiple episodes of vomiting with dull activity along with erythematous rash over all body for 1 day prior to admission. For the above complaints, she was treated at referral center, but in view of persistence of symptoms, she was referred to Rainbow Children's Hospital for further management.

Outside Investigations: Complete blood picture done on 10.06.2026 showed hemoglobin 12.0 gm%, white blood cells count of 7000 cells/cumm, platelet count of 1.10 lakhs/cumm and C-reactive protein was 105.3 mg/l. Serum electrolytes showed serum sodium - 135 mmol/L, serum potassium -3.4 mmol/L, chloride - 98 mmol/L. ESR 46 mm/hour in First hour and 80 mm/hour in second hour.

Examination: She was afebrile, maintaining saturations at 2 Lit/Min oxygen. Heart rate-138/min, blood pressure -99/52 mmHg and respiratory rate 40/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 normal heart sounds and there was no murmur. Abdomen was soft, distended without organomegaly. Bowel sounds were heard. Neurologically, she was conscious and irritable (GCS 14/15). Examination of other systems including spine was normal. Erythematous rash present, flushing and petechiae present.

Weight on admission : 38 kgs.

Investigations: Enclosed.

Management: She was admitted in the Pediatric Intensive Care Unit, started on 10 Lit oxygen NRM, given NS bolus and plasmalyte bolus and started on IV fluids and IV antibiotics. She was treated symptomatically with antipyretics and antacids.

Respiratory distress: In view of respiratory distress, she was started on HHHFNC 30 Lit, 30% Fio₂.

Cardiac dysfunction: Functional Echo showed IVC congestion and poor contractility in view of suspected cardiac dysfunction, She was started on Furosemide infusion. Cardiologist opinion was taken and advice followed. In view of hypotension, she was started on inotropes (Nor adrenaline Dobutamine @ 5 mcg/kg/min, Adrenaline - 0.1 mcg/kg/min). In view of suspected myocarditis, Troponin-I was sent, was elevated. Hence steroids were started Methyl prednisolone 10mg/kg/day.

Invasive hemodynamic monitoring was started. Serial arterial blood gas and chest x-rays were done, As the distress started improving, HHHFNC tapered shifted to low flow oxygen later to room air.

Name

Baby T SRI VISHWAIKA UHID



As her blood pressures stabilized and cardiac function improved inotropic support was tapered and stopped. Repeat 2D Echo was done showed normal biventricular function, Normal coronaries.

GIT: Her liver function tests showed SGPT 263 U/L, SGOT 535 U/L, ALP 114 U/L, total serum bilirubin was 2.6 mg/dl with direct fraction 1.7 mg/dl and indirect fraction 0.9 mg/dl, serum albumin was 2.3 g/dl, total protein was 4.9 g/dl, S.globulin was 2.6 g/dl. Coagulation profile showed PT 28 sec, INR 2.0, APTT 50 sec. Injection Vitamin-K given. Ultrasound abdomen showed mildly edematous wall of gallbladder. Per abdomen examination was normal. Child was started on IV fluids as oral intake poor, later IV fluids gradually tapered and stopped as oral intake improved.

Infection/Hyperferritinemia: On admission, complete blood picture showed hemoglobin 10.8 gm%, white blood cells count of 6,760 cells/cumm, platelet count of 60,000/cumm and C-Reactive Protein 132mg/l. Blood culture was sterile after 48 hours of incubation.

Due to ongoing fever spikes and rising inflammatory markers, antibiotics were upgraded, and further workup for hyperinflammatory conditions was conducted. Results showed LDH 1327 U/L, Triglycerides 125 mg/dl, Ferritin 1010 ng/ml, Plasma fibrinogen 372.84, steroids were continued.

She was regularly monitored for platelet count and bleeding manifestations.

As she remained hemodynamically stable, maintaining saturations on room air and accepting feeds well, she was shifted to ward for further management.

During the ward stay, her vitals were regularly monitored. Repeat hemogram done on 17.06.2026 showed hemoglobin 12.5 gm%, white blood cells count of 16,870 cells/cumm, platelet count of 2.57 lakhs/cumm and C-reactive protein was 12 mg/l. Serum electrolytes showed Na 141 mmol/L, K 5.8 mmol/L, Cl 94

mmol/L. Liver function tests showed SGPT 111 U/L, SGOT 35 U/L, ALP 296 U/L, total serum bilirubin was 1.3 mg/dl with direct fraction 0.3 mg/dl and indirect fraction 1.0 mg/dl, serum albumin was 3.9 g/dl, total protein was 7.5 g/dl, S.globulin was 3.6 g/dl. She further improved gradually and she remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Discharge Advice:

1. Diet as advised.
2. Tablet Cefixime (200mg) 1 tablet, 12th hourly for 5 days (after food).
3. Atarax lotion for local application, 8th hourly (if itching).
4. Mupirocin ointment for local application, 8th hourly for 3 days.
5. Zytee-L gel for local application (in oral cavity), 8th hourly for 5 days.
6. Tab. Pantoprazole (40mg) 1 tablet 12th hourly for 5 days (30 minutes before breakfast).
7. Syrup Sucralfate, 5ml, 12th hourly for 5 days.
8. Refresh eye drops, 2 drops in each eye, 6th hourly for 5 days.
9. Moisturex lotion for local application, 12th hourly for 5 days.
10. Tablet Methyl prednisolone (16mg)
1/2 tablet 12th hourly for 3 days (from 18.06.2026 to 20.06.2026)
1/4th tablet 12th hourly for 3 days (from 21.06.2026 to 23.06.2026) and stop.
11. Kindly consult Dr. Preetham Kumar Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).
12. Follow up with Dr. Indu priya, Consultant Pediatrician.

Name

Baby T SRI VISHWAIKA UHID



In case of Fever:

Syrup P-500 (5ml=500mg), 5ml (if needed) if fever more than 99.6°F (maximum 4-6 hourly).

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

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

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

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

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

Name : *Shobha*

Signature : *Shobha*

Relationship with patient : *mother*

This summary has been explained by :

Admitting PICU fellow : Dr. Sweety

Name

Baby T SRI VISHWAIKA UHID

VIH-00151395

Summary prepared by: Dr. P. Thanuja / Dr. Vishwaja
DEO : MD Younus Pasha

Registrar/Fellow

Dr. PREETHAM KUMAR

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

PatientName : Baby T SRI VISHWAICA
Age/Gender : 8 Y 7 M 13 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00080308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :11-06-2026 00:53			
HEMOGLOBIN (Colorimetry)	10.8	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	3.97	10 ¹² /L	L 4 - 5.2
PCV/HCT (Calculated)	29.6	VOL%	L 35 - 45
MCV (Calculated)	74.5	fL	L 77 - 95
MCH (Calculated)	27.3	pg/cells	25 - 33
MCHC (Calculated)	36.6	g/dL	H 32 - 36
RDW-CV (Calculated)	12.8	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	60	10 ⁹ /L	L 150 - 450
MPV (Calculated)	8.8	fL	6.5 - 10
WBC COUNT (DC Detection Method)	6.76	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	81	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	10	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	06	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	03	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC , NORMOCYTIC / HYPOCHROMIC WBC - TC NORMAL WITH RELATIVE NEUTROPHILIC 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 :11-06-2026 00:53			
CRP (Immunoturbidimetry)	132	mg/L	H <10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :11-06-2026 00:53			

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
Age/Gender : 8 Y 7 M 13 D/ Female Admit Date : 11-06-2026
Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Enzymatic)	0.6	mg/dl	0.2 - 0.6



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Consultant Pathologist, Reg No : 39356

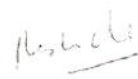
Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date : 11-06-2026 00:53	
SODIUM (Direct ISE)	137	mmol/L	134 - 143
POTASSIUM (Direct ISE)	3.4	mmol/L	L 3.7 - 5
CHLORIDE (Direct ISE)	109	mmol/L	H 98 - 108



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 : 11-06-2026 00:53	
FERRITIN (CLIA)	1010	ng/ml	H 7 - 140



Dr. RASHIDA MAHREEN, MBBS,MD

CONSULTANT BIOCHEMIST, Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date : 11-06-2026 00:53	
TOTAL BILIRUBIN (Azobilirubin)	2.6	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	1.7	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.9	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	535	U/L	H 15 - 40
SGPT (ALT) (Kinetic with P5P)	263	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	114	U/L	L 145 - 420
PROTEIN (Biuret method)	4.9	g/dL	L 6.2 - 8.1
ALBUMIN (Bromocresol Green)	2.3	g/dL	L 3.7 - 5.6

Rainbow Children's Hospital - Secunderabad

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PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 13 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
GLOBULIN (Calculated)	2.6	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	0.8		L 1.4 - 3.4

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 :11-06-2026 00:53
PROCALCITONIN	16.4	ng/ml	H <0.5

Dr. RASHIDA MAHREEN, MBBS,MD

CONSULTANT BIOCHEMIST, Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 00:53
PT (Optical Clot Detection)	28.0	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	2.0		
APTT (Optical Clot Detection)	50.0	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 00:53
UREA (Kinetic, Urease)	20.9	mg/dl	9 - 34

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

PatientName	: Baby T SRI VISHWAIKA	Inpatient No.	: IP-00060308
Age/Gender	: 8 Y 7 M 13 D/ Female	Admit Date	: 11-06-2026
Ward/Bed	: N 1F-PICU/ PICU 139	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
HIV TEST (CARD METHOD) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :11-06-2026 00:54
HIV TEST (CARD METHOD)	Non-reactive		



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 :11-06-2026 01:18
PH (Reagent Strip/Double PH Indicator)	7.33	unit	L 7.35 - 7.45
pCO2	31.0		
pO2	164	mm Hg	H 83 - 108
HCO3	16.3		
BE	-8.9	mmol/L	
O2 Sat	99.2%	mmol/L	
HCT (Pulse Height Detection)	36%	%	10 - 75
ctHb	11.6	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :11-06-2026 02:05
BLOOD GROUP	O		
RH (D) TYPE	POSITIVE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :11-06-2026 03:17
RANDOM BLOOD GLUCOSE (GOD/POD)	122	mg/dl	70 - 140



Rainbow Children's Hospital - Secunderabad

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PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 13 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00660308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
LDH (LACTATE DEHYDROGENASE) (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :11-06-2026 06:37	

LDH (L to P-IFCC Ref. PROC.,Calibrated) **1327** U/L H 150 - 500

INTERPRETATION

The Lactate Dehydrogenase (LDH) enzyme is widely distributed in tissue, particularly in the heart, liver, muscles and kidneys. Elevated serum levels of LDH have been observed in a variety of disease states. The highest levels are seen in patients with megaloblastic anemia, disseminated carcinoma and shock. Moderate increases occur in muscular disorders, nephrotic syndrome and cirrhosis. Mild increases in LOH activity have been reported in cases of myocardial or pulmonary infarction, leukemia, hemolytic anemia and non-viral hepatitis

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

PatientName	: Baby T SRI VISHWAIIKA	Inpatient No.	: IP-00060308
Age/Gender	: 8 Y 7 M 13 D/ Female	Admit Date	: 11-06-2026
Ward/Bed	: N 1F-PICU/ PICU 139	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 06:42	
HEMOGLOBIN (Colorimetry)	11.5	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.15	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	31.0	VOL%	L 35 - 45
MCV (Calculated)	74.6	fL	L 77 - 95
MCH (Calculated)	27.7	pg/cells	25 - 33
MCHC (Calculated)	37.1	g/dL	H 32 - 36
RDW-CV (Calculated)	13.1	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	45	10 ⁹ /L	L 150 - 450
MPV (Calculated)	9.7	fL	6.5 - 10
WBC COUNT (DC Detection Method)	11.62	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	86	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	05	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	06	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	03	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / NORMOCHROMIC, NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL WITH RELATIVE NEUTROPHILS SHOWING TOXIC GRANULES PLATELETS : REDUCED		



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 :11-06-2026 06:42	
PT (Optical Clot Detection)	26.7	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.90		
APTT (Optical Clot Detection)	42.0	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		



Dr. SRUJANA SHYAMALA, MD, DNB

PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 13 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
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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COMPLETE URINE EXAMINATION (Specimen : URINE)

TEST RESULT STATUS : REPORT AUTHORISED
Order Date :11-06-2026 07:59

PHYSICAL

COLOUR (Visual Examination)	PALE YELLOW		
APPEARANCE (Gross Examination)	CLEAR		
pH (Double pH indicator)	6.0		5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.010		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)	POSITIVE +		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
LEUCOCYTES (Esterase reaction)	NEGATIVE		NEGATIVE

MICROSCOPY

PUS CELLS	2 - 3	HPF	L 0 - 5
EPITHELIAL CELLS	3 - 5	HPF	L 0 - 5
RBCS.	6 - 8	HPF	L 0 - 2

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

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

TEST RESULT STATUS : REPORT ENTERED
Order Date :11-06-2026 08:03

PH (Reagent Strip/Double PH Indicator)	7.38	unit	7.35 - 7.45
pCO2	27.9		
pO2	323	mm Hg	H 83 - 108
HCO3	16.5		
BE	-7.8	mmol/L	
O2 Sat	99.8%	mmol/L	
HCT (Pulse Height Detection)	39%	%	10 - 75
ctHb	12.5	gm/dL	

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
Age/Gender : 8 Y 7 M 13 D/ Female Admit Date : 11-06-2026
Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :11-06-2026 08:04
PH (Reagent Strip/Double PH Indicator)	7.33	unit	L 7.35 - 7.45
pCO2	29.7		
pO2	144	mm Hg	H 83 - 108
HCO3	15.6		
BE	-9.4	mmol/L	
O2 Sat	98.9%	mmol/L	
HCT (Pulse Height Detection)	37	%	10 - 75
ctHb	12.0	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :11-06-2026 08:04
RANDOM BLOOD GLUCOSE (GOD/POD)	62	mg/dl	L 70 - 140

Investigation	Result	Unit	Biological Reference Interval
TROPONIN T/I (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 08:41
TROPONIN - I	0.081	ng/ml	H <0.034

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
PLASMA FIBRINOGEN (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 09:54
PLASMA FIBRINOGEN	372.84	mg/dl	189 - 475

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081



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040-42462200, Ext 2000,2001,2002,



PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 13 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
TRIGLYCERIDES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :11-06-2026 09:54
TRIGLYCERIDES (Enzymatic with end point)	125	mg/dl	H <75

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
 Age/Gender : 8 Y 7 M 13 D/ Female Admit Date : 11-06-2026
 Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :11-06-2026 13:54			
AMMONIA (Specimen : PLASMA)			
AMMONIA	40	µmol/L	H 11 - 35

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

CONSULTANT BIOCHEMIST, Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :11-06-2026 15:57			
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
HEMOGLOBIN (Colorimetry)	12.6	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.54	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	33.5	VOL%	L 35 - 45
MCV (Calculated)	73.9	fL	L 77 - 95
MCH (Calculated)	27.8	pg/celis	25 - 33
MCHC (Calculated)	37.6	g/dL	H 32 - 36
RDW-CV (Calculated)	13.0	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	35	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.6	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	10.77	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	88	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	07	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	04	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4

PERIPHERAL SMEAR (Microscopy, Leishman stain)

RBC - NORMOCYTIC / NORMOCHROMIC
 WBC - MORPHOLOGY NORMAL WITH RELATIVE NEUTROPHILIA
 SHOWING TOXIC GRANULES
 PLATELETS -REDUCED

Srujana

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :11-06-2026 15:57			
C REACTIVE PROTEIN (Specimen : SERUM)			

PatientName : Baby T SRI VISHWAIKA
 Age/Gender : 8 Y 7 M 13 D/ Female
 Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
 Admit Date : 11-06-2026
 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	168	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 :11-06-2026 15:57
SODIUM (Direct ISE)	139	mmol/L	134 - 143
POTASSIUM (Direct ISE)	3.8	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	105	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 :11-06-2026 15:57
TOTAL BILIRUBIN (Azobilirubin)	3.2	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	2.0	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	1.2	mg/dl	H <1.1
SGOT (AST) (Kinetic with P5P)	435	U/L	H 15 - 40
SGPT (ALT) (Kinetic with P5P)	376	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	118	U/L	L 145 - 420
PROTEIN (Biuret method)	5.9	g/dL	L 6.2 - 8.1
ALBUMIN (Bromocresol Green)	3.0	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	2.9	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)**TEST RESULT STATUS : REPORT ENTERED**

HIMAYATNAGAR BANJARA HILLS UCL (NABL Accredited) HYDERABAD (NABL Accredited) KONDAPUR OUTPATIENT CLINIC (UCL Accredited-IVF) SECUNDERABAD (NABL Accredited) KONDAPUR L.B.NAGAR (NABL Accredited) BANJARAMUDA
 Emergency ☎ 040 - 4873090 Emergency ☎ 040 - 4466 5555, 91009 25516 Emergency ☎ 040 - 4246 2300 Emergency ☎ 040 - 4246 2100 Emergency ☎ 040 - 4246 2200 Emergency ☎ 040 - 4246 2200 Emergency ☎ 040 - 4246 2200 Emergency ☎ 040 - 4246 2200

Order Date :14-06-2026 16:05

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
Age/Gender : 8 Y 7 M 13 D/ Female Admit Date : 11-06-2026
Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
PH (Reagent Strip/Double PH Indicator)	7.43	unit	7.35 - 7.45
pCO2	34		
pO2	90	mm Hg	83 - 108
HCO3	23.2		
BE	-7.7	mmol/L	
O2 Sat	97.1%	mmol/L	
HCT (Pulse Height Detection)	40%	%	10 - 75
ctHb	13.0	gm/dL	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			
TEST RESULT STATUS : REPORT ENTERED Order Date :11-06-2026 18:51			
RANDOM BLOOD GLUCOSE (GOD/POD)	217	mg/dl	H 70 - 140

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT ENTERED Order Date :11-06-2026 21:39			
PH (Reagent Strip/Double PH Indicator)	7.53	unit	H 7.35 - 7.45
pCO2	26.8		
pO2	127	mm Hg	H 83 - 108
HCO3	22.1		
BE	-0.6	mmol/L	
O2 Sat	99.0%	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :12-06-2026 04:06			
HEMOGLOBIN (Colorimetry)	11.2	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	4.02	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	29.4	VOL%	L 35 - 45
MCV (Calculated)	73.1	fL	L 77 - 95
MCH (Calculated)	27.8	pg/cells	25 - 33
MCHC (Calculated)	38.0	g/dL	H 32 - 36
RDW-CV (Calculated)	12.8	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	30	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.4	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	11.29	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	76	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	20	%	L 28 - 48

PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 14 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
MONOCYTES (Microscopy, Leishman stain)	02	%	L 4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	02	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC WBC : TC NORMAL WITH RELATIVE NEUTROPHILS SHOWING TOXIC GRANULES 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 :12-06-2026 04:06
SODIUM (Direct ISE)	140	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.1	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	103	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 04:06
TOTAL BILIRUBIN (Azobilirubin)	3.2	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	2.0	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	1.2	mg/dl	H <1.1
SGOT (AST) (Kinetic with P5P)	255	U/L	H 15 - 40
SGPT (ALT) (Kinetic with P5P)	347	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	82	U/L	L 145 - 420
PROTEIN (Biuret method)	5.5	g/dL	L 6.2 - 8.1
ALBUMIN (Bromocresol Green)	2.6	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	2.9	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	0.8		L 1.4 - 3.4

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
 Age/Gender : 8 Y 7 M 14 D/ Female Admit Date : 11-06-2026
 Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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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 :12-06-2026 04:06
PT (Optical Clot Detection)	24.0	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.7		
APTT (Optical Clot Detection)	43.0	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
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :12-06-2026 04:07
PH (Reagent Strip/Double PH Indicator)	7.50	unit	H 7.35 - 7.45
pCO2	27.4		
pO2	94	mm Hg	83 - 108
HCO3	21.6		
BE	-1.2	mmol/L	
O2 Sat	97.8%	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :12-06-2026 04:07
RANDOM BLOOD GLUCOSE (GOD/POD)	118	mg/dl	70 - 140
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :12-06-2026 07:34
RANDOM BLOOD GLUCOSE (GOD/POD)	156	mg/dl	H 70 - 140

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :12-06-2026 16:01
HEMOGLOBIN (Colorimetry)	11.2	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	4.02	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	29.4	VOL%	L 35 - 45

Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002.



PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 14 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
MCV (Calculated)	73.2	fL	L 77 - 95
MCH (Calculated)	27.8	pg/cells	25 - 33
MCHC (Calculated)	37.9	g/dL	H 32 - 36
RDW-CV (Calculated)	12.8	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	30	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.8	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	10.61	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	70	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	27	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	02	%	L 4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : 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 :12-06-2026 16:01
SODIUM (Direct ISE)	138	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.7	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	102	mmol/L	98 - 108

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 :13-06-2026 05:39
HEMOGLOBIN (Colorimetry)	10.1	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	3.71	10 ¹² /L	L 4 - 5.2
PCV/HCT (Calculated)	27.6	VOL%	L 35 - 45

PatientName	: Baby T SRI VISHWAIKA	Inpatient No.	: IP-00060308
Age/Gender	: 8 Y 7 M 15 D/ Female	Admit Date	: 11-06-2026
Ward/Bed	: N 1F-PICU/ PICU 139	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
MCV (Calculated)	74.3	fL	L 77 - 95
MCH (Calculated)	27.2	pg/cells	25 - 33
MCHC (Calculated)	36.6	g/dL	H 32 - 36
RDW-CV (Calculated)	13.0	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	30	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.5	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	8.34	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	64	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	32	%	28 - 48
MONOCYTES (Microscopy, Leishman stain)	03	%	L 4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL WITH NEUTROPHILS SHOWING TOXIC GRANULES 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 :13-06-2026 05:39
SODIUM (Direct ISE)	139	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.5	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	102	mmol/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 :13-06-2026 05:39
FERRITIN (CLIA)	1320	ng/ml	H 7 - 140

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.

PatientName : Baby T SRI VISHWAIKA
 Age/Gender : 8 Y 7 M 15 D/ Female
 Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No: IP-00060308
 Admit Date : 11-06-2026
 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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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.

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
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PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT AUTHORISED
 Order Date :13-06-2026 05:39

PT (Optical Clot Detection)	14.0	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.0		
APTT (Optical Clot Detection)	35.0	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

Srujana

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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C REACTIVE PROTEIN (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED
 Order Date :13-06-2026 06:15

CRP (Immunoturbidimetry)	64	mg/L	H <10
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Srujana

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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LIVER FUNCTION TEST (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED
 Order Date :13-06-2026 06:15

TOTAL BILIRUBIN (Azobilirubin)	3.2	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	2.2	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	1.0	mg/dl	<1.1

PatientName : Baby T SRI VISHWAIKA Inpatient No. : IP-00060308
Age/Gender : 8 Y 7 M 15 D/ Female Admit Date : 11-06-2026
Ward/Bed : N 1F-PICU/ PICU 139 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
SGOT (AST) (Kinetic with P5P)	68	U/L	H 15 - 40
SGPT (ALT) (Kinetic with P5P)	236	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	258	U/L	145 - 420
PROTEIN (Biuret method)	5.3	g/dL	L 6.2 - 8.1
ALBUMIN (Bromocresol Green)	2.7	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	2.6	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1		L 1.4 - 3.4



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 :14-06-2026 04:10	
HEMOGLOBIN (Colorimetry)	10.0	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	3.68	10 ¹² /L	L 4 - 5.2
PCV/HCT (Calculated)	27.3	VOL%	L 35 - 45
MCV (Calculated)	74.3	fL	L 77 - 95
MCH (Calculated)	27.2	pg/cells	25 - 33
MCHC (Calculated)	36.6	g/dL	H 32 - 36
RDW-CV (Calculated)	12.7	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	35	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.3	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	7.55	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	58	%	33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	32	%	28 - 48
MONOCYTES (Microscopy, Leishman stain)	9	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	1	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL PLATELETS : REDUCED		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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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 : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 16 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060306
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :14-06-2026 04:10			
CREATININE (Enzymatic)	0.7	mg/dl	H 0.2 - 0.6

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 :14-06-2026 04:10			
SODIUM (Direct ISE)	138	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.7	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	99	mmol/L	98 - 108

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 :14-06-2026 04:10			
UREA (Kinetic, Urease)	51.3	mg/dl	H 9 - 34

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 07:05			
HEMOGLOBIN (Colorimetry)	10.3	g/dL	L 11.5 - 15.5
RBC COUNT (DC detection method)	3.82	10 ¹² /L	L 4 - 5.2
PCV/HCT (Calculated)	28.7	VOL%	L 35 - 45
MCV (Calculated)	75.1	fL	L 77 - 95
MCH (Calculated)	27.1	pg/cells	25 - 33
MCHC (Calculated)	36.1	g/dL	H 32 - 36
RDW-CV (Calculated)	12.7	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	80	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.2	fL	H 6.5 - 10

HIMAYATHRAGAR Emergency ☎ 040 - 48873000 BANAJARA HILLS (NABL & NABL Accredited) Emergency ☎ 040 - 4466 5355, 91909 25318 HYDERNAGAR (NABH Accredited) Emergency ☎ 040 - 4246 2300 KONDAPUR OUTPATIENT CLINIC (ICI Accredited-IVF) Emergency ☎ 040 - 4246 2100 SECUNDERABAD (NABH Accredited) Emergency ☎ 040 - 4246 2200 KORDAPUR Emergency ☎ 040 - 4246 2400 L. S. NAGAR (NABH Accredited) Emergency ☎ 040 - 7111 1333 NANAKRAMGUDA 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	: Baby T SRI VISHWAIKA	Inpatient No.	: IP-00060308
Age/Gender	: 8 Y 7 M 17 D/ Female	Admit Date	: 11-06-2026
Ward/Bed	: N 1F-PICU/ PICU 139	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
WBC COUNT (DC Detection Method)	14.04	10 ⁹ /L	H 4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	45	%	33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	45	%	28 - 48
MONOCYTES (Microscopy, Leishman stain)	08	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	02	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC,MICROCYTES(+) WBC : LEUCOCYTOSIS 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 :15-06-2026 07:05
CRP (Immunoturbidimetry)	19.0	mg/L	H <10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 07:05
CREATININE (Enzymatic)	0.6	mg/dl	0.2 - 0.6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 07:05
SODIUM (Direct ISE)	137	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.6	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	101	mmol/L	98 - 108

PatientName : Baby T SRI VISHWAIKA
Age/Gender : 8 Y 7 M 17 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00060308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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LIVER FUNCTION TEST (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :15-06-2026 07:05

TOTAL BILIRUBIN (Azobilirubin)	1.3	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.4	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.9	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	38	U/L	15 - 40
SGPT (ALT) (Kinetic with P5P)	127	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	303	U/L	145 - 420
PROTEIN (Biuret method)	5.7	g/dL	L 6.2 - 8.1
ALBUMIN (Bromocresol Green)	2.9	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	2.8	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

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

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :15-06-2026 07:05

UREA (Kinetic, Urease)	42.0	mg/dl	H 9 - 34
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

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

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :17-06-2026 06:21

BICARBONATE (Enzymatic)	37	mmol/L	H 22 - 29
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Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002,

PatientName :	Baby T SRI VISHWAIKA	Inpatient No. :	IP-00060308
Age/Gender :	8 Y 7 M 19 D/ Female	Admit Date :	11-06-2026
Ward/Bed :	N 1F-PICU/ PICU 139	Discharge Date :	

Investigation	Result	Unit	Biological Reference Interval
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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 :17-06-2026 06:21

HEMOGLOBIN (Colorimetry)	12.5	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.56	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	34.9	VOL%	L 35 - 45
MCV (Calculated)	76.7	fL	L 77 - 95
MCH (Calculated)	27.4	pg/cells	25 - 33
MCHC (Calculated)	35.8	g/dL	32 - 36
RDW-CV (Calculated)	13.1	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	257	10 ⁹ /L	150 - 450
MPV (Calculated)	8.4	fL	6.5 - 10
WBC COUNT (DC Detection Method)	16.87	10⁹/L	H 4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	68	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	25	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	06	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC :NORMOCYTIC / NORMOCHROMIC, NORMOCYTIC / HYPOCHROMIC WBC :LEUCOCYTOSIS PLATELETS : ADEQUATE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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C REACTIVE PROTEIN (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :17-06-2026 06:21

CRP (Immunoturbidimetry)	12.0	mg/L	H <10
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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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 : Baby T SRI VISHWAICA
Age/Gender : 8 Y 7 M 19 D/ Female
Ward/Bed : N 1F-PICU/ PICU 139

Inpatient No. : IP-00000308
Admit Date : 11-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :17-06-2026 06:21
CREATININE (Enzymatic)	0.6	mg/dl	0.2 - 0.6

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 :17-06-2026 06:21
SODIUM (Direct ISE)	141	mmol/L	134 - 143
POTASSIUM (Direct ISE)	5.8	mmol/L	H 3.7 - 5
CHLORIDE (Direct ISE)	94	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 :17-06-2026 06:21
TOTAL BILIRUBIN (Azobilirubin)	1.3	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.3	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	1.0	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	35	U/L	15 - 40
SGPT (ALT) (Kinetic with P5P)	111	U/L	H 10 - 35
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	296	U/L	145 - 420
PROTEIN (Biuret method)	7.5	g/dL	6.2 - 8.1
ALBUMIN (Bromocresol Green)	3.9	g/dL	3.7 - 5.6
GLOBULIN (Calculated)	3.6	g/dL	H 1.6 - 3.5
A/G RATIO (Calculated)	1		L 1.4 - 3.4

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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PatientName	: Baby T SRI VISHWAIKA	Inpatient No.	: IP-00060308
Age/Gender	: 8 Y 7 M 19 D/ Female	Admit Date	: 11-06-2026
Ward/Bed	: N 1F-PICU/ PICU 139	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 06:21
UREA (Kinetic, Urease)	33.7	mg/dl	9 - 34



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



MC-7373

Laboratory Report

Rainbow
Children's
Hospital

9908692120

Rainbow
Children's
HospitalBirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name	Baby T SRI VISHWAIKA	Patient Ph. No	9908692120
Age	8 Y 7 M 14 D	Requisition No	VI26019965
Gender	Female	Collected on	11-06-2026 06:39 AM
IP / Bill No.	IP-00060308	Received on	11-06-2026 07:08 AM
UHID No.	VIH-00151395	Reported on	12-06-2026 08:16 AM
Ref Doctor	Dr. PREETHAM KUMAR	Ward/Bed No	

DENGUE NS1 + DENGUE IGM (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

DENGUE NSI

REPORT : NOT DETECTED (3.0 PANBIO UNITS)

NEGATIVE: < 9 PANBIO UNITS

EQUIVOCAL : 9 - 11 PANBIO UNITS

POSITIVE: > 11 PANBIO UNITS

METHODOLOGY: ELISA

DENGUE IgM

REPORT : NON REACTIVE (7.4 PANBIO UNITS)

NEGATIVE: < 9 PANBIO UNITS

EQUIVOCAL : 9 - 11 PANBIO UNITS

POSITIVE: > 11 PANBIO UNITS

METHODOLOGY: ELISA

ADVISED : SCRUB TYPHUS IgM.

Dr. VIJENDRA KAWLE MD DNS

(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB

(CONSULTANT MICROBIOLOGIST)

..... End of the Report

HIMAYATHNAGAR
Emergency ☎ 040 - 48873000BANJARA HILLS (JCI, NABH & NABL Accredited)
Emergency ☎ 040 - 4466 5555, 91009 25516HYDERNAGAR (NABH Accredited)
Emergency ☎ 040 - 4246 2300KONDAPUR OUTPATIENT CLINIC (JCI Accredited-IVF)
Emergency ☎ 040 - 4246 2100SECUNDERABAD (NABH Accredited)
Emergency ☎ 040 - 4246 2200KONDAPUR
Emergency ☎ 040 - 4246 2400L B NAGAR (NABH Accredited)
Emergency ☎ 040 - 7111 1333NANAKRAMGUDA
Emergency ☎ 040-69313233

1800 2122

www.rainbowhospitals.in

Baby T SRI VISHWAIKA

9908692120

8 Y 7 M 13 D

R26-009336

Female

11-06-2026 05:11 AM

IP-00060308

13-06-2026 04:57 PM

VIH-00151395

PREETHAM KUMAR

DRAFT

X-RAY CHEST AP VIEW

Cardiothoracic ratio within normal limits.

No evidence of fracture of the ribs.

Clavicle and shoulder girdle normal.

No pneumothorax / pleural effusion.

Prominent bilateral bronchovascular markings.

CVL in situ.

CP angles are clear.

Domes of diaphragm are normal.

Baby T SRI VISHWAIKA

8 Y 7 M 13 D

Female

IP-00060308

VIH-00151395

PREETHAM KUMAR

R26-009368

11-06-2026 12:52 PM

11-06-2026 01:00 PM

11-06-2026 01:00 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	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 11-06-2026 01:00 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 3

Baby T SRI VISHWAIKA

9908692120

8 Y 7 M 13 D

R26-009368

Female

11-06-2026 12:52 PM

IP-00060308

11-06-2026 01:00 PM

VIH-00151395

11-06-2026 01:00 PM

PREETHAM KUMAR

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.7		Tricuspid Annulus		
LA	1.9		Mitral Annulus		
IVSd	0.7		Aortic Annulus		
LVIDd	3.5		PA Annulus		
LVPWd	0.7		RPA		
IVSs	1.0		LPA		
LVIDS	2.1		MPA		
LVPWs	1.3		AO Isthmus		
EF	69%		LV Mass		
FS	35%		Others		

Impression

SITUS , SOLITUS, LEVOCARDIA

STRUCTULLY NORMAL HEART

NORMAL SIZED CARDIAC CHAMBERS

GOOD BIVENTRICULAR FUNCTION

LEFT ARCH , NO COA

Baby T SRI VISHWAIKA

8 Y 7 M 13 D

Female

IP-00060308

VIH-00151395

PREETHAM KUMAR

R26-009368

11-06-2026 12:52 PM

11-06-2026 01:00 PM

11-06-2026 01:00 PM

Dr. NAGESWARA RAO KONETI
MBBS,MD,DM,FELLOWSHIP IN PAEDIATRIC CARDIOLOGY
Reg No: 19320

Baby T SRI VISHWAIKA

8 Y 7 M 13 D

Female

IP-00060308

VIH-00151395

PREETHAM KUMAR

R26-009381

11-06-2026 02:58 PM

11-06-2026 04:07 PM

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 11 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

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

SPLEEN : Normal in size 9.3 cm and echotexture, No obvious focal lesions.

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

KIDNEYS :

Right kidney : 83x35 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 89x41 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.

No ascites / lymphadenopathy. No evidence bowel wall thickening / edema.

Print Date/Time : 11-06-2026 04:07 PM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 2

Baby T SRI VISHWAIKA

9908692120

8 Y 7 M 13 D

R26-009381

Female

11-06-2026 02:58 PM

IP-00060308

11-06-2026 04:07 PM

VIH-00151395

PREETHAM KUMAR

Impression

- 1. Mildly edematous wall of gall bladder**
- 2. Rest unremarkable**

Suggested clinical correlation.

DEFICIENCY CHECKLIST OF MEDICAL CASE SHEET



VIH-00151395
 Baby T SRJ VISHWAIKA IP-00060308
 29-10-2017 8 Y 7 M 19 D
 Dr. PREETHAM KUMAR (F)

Patient Name :

IP.No:

Ward:

DOA:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01			
2	Discharge Summary	02			
3	Nursing Initial assessment form	03			
4	Patient Transfer Forms	02			
5	In-patient Medical Record	03			
6	Doctors Progress Sheets	18			
7	Nurses Progress notes	03+7			
8	Consultation Sheets				
9	General Consent for Treatment	01			
10	Consent for Surgery				
	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test	01			
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	04			
26	Intake and Output chart (fluid Chart)	04			
	Drug Chart (Regular prescription)	04			
28	Daily Investigation sheet	02			
29	Investigation Values (Result Sheet)				
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01			
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Attempty deumpty	01			
	Thromb	02			
	Others	80			
	Billin	04			
	Intensive Care unit	5			
	VBCG	6			
	Total No. of Pages	83			

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

VIH-00151395 IP-00060308
 Baby T SRI VISHWAJKA 8 Y 7 M 18 D (F)
 29-10-2017
 Dr. PREETHAM KUMAR

111

B.P



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
16/6/26	00.00	80/49 (58) - 7pm		
	01.00	80/54 (63) ^{upper hand} - 8pm		
	02.00	96/64 (70) ^{lower leg} - 8pm		
	03.00	9pm - 93/55 (68) ^{Left lower leg}		
	04.00	10pm - 96/64 (75)		
	05.00	11pm - 90/54 (65)		
17/6/26	06.00	12am - 88/60 (71)		
	07.00	1am - 95/67 (75)		
	08.00	2am - 90/45 (58)		
	09.00	3am - 95/52 (66)		
	10.00	4am - 89/53 (65)		
	11.00	5am - 94/56 (68)		
	12.00	6am - 97/62 (76)		
	13.00	7am - 109/58 (73)		
	14.00	9am - 92/60 (7) ^{Dommy}		
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

AH-00151395 IP-00060308
 Baby T SRI VISHWAIKA (F)
 20-10-2017 8 Y 7 M 16 D
 Dr. PREETHAM KUMAR

MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: PIU - Shifted to: III

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	2MS MEROPENEM	1.5 gm	IV	8hrly		<input type="checkbox"/> C <input type="checkbox"/> DC
2	TAB PAWTOPIRACLOL	40mg	PO	12hrly		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	ATDAX LOTION	Skin of rashes	U/A	8hrly		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4	ZYTEOL GEL	Oral	U/A	8hrly		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	MUPIROCGW Ointment		U/A	8hrly		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
6	TAB METHYLPREDNISOLONE (1TAB=16mg)	1TAB	PO	12hrly		<input checked="" 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. Preetham P

Date & Time: 14/6/20 10:50 AM

Nurse Name & Signature: Jagan

Date & Time: 14/6/20 at 11 AM

VITAL SIGN TARGETS

VH-00151395 IP-00060308
Baby T SRI VISHWAIKA
29-10-2017 8 Y 7 M 13 D (F)
Dr. PREETHAM KUMAR



PATIENT STICKER

WEIGHT : 38 kg. HEIGHT: _____ BMI: _____

TEMPERATURE : 97.5°C

HEART RATE : 80 - 110/min

RESPIRATORY RATE : 20 - 25/min

SATURATION: 92 - 95%

BLOOD PRESSURE :

	5 TH P	50 TH P	90 TH P	95 TH P	99 th P
SBP	86	98	111	115	122
DBP	50	58	72	76	83
MBP	62	(68)	(85)	89	96

URINE OUTPUT: 1-2 ml/kg/hr.

ADMISSION SHEET

Registration Details :



Admission No : IP-00060308 Admit Date : 11-Jun-2026 Admit Time : 12:22 AM UHID : VIH-00151395

Patient Details :

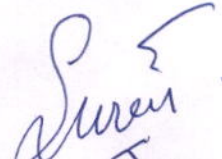
Patient Name : Baby T SRI VISHWAIKA Age : 8 Y 7 M 13 D
Guardian : Mr RAJKUMAR TIRTHALA DOB : 29-10-2017
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 2-26/3 EDULAGATTE PALLY MANAKONDUR Phone No : 9908692120
KARAMINAGAR Mana Kondur Karimnagar E-mail : na@gmail.com
Telangana INDIA 505469

Admission Details :

Bed Type : PICU Bed No : PICU 139 Ward Name : N 1F-PICU
Room No : PICU 139 Admission Type : First Visit

Contact Details :

Name : Mr RAJKUMAR TIRTHALA Relationship : D/O
Contact Address : 2-26/3 EDULAGATTE PALLY MANAKONDUR Phone No : 9908692120 / 9866175727
KARAMINAGAR Mana Kondur Karimnagar
Telangana INDIA 505469


Signature


Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR Specialisation : GENERAL PEDIATRICS
Referral Doctor : DR.INDU PRIYA Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : HERITAGE HEALTH INSURANCE TPA
PVT LTD

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00151395 IP-00060308 Baby T SRI VISHWAIKA 29-10-2017 8 Y 7 M 16 D (F) Dr. PREETHAM KUMAR 		Date & Time of Admission 11/6/20 @ 12:22 AM	Date & Time of Transfer Order 14/6/26 @ 11:35 AM
		Transfer Ordered by Dr. Preetham	Reason for Transfer Stable
From Unit PICU	To Unit 1st floor (TU)	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Number of Sheets in Clinical File 65	Number of Imaging Films X-ray - 2 ABG - 6	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	5cc - 2		
2.	10cc - 3		
3.	2g tube - 6 Oral - 1		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. Vishnu vardhan		Name of Person Ordered Transfer Dr. Tharjia	
Patient & Clinical Records Received by : Sr. Bevonika			
Date & Time of Patient Received : 14/6/26 @ 11:35 AM			

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

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 11/06/2016
 Source of Admission: OPD Ward Other: Shreeaksha Hospital
 Reason for Admission: CLD Fever 3 days
 Admission Diagnosis: Septic Shock sepsis
 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 checked="" 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>Shreeaksha Hospital</u>
	Family History: <u>Mitt</u>		
	Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
CURRENT MEDICATIONS	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Observations: Weight: _____ Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>98.6 F</u> HR: <u>126 bpm</u> RR: <u>23 b/min</u> BP: <u>92/65 (72)</u> Pain Score: <u>0</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Score: <u>9</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>26</u>) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission:

- Sleeping Crying Calm Distressed/Console 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

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

Orientation has been given regarding the following aspects:

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

Orientation given to: Family Others specify

Name of Person Orientation was given to: mother

Orientation not given Reason:

Nurse Name: Bri Nandiswar

Nurse Signature: Bri Nandiswar

Date & Time: 11/06/26 @12:15AM

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: 2/0 Avere 3 days

Nurse Name: Bri Nandiswar

Nurse Signature: Bri Nandiswar

Date & Time: 11/06/26 @12:15AM



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Severe & moderate hypoglycemia

Arrival Time: 11:25 AM Mode of Arrival: Admitting From: ER OPD Direct

Allergy / Adverse Reaction Body Weight: 3.8 Kg
 no Height: cm

Past Medical History: Obtained From Patient Family Member Medical Record Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	

Family History:
 no

Has the child or close family member had recent contact with a communicable disease? Yes No

If yes please list,

Was the child's birth normal? Yes No If No, please describe problems:

Are the child's immunization up to date? Yes No

Current Medication: None Yes, If Yes, fill reconciliation form

Observations: Weight: 2.8 kg Length: Head Circumference (< 2 years):

Temp.: 98.5°F HR: 102 b/min RR: 24 b/min BP: 99/65 (3.6)

Pain Score: 0 Specify Site: nil (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: Yes No Score: 13 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 21) (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character of Pain 0 Location nil Frequency Duration

FUNCTIONAL SCREENING: No Abnormalities Detected
 Mobility Problem Walking Problem
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormalities Detected
 Underweight Overweight 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?) 1

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No Waste Disposal Explained: Yes No

Infusion Pump : Yes No Hand hygiene Explained: Yes No Others

Patient Rights & Responsibilities: Yes No

Information given to mother and father

Nurse's Name: Bernika Date: 11/10/26 Time: 12pm

Bernika
Signature



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VH-00151395 IP-00060308

Baby T SRI VISHWAIKA

29-10-2017 8 Y 7 M 13 D (F)

Dr. PREETHAM KUMAR

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Srivishwakas Age/Sex eylf

Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

cl/o face :: 3 days
 cl/o rash :: today morn
 cl/o vomitings, generalized weakness :: today morning.

History of present illness :

Child was apparently asymptomatic 4 days back then started

cl/o loose stools - for 2 days
 (5-6) episodes/day
 Subside Now.

cl/o Abdomach pain :: 4 days.
 Diffuse Abd. pain - more in the epigastric region.

cl/ flb → Fever :: 3 days
 mild - high grade fever.

Not Subside on oral medication.
 Consulted outside hospital - and medications.

cl/ flb Rashes all over the body :: today morn
 Initially started on the face
 urticarial rash. then progressed to trunk, upper limbs.

cl/o vomitings (2-3) episodes NB/wpl non blood
 Ateined :: today

cl/o generalized weakness :: today morn

Admitted in referral hospital

Ateined cl/ Ijg meperan, Ijg-pipter, Ijg-Noradrenaline.



Pediatric Multiorgan History & Physical Examination

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

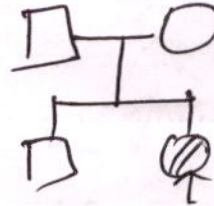
10/6/22
Hb → 12.0 H/L → 80/16 S-Cr → 0.8
PLT → 1.10 lakhs WBC → 7K ESR → 46 mm/hr - 1st hr
CRP → 105.3 80 mm/hr - 2nd hr

10/6/26 LFT
APTT → 52 sec T.B → 2.5 mg/dL ALP → 168.
PT → 24 sec DB → 1.6 mg/dL A/G ratio → 1.0
INR → 1.75 TDB → 0.9 mg/dL Alb → 3.8

Nat → 135 Cr → 98 SGOT → 448 u/L
K⁺ → 3.4 Supt → 199 u/L Dengue NSI → Negative
Cue → 6-8 pus cells

Birth & Neonatal History:

Term | 3 kg | NVD
No NICU admission.



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____

Developmental History :

Development achieved as per age - In all 4 domains.

Immunization History :

Immunized as per age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

On Examination :

Temperature : _____ Pulse Rate : _____ B.P. _____ SPO2 _____
Resp.rate and type of breathing : _____

Rash _____ (+) urticarial rash all over the body

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____ (M)

Heart Sounds : _____ S1 S2 (+)

Any murmur : _____ (+)

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

Per Abdomen :

Inspection _____ (M)

Palpation : _____ P/A = soft

Auscultation : _____

Spine : _____ (M) External Genitalia : _____ (M)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : (N) _____

Motor System:

Nutrition : _____

Tone: 2 (N) Power: _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : (N) _____

Reflexes :

DTR

Superficials:

Plantars flexion.

Sensory System :

(N) _____

Bladder / Bowel : (N) _____

Clinical Summary & Diagnostic:

Septic & Septic shock with
? Yersinia, Leishmania
(? Secondary Mupirocin^u)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, CRP, creat, stez,
S. creat, S. urea,
LFT, PT/APTT
INR, PCT
S. femtin, DBU, u/cle.

B/cle → done @ outside lab pit
↓
report awaited.

Planned Management

Dr. Preetham Kumar Reddy
Reg. No: 39859

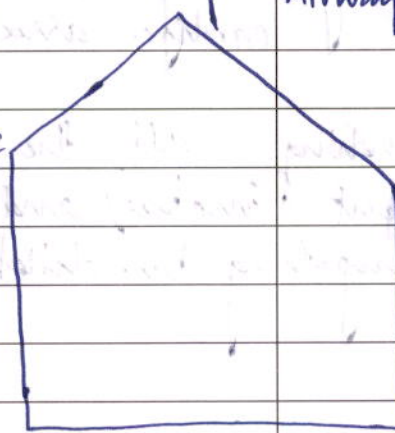
Signature of the Doctor: _____
Name of the Doctor: Dr. Swathy
Date & Time: 11/6/2026, 1.00 AM

Signature of the Consultant: _____
Name of the Consultant: Dr. Preetham
Date & Time: 11/6/26 9hr

[Faint handwritten notes]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>10/6/2026 11 PM</p>	<p>Child is referred Hospital:</p>	<p>Airway: open, child connected to bw flow @ 2L/min</p>
	<p>Exposure: Temp: 99°F</p> 	<p>Breathing: Child having RD with tachypnoea, mild SCR. Chest: B/L AE @ rt spo₂: 100%</p>
	<p>Disability - GrCs E₃ V₅ M₆ (to speak) (14/15) GRBs: 122mg/dl</p>	<p>Circulation: CRT: Boredline Peripheric cold. BP: 99/52 (64) HR: 138/min. Child @ 0.2mcg/kg/min Noradr</p>
	<p>Assessment: - Hypotensive shock with Respiratory distress.</p>	
	<p>Adv: ① NS Bolus (Push-Pull) : @ 10ml/kg stat ② Connected her ↓ child to NRM @ 10L/min.</p>	
	<p style="text-align: center;">96/50 (65)</p>	
	<p style="text-align: center;">↓</p> <p>Plasmalyte Bolus @ 5ml/kg. - Brachial cannula placed. - BP: 90/65 (74). - continued on 0.3mcg/kg/min of Noradr (pump head dilution)</p>	



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/2020 12.10 PM	Upon arrival at PICU.	
	Stomach: open, maintainable with NRM @ 104/min. Risk for difficult intubation d/t obesity	
	Breathing: R/R: mild SCR (+) Inf Chest: B/L AE present Spo ₂ : 100% under NRM.	
	Circulation: CRT > 3sec BP: 82/72 (65) HR: 126/min. Peripheries: cool, peripheral pulses: thready pulse.	child on Noradrenalin @ 0.3 mg/kg/min.
	Disability: E ₃ V ₅ M ₆ (14/15)	
	Expos: No fever spike.	
	Adv: (1) Arterial line placement (planned) (2) POCUS: done: IVC collapse with Breathing. 4 chamber view: ? LV dysfunction. Bolus: @ 10ml/kg & paralytic smoothly given. (3) Another brachial cannula placed and peripheral Adrenalin started.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2020 1.00 AM	<p><u>Abused Cannula Placement</u></p> <p>Under all aseptic and antiseptic condition (R) Radial arterial line placed done. Good Back flow observed and line secured</p>	
	<p><u>Ureinary Catheter Placement</u></p> <p>Under all aseptic and antiseptic condition ureinary catheter placed was done. Bump inflated with DW : and secured.</p>	
	<p><u>Respirator</u></p>	
		<p>Dr. Preetham Kumar Reddy Reg. No: 39859 11/6/2020</p>

3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2016 1:30 AM	Child admitted in ICU.	C/S/B Dr Keerthi Sir
1.	evaluate	
	respiratory status	
	Child seen by Keerthi Sir,	
	- history and	Blood report s/o sepsis & Septic shock
		& Hepatic involvement
		is ? hypoinflammation
	Adv: ①	As child is needing 2 inotropes,
		child planned for Central line
		Placement.
	②	As child has 14/15, Plan for
		Intubation & ventilation s/o
	③	Counseling to parents regarding critical
		condition.
	- steroid, (NT-ProBNP, Tropon I)	VLS score
	- Cardiology consult	
	- Trans Ferritin.	
	- stress dose of hydrocort	
11/6/2016 1:30 AM		

11/6/2016

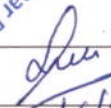
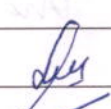
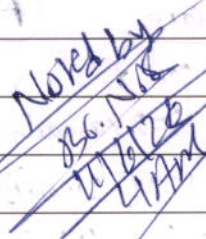
11/6/2016
1:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/16/22 1:30 Am.	<p style="text-align: center;"><u>Counseling notes</u></p> <p>Parents were counseled by Dr. Kiran for The reason for rash could be due to injection / Drug or food Allergy. The current condition of child is low BP - may be due to injection / blood loss. And condition associated to high injection doses are ↓ B.P ↓ 40 Drowsy, lethargic. We hence started medication / Inf to increase B.P. B.P is not able to maintain. If B.P is not responding to Inf / Inotropes. ↓ parent was counseled regarding need for Intubation & Central line. At Now B.P is not maintaining on Inotropes → explained about need for central line - Now. (Cvs) - Intubation. explained about the need for NEM. There might be chance of low O₂ d/t shunt. And explained about the need for sedation during central line. And possible side effects of sedation. - Parents were reassured.</p>	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2026 4.00PM	<p style="text-align: center;"><u>Central line Placement</u></p>	
	<p>Under all aseptic and antiseptic conditions 5.5 Fr, 8cm central line Placement was done in Right IJV. Position ascertained with Xray of line (Post procedure).</p>	<p style="text-align: right;">  11/6/2026 Dr. Preetham Kumar Reddy Reg. No. 39859 </p>
	<p style="text-align: center;"><u>CPD/W Dr. Preetham Sr.</u></p>	
	<p>- History, discussed with Blood report:</p>	
	<p>Adv: ① CBP, APTT, PT-INR at 8AM ② BH LDH to be sent. ③ Dengue NS1, IgM</p>	<p style="text-align: right;">  Dr. Preetham Kumar Reddy Reg. No. 39859 </p>
	<p>Noted by  11/6/26 4PM</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/20 7.00AM	<p>Δ: Sepsis & Septic shock with Hepatic involvement with Thrombocytopenia [MODS] (To r/o Dengue / Hypersplenism)</p>	
	<p>Airway: Maintainable at 20ml/min (HFNC: FiO₂: 30, Flow: 25-30l/min)</p>	
	<p>Breathing: Respiratory distress present Tachypnoea, SCR out B/L - Air entry present</p>	
	<p>Circulation: CRT < 3sec Peripheral pulses: well felt BP: > 50mmHg possible</p>	
	<p>Disability: GCS: E₃ V₅ M₆ (14/16) RBS: ...</p>	
	<p>Exposure: One spike 99.7°F, 100°F</p>	
<p>W 11/6/20 Preetham</p>	<p>VIS score: 0.15 mg/kg/min @ 100 0.15 mg/kg/min @ 100 30 20: High support</p>	<p>Pharm score: (F) Resp: 1 point (on support) Cardiovascular: 2 point: ≥ 2 vasoactive BP: (I) Inlet: 5-10.9 (1 point) Coagulation: 1 point: (pt < 1.1k) 1 point: INR > 1.3 D dim Fibrinogen</p>

Neurologic: GCS: > 10





5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2022 9:30 AM	c/D/w Dr Bhargavi Maam Patient's history, blood report Pocus, shared with maam.	
	- so LV dysfunction.	
	- Adv. (1) Continue Nor adrenaline, & Adrenaline (2) Send Trop E (3) SOS IVC if high Trop E (4) SOS Lasix infusion @ 0.05 - 0.1mg/kg/hr if IVC congested.	
11/6/2022 9:15 AM	c/s/B Dr Preetham so	
Noted by Jaganani 11/6/2022 09:15	(1) USG abdomen (2) SOS Inj Melhylpred again (3) Cardiology consultation & 2DECHO (Dysplasia, & Corrosion) (4) Start Lasix @ 0.1mg/kg/hr (5) Send Triglyceride, Fibrinogen level. (6) Taper Norad & plan to start Dobutamine..	<p style="text-align: right;"> Dr. Preetham Kumar Reddy Reg-No: 39859 11/6/2022 30 US 0.5 0.6 0.5 0.5 </p>



PROGRESS NOTES AND DOCTOR'S ORDER


Date & Time	Progress Notes	Doctor's Order
14/6/2026 9:30 AM		Counselling by Dr. Preetham Giris
	<p>The present condition of child explained. The child is on inotropic & oxygen support. The child is having low blood level of Hb & Platelet, along with deranged liver function. The child came in shock and has effected low heart too. The heart pumping activity has is low and along with Xray showing lung involvement. The infection in body had lead to hypotension. The child is unstable currently. The child is on HFNC, & medication for BP support and high level antibiotic also has been started. We will give steroid and also given one dose already. The child also might need IVIG which might be very costly. We will wait for his report and if needed we might need IVIG too. Respiratory distress is there and if needed the child might need intubation. Due to multiple organ involvement the child's chance of mortality is very high up to 70-80% and child might even die due to severe disease of infection. has with</p>	
	Mother	Father, Relative  Dr. Preetham Kumar Reddy Reg. No.: 39839 

VH-00151395 IP-00060308
 Baby T SRI VISHWAIKA
 29-10-2017 8 Y 7 M 13 D (F)
 Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/20	<p>CS/B 1st Preterm (Cesarean)</p>	
	<p>Sepsis → hyperreflexia</p>	
	<p>on HFK 30/25</p>	
	<p>on adre → O-oxyltin, Noradre → O-oxyltin, Dobutamine →</p>	
	<p>1) stop Dobutamine - altv. Noradrenaline</p>	<p>Seq 2</p>
3: 6:00pm	<p>2) 2 Cap, LFT, SGPT → now - and <u>CPE</u></p>	
	<p>3) 1st stop Noradrenaline → to see any</p>	
	<p>worsen of cardiac function</p>	

Noted by
 Br-Bunsh
 11/6/20 6:00pm
 3:40pm


 Dr. Preetham



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>11/6/20</u>	<p><u>Counselor by Dr. Preetham Kumar</u> To mother, father, 2 male attendants</p>	
<u>3:40 PM</u>	<p>We are on inotropic support but BP & heart rate are fluctuating We will opt CRP LFT → new Explain about the reports - hyper inflammatory markers are elevated → we will see if any chgs on next report → if more organs are involved → it will take more time & need to be watchful all organ functions & support accordingly → jawer spike OK present → eye has red spot → bleed → due to platelet low which is triggered by infection</p>	
<p>Rajkumar <u>father</u></p>	<p>Shobha <u>mother</u></p>	<p>Z NRTM</p>
-		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>11/6/26 18:45</p>	<p><u>CS/B Dr Preetham</u></p>	
	<p>△ Septic Shock & Thrombocytopenia</p>	
	<p><u>Current Status:-</u></p>	
	<p>- on HAVC 25/20%</p>	
	<p><u>Plan</u></p>	
	<p>- CBP, PT/APTT, LFT, S/E, ABG T/M</p>	
	<p>- Xray T/M</p>	
<p>QJ ASH</p>		<p>Noted by Br. Banu 11/6/26 at 6:45 pm</p>

VIH-00151395

IP-00060308

Baby T SRI VISHWAIKA

29-10-2017

8 Y 7 M 13 D (F)

Dr. PREETHAM KUMAR



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26 7:30 AM	<p><u>CL&B Resident</u></p> <p>Δ Sepsis & septic shock with Hepatic Involvement with Thrombocytopenia</p> <p><u>Current Issues:</u> → BP Fluctuates → Flushing over entire body → Blood gases s/o Respiratory Alkalosis</p> <p><u>Airway:</u> - Open & Maintainable on low flow nasal prong at 2 Ltr/min</p> <p><u>Breathing:</u> - NO Respiratory Distress B/LAE ⊕</p> <p><u>Circulation:</u> - on Dobutamine 5 mcg/kg/min Adrenaline 0.01 mcg/kg/min Peripheral pulses well felt CRT < 3 sec BP > 50th percentile</p> <p><u>Deability:</u> - GCS - 15/15 RBS - 118 mg/dl</p> <p><u>Exposure:</u> - 2 fever spikes overnight 100.5°F</p>	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p><u>12/16/26</u> <u>10:25</u></p>	<p><u>CS/B Dr Vishnu</u> <u>Δ Hyperferritemic Sepsis</u></p>	
	<p><u>Cement stabs</u></p> <ul style="list-style-type: none"> - M low flow O₂ - 2^h Dobutamine 5mcg/kg/min - 2^h Lasix 0.02mg/kg/min 	
	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Taper Dobutamine - Encourage soft diet - Check NIBP - Stop lasix infusion if required bolus can be given 	
<p>Noted by Jaganani <u>12/16/26</u> <u>at 10:25</u></p>	<ul style="list-style-type: none"> - Restrict fluid to 50% maintenance including infusions - If totally okay then fluid can be tapered - Incentive Spirometry - Ambulate the child - Repeat CBP @ 6 PM - CBP, CRP Tm 6 AM 	<p><i>[Signature]</i> <i>[Signature]</i></p>

Dr. Vishnu Vardhan Reddy
 Reg. No. APNC/FMR/79982



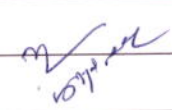
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/10/2026 10:25 AM	<u>Counseling notes (Dr Vishnu)</u>	
	Better today	
	Hem support we stopped	
	BP & cardiac medication are being tapered	
	There is haemorrhagic fever time to become normal	
	Platelets are low but as there is no	
	bleeding manifestations, we are holding on platelet	
	transfusion.	
	child is having hyperfibrinogenemia causing autoimmunity level	
	of vitals. There is immune dysregulation causing	
	these features	
	child is still sick and chances of deterioration if	
	present. P	
	once fever resolves and platelet improve, we expect	
	stability	
	child should be ambulated & chest physio - spirometry should	
		be done
		by nurse
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu
		Dr Vishnu



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/2026	C/S/13	Dr. Vishnu
	1) - change fluids	to DMS + 5ml KCl (50% maint)
	2) - Allow orally (Clear fluids)	[T/M - CBP, Sr. Electrolyts, PT, INR, ADPIT] Ferritin.
Noted by Sr. Paramedical GT	3) - Lasix stopped.	
	4) - Syp Atarox 5ml 12 th hly	
	5) - Atarox Anti-itch lotion.	
	6) - To do spirometry 8 th hly	
	7) - T/M (Ses) - Remove Foley's catheter	
12/6/2026 5:40 PM	Counseling note (Dr. Vishnu)	
	Metals sent in am → morning. Plan to repeat Blood test tomorrow Insulin has been stopped Plan to continue spirometry & Arterialization	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/06/2016 8:00 AM	<p>U/S/B paco follow</p>	<p>(No of illness by of admission)</p>
	<p>Is - Hypertensive sepsis Thrombocytopenia</p>	<p>Acute liver injury encephalopathy cardiac dysfunction</p>
	<p>ON Room air, maintaining saturation > 95% from No distress / tachypnea RR - (20), AB - (N) BP ~ 5th centile Alert & active</p>	
	<p>No fever spikes, away Petechiae (+), Purpura (+) No Bleeding manifestations</p>	
	<p>Accepting orally 2ml → 50% maintenance to kcal (5ml) 2 835g 0 620</p>	
	<p>U/O → 1.1 cct/plmr net → -184.4 ml cumulative balance → (-1237.4 ml)</p>	
	<p>on meropenem vancomycin } (P3)</p>	<p>central line - (P4) arterial line - (P5)</p>
	<p>Methylprednisolone 1 (3) dose given</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Mer</u>	
	1) To wait desaturation (SpO2 > 95%) 2) BP monitoring 3) stop Vit (K) 4) Please Perkin report of manual platelet count 5) to stop war, if and intake improve 6) Symmetry @ Arteries	
	Noted by Dr. B... 13/6/16 SAM	Dr. Preetham Kumar Reddy Reg. No: 39859
	13/6/16 PA Dr. Preetham H ⁺ - sepsis i norm Thrombocytopenia	<u>Mer</u>
	on BP monitoring scheduled on 25 th center	1) 2mg/kg/day prednisolone
	my original	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/10/17 9:10 AM	<p> cephaly note (as per them) </p>	
	<p>no fever spikes</p>	
	<p>no on iontophore, intermittent hypotension present</p>	
	<p>but enzymes improving</p>	
	<p>Clotting parameters improved</p>	
	<p>low oral intake here continued on oral fluids</p>	
	<p>skoid is being decreased in dose &</p>	
	<p>Thrombocytopenia present</p>	
		<p>Signature</p>
	<p><u>Mother</u></p>	
	<p><u>Father</u></p>	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/11/17	C/LB Plao f/des	
3:38pm	fev 99.3°F	
	<u>Plao</u>	
Noted by Sushma 13/11/17 3:38pm	1) Gene Sample → Blood ora, Sr culture 2) Plan to do C/S, S/C, T/m on 14/11/17 3) Remove central cath naad (A) Stop Vancomycin Consulting by Dr Prabhu	Blood ora Sr culture
	The child current condition explained. The child is currently stable, off oxygen, but platelet count & LFT still deranged - so, it will take time for resolving of symptoms. The child takes time for resolving.	2 nr 2 times
	<u>Falav</u> 	<u>Moku</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/10/18 8 AM	<p><u>CLB Resident</u></p> <p>Hypergenthemic sepsis - MODS</p> <p><u>Current status:</u></p> <ul style="list-style-type: none"> - on Room Air - mainly BP - Tolerably oral feeds - NO fever spikes - vly stable - on incentive spirometry & Ambulation - central line intact 	
	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Continue same - methyl pred 2mg/kg/day from today - wlf Hypertension 	
<p><i>[Signature]</i> Dr. Preetham</p>		<p><i>[Signature]</i> Noted by Jaynani 14/10/18 8 AM</p>



13

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>10/10/17 9:15 AM</p>	<p><u>CLSB Dr Vishnu</u></p> <p>Hyperthermia sepsis</p>	
	<p>- on Room 14 - oral vit</p>	
	<p><u>Plan</u></p>	
	<p>- Shift to Room - change to oral med - line care & continue decolonization regimen - 2x methylpred 1mg/kg/dose BD → oral - BD - continue soft diet</p>	<p>Dr. Vishnu Vardhan Reddy Reg.No.APMC/EMR/79982</p>
	<p><u>Counselor's Note</u></p>	<p>Dr Vishnu</p>
	<p>- we will shift the child to room. Pletlys are still low & we will monitor it daily. we will shift with central line and care has to be taken. as it is difficult to cannulise & sample</p>	
<p>Dr Vishnu</p>		<p>Noted by Jagannath 10/10/17 10:30 AM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/10/16	USG of abd	
11/10/16	Sepsis with MODS with hyperferitemia	
	8 years old female child fever 2 days Rash 2 days Vomiting, generalized weakness - 1 day	
	Child not was admitted at Sunrise & started on low flow oxygen & noradrenaline for low BP & was noted to have low perfusion with high cap hence child was shifted to OR transported to RCH	
	Initially started on 1) 100% F ₂ O ₂	
	2) Adrenaline started along with Noradrenaline infusion	
	3) Central of arterial line placed	
	4) High cap, legs perfusion, high LDU => Hyperinflation was also suspected	
	-> dr methylprednisolone (10mg/kg) - started	
	5) 2 doses of LU Dopamine - started on Dobutamine & later infusion	
	6) mesopren & vawagycin Gradually clinical status was improved in terms of blood pressure, mainly	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>Protocols were typed & stopped once child maintained Bp & cardiac function improved HFM was typed & used to low flow - which was gradually stopped then were decrease in fever spikes with further decrease in Crp levels</p>	
	<p>here child is being started to walk with policy advice</p>	
		<ol style="list-style-type: none"> 1) CENTRAL LINE CANN 2) Clf Dms → 30ml/24hr 3) 4p meperidine 4) Tab paracetamol 5) Atelap lots 6) Zytex L gel 7) mupirocin ointment 8) methylprednisolone 16mg/12hr 9) continue monitoring 10) T/m plan to do CAP, CRP, SE, LFT ON Bloods, sputa, 15/6/16 at 6am 11) Spirometry - well being 12) Ambulate the child
	<p><i>Wrote by Jagannath 14/6/16 at 11 AM</i></p>	

to Mrs

VH-00151395 IP-00060308
 Baby T SRI VISHWAIKA
 29-10-2017 8 Y 7 M 15 D (F)
 Dr. PREETHAM KUMAR

...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>14/6/16</u>	<u>Discussed with Dr. Pradeep w</u>	
<u>11:30</u>	<p><u>1) oral mety/prednisolone -> 16g/BD</u> <u>2) plan to do</u> <u>CRP, CRP, SE, BFT</u> <u>Tham</u> <u>blood urea, glucose</u> <u>at 6am on 15/6/16</u></p>	
	<p><u>3) STRICT CENTRAL LINE CARE</u></p>	
		<p><u>Z</u> <u>WRL</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/26 12:15 pm	S/B Resident ASU - sepsis c MODS c hyperferritinemia.	
	O/E	
	child alert	
	Euthermic	
	Vitals stable	
	On RA. SpO2 - 97-98%	
	BP ~ 5th centile	
	HR - 88/min	
	Central line patent.	
		Plan
		1) Continuous monitoring
		2) Central line care
		3) IVF DMS - 30ml/hr
	add sup. Surafate	4) Puj meropenem
		5) Tab. pantoprazole
		6) Atarax lotecor
		7) Zyltec gel
		8) mupirocin ointment
		9) Tab. methylprednisolone 80 - ^{from} T/m
		10) CRP
		CRP B-urea } T/m (15/6/26)
		S/E C-react } @ 6am.
		LFT
		11) Spasmolytic - ondansetron
		12) Ambulation

6
 Ampicillin
 14/6/26
 3-20pm

ambulation



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/26 5pm	<p><u>S/B Resident</u></p> <p>Sepsis - mode - hyperfermentum</p>	
	<p><u>o/e</u> child asleep Cheek - flushing / Redness (+) Abdominal pain - (↓) o/e Guttural Bp - 97/57mmHg RR - 28/min HR - 116/min SpO₂ - 96-97% @ RA Cvs - S2 (+) Rpr - RAE (+) P/A - soft</p>	
		<p><u>Plan</u></p> <ol style="list-style-type: none"> 1) monitor Bp 2) monitor SpO₂ charting 3) CBT 4) Tab. methylpred 7/m 5) CRP B. urine } t/m 6am CEP secret } S/E secret } CBT 6) Perform eos.
	<p><u>Dr. Vishwaje</u></p>	<p>Noted by Subham 14/6 @ 7pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 8 AM	S/13 Resident	
	Septic - mono - hyperferitinemia.	
	O/E child afebrile.	
	Euthermic.	
	Abdominal pain (↓)	
	BP - 108/65 mmHg	
	PR - 80/min	
	SpO2 - 97% RA	
	CVC - S/S2 (+)	
	Rf - RAE (+)	
	P/A - S/14	
	Input: 606ml + Oral liquids	<p style="text-align: center;">Plan</p> <ol style="list-style-type: none"> 1) Continuous monitoring 2) Contact line care 3) iVf D/Ds - 30ml/hr 4) Pn/menopenem 5) Tab. pentop 6) Syr. sucralofate 7) Zylke gel 8) mupirocin oint 9) Tab methylpred BD 10) Trace reports 11) Spirometry 2nd half 12) Ambulation
	Output: 1cc/kg/hr	
	<p style="text-align: center;">15/6/26</p> <p style="text-align: center;">D. Preetham</p>	

Noted by Dr. P. K. P. M.
 17/6/26

Dr. Preetham



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/22 6:00pm	<p><u>C/S/B Resident</u></p> <p>Dis: sepsis MODSE hyperthermia, No fever spikes.</p>	
	<p>Central line removed. Plugged. IVF.</p>	<p>O/e</p> <p>Child Alert & Active Euthenic.</p>
	<p>O/I - Betser.</p>	<p>No CloAhd. pain. BP → 90/50 mmHg. HR → 100b/m. SpO2 → 97-99% RA.</p>
<p>Dr. Srinivas Dr. Srinivas 15/6/22 Spm</p>	<p>CU: 11/1 ⊕ PU: BLAC ⊕ PLA: kolt CU: NAP</p>	<p><u>plan</u></p> <ul style="list-style-type: none"> - Continuous monitoring. - Inj. meropenam - DS - Tab. panhop. - Syp. Sucragate. - Zyltegel - Tab. methylprednisolone P/O - 12 hourly - Rymeth eye drops - acetophi lotion - encourage Ambulation. - Spm Spirometry - and held.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Resident	
16/6/20		
9:10 AM	Ari: Separation of hyperferritinemia.	
	No fever.	
	No griddiness	
	No Abd. pain in the epigastric region	
2/1/20		↓ Intensifying.
	O/E	
4/1/20	Child Alert	
	BP: 90/60 (64)	Plan
	HR: 70-80b/m.	
	C/S: well	- Clf, Clf SP BP 2
	M: BLAC@	60, LFT - 1/m.
	Plt: well	
	C/S: well	- Ty - neuroprom-D6.
16/6/20		
		- Tab. paracetamol.
		- sup. Sacralate.
		- Tab. methylprednisolone.
		- Encourage Ambulation.
		- Encourage oral feed.
	Noted by	
	Bevonia	
	16/6 @ 2pm	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/20 3pm	<p style="text-align: center;">C/S by - Dr. Kumara</p>	
	<p> Severe with MODS with hypoperfusion no fuses o/p child awake CRT < 2 sec apheic aus - S, S, S RS - BAC, clear P/A - soft </p>	<p> Plan - Cont IV antibiotic - (SOs) IV fluids - Vitals holy </p>
<p> Strict i/o charting Hourly BP: Inform if < 90/50 Tr fluids - SOs. </p>	<p> CBP CRP RPR ADT </p>	<p> Same (Dr. Sameer) </p>
<p> 7/m. 16/6/20 3pm </p>	<p> Dr. Kumara 16/6/20 3pm </p>	<p> Noted by Anette 16/6 @ 4pm </p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/R Resident	
17/10/2017 8 AM	Sepsis in MODS with hyperferritinemia no fever spikes. ofc child awake/alert CRT < 3 sec Vitals stable Afebrile CVS - S1S2 (+) R/L - RAE (+) Bp: 102/58 mmHg Pla - soft CNS - NAD.	
		plan
	oral intake better u/o: 1.7cc/kg/hr stool (+)	1) Pril Mepremem D ₂ + Add oral Cefixime x 5d. 2) Atorax loted 3) Mupirocin oint 4) Zyrtec gel 5) Tab pantoprazole 6) Tab. methylpred D ₃ 14 7) Syr. Sucralofate 8) Refresh eye drops 9) cephal lotion 10) Ufloride - nos. 11) -syr cyclopam - 5d
	a/s TODAY Review after 3 days. Dr. Swaminath 17/10/2017 10 AM	Noted by Rishi @ 10 AM 17/10/2017

ULTRA SOUND ABDOMEN REQUEST FORM

PICU

11/05/2026

AFTERNOON

PATIENT NAME :

VIH-00151395 IP-00060308
Baby T SRI VISHWAIKA
29-10-2017 8 Y 7 M 13 D (F)
Dr. PREETHAM KUMAR

DATE:



LIVER : Normal in size ^{11cm} and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal. ^{Mildly thickened gall bladder wall}

SPLEEN : Normal in size ^{9.3cm} and echotexture.

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

KIDNEYS : Right kidney : ^{83x35} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : ^{89x41} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal. No ascites / Lymphadenopathy.No evidence bowel wall thickening /edema.

IMPRESSION: ~~No obvious sonological abnormality in abdomen.~~

~~Rest unremarkable~~

1) Mildly edematous wall of GB

Suggested clinical correlation.

2) Rest unremarkable.

DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

DR VAISHNAVI REDDY B (MD)

(Consultant Radiologist)

Patient Name	Baby T SRI VISHWAIKA	Patient Ph. No	9908692120
Age	8 Y 7 M 13 D	Requisition No	R26-009368
Gender	Female	Billed on	11-06-2026 12:52 PM
IP / Bill No.	IP-00060308	Scanned on	11-06-2026 01:00 PM
UHID No.	VIH-00151395	Reported on	11-06-2026 01:00 PM
Ref. Doctor	PREETHAM KUMAR	Ward / Bed No	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	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	Normal
PDA	Normal
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 11-06-2026 01:00 PM

Printed By : RANGANATH
RELANGI

Page: 1 of 3

For Further Details
Scan QR Code



Patient Name	Baby T SRI VISHWAIKA	Patient Ph. No	9908692120
Age	8 Y 7 M 13 D	Requisition No	R26-009368
Gender	Female	Billed on	11-06-2026 12:52 PM Page: 1 of 3
IP / Bill No.	IP-00060308	Scanned on	11-06-2026 01:00 PM
UHID No.	VIH-00151395	Reported on	11-06-2026 01:00 PM
Ref. Doctor	PREETHAM KUMAR	Ward / Bed No	

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	1.7		Tricuspid Annulus		
LA	1.9		Mitral Annulus		
IVSd	0.7		Aortic Annulus		
LVIDd	3.5		PA Annulus		
LVPWd	0.7		RPA		
IVSs	1.0		LPA		
LVIDS	2.1		MPA		
LVPWs	1.3		AO Isthmus		
EF	69%		LV Mass		
FS	35%		Others		

Impression

SITUS , SOLITUS, LEVOCARDIA
STRUCTULLY NORMAL HEART
NORMAL SIZED CARDIAC CHAMBERS
GOOD BIVENTRICULAR FUNCTION
LEFT ARCH , NO COA



Patient Name	Baby T SRI VISHWAIKA	Patient Ph. No	9908692120
Age	8 Y 7 M 13 D	Requisition No	R26-009368
Gender	Female	Billed on	11-06-2026 12:52 PM Page: 2 of 3
IP / Bill No.	IP-00060308	Scanned on	11-06-2026 01:00 PM
UHID No.	VIH-00151395	Reported on	11-06-2026 01:00 PM
Ref. Doctor	PREETHAM KUMAR	Ward / Bed No	

Dr. NAGESWARA RAO KONETI

MBBS,MD,DM,FELLOWSHIP IN PAEDIATRIC CARDIOLOGY
Reg No: 19320

11-06-2026 12:52 PM Page: 2 of 3

11-06-2026 01:00 PM

11-06-2026 01:00 PM

NAGESWARA RAO KONETI

PAEDIATRIC CARDIOLOGY
Reg No: 19320

11-06-2026 01:00 PM Page: 2 of 3

11-06-2026 01:00 PM

11-06-2026 01:00 PM

NAGESWARA RAO KONETI

PAEDIATRIC CARDIOLOGY
Reg No: 19320

11-06-2026 01:00 PM Page: 2 of 3

11-06-2026 01:00 PM

11-06-2026 01:00 PM

Note: Clinically Correlate, Kindly discuss if necessary.



ANTIBIOTIC JUSTIFICATION FORM

Date of Admission: 11/6/20

Antibiotic Name	Date & Time	Reason	48 Hours Culture	Antibiotic Reviewed at 72 Hours (If No Please Justify)
1. Meropenem	10/6/20	Sepsis + MRSA suspicion	Awaited	
2.				

<p>A. Reasons for Starting Empirical Antibiotics:</p> <ol style="list-style-type: none"> Preterm's with risk factors: <ol style="list-style-type: none"> PPROM Positive Maternal Culture (HVS/Urine C/S Maternal Pyrexia / Chorioamnionitis Term Babies <ol style="list-style-type: none"> PROM > 18 hours Sepsis Screen Positive at 12 hours <ol style="list-style-type: none"> High TLC/ High CRP / High PCT / Thrombocytopenia / Leukopenia Shift to left / Band forms / Neutrophilia on PS Out born with suspected sepsis Culture negative Sepsis 	<ol style="list-style-type: none"> Clinical Sepsis <ol style="list-style-type: none"> Frequent Apnoea's attributed to suspected sepsis Hemodynamic instability Temperature instability Suspected NEC Lethargy VAP Congenital Pneumonia Meningitis Aspiration Pneumonia Any sick newborn 	<p>B. Prophylactic Antifungals</p> <p>B1 – Extreme PT (<28 Weeks) or ELBW (<1000 grams) B2 – Central line in situ (PICC / UVC) in < 28 weeks & < 1kg. B3 – Septic Shock</p> <p>C. Culture Positive Sepsis</p>
---	--	---

Consultant Name & Signature :

Name & Signature of Infection Control Nurse :

Date & Time : 11/6/20

Date & Time : 11/6/20

..... Date & Time :
 Consultant Name & Signature :

..... Date & Time :
 Name & Signature of Infection Control Nurse :

- A. Reasons for Starting Empirical Antibiotics:**
1. Preterm's with risk factors:
 - a. PROM
 - b. Positive Maternal Culture (HSV/Urine C/S)
 - c. Maternal Pyrexia \ Chorioamnionitis
 2. Term Babies
 - a. PROM < 18 hours
 - b. Sepsis Screen Positive at 12 hours
 - i. High TLC\ High CRP \ High PCT \ Thrombocytopenia \ Leukopenia
 - ii. Shift to left \ Band forms \ Neutrophilia on PS
 3. Out born with suspected sepsis
 4. Culture negative Sepsis

5. Clinical Sepsis
- a. Frequent Apnoea's attributed to suspected sepsis
 - b. Hemodynamic instability
 - c. Temperature instability
 - d. Suspected NEC
 - e. Lethargy
 6. VAP
 7. Congenital Pneumonia
 8. Meningitis
 9. Aspiration Pneumonia
 10. Any sick newborn

- C. Culture Positive Sepsis**
- B3 - Sepsis Shock > 1kg.
 B2 - Central line in situ (PICC \ UVC) in > 28 weeks & or
 B1 - Extreme PT (> 28 Weeks) or ELBW (> 1000 grams)
- B. Prophylactic Antibiotics**

Antibiotic Name	Date & Time	Reason	48 Hours Culture	Antibiotic Reviewed at 72 Hours (If No Please Justify)

..... Date of Admission:

ANTIBIOTIC JUSTIFICATION FORM



PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)



Patient Name: Baby + Sri V. Sridharan Gender: Male Female UHID No: 60308/151396 Age: 8y

Date: 11/12/20 In-Time: 12:30 AM Out-Time: 12:45 AM

Doctor Performing Procedure: Dr. Smity Doctor Giving Sedation: Dr. Smity Assisting Nurse: Bo-N.R.

SIGN IN	Time:	Yes	No	NA
Patient is verified using two identifiers (Name & UHID)		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All required documents, images, studies are available		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPO Status Checked from Patient / Patient Attendant		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent is Signed		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any need for blood products		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If Yes Comment:				
Any Risk of Hemodynamic Compromise		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If Yes Comment:				
Any drug or food allergy		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If Yes Comment:				
Correct Site of Procedure Marked		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All resources required are correct, available and functioning		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signature of the Doctor:				
Name of the Doctor:				

TIME OUT	Time:	Yes	No	NA
Correct Patient		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correct Site		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correct Procedure		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All the team members introduced		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signature of the Nurse: <u>Bo-N.R.</u>				
Name of the Nurse: <u>Bo-Nandyan</u>				

SIGN OUT	Time:	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrument, Sponge and Needle Count Completed		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specimens are labeled		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any equipment problems are addressed		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Signature of the Nurse: <u>Bo-N.R.</u>				
Name of the Nurse: <u>Bo-Nandyan</u>				

Any Adverse / Unexpected Events

.....

.....

.....

PROCEDURE CHECK LIST

VIH-00151395 IP-00060308
Baby T SRI VISHWAIKA
29-10-2017 8 Y 7 M 13 D (F)
Dr. PREETHAM KUMAR

Date: 12/6/26



Ward

PICU NICU ER Other: _____

Procedure Name: _____

Diagnosis: Mds c septic shock.

Procedure done by: Dr. Sweety

Assisted by: _____

PROCEDURE CARE BUNDLE COMPLIANCE

Barrier precautions	
Hand wash	<u>Y/N</u> _____
Gown	<u>Y/N</u> _____
Mask & cap	<u>Y/N</u> _____
Gloves	<u>Y/N</u> _____
Eye protection	<u>Y/N</u> _____

Skin preparation done using:

1. Betadine

2. Bactoprep

Procedure related equipment check list (as per procedure)

Airway/ Nasal prongs	<u>Y/N</u> _____	Monitor: QRS volume audible	<u>Y/N</u> _____
Oxygenation: Ambu/Bains	<u>Y/N</u> _____	BP autocycling	<u>Y/N</u> _____
Mask (appropriate size)	<u>Y/N</u> _____	SpO2	<u>Y/N</u> _____
Laryngoscope with blade	<u>Y/N</u> _____	Medication: Sedation/Analgesia	1. _____
			2. _____
ET tube/LMA (appropriate size)	<u>Y/N</u> _____	Paralysis	<u>Y/N</u> _____
Oxygen connectors	<u>Y/N</u> _____	Adrenaline	<u>Y/N</u> _____
Suction apparatus	<u>Y/N</u> _____	Atropine	<u>Y/N</u> _____

Post procedure care bundle compliance

Have all the sharps been disposed? Y/N _____
 Was the sterile field maintained? Y/N _____
 Has the procedure been documented? Y/N _____

Monitoring after procedure

yes. vitals monitor

Adverse events - Y/N

If yes, details _____

Position check required - Y/N

If yes, details _____

Please attach this to the patient file)

Signature of Doctor



HOUR-1 SEPSIS BUNDLE

Patient Location: Emergency Room

PICU

NICU

Date:

Bundle Initiation Time:

1. **Recognition of Early Sepsis: Time to be mentioned:**

Identify signs of Pediatric Sepsis

Fever > 38.50C

Hypothermia <36 C

Tachycardia

Bradycardia

Hypotension

Altered Mental Status

Delayed Capillary Refill

Cool extremities

2. **Obtain Vascular Access: Time to be mentioned:**

Peripheral IV Access

EJV

Central Line

3. **Labs and Cultures: Time to be mentioned:**

Blood Culture before Antibiotics Lactate Levels Mention the level.....

CBP

CRP

Coagulation profile

Blood Gas

4. **Administer Broad Spectrum Antibiotics: Administer within 60 minutes of sepsis recognition.**

Confirm antibiotic indication: Sepsis Suspected sepsis shock

Confirm patient drug allergy status No (Not known any drug allergy)

Yes, if yes mention the name of the Drug.....

Determine the likely source of Infection:

Respiratory

Urinary

Abdominal

CNS

Skin /Soft Tissue

Unknown

Select appropriate empiric antibiotic(s) based on:

Suspected Source

Local Antibigram / Resistance Patterns

Patient History (e.g. immunocompromised, recent hospital stay, indwelling devices)

Record exact time, dose and route of Antibiotic Administration.....

5. **Fluid resuscitation: Time to be mentioned:**

Give 10 mL/kg of isotonic crystalloid (NS or LR) bolus over 20 minutes

Reassess after each bolus (lung sounds, perfusion)

Up to 60 mL/kg in first hour if no signs of fluid overload

6. **Vasopressors Needed :**

Yes

No

Shock Persisting:

Yes

No

IV Fluid Bolus Administered

Yes

No

Mention the Fluid Administered to the Patient along with dose, Route and Time

.....

7. **Monitoring Vitals till patient stabilizes.**

Every 15 minutes if vitals are unstable

Every 1 hourly if vitals are stables

Doctor: Signature: Name: Date & Time:

Nurse: Signature: Name: Date & Time:

RESTRICTED ANTIMICROBIAL USE JUSTIFICATION FORM

Patient Name : Age : Gender : Male Female

UHID No. : Department: Date of Admission:

Diagnosis :

Brief Clinical History:

--

Clinical Features & Relevant Investigations Suggestive of Infection

Date					
Fever					
Other C/F					
HB					
TLC					
N,L,E					
PLT					
CRP					
PCT/ESR					
WIDAL					
MP Optimal					
WEIL-FELIX					
CUE					
BODY FLUID CYTOLOGY					
LATEX					

Restricted Antimicrobial Use

Antimicrobial	Date	DOA	Justification	Antimicrobial	Date	DOA	Justification
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Any Other Comment:

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

Elaboration:

If no please justify

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 ion(>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	Suspected Septic Shock-hit First Hit hard Policy	16	Immunosuppression
17	Other	17	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	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	Suspected Septic Shock-Hit First Hit Hard Policy
		L8	Others

Signature of Consultant

Signature of Microbiologist

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Baby T. Sri Vishwakha Gender: Male Female

UHID No : 151395 Department : PICU Date : 11/06/26

I T. Shobha S/D/W/O T. Raj Kumar

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

For my patient, Named : vishwakha

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

- foreign sensation
- mild discomfort.

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 : T. Shobha

Relationship with Patient: mother

Date & Time : 11/06/26 @ 1AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Sweety

Date & Time : 11/06/26 @ 1AM

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 : Baby T. Sri Vishwika Gender: Male Female

UHID No : 151395 Department : PICU Date : 11/06/26

I T. Shobha S/D/W/O T. Ray Kumaran

Here by give consent for procedure of : Central line insertion

For my patient, Named : vishwika

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

- pneumothorax
- bleeding

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 : T. Shobha

Relationship with Patient: mother

Date & Time : 11/06/26 @ 11Am

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : CH. Ganesh

Date & Time : 11/06/26 @ 11Am

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 రోగికి, 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 : Baby T. Sri Vishwaika Gender: Male Female

UHID No : 151395 Department : PICU Date : 11/06/26

I T. Shobha S/D/W/O T. Raj Kumar

Here by give consent for procedure of : Arterial line -

For my patient, Named : Vishwaika

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

- Gangrene (rare)
- Thrombosis
- Blue limbs.

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

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 : T. Shobha

Relationship with Patient: mother

Date & Time : 11/06/26 @ 1AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Arshvam

Date & Time : 11/06/26 @ 1AM

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 రోగికి, 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 SEDATION



Patient Name: Baby T. Sri Vishwajika Gender: Male Female
UHID No: 151395 Department: PLU Date: 11/06/26

I, T. Shabha S/D/W/O T. Rajkumar
Here by give consent for procedure for my patient: Central & Arterial lines

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : Intravenous.
- Possible complications from the procedure of sedation:
Peri depression

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

Patient Attendant :
Signature : [Signature]
Name : T. Shabha
Relationship with Patient: Mother
Date & Time : 11/06/26 @ 1 AM

Witness :
Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :
Signature :
Name :
Date & Time : 11/06/26 @ 1 AM

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

Name: Baby T. Sri Vishwaika Age: 8y Gender: Male Female
 UHID.No: 151395 Date: 11/06/26

I, T. Shobha S/o, D/o, W/o, T. Rajkumar hereby
T. Vishwaika who is related to me as _____

declare that our patient Master/Baby _____ is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 10/6/2026.
 The doctors have explained to me in a language understood by me that my child has following health related issues :
Liver transplants
Shock.

The doctors have clearly explained to me that my patient Master / Baby Vishwaika 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 : Vishwaika _____ 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.

Patient Attendant :
 Signature: [Signature]
 Name: T. Shobha
 Relationship with Patient: Mother
 Date & Time: 11/06/26 @ 1Am

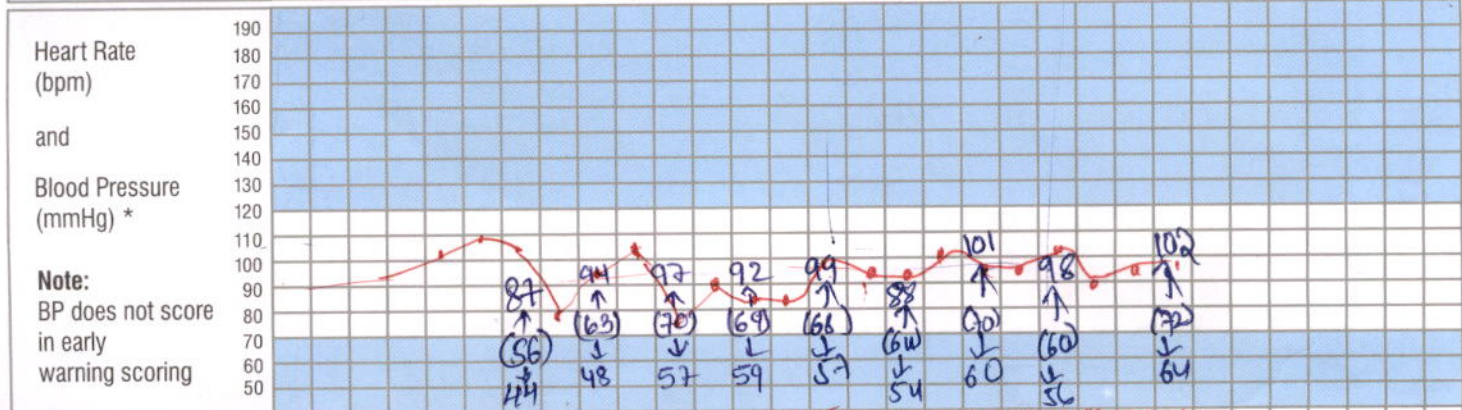
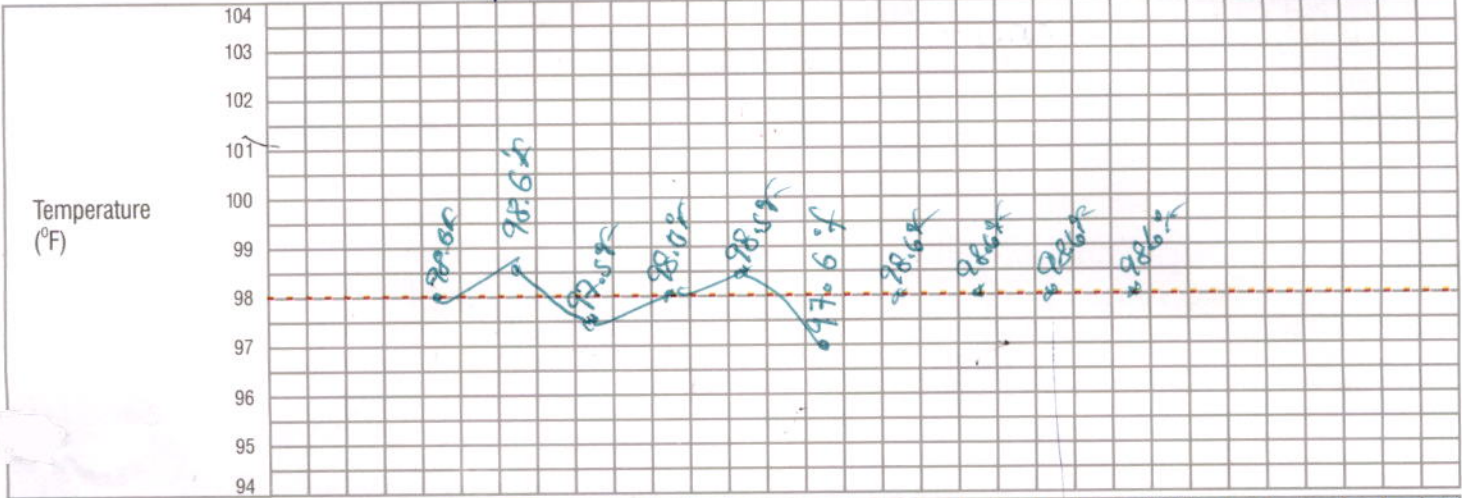
Witness
 Signature
 Name
 Date & Time

Doctor (who is taking the consent) :
 Signature: [Signature]
 Name: Dr Swathy
 Date & Time: 11/06/26 @ 1Am

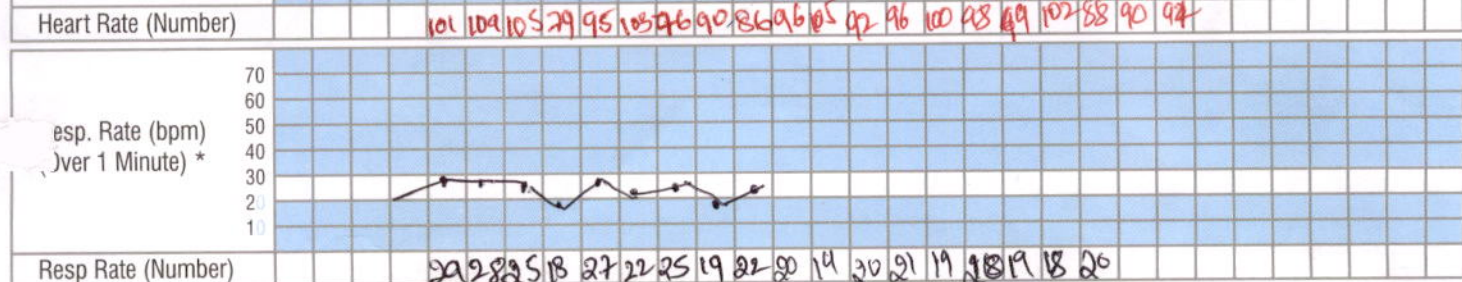
Date & Time: 11/06/26

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 14/6..... Time:	12	2	4	6	8	10	12	2	4	7
Doctor / Nurse / Family Concern?	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM



Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)	101	109	105	79	95	105	96	90	86	96	85	92	96	100	98	99	102	88	90	97
Resp Rate (Number)	22	22	25	22	25	19	22	20	14	20	21	19	18	19	18	20				
Resp Mod/ Severe Distress																				
Receiving O ₂ (l/min)																				
O ₂ Saturations (%)	96	97	99	100	96	98	97	99	96	97	98	97	96	97	98	97	96	97	99	98
Conscious Level	N	N	N	N	N	N	N	N	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	15	15	15	15	15	15	15	15

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

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

* NB: 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:

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- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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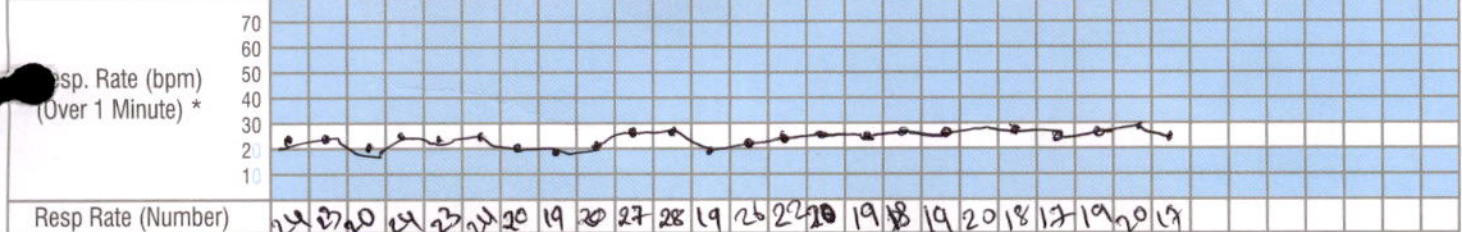
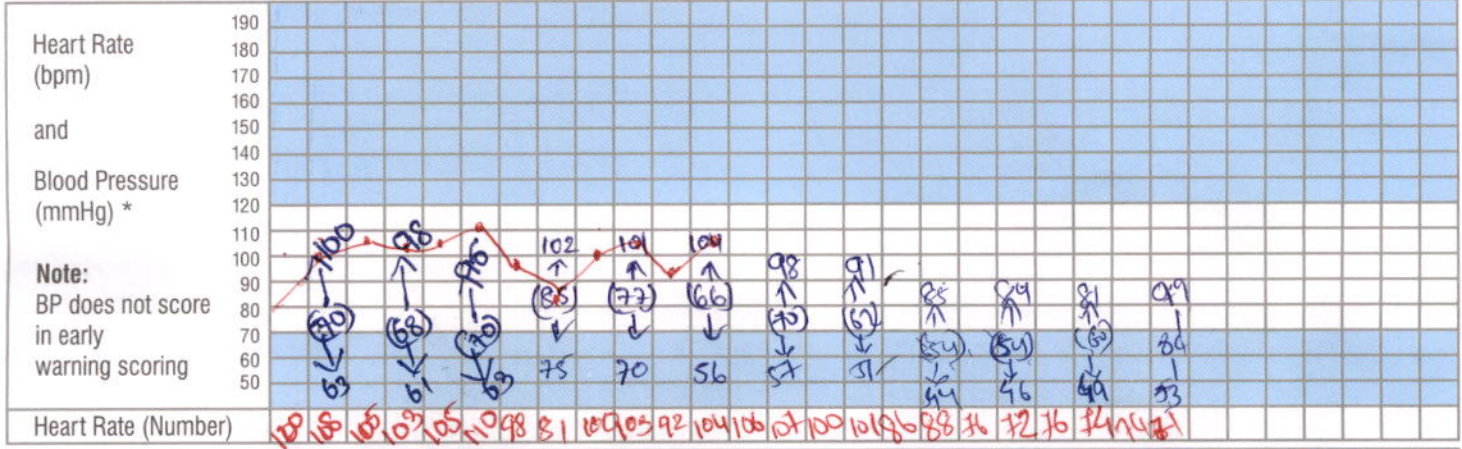
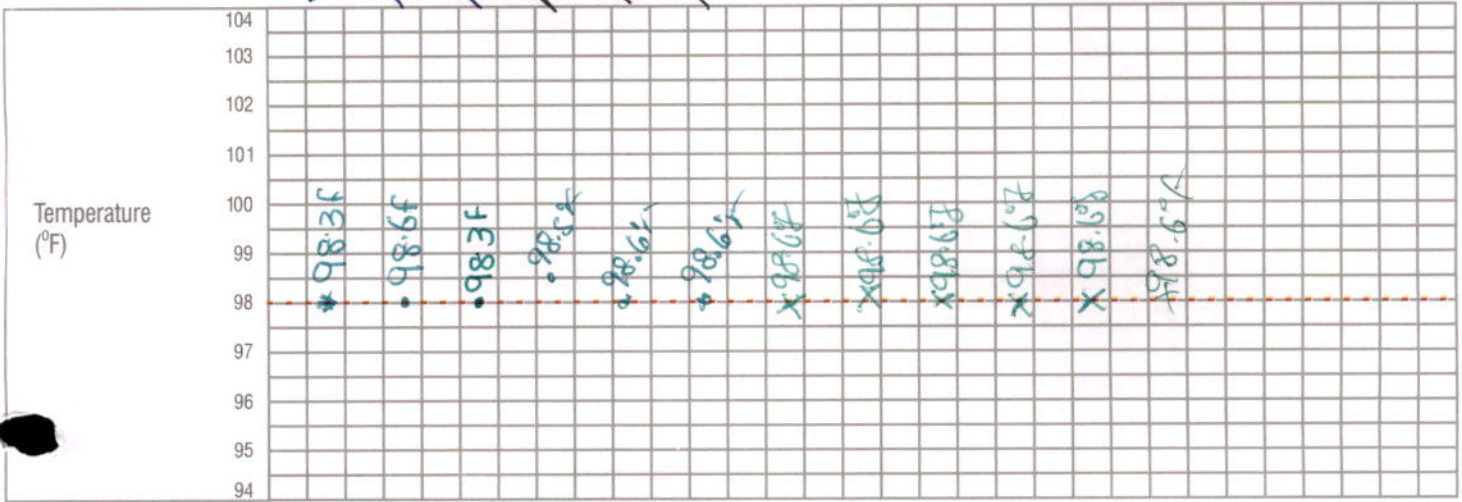
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A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/10	Time: 9	11	1	3	5	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?	Am	Pm	Pm	Pm	Pm	Pm	Pm	Pm	Am	Am	Am	Am



Resp Distress	Mod/ Severe	None / Mild																				
Receiving O ₂ (l/min)	O ₂ Saturations (%)		99	99	98	98	97	100	98	100	99	98	99	99	100	100	99	100	98	98	98	98
Conscious Level	Normal / Altered		N	N	N	N	N	N	N	N	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	15	15	15	15	15	15	15	15

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

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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Date	Time	Early Warning Score	Date	Time	Name

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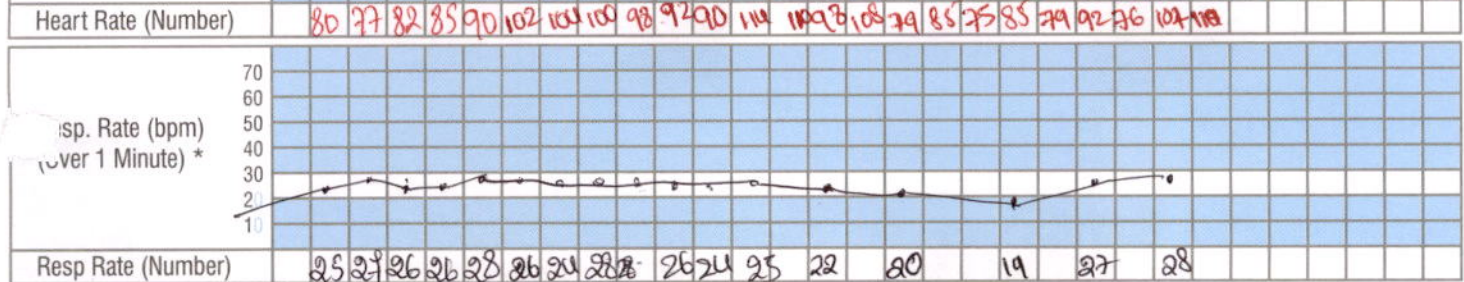
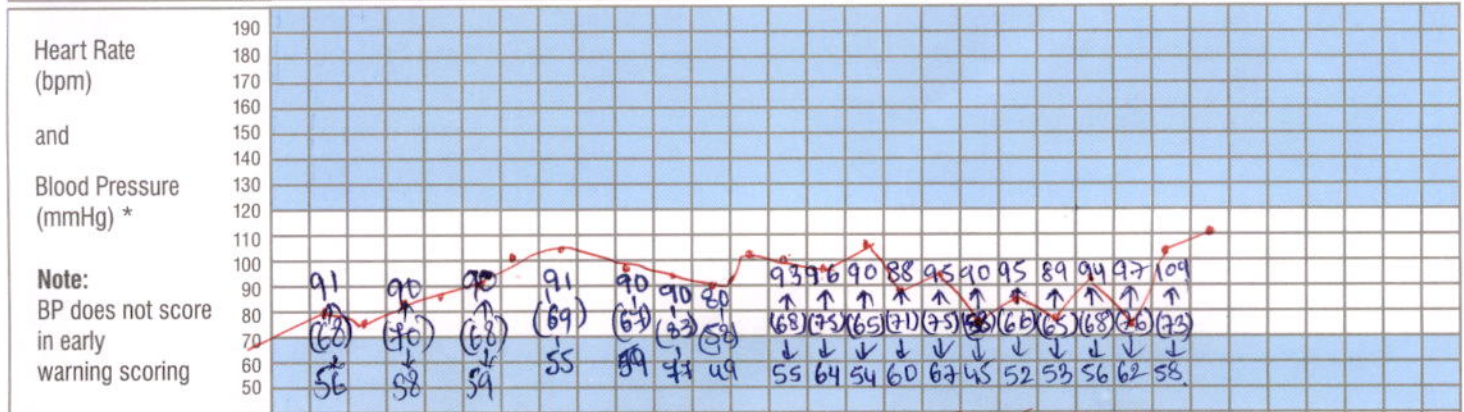
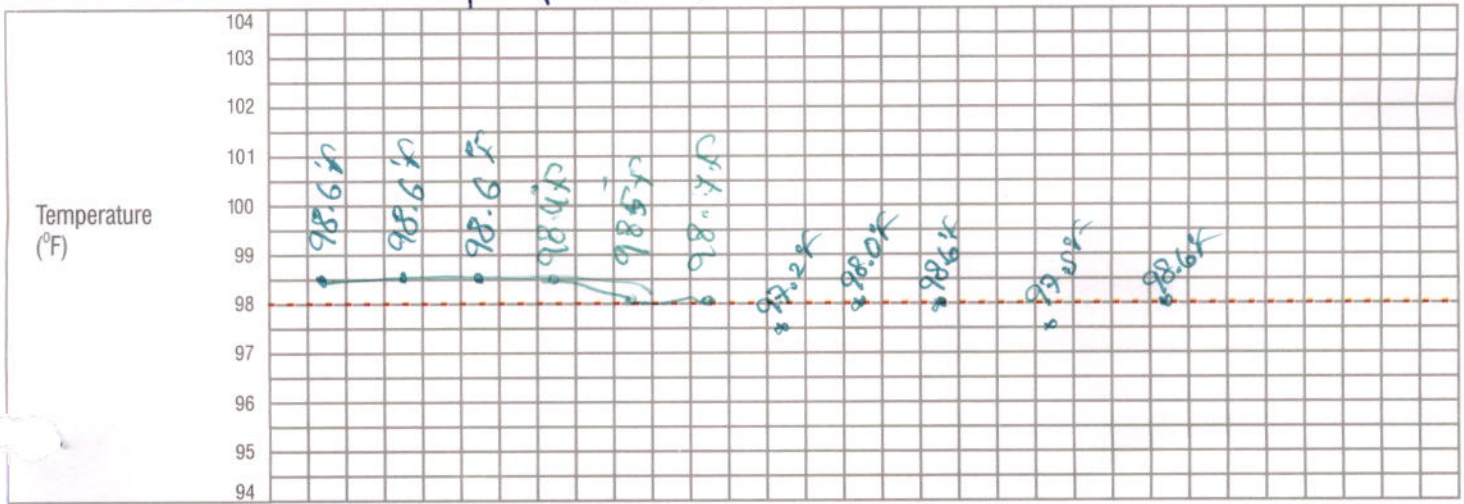
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/6 Time:	9	11	1	3	5	7	9	10	11	12	1	2	3	4	5	6	7	8
Doctor / Nurse / Family Concern?	am	am	pm	pm	pm	pm	pm	pm	pm	am	am	am	am	am	am	am	am	am



Resp Distress	Mod/ Severe	None / Mild	N	N	N	N	N	N	H	H	N	N	H	H								
Receiving O ₂ (l/min)	O ₂ Saturations (%)		99	97	98	99	97	97	98	99	100	98	99	98	97	100	100	99	98	95	100	98
Conscious Level	Normal / Altered		N	N	N	N	N	N	H	H	N	N	H	H								
GCS *			15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15

TOTAL SCORE																						
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	B	B	B	SA	SA	SA	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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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. : 1

14/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	Route	NS	NG	Diarrhoea	Vomit	Drainage	Urine			
13/6/26			Mouth	Oral +V	NS NG								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am				Oral								
	12:00 pm		water		30ml					✓			
01:00 pm				30ml									
Total Intake :			60 ml			Total Output :							
14/6/26	02:00 pm			30ml									
	03:00 pm		water	30ml									
	04:00 pm			30ml									
	05:00 pm			30ml									
	06:00 pm			30ml									
	07:30 pm			30ml						165ml			
Total Intake :			180ml			Total Output :							
14/6/26	08:00 pm			30ml	0.5ml								
	09:00 pm		rice water	30ml	0.5ml								
	10:00 pm			30ml	0.5ml								
	11:00 pm				0.5ml					305ml			
	12:00 am				0.5ml								
	01:00 am				0.5ml								
Total Intake :						Total Output :							
15/6	02:00 am				0.5ml								
	03:00 am				0.5ml								
	04:00 am				0.5ml								
	05:00 am				0.5ml								
	06:00 am				0.5ml					300ml			
	07:00 am				0.5ml								
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output 770 ml (1.1 cc/ml/kg) over 18 hrs

16/06

Hand - 71/41 (54)
79/39 (48)

leg - 98/46 (63)
98/48 (62)

Sitting position - 85/44 (54)
81/46 (54)

FLUID CHART

Sheet No. : (2)

16/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thromboprophlebitis Score	Sign. Nurse	
			Mouth	I.V	NG	Diarrhoea	Vomit	Drainage	Urine				
15/6					N.G								
	08:00 am			30ml	0.5ml					930ml		} 2 order @ 9pm 15/6/26	
	09:00 am	Idly		30ml	0.5ml								
	10:00 am	Idly + water		30ml	0.5ml					910ml			
	11:00 am			30ml	0.5ml								
	12:00 pm			30ml	0.5ml								
01:00 pm									200ml				
Total Intake :			150ml	1.5ml		Total Output :					640ml		
15/6	02:00 pm									278ml	} Subham @ 9pm 15/6/26		
	03:00 pm									285			
	04:00 pm	Rice + water											
	05:00 pm									328ml			
	06:00 pm												
	07:00 pm									167ml			
Total Intake :						Total Output :					991ml		
	08:00 pm									154ml	} Subham on 16/6/26 @ 8AM		
	09:00 pm												
	10:00 pm	Rice + water								240ml			
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :					394ml		
	02:00 am									250ml	} Subham on 16/6/26 @ 8AM		
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am									300ml			
	07:00 am									210ml			
Total Intake :						Total Output :					760ml		

Total 24 hrs. Intake 151.5ml

Total 24 hrs. Output 2575 (3056/18)
 + 260
 = 2785



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
16/6	08:00 am						<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		Subher 16/6/20
	09:00 am					<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm								290ml			
Total Intake :						Total Output :						
16/6	02:00 pm											Subher 16/6
	03:00 pm		Rice						178 ml			
	04:00 pm		water									
	05:00 pm		Juice									
	06:00 pm		ORS						172 ml			
	07:00 pm								400 ml			
Total Intake :						Total Output :						750 ml
16/6	08:00 pm											Subher 16/6/20
	09:00 pm		Rice						256ml			
	10:00 pm		water									
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						256 ml
17/6	02:00 am								200 ml			Subher 17/6 @ 7 AM
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am								177 ml			
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output			1603 ml (1.7 cc/kg)			

FLUID CHART

Sheet No. : 4

17/6/20

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.

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
29/6/17	08:00 am	Fdy water							10ml		1 0 1 0 0 0 0	Sudh Sudh Sudh Sudh Sudh Sudh Sudh
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

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

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

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

VIH-00151395 IP-00060308
 Baby T SRJ VISHWAIKA (F)
 29-10-2017 8 Y 7 M 13 D
 Dr. PREETHAM KUMAR



DRUG CHART

Date of Admission: 11/06/26 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 : INJ PARACETAMOL				Date/Time	11/6	11/6	11/6	11/6												
Dose	Route	Frequency	Start Date		7A	3PM	8PM	11A												
570mg	IV	6HOURLY	11/6/26		15	15	15	15												
Doctor's Signature		Valid Period	Pharm																	
Additional Instructions:																				
		@ 10-15 mg/kg/dose.																		

DRUG : SYP PARACETAMOL				Date/Time	11/6															
Dose	Route	Frequency	Start Date																	
5ml	PO	6HOURLY	13/6/26																	
Doctor's Signature		Valid Period	Pharm																	
Additional Instructions:		(SYP P-500)																		
		(5ml 500mg) (10-15 mg/kg/dose)																		

DRUG :				Date/Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY : Name Chithy 11/6/26
 at ST
 13/6/26



REGULAR PRESCRIPTIONS

Weight 38kg Ward P.I.E.U

Rajyalakshmi D. Debbala 11/06/26
 Rajyalakshmi Debbala 11/6/26
 Rajyalakshmi Debbala 11/6/26
 Rajyalakshmi Debbala 11/6/26

DRUG : INJ. MEROPENEM.				Date
				Time
Dose	Route	Frequency	Start Date	11/6
1.5gm	IV	8 Hourly	11/6/2026	11/6 12/6 1/6 2/6 3/6 4/6 5/6 6/6
Name & Signature of the Doctor Starting the Drugs:				11/6 AM PM 12/6 AM PM 1/6 AM PM 2/6 AM PM 3/6 AM PM 4/6 AM PM 5/6 AM PM 6/6 AM PM
Additional Instructions:				10 AM PM 12 AM PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM
Daily Doctor's Endorsement by a Sign				D1 D2 D3 D4 D5 D6

DRUG : INT VANCOMYCIN				Date
				Time
Dose	Route	Frequency	Start Date	11/6
750mg	IV	6 Hourly	11/6/2026	11/6 12/6 1/6 2/6 3/6 4/6 5/6 6/6
Name & Signature of the Doctor Starting the Drugs:				6 AM PM 12 AM PM 6 AM PM 12 AM PM 6 AM PM 12 AM PM 6 AM PM 12 AM PM
Additional Instructions:				13/6/2026 P
Daily Doctor's Endorsement by a Sign				

DRUG : INJ PANTOPRAZOLE				Date
				Time
Dose	Route	Frequency	Start Date	11/6
40mg	IV	12 Hourly	11/6/2026	11/6 12/6 1/6 2/6 3/6 4/6 5/6 6/6
Name & Signature of the Doctor Starting the Drugs:				2 AM PM 12 AM PM 1 AM PM 2 AM PM 12 AM PM 1 AM PM 2 AM PM 12 AM PM
Additional Instructions:				2 PM 12 PM 1 AM
Daily Doctor's Endorsement by a Sign				

DRUG : INJ VITAMIN K				Date
				Time
Dose	Route	Frequency	Start Date	11/6
10mg	IV	ONCE DAILY	11/6/2026	11/6 12/6 1/6 2/6 3/6 4/6 5/6 6/6
Name & Signature of the Doctor Starting the Drugs:				2 AM PM 12 AM PM 1 AM PM 2 AM PM 12 AM PM 1 AM PM 2 AM PM 12 AM PM
Additional Instructions:				x3 days @ 0.3mg/kg/dose.
Daily Doctor's Endorsement by a Sign				

Weight. 38.6 kg Ward. plw



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/6/26	12:30 AM	IVF NS SOLU	400 ml.	IV	sf	IVF Pant
11/6/26	11:30	PLASMAYTE	200 ml	IV	sf	IVF Pant
11/6/26	12:15	PLASMAYTE	200 ml	IV	sf	IVF Pant
11/6/26	2 AM	INS VITAMIN K	10 mg	IV	sf	IVF Pant
11/6/2024	7:37 AM	INS METHY PREDNISOLONE	75 mg	IV	hu	IVF Pant
11/6/26	9 AM	INS METHY PREDNISOLONE	300 mg	IV	hu	IVF Pant
11/6/26	10 AM	INS THIAMINE	100 mg	IV	hu	IVF Pant
11/6/26	9:30 AM	INS TRAMADOL	40 mg	IV	sf	IVF Pant
11/6/26	10:30 AM	INS TRAMADOL	35 mg	IV	sf	IVF Pant

VERIFIED BY : Name

Prof. Preetham Kumar 11/06/26

I.V. FLUIDS CHART

Weight: PKG Ward: 38 Key

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
10/6/20	12:20 AM	IVF - DNS fuu(m)	IV	40ml/hr	R	Sushree Rinta	11/6/26		
11/6	4 AM	IVF (80%) DNS + 5ml Kcl	IV	60ml/hr		Rinta Rinta	11/6/26		
		IVF (All total) 60% DNS + 5ml ka	IV	40ml/hr					
11/06/26	10 AM	2ND FURROSEMIDE 9.6ml + 12.4ml NS 1ml = 4mg (0.5ml = 2mg) 0.5mg/kg/hr = 0.3ml/kg/hr 0.5 - KES 3ml/hr	IV	0.53		Jay J	12/6/26		Bans J
11/6/26	12 PM	IVF DNS + 5ml kcl	IV	38ml/hr		Jay J	11/6		N. S Rinta
11/6/26	10 PM	IV Fluid DNS + 10ml Kcl	IV	38		N. S Rinta	12/6		Jay J
12/6	8 AM	IV Fluid DNS + 7.5ml Kcl	IV	38		Jay J	12/6		Jay J
12/6	9 PM	IVF DNS + 5 ml kcl	IV	30		Jay J	12/6 4:30 PM		Bans Kishore
12/6	6 PM	IVF DNS + 5ml Kcl	IV	30		Bans Kishore	13/6		Jay J

Signature
VERIFIED BY : Name

VH-00151395 IP-00060308
 Baby T SRJ VISHWAIKA
 Patient 29-10-2017 8 Y 7 M 13 D (F)
 Dr. PREETHAM KUMAR



I.P. No. Sheet No. Wards Weight (kg)
 ① P10 38kg

REGULAR PRESCRIPTIONS

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

DRUG	Dose	Route	Frequency	Start Dt.	Date	Time
INS METHYLPREDNISOLONE	380mg	IV	once	12/6/26	12/6	13/6
Name & Signature of the Doctor starting the Drugs: @ Dr Shiwam						
Additional Instructions: Dilute in 20ml NS over (10mg/kg/dose) 1hour						
Daily Doctor's Endorsement by a Sign.						

DRUG	Dose	Route	Frequency	Start Dt.	Date	Time
INS PANTOPRAZOLE	40mg	IV	12 th ly	11/6/26	11/6	12/6
Name & Signature of the Doctor starting the Drugs: @ Dr Shiwam						
Additional Instructions: 1mg/kg/dose						
Daily Doctor's Endorsement by a Sign.						

DRUG	Dose	Route	Frequency	Start Dt.	Date	Time
SYP. STARAX	Sml	PO	1 st 1 st ly	12/06	12/6	13/6
Name & Signature of the Doctor starting the Drugs: Dr. M. S. Sreedhar						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign.						

Dr. Preetham Kumar 12/6/26 at 7:30
 Chitra 12/6/26
 Dr. Shiwam 11/6/26
 Dr. M. S. Sreedhar 12/6/26 at 7:30

Dr. Preetham Kumar 12/6/26 at 7:30
 Chitra 12/6/26
 Dr. Shiwam 11/6/26
 Dr. M. S. Sreedhar 12/6/26 at 7:30



Patient Name :



I.P. No.

Sheet No.

Wards

Weight (kg)

2

PICW

38.5kg

REGULAR PRESCRIPTIONS

DRUG : ANAP Lotion

Dose	Route	Frequency	Start Dt.	Date								
				Time	12/6	13/6	14/6	15/6	16/6	17/6		
4A	4A	8 TTY	14/6	6 AM	X	X	X	X	X	X		
Name & Signature of the Doctor starting the Drugs:				2 PM	X	X	X	X	X	X		
Additional Instructions:				10 PM	X	X	X	X	X	X		
Daily Doctor's Endorsement by a Sign.												

DRUG : Mupirocin oint

Dose	Route	Frequency	Start Dt.	Date								
				Time	12/6	13/6	14/6	15/6	16/6	17/6		
4A	4A	8 TTY	12/6	6 AM	X	X	X	X	X	X		
Name & Signature of the Doctor starting the Drugs:				2 PM	X	X	X	X	X	X		
Additional Instructions:				10 PM	X	X	X	X	X	X		
Daily Doctor's Endorsement by a Sign.												

DRUG : 2m. METHYL PREDNISOLONE

Dose	Route	Frequency	Start Dt.	Date								
				Time	14/6 <th colspan="5"></th>							
75mg	IV	ONCE DAILY	14/6									
Name & Signature of the Doctor starting the Drugs:												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign.												

DRUG : 2m. METHYL PREDNISOLONE

Dose	Route	Frequency	Start Dt.	Date								
				Time	14/6							
75mg	IV	ONCE DAILY	14/6									
Name & Signature of the Doctor starting the Drugs:												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign.												


Tandu 12/6/26 Dr. Preetham at 7:30N

Tandu 12/6/26 Dr. Preetham at 7:30N

Dr. Preetham

14/6/26

date copied to app

Patient Name	I.P. No.	Sheet No.	Wards	Weight (kg)
		③	PIW	38kg

REGULAR PRESCRIPTIONS

DRUG : 24TEE-L CIEL				Date	13/6	14/6	15/6	16/6	17/6
				Time					
Dose	Route	Frequency	Start Dt.						
4A	8hrly		13/6/2017						
Name & Signature of the Doctor starting the Drugs:				<p>Dr. Preetham Kumar</p> <p>13/6 AM X 14/6 PM X 15/6 AM X 16/6 AM X 17/6 AM X</p>					
Additional Instructions:				<p>X3 days</p>					
Daily Doctor's Endorsement by a Sign.									

DRUG : TAB PANTOPARAZOLE				Date	14/6	15/6	16/6	17/6
				Time				
Dose	Route	Frequency	Start Dt.					
1 TAB 40mg	PO	12hrly	14/6/2017					
Name & Signature of the Doctor starting the Drugs:				<p>Dr. Preetham Kumar</p> <p>14/6 AM X 15/6 AM X 16/6 AM X 17/6 AM X</p>				
Additional Instructions:				<p>1 TAB = 40mg (1mg/1g/day)</p>				
Daily Doctor's Endorsement by a Sign.								

DRUG : TAB METHYLPREDNISOLONE				Date	15/6	16/6	17/6
				Time			
Dose	Route	Frequency	Start Dt.				
1 TAB	PO	12hrly	15/6/2017				
Name & Signature of the Doctor starting the Drugs:				<p>Dr. Preetham Kumar</p> <p>15/6 AM X 16/6 AM X 17/6 AM X</p>			
Additional Instructions:				<p>By Dr. Preetham Kumar</p> <p>= 1mg/1g/day</p> <p>(1 TABULET = 16mg)</p>			
Daily Doctor's Endorsement by a Sign.							

DRUG : SYP. SUCRALFATE				Date	14/6	15/6	16/6	17/6
				Time				
Dose	Route	Frequency	Start Dt.					
5ml	PO	12th hourly	14/6					
Name & Signature of the Doctor starting the Drugs:				<p>Dr. Vishwaja</p> <p>14/6 AM X 15/6 AM X 16/6 AM X 17/6 AM X</p>				
Additional Instructions:				<p>50mg/1g/day</p> <p>1g/5ml</p>				
Daily Doctor's Endorsement by a Sign.								

Dr. Preetham Kumar

Dr. Preetham Kumar

As per doctor's order

Dr. Vishwaja

VIH-00151395 IP-00060308
 Baby T SRI VISHWAIKA
 29-10-2017 8 Y 7 M 16 D (F)
 Dr. PREETHAM KUMAR

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

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

REGULAR PRESCRIPTIONS

DRUG : REFRESH EYE DROPS				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
EYE																			
Name & Signature of the Doctor starting the Drugs:																			
<i>M. Ar. Jayasree</i>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG : REFRESH EYE DROPS				Date	15/10/16	16/10/16	17/10/16													
				Time	12 AM	6 AM	12 PM	6 PM												
Dose	Route	Frequency	Start Dt.																	
20	EYE DROPS	6 HOURLY	15/10																	
Name & Signature of the Doctor starting the Drugs:																				
<i>M. Ar. Jayasree</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign.																				

DRUG : CETAPHIL LOTION				Date	15/10/16	16/10/16	17/10/16													
				Time	6 AM	12 PM	6 PM													
Dose	Route	Frequency	Start Dt.																	
	LA	12 hourly	15/10/16																	
Name & Signature of the Doctor starting the Drugs:																				
<i>Dr. Preetham Kumar</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign.																				

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

VIH-00151395 IP-00060308
 Baby T SRI VISHWAIKA
 29-10-2017 8 Y 7 M 13 D (F)
 Dr. PREETHAM KUMAR



I.V. FLUIDS CHART

Weight. 38kg Ward. P10

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
13/6/26	9:30 Am	DNS + 5ml KCl	IV	20	Shree	Neels Shree	14/6	Shree	Neels Shree
14/6	8Am	DNS	IV	30	Shree	Neels Shree	16/6	Shree	Neels Shree

Signature
VERIFIED BY: Name



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STATE OF CALIFORNIA

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